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Exploring psychological distress among a sample of pregnant women from a low-income area who self-identify as being distressed

Robyn Singh

3608661

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in the Department of Psychology, University of the Western Cape

Supervisor:

Professor Michelle Andipatin

Co-supervisor:

Dr Rizwana Roomaney

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Abstract

Psychological distress during pregnancy has been a fairly neglected phenomenon and has only recently started emerging as an area of research interest. The existing body of scholarship on distress during pregnancy has largely been conducted from a positivist paradigm, emphasising the identification, incidences and risks. There is thus a dearth of qualitative inquiry into pregnant women's experiences and accounts of distress. In an attempt to address these gaps within the literature, my study explored psychological distress among a group of pregnant women from socio-economically disadvantaged contexts. The specific objectives of my study was to explore how pregnant women conceptualised psychological distress within the context of pregnancy; the feelings or symptoms of psychological distress; what pregnant women perceived as its causes; and the psychosocial needs of pregnant women in relation to antenatal distress. This study was guided by a feminist approach and a feminist standpoint epistemology in particular. This lent itself to exploring the phenomenon while departing from a clinical, decontextualised position which translated into an investigation with pregnant women who subjectively perceived themselves to be distressed. A qualitative methodology was adopted. Ethics clearance to conduct this study was received from the University of the Western Cape's Senate Higher Degrees Committee and Human and Social Sciences Research Ethics Committee. Data was collected at a non-governmental organisation located in Cape Town after written permission was obtained from the chairperson. A convenience sampling strategy was used to recruit participants, while data collection entailed the use of individual semi-structured interviews with ten pregnant women in a face-to-face manner. Data was analysed using inductive thematic analysis. The findings highlighted the multifaceted nature of pregnant women's distress which comprised of an array of cognitive, emotional, physical and behavioural experiences. Pregnant women's experience of distress emerged as rooted

within the social conditions of their lives. Factors such as gender inequality, troublesome interpersonal relationships, inadequate social support and homelessness produced a profound context within which pregnancy occurred which ultimately affected the participants' mental well-being. Based on the participants' accounts, potential strategies for minimising distress are suggested. The findings of this study contributes to the growing body of knowledge related to psychological distress during pregnancy and proposes recommendations for future research.



Declaration

I hereby declare that this thesis, unless stated otherwise in the text, is my original work and that I have not submitted it, or any part thereof, for a degree at another university.

Robyn Singh

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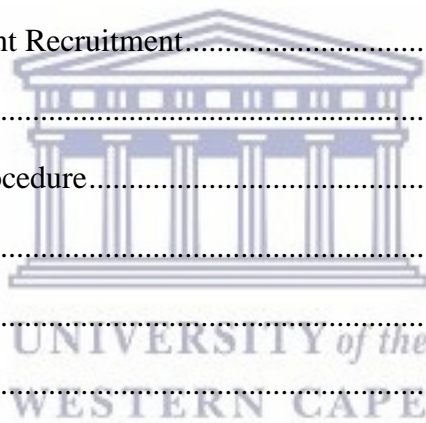
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Chapter One: Introduction

1.1. Background

Pregnancy is commonly viewed as a blissful and positive experience for women (Staneva, Bogossian, Morawska & Witkowski, 2017). A review of the literature, however, indicates that a significant number of women experience psychological distress, defined as depression, anxiety and/or perceived stress, during pregnancy (Staneva, Bogossian & Wittkowski, 2015). Despite occurring in the perinatal (antenatal/postnatal) period in general, some scholars argue that psychological distress is particularly prevalent during the antenatal period or pregnancy (Edwards, Galletly, Semmler-Booth & Dekker, 2008; Evans, Heron, Francomb, Oke & Golding, 2001).

Globally, perinatal psychological distress is a major health issue (Stewart, Umar, Gleadow-Ware, Creed & Bristow, 2015). Bennett, Einarson, Taddio, Koren and Einarson (2004) conducted a systematic review by analysing 21 studies that were published between 1989 and 2002, from mostly high-income settings, such as the United States of America (USA) and urban areas. They provided evidence of the prevalence of psychological distress for each trimester of pregnancy. The articles included in their review employed screening measures commonly used to assess for probable depression during the perinatal period, such as the Edinburgh Postnatal Depression Scale (EPDS) and the Beck Depression Inventory (BDI). Studies using structured clinical interviews were also analysed. Their meta-analysis of the data revealed prevalence rates of psychological distress of 7.4%, 12.8% and 12.0% for each trimester of pregnancy respectively (Bennett et al., 2004).

Notably, research demonstrates that the prevalence rates of psychological distress among pregnant women from low- and middle-income (LAMI) countries are higher than for women in high-income settings (Spedding, 2017). Fisher and colleagues' (2012) systematic

review provided prevalence rates for common mental disorders (CMDs) during the perinatal period in low and LAMI countries. CMDs are considered non-psychotic mental health disorders comprising of depression, anxiety, adjustment and somatic disorders, believed to undermine daily functioning. The 47 studies included in their meta-analysis primarily investigated depression, while 13 articles specifically reported the prevalence rates of antenatal CMDs. Their analysis revealed a 13.43% prevalence rate of antenatal psychological distress as measured by self-report instruments (Fisher et al., 2012). In contrast, Bennett et al. (2004) revealed that women with a low socio-economic status had elevated rates of psychological distress: 47% and 39% were reported for the second and third trimesters of pregnancy respectively, as indicated by self-report scales.

South African research indicates considerably high prevalence estimates of antenatal distress, while some argue that a depressed mood is the most commonly identified psychological difficulty among prenatal women from Africa (Sawyer, Ayers & Smith, 2010). Hartley et al. (2011) investigated the extent of depressive symptoms among 1062 socio-economically deprived pregnant women residing in two peri-urban areas in Cape Town. Pregnant women were screened for depression using the EPDS and a depressed mood was reported by 39% of the women (Hartley et al., 2011). Manikkam and Burns (2012) found a similar prevalence rate of psychological distress (38.5%) among their sample of 387 pregnant women in KwaZulu-Natal, as identified by the EPDS.

The high prevalence rate of psychological distress among pregnant women in South Africa persists. Groves, Kagee, Maman, Moodley and Rouse (2012) administered the Hopkins Symptom Checklist (HSCL-25) to pregnant women residing in Durban. Scores above the cut-off point, although not a clinical diagnosis, represented probable cases of major depression or generalised anxiety disorder. From the 1402 pregnant women who participated in their study,

33.38% reported experiencing emotional distress (Groves et al., 2012). More recently, a study was conducted by Spedding (2017) who administered the World Health Organisation's Self-Report Questionnaire (SRQ-20) to 664 pregnant women in Cape Town. The SRQ-20 is a screening measure that assesses psychological distress, expressed as indicators of various CMDs, such as depression, anxiety and somatoform disorders. The results showed that 38.6% of the pregnant women reported experiencing psychological distress (Spedding, 2017).

The studies reported previously uncover the burden of antenatal psychological distress in LAMI settings, including South Africa. Despite alarmingly high prevalence rates of antenatal psychological distress as well as global and local imperatives to improving maternal health, psychological distress among pregnant women remains consistently overlooked both in research contexts and the public health care system in South Africa (Hartley et al., 2011; Manikkam & Burns, 2012).

Scholars have proposed various explanations for the manifestation of psychological distress. However, the mainstream formulation regarding changes to individuals' mood and psychological distress is rooted in the biomedical paradigm (Lafrance & McKenzie-Mohr, 2013; Staneva et al., 2017). The biomedical view advances a medicalised understanding of distress resulting from a chemical or hormonal imbalance and predetermined risk factors (Lafrance & McKenzie-Mohr, 2013; Staneva et al., 2017). In the context of pregnancy, this theorisation of distress rejects the substantial impact of the psychological and social determinants rooted in the cultural, economic and political context within which pregnancy and motherhood are inextricably situated (Staneva et al., 2017). The absence of a multifaceted understanding leads to a constricted view of pregnant women's experiences and by implication, the cause and the blame become situated *within* pregnant women themselves (Mauthner, 1993; Staneva et al., 2017). In turn, this has important implications in terms of

treatment. Interventions from this model centres on the individual as opposed to the problematic social circumstances within pregnant women's lives which may trigger significant distress (Lafrance & McKenzie-Mohr, 2013).

Thus, it is important to acknowledge the numerous personal, relational and social conditions within which pregnancy occurs as these contexts inevitably shape pregnant women's inner psychological experiences (Slade, Cohen, Sadler, & Miller, 2009). A feminist perspective recognises that motherhood, including pregnancy is entangled within its unique contexts. Kruger (2006) views motherhood as a "culturally mediated experience, an experience that is profoundly shaped by culture and society" (p. 183). Collins (1994) claims that motherhood occurs within historical contexts structured by interconnected configurations of race, class and gender which ultimately shape all women's experience of motherhood. Therefore, in contrast to the biomedical understanding of distress, a feminist explanation accentuates these structures within women's lives and maintain that these may give rise to considerable psychological distress (Lafrance & McKenzie-Mohr, 2013). These structures may include the "socio-political factors that produce deprivation, discrimination, exclusion, oppression and marginalisation" (Marecek & Hare-Mustin, 2004, p. 90).

The high rates of antenatal psychological distress served as an impetus to further explore this phenomenon while departing from a clinical, decontextualised approach. This translated into exploring the contours of distress within the context of pregnancy from women who subjectively perceived themselves to be psychologically distressed (women who have not been diagnosed with a mental health disorder). Research suggests that the sole use of diagnostic labels by scholars and practitioners may overlook the experiences of pregnant women who do not meet the diagnostic criteria for depression but who subjectively perceive themselves as experiencing psychological distress (du Toit, 2017). Moreover, it has been recommended that the term psychological distress be used to encourage a broader

understanding of distress during the perinatal period (Rowe, Fisher & Loh, 2008).

Furthermore, to allow for a contextualised understanding of antenatal psychological distress, this study utilised a feminist standpoint epistemology. Thus, I reject the view of distress as rooted within the individual and acknowledge that it is socially located (Kruger & Lourens, 2016).

1.2.Rationale

The literature advances several arguments which underscore the need for this particular study. These reasons are illuminated in the following section.

There is consensus that most research on psychological distress among pregnant women and mothers are often conducted from a positivist paradigm, emphasising the identification, incidences and risks (du Toit, 2017; Raymond, 2009; Staneva et al., 2017). Consequently, few studies employ a qualitative approach to investigate mental health during the perinatal period (Stewart et al., 2015). More importantly, women's experiences, accounts and perceptions regarding antenatal psychological distress and helpful support measures have been largely neglected (Raymond, 2009; Staneva et al., 2015; Staneva et al., 2017; Tseng, Hsu, Lui & Chen, 2008). Therefore, a qualitative exploration into antenatal psychological distress is timely. This is supported by South African scholars who recommend inquiry into women's meanings and experiences of psychological distress, particularly among women from economically disadvantaged settings (Dukas & Kruger, 2016). An improved understanding of psychological distress may enhance our understanding of the phenomenon which may, in turn, inform and strengthen the support provided to women (Stoppard, 2000).

Moreover, research on antenatal psychological distress is deficient, particularly in South Africa. Research on perinatal mental health has primarily focused on maternal distress during the postnatal period (Howard et al., 2014; Manikkam & Burns, 2012; Rallis,

Skouteris, McCabe & Milgrom, 2014). In contrast, psychological distress within the antenatal period has been fairly neglected and has only recently started emerging as an area of research interest, particularly in LAMI countries, such as South Africa (Fisher et al., 2012; Hartley et al., 2011; Rallis et al., 2014).

The higher rates of psychological distress during pregnancy as opposed to the postnatal period provides further impetus for this study. Edwards and colleagues' (2008) study which measured antenatal and postnatal psychological distress among 154 women from socially and economically disadvantaged areas, reported rates of 30% and 22.6% for the antenatal and postnatal periods respectively. Although there may be conflicting evidence regarding which period carries a higher risk for psychological distress, scholars have argued that antenatal psychological distress may be largely minimised and underreported due to inadequate recognition and evaluation, ultimately causing it to be identified post childbirth and regarded as postnatal psychological distress (Howard et al., 2014). Nevertheless, evidence suggesting higher rates during the antenatal period underscores the importance of understanding psychological distress during pregnancy (Evans et al., 2001) as women's understandings may inform interventions, including preventative strategies which may potentially avert postnatal distress.

Furthermore, the literature indicates that antenatal psychological health is associated with postnatal psychological well-being (Sawyer et al., 2010). Numerous studies have demonstrated that antenatal psychological distress, such as depression strongly predicts postpartum depression (Abdollahi et al., 2014; Edwards et al., 2008; Hussain et al., 2011). The identification and management of distress during pregnancy may potentially minimise the number of women at risk for postnatal depression (Bennett et al., 2004). Moreover, severe distress makes women vulnerable to psychosis, self-injurious and impulsive behaviours

(Manikkam & Burns, 2012), emphasising that research related to antenatal psychological distress, that may potentially inform prevention interventions (Rallis et al., 2014), is of paramount importance.

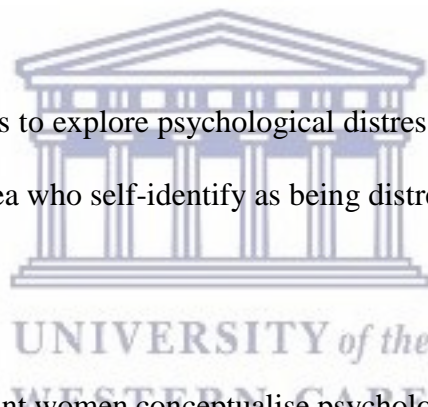
Finally, researchers have recommended that scholarly work be conducted to explore antenatal mental health beyond the biomedical paradigm (Staneva et al., 2017). Likewise, Dukas (2014) called for increased research regarding women's distress using a feminist framework. Acknowledging the social and cultural factors of women's lives may potentially improve insights into distress, thereby facilitating the generation of solutions to the troubles that impact the quality of women's lives (Dukas, 2014).

1.3. Study Aim

The aim of this study is to explore psychological distress among a sample of pregnant women from a low-income area who self-identify as being distressed.

1.4. Objectives

1. To explore how pregnant women conceptualise psychological distress in the context of pregnancy.
2. To explore symptoms of psychological distress among pregnant women.
3. To explore what pregnant women perceive as the causes of their psychological distress during pregnancy.
4. To explore the psychosocial needs of pregnant women who identify themselves as experiencing psychological distress during pregnancy.



1.5. Thesis Outline

This chapter outlined the background, context, rationale, aim and objectives of the present study. Chapter two outlines the epistemological basis of this study, namely feminist standpoint epistemology and will demonstrate the ways in which feminists conceptualise psychological distress. Chapter three presents a review of the literature which commences with an exploration into the context of pregnancy and motherhood, particularly within South Africa and describes the concept of psychological distress in more detail. Moreover, the literature review will unpack pregnant women's understandings of psychological distress, their subjective perceptions of its causes and their psychosocial needs in relation to psychological distress. Chapter four outlines the methodology and processes followed in conducting the study, as informed by the feminist approach. Chapter five presents the findings of the study and my interpretation thereof. Finally, chapter six outlines a summary of the key findings and includes a discussion on the methodological limitations of this study. It further proposes recommendations for future research.



Chapter Two: Theoretical Framework

The aim of this chapter is to explore the epistemological framework within which this study is embedded, namely feminist standpoint epistemology. In addition, this chapter considers the ways in which feminists conceptualise psychological distress and provides a brief critique of the feminist standpoint approach.

2.1. Theoretical Frameworks for Understanding Psychological Distress in Pregnant Women

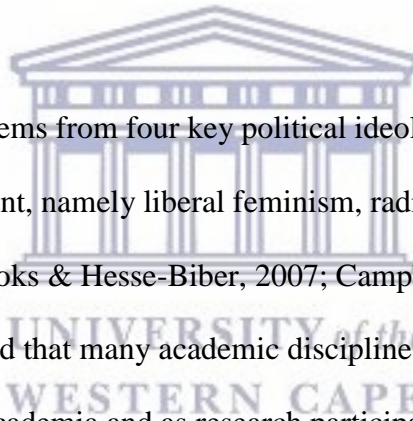
Theoretical accounts regarding depression, and possibly psychological distress, among women include biological, psychological, social and biopsychosocial explanations (Stoppard, 1999). Furthermore, when investigating psychological distress, researchers commonly employ a positivist framework (Stoppard, 1999). Feminist research rejects the assumptions of the positivist paradigm, such as objectivity, rationality and positivist scientific methods (Eagle, Hayes & Sibanda, 2006; Harding, 1991; Stoppard, 1999). Positivism has been critiqued for being dualist; reductionist; androcentric; patriarchal; homogenised; and has also been criticised for ignoring the broader sociocultural conditions of women's lives (Eagle et al., 2006; Stoppard, 1999).

Conversely, feminist approaches depart from traditional, positivist ways of producing knowledge to more holistic, contextual and ethical inquiry (Gersohn, 2004). The research process reflects key feminist principles such as respect, care, teamwork, engagement and political commitment (Campbell & Wasco, 2000). Each level of the research process is emphasised. These include the development of the research questions, the theoretical underpinnings, the methodological processes, through to the reporting of the research results (Brooks & Hesse-Biber, 2007). Furthermore, feminist research foregrounds the contexts of women's lives (Gersohn, 2004). A feminist research approach considers the larger historical,

social, political and cultural elements of women's lives that provide insight into women's experiences (Staneva et al., 2015).

More specifically, feminist standpoint epistemology provides a means through which researchers can compensate for the constraints associated with the positivist approach (Stoppard, 1999). For example, feminist standpoint epistemology emphasises the use of qualitative methodologies to highlight women's voices and experiences (O'Shaughnessy & Krogman, 2012). In this way, a feminist approach, rather than a positivist mode of inquiry, may be more suitable, and possibly more liberating, in terms of understanding psychological distress among pregnant women as women's voices and lived experiences are recognised.

2.2. Feminist Research



Feminist scholarship stems from four key political ideologies of the 1960s and 1970s second wave feminist movement, namely liberal feminism, radical feminism, socialist feminism and womanism (Brooks & Hesse-Biber, 2007; Campbell & Wasco, 2000). Early feminist researchers highlighted that many academic disciplines and prevailing social science research excluded women in academia and as research participants (Brooks & Hesse-Biber, 2007; Harding, 1991). Moreover, they noted that research topics failed to incorporate issues related to women, such as women's interests and experiences (Brooks & Hesse-Biber, 2007; Harding, 1991). Harding (1991) argues that "never was what counts as general social knowledge generated by asking questions from the perspectives of women's lives" (p. 106), emphasising the need for increased women-centred knowledge generation. Additionally, feminists observed that women's views and experiences were inaccurately reflected (Brooks & Hesse-Biber, 2007; Harding, 1991). These biases within academia and mainstream inquiry informed the restructuring of traditional theoretical and methodological approaches.

Moreover, the gaps identified by early feminists encouraged the development of entirely new

modes of research (Brooks & Hesse-Biber, 2007). More specifically, three feminist epistemological or methodological approaches have developed in response to the challenges identified within academia and mainstream research – feminist empiricism, feminist standpoint epistemology and feminist postmodernism (Harding, 1987, 1991). Feminist empiricism represents an approach which moderately challenges the underlying explanations and practices of the philosophy of science (Harding, 1993). In contrast, feminist standpoint theory and feminist postmodernism redefines the way in which research has traditionally been conducted (Campbell & Wasco, 2000).

Despite the different feminist research approaches, there are commonalities. At an epistemological level, feminist research regard women’s lives and experiences as valid and central in terms of knowledge production (Campbell & Wasco, 2000; Eagle et al., 2006). Particularly, from a feminist standpoint perspective, the importance of women’s lives and experiences are regarded as very significant therefore, women are given epistemic authority.

2.3. Feminist Standpoint Epistemology

Feminist standpoint epistemology is grounded in post-positivist critical theory (Campbell & Wasco, 2000). In the same way that critical theory argues that reality is understood from certain “social, political, cultural, economic and gender” (Guba & Lincoln, 1994, p. 10) perspectives, feminist standpoint epistemologies are based on the ontological belief that there is no one real truth (Campbell & Wasco, 2000). Instead, factors such as “class, race, gender and sexual orientation” shape reality (Campbell & Wasco, 2000, p. 781). In the context of this study, I reject the ontological notion of a single objective truth in terms of psychological distress during pregnancy. This will facilitate my commitment to the ways in which each pregnant women’s specific context shapes her reality of psychological distress.

Feminist standpoint epistemology comprises of two key tenets - the situated-knowledge thesis and the thesis of epistemic advantage (Intemann, 2010). A third tenet has also been identified which is methodological in nature and specifies that research which includes or has an impact on less powerful groups, should start with their lives and experiences (Intemann, 2010). The tenet of epistemic advantage refers to the idea that some standpoints, particularly the standpoints of less powerful groups, are epistemically preferred (Harding, 1986; Wylie, 2003). In societies where hierarchies exist such as race, ethnicity, class, gender, sexuality or other factors that shape societal arrangements, those situated at the bottom of these social arrangements provide a basis from which thought can begin (Harding, 1993). The feminist standpoint perspective maintains that dominant perspectives are limiting, damaging and that mainstream thought produce less objective knowledge (Harding, 1993; Ruddick, 1995). Thus, feminist standpoint epistemology argues that less powerful groups may know distinct things or may have a better understanding of some things in comparison to individuals who are socially or politically privileged (Wylie, 2003).

In particular, feminist standpoint epistemology claims that when one begins thought from the lives of women, more complete descriptions may emerge regarding the social world (Harding, 1987, 1991, 1993). Feminist standpoint theorists base the claim that women are privileged in terms of knowledge production on several arguments, such as women's fight against male domination (Harding, 1991). Harding (1993) adds that the circumstances of women's lives are, in many instances, far worse than that of men's and therefore women's lives, in its own right, is a valuable point at which inquiry can begin. Additionally, Ruddick (1995) argues that the work which women are tasked to do, such as mothering, childbirth and housework, are arranged in relation to the satisfaction of others' needs and gratifications; and that this may be incapacitating for women as these activities are often conducted within contexts of control and misuse, by both men and women, creating vast power imbalances.

Several authors state that when conducting inquiry from the perspectives of women, the social structures that dominate and marginalise women, such as patriarchal institutions and ideology, will be revealed (Chesselet, 2005; Gersohn, 2004).

In terms of the situated-knowledge thesis, this refers to the view that social location shapes experience and moulds but also restricts knowledge (Wylie, 2003). It is important to note that although location can refer to geographical location, feminist standpoint theorists emphasise the metaphorical social, cultural and political locations as well as the power relations that these maintain (Crasnow, 2013). These social, cultural and political locations are said to produce different experiences and as a result, different kinds of knowledge (Crasnow, 2013; Intemann, 2010).

By giving pregnant women epistemic authority in terms of the concept of psychological distress within the context of pregnancy, I argue that more complete explanations of psychological distress may be revealed. Moreover, their accounts will expose the power of social, cultural and political factors in shaping their experiences of psychological distress during pregnancy.

2.4. Feminist Standpoint Epistemology and Psychological Distress

Research has traditionally made sense of women's experiences from the perspective of dominant male discourses (Harding 1986, 1987). More specifically, dominant perspectives view depression, and possibly psychological distress, as a disorder or psychopathology that resides within an individual; and adopts a victim-blaming position (Stoppard, 1999). From mainstream perspectives, women are given a choice between either their biological bodies, such as neurotransmitters or hormonal effects; or their lives stripped of gender considerations, such as gender-blind concepts like stressful life events, as explanations for distress. Despite attempting to incorporate social aspects into understanding distress,

mainstream perspectives tend to confine these to negative life events and stressful situations. This view excludes the structural and material factors that play a role in psychological distress, such as income and employment inequalities; inadequate child support; and a lack of inexpensive day-care services to name a few, resulting in a decontextualised and ahistorical understanding of the conditions of women's lives. A feminist perspective emphasises factors which are ignored in mainstream conceptualisations of psychological distress, such as economic and political aspects; and the ways in which these aspects shape and constrain women's lives (Stoppard, 1999). This is especially vital since it is suggested that 'illness', 'health' and possibly, the concept of psychological distress is shaped by social activities, relationships, language, roles, culture and history (Chesselet, 2005).

As a result, Stoppard (1999) claims that research findings conducted from mainstream perspectives lack adequate knowledge for understanding and explaining psychological distress in women and states that if an understanding of psychological distress is sought, inquiry should start from a different point. Inquiry should be grounded in women's lives and experiences because women are marginalised within patriarchal and androcentric contexts (Harding, 1993; Stoppard, 1999). Letherby (2003) reinforces this by stating that reality, as defined by men, provides little meaning for the experiences and lives of women. Patriarchal and androcentric explanations of distress are considered inadequate for understanding women's experiences (Stoppard, 1999).

2.5. Critique

Feminist standpoint epistemology and its situated-knowledge thesis, has been understood as asserting that women hold particular knowledge, different to that of men due to women's gender identity and therefore, has been criticised for perpetuating gender categories (Hekman, 1997; Intemann, 2010; Wylie, 2003). Furthermore, it has been criticised for

claiming that women and marginalised groups have common and universal experiences and concerns, given their disadvantaged positions (Hekman, 1997). The approach, particularly the thesis of epistemic advantage, has been associated with a “thesis of automatic epistemic privilege”, referring to the idea that less powerful individuals, especially women, inevitably have more or have superior insight merely because of their socio-politically marginalised positions (Wylie, 2003, p. 28). Despite these critiques, the nature of this study and its’ aims required an exploration into pregnant women’s subjective accounts of psychological distress and therefore pregnant women were the most suitable participants for addressing the research question.

2.6. Conclusion

In this chapter I argued that a feminist approach in general and a feminist standpoint approach in particular is a more suitable and liberating way of exploring psychological distress among pregnant women. Feminist standpoint epistemology is based on the ontological belief that there is no one real truth as factors such as race, class, gender and other factors intersect to shape reality. I also argued from a standpoint position that women’s lives and experiences are significant and should be explored from their vantage point. Given this position, I argue that women be given epistemic authority and in this way their accounts of distress will provide more complete explanations and will expose the power of social, cultural and political factors in shaping their experiences. The following chapter presents the literature review of this thesis.

Chapter Three: Literature Review

This chapter primarily centres on the literature pertaining to psychological distress within the context of pregnancy. This chapter commences with a discussion on the context of pregnancy and motherhood, particularly within South Africa and proceeds to exploring the meaning of psychological distress. Following this, I unpack the qualitative literature pertaining to pregnant women's understandings of psychological distress, their subjective perceptions of its causes and their accounts of their psychosocial needs in relation to psychological distress.

3.1. The Context of Pregnancy and Motherhood

3.1.1. The transition to motherhood. In attempting to understand women's experiences during pregnancy and the context within which antenatal distress occurs, it became evident that authors situate pregnancy and motherhood within the context of transition and as a developmental life event, involving shifts from a known reality to an unknown and new world, requiring various adjustment processes (Mercer, 2004; Slade et al., 2009). These may include several physical, emotional and relational adjustments (Staneva et al., 2017). Moreover, the adjustments related to the transition to motherhood is viewed as a contributory factor to psychological responses, such as diminished mental well-being and an overall increase in psychological distress (Mwape, McGuinness, Dixey & Johnson, 2012).

Some researchers state that the transition to motherhood involves establishing a maternal identity, understood as a woman "having a sense of being in her role, along with a sense of comfort about her past and future" (Rubin as cited in Mercer, 2004, p. 227). Rubin (as cited in Mercer, 2004) conceptualised maternal identity as an element that becomes integrated into a women's personality through a series of cognitive tasks, commencing during the period of pregnancy through to the postpartum period.

In addition to developing a maternal identity, Rubin (1976) argued that pregnancy involves interconnected psychosocial tasks representative of maternal behaviour. These include seeking safety for herself and the foetus; seeking social acceptance of the foetus by significant others; acquiring the ability to give and exploring the meaning of giving and receiving; as well as identification with the child and the self in relation to the child (DeJoseph, 1993; Rubin, 1976).

Other scholars, such as Mercer (2004), argued that the transition to motherhood commences before conception, continues through pregnancy and the postpartum period; and that becoming a mother is an ongoing process. While largely focusing on the postpartum period, Mercer (2006) argued that the pregnancy-related processes involve making a commitment to the pregnancy; striving for a healthy baby; attachment development; fantasising about motherhood; seeking family acceptance and support; and making physical preparations for the baby.

These processes highlight that pregnancy and becoming a mother requires substantial work (DeJoseph, 1993). It is important to note, however, that the majority of scholarly work regarding the transition process to motherhood has centred on Western experiences and that of middle-class women. The experiences of working-class women and women with varying racial and ethnic backgrounds are thus silenced (DeJoseph, 1993). Research has found that among low-income women, rather than focusing on the adjustment processes involved in the transition to motherhood, women were more concerned with securing food and shelter for their family (Abrams & Curran, 2009).

A pervasive theme in the literature related to pregnancy and motherhood, is the point that women become mothers within the context of influential ideologies of motherhood that have a substantial impact on their experience (Kruger, 2006). The section which follows

describes some of the ideologies within which women experience pregnancy and become mothers.

3.1.2. The ideological bases of motherhood. Glenn (1994) defines ideology as a “conceptual system by which a group makes sense of and thinks about the world” (p. 9). Ideology therefore shapes the way we understand and conceptualise the world and allows us both to see and conceal our experiences (Rothman, 1993). Rothman (1993) asserts that the Western understanding of motherhood is rooted in three ideologies: an ideology of patriarchy, an ideology of technology and an ideology of capitalism.

Within patriarchal contexts and in many societies, women’s realities do not constitute the dominant reality and women’s worldviews are often overridden by that of men’s (Rothman, 1993). Thus, in patriarchal systems, paternity is emphasised as the essential social relationship. In a patriarchal set-up, emphasis is placed on the concept of the ‘seed’. The seed is viewed as the piece of the man, carried in women’s bodies, developing into the man’s image and believed to be the basis of an individual’s being. Women, in contrast, are viewed as merely carrying and nurturing men’s seed as well as producing their children. Therefore, within patriarchal settings, a man’s seed is significantly valued and less emphasis is placed on the nurturance, intimacy and care of children beginning from the moment of conception. Despite shifts in these beliefs, such as the recognition that women and men’s genetic contributions are equal, Rothman (1993) argues that these ideas continue to be the basis of our current beliefs regarding reproduction.

The ideology of technology centres on the medicalisation of pregnancy and on mind-body dualisms wherein physical bodies are viewed as equipment that can be monitored and managed (Rothman, 1993; Taylor, 2011). From this perspective, childbearing women are regarded as unskilled workers, as equipment or vessels carrying valuable genetic matter

(Rothman, 1993). This leads to a division of labour wherein women's bodies are used for the menial physical tasks of childbearing and childrearing. Rationality is valued while the body and physical work is underrated (Rothman, 1993).

Rothman (1993) primarily focuses on the capitalist ideology in terms of ownership. The aim in a capitalist world is the generation of wealth (Taylor, 2011). However, workers do not own the products that they produce. Rothman (1993) applies this logic to the ownership of the foetus and women's bodies. It seems understandable that those who adopt the capitalist ideology view women as owning their bodies and that which is inside of their bodies. However, in a capitalist society, women's rights and powers as mothers are undermined (Glenn, 1994).

The literature highlighted hegemonic ideologies of motherhood, such as the ideology of intensive mothering, identified by Hays (as cited in Lee, Bristow, Faircloth & Macvarish, 2014). Intensive mothering involves lavishing a considerable amount of time, energy and economic resources to a child. It is a child-centred view in that children's needs are prioritised (Hays as cited in Lee et al., 2014). This position is often undertaken by women who internalise these messages and ultimately use it as a benchmark to assess their practices and arrangements (Arendell, 2000; Hays as cited in Lee et al., 2014). Despite hegemonic ideologies of motherhood, alternative ideologies emerged in the literature. Collins (1994) highlighted that caring for a child and the ability to economically provide are important concerns amongst African American mothers. Moreover, she asserted that for Black women, survival, power and identity form the bedrock of mothering practices (Collins, 1994).

3.1.3. Motherhood and South Africa. The study of mothering and motherhood has received increasing attention over the last decade (Arendell, 2000; Kruger, 2006). Presently, the literature on mothering and motherhood has extended from a solitary focus on the impact

of mothering on children, to include the study of mothers' subjective experiences (Kruger, 2006). Despite the increase of scholarship on motherhood, there remains a dearth of literature related to motherhood within the South African context and the subjective experiences of mothers in South Africa (Kruger, 2006). Moreover, despite the recognition that motherhood occurs within interlocking contexts of race, class, gender and culture, there is a paucity of South African studies related to the ways in which mothers are psychologically affected by these structures (Collins, 1994; Kruger, 2006).

South Africa's apartheid history is characterised by political, economic, social and racial divisions (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). Black South African women in particular, were severely disadvantaged, often unemployed due to limited job opportunities and resided in deprived rural areas with inadequate healthcare services, environmental hazards and food insecurity (Chopra, Daviaud, Pattinson, Fonn & Lawn, 2009; Coovadia et al., 2009). Moore (2013) reminds us that during this period, motherhood was influenced by the prevailing social conditions, such as political unrest; apartheid housing and labour policies; movement between urban and rural areas; and relationships to a child's father. Mothering in South Africa is located within this unique, profoundly unequal socio-political history, resulting in varying experiences of motherhood which differ along racial lines (Arnfred, 2003; Walker, 1995).

The South African literature on motherhood highlighted that women from different racial backgrounds rely on different forms of support and engage in diverse approaches to childrearing. Working-class women, for instance, relied on their family for support with childrearing, while middle-class working women often delegated childcare tasks to a domestic worker or helper (Walker, 1995). This also pointed to the ways in which socio-economic standing and culture may shape mothering (du Toit, 2017). Amongst Black

mothers, mothering was understood as a collective, rather than individual experience (Magazwa, 2003). The extended family therefore emerged as imperative amongst mothers from African cultures (Sudarkasa, 2004).

Andipatin (2012) argued that South African society remains entrenched in patriarchal beliefs. This has translated into gendered arrangements in terms of mothering within South Africa (du Toit, 2017). The South African literature revealed that motherhood occurs largely within the frame of gender inequality (Frizelle & Kell, 2010; Jeannes & Shefer, 2004). This mirrors international findings where the gendered expectation of parenting was found to encapsulate women's experiences of pregnancy (Staneva et al., 2017). Women are believed to have a natural propensity to be mothers by virtue of their reproductive make-up and they remain tasked with the sole responsibility of childrearing (Glenn, 1994; Magazwa, 2003; van Doorene, 2009). This perpetuates the notion that motherhood is a fundamental aspect of femininity or being a woman and that a woman only fully becomes a woman when she becomes a mother (Jeannes & Shefer, 2004; Magazwa, 2003; van Doorene, 2009).

In South Africa, race, class, gender, economic position and ideology intersect to shape the experience of motherhood. Gender inequality in terms of mothering may be experienced along with economic deprivation, leaving South African mothers with the sole responsibility of childcare, a lack of support and a struggle for survival, creating a burdensome context within which motherhood occurs.

3.2. Conceptualising Psychological Distress

Psychological distress is a multifaceted term. Although commonly used, it remains ambiguous and lacks a definitive definition (Arvidsdotter, Marklund, Taft & Kylén, 2015; Rallis et al., 2014). Mirowsky and Ross (2003) suggests that psychological distress is an “unpleasant subjective state” which manifests in two main forms, namely, depression and

anxiety (p. 23). Similarly, scholars thus far have defined perinatal psychological distress as the experience of psychological difficulties, such as depression and anxiety during pregnancy and the postnatal period (Matthey, 2010). Scholars such as Rallis and colleagues (2014) recognised that the use of psychological distress as an umbrella term for mainly clinical depression and anxiety is problematic. They questioned whether these two experiences adequately account for the depth of emotional difficulties that some women are confronted with during the transition to motherhood. Resultantly, they conceptualised psychological distress on a continuum and stated that perinatal emotional well-being ranges from ‘excellent adjustment’, expressed in the form of low levels of depression and anxiety symptoms, to ‘poor adjustment’, typified by poor functioning and symptoms reflecting clinical depression and anxiety (Rallis et al., 2014). Similarly, Emmanuel and St John (2010) asserted that psychological distress during pregnancy may vary from common feelings of distress to experiences indicative of a more serious psychological health problem. Rallis and colleagues (2014) further argued that stress be incorporated into understandings of psychological distress. Therefore, in the present study, psychological distress is viewed as symptoms of depression, anxiety and/or perceived stress (Staneva et al., 2015). Evidently, I reject the sole use of clinical depression and anxiety into my understanding of antenatal psychological distress.

Despite the endorsement of a broad definition of psychological distress, this study explored pregnant women’s experiences of psychological distress, by engaging women who self-identified as psychologically distressed by experiencing a low mood and a lack of pleasure or interest in activities. This decision was based on the high prevalence rates of a depressed mood during pregnancy in South Africa (e.g. Hartley et al., 2011). Furthermore, the literature shows that scholars have explored antenatal psychological distress in the form of symptoms of depression, as self-reported by women (Raymond, 2009; Staneva et al.,

2015). As such, the next section provides a brief description on depression and its conceptualisation during the period of pregnancy.

3.2.1. Major depressive disorder and antenatal depression. Key indicators of depression have been delineated by the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) (American Psychiatric Association [APA], 2013). A diagnosis of major depressive disorder (MDD) in the general population and during pregnancy, are usually based on symptoms described by an individual (Bennett et al., 2004). The standard method for classifying an individual as depressed is through the use of a structured clinical interview, conducted by a mental health practitioner.

According to the DSM-5, the main clinical features of a major depressive episode include a low or depressed mood or a loss of pleasure or interest in almost all activities (APA, 2013). The individual must also present with five or more additional symptoms from a list that includes symptoms such as changes in weight or appetite, sleep and psychomotor activities; diminished energy; feelings of worthlessness or guilt; difficulty with concentration or decision-making as well as recurrent thoughts of death, suicidal ideation, attempts or plans. The symptoms must be persistent and must be experienced for most of the day, nearly every day and for a period of at least two consecutive weeks. Moreover, the symptoms must be accompanied by clinically significant distress or impairment in social, occupational or other important areas of functioning (APA, 2013).

In its diagnostic criteria, the DSM-5 includes a specifier namely “with peripartum onset” (APA, 2013). This specifier signifies the onset of mood symptoms either during the course of pregnancy or during the four weeks after delivery. Rochat (2011) succinctly defines antenatal depression as having a major depressive episode, with an onset in the antenatal period.

To reiterate a key observation in the literature, several authors contend that current research on psychological distress among pregnant women are often conducted from a positivist paradigm, emphasising the identification, incidences and risks (du Toit, 2017; Raymond, 2009; Staneva et al., 2017). As a consequence, qualitative studies on antenatal psychological distress are scant, although there are a few notable exceptions. The following section highlights the qualitative research conducted in the area of antenatal psychological distress and underscores pregnant women's subjective perspectives.

3.3. Pregnant Women's Understandings of Psychological Distress

Furber, Garrod, Maloney, Lovell and McGowan (2009) explored the experiences of self-reported psychological distress among 24 pregnant women in England. They found that the pregnant women who self-identified as distressed reported feeling low, crying excessively, panic, anxiety, worry, withdrawal and diminished energy levels (Furber et al., 2009).

Another study, conducted in England, explored depressive symptoms that perinatal women self-identified on internet forums (Jarrett, 2017). The women in the study recounted unsolicited and invasive thoughts, particularly around self-harm and suicide. Their emotional experiences included feelings of guilt and shame as well as feeling anxious, scared, worried and angry. Some of their physical experiences included sleep disturbances, specifically insomnia as well as altered energy levels. In terms of behavioural experiences, they reported crying due to feeling overwhelmed and depleted and also tended to isolate and withdraw themselves from others (Jarrett, 2017).

Edge and Rogers (2005) explored women's views regarding perinatal 'depression' among a sample of Black Caribbean women residing in the United Kingdom (UK). The women articulated challenges in dealing with everyday activities; the presence of atypical

behaviours, such as crying; being scared, worried or short-tempered; and sleep difficulties. Sleep difficulties were viewed as tied to rumination, referring to experiencing difficulties in controlling unsolicited thoughts, such as thoughts of self-harm (Edge & Rogers, 2005).

Blanchard, Hodgson, Gunn, Jesse and White (2009) highlighted that psychologically distressed pregnant women in the United States (US) reported experiences, such as tearfulness, irritability, anger, nervousness, despair as well as fear. Some of the pregnant women explained that their emotions felt intensified during pregnancy and that certain feelings appeared unexpectedly. Resultantly, many pregnant women experienced pregnancy as a time of unhappiness (Blanchard et al., 2009).

Staneva and colleagues (2017) explored psychological distress among Australian pregnant women. The women's narratives revealed uncontrollable worry and persistent negative thoughts. Worry was related to the unborn baby and concerns around their personal capacity to parent. All the women in the study were in heterosexual relationships and anticipated that they would largely be held responsible for physical and emotional care in terms of child-rearing, indicative of traditional gendered ideas of parenting. Inequalities related to parenting emerged as a source of concern for the women in the study (Staneva et al., 2017).

In Africa, women reported that adversities experienced during the perinatal period contributed to a state translated into 'thinking too much', characterised by certain cognitions, emotions and behavioural aspects (Stewart et al., 2015). Some of the signs representative of this experience were unhappiness, worry, not wanting to talk and wanting to be alone.

These studies illustrate that antenatal psychological distress manifests in the form of several cognitive, emotional, physical and behavioural experiences. Furthermore, despite different contexts, there appears to be similarities between the reported experiences of

psychological distress during pregnancy, with many studies highlighting the pervasiveness of crying, anxiety and worry.

3.4. Pregnant Women's Perceived Causes of Psychological Distress

In keeping with a feminist perspective, the literature illustrates that pregnant women locate the causes of distress within their social contexts, as opposed to explaining it in terms of biological or genetic aetiologies (Davies, Schneider, Nyatsanza & Lund, 2016). Pregnant women foregrounded contextual factors, such as social, relational and material adversities as implicated in their mental health difficulties (Franks, Crozier & Penhale, 2017). Multiple adversities, such as troubled interpersonal relationships, limited social support and lack of housing creates substantial anguish during the period of pregnancy. Each of these will be described in the section which follows.

3.4.1. Partner relationship. The literature defines a partner as someone with whom one is either married to, cohabiting with or in a long-term intimate relationship (Blanchard et al., 2009). Although intimate partner violence (IPV) and infidelity was identified by pregnant women as a contributory factor to antenatal psychological distress in both high and lower income settings, relationship conflict with a partner and the baby's father is an important determinant (Franks et al., 2017; Stewart et al., 2015).

Pilkington, Milne, Cairns, Lewis and Whelan (2015) maintains that relationship conflict comprises of disagreements and the expression of verbal aggression toward one another in a relationship. Blanchard et al. (2009) revealed that the experience of conflict, such as disagreements between psychologically distressed pregnant women and their male partners was found to amplify feelings of distress. Additionally, some of the pregnant women attributed distress to spending less time with their partners upon becoming pregnant and their partners' lack of enthusiasm in terms of the pregnancy. This created a situation in which

pregnant women felt concerned about whether the baby's father would participate and be committed to raising the child (Blanchard et al., 2009).

Raymond (2009) conducted a retrospective exploration into nine women's feelings and experiences of antenatal psychological distress. The women who participated in the study resided in a socio-economically disadvantaged setting in the UK. They were from diverse ethnic backgrounds, some of which were identified as Black African, Black Caribbean and White Australian. They subjectively identified themselves as experiencing a low mood or depression during pregnancy. The results of the study revealed that the pregnant women endured continuous conflict with the baby's father. Additionally, they reported that the baby's father failed to acknowledge the pregnancy by denying it; emotionally distanced themselves from the pregnancy; and displayed reluctance to communicate about the pregnancy. The author suggested that the fathers' refusal to acknowledge the pregnancy was perceived by the pregnant women as a form of personal rejection which resulted in distress (Raymond, 2009).

In Ethiopia, Hanlon, Whitley, Wondimagegn, Alem and Prince (2010) revealed that within already hard living conditions, pregnancy may be an inconvenience and may be a source of arguments within the home. Furthermore, among their sample, pregnancy perpetuated negative marital relationships or created negative relationships from those that were good. Pregnancy was viewed as a time of increased demands and with a lack of resources to meet these needs, conflict emerged between the pregnant women and their husbands. Poor or worsening intimate relationships impacted pregnant women's psychological well-being (Hanlon et al., 2010).

As found in Hanlon and colleagues' (2010) research, Sawyer and colleagues' (2011) study in The Gambia revealed that pregnancy placed significant pressure on women's

relationships with their husbands, especially when there was pre-existing relationship challenges. Difficulties within intimate relationships was thus a source of psychological distress for the women in their study (Sawyer et al., 2011).

3.4.2. Social support. Social support is a multifaceted concept and can be derived from four domains (Cohen & Wills, 1985; du Toit, 2017). Despite variations, some scholars only emphasise instrumental, emotional and informational support (Morrison & Bennett, 2009). Emotional support refers to information that an individual is valued and accepted which encourages individuals' sense of self-worth (Cobb, 1976; Cohen & Wills, 1985). Informational support manifests when individuals receive assistance in terms of understanding and managing challenging circumstances (Cohen & Wills, 1985). Finally, instrumental support, also known as material or tangible support, denotes the supply of financial and material assistance as well as other necessary services (Cohen & Wills, 1985).

Evidence suggests that social support is associated with psychological outcomes (Dibaba, Fantahum & Hindin, 2013). Furthermore, scholars have suggested that social support serves a protective function in terms of antenatal psychological distress, especially in contexts of deprivation. The mere existence of a support network within pregnant women's lives enhances the accessibility of social support and resources and thereby contributes to coping (Dibaba et al., 2013). Other scholars not only view social support as a protective factor but regard it as mitigating the effects of psychological distress (Cobb, 1976; Cohen & Wills, 1985; Raymond, 2009).

Although pregnant women identified as psychologically distressed reported receiving social support from family members and friends, unsupportive family and friends play a key role in terms of antenatal psychological distress. In Taiwan, pregnant women indicated that a lack of support from their family or friends rendered them vulnerable to emotional difficulties

(Tseng et al., 2008). In Raymond's (2009) study, physical isolation and emotionally unsupportive family and friends were key to psychological distress during pregnancy. Franks and colleagues (2017) found that pregnant women experienced troubles with seeking and receiving support from their family, especially when their family criticised and judged them. Experiences of isolation and a lack of emotional support from family and friends was reported to be especially strong for women who were refugees (Raymond, 2009). Conversely, when social support from family and friends was present, this manifested as beneficial in terms of pregnant women's mood (Blanchard et al., 2009). Parents, for instance, were important sources of support for pregnant women as they offered experiential insight into childrearing. Stewart and colleagues (2015) found in the African region that practical support from family members was viewed as important, especially when a woman experienced abandonment and mistreatment from a husband.

Despite highlighting the importance of social support from family and friends, the literature demonstrates that a lack of support from pregnant women's partners are central to psychological distress. In an Australian sample of pregnant women who were in heterosexual relationships, pregnant women cited partner involvement and support as central to their psychological well-being (Staneva et al., 2017). Specifically, these pregnant women recounted concerns with their partners' lack of emotional support, including a lack of understanding, listening and opportunity for discussing concerns (Staneva et al., 2017).

In the African context, Stewart and colleagues (2015) identified that the pregnant women in their study foregrounded emotional, economic and practical support from their husbands, while placing less emphasis on support from family and friends in this regard. In particular, the women in their study expressed an expectation that their partners' should provide love, affection and the fulfilment of needs such as food and childbirth preparations.

The fulfilment of these expectations were viewed as indicators of their partners' commitment to the intimate relationship and the baby. Although, it was acknowledged that in this setting, poverty may constrict the women's husbands' ability to provide, it was reported that their husbands often played less of a supportive role during the perinatal period due to deserting their wives. Stewart and colleagues (2015) argued that an unsupportive husband may have implications in this context because the women were found to be dependent on men for material support. Moreover, they argued that if the relationship between a pregnant woman and her husband deteriorated, the advantages of emotional support and shared domestic-related responsibility declined (Stewart et al., 2015). Other research conducted in the African region similarly indicated that inadequate support from a husband during pregnancy was a source of psychological distress (Hanlon et al., 2010; Sawyer et al., 2011).

3.4.3. Homelessness. The term homelessness is a multi-layered phenomenon which manifests differently, depending on the context within which it occurs (Sikich, 2008). Homelessness within lower income settings, such as South Africa, would likely take on a different form, in comparison to homelessness within high-income contexts. In lower income areas, women who are homeless often live in settings, such as temporary shelters or squatter areas. Borrowing from the European Federation of National Organisations working with the Homeless (FEANTSA), Sikich (2008) explains that homelessness refers to (1) rooflessness, which refers to the absence of any form of shelter or rough sleeping; (2) houselessness, which refers to living in an establishment on a short-term basis, such as living in shelters; (3) living in insecure housing, characterised by vulnerability to exclusion through factors such as insecure tenancies, eviction or domestic abuse and; (4) residing in poor housing, such as caravans on illegal camping grounds or in contexts with severe overcrowding.

The literature identifies a number of factors that may lead to homelessness and specifically highlights factors that tend to play a greater role in women's homelessness. These include factors such as domestic/sexual violence by a male partner (Sikich, 2008; Tischler, Rademeyer & Vostanis, 2007). Additionally, partner relationship breakdown, housing difficulties or a lack of affordable housing are implicated in homelessness among women (Cosgrove & Flynn, 2005; Tischler et al., 2007). In comparison to high-income contexts, the experiences of women in low-income settings are often exacerbated by the country's structural arrangements; inadequate rights, for example, legal, property and women's rights in general; and inadequate access to schooling, social services or employment opportunities (Sikich, 2008). Among migrant women, circumstances such as insufficient social support as well as cultural and language barriers may contribute to homelessness.

Tischler et al., (2007) expands and suggested that mothers become homeless and isolated due to estrangement from their family and friends through factors such as family friction and rejection. Furthermore, disintegrated relationships between family and friends preceded homelessness among the mothers in their study. Other factors implicated in homelessness among mothers included moving away from areas to flee from violence or to seek safety (Tischler et al., 2007).

There are limited qualitative studies focused on effect that homelessness has on the mental health of mothers (Tischler et al., 2007). In the USA, Dworsky and Meehan (2012) explored the experiences of 27 homeless adolescent mothers and pregnant youth between the ages of 16 and 20 years. The participants were current or former residents of a shelter that specifically housed pregnant adolescents and young mothers. The mothers in their study experienced significant stress stemming from financial limitations, concerns about how they

would provide for their children's basic needs and concerns about where they would live after having to leave the shelter (Dworsky & Meehan, 2012).

Tischler and colleagues' (2007) explored the experience of homelessness among mothers living in homeless centres in Europe. Their results highlighted that the women perceived the shelter environment as a source of distress. The shelter was described as a highly coercive and institutional environment with multiple rules and regulations contributing to constrained autonomy. The women thus largely reported feelings of powerlessness and loss. Moreover, the mothers perceived feelings of psychological distress, including depressive symptoms and stress as well as severe distress such as suicidal ideation. A lack of social support from the staff members, at times, intensified their feelings of distress. Conversely, some of the women highlighted the value of the support that they received from staff members of the hostels and cited that the centre provided a sense of relief from difficult situations, and thus enhanced their mental well-being. Therefore, in Tischler and colleagues' (2007) study, mothers' viewed the shelter as a source of distress but also a source of physical and psychological support.

Others have indicated that having to move from one place to another affected pregnant women's mental well-being (Franks et al., 2017). Among pregnant women identified as psychologically distressed, being pregnant was found to escalate housing-related troubles due to increasing financial difficulties (Blanchard et al., 2009). In order to cope financially, pregnant women reported accepting accommodation that they would not usually accept, given the contexts of financial strain (Blanchard et al., 2009). Another source of distress perceived by pregnant women relates to being told by their parents to move in with the father of the child, who might still be living with his parents or caregivers (Mwape et al.,

2012). This arrangement places the pregnant woman in an unfamiliar home where she may be misused and controlled in terms of what she may or may not do (Mwape et al., 2012).

3.5. The Psychosocial Needs of Pregnant Women who Self-identify as Psychologically Distressed

Furber and colleagues' (2009) study identified several alleviating factors in relation to psychological distress among pregnant women. These included having a supportive partner, particularly an instrumentally supportive one who assists with household tasks and childcare (Furber et al., 2009). Similarly, several studies highlight the importance of social support (Raymond, 2009; Staneva et al., 2017). Raymond's (2009) study identified the value of practical and emotional support for alleviating psychological distress among pregnant women. Staneva and colleagues (2017) illustrated that pregnant women indicated the need for equal contribution to parenting responsibilities, decision-making, financial and practical arrangements in the household; and emphasised the need to be cared for by their partners. Likewise, in Africa, women have reported the significance of emotional support, such as the expression of kindness and love from their partners (Sawyer et al., 2011). The provision of practical support and increased involvement from the babies' fathers or pregnant women's partners was considered important for women during the perinatal period in the study by Sawyer et al. (2011).

3.6. Conclusion

Although this chapter explored psychological distress within the context of pregnancy, important gaps within the existing literature were highlighted. There is a paucity of qualitative research exploring psychological distress from the perspectives of pregnant women residing in South Africa. Overall, many of the studies presented in this chapter originated either in high-income or lower income contexts, such as Europe, America and the

larger African region. As such, my study aimed to fill the gap within the South African literature on distress during pregnancy. The methodological processes involved in attempting to fill this gap is be presented in the following chapter.

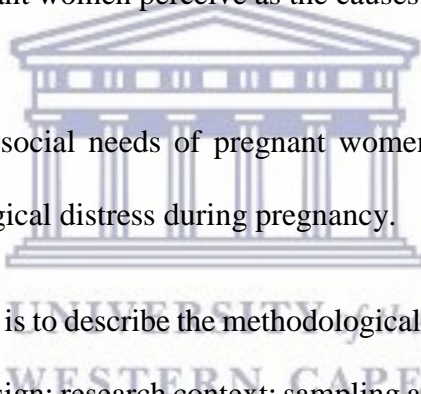


Chapter Four: Methodology

4.1. Introduction

To reiterate the overarching aim of the current study, I sought to explore psychological distress among a group of pregnant women from a low-income area who self-identified as psychologically distressed. This study was specifically guided by the research objectives below:

1. To explore how pregnant women conceptualise psychological distress in the context of pregnancy;
2. To explore symptoms of psychological distress among pregnant women;
3. To explore what pregnant women perceive as the causes of their psychological distress during pregnancy;
4. To explore the psychosocial needs of pregnant women who identify themselves as experiencing psychological distress during pregnancy.



The goal of this chapter is to describe the methodological process of this study. I present a discussion on the research design; research context; sampling and participants; data collection methods and procedures followed; data analysis; reflexivity; trustworthiness and ethics. In discussing the study's methodology, I attempt to highlight how the epistemological position of this study informed various methodological decisions and processes.

4.2. Research Design

As indicated in the introductory chapter of this thesis, women's subjective accounts and perceptions regarding antenatal psychological distress has, to a large extent, been omitted from the literature. Likewise, antenatal psychological distress is a fairly under-researched area. This lent itself to an exploratory qualitative investigation. An exploratory design is particularly

suitable for studies which aim to examine “relatively unknown areas of research” in order to gather new knowledge into phenomena (Durrheim, 2006, p. 44). It allows for an open, flexible and inductive way of conducting a study, harmonious to the qualitative mode of inquiry.

Qualitative research is based on the ontological assumption of multiple and subjective realities (Creswell, 2007). Epistemologically, qualitative researchers aim to reduce the gap between themselves and that being studied (Creswell, 2007). The ontological and epistemological basis facilitates research that is conducted from a naturalistic, holistic and inductive stance in that it attempts to explore a phenomenon as it occurs; as interconnected wholes; and attempts to engender an understanding that is grounded in the data (Durrheim, 2006). The qualitative approach suited this study as its emphasis on differing and subjective realities complements an investigation into psychological distress which is believed to be a deeply subjective experience, manifesting in several ways (Raymond, 2009). The qualitative approach therefore facilitated an in-depth exploration into the experiences of psychological distress, from pregnant women’s perspectives, the meaning that psychological distress has to pregnant women and the contextual factors that shape their distressing experiences (Rochat, Tomlinson, Bärnighausen, Newell & Stein, 2011).

Furthermore, this study is placed within a qualitative feminist standpoint epistemology. Feminist standpoint epistemologies are largely affiliated with the qualitative methodology (O’Shaughnessy & Krogman, 2012). As with qualitative research, feminist research views social reality as complex and multifaceted (Hesse-Biber, 2007). Moreover, like the qualitative approach, a feminist perspective to understanding psychological distress among pregnant women underscores women’s subjective narratives of their experience of distress and the meanings that they attach to it (Stoppard & McMullen, 1997; Mauthner, 1993). The major goals of feminist research are to capture women’s lived experiences in a respectful manner that validates women’s voices as important sources of knowledge; to highlight the ways in which

multiple types of oppression affect the lives of women; and to empower women to share their experiences by providing a respectful, caring and egalitarian research context (Campbell & Wasco, 2000).

4.3. Research Setting

Research was conducted at a non-governmental organisation (NGO) located in a suburb in Cape Town. The NGO is a home and shelter for pregnant women who are in crisis. The crisis can be related to a variety of issues such as, poverty; traumatic experiences; violence or abuse; rejection or desertion; as well as physical and mental health difficulties. The shelter is rooted in Catholicism and is committed to maintaining the right to life in relation to unborn babies. Therefore, the NGO provides alternatives to termination of pregnancy and does so mainly in two ways. Firstly, mothers are provided with hope and opportunities that facilitate their ability to care for babies. Secondly, mothers are provided with assistance and support when the decision of adoption is made. While fostering skills to facilitate renewal in terms of autonomous living, the home fosters recuperation from traumatic experiences and seeks to facilitate women's empowerment, resilience and self-esteem.

In the year 2016, the residents of the NGO were mainly from South Africa (72%), Zimbabwe (8%) and Burundi (5%). The majority of the residents were Black African¹ (56%), Coloured (36%) and White (5%). Referrals to the NGO were usually made from maternity hospitals, clinics, the South African Police Service (SAPS) as well as abortion clinics. The women who occupy the home may be regarded socially and economically burdened as the key reasons for admission was economic deprivation (52%) as well as physical and sexual violence (26%). Other reasons for admissions to the home include women's attempt to prevent abortion

¹ I am cognisant that these racial categories are rooted in the apartheid era and is therefore highly problematic. However, these categories are used here as they continue to hold social meanings and largely influence current power relations and citizen growth in South Africa (du Toit, 2017; Spedding, 2017).

(13%). Furthermore, many of the women entering the home are without employment and economically dependent on partners for support.

The NGO operates within a resource-constrained context, functioning primarily from donor funding and support. Despite financial limitations, women are provided with tangible support and ongoing material support, such as food is given to those who are in need, subsequent to leaving the home. Other forms of support provided to women residing in the home include, accessibility to physical and mental health services, such as antenatal services and weekly on-site counselling services from intern Registered Counsellors as well as social workers, physicians and mental health professionals based at a maternity hospital located close to the home.

4.4. Sampling and Participant Recruitment


Convenience sampling denotes a sampling strategy which relies on available subjects or those that are easily accessible (Berg, 2009). Participant recruitment naturally followed the convenience sampling strategy. The number of pregnant women living in the home at particular time points varied. At times, no new women sought shelter at the home, while on other occasions, more women accessed the home, which resultantly, facilitated participant recruitment.

The inclusion criteria for the study was as follows: pregnant women eligible to sign consent i.e. 18 years and older; pregnant women who subjectively identified themselves as psychologically distressed by experiencing a low or depressed mood or a loss of interest or pleasure in activities for two weeks or more during pregnancy. Thus, this inclusion criteria facilitated a subjective evaluation of mental well-being during pregnancy. Saturation was reached at 10 participants.

4.5. Participants

The participants consisted of 10 pregnant women who resided at the research site at the time of recruitment and data collection activities. I present their biographical information in the table below (Table 1). Pseudonyms are used here and throughout my thesis to uphold anonymity and confidentiality.

Table 1: Participant demographics



Participant pseudonym	Age	Race	Gestational age	Number of children	Relationship status	Education level	Employment status
Victoria	21	Black	38 weeks	None	Single	College	Unemployed
Sally	32	Coloured	35 weeks	Three	Separated	Grade 10	Unemployed
Bianca	19	Coloured	25 weeks	None	Relationship	Grade 12	Unemployed
Tara	40	Coloured	18 weeks	One child, one miscarriage	Single	College	Unemployed
Munati	35	Black	37 weeks	None	Single	Diploma	Unemployed
Nancy	24	Black	Eight months	None	Single	Grade 12	Unemployed
Kumama	40	Black	Five months	Two	Single	Grade 12	Self-employed

Participant pseudonym	Age	Race	Gestational age	Number of children	Relationship status	Education level	Employment status
Bonnie	29	Black	17 weeks	None	Single	College	Employed
Jenny	20	Coloured	18 weeks	None	Single	College	Unemployed
Amanda	20	Black	Seven months	None	Relationship	Completed first year university	Unemployed



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4.6. Data Collection and Procedure

Ethics clearance to conduct this study was received from the University of the Western Cape's (UWCs) Senate Higher Degrees Committee and Human and Social Sciences Research Ethics Committee (please refer to Appendix A). Written permission to conduct this study at the NGO was obtained from the chairperson prior to data collection activities (please see Appendix B).

Recruitment and data collection commenced in June 2016 through to March 2017. I worked closely with the chairperson of the NGO to determine the most suitable recruitment process, one that did not interfere with the daily activities of the pregnant women living in the home. As suggested by the chairperson, I introduced the study at the NGO by having an interactive group session at the home with four pregnant women who were residing there at the time. This group session included a presentation and discussion that centred on the study description, such as its aims and inclusion criteria; feelings associated with psychological distress such as, a low mood and a loss of interest or pleasure in activities; as well as the possible impact and benefits of the research.

I contacted each woman shortly after this group session to ascertain whether they were eligible and interested in participating in the study. Two pregnant women were recruited from this initial group session and were interviewed, one of which required a follow-up interview which could not be secured as the participant was unavailable. Subsequent recruitment was done individually or in groups, depending on the number of new admissions to the home.

A structured questionnaire was used to collect the demographic details of each participant (please see appendix C). Individual semi-structured interviews were conducted in a face-to-face manner using a semi-structured interview schedule (please refer to appendix D). Prior to conducting the first interview, I received training by my supervisors regarding the

semi-structured interview process. I developed the semi-structured interview based on my reading of the literature. As pilot interviews provide an opportunity to examine the effectiveness of an interview schedule, I piloted the interview guide during the first interview and refined it accordingly (Hesse-Biber, 2007). Semi-structured interviews were appropriate for this study for several reasons. O'Shaughnessy and Krogman (2012) revealed that interviews, particularly semi-structured interviews are emphasised in feminist qualitative research and feminist standpoint epistemologies, as it attempts to highlight women's socially-located voices and experiences. Although semi-structured interviews consist of a number of predetermined questions, it permits valuable flexibility and spontaneity (Berg, 2009; Hesse-Biber, 2007). It allowed me freedom to digress from the predefined set of questions, thereby eliciting the participants' subjective accounts and perceptions of psychological distress (Berg, 2009; Hesse-Biber, 2007). The questions in the interview schedule centred on how pregnant women came to the understanding that they were distressed, how they explain their experience of distress, what it felt like to be distressed while pregnant, the feelings or symptoms that they were experiencing, their subjective perceptions of the factors implicated in their experience of distress and what they felt would help them cope with their feelings of distress.

The interviews were conducted on the premises of the NGO, in a private room and was conducted in English, as per the participants' preferences. The interviews lasted approximately 60 to 90 minutes. I envisaged to schedule follow-up interviews with participants in instances where more in-depth information or clarity was required. Follow-up interviews were necessary for a total of two participants where all interview questions were not asked due to already lengthy interviews. Only one participant agreed to a follow-up interview while, as aforementioned, one was unavailable. I provided all participants with light refreshments after their individual interviews.

I sought participants' permission to audio-record the interviews. I transcribed eight interviews, while three interviews were transcribed by Psychology students who signed confidentiality agreements. Transcribers were advised on how to transcribe interviews and all interviews were transcribed verbatim, with the aim of thoroughly capturing the nature of the participants' articulations. Audio-recordings were listened to repeatedly and transcriptions were checked against each audio-recording for accuracy. Moreover, transcriptions were read repeatedly to ensure accuracy and immersion into the data.

4.7. Data Analysis

Data was analysed using thematic analysis which is defined by Braun & Clarke (2006) as a method for “identifying, analysing and reporting patterns (themes) within data” (p. 79). This method of analysis is well-suited for a variety of epistemological positions and has the potential for the identification of latent beliefs, understandings and ideologies that are theorised as shaping participants' accounts, a key aim of feminist standpoint epistemology. Additionally, this approach enables a depiction of participants' subjective accounts, including their meanings, experiences and realities, a central component of this research (Braun & Clarke, 2006). Thematic analysis has been recognised by feminists as an approach to investigating women's distress (Stoppard, 1999). On the basis of these considerations, I deemed thematic analysis an appropriate analytic tool for my research. Braun and Clarke (2006) proposed six phases of thematic analysis. Each of these phases will be discussed in relation to my analysis in the section that follows.

Thematic analysis begins by immersing oneself into one's data. I achieved this by actively engaging with the data through reading and re-reading the transcriptions as well as listening to the corresponding audio-recording. Furthermore, transcribing the majority of the interviews as well as checking the transcriptions for accuracy, contributed to my familiarisation

and comprehension of the data. This initial phase already stimulated some analytic patterns in relation to the data.

Following this phase, I coded the data set which was facilitated by using the qualitative data management programme, Atlas ti version 7.5.16. This programme grouped extracts relevant to each code. Each participants' transcription was coded inductively, an approach to coding which is grounded in the raw data rather than the inquirer's preconceived theoretical conceptions. This approach was suitable as I sought to concentrate on the participants' narratives and depict their subjective accounts of psychological distress within the context of childbearing. I refined codes in several ways. For instance, my supervisors and I reviewed and deliberated each transcription and its related codes; and I refined it accordingly, for example by renaming them or by merging similar codes. This was done in an attempt to ensure that the codes reflected the participants' accounts.

The third step in the analysis involved identifying themes. This was achieved by conceptualising and arranging codes, with its corresponding extracts, into initial overarching themes and sub-themes. The conceptualisation of codes into broader themes and sub-themes was facilitated by constructing a table.

The next step in the analysis was to review and refine each of the initial themes identified. In this step, I reviewed the extracts corresponding with each theme to ensure the congruity of the theme and its extracts. This step resulted in reworking some themes and integrating some sub-themes into others. Additionally, this phase involved considering each theme in relation to the data set as a whole.

I then progressed to defining and naming the themes. This allowed me to understand the nature of each theme and relevant content. Each theme was individually analysed and analysed in relation to the overall narrative of the data and the research question.

The final phase of the analysis comprised of generating the report. The report was produced by presenting each theme; sub-theme; clear and convincing examples of the interview extracts; as well as the final analytical interpretation of each of the themes.

4.8. Reflexivity

Feminist standpoint epistemology proposes that knowledge is derived from women's experiences but also in the subjectivity of the researcher (Scattolon & Stoppard, 1997). Therefore, researchers working from a feminist frame attempt to acknowledge and verbalise the ways in which their personal backgrounds, interests, values and attitudes shape the research process, from conceptualisation to discussion writing (Hesse-Biber, 2007; Scattolon & Stoppard, 1997). This reflexivity, a process of turning inward and critically considering my own reality in relation to the research process is thus emphasised (Hesse-Biber, 2007). Feminist standpoint theorists such as Harding (1993) argued that objectivity is ultimately maximised through the process reflexivity.

As such, I should explain from the outset my concern and interest in exploring psychological distress. During my undergraduate education in Psychology, I was frequently confronted with the argument that women have a higher likelihood of certain mental health difficulties, such as depression and by extension psychological distress. Although I must admit that at the time, I unquestionably accepted these statements, limited emphasis was placed on the ways in which the contexts of women's lives may lead to distress. These early experiences prompted my interest in gaining a deeper understanding of psychological distress, but from women's perspectives. Furthermore, during my Bachelor of Psychology training, my internship as an Intern Registered Counsellor entailed working at a Midwife Obstetrics Unit (MOU) in Cape Town. I provided psychological support to pregnant women in distress, many of whom were experiencing immense economic and interpersonal difficulties. Thus, my

undergraduate education and my internship largely shaped my interest in systematically exploring the experiences of pregnant women; their experiences of distress; the stressors that they implicate in distress; and the measures helpful for managing psychological distress. It is therefore imperative to note that my undergraduate education and my internship influenced the conceptualisation of this study and may have influenced the way in which I approached the process of data analysis.

It is also important for me to indicate that I am a ‘Coloured’ South African woman in her 20s, studying a master’s degree in Research Psychology, with no children and no experience in terms of pregnancy and childrearing. Despite some differences between the participants and I, contextual and experiential similarities emerged as beneficial for this study. For instance, one participant expressed that her willingness to participate in this study was due to our shared experience of being students and that she felt the need to assist me in terms of my academic endeavours. Thus, similarities between the participants and I may have facilitated the establishment of rapport and openness in terms of the participants’ sharing of stories. In turn, this may have equipped me with a better understanding of the participants’ lived experiences.

Feminist researchers are concerned with and cognisant of the nature of their relationships to the participants that are interviewed and the role that they play in terms of power and authority over the data collection processes (Hesse-Biber, 2007). Feminist researchers maintain that unequal power relations inhibit participants’ sharing of their stories. Therefore, reducing hierarchies between the researcher and participants are particularly important in feminist research.

I acknowledge that fulfilling the role of a researcher may have created an unsolicited power imbalance between myself and the participants in my study. I may have been positioned as the ‘expert’ in terms of the research project. However, I actively sought ways of equalling

the plane between myself and the participants. I believe that my participation in certain organisational events or activities facilitated this. For example, the organisation hosted a South African Women's Day event and invited me to attend. I accepted their invitation because I sought to display my deep interest, respect and support for the pregnant women living in the home and in initiatives that were *for* the women. At the event, I participated in a movement exercise with the staff and the pregnant women who were living at the research site at that particular time. In doing so, I needed to forgo my inhibitions and some of that which I learnt as a Psychology student, particularly those aspects involved in the traditional, positivist mode of inquiry, such as maintaining objectivity and a detached relationship with participants. By breaking down my inhibitions, I placed myself in an unfamiliar position but nevertheless embraced this as some of the participants may have similarly been in unknown territory resulting from their participation in this research study.

4.9. Trustworthiness

Both the quantitative and qualitative paradigms are required to demonstrate the credibility of their research (Golafshani, 2003). From the quantitative perspective, concepts such as validity and reliability are employed to do this, while positivists have critiqued the qualitative paradigm on the basis that validity and reliability cannot be similarly established (Golafshani, 2003; Shenton, 2004). Conversely, qualitative researchers posit that conventional criteria for addressing trustworthiness, are inadequate (Golafshani, 2003). Although these concepts have been adopted within the qualitative approach, it has been subject to numerous revisions (Morse, 2018).

In contrast to the quantitative paradigm, naturalistic research is based on a different set of assumptions, produces different forms of knowledge and therefore, require different evaluative criteria for establishing trustworthiness (Lincoln & Guba, 1985). Lincoln and Guba

(1985) reconceptualised quantitative understandings of reliability and validity for use within the qualitative paradigm. Resultantly, these revitalised ideas were subsumed under the broader concept of trustworthiness, comprising of four key strategies for demonstrating trustworthiness. These strategies include credibility, transferability, dependability and confirmability. In the section below, each of these techniques will be discussed in relation to my study.

4.9.1. Credibility. As suggested by Lincoln and Guba (1985), I employed peer debriefing to add to the study's credibility. Peer debriefing involves exposing an inquirer to a peer well-versed in the topic and methodology of the inquiry, who acts as a "devil's advocate" (Lincoln & Guba, 1985, p. 308). I worked closely and frequently with my supervisors to explore various aspects of this research such as biases, understandings, interpretations as well as methodological and ethical processes (Guba & Lincoln, 1985). Although my supervisors confirmed many of my interpretations regarding the data, they often challenged some and provided alternative insight in terms of my analysis and write up of the final report.

Member checks allow researchers to verify aspects such as interpretations and conclusions with the individuals from which the data is derived (Lincoln & Guba, 1985). Shenton (2004) suggests that member checks may occur immediately or after data collection. Due to the nature of the research site, I did not employ member checks with the participants after the completion of all interviews as some of the participants departed the home by then. Despite this, member checks were more immediate and spontaneous in nature - participants were given opportunities to confirm or correct my interpretations as well as clarify and expand their accounts during the course of their interviews. For example, during each participants' interview, I summarised my understandings of their experiences to them. This allowed participants to confirm whether I accurately interpreted their experiences. Moreover, before a follow-up interview with one of the participants, I re-listened to the first interview recording

and noted my understandings of her account. During the follow-up interview, I presented my understanding of her narrative. This enabled her to assess and make explicit the extent of congruity between my understandings of her experience and her reality. Member checks enriched my comprehension of the participants' lived experiences, which is regarded a vital strategy for achieving credibility (Lincoln & Guba, 1985).

4.9.2. Transferability. I employed the concept of 'thick description' in my study. Anney (2014) suggests that thick descriptions involve "elucidating all the research processes, from the data collection, context of the study to the production of the final report" (p.278). Ponterotto (2006) suggests several ways in which researchers can produce thick descriptions. As suggested by Ponterotto (2006), I describe the sample in order to reveal the participants' demographic details. I outline the research setting/site and the methodological processes followed while conducting the study, in order to methodologically contextualise the study's findings. Additionally, I provide ample thick descriptions of the participants' accounts and the contextual factors which informed my interpretations of the participants' experiences. By presenting thick descriptions of psychological distress during pregnancy and the contexts within which this occurred, the reader is able to evaluate whether the transferability of the findings and inferences, to other situations, are possible (Lincoln & Guba, 1985; Shenton, 2004).

4.9.3. Dependability. It has been suggested that dependability logically follows from using strategies that demonstrate credibility (Lincoln & Guba, 1985). By reporting, in detail, the methodological processes followed and the contextual underpinnings of my conclusions, the dependability of my study is strengthened (Shenton, 2004; van der Riet & Durrheim, 2006). This contributes to readers' understanding of the study's methodology and produces the potential for similar future research into psychological distress during pregnancy. It is important to note, however, that different results may be produced from a similar inquiry as

these are shaped by the contexts within which the qualitative inquiry occurs (Shenton, 2004; van der Riet & Durrheim, 2006).

4.9.4. Confirmability. Authors advocate for the use of a reflexive journal to demonstrate the confirmability of qualitative research studies (Lincoln & Guba, 1985). A reflexive journal contains descriptions of events that occurred while engaging in fieldwork activities; explanations that underlie the methodological decisions made; as well as the researcher's personal reflections (Anney, 2014; Lincoln & Guba, 1985; Shenton, 2004). While conducting this study, I kept notes in relation to fieldwork activities as well as my personal values, interests and insights in relation to this study. This allows the reader to consider the degree to which the researcher's biases affected the results and conclusions of the study (Lincoln & Guba, 1985).



4.10. Ethical Considerations

All participants were treated in strict accordance with the ethics principles and guidelines of UWC and the NGO. Potential participants at the NGO were invited to participate and an information sheet (please see Appendix E) was read and explained to them. The information sheet contained all relevant details regarding the nature of the study and the ethics principles that the study maintains such as confidentiality and anonymity. Data collection commenced once participants completely understood the information sheet, felt comfortable proceeding with the interview and completed an informed consent form (please see Appendix F) confirming agreement to voluntarily participate in the study.

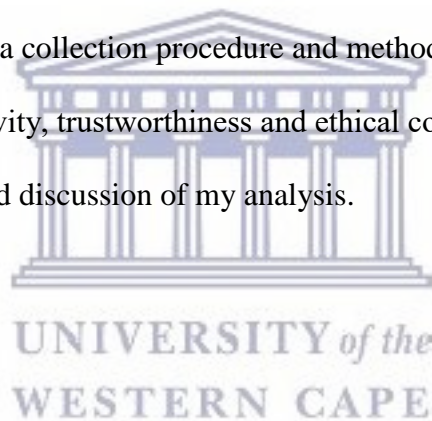
I explained the availability of on-site counselling services to all women attending the recruitment sessions and all participants who participated in interviews. In addition, I provided the women with the contact details of counselling services at a nearby maternity hospital; and

requested them to make use of this should psychological support be necessary. Participants who required a referral were referred to the counsellor at the nearby maternity hospital.

The confidentiality agreement signed by the Psychology students who transcribed three of the interviews stipulates, for example, that the transcriber keep the study's information completely confidential and secure; and that the transcriber destroy all study information after completing their tasks, such as information stored on a computer.

4.11. Conclusion

This chapter outlined the methodology used in this study which was guided by the feminist standpoint epistemology. I outlined the study's research design, setting, the sampling strategy used, participants, data collection procedure and method of analysis. Following this, I discussed the study's reflexivity, trustworthiness and ethical considerations. The next chapter presents the results and discussion of my analysis.



Chapter Five: Results and Discussion

In this chapter, I present key themes which emerged in exploring psychological distress within the context of pregnancy. In keeping with the feminist standpoint epistemology, the themes identified are grounded in the pregnant women's lives and accounts of their experiences during pregnancy which resulted in them self-identifying as distressed.

This chapter integrates the results and discussion. I will present five themes namely, *pregnant women's understandings of psychological distress; rejection of the pregnancy by the baby's father; relationship conflict with the baby's father; inadequate social support; and difficulties related to pregnant women's living environment*. All the themes are presented in light of the overarching aim of this study, its theoretical underpinnings as well as the existing literature in terms of antenatal psychological distress.

5.1. Pregnant Women's Understandings of Psychological Distress

The participants in my study explained psychological distress in terms of the presence of a range of different physical, emotional, cognitive and behavioural experiences. The most common included experiences, such as anger, sadness, crying, feelings of guilt, not wanting to talk to anyone, sleep disturbances, unhappiness, wanting to be alone and especially common were excessive thinking or rumination and worry. These experiences contributed to the participants' understandings of what psychological distress meant and also contributed to them identifying as psychologically distressed.

For example, Munati expressed her view of psychological distress and the feelings that she experienced as follows:

In my own words it means your anxieties, your worry, your sleeplessness, your... Your unhappiness, you know? Your panic attacks, all of that, you know?

Similarly, Amanda expressed her experience and conceptualisation of psychological distress as follows:

Constantly worried about what's gonna happen tomorrow, always have to think about everything... You end up overthinking things, also. That's distress.

The self-reported understandings and experiences of psychological distress, as identified by the pregnant women in my study, confirms that a narrow view regarding women's emotional experiences can be problematic. The participants' accounts were multifaceted. For example, they reported understandings and experiences that align with the symptoms of depression and anxiety but also made reference to experiences of stress. One participant, Bonnie, explained:

... Us as pregnant women or generally pregnant women go through a period of being stressed... Being stressed... Or depressed.

Similarly, Munati understood her experience as stress:

I did know what was going on because it was the stress: What am I going to do? What does tomorrow hold? You know? What, what is it holding for me?

In line with the current study's findings, research has noted similarities between women's accounts of distress and diagnostic criteria for depressive and anxiety disorders (Staneva et al., 2017; Stewart et al., 2015). Importantly, the participants' accounts support Rallis and colleagues' (2014) call to include stress into understandings of psychological distress. Thus, as demonstrated by the participants', viewing psychological distress mainly in terms of clinical depression and anxiety and by implication, pathologising women's emotional experiences restricts our understanding of distress. In turn, pathologising women's emotional experiences would overlook distress as a valid response to the conditions of

women's lives that may understandably produce distress (Dukas & Kruger, 2016), such as socio-economic factors.

The pervasiveness of rumination and worry is illustrated elsewhere among pregnant women in Africa (Stewart et al., 2015). In terms of my study, the fabric of the participants' worries and excessive thoughts centred on post-birth factors, such as uncertainties related to employment, finances and whether they would be able to provide for their baby's needs in terms of food, shelter and clothes, given their hardships and the absence of support. For example, after asking Victoria about the content of her thoughts, she expressed that it comprised of:

Things like when I get the baby maybe I'm still not working and I have to leave this place, how am I gonna survive after that?

Similarly, Munati expressed worry about what would happen following the birth of her child:

Because I remember that time I was in a hospital for five days... I had a bladder infection but the doctor thought I'm having um birth contractions. And I was like, "Oh my God, this cannot happen". Can you imagine that feeling: this cannot happen? If I give birth right now, what will happen? What will this baby wear? Number one. Where will I go with this baby?

Another participant, Nancy, stated that her thoughts centred on:

The fact that I'm pregnant...It's, it's a big issue for me...A really, really big. To raise a child is really expensive...More especially if you didn't plan it...You are not working...So I don't have anything to, to support my child...I don't know; even from here to where.

Hanlon and colleagues (2010) found that within hard living conditions, physical survival was a central feature of pregnant women's experiences, creating a burdensome context within which pregnancy occurred. Collins (1994) concurs and argues that physical survival is a core feature of motherhood, particularly among women from socio-economically disadvantaged settings. Additionally, when mothers focus on the needs of others to maintain these individuals' physical survival, the mother may experience losses such as limitations in terms of her own personal growth (Collins, 1994). Therefore, motherhood may entail an element of psychological survival. The idea that motherhood involves aspects of both physical and psychological survival, emerged in my study. As noted in the participants' accounts, they expressed uncertainties regarding aspects such as where they would live following the birth of the babies and their preparedness for motherhood, such as whether they would find employment to financially provide for their own as well as their children's needs. These uncertainties were considerable sources of distress, as reported by the pregnant women. The experience of worry and rumination are valid reactions to the housing, economic and employment uncertainties that the participants in my study were confronted with during pregnancy.

In line with the feminist approach and the literature review of this thesis, the participants framed their subjective perceptions of the causes of psychological distress within the social conditions of their lives. This translated into highlighting factors such as, economic, employment and housing concerns as well as difficulties in terms of their interpersonal relationships, specifically with their families and the fathers of the babies. The following section expands on some of the key factors that are implicated in the participants' experience of psychological distress.

5.2. Rejection of the Pregnancy by the Baby's Father

While there may be considerable overlap between the themes, *rejection of the pregnancy by the baby's father*, *relationship conflict with the baby's father* and *inadequate support from the baby's father*, these are discussed separately due to its prominence in the participants' narratives.

This theme, *rejection of the pregnancy by the baby's father*, represents the participants' interpretations of the fathers' reaction to the pregnancy. Rejection has been viewed as avoidance in interactions (Segrin, 1993). In the context of this study's findings, the pregnant women stated that once the babies' fathers discovered that they were pregnant, they appeared ambivalent about the pregnancy, failed to acknowledge it and also evaded the situation by avoiding them. This theme was often a point of reference when participants were asked to identify the first time that they noticed the distress. This theme manifested in the form of the two sub-themes, namely, *abandonment of the baby during pregnancy* and *denial of paternity* from the baby's father.

5.2.1. Abandonment of the baby during pregnancy. Many of the participants reported that the fathers abandoned the baby during pregnancy and cited this abandonment as a source of distress. For example, despite being in a physically and emotionally abusive relationship with the father of the baby, one participant, Jenny, was even more distressed when her partner abandoned her and the baby than she was when she experienced abuse. Jenny expressed the following:

Okay. For me my, my distress came from my boyfriend rejecting me and the baby.

Moreover, Tara explained what contributed to her distress:

When I found out I was pregnant and the father rejected me...And, or the baby, rather that that I could see that I, actually I went into a, like a spin from there.

Pregnant women in low-income Sub-Saharan African countries such as The Gambia, Malawi and Zambia attributed distress to a lack of acknowledgement of the pregnancy, abandonment during the perinatal period and refusal of responsibility by the father of the baby (Mwape et al., 2012; Sawyer et al. 2011; Stewart et al., 2015). Furthermore, the literature indicated that motherhood occurs within the context of gender inequality (Frizelle & Kell, 2010; Jeannes & Shefer, 2004; Staneva et al., 2017). The abandonment of the baby during pregnancy may potentially produce a context in which women are primarily responsible for childrearing. In turn, this expectation may be a source of concern for pregnant women. The idea of women's greater involvement in the physical and emotional work related to childrearing has been cited as a source of concern among psychologically distressed pregnant women (Staneva et al., 2017). Ultimately, an arrangement which situates women as the sole caregivers of children, reproduces beliefs that motherhood is an essential aspect of being a woman by virtue of their reproductive capacity.

5.2.2. Denial of paternity. Many participants indicated that the baby's father questioned the paternity of the unborn child and this was often explained as a source of psychological distress. Denial of paternity, however, emerged as complex. Victoria, spoke about others' influencing the baby's father to question the paternity of the child. She expressed:

The friend is telling him that the baby might not even be his when he really knows that the baby is his cause when I fell pregnant I was staying with him and I was only seeing him at the time...Then the friend comes and tells him that I use to be a lot of things behind his back and

then he believed that but he also tells me that he didn't see but people say so he's just listening to he said, she said.

Another participant, Tara, was thrilled at the discovery of her pregnancy, particularly because the baby's father and partner at the time of conception, wanted to have her child. She explained her interest in the use of contraceptives but her partner insisted against this. Despite the father's seeming desire for the pregnancy, discovering that she was pregnant eventually became a negative experience due to his denial of paternity. The term she used to describe her experience from that point included: going into an “*emotional whirlpool*”. She explained the reaction of the baby's father:

When I was, it was about seven weeks when I went to the clinic and I did a pregnancy test there...And they confirmed that I was pregnant, I immediately informed the father and he denied...even having a relationship with me and that it's his baby and all that.

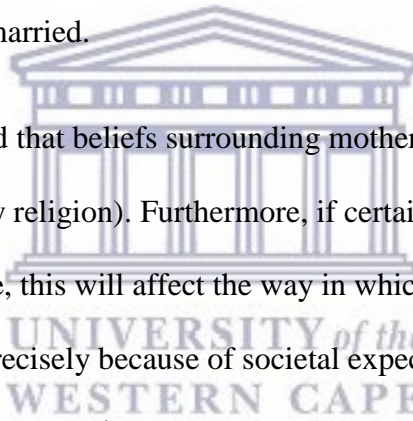
Similarly, Jenny indicated that her pregnancy was planned and that the father's denial of paternity caused psychological distress.

When I, when I told John I was pregnant and he told me it's not his child... That's when I found out I was distressed.

Jenny added that the baby's father told others that he was not the father, causing her to be concerned about the potential repercussions of this, such as others' perception of her. She stated:

He's telling everybody this isn't his child and people are believing him and I'm looking like a, like a slut... Which I'm not.

A number of African studies substantiates the current study's finding that denied paternity is implicated in psychological distress among pregnant women (Mwape et al., 2012; Nduna & Jewkes, 2012). Turney (2011) reported that denied paternity was a stressful experience for women. They reported feelings of shame, anger and hurt. They felt personally and publicly humiliated due to the fathers' refusal of paternity and the associated interrogation of their morality and faithfulness by their family, friends and acquaintances. Turney (2011) explained that within the context of denied paternity, "pregnancy was an embodied manifestation of shame and immorality" (p. 9). Furthermore, powerful deviancy discourses exist which stigmatise women who become mothers outside of marriage and Turney (2011) revealed that the women in the study were perceived as deviant as result of being single, pregnant and unmarried.



Kruger (2006) observed that beliefs surrounding motherhood appears strongly entrenched in morality (usually religion). Furthermore, if certain beliefs about motherhood are dominant in a given culture, this will affect the way in which motherhood is experienced. Kruger (2006) adds that it is precisely because of societal expectations that motherhood is experienced as stressful. Jenny's experience potentially illustrates how deviancy discourses surrounding motherhood shaped her experience. She expressed her concern around being portrayed as promiscuous and this had a serious impact on her mental well-being.

The immense value that some of the participants in my study attached to paternity acknowledgement by the baby's father, may be understood through the work of Rothman (1993). To reiterate, Rothman (1993) asserted that motherhood has its origins in a patriarchal ideology which emphasise the paternal relationship and the significance of men's seed. Rothman (1993) argued that such beliefs continue to be the basis of our current understanding regarding reproduction. Evidently, considerable value was placed on the father's

acknowledgement of paternity, so much so that it shaped the psychological well-being of some of the participants in my study. When the paternal relationship and the seed is underscored, however, the substantial work that women engage in during the transition to motherhood, becomes undervalued (Rothman, 1993).

5.3. Relationship Conflict with the Baby's Father

The third theme derived from the analysis is termed, *relationship conflict with the baby's father*. The theme specifically focuses on the conflict that the participants experienced within their relationships with the babies' fathers. In my analysis, the theme *relationship conflict with the baby's father* is captured in the sub-themes *relationship difficulties* and *relationship breakdown*.

5.3.1. Relationship difficulties. This sub-theme represents the troubles that the participants endured in their relationships with the babies' fathers, some of whom were also their partners at the time of conception. Bianca indicated that continuous arguments with her partner led to her feeling unhappy. She stated:

Like me and my boyfriend also had an argument. We always have arguments. Since I got pregnant, we have every time arguments, the whole time.

Sally, a married participant described her circumstances at the time of the pregnancy and when she noticed feeling psychologically distressed. She experienced a deterioration in her marriage stemming from various sources such as, conflict between her and her mother-in-law, deceitfulness from her husband, her husband's substance use and his abuse toward her. Gender-based violence within her household was all-encompassing in that her husband not only physically, emotionally and psychologically abused her, but her mother too. The conflict in her relationship ultimately led to a separation between her and her husband. Most of the

troubles experienced within her marital relationship and ultimately, some of the factors that contributed toward her psychological distress are captured below:

... I wanted him to stop [drugs] but he refused to stop and our marriage got worse. We constantly have arguments. It affected me and the children... And wherever we were staying, we will always be a problem about stealing, using drugs but the reason why I know all this like is because he did start selling my stuff, start being rude, violent that I had to get a protection order out. He started threatening me and start hitting me. He even start to hitting my mommy that my mommy also had to get an interdict against him.

Experiencing intimate partner relationship difficulties and therefore, a potentially poor relationship quality may contribute toward psychological distress among pregnant women, as perceived by the pregnant women in my study. Several studies are consistent with my findings that psychological distress may be shaped by the quality of a pregnant women's relationship with her partner. Tischler et al. (2007) argued that relationship difficulties "can cause considerable psychological distress" (p. 247). Furthermore, a recent systematic review conducted by Pilkington and colleagues (2015) found that relationship conflict during the antenatal period was found to increase the risk for depression during pregnancy. More recently, Jonsdottir and colleagues (2017) illustrated a relationship between perinatal distress and dissatisfaction with partner relationship during the antenatal period. Others, such as, Franks et al. (2017) found that relationship difficulties, such as IPV, as experienced by Sally, contributed to undermining pregnant women's mental health.

In Africa, Hanlon and colleagues (2010) found that within already hard living conditions, pregnancy was an inconvenience. Increasing demands and a lack of resources to meet these needs resulted in conflict between pregnant women and their husbands. Poor or worsening marital relationships ultimately had a negative impact on the pregnant women's

mental well-being (Hanlon et al., 2010). This finding illustrates how pregnancy and economic strain can contribute to strained interpersonal relationships and in turn, psychological distress.

In South Africa, women attributed distress to the quality of their relationships with their partners, their satisfaction with their relationships and abuse (Dukas, 2014).

Interestingly, Dukas (2014) highlighted that the intimate partner relationship or the relationship with a child's father played a central role in women's descriptions of the causes of their distress. These relationships had a greater impact on women's psychological well-being than their relationships with their family. The depth of the impact of troublesome relationships with the babies' fathers are captured by Jenny who stated that:

...Not even my family rejecting me made me feel like I'm feeling cause I didn't care. But from him! The person who made me pregnant...that just...that was the cherry on the cake for me.

Conversely, researchers have considered the role of a positive relationship between perinatal women and their partners, which has been identified as an important factor in terms of their mental well-being (Stewart et al., 2015). Pilkington and colleagues (2015) found that emotional closeness within romantic relationships, typified by aspects such as a sense of belonging, affection and relationship commitment, during pregnancy was found to reduce the risk for antenatal distress. This is because a positive relationship or romantic connection was identified as a barrier to emotional difficulties and key to reducing psychological distress during pregnancy and encouraging financial security (Alio, Lewis, Scarborough, Harris & Fiscella, 2013; Stewart et al., 2015). The findings related to the value of a positive relationship in terms of pregnant women's mental well-being further emphasises the mental health implications of relationship conflict among pregnant women and their partners. The pregnant women in my study often experienced a lack of a positive relationship with their partners and reported that this contributed to their psychological distress.

5.3.2. Relationship breakdown. Apart from relationship difficulties, some of the participants in my study also experienced a breakdown in their relationships with the baby's father, despite indicating that their relationships were good before the pregnancy.

Furthermore, some mentioned that they discussed their future with the baby's father, such as starting a family. Despite this, the relationship between some of the participants and their partners disintegrated during pregnancy. Jenny described how her partner rejected her after discovering that she was pregnant.

When I got my pregnancy test and I saw I was pregnant and I told him like my whole life just went down the drain. It was like this baby wasn't planned for which it was, but when it happened he just backed out of everything just like that and I, like he, he threw me away. Even though I was living there, he threw me and my baby away.

Similarly, a number of African studies reported that men leave or abandon women during pregnancy and that women described this desertion as a source of distress (Mwape et al., 2012; Sawyer et al., 2011). Stewart et al. (2015) suggested that in some African contexts, an intimate relationship was viewed as facilitative of both financial and emotional well-being and that a deteriorating relationship may minimise emotional support and shared domestic-related responsibility.

5.4. Inadequate Social Support

Participants reported that inadequate social support was a source of distress for them. The most common social support difficulties reported by the pregnant women in this study included inadequate support from the baby's father and their family. Each of these will be discussed below.

5.4.1. Inadequate support from the baby's father. Substantially tied to the rejection of the pregnancy by the baby's father and the relationship conflict is the resultant experience of inadequate support from the baby's father during pregnancy. The participants reported that limited support from the baby's father, or a total lack thereof, contributed to their experience of distress. For example, the accounts of Bonnie demonstrates the lack of support that she experienced:

I noticed the distress when... Um when I saw that the father of the baby cares less about the pregnancy... I was; I thought maybe we are in this together and I then I'm gonna get the support from him. When I saw that he is...you know ... He's not supporting and he's not there for me so I just started having all this...ja...um... depressed emotions [laughs] if I can put it like that.

The literature demonstrated that partner support is central to antenatal psychological distress. For example, Stewart and colleagues (2015) identified that the pregnant women in their study emphasised the importance of emotional, economic and practical support from their partners, while placing less emphasis on support from family and friends. Among, emotionally distressed mothers living in impoverished communities in the Western Cape, women expressed concerns around the lack of emotional support received from their children's fathers (du Toit, 2017). Many of the mothers expressed that they did not want to raise their children alone (du Toit, 2017). Research has shown that the expectation of support is often viewed with powerful ideas of happy families (Choi, Henshaw, Baker & Tree, 2005). Integrated in the pregnant women's narratives were ideas of mothering in contexts of partner support and happy families. Many of the women, however, found themselves in circumstances contradictory to these ideas of motherhood. Therefore, the realisation that they

would not be able to achieve their ideal family may have potentially led to feelings of distress.

Additionally, the study by du Toit (2017) found a lack of financial support among mothers from their children's fathers. Limited financial support from the father of their children meant that motherhood entailed financial strain. Mothers were confronted with the sole responsibility for their babies within the context of financial hardships (du Toit, 2017). Likewise, Lesch and Englebrecht (2011) confirmed that among economically deprived communities in South Africa, women are tasked with the sole responsibility of caring for the family, without receiving any support. Bonnie's account reflects a lack of support from the baby's father and therefore, she bears the sole responsibility for the well-being of the unborn child. Additionally, within the context of her partner leaving her and the unborn child, she potentially faces the sole responsibility of childrearing. Her experience evidently led to what she called 'depressed emotions'. Overall, the relationship that the participants had with the babies' fathers disintegrated during pregnancy which led to inadequate support from them and resulted in feelings of distress.

5.4.2. Inadequate family support. Family support manifested in various forms in my study. Participants either expressed limited family support or a complete lack of family support, often due to rejection by some of their family members subsequent to learning about the pregnancy. Despite the nuances in participants' accounts, when interpreted together, the idea of inadequate family support emerged in the analysis. Inadequate family support was often a source of distress for a number of participants. Victoria's accounts regarding inadequate family support is presented below:

Like... as for the family, most of them they, they used to be there for me most of the times even when I was lacking something I used to go to them and they would help me but when they

found out that I was pregnant, they just started distancing themselves from me... Most of my aunts and uncles they have started being busy all of a sudden. Some of them; they don't take my calls anymore and some, they even changed their numbers. They just; most of them just disappeared on me.

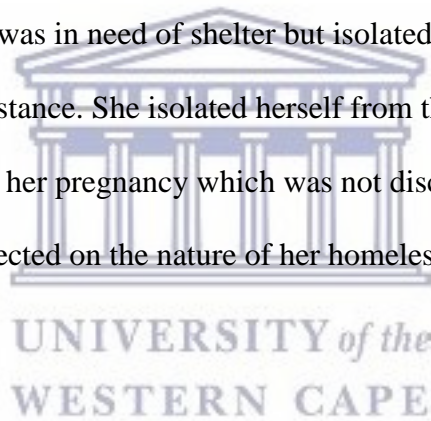
As highlighted in the literature, unsupportive family plays a key role in terms of antenatal psychological distress. Physical isolation and emotionally and practically unsupportive family in particular contributed to psychological distress during pregnancy, especially in situations where women experienced abandonment and mistreatment (Raymond, 2009; Stewart et al., 2015).

Cultural practices in relation to motherhood may potentially account for the psychological impact of unsupportive family. Anfred (2003) suggested that collectivism shapes motherhood in Black communities. In collectivist cultures, individuals are viewed in relation to others and conceptualised as interdependent with others (Mkhize, 2004). In Black communities, mothering is facilitated by co-mothering where mothering is a shared activity (Anfred, 2003). Thus, in African cultures, the extended family forms the context of raising a child (Sudarkasa, 2004). Pregnant women who subscribe to these beliefs may potentially experience distress in contexts of unsupportive family as inadequate family support may limit the provision of emotional and practical support in childcare.

5.5. Difficulties Related to Pregnant Women's Living Environment

Participants commonly experienced difficulties within the environments in which they lived and also experienced various forms of homelessness. The difficulties related to participants' living environments often emerged in the form of the sub-themes, namely *homelessness* and *paternalistic shelter conditions*.

5.5.1. Homelessness. The experience of homelessness was a pervasive matter among the participants in my study. According to the definition of homelessness described in the literature review, the participants reported various forms of homelessness in their lives. Before living in the organisation/research site but during the pregnancy, one participant mentioned that she slept on the street. Others explained the nature of their previous living situations as moving from one place to another. Additionally, some participants reported psychological distress because of experiencing homelessness because of living in a temporary shelter, i.e. the organisation/research site. These difficulties related to the participants' living environments had a substantial impact on their psychological well-being. For example, Nancy was a student and explained that she had to leave university hostels due to protest action. As a result of this, she was in need of shelter but isolated herself from her family and friends and their potential assistance. She isolated herself from the assistance of family and friends as a way of concealing her pregnancy which was not disclosed to any of them at the time of the interview. She reflected on the nature of her homelessness and how it made her feel:



It was horrible. More than that I couldn't believe that I'm the one who's sleeping on the street. I couldn't believe! It was just like a dream! Or I'm reading a story. And the first day I came here [to the shelter], yor I cry the whole night.

Tara, similarly highlighted the psychological distress associated with her experience of homelessness:

I didn't really have a place to stay ... so having a baby and bringing a baby into this whole set up was quite distressing for me.

Munati explained that homelessness manifested after she exhausted alternative sources of accommodation. She found herself having to move from one friend to another and stated the following:

... Everything just fell apart. I lost my relationship and then I didn't have a place to, to live in, you know? I was practically homeless, moving from one friend to the other, you know which was not very normal. You know? And you like, oh God, how is this going to turn out, you know? Cause you can't continue living like this, especially if there's someone on the way. That's not an ideal kind of life you'd like for, for your child. So that's where all the anxieties come in.

Bianca was raised in a Catholic children's home based in Cape Town. She lived there for roughly 14 years because her mother was unable to care for her due to a cancer diagnosis and treatment. Bianca was unable to continue living at the shelter where she was staying because of her pregnancy. She experienced a deep sense of loss and sadness as a result of having to leave the shelter, expressing that her *"heart is still at that place"*. The nature of her shelter-related difficulties becomes clear in the following extract:

When my family found out I was pregnant they said they can't take me ... Then the home [Catholic children's home] said I can't live there any longer ... That is a Catholic place, because they can't look after you and your child. That's not legal by them.

The literature indicates that homelessness may trigger psychological distress among mothers, including anxiety, depression, stress and suicidal thoughts, which became evident in my study (Banyard & Graham-Bermann, 1998; Tischler et al., 2007). However, my findings contradict recent research among low-income South African mothers diagnosed with depression, where a lack of housing was not a central feature of their distress (Kruger & Lourens, 2016). However, poverty, in general was viewed as implicated in psychological

distress (Kruger & Lourens, 2016). Furthermore, my findings contrast the findings of Raymond (2009) who illustrated that despite experiencing difficulties in terms of accommodation, the pregnant women did not highlight this as sources of distress. Raymond (2009) resultantly theorised that the participants may have been desensitised to the social conditions within which they became pregnant, that their hardships may have been normalised, as it did not have a significant impact on their antenatal mental well-being. In comparison, the participants in my study placed significant emphasis on the social hardships that they experienced, such as accommodation difficulties and directly implicated this in psychological distress.

In the interviews, the participants in my study made reference to the “ideal of the all-providing, ever-giving, self-sacrificing mother” (Kruger & Lourens, 2016, p. 137). However, given their hardships, such as their current lack of housing and the threat that they may not be able to provide their babies with shelter, this idealised image of motherhood was threatened and as a result some women felt like failures. A “good” mother has been regarded as one that could provide and care for her child (Kruger & Lourens, 2016). However, the lack of housing threatens the pregnant women’s future ability to provide for their children in the form of shelter. Therefore, the contradictions between participants’ ideas of ideal motherhood and their forecasted difficulties with regard to meeting these ideals within contexts of poverty may have understandably led to their experience of psychological distress.

Psychological distress among homeless pregnant women may also be interpreted in light of stereotypes related to homeless mothers. Wardhaugh (1999) highlighted that homeless women have been constructed as deviant. Homeless mothers have reported feeling stigmatised, degraded and disrespected as a result of their living circumstances and have identified that parenting in the context of being perceived as deviant is a source of stress

(Cosgrove & Flynn, 2005). Stereotypes related to homeless mothers may have contributed to the psychological distress experienced by the pregnant women in my study as many women expressed that being pregnant and living in a shelter is not the “*ideal thing to do when you are pregnant*”.

5.5.2. Paternalistic shelter conditions. This sub-theme was not as common among the participants because many women expressed a deep sense of appreciation related to the fact that the home served to meet their basic needs such as shelter, food and hygiene. Despite this, it is important to point out that three women felt that the conditions within the organisation contributed to their feelings of psychological distress. For instance, they often felt compelled to participate in activities or do chores, despite not feeling up to it. They felt restricted and lacked autonomy in terms of making their own decisions and this negatively affected their psychological well-being. One woman expressed her feelings of unhappiness due to the rigid rules regarding visiting family and friends. She stated that women in the home were only allowed to visit family and friends for one day and were expected to return to the home on that particular day. This ultimately led her to avoid visiting her family in order to prevent her from feeling alone upon her return to the home. This exacerbated her feelings of isolation from her loved ones. Victoria captures her experience of paternalism while living in the shelter:

... I think the reason I've been feeling like that is because of the place I am right now... where I'm staying right now. It's really different from being at home. It's... I don't know what I can say but it's just not the same, you're not really free... And most of the times you get forced to do things you don't wanna do or participate in some activities you don't wanna participate in. It really makes me feel like you don't value my opinion or what I think or my decision about doing things because like they say there's something maybe, ceremony going

on or an activity and then they tell you it's up to you whether you wanna participate or not then when the day comes, they force you to go and do it. Whether you want to or not or you don't want to do it.

Coercive and institutional conditions within shelters for homeless individuals or mothers have been implicated in mothers' feelings of powerlessness and loss (Tischler et al., 2007). Furthermore, rules and regulations within homeless shelters have been found to restrict mothers' autonomy, the experience of which has been compared to that of imprisonment (Tischler et al., 2007). This practice of power within shelters for homeless individuals is perhaps a reflection of the way in which structural or organisational factors shape women's feelings of psychological distress. Living in new and restrictive environments has been implicated in psychological distress among pregnant women in the African region and this emerged in my study (Mwape et al., 2012).

5.6. Conclusion

This study explored psychological distress within the context of pregnancy, from a group of pregnant women living in economically disadvantaged contexts. The results indicated the multifaceted nature of antenatal psychological distress and provided a contextualised account of distress which was grounded in women's lived experiences.

This study revealed that antenatal psychological distress is multifaceted. The findings of this study is in support of recent calls which caution against taking an overly simplistic approach to understanding women's emotional experiences. By commencing this study with a broader view of psychological distress, the nuances in terms of women's understandings and experiences of distress emerged. Antenatal psychological distress was conceptualised and experienced in terms of a broad range of understandings as well as various physical, emotional, cognitive and behavioural experiences.

The analysis revealed that pregnant women's experiences of psychological distress is located socially and structurally. The structural conditions of women's lives such as patriarchal ideology and gender inequality contributed to the participants' experiences of psychological distress. Moreover, contextual factors, such as social, relational and material adversities emerged as implicated in antenatal psychological distress. Multiple adversities, such as troublesome interpersonal relationships, inadequate social support, absent and stressful shelter environments as well as financial and employment concerns produced profound psychological distress among the participants in this study. The analysis revealed that psychological distress is an understandable expression to the structural and social adversities of pregnant women's lives.

The chapter that follows presents a summary of the findings derived from this study. The chapter includes a discussion on the methodological limitations of this study. I conclude with suggestions and recommendations for future research.



Chapter Six: Conclusion and Recommendations

In concluding my thesis, this chapter commences with a summary of the key findings followed by a discussion on the key psychosocial needs of pregnant women, which emerged from this inquiry. I also present the methodological limitations of this study and conclude with some recommendations for future research.

6.1. Summary of Findings

6.1.1. Pregnant women's understandings of psychological distress. This study highlighted that pregnant women who self-identified as psychologically distressed described their distress within the context of an array of physical, emotional, cognitive and behavioural experiences. The participants reported experiences that echo symptoms of depression and anxiety but also made reference to experiencing stress. The multifaceted nature of women's understandings and experiences of psychological distress reinforces arguments that overly narrow beliefs about women's psychological difficulties can be limiting. Generally, researchers have largely conceptualised psychological distress during the perinatal period as the experience of clinical depression and anxiety (Matthey, 2010). Thus, the participants' accounts are in agreement with the recent debate which questions whether "these two affective states alone comprehensively describe the broad range of negative emotional experiences that can occur during the transition to motherhood" (Rallis et al., 2014, p. 68).

6.1.2. Rejection of the pregnancy by the baby's father. Despite some of the fathers' seeming desire for the pregnancy, they denied paternity and abandoned the baby while the participants' were pregnant. These experiences endured by the pregnant women were considerable sources of psychological distress for them. The literature indicated that motherhood occurs within the context of gender inequality (Frizelle & Kell, 2010; Jeannes & Shefer, 2004; Staneva et al., 2017). The abandonment of the baby during pregnancy meant

that women are primarily responsible for the substantial psychosocial work involved in the transition to motherhood and may potentially produce a context in which women raise children with limited support. This perpetuates gender inequality and reinforces those beliefs which regard motherhood as an essential aspect of womanhood by virtue of women's reproductive capacity.

6.1.3. Relationship conflict with the baby's father. The participants in this study reported disruptions within their relationships with the babies' fathers, some of who were their partners at the time of conception. They endured disagreements and arguments, partner substance use and IPV. As a result, the conflict within the participants' relationships with the babies' fathers ultimately led to a poor relationship quality which had an immense effect on their psychological well-being. In addition to difficult relationships, many of the participants' relationships with the babies' fathers broke down during pregnancy. This was an interesting finding as many of the participants reported that their relationships were good before the pregnancy and that they were planning a future with the babies' fathers, which included children.

6.1.4. Inadequate social support. The literature highlighted the value of emotional, practical, and financial support from family members and as well as babies' fathers. The participants in my study, however, reported inadequate support during pregnancy from both their families and the babies' fathers. Poor support from families and the babies' fathers contributed to the psychological distress that the participants were experiencing. Ultimately, the participants experienced pregnancy within a context of substantial isolation.

6.1.5. Difficulties related to pregnant women's living environment. Homelessness was a significant theme in this study. The difficulties that pregnant women experienced in terms of their living environment, prior to living in the home, impacted their mental well-

being during pregnancy. Furthermore, the fact that they were residing in a shelter at the time of the interview caused them significant distress. It appeared that the participants' ideas of a 'good' mother contradicted their reality. A mother was thought of as all-giving and the threat of not being able to provide for their baby's needs in terms of shelter, due to employment and economic adversities, potentially led to feelings of distress.

6.2. The Psychosocial Needs of Pregnant Women

Two key psychosocial needs emerged from the interviews with the participants. Firstly, homelessness was central to the participants' experiences of psychological distress. Many participants' were living with the babies' fathers when discovering that they were pregnant. The subsequent breakdown in their relationships with the babies' fathers ultimately left the women stranded. Several participants therefore expressed the need for increased shelters for pregnant women who have nowhere to go. Furthermore, one participant articulated the need for increased awareness and visibility of shelters that serve pregnant women. These suggestions from the participants in this study may potentially contribute to alleviating psychological distress among socio-economically disadvantaged pregnant women.

Secondly, the participants narrated a strong need for social support. Both the participants' families and babies' fathers were identified as sources of social support that could assist them in terms of psychological distress.

Franks et al. (2017) identified the need to address social, material and support needs to promote pregnant women's psychological well-being. Likewise, Tischler and colleagues (2007) suggested that within the context of homelessness, service providers should attempt to assist homeless mothers in terms of upholding their contact with their support networks.

6.3. Limitations

6.3.1. Methodological limitations. Methodologically, it is important to acknowledge that the participants were a homogenous group by virtue of residing in the same shelter (the research site). This is a limitation of the current study and it evidently had significant implications in terms of the study's results. For example, the participants expressed anguish regarding their lack of a place to live. Therefore, the findings may not be generalisable to pregnant women experiencing psychological distress in other settings. Women with accounts that are different to the participants', but nevertheless valuable, is thus not represented in this thesis. Despite this limitation, however, I do not problematise the limited generalisability as the fundamental intention of this study was to explore pregnant women's subjective accounts and perceptions of psychological distress (du Toit, 2017). Furthermore, as in this study, qualitative inquiry is generally not too concerned about the extrapolation of findings, but are more focused on participants' meanings and lived experiences (Hesse-Biber, 2007).

Despite the above limitation, it was noted that the results of this research parallel several studies which explore antenatal psychological distress. As such, this study contributes to the growing knowledge base regarding psychological distress during the antenatal period, which up until recently, has been largely omitted (Rallis et al., 2014). Moreover, a major strength of this study is its contemporaneous investigation of antenatal psychological distress. Other studies with a similar focus were retrospective in nature, such as the research conducted by Raymond (2009). Such investigations may be constrained by recall bias because of the reliance on women's recall of their experiences prior to birth (Furber et al., 2009).

6.4. Recommendations

Although this study contributes to the literature pertaining to antenatal psychological distress among socially and economically marginalised women, I agree with several authors who state that distress during pregnancy requires further qualitative exploration, especially within South Africa. This would address the limited qualitative research that has been conducted in the area and would facilitate a deeper understanding of psychological distress during pregnancy.

As the participants in my study were understood as a homogenous group, the accounts of pregnant women from other contexts i.e. pregnant women not living in a shelter, are therefore needed. More specifically, antenatal psychological distress should be explored from women who reside in different regions as well as women from various socio-economic, racial and cultural backgrounds (Dukas, 2014). Exploring psychological distress from the perspectives of pregnant women from different settings may potentially highlight additional socio-political factors that are implicated in women's distress. Resultantly, solutions to these additional and potentially debilitating factors may be generated.

Due to the crucial role that the babies' fathers played in terms of the participants' emotional experiences, this study highlights the need for promoting fathers' support during pregnancy. Relatedly, there appears to be a substantial need for inquiry into men's views regarding their involvement and support (or lack thereof) during pregnancy.

The multifaceted nature of distress and the findings that antenatal distress is rooted in the social conditions of women's lives has implications in terms of mental health interventions. In particular, these findings point to the importance of interventions that are grounded in women's lived experiences.

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Appendices

Appendix A: Ethics Clearance Form



OFFICE OF THE DIRECTOR: RESEARCH
RESEARCH AND INNOVATION DIVISION

Private Bag X17, Bellville 7535
South Africa
T: +27 21 959 2988/2948
F: +27 21 959 3170
E: research-ethics@uwc.ac.za
www.uwc.ac.za

09 June 2016

Ms R Singh
Psychology
CHS Faculty

Ethics Reference Number: HS/16/3/39

Project Title: Exploring the psychological distress among a sample of pregnant women from a low-income area who self-identify as being distressed.

Approval Period: 10 MAY 2016 – 10 MAY 2017

I hereby certify that the Humanities and Social Science Research Ethics Committee of the University of the Western Cape approved the methodology and ethics of the above mentioned research project.

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval. Please remember to submit a progress report in good time for annual renewal.

The Committee must be informed of any serious adverse event and/or termination of the study.

A handwritten signature in black ink, appearing to read 'Josias', is written over a faint, large watermark of a sunflower.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

Appendix B: NGO Permission Letter

9 March 2016

APPROVAL TO CONDUCT RESEARCH AT [REDACTED]

Dear Robyn

Approval is herewith granted for you to conduct your research study in respect of antenatal depression at [REDACTED].

The approval is subject to the following conditions:

1. the individual residents at [REDACTED] each consenting to their participation – as there is a natural turnover of residents, the consent can only be obtained closer to the commencement of the study;
2. confidentiality is maintained throughout – specifically residents cannot be identified in any report or publication;
3. personal information obtained or observed during interaction with the resident cannot be divulged unless harm is likely to occur otherwise.
4. The availability of the residents for interviews and sessions will be dependent on their daily programme but [REDACTED] commits to full co-operation with the researcher.

Please contact the undersigned timeously regarding the date of commencement at which time further practical arrangements can be discussed.

With kind regards

[REDACTED]

WESTERN CAPE

Appendix C: Participants' Demographic Details Sheet

Pseudonym:

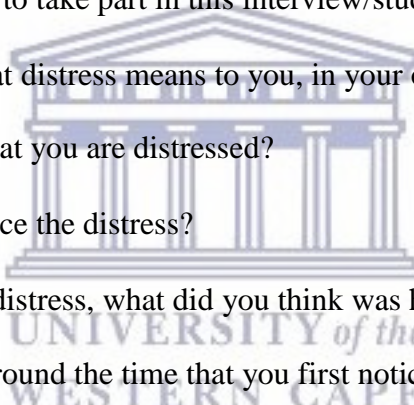
1. Age
2. DOB
3. Race/ethnicity
4. Gestational age
5. Number of children
6. Educational level
7. Employment status
8. Relationship status



Appendix D: Semi-structured Interview Schedule

I am going to ask you a few questions about distress. Please share with me as much or as little as you feel comfortable with. However, the more information that you share with me the better. If there are any questions that make you feel uncomfortable you do not have to answer. If you would like to end this interview at any time you may do so. Everything that you say to me is confidential and only my supervisors and I will have access to this interview. Do you have any questions? Can we start the interview?

This study is about pregnant women and distress. I am interviewing you because you indicated that you are distressed.

- 
- What made you decide to take part in this interview/study?
 - Tell me a bit about what distress means to you, in your own words.
 - 1. What makes you say that you are distressed?
 - When did you first notice the distress?
 - When you noticed the distress, what did you think was happening or going on?
 - 2. What was happening around the time that you first noticed the distress?
 - What was happening in your life?
 - 3. In your own words, can you explain your experience of distress?
 - How does it make you feel?
 - 4. In your own words, can you explain your experience of pregnancy, while being distressed?
 - How she finds pregnancy while being distressed.
 - Is her experience different or similar to how she thought it would be?
 - Is her experience a source of distress?
 - Tell me a bit about how you view pregnancy?

- Tell me a bit about how you view motherhood?
5. Now I'd like to know a bit more about the feelings that you've been having or experiencing. Please tell me more about the feelings that you've been having.
 6. In your own words, can you tell me what you feel is causing your feelings of distress?
 - Can you tell me about any possible events or experiences that led up to you feeling distressed?
 7. Tell me a bit about the father of the baby.
 - Her place/her role/their roles, in terms of the pregnancy or baby.
 8. Can you tell me a bit about how the feelings of distress that you have been experiencing affects your everyday life?
 9. Tell me about how the feelings of distress that you have been experiencing affects the quality of your life?
 10. Tell me a little more about how you plan to take care of the baby.
 11. Can you tell me a bit about the support that you have available in your life?
 12. What do you think will help you cope with your feelings of distress?

Is there anything else related to your distress that we haven't spoken about today, which you'd like to share?

Do you have any questions for me?

Appendix E: Information Sheet



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9593712, Fax: 27 21-9593712

E-mail: robysingh22@gmail.com

INFORMATION SHEET

Project Title: Exploring psychological distress among a sample of pregnant women from a low-income area who self-identify as being distressed.

What is this study about?

This is a research project being conducted by Robyn Singh from the University of the Western Cape. The purpose of this research project is to explore and understand psychological distress among pregnant women who self-identify as being distressed.

What will I be asked to do if I agree to participate?

You will be asked to participate in one interview that will last approximately one hour. A follow-up interview will be scheduled should the need arise. The interviews will take place on the premises, in a private area. The interview focuses on how pregnant women come to understanding that they are distressed; how pregnant women explain their experience of distress; what it feels like to be distressed while pregnant; the symptoms or feelings that pregnant women who identify themselves as distressed are experiencing; what pregnant women feel is causing the distress; and what pregnant women feel will help them cope with their feelings of distress. With your permission, the interview will be audiotaped.

Would my participation in this study be kept confidential?

The researchers undertake to protect your identity and the nature of your contribution. To ensure anonymity, your name will not be used at all. Rather, pseudonyms will be used and only the researcher will know which pseudonym is linked to your name. To ensure confidentiality, data of the interviews will be stored in filing cabinets, under lock and key. I will also make use of password-protected computer files to protect the study's data. Study data will be destroyed after five years.

If we write a report or article about this research project, your identity will be protected. Extracts from the interviews will be read by my supervisors and examiners but no names will be used so there is no way to identify you being part of this study. If you wish, a summary of the results will be made available to you and your information will be protected in this summary.

This research project involves making audiotapes of you to accurately capture your accounts. For transcription purposes, the audiotapes will be heard by reputable external transcribers that adheres to the ethical standards and guidelines of research. The audiotapes will be stored in a locked cabinet and on a password-protected computer. Audio-recordings will be destroyed after five years.

In accordance with legal requirements and/or professional standards, we will disclose to the appropriate individuals and/or authorities information that comes to our attention concerning potential harm to you or others. In this event, we will inform you that we have to break confidentiality to fulfil our legal responsibility to report to the designated authorities.

What are the risks of this research?

There may be some risks from participating in this research study and there may be some risks to the fetus that is currently unforeseeable, as this research study is sensitive in nature and there

is potential for psychological discomfort. However, the aim of this research and the interview process is neither to cause harm to you or your baby; nor psychological discomfort.

All human interactions and talking about the self or others carry some amount of risks. We will nevertheless minimise such risks and act promptly to assist you if you experience any discomfort, psychological or otherwise during the process of your participation in this study. Where necessary, an appropriate referral will be made to a suitable professional for further assistance or intervention.

What are the benefits of this research?

This research is not designed to help you personally, but the results may help the investigator learn more about psychological distress during pregnancy. We hope that, in the future, other people might benefit from this study through improved understanding of psychological distress among pregnant women. Exploring psychological distress during pregnancy will contribute to knowledge regarding mental health during pregnancy and could possibly contribute to informing and developing local interventions for prevention and treatment.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may stop participating at any time. If you decide not to participate in this study or if you stop participating at any time, you will not be penalised or lose any benefits to which you otherwise qualify. If there is any question that you do not feel comfortable answering, you have a right to refuse to answer it.

What if I have questions?

This research is being conducted by Robyn Singh, Department of Psychology, at the University of the Western Cape. If you have any questions about the research study itself, please contact Robyn Singh at: 0744576663; Email: robysingh22@gmail.com

Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Head of Psychology Department and research supervisor:

Professor Michelle Andipatin

Tel: 021 959 2283/2454

Email: mandipatin@uwc.ac.za

Co-supervisor:

Dr Rizwana Roomaney

Tel: 021 808 3973

Email: rizwanaroomaney@sun.ac.za



Dean of the Faculty of Community and Health Sciences:

Prof José Frantz

University of the Western Cape

Private Bag X17

Bellville 7535

chs-deansoffice@uwc.ac.za

This research has been approved by the University of the Western Cape's Senate Higher Degrees Committee and Human and Social Sciences Research Ethics Committee.

Appendix F: Informed Consent Form



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535, South Africa

Tel: +27 21-9593712, Fax: 27 21-9593712

E-mail: robysingh22@gmail.com

Project Title: Exploring psychological distress among a sample of pregnant women from a low-income area who self-identify as being distressed.

The study has been described to me in language that I understand. My questions about the study have been answered. I understand what my participation will involve and I agree to participate of my own choice and free will. I understand that my identity will not be disclosed to anyone.

I understand that I may withdraw from the study at any time without giving a reason and without fear of negative consequences or loss of benefits.

This research project involves making audiotapes of you to accurately capture your accounts. For transcription purposes, the audiotapes will be heard by reputable external transcribers that adheres to the ethical standards and guidelines of research. The audiotapes will be stored in a locked cabinet and on a password-protected computer. Audio-recordings will be destroyed after five years

___ I agree to be audiotaped during my participation in this study.

___ I do not agree to be audiotaped during my participation in this study.

Participant's name.....

Participant's signature.....

Date.....