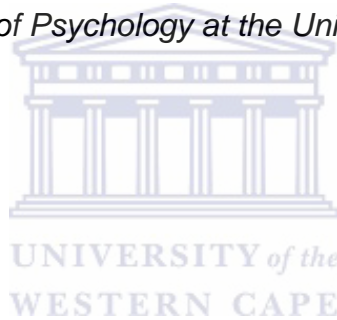


Experiences and perceptions of mothers recovering from depression with regard to the impact of depression on family roles and coping skills.

AYANDA XABAKASHE

A mini-thesis submitted in partial fulfillment of the requirements for the degree of M.Psych in the Department of Psychology at the University of the Western Cape



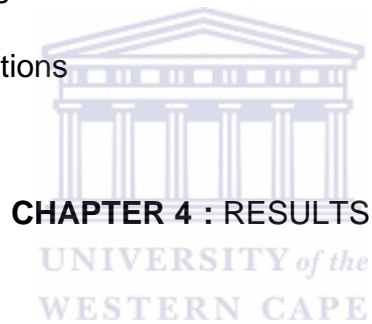
SUPERVISOR: Prof.K.Mwaba

September 2007

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ABSTRACT

The aim of the present study was to explore the subjective experiences and perceptions of mothers diagnosed with depression. The study investigated mothers' understandings of the extent to which their illness had impacted on their appraisal of their mothering and associated roles within the family. Furthermore, it investigated mothers' coping skills with regard to their illness. The study was qualitative in nature, utilising semi-structured interviews with six patients who had been diagnosed with depression. Participants were drawn from a Hospital (Outpatient psychiatry clinic) in Delft, Cape Town. Their age range was between 24 and 35 years old. All participants had one child that was two years or older. The results indicated that participants viewed themselves and their relationships in negative ways. They demonstrated different coping mechanisms in the study. All of them said that they relied mostly on divine inspiration and had a positive perspective on life. All the participants said that they benefited immensely from the support received from friends and neighbours. Two participants were abusing drugs. All of the participants were unemployed at the time of the interview. The researcher therefore could not explore the impact of the participants' depression on their work roles. Fifty percent of the participants said that they had different sources of finance. They were either self employed or supported by their partners. The financial position of all participants differed from

person to person. It is then advisable that future researcher would have to obtain participants who were employed or in a similar financial bracket. It is advisable that a female researcher should conduct a similar study in the future. My gender could have had a negative impact in the study. The fact that I am a male could have had a negative impact on the participants. If all the participants were screened to ascertain whether all of them had partners, the research could have been better. That would allow the researcher to interview only participants who had partners in their lives. In my study, only two participants had partners in their lives during their depression.



KEYWORDS: Depression, social support, mothers, perceptions, experiences, family, coping, cohesion, impact, parental discord, children.

DECLARATION

I Ayanda Xabakashe of the Faculty of Community and Health Sciences in the University of the Western Cape sincerely declare that the copy of the research project submitted in 2007 is the original work and the true result of my efforts.

Signed: Ayanda Xabakashe



Dated: 2007

ACKNOWLEDGEMENTS

First and foremost I would like to give thanks and praise to the creator of mankind God for providing strength and wisdom to persevere. I would also like to thank everyone that has supported me through the difficult times during my early days at the university.

This thesis is dedicated to my mother Nonzwakazi who was diagnosed with major depression in 1992. Since that day, it has been my quest to investigate more about the illness and its impact on the offspring of depressed mothers. I would also like to thank my uncle, Mhleli Xabakashe and his family for always being there for me. Thank you for everything, and I love you. I gratefully acknowledge the six mothers who shared their painful experiences with me. This project could not have materialised without your input and willingness to open up your heart to me. Thank you so much for taking that risk with me; I understand that it was not easy.

Last but not least, I would like to thank my supervisor Prof. K. Mwaba for believing in my potential and encouragement. I do not think I would have been this far if it was not for you. Prof. C. Malcolm, thank you so much for the skills that you offered me during my darkest days. No one compares to you, thanks “Coach”. To Mr. M. Adam, you have been there for me since my first year and you are still here for me, much love to you always.

CHAPTER 1:

1.1 INTRODUCTION

Life is full of emotional highs and lows and it is not unusual to feel that way.

However, when the low periods are long lasting or impair one's ability to function, it may be due to suffering from a severe common disorder called depression.

Johnson and Indivink (1997) state that depression pessimistically affects how individuals feel, determining their moods, actions and thinking processes. West (1992) describes depression as a persistent and sustained feeling that the self is worthless, the world meaningless and the future hopeless.

According to a study by McLean (2002), clinical depression is globally ranked as the most costly illness, together with heart disease, cancer and AIDS. In addition, it is the leading cause of disability worldwide, with chronic poverty and social adversity as key risk factors according to the Committee on Nervous Disorders in Developing Countries (Institute of Medicine Board on Global Health, 2001).

Patel, Araya, Lewis and Swartz (2001) state that it is well established that social factors, including poverty, place people at increased risk of depression and anxiety. Johnson and Indvink (1997) estimate that by the year 2020, globally depression will be the leading cause of disability. Being disabled refers to anyone who suffers from a condition that superficially limits one's functioning.

Females are more likely to seek treatment for depression thus statistics for this grouping appears higher in most research (Reynolds, 2000). This reason has resulted in the researcher having more interest in understanding more about females in comparison to males.

Women experience depression at 1.5 to 3 times the rate of men (Kessler, *et al.*, 1994). The peak age of occurrence is 18 to 29 years; with a high prevalence rate continuing through 44 years of age (Wittchen, Knauper, & Kessler, 1994). These findings add up to considerable concern about young women in some of their most formative years — years of establishing independent identities, intimate relationships, careers, and child-bearing. These years of emerging adulthood are laden with challenges and stressors, and they mark a period during which young women in effect create the environments with which they will interact for years to come. On the other hand, Brown and Moran (1997) state that males are more likely to use alcohol or illegal drugs for self-medication in an attempt to cope with their depression.

Many mothers face a variety of stressors such as responsibilities in the home, career and caring for children and aging parents (Sheppar, 1994). For that reason, being a mother carries an extra burden because mothers have to fulfill multiple roles at work, home, and in the community. According to theorists like

Winnicott, Klein and Mahler (Maddi, 1996), mothers play a nurturing role to children and therefore are crucial in their children's healthy upbringing (Maddi, 1996). Though times are changing, fathers share the responsibility of nurturing children as well, but this study will focus only on the mother's role. In summary this study sought the understanding of mothers' personal experiences and perceptions about depression, which likely challenged their ability to fulfill social roles. A study of this nature is important, as few studies in South Africa have sought to understand how Colored mothers perceive and experience depression.

1.2 AIMS AND OBJECTIVES

To understand experiences and perceptions of mothers recovering from depression with regard to;

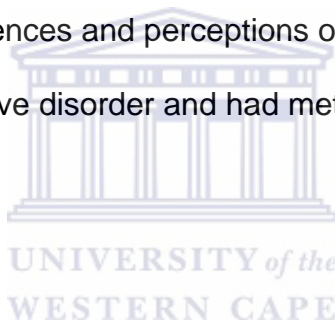
- The impact of depression on family roles.
- Their coping skills in the process of recovery from depression.

1.3 RATIONALE

To date, minimal research has been conducted with regard to the subjective experiences and perceptions of depressed Colored mothers in South Africa. (Mental Health Information Center, 2003). Research conducted thus far has mainly been longitudinal in nature Weissman, Warner, Wickramaratne, Moreau, & Olfson, 1997) and the focus of the research has been on peripheral factors that

cause depression (Beardslee, Versage & Gladstone, 1998), or has concentrated on the impact of depression on family members (Yoshikawa, 1994).

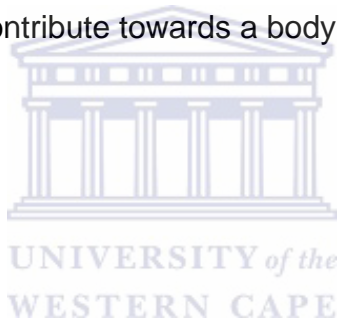
Few local studies have focused exclusively on the subjective experiences and perceptions of depressed mothers. Other studies have focused on post-natal depression and the impact of the illness on the mother – child dyad. As a result the present study was exploratory in nature and wanted to fill the literature gap that exists in relation to communities in South Africa. For that reason the present study focused on the experiences and perceptions of Colored mothers who have histories of a major depressive disorder and had met the criteria for major depression (DSM-IV-TR).



The following chapter explores mother's experiences and perceptions with regard to depression. Chapter 3 shows steps that have been undertaken to collect and analyse data that had been gathered. The research design and methodology utilised are described within this chapter. Chapter 4 comprises of the research findings and the analysis of the results. Chapter 5 constitutes the discussion of the study, the direction for future research and conclusions.

1.4 SIGNIFICANCE OF THE STUDY

As highlighted above, there are gaps in literature with regard to the understanding of mothers' experiences and perceptions of depression. A study, such as this one, which has as its aim a better understanding of the subjective experiences and perceptions of mothers with depression histories, was not only important but also imperative in the face of social urgency to challenge depression globally and locally. I believed that this research could only make a contribution towards the understanding of mother's subjective experiences and perceptions, but may also contribute towards a body of knowledge in the health profession.



CHAPTER 2:

LITERATURE REVIEW

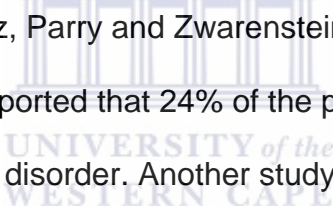
2.1 Introduction

Clinical depression is treatable. Yet, most people with depression do not seek professional help and research conducted in the US and South Africa indicates that the rate of undetected depression is high (Sheppard, 1994). Corrie (2002), states that about one hundred million people worldwide are depressed at any one time. South Africa, is in addition, regarded as one of the highly stressed societies in the world and is described as having many social problems that can lead to high levels of stress and depression (PSYSSA newsletter, 1997).

Cox, Murray and Chapman (1993) indicate that depression is a major cause of morbidity in mothers and is estimated to affect between 10 and 30 percent of mothers of young children. Other readings state that the effects of maternal depression, both during pregnancy and during a child's early development, have been intensively investigated within the last 20 years. There are some research developments which indicate that offspring of depressed mothers show significant developmental differences when compared to children of non-depressed mothers. In essence, maternal depression has become a significant

construct for scholars seeking to comprehend its contribution to the route of child development (Weissman, Warner, Wickramaratne, Moreau, D. & Olfson, 1997).

It has been shown by Brooks-Gunn, Berlin, and Fuligni (2000), that maternal depression signifies a prominent developmental concern. Their study states that depression disturbs the mother–child relationships during the first years of life, a developmental period which has become increasingly accepted as laying the foundation for the future development of self-regulatory, cognitive, and social competencies.



In a study by Rumble, Swartz, Parry and Zwarenstein (1996), conducted in the rural Western Cape it was reported that 24% of the population were either depressed or had an anxiety disorder. Another study by Bhagwanjee, Parekh, Paruk, Petersen, and Subedar (1998), in KwaZulu-Natal, reports that 24% of the population had depression and /or Generalized Anxiety Disorder (GAD). However these studies did not to indicate the prevalence of depression in mothers.

To date, the exact causes of depression are still not known, despite continuous research the world over (Corrie, 2002). However, the causes seem to include some or all of the following factors (these may add in differing degrees from person to person with a lowered mood):

- Childhood events-including poor parenting
- Genetic factors
- Current psycho-social problems
- Little apparent support from family and friends (Corrie, 2002).

2.2 TYPES OF DEPRESSIVE ILLNESS

There are two main types of depressive illness, reactive and endogenous;

- **REACTIVE DEPRESSION**

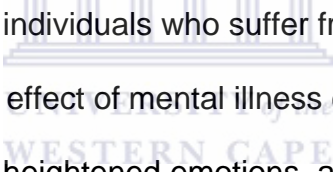
According to Shreeve (1984), this type of depression is said to be related to the events in the patient's past. It is reported to be four times the more common of the two and more often than not, is nearly always accompanied by anxiety.

Shreeve (1984) adds that it affects more women than men. Mourning is one example of reactive depression. Sanders (1984) states that there is a type of sleep disorder which - when present - assists in distinguishing reactive depression from other forms of the illness. It is said that an individual suffering from reactive depression has a chance of experiencing primary insomnia, but once asleep, can expect to sleep right through. Alternatively, someone suffering from endogenous depression, after getting to bed, the individual is likely to fall asleep, and then experiences secondary insomnia.

- ENDOGENOUS DEPRESSION

Shreeve (1984) states that this type of a depressive illness occurs for no apparent reason to the victim, and cannot be related to any particular “trigger” event within the recent experience or current lifestyle. Sanders (1984) states that this is the result of years of unresolved stress, with its origin long buried in the unconscious. Symptoms are usually more physical, and more severe, than in reactive depression.

2.3 FAMILIES AND DEPRESSION



Depression impacts not only individuals who suffer from the illness, but their family members as well. The effect of mental illness on family life can include modifications of family roles, heightened emotions, and disruptions of usual routines (Anthony, 1970). In numerous outpatient studies, families of depressed mothers are described as less cohesive, less secure, less communicative, less warm and less supportive, more tense, antagonistic, and critical (Kaslow, Deering & Racusin, 1994). A study by Downey and Coyne, (1990) reports that these families tend to be characterised by poorer parenting, greater marital discord and higher rates of divorce than the families of nondepressed parents. Corrie (2002), adds that the attendant stresses, strains and sheer hard work of bringing up young children which is involved in motherhood, can often increase the risk of depression. In a UCLA offspring study it is reported that there are high

levels of marital discord and divorce among couples where there is a depressed mother (Hammen, 1999; Romito, Saurel-Cubizolles & Lelong, 1999; Gotlib & Beach, 1995).

According to a study by Murray and Lopez (1996), some mothers feel humiliated talking about their problem and would rather suffer in silence. In a study by Sheppard (1994), it is reported that women with close and confiding relationships with their partners, were four times less likely to develop depression under stress. According to Appleby, Warner, Whitton and Faragher (1997), the availability of a husband or spouse contributes positively to the mother's distress of the illness.



2.4 DEPRESSION AND CHILDREN

Depression profoundly affects a person's social and interpersonal functioning, and it is common among mothers with young children (Murray, Hipwell, Hooper, Stein & Cooper, 1996). Goodman, Brogan, Lynch and Fielding (1993), indicate that having a depressed mother is the strongest predictor of risk for depression in adolescents. Ashman and Dawson (2002), add that depression may manifest among mothers in the form of less sensitive and responsive parenting, as well as leading to higher maternal negativity, impaired communication, and diminished emotional involvement. This study further increased the challenge in the present

study to investigate whether the mother is aware that she is affecting her child with her illness.

Parents with psychosocial problems often perceive their children negatively and may report more child behavioral problems in their children than nondepressed parents (Boyle & Pickles, 1997). An example of such a psychosocial problem is an individual's financial status. Lovejoy, Graczyk, O'Hare, & Neuman (2000), reveal that the effects of maternal depression on child development seem to be amplified for mothers and children who live under economically disadvantaged circumstances. They say that it is probably due to a number of factors that make parenting more difficult such as single parenthood, lower levels of social support, and inability to afford services that might alleviate stress. Orr and James (1984), state that poverty seems to increase the sheer percentages of mothers who are affected by depressive symptomology. It has also been documented by Shonkoff and Phillips (2000) that children born into poverty have more medical illnesses and are at greater risk of having temperaments which promote difficulties which affect regulation.

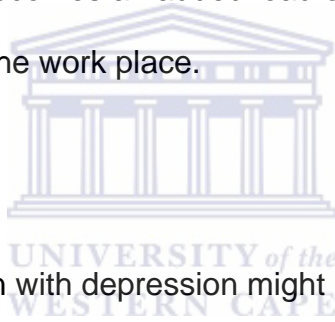
Depressed mothers (those with low anxiety and low anger), mothers with the comorbid states of anxiety or anger showed less positive affective behaviour (less smiling, exaggerated faces and game playing). In turn these impaired parenting qualities place children at risk for a multitude of developmental problems.

According to Ashman and Dawson (2002), these developmental problems include poorer regulation of negative affect, less reciprocity and mutual positive affect, lower rates of compliance, lower levels of vocalisation and activity, and less interest in interacting with inanimate objects. Additionally, depressed mothers demonstrated less imitative behavior, although their vocalising and touching were not affected by their co morbid anxiety and anger mood states (Malphurs, Field, Larrain, Pickens, Pelaez-Nogueras, Yando, *et al.*, (1996).

Other studies frequently show distress in the mother-child interaction, with depressed mothers being fewer contingents, less affectively positive, less energetic, and less effortful (Field, 1995). There are indications that children of chronically depressed mothers may develop their own "depressive" style of responding and may have compromised intellectual and emotional development (Field, 1995; Pelaez-Nogueras, Field, Cigales, Gonzalez & Clasky, 1994). The child then becomes fixed into a childish pattern when relating to his/her parents. LaHale (1994) adds that as an adult, the same child then has to contend with a strong depressive tendency. Consequently these research studies confirm that the mother's depression has an impact on children.

2.5. DEPRESSED MOTHERS AND WORK

In a study by Steinhauer (1998), an important variable that may have an impact on mothers was identified as the conflict between work pressure and home demands. Women deal with many roles: being a mother, wife, employee and daughter. In addition to that, if a mother is depressed as well, her life becomes more difficult. Consequently, high rates of depression correlate with these demands in accordance with research. The National Mental Health Association (1996) (NMHA), state that depression is the number one barrier women face in the workplace. The illness becomes an added load on the mother's life and thus impedes her productivity in the work place.



The survey adds that women with depression might be more likely to call in sick or leave early and less likely to return phone calls. They might also avoid co-workers. This may lead to some women ultimately losing their jobs as a result. Eighty-nine percent of the women who quit or lost a job while depressed blamed their depression. And almost one-third said it completely interfered with their ability to do the job (NMHA, 1996).

Depression elicits rejection from others (Joiner & Coyne, 1999). It seems that depression is burdensome to others, initially eliciting comfort and support but eventually exhausting or frustrating the other person. Alternatively, depression

tends to distance women from their loved ones and may cause emotion isolation. It can be concluded that depression has a significant impact on mothers and her loved ones. Weissman (2006) reports that working women who looked for help right away were fewer than half. Research added that they did not know where to go for help, feared insurance would not cover the costs, felt pressure from work-related time constraints, and worried they could lose their jobs.

2.6 THEORETICAL FRAMEWORK

Phenomenology was used as an investigative philosophy for this study.

Phenomenology is a school of philosophy whose principal purpose is to study the phenomena, or appearances of human experience while attempting to suspend all consideration of their objective reality or subjective association (Moustakas, 1994). Plummer (1983) and Oakley (1981) emphasise that if a good level of rapport and empathy is established, deeper information would be gained. This relationship between the researcher and the participant is particularly pivotal when investigating matters where the participant has a strong personal stake.

This method afforded me an opportunity in understanding the depressed mothers' subjective experience, thus gaining insight into their motivations and actions. What's more, the fact that phenomenology is effective at bringing to the

fore the perceptions and experiences of the participants from their perspectives, it is able to challenge structural or normative assumptions.

The positive aspect about this method is that it offered ways of understanding not offered by other research methodologies and according to Van Manen (1990), it is an exploration of 'the essence of lived experience'. The phenomena studied are those experienced in various acts of consciousness, mainly cognitive or perceptual acts, but also in such acts as valuation and aesthetic appreciation (Crotty, 1996).



Husserl (1970) mentions other qualitative approaches such as ethnography; hermeneutics and symbolic interactionism all have overlaps with phenomenological research. Pure phenomenological research starts from a perspective free from hypothesising or preconceptions (Hursel, 1970). Moreover this approach seeks essentially to describe rather than explain.

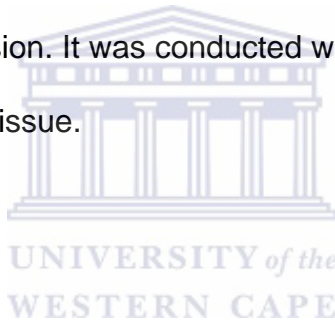
Phenomenological research has some challenges as well. For example, it generates a large quantity of tape recordings, interview notes or other records of information that need to be analysed. That consequently takes more time than quantitative methods that rely mainly on statistical evidence.

CHAPTER 3:

RESEARCH DESIGN AND METHODOLOGY

3.1 INTRODUCTION

The present study was an investigation into the experiences and perceptions of mothers recovering from depression. An understanding of the inner 'world' was of primary importance to the researcher, therefore a phenomenological approach was utilised in this regard. This study attempted to explore the views and experiences of mothering when they were depressed and the intention was to provide insights into depression. It was conducted with aim of providing each mother's perspective on the issue.

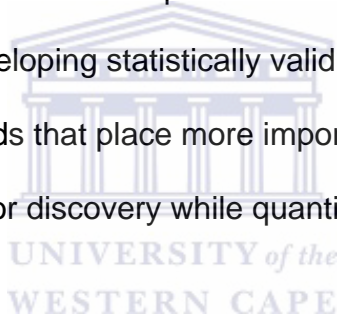


3.2 METHODOLOGICAL FRAMEWORK

This study utilised a qualitative research design. Based on phenomenological research, qualitative researchers are concerned with understanding the richness of individual experiences. They work from the assumption that it is important to understand reality from the subjective perceptions of individuals and that knowledge is derived inductively from the study of the phenomenon it represents. It involves an in-depth understanding of the reasons that govern behaviour and in-depth understanding of human behaviour. In comparison to quantitative research, qualitative research is said to rely on reasons behind various aspects of behaviour (Wolcott, 1999).

Wolcott (1995) further contends that qualitative research generally relies on three basic data gathering techniques: participant observation, interviews and content analysis. Quantitative research methods are occasionally utilised with qualitative research methods to obtain deeper comprehension of the origins of social phenomena (Wolcott, 1995). In other cases, the combination of these methods is employed to generate questions for further research.

Denzin and Lincoln (2000) state that in qualitative research methods, little importance is placed on developing statistically valid samples in comparison to quantitative research methods that place more importance. Qualitative research methods describe meaning or discovery while quantitative establish causation.



In this study the focus was on the understanding of how depressed mothers had experienced and perceived their illness in relation to their family members and other people in general. According to Sarantakos (1998) the main principles of qualitative research centers around fundamental concepts such as communication, subject and everyday life.

3.3 PARTICIPANTS

The participants of the study were a convenient sample from an Outpatient psychiatric clinic in Delft, Cape Town. Participants comprised of Afrikaans speaking Coloured mothers who participated voluntarily. All spoke English as a second language.

The recruitment of the participants was a challenging task due to the sensitive nature of the topic. Participants were mothers recovering from a major depressive disorder as outpatients at the hospital and a professional nurse provided the participants. All participants had been diagnosed with major depression within the past twelve months from the date of the interviews. They were able to recall their stories to me with ease. They were reluctant to part take though, and the researcher almost gave up due to their lack of interest.

Two of the participants had partners. The third participant terminated her relationship with her boyfriend. The rest of the participants were dumped by their partners and that had led to their depression. All of the participants were not first time mothers. They had at least one child prior their depression. All of their children were more than two years old at the time of illness. The age range of the participants was between 24 and 35 years old.

There was also lack of emotional support from the majority of partners of the participants. Only two out of the six participants were involved in a relationship with partners/husbands in their lives during their depressive phase (participant # three and participant # six). Participant number one's husband and her son were shot dead in front of their house. Her depression was a reaction to the incident. Participant # two was unfortunate because her husband had impregnated another woman. Her husband said that he did not want to divorce the participant, but wanted her to remain as a senior wife. She refused and later became depressed. Participant # four decided to end her relationship after she discovered that her boyfriend had been cheating on her with another woman. The participant caught her partner sleeping with the woman in their house. Participant # five was caught cheating with another woman as well. In summary, during their times of depression, there were only two participants who had the privilege of emotional support from their partners.

3.4 INSTRUMENT

An interview schedule was used to guide the process of the interviews (Appendix D). This method allowed participants to express their inner most feelings in a nonthreatening environment. The interviews were semi-structured and consisted of open- ended questions. The questions investigated the mother's experiences and perceptions of depression. The interviews were tape-recorded.

3.5 PROCEDURE

Permission to conduct the study was obtained from the Superintendent of the hospital (Appendix A). A letter was sent to the participants in explaining the purpose of the study (Appendix B). The Senior Nursing Sister screened the participants for depression histories then referred them to me. Participants were then given consent forms to complete (Appendix C).

The researcher conducted interviews with six participants. Both the researcher and the participants spoke English as a second language. Therefore sufficient linguistic precautions were undertaken before interviews were conducted. This was done to minimise errors or confusion that could arise during the interview between the researcher and participants. The interviews were conducted in an informal, non-threatening manner at the hospital. That allowed more flexibility in the interview where the participants' understanding of their experiences could be explored.

During the course of the interview, all participants became emotional when we discussed some of their painful ordeals. Fifty percent said that it could have been better if the researcher were a female; maybe the researcher could have been more understanding according to them. The researcher reassured them that he was a Masters student in clinical psychology and that his training was sufficient to contain any emotion that could present itself.

Participants were informed about the ethical issues of confidentiality, anonymity, their right to terminate the interview at any stage or not respond to sensitive issues. The interviews were audio recorded with the permission of the participants and were transcribed verbatim. Debriefing with each of the participants took place and that allowed the researcher to deal with sensitive feelings that surfaced during the course of the interview.

3.6 DATA ANALYSIS

The audiotapes were transcribed verbatim in order to analyse data through the extraction of themes. Thematic analysis was the method that was utilised by the researcher. Mahrer (1988) and Spradley (1979) state that there are many other ways to analyse participants' interviews and experiences; furthermore thematic analysis is just one of the methods. They point out that the ideas that surface during the course of the interview can be better understood under the control of a thematic analysis. The reason being that thematic analysis focuses on identifiable themes and patterns of living and behaviour (Aronson, 1994).

The first step that was taken by the researcher was to collect data by using audiotapes and the data was transcribed verbatim. Spradley (1979) corroborates the fact that audiotapes ought to be gathered to study an ethnographic interview. Consequently, patterns of experience which were transcribed from the interviews were then listed. The names of the participants were also eliminated to guarantee anonymity.

The second step was to identify all the data that relates to the already classified patterns or themes. Moreover, the identified themes were then developed and the conversations that fitted under a specific pattern were identified and placed with a corresponding pattern. Terre Blanche and Durrheim (1999) state that it is often helpful to identify themes and bring them together because they are often meaningless when viewed alone.

Thirdly, the following phase was to combine and catalogue related patterns into sub-themes. Taylor and Bogdan (1989, p.131) state that themes should then be defined as units derived from patterns such as “conversation topics, vocabulary or recurring activities.” A comprehensive representation of the participants’ collective experience was then pieced together using emerging themes from the interviews. Aronson (1994) reiterates this point and says that it is effortless to notice a pattern emerging when gathering sub-themes to attain a comprehensive view of the information.

The final phase of analysis was to substantiate with a valid argument why those themes were selected. This point is echoed by Aronson (1994) who says that the reading of related literature is constructive when the interviewer wants to build a valid argument for choosing the themes. A storyline was then developed by formulating theme statements after the themes had been collected subsequent to the studying of the relevant literature.

3.7 REFLEXIVE ANALYSIS

Reflecting on how you may have influenced the process or outcome is thus of utmost importance to the quality of the research (Baumgartner & Strong, 1998). This approach was informed by the perspective that the researcher was inevitably part of the social world that was being studied (Hammersly & Atkinson, 1991). Thus the researcher was an active participant in the situated activity that was being recorded.

In his personal life, the researcher has been exposed to people of his extended family who suffered from depression. Given this experience it has impacted on his interest in this area. Another influence has been his intellectual growth in the field of psychology and that has reinforced his passion to make a contribution to the existing body of knowledge. Regarding his status as a man, the researcher was aware that the participants were likely to withhold some information from him. They might not have revealed sensitive information to him due to his status as a male. Therefore his personal investment in the research inevitably shaped and structured his research and findings.

3.8 ETHICAL CONSIDERATIONS

The participation was voluntarily with informed consent. The participants were assured that the information would be treated anonymously and confidentially. Participants were informed of the aims of the research and their role in the said research. Written consent forms were issued to mothers willing to participate. All names or potential identification was deleted from the transcriptions and omitted in the final research product. Given that maternal depression is a sensitive issue, support in the form of counselling by experienced nurses was provided. The university ethics committee approved the study because all ethical considerations were adhered to.

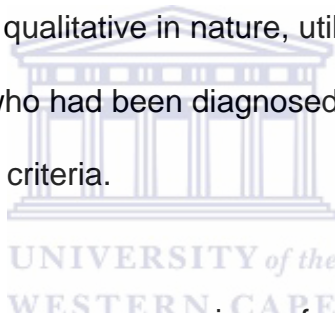


CHAPTER 4:

RESULTS

4.1 INTRODUCTION

This chapter documents the results of the researcher's fieldwork. The study investigated mothers' perceptions of the degree to which their illness had impacted on their assessment of their mothering, associated roles within the family and at work. Furthermore, the study explored mothers' coping skills with regard to their illness. It was qualitative in nature, utilising semi-structured interviews with six patients who had been diagnosed with major depression according to the DSM-IV-TR criteria.



Subjectively, depressed persons may experience feelings of sadness or irritability, an inability to experience pleasure or have fun, lethargy, sleep problems (this may include sleeplessness, increased sleep, interruption in normal sleeping patterns), appetite changes (lack of appetite or an increase in appetite), feelings of hopelessness and helplessness, social isolation, and suicidal ideas or attempts (APA, 2000).

Kung (2000) further says that these difficulties may hamper with social interactions and functioning at home, school or work. People who are depressed may also be apprehensive and agonise a lot, and might experience panic attacks

as well. Alcohol or drug abuse may occur as a coping strategy (Health Canada, 1996).

Kung (2000), states that objectively, individuals may possibly show signs of significant weight loss or weight gain, and psychomotor retardation or agitation. Most of the time they look sad and may abandon their appearance, and may be tearful and cry often. They often have low self-esteem (negative feelings about one's own intelligence and personality), very negative views of the world and the future (APA, 2000).

4.2 EMERGING THEMES



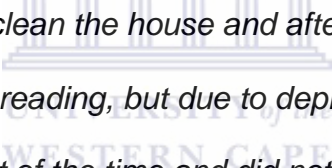
After the researcher analysed the data, there were various themes that surfaced. The findings will be divided into four central analytical categories according to some of the aims of the study and only five of the predominant depressive symptoms that emerged in the study will be highlighted.

- (1) Experiences of depression
- (2) Relationship with the children
- (3) Relationship with the partner
- (4) Coping mechanisms

4.2.1 EXPERIENCES OF DEPRESSION

4.2.1 (a) Anhedonia

All of the participants had similar experiences with regard to depression. As mentioned earlier on, all the participants had to fulfill the DSM-IV- TR criteria for major depressive disorder. Within the criteria, anhedonia was the most predominant symptom experienced by participants, as portrayed by the following quotes:



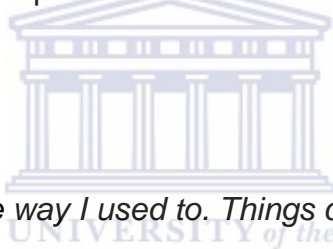
“Every weekend I would clean the house and after that, I would have something to read. I love reading, but due to depression, I did not do that anymore. I was tired most of the time and did not want to do anything. Nothing seemed to be enjoyable to me anymore” (participant #5).

“I lost interest in everything I used to do. The whole house would be dirty for days and I did not think it was that bad until a friend commented about the dirty conditions” (participant t#4).

Franken, Rassin and Muris (2006) confirm that anhedonia, the inability to experience pleasure, is a major endophenotype of depression.

4.2.1 (b) Feelings of worthlessness

The participants did not have hope to continue with life. Life seemed worthless as they viewed daily events in their lives negatively. Most of them felt that way. A study by Kochanska, Kuczynki, Radke-Yarrow and Welsh, (1987) corroborated that depressed mothers had been found to be more likely to express negative views of themselves as parents. In addition, they saw themselves as having less control over their child/ren's development and less ability to make a positive impact on them. One mother mentioned the following:



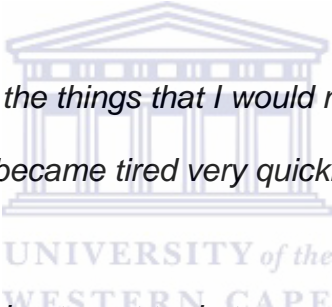
"I did not enjoy life the way I used to. Things changed between family and me. All that I wanted to do was to be away from everybody and just be alone."(participant #5).

Another mother mentioned that she could not experience any joy on each and every aspect of her life:

"Everything, the will to continue living and my purpose in life.... ja, everything was a mess. My whole life was a mess."(participant #4).

4.2.1 (c) Fatigue /loss of energy

Fatigue is a physical and/or mental fatigue that can be activated by stress, medication, overwork, mental and physical illness or disease (Hammen, 1991); in this study fatigue is caused by mental illness. Most mothers, who were full of life before the illness, mentioned that they became incompetent. They did not have enough vigour to execute all the tasks that they had set out to complete. They became lazy and left tasks unfinished. Some comments were:



"I could not complete the things that I would normally complete when I was not depressed. I became tired very quickly." (participant #2).

"I became lazy and did not want to do too many things. If I did manage to work, I would do few tasks because I did not have too much energy." (participant #4).

Due to the loss of energy, one mother said that she would sleep the whole day and felt like doing nothing. Denzin and Lincoln (2000) state that physically, fatigue is differentiated by profound exhaustion, feelings of muscle weakness, and sluggish movements. In addition, it is mentioned that it can cause serious mental tiredness (Hammen, 1991). Participant five said the following:

"I did not want to talk to people any more, including my best friends. I just wanted to be left alone. I would sleep the whole day and could not find the energy to do anything."(participant #5).

4.2.1 (d) Diminished ability to think

One of the many challenges that faced all of the participants was the decline in their cognitive ability during the illness. This inability led to some of them losing concentration as a result. Two of the mothers discussed the following:

"I could not work properly, I lost concentration. Sometimes the boss would talk to me but I could not understand what he was saying."(participant #1).

"I would lose concentration easily." (participant #5).

Persistent fatigue due to depression has a potential to cause difficulty in concentration, and in some cases, memory loss (Hammen, *et.al.*, 1987). In view of the above quotations, poor concentration poses a real danger to the mentally ill mother. She cannot only harm herself, but indirectly harm others as well due to a possible accident that she could cause. For example, participant number one used to work with dangerous machinery at a factory when she had been

diagnosed a year earlier. As a result of possible dangers that could have been caused by her low concentration levels, she was excused from work. During the time of the interview she was unemployed when she was diagnosed with depression.

4.2.1 (e) Insomnia or hypersomnia

The illness rendered all of the mothers unable to enjoy life during the day due to differing factors. They were unable to sleep at night as they experienced insomnia (primary). They experienced constant thoughts about how their misery could be eliminated. Hammen, *et.al.* (1987) state that sleep is physiologically abnormal in persons at risk for depression. For example, reduced REM sleep latency is present not only during clinical episodes of depression, but also before the clinical episode in subjects at risk for depressive illness (Lustberg & Reynolds 2000). Some participants expressed the following:

“I could not sleep at night. So I was given tablets in order to help me sleep at night. If I did not take those tablets I would not sleep”.
(participant #1).

“You see at night I could not sleep, everything would come back to me. All the painful thoughts would come back to me. I was thinking about all the sacrifices I had done for him...” (participant #2).

There were some mothers who experienced secondary insomnia. They did not experience any problem with sleeping at their normal times. Kupfer (2006) contends that all patients diagnosed with major depression report experiencing insomnia, oversleeping and poor quality sleep. One mother said:

“I only slept in the early hours of the morning. As a consequence, I would feel very tired in the morning and did not want to do anything but sleep”
(participant #6).

4.2.2 RELATIONSHIP WITH THE CHILDREN



4.2.2 (a) Irritability towards children of the

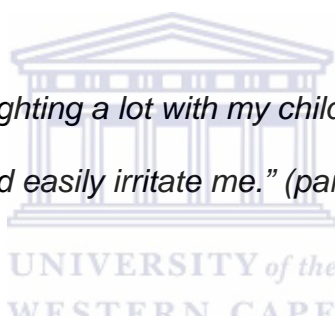
All of the participants reported that they felt very lonely during their depressive spells. They did not want to socialise with their children. They were irritable and would lash out at them. This hostile environment resulted in children being frustrated by the situation and as a result began to withdraw. They could not predict their mother’s behaviour. Some mothers mentioned the following:

“My family consisted of my husband and my two children. When my husband and my son got shot dead, I was left with my paraplegic son. He needed extra care, which at times I could not provide because he could

not do anything for himself. That became an extra burden for me because I could not provide everything that he needed as I could before. I often got frustrated and irritated by him, and I could not understand why that was happening. My relationship with him gradually worsened” (participant #1).

“Everything was working on my nerves. Whenever I was at home, I wanted everything to be silent. I did not want anyone to make a noise. Even the children were shocked about what was happening” (participant #2).

“I noticed that I was fighting a lot with my children. Things I used to handle would easily irritate me.” (participant #6)



Reynolds (2000) states that depressed mothers are poor models for mood regulation and problem solving. They are said to be less likely to set limits on their children and to follow through if they did set limits (Kochanska, Kuczynski, Radke-Yarrow & Welsh, 1987).

*“There were times that I did not want to have anything to do with my son. I could not understand why I was not relating good with my child. I mean, I was living my life for him, but my behavior contradicted that.”
(participant #4)*

Ashman and Dawson (2002), say that feelings such as hopelessness, self-absorption, irritability, and fatigue, may manifest among mothers in the form of less sensitive and responsive parenting. This ultimately leads to reduced emotional involvement, higher maternal negativity and weakened communication. The individual who suffers from mental illness is not the only one affected, but, their families as well, especially the children. Fendrich, Warner and Weissman (1990) states that the offspring of parents with a mental illness such as depression can be at higher risk for psychopathology.

4.2.2 (b) Emotional distance

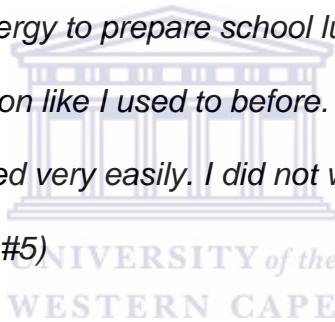
A combination of factors resulted in all of the participants being emotionally distant from their children. The irritability, lack of energy and self isolation directed towards the children resulted in them being afraid to interact with their mother. They gradually spent little time around their mother's company. Other comments were:

"I would become easily tired and did not want to do anything. I guess everything was mostly affected. I just wanted to close myself in the house and did not want to talk to anyone."(participant #1)

"I did not have time anymore with my children. I just wanted to be alone. I could feel that there was a distance between them and myself."(participant #2)

One of the mothers said that the predominant feature in her illness was the inability to have enough energy to utilise with her child. Thus the lack of vigour was another variable that decreased the amount of quality time between the mother and her child. She said the following statement:

"I did not have the energy to prepare school lunch and could not spend quality time with my son like I used to before. I just did not have the vigour because I became tired very easily. I did not want to do anything."(participant #5)

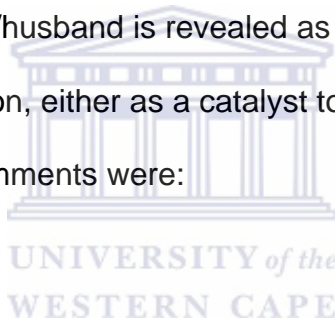


Seemingly, the risk for children of depressed mothers developing depression early in their childhood increases if the onset of mother's major depression is before the age of 30 years (Wickramaratne & Weissman 1998). Major depression also places children at high risk for other psychopathology like anxiety and conduct disorder (Hammen, Gordon, Burge, Adrian, Jaenicke & Hiroto, 1987).

4.2.3 RELATIONSHIP WITH A PARTNER

4.2.3 (a) Irritability towards partner

Even with their partners, the mothers experienced a similar stressful combination of factors. Arguments between the partner/husband had increased in comparison to when the mothers were not depressed. Some mothers no longer enjoyed spending quality time with their partners. Kung (2000) has discovered that marital conflict correlates highly with accompanying depression. In addition to that, discord between the partner/husband is revealed as a significant source of stress that can impact on depression, either as a catalyst to its development or as a maintaining force. Some comments were:



“Things would be better when I was left alone in the house.”

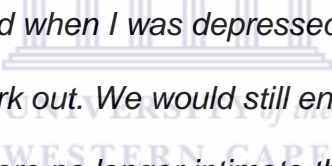
(participant #6)

“I did not want to see him, he had disappointed me.” (participant #3)

Discord in a relationship (spouse or husband) is also described affecting the patient’s responsiveness to treatment and acts as a predictor of relapse (Kung, 2000).

4.2.3 (b) Emotional distance between partners

Depression renders people unable to express positive feelings towards their partner/husband. This phenomenon is similar to when the mother isolates herself from her children. This inevitably creates an emotional gap between the couples and gradually communication lessens. Each partner blames the other for the negative behavior. Kung (2000) highlights that when depressed persons interact with their partners, both parties perceive their partners as more negative, hostile, mistrusting and detached. One mother said the following:



“But during that period when I was depressed, even when we sat down to talk, things did not work out. We would still end up arguing. That affected our sex life too. We were no longer intimate the way we used to be.”

(participant #6).

4.2.4 COPING MECHANISMS

4.2.4 (a) Emotional support from a child/children

It has been found that depressed mother's children are affected by the illness as well. Most of the mothers could not receive emotional support from their children. Consequently, the children withdrew and feared their mother's irregular temper.

That resulted in them being constantly anxious in their mother's company. Two of the mothers said the following:

"My son was not comfortable when he was around me, He became a bit inhibited, and he did not speak that much. At least he knew what I was going through and understood that things were difficult for me. He was supportive and I thank him for that. That is why I am still thankful till today."(participant #5)

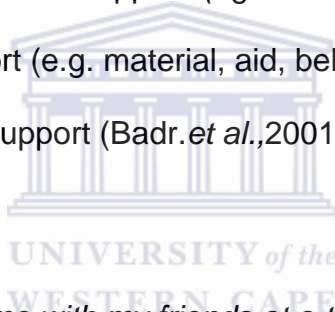
"They were supportive but scared of me; I could see that they wanted to help me. They felt the pain that I was experiencing. I realised later that I was the one who was fighting against them. But during that time, I could not see that. I just saw them as people who were working on my nerves."(participant #2)

The amount of support from their children has implications on the prognosis of the illness. Paykel (1994) says that the absence of social support appears to be associated with the onset and relapse of depression. In addition, the occurrence of major life events indicates an increased period of increased risk when supportive interventions may prevent progression of distress to disorder. Though the participants were ill and irritable, the support they were receiving from their children is invaluable.

4.2.4 (b) Social support from friends

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

The family, close friends, neighbours, co-workers and professionals are members of the social support networks. 'Support' is the second element that warrants attention. The source of 'support' (eg. relatives, friends, etc.) and secondly, the types of support (e.g. material, aid, behavioural assistance, etc.) as two differing dimensions of support (Badr. *et al.*, 2001).



"I would spend my time with my friends at a tavern down the road and have a few drinks."(participant #6)

"I had two friends who would just pop in on their way home from work, who would see how I am doing. Every Wednesday they would bring me grocery parcels because I did not have any source of income". (participant #1)

"Besides the medication, I guess my family and friends made me cope."(participant #4)

4.2.4 (c) Spiritual support

As mentioned previously in this study, the social support network is vital for the betterment of the depressed individual. All of the participants declared that during their most difficult times, they relied on divine inspiration. Some would pray individually in their own private space. One mother said:

"I kept on praying and I hoped that things would be better soon."

(participant #5)

"Even the people at church were instrumental in my recovery."

(participant #6)



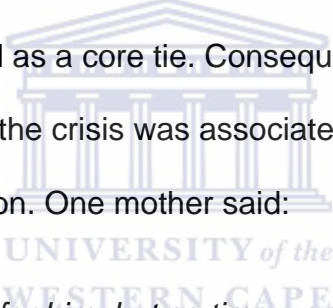
"I spoke with the Minister at church, family and friends."(participant #4)

Physical health, mental health and mortality due to depression are said to decrease due to the beneficial effects associated with social support (Sheppar, 1994). Some of the mothers would receive groceries on a weekly basis. Some would be visited by church officials who would conduct prayers with the depressed mothers. Some church members would insist that the mothers should be active in other activities within the church.

4.2.4 (d) Support from the partner

Out of six participants, only few mothers were fortunate to receive emotional support from their partners. The rest of the interviewed mothers were unfortunate, their partners were not involved due to differing reasons. Initially, it was difficult for the partners to be supportive, but as time went by, and the partner became sympathetic. Self esteem was said to correlate highly with some measures of support (Brown, Andrews, Harris, Adler & Bridge, 1986).

Brown, *et.al.* (1986) state that a husband, lover or someone named as very close at first contact was described as a core tie. Consequently, the lack of support from a core tie at the time of the crisis was associated highly with an increased risk for subsequent depression. One mother said:



“At first it was difficult for him, but as time went by, he was understanding and supportive. Even when we had our arguments, he would try and talk to me about our misunderstandings” (participant #6).

In the present study most of the participants did not have the privilege of having a partner to confide in which is one of the limitations that will be discussed in the following chapter.

4.2.4 (e) Abuse of alcohol or other methods

Other mothers used additional methods of coping thinking that they would alleviate their burdens. Participant number six utilised alcohol more at the time she was ill. She noticed that she was spending more money and time at a nearby tavern. She thought that her problems would seize if she drank more often until she decided to change her behaviour. One mother mentioned:

“I used to drink on weekends only, but now I realized that I was also drinking during the week. That is when I decided to quit all together. I had even decided to stop smoking cigarettes.” (participant #6)

Another participant used medication more than the required prescription; she thought that she would escape her troubles by sleeping for longer periods. She said the following:

“I drank some red tablets to help me sleep. On that day, I drank four of them. I knew that I was not supposed to have drank four, but I was supposed to have drank only two. So that day, I slept the whole day and woke up the following day.”(participant #2)

When people are faced with major life challenges, they utilise a variety of coping mechanisms. Some contribute to better health, while others place the individual

at a greater risk. The negative coping mechanisms include smoking, drug and alcohol use. Conversely, physical activity adds to physical and mental health. Besides the physical fitness, active people tend to have a greater self-esteem and a positive body image (Health Canada, 1999). All of the participants had mentioned that they could not complete the majority of the tasks that they had set out to do. In addition to that, attributable to the lack of energy and other factors, they would end up sleeping most of the day and distance their support structures.



CHAPTER 5

CONCLUSION AND RECOMMENDATIONS

5.1 SUMMARY AND DISCUSSION OF SALIENT POINTS

The present study sought to gain insight into experiences and perceptions of mothers recovering from depression with regard to;

- *The impact of depression on family roles,*
- *Their coping skills in the process of recovery from depression.*

The researcher recruited mothers who had a history of major depression. Mothers who were currently depressed did not qualify to part take in the study as the researcher was interested in their past experiences only. Kessler, *et al.*, (1994) states that women experience depression at 1.5 to 3 times the rate of men. That was evident when the researcher was conducting the fieldwork. All the people that were diagnosed with depression were females in my research site. Whether they were currently depressed or had histories of depression, females represented the only population at the time. Reynolds (2000) states that females are more likely to seek treatment for depression, thus statistics for this grouping appears higher in most research.

Brown and Moran (1997) report that males are more likely to use alcohol or illegal drugs for self-medication in an attempt to cope with their depression. That could explain why there were no males who came forward to report those cases whilst research was being conducted.

5.2 IMPACT OF DEPRESSION ON FAMILY ROLES

5.2.1 (a) Mother's relationship with children

Kaslow, Deering and Racusin (1994) report that in several outpatient studies, families of depressed mothers are described as less cohesive, less secure and less communicative. They are also illustrated as less warm, less supportive and as more tense, aggressive, and critical. In this study, all of the participants reported that they felt very lonely and refused to interact warmly with their children. They were irritable and would shout at them most of the time, consequently, their relationship with their children was strained. Hammen, *et.al*, (1987) confirm that major depression also places children at high risk for other psychopathology like anxiety and conduct disorder.

5.2.1 (b) Depressed mother's relationship with partner

Depression had a negative impact as well on the participants' relationships with their partners. Coyne and Downey (1991) state that studies on marriage and depression show that the latter can be the cause and the result of marital problems and dissatisfaction. A bad relationship can become more challenging in highly stressed marriages whereby depression can impact one or both partners.

In the present study, all of the participants said that their relationships/marriages were affected negatively by depression. Jacobson, Dobson, Fuzzetti, Schmaling, and Salusky (1988) also state that depression can cause people in reasonably happy marriages/relationships to view themselves and their relationships in unenthusiastic ways. Consequently, depression affected all of the participants' relationships/marriages.

5.2.1 (c) Lack of ability to complete tasks

Depression rendered all the participants less productive with regard to the completion of their daily duties. They were unable to finish all the tasks they had set themselves to complete due to lethargy as a major factor among other things. They did not feel enthusiastic about life. They felt that they were ineffective as mothers because they were not in control of their lives due to the illness. Anhedonia, feelings of worthlessness, fatigue, diminished ability to think, insomnia or hypersomnia were the most common symptoms encountered amongst the participants. They were largely responsible for all the participants' lack of productivity.

5.2.2 COPING MECHANISMS

5.2.2 (a) Social support from friends

All the participants said that they benefited immensely from the support received from friends and neighbours. They stated that the visits minimised their emotional difficulties significantly. They point out that their situation became better because they were able to share their problems and during those visits they were not as lonely as before.

5.2.2 (b) Emotional support from child/children

It has been shown in literature that depression does not only affect the mother, but the immediate family as well. The family usually includes the partner, children and other relatives in some cases. In this study, four participants who had children did not receive emotional support from them. That was caused by the participants' unpredictable behaviour which ultimately distanced the children. The lack of emotion resulted in children being constantly anxious in their mother's surroundings. Feelings such as irritability, fatigue, self-absorption, and hopelessness, may manifest among mothers in the form of less sensitive and responsive parenting (Ashman & Dawson, 2002). Only two mothers felt that they were emotionally supported by their children, the rest were unfortunate.

5.2.2 (c) Spiritual support

Three of the participants said that they relied on spiritual upliftment from church during their difficult times. They prayed mostly and were optimistic that their condition would improve. One participant mentioned that she would confide in the Minister at church. She said that the disclosure helped very much because she felt relieved every time she met with the Minister. The rest of the participants did not go to church, but prayed on their own.

5.2.2 (d) Support from the partner

Two of the participants had partners. They were in an opportune position of being supported. The rest of the participants were not so fortunate. They were either neglected by the partners or voluntarily dumped their partners before they became ill.


5.2.2 (e) Abuse of alcohol or other methods

Two of the participants utilised other means of coping with their depression. One participant abused medication as a coping strategy. She was fully conscious at the time of the incident. The other participant abused alcohol frequently during her depressive spells. She spent most of her time at the shebeen.

5.3 CONCLUSION

The study investigated experiences and perceptions of mothers recovering from depression. It was also able to illustrate how depression impacts on family roles. The results indicated that participants viewed themselves and their relationships in negative ways. They demonstrated different coping mechanisms in the study. All of them said that they relied mostly on divine inspiration and had a positive perspective on life. Two participants were abusing drugs.

5.4 LIMITATIONS OF THE STUDY



The study offered mothers an opportunity to express themselves with regard to their experiences of being depressed and their coping mechanisms. However, there were some limitations. All of the participants were drawn from historically Coloured areas. White or Black females were not represented in the study. The participants were drawn from a working class area and they were more comfortable conversing in Afrikaans, though the interviews were conducted in English. The researcher struggled at times during the interviews as he had to explain some of the terms or words to the participants.

All of the participants were unemployed at the time of the interview. The researcher therefore could not explore the impact of the participants' depression on their work roles. They had different sources of income.

My gender (being a male) could have had a negative impact in the study. For example, while the researcher was doing interviews, three of the mothers had indicated that a female researcher would be more empathic to their unique situations. They said that they took much longer to trust me. It is advisable that a female researcher should conduct a similar study in the future.

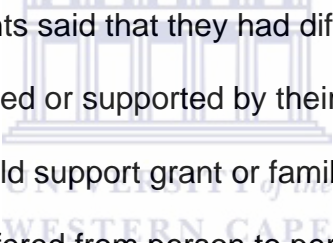
5.5 RECOMMENDATIONS FOR FUTURE RESEARCH

During data collection the researcher encountered some challenges which almost impeded the research process. Hopefully by documenting these intricate difficulties, future research will be conducted much easier than my study. For instance, if all the participants were screened before they were interviewed, the research could have been better. That would allow the researcher to interview only participants who had partners in their lives. Furthermore, this would be reflective of how depressed mothers deal with their illness when they have emotional support from their partners. In my study, only two participants had partners, the other four mothers were not involved due to different reasons. In addition, it would also explore how the mothers were coping with the situation whilst living in financially unstable conditions.

Secondly, the researcher could not select mothers who had children only within a particular age range, for instance, mothers of toddlers or teenagers. In this study, the researcher had to interview all mothers who were willing to participate in the study. Due to the scarcity of participants, I could not discriminate against the

participants given to me. The mothers had children in different age groups, so there was no uniformity.

It is also important that future studies focussing on Black mothers within the townships be pursued. Mothers who lived in the rural areas would be a recommendation for future research. The study would target areas where there is a high proportion of unemployment. The area where my study was conducted has a high unemployment rate as well, but the difference is that it is not in the rural areas. The latter would be a determining factor.



Fifty percent of the participants said that they had different sources of finance. They were either self employed or supported by their partners. The rest of the participants depended on child support grant or family members. The financial position of all participants differed from person to person. It is then advisable that the future researcher would have to obtain participants who were in a similar financial bracket. Alternatively, if all the participants had a steady job with guaranteed income, that would allow the researcher to explore the impact of their depression at work.

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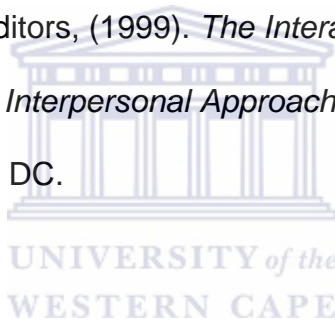
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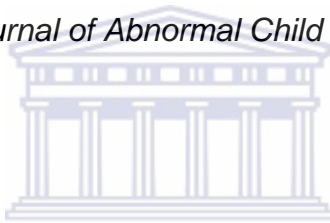
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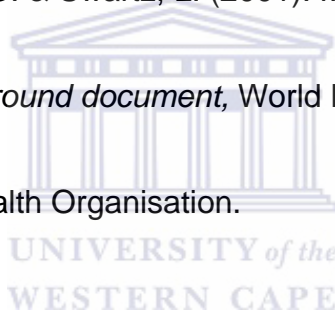
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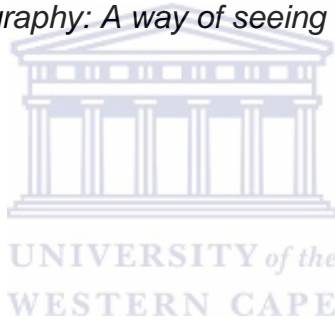
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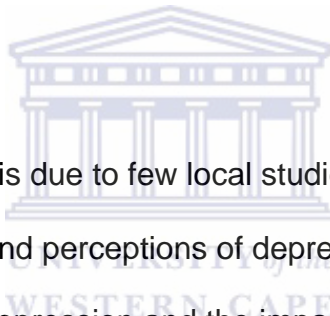
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APPENDIX A: PERMISSION LETTER TO ACCESS PARTICIPANTS

02 September 2004

Dear Sister in charge

Thank you very much for making time to read my request. My name is Ayanda Xabakashe and I am a Masters Clinical Psychology student in the department of Psychology at the University of the Western Cape. I am interested in investigating experiences and perceptions of mothers recovering from depression. The study would also evaluate the impact of depression on family roles and coping skills.



The motivation for the study is due to few local studies focusing exclusively on the subjective experiences and perceptions of depressed mothers. Other studies had focused on post-natal depression and the impact of the illness on the mother – child dyad. As a result the present study will be exploratory in nature and wants to fill the literature gap that exists in relation to communities in South Africa. Ultimately the results of the study will enhance the existing body of knowledge available to practitioners. For any enquiries please contact me on this telephone number: 0829760598

Thanking you in advance

Yours truly,
Ayanda Xabakashe

APPENDIX B: LETTER TO PARTICIPANT

02 September 2004

Dear Mother

This study investigates experiences and perceptions of mothers recovering from depression. The study will also evaluate the impact of depression on family roles and coping skills. It will be exploratory in nature and wants to fill the literature gap that exists in relation to communities in South Africa. You will be required to talk about your own experiences when you were depressed. As a result of your contribution in this study, your input will enhance the existing body of knowledge available to practitioners. The interviews will be audio recorded.

Your identity will not be recorded on any forms or released in any way in the study. The study will be done if you consent. If you choose to participate, you can refuse to answer questions that you do not want to answer and can withdraw yourself from the study, without penalty, at any time. The results of this study will be given to you if you ask for them and your questions will be answered in a timely manner. If there are any questions, anyone can refer to Sister Walters (Psychiatric nurse) or the researcher at any time.

For any enquiries please contact me on this telephone number: 0829760598

Thanking you in advance

Yours truly,

Ayanda Xabakashe

APPENDIX C: INFORMED CONSENT FORM

The aim of this research is to investigate ***experiences and perceptions of mothers recovering from depression with regard to the impact of depression on family roles coping skills***. Ayanda Xabakashe is conducting this study. The research will form part of his Masters degree in Clinical Psychology at the University of the Western Cape.

I understand that my name will not be recorded on any forms or released in any way in the study. I have been advised that personal evaluation is part of this study but my identity will remain confidential.

The study will be done if I consent .If I choose to participate, I am aware that I can refuse to answer questions that I do not want to answer and I can withdraw myself from the study, without penalty, at any time.

I understand that the results of this study will be given to me if I ask for them and that my questions will be answered in a timely manner. If there are any questions, anyone can refer to Sister Walters (Psychiatric nurse) or the researcher at any time.

Participant: _____

Researcher: _____

My Supervisor: Prof. K. Mwaba

Tel: (021)959 2283

Email:kmwaba@uwc.ac.za

Main Researcher: Ayanda Xabakashe

Tel: 0829760598

Email:roots@webmail.co.za



APPENDIX D: INTERVIEW SCHEDULE

1. What did depression change in your life?
2. What part of your life was most affected?
3. In which ways was it affected?
4. What effect has depression had on you as a mother?
5. What was most affected?
6. What effect did depression have on your relationship with your children?
7. How did your children respond to your being depressed?
8. What impact did depression have on your relationships with your partner or husband?
9. How did your husband/partner respond to your being depressed?
10. What kind of effect did depression have on your ability to work?
11. What impact did depression have on your doing other activities such as hobbies, and other things you usually enjoyed?
12. What impact did depression have on your relationships with your colleagues/friends?
13. What was their response to your being depressed?
14. How did you cope with being depressed?
15. Did you use alcohol or drugs to cope with your difficulties?
- 15.1 What other coping did you resort to?
- 15.1 Who did you turn to in your efforts to cope?