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# Unpacking the impact of social support on maternal mental health

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**Masters Research Report: Sociology (Full-time)**

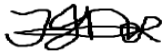
# *Unpacking the impact of Social Support on Maternal Mental Health*

**Supervisor: Dr Kezia Lewins**



## Plagiarism Declaration

I declare that this masters research report is my own work. This report is submitted for the degree of Masters in Sociology at the University of the Witwatersrand, Johannesburg. This research has not been submitted before for any other degree at any other university.



Student Signature

10 August 2020

## Acknowledgements

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## Abstract

The purpose of this research is to shed light on maternal mental health, specifically antenatal anxiety and depression. This was done because of the lack of awareness and support for mothers' mental well-being during their pregnancy journey, especially for first time mothers. The research aimed to highlight these gaps by showing the real-life impact that these gaps have on mothers, through unpacking their narratives and experiences of pregnancy. Due to the sensitivity of such a study, it was very important to tread lightly and to be mindful of the mothers' well-being throughout. This research investigated, at great length, the role healthcare professionals played in mothers' pregnancy journeys and even more importantly how social support or a lack thereof was received by mothers. This study unpacked social support as an indicator of antenatal anxiety and depression, which has been under-researched. Support was at the epicentre of mothers' narratives and told a story of antenatal anxiety and depression that has not nearly been researched enough. The use of the qualitative approach allowed for these narratives to be told and analysed in this study. This research unpacked the numerous gaps that arise due to a lack of supportive maternal mental healthcare, and identify the need for further mental healthcare assessments, and the unpacking of the severity of the structural violence experienced by mothers during pregnancy. This is important so as to understand the nature of the problem and so as to no longer subject mothers to such experiences.

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# Introduction

This research study looks at maternal mental health care, specifically focusing on antenatal anxiety and depression. Research by Biaggi, Conroy, Pawlby & Pariante (2016) shows that in developing countries such as South Africa, between one in three and one in two mothers experience antenatal anxiety and depression. Therefore, the purpose of this explorative research is to further understand the experiences of mothers' mental health and healthcare during their pregnancy.

Not only is this a study of mental health but one primarily focused on investigating such from the mothers' perspectives. The focus of this study was chosen as Davis and Segre (2013: 6) argue that: "Fifty percent of "postpartum" major depressive episodes actually begin prior to delivery". Furthermore, there is currently not enough research into the extent and experiences of anxiety and depression during pregnancy. This is particularly problematic because existing literature shows it to be a burdensome experience for pregnant women (Biaggi et al., 2016).

The second reason this research was embarked upon was because most studies are western focused. Thus, this research aimed to provide further scholarly insight by focusing on the South African context and experience.

The core research question is "What are expectant mothers' perceptions and experiences of antenatal depression, antenatal anxiety and antenatal mental healthcare in the South African context?" A range of sub questions helped navigate this research, these were: Firstly, what are or were mothers' experiences of pregnancy? Second, how do or did mothers' experience this as 'different' (to their usual state? Third, do or did they seek help and/or healthcare for this (why or why not)?

This research is of particular importance sociologically and has policy implications because it engages with the structural violence that is experienced during women's or girls' pregnancy. In society and even in healthcare, expectant mothers' narratives and experiences of antenatal mental health well-being are generally unheard and as a result there is a growing treatment gap (Bezuidenhoudt, 2016: 1). This research was conducted through a qualitative method that ensured room for mothers' authentic and organic accounts ensuring that their experience and accounts are fully understood. This study also unpacked contemporary concepts, such as support and obstetric violence, that shaped the analysis of the expectant mothers' perceptions and experiences of anxiety and depression. The various forms of social support i.e. Emotional support, Instrumental support, Informational support and Appraisal support were used to further understand the experiences women faced during pregnancy and what facilitated or protected against anxiety and depression. When analysing the data, support was a huge factor that emerged in women's experiences and perceptions of mental health and well-being as a whole.

In addition, obstetric violence was also unpacked to further understand how this is experienced by patients when there is a lack thereof support, what accompanies that, and the implications of such maltreatment on an individual level and structural level. Originally the concept obstetric violence emerged during the 2000s in Spain and Latin America. It was an extension of the activist struggle that aimed to humanise and demedicalise childbirth and therefore

empower women and girls during pregnancy. Following that it became a legal concept in 2007 in Venezuela, was then adopted by Argentina in 2009, and then by Mexico in 2014 (Chadwick, 2016).

In this research the main aim of unpacking obstetric violence was to further highlight the gap that is seen in maternal mental health and maternal health at large. Chadwick (2016) discusses this in-depth and makes recommendations for how the mistreatment of women and girls need to be addressed. This research shows how mothers really go through a lot during pregnancy, far beyond the narratives of "pregnancy is tough" and "you'll get through it". Mothers go through various mental and emotional circumstances that in turn impact on their maternal health. Just to give a little insight of the intensity of these experiences. There were mothers who were hospitalised, a mother who felt that without some form of support she would not have made it through, and a mother who thought to herself of just ending it all right there and then, in her kitchen.

As Chadwick (2016) highlights the lack of attentiveness and mistreatment of women and girls during pregnancy is a form of violence against them and should be viewed with that level of severity.

The rest of the layout of this report will consist of: a literature review, methodology, findings and analysis chapter and lastly a conclusion. The literature review will engage with key issues and debates brought about in relation to mental illness. As well as highlight gaps that are seen within existing discourse. In the literature review chapter, a range of issues are discussed, from approaches to mental health care to the unpacking of debates around mental health care, i.e. existing policies, processes and practices and their key challenges; to debates around the role of culture in mental healthcare: What is biomedically understood as depression and generalised anxiety; what is maternal mental health and what is understood by it; and specifically what is ante-natal anxiety and depression, what are the known symptoms and contributing factors? The topic of obstetric violence is raised and how that brings a contemporary understanding to maternal health from a psycho-social perspective. Lastly, the manner in which social support shapes contemporary debates and maternal mental health is also discussed in light of its significance for this project.

The methodology chapter unpacks the exact manner in which the research was conducted. Due to its sensitive nature it was imperative that all methods were best suited to the study. This study is centred around understanding personal experiences and accounts. Hence, the need to unpack: the context and location, the methodological approach, research method, sampling, gaining access to the research site, interpretation of data, the lessons learned, ethics as well as recommendations for any prospective research. The findings and analysis chapter then places particular focus on the actual accounts and narratives of maternal well-being, the support or the lack thereof available to the mothers during their experience of pregnancy, and how that impacted on their maternal mental well-being. This chapter analysed the findings and interpreted and analysed mothers' experiences of contributors of anxiety and depression. It also included discussion of healthcare professional support from the perspective of a few healthcare workers and from the perspective of mothers. The data was interpreted through the concept of

social support and obstetric violence, which were found to unpack and cement mothers' perceptions and experiences.

Lastly, the report will conclude with a brief overview that summarises the key points, provides recommendations, highlights the strengths as well as the limitations of the study and considers how the research answered the question: "what are expectant mothers' perceptions and experiences of antenatal depression, antenatal anxiety and antenatal mental healthcare in the South African context?" Due to the fact that there is not much done to monitor mothers' mental well-being during their pregnancy, this lack of attentiveness amounts to mistreatment and is therefore seen as a form of violence against women and girls. Even more so, because "fifty percent of "postpartum" major depressive episodes actually begin prior to delivery" (Davis, 2013: 6), action is needed to remedy this situation.

# Literature Review

## Introduction

In this section, I will engage with key issues and debates brought about in relation to mental illness. I will engage the key theorists in this field, both classic and contemporary, as well as highlight any gaps that emerge from the existing literature. Lastly, I will show how mental illness is responded to in relation to the existing structures. This literature review will discuss the following themes: a summarized discussion of the approaches to mental health care in South Africa; the role culture plays; mental health policies and processes; it will unpack what anxiety and depression mean as well as how it is understood from a range of perspectives; it will unpack what is meant by antenatal anxiety and depression specifically; how social support is understood within this context; and the significance of obstetric violence within this field. This chapter will conclude with a brief theoretical framework that provides the definitions of key terms used in this research.

### 1) Approaches to mental health care

#### a) Western biomedical, psychological and biopsychosocial models

Before unpacking mental health approaches and their impact on patients, it is important to know what each general model entails. In regard to overall health, "the biomedical model sees the body completely separate from any social and psychological processes" (Warwick-Booth, Cross, & Lowcock, 2012:10). Most causes of poor health are seen from a biological or physiological perspective. This model is centred around five assumptions according to Warwick-Booth et al., (2012) and Nettleton (2013). The first assumption states that the mind and body are not viewed as an integrated whole but rather separate components (Nettleton, 2013). The second assumption states that the body, when broken, is seen as something that can be fixed and mended (Nettleton, 2013). Third, technological interventions result in medicine adapting to and being driven by technology itself. Fourth, is that every disease is caused due to a specific biological reason (Nettleton, 2013). The final assumption, is that the biomedical model is reductionist in that it neglects other factors that influence health and well-being such as societal, mental or emotional factors.

These same premises are applied to mental healthcare. For example, Applebaum (1997) noted that by its very nature, mental health is biological and goes through biological processes, hence the importance of manuals such as the "Diagnostic and Statistical Manual of Mental Disorders" (DSM) in (Regier, Kuhl, & Kupfer, 2013). In the process of the DSM being developed 400 experts from 13 different countries contributed. These experts were from a number of mental health care fields, e.g. psychiatry, psychology, neurology (Regier et al., 2013). The current organizational structure for the DSM- 5 is planned to better reflect the relative strength of relationships between the distinguished disorder categories as opposed to more of a child to adult perspective of development (Regier et al., 2013). According to Gold (2009 in Regier et al., 2013), the main advantage the biomedical model has is that it provides a neuroscientific understanding of the brain, and how we understand mental illness and disorders today is through brain imaging techniques and genetic testing. However, it unfortunately leaves very

little room for social and psychological understanding of mental health. (Lilienfeld, 2007 cited in Regier et al., 2013).

In contrast to the biomedical model, the psychological model takes into consideration factors such as the environmental, political, economic, social and cultural influences. The psychological model highlights causes of ill-health outside the physical body (Nettleton, 2013). The psychological model operates on the grounds that health is influenced by a number of factors and that there are individual differences when it comes to how these influence and shape mental health and the individual's actual ill/health experiences. In this case, the psychological model normally treats mental health with psychotherapy and by focusing on the most relevant psychosocial components (Nettleton, 2013). However, it has been argued that the psychological model is broad and a complex way of understanding health as the psychological model places great emphasis on the collective and social responsibility for health. Whereas, the next, the biopsychosocial model also focuses on these aspects, but also considers the dimensions of the biomedical model that are missing from the psychological model.

The biopsychosocial model attempts to overcome the disadvantages of the biomedical model by emphasising that good mental and emotional health are an important aspect of well-being. It also highlights that an individual's well-being is not solely in the hands of medical experts, but is, partly in control of the patients themselves (Deacon, 2013). In addition to the biological aspect of health care and treatment, patients and their families can assist too in maintaining their well-being (Deacon, 2013). Similarly, to the psychological model, it advocates for a more societal approach that promotes community-based treatment and the unwell living within societies. The biopsychosocial model is said to positively affect the general well-being of a society at large for the better (Deacon, 2013). The disadvantage of the biopsychosocial model is that the inclusion of all factors and influences, may create a sense of vagueness in terms of effect and treatment priority.

**b) Traditional approaches to mental health**

When it comes to traditional approaches to mental health there are three commonly referred to approaches, a holistic approach, a traditional healing approach and a religious approach. These approaches to dealing with mental health are of importance because not everyone seeks assistance within the biomedical sphere nor does everyone feel comfortable seeking assistance within the biomedical sphere. It is equally important to explore other options used and/or that people may feel more comfortable using, such as traditional approaches to mental health.

Studies have shown how people worldwide are exploring more holistic forms of healing in the hopes to start establishing more contemporary forms of healing. Examples include mind-body practices which are often used in holistic approaches to anxiety and/or depression (adaa.org). As highlighted by ADAA (2010: 1) 'mind-body practices are techniques that can be used to enhance the mind's positive impact on the body and vice versa' For example these practices include; relaxation training, meditation, hypnosis and imagery (Emmons, 2010). These methods have been seen as particularly important when speaking of transitional healing methods of mental health (Emmons, 2010).

In relation to South Africa, many African beliefs view mental health as something that stems from ancestors or bewitchment as result a traditional healer or religious leader will be sought out for assistance and/or care due to them being seen as experts in these areas (Abdool, Ziqubu-Page, 2004: 1). Although, there is a gap in literature when it comes traditional healing practices, it was found in a small study that approximately 41-61% of patients with mental illnesses have consulted traditional healers (Abdool et al., 2004: 1). Traditional healers include two types of specialists, the first is a herbalist and the second is a diviner. The herbalist's expertise lies in the production of herbal medicine whereas the diviner's expertise lies in the 'ability to divine the cause of the illness and misfortune' (Edwards,1986; Freeman and Motsei, 1992: 1). Although, literature does not stipulate which traditional specialist is utilised more it is clearly seen that alternative forms are being used at an increasing rate and should be explored more in future studies.

### c) Current practice approaches

As highlighted above, the biomedical model does not recognise or distinguish social context. With that being said, the Western biomedical model, used in South Africa does not adequately consider the specificities of the South African context. As a result of the prevalence of HIV/AIDS and TB in South Africa, Bezuidenhoudt (2016) noted that context-specific mental health procedures and treatments would be beneficial. This is important because there is a great deal of anxiety that comes with an HIV/AIDS and TB diagnosis, even more so for pregnant women. Bezuidenhoudt (2016) also found that in most communities, people with mental illnesses are often discriminated against and stigmatised. As a result, people do not access the mental health care they need (Bezuidenhoudt, 2016).

Furthermore, Bezuidenhoudt (2016) argues that, there should be processes put in place to guarantee the delivery of quality mental health care management and services. This is particularly important because as highlighted by the psychological model, mental health care management and services is what needs to be prioritised: mental health care needs to be "de-institutionalised" so that community-based care can be set up in an orderly way (Nettleton, 2013). Stein (2014) elaborates on this point, by highlighting that it is only achievable by first strengthening and expanding approaches such as community-based care. This would entail establishing responsive mental health care approaches and community-based services that promote quality mental health care (Stein, 2014). Organisations such as the Society of Psychiatrists of South Africa (SASOP) recommends detail-focused community-based services, but also emphasises that the promotion of integrated mental health care does not mean there should be a dismantling or erasure of the biomedical approach to mental health care, thus suggesting a more biopsychosocial approach in conjunction with the biomedical approach. (Stein, 2014).

Most importantly, when looking at implementation, the issue of resources has to be discussed. The existing approaches grapple with the issue of resources or the lack thereof. According to Bezuidenhoudt (2016) there are not enough professionals trained in mental health care, in South Africa. Bezuidenhoudt (2016) and Stein (2014:1) acknowledge that there has been an increased interest in evidence-based policy making; but there is less focus on the "question of the individual and social factors that promote the development and implementation of such policy making" as a result there is less attention and care given to the individual themselves.

According to WHO-AIMS (2007), "the total number of professionals working for the Department of Health's mental health facilities or [for] NGOs are 0.28 psychiatrists, 0.45 other medical doctors (not specialized in psychiatry), 7.45 nurses, 0.32 psychologists, 0.4 social workers, 0.13 occupational therapists" per 100,000 population (WHO-AIMS, 2007: 6). Due to information systems put in place for monitoring staff being weak, it is hard for the Department to monitor aspects such as professional training or to follow up on professional development programs after initial qualifications have been received (WHO-AIMS, 2007). It is important to be aware of such processes and operational constraints before unpacking specific aspects of mental health care i.e. maternal health.

### d) Key challenges

There is a great reliance on hospitals to treat and monitor mental health (Bezuidenhoudt, 2016). However, the public mental healthcare services are not easily accessible for vulnerable populations (Bezuidenhoudt, 2016). Up to 75% of people with mental illness do not have access to mental health care (Bezuidenhoudt, 2016: 1). Regardless of the impact mental illness has on people and society, it is often a neglected area of care, when it comes to the allocation of services and resources (Bezuidenhoudt, 2016). It is argued that mental health should be prioritised especially since mental health and mental health disorders are the third largest contributor to the burden of disease after HIV/AIDS and other infectious diseases (Bezuidenhoudt, 2016). Lastly, as shown above, human resources are simply not enough, particularly mental health care professionals (including at the management level) (Bezuidenhoudt, 2016).

Although there are policies that have been developed for mental health care (which will be discussed further in the next theme), implementation is a major challenge. When it comes to South Africa and its mentally ill, policies have recently improved (Bezuidenhoudt, 2016). However, policies alone such as the National Mental Health Policy Frameworks; Strategic Plan; the Mental Health Care Act; the White Paper On Rights Of People With Disabilities, are not reaping the desired outcome (Bezuidenhoudt, 2016), as seen in the Life Esidimeni case where "1300 mental health patients were transferred from [the] mental health facility to non-governmental organisations" (Bezuidenhoudt, 2016). Despite all the policies put in place regarding the care and rights of mentally ill patients, the government went ahead and transferred patients to organisations that were not equipped to manage this care, and, in some instances, it led to devastating effects and loss of life.

## 2) The role of culture in mental health

When evaluating the approaches to mental health care and mental illness, it is important to acknowledge the role that culture plays. There are multiple definitions of culture but this particular discussion is going to be centered around culture as "something that shapes behaviour and is tied to traditions, customs and beliefs" (Gilbert, Walker, Cooper, Lewins, Matshedisho, Nunez-Carraso, Selikow, 2019: 89). Cultural influences are particularly important for health professionals to be aware of when addressing their patients' discomfort, distress and pain (Helman, 2007). Culture plays a huge role especially in regard to mental health because it is directly connected to traditions, customs and beliefs. In addition, it greatly shapes the way in which people behave (Gilbert et al, 2019). As a result, it influences the decisions that are made in regard to health and illness and how pain is experienced (Gilbert et al, 2019). Culture takes place in a social context; it is socially constructed and not biological or inherent, and "[a]ll communities understand health in terms of their culture (Gilbert et al, 2019: 91)"

Helman (2007) emphasises that not all cultural groups respond to pain or distress in the same way. This is particularly important to note in relation to maternal mental health because pain and discomfort is not always articulated, perceived, responded to and addressed in the same way. As further highlighted by Helman (2007: 107) social factors and culture influences "how, and whether, people communicate their pain to health professionals and to others." In some cultural groups, pain is deliberately kept silent as cultural influences play a role in regard to whether people value or discourage emotional expression.

Not only does this highlight that there is not only one way to respond or perceive pain or discomfort, but it also highlights the various ways mental health can be addressed as a result of the many influences such cultural and social factors. Complementary and alternative medicine (CAM) offer additional understandings of health, illness and treatment. As cultural and social factors play a huge role in the manner in which people address pain, CAM which focuses not only on the biomedical but also the social, environmental and cultural aspects of health have grown in popularity (Stratton et al, 2008). Such a form of alternative thinking and understanding of medicine is important because people are greatly shaped by their surroundings, cultural groups and communities. Therefore, response and articulation to distress, pain and discomfort will differ.

Placing emphasis solely on the biomedical understanding of health, especially in the case of maternal mental health is problematic. When it comes to mental health the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) is looked to in order to determine whether a cluster of symptoms is recognized as a disorder, according to the American Psychiatric Association (APA) (Davis et al, 2013). However, the DSM-5 has limitations especially when it comes to addressing maternal mental health during pregnancy. There is currently a significant emphasis and focus on anxiety and depression, post-pregnancy. However, not enough is said about anxiety and depression, during pregnancy (Davis et al, 2013). Davis et al (2013) highly recommend that the DSM-5 include anxiety and depression during pregnancy. They argue that:

“Fifty percent of “postpartum” major depressive episodes actually begin prior to delivery. (Davis et al., 2013: 6). Thus, placing greater emphasis on understanding the experiences and perceptions of antenatal anxiety and depression will provide crucial diagnostic and treatment guidance. However, this will be unpacked further when discussing the current understanding of anxiety and depression as well as the unpacking the understandings of maternal mental health. As well as the role culture plays in these understandings.

### 3) Background on mental health policies and processes

According to Janse Van Rensburg (2007), South African legislation for mental health care practice includes the Mental Health Care Act, of 2002; the National Health Act of 2003 and the proposed Traditional Health Practitioners Act, of 2004. Janse Van Rensburg (2007) highlights the importance of these as they form the base of the values and standards for care recommended by organized mental health care practitioner groups such as SASOP. Lastly, Janse Van Rensburg (2007) emphasised that public sector mental health practitioners operate as state employees. As a result, the implications are that HCPs often work in environments where staff is limited and there is an inadequacy of clinical interventions resulting from insufficient infrastructure just to mention a few (Janse Van Rensburg, 2007: 1).

The first policy that will be discussed is the Mental Health Care Act of 2002 (MHCA). This act was put in place to ensure the human rights of people with mental disabilities in South Africa. According to the MHCA, it is the State’s responsibility to provide any infrastructure and systems needed for mental health care (Janse Van Rensburg, 2007). The “World Health Organization Assessment Instrument for Mental Health Systems” (WHO-AIMS) was put together to attain data on the mental health system in South Africa (WHO-AIMS, 2007). It was found by WHO-AIMS (2007) that the revised Act brought about a number of changes. For example, the policy included “developing community mental health services; downsizing large mental hospitals; developing a mental health component in primary health care; relocating human resources” to mention a few (WHO-AIMS, 2007: 7). However, problematically so because none of the additions actually headed towards what one might view as a more ‘patient-centred’ approach to psychiatric care. As elaborated by Szabó (2010) the existing MHCA brought with it a raft of changes which show very little signs of a ‘patient-centred’ approaches. However, the revised Act required that ‘patients’ be treated with as little restriction as possible and ultimately with the least discomfort and inconvenience, and as close to their place of residence as possible (WHO-AIMS, 2007). This is a noble sentiment which no self-respecting practitioner would disagree with (Janse Van Rensburg, 2007).

When it comes to clinical practice there are a number of elements that have changed. For example, the administrative burden has increased a great deal specifically with regard to both assisted and involuntary treatment categories of patients (WHO-AIMS, 2007). Due to common cases of mental health care being a burden, it further results in even less care and attention for specialised cases, such as maternal mental health care. For example, the provision of care is struggling to keep up with the demand for assistance because of issues such as inadequate infrastructure, limited staff and resources in existing hospitals that cater to mental health care.

In other words, there is already a struggle to meet existing mental healthcare, but the demand continues to increase.

**4) Depression and generalised anxiety**

Depression and generalised anxiety are fairly prevalent forms of mental illness within the general population. According to Winch (2015), depression is when the individual is in an 'abnormal emotional state'. This emphasises that "depression is a mental illness that affects the way in which the individual thinks, expresses their emotions, perceives things, and behaves in general and towards others" (Winch, 2015: 1). For an individual to experience depression or be in a depressive mood does not require a certain situation, i.e. a loss, or a turn of events to occur (Winch, 2015). It is often found that when observing their life in hindsight their life might be totally fine and yet a depressed person still feels horrible or has an extreme sense of sadness within. One of the main factors that distinguishes depression from sadness is the longevity, depression is an abnormal emotional state that one cannot just 'get over' (Winch, 2015: 1).

Winch (2015:1) states that when an individual is depressed, they experience emotional changes and everything is "less enjoyable, less interesting, less important, less lovable, and less worthwhile" According to Freeman, (2019) in Regier et al., (2013) the DSM-5 there are five to nine symptoms of depression, these symptoms can cause personal distress, and changes in how you function socially and professionally. According to Regier et al., (2013) the symptoms are appetite changes either "weight loss or weight gain; sleeping too much or too little; fatigue or loss of energy; slowing or speeding up of physical activity; feelings of worthlessness; feelings of excessive or inappropriate guilt; difficulty concentrating or being indecisive and regular thoughts of death or suicide" (Freeman, 2019: 1).

Whereas "Generalised Anxiety Disorder" (GAD) "is more than the anxiety individuals' experience day to day, it is an exaggerated type of worry and tension" (SADAG: 2019: 1). According to SADAG (2019), when experiencing GAD one always anticipates disaster which often entails worrying excessively. This worry can stem from issues around health, money, family, or work to mention a few. Granted that the source of the worry is sometimes hard to pinpoint. When an individual experiences GAD, "the thought of getting through the day is enough to provoke anxiety" (SADAG, 2019: 1). Thus, further highlighting more often than not social factors play a role when it comes to GAD but they do present themselves in ways that the biomedical model has acknowledged i.e. trembling, twitching, muscle tension, headaches, irritability, sweating, or hot flashes.

Individuals with GAD often find it hard to shake their concerns, in spite of their realisation that their anxiety is more intense than the situation is in reality (SADAG, 2019). People with GAD go through a number of experiences as a result of their GAD as mentioned in the paragraph above (SADAG, 2019: 1). In general, the symptoms of GAD seem to diminish with age. In regard to treatment, successful treatments may include the use of anti-depressants and benzodiazepines (SADAG, 2019). According to SADAG (2019) cognitive-behavioural therapy, relaxation techniques, and biofeedback to control muscle tension has also been beneficial as a form of treatment.

## 5) Maternal Mental Health

According to WHO (2019), when it comes to maternal mental health worldwide 15.6% of women experience mental health issues during pregnancy. In worst case scenarios, the suffering might be so severe that mothers cannot function properly and may even commit suicide (WHO, 2019). As a result, the way in which the child grows and develops may be negatively affected as well (WHO, 2019). Despite this, maternal mental disorders are treatable (WHO, 2019). Effective interventions can be delivered even by well-trained non-specialist health providers such as community health care providers (WHO, 2019). WHO (2019) has found that depression experienced during pregnancy has caused enormous suffering and disability. The evidence indicates that treating the depression of mothers leads to improved growth and development of the new born (WHO, 2019). Across the globe, maternal mental health problems are considered a major public health challenge. However, there are not enough resources put into maternal health care (WHO, 2019).

When it comes to maternal health it is important to note that the support given to pregnant mothers varies, dependant on whether the patient utilises the public or private sector. In the public sector, mental health care/help can be provided once a mental condition is picked up. A referral is then made to a social worker, psychologist or psychiatrist depending on the type of support needed. However, within the private sector there is a great deal more support available. For example, dedicated mental health clinics, where psychological and psychiatric support and services are provided. This support is predominantly instrumental support because the support is centred around the active provision of healthcare services (Bowsher et al., 1997). By providing an in-depth exploration into this topic, this study aims to show the importance of this topic and the need to invest more into maternal health care.

### a) Antenatal anxiety and depression

The prevalence of antenatal anxiety and depression is between 7% and 20% in High Income Countries (HIC). However in developing countries, it has been found that the prevalence of anxiety and depression is 20% or more (Biaggi et al., 2016: 1). A considerable number of pregnant women face immense anxiety and depressive symptoms during their pregnancies. These symptoms of anxiety and depression can emerge in any trimester. It is very rare that clinicians pay particular attention to cases of anxiety and depression during any particular stage of pregnancy, as ongoing screening is done throughout (Biaggi et al., 2016). This is because there is less emphasis placed on maternal mental health as there is on other medical issues during pregnancy. More attention is placed on anxiety and depression arising from an HIV/AIDS diagnosis but there is a gap in relation to antenatal anxiety and depression (Biaggi et al., 2016). During the antenatal period, potential signs of depression and anxiety present a significant burden to the expecting mother. In order to understand this, this research will explore the accounts and experiences of antenatal anxiety and depression amongst mothers in relation to the impact social support has on these experiences; as existing literature focuses solely on known symptoms and its contributing factors but not much on how various forms of

social support or the lack thereof may also contribute to perceptions and experiences of antenatal anxiety and/or depression.

### 6) Symptoms

Symptoms of antenatal anxiety and depression are unique to each patient, but the most commonly seen symptoms are detailed below. According to Digital (2017) some of the symptoms include

> "a racing heart, palpitations, shortness of breath, shaking or feeling physically 'detached' from your surroundings, persistent, heightened worry often focused on fears for the health or wellbeing of the baby. Some symptoms can also include the development of obsessive or compulsive behaviours, abrupt mood swings, constant feeling of sadness or having thoughts of death or suicide, or self-harm"

According to Winch (2015:1) the main factor that distinguishes sadness from depression or worry from anxiety is often the longevity of that emotional state. Its important to know what existing literature says about the known symptoms and contributing factors as this will inform the analysis of this research and determine to what extent expectant mothers' experiences and perceptions align or differ from such.

**Contributing Factors**

According to Lee et al (2007:01) the most relevant factors associated with antenatal depression or anxiety are: the "lack of partner or of social support; history of abuse or of domestic violence; personal history as this is seen when depression or anxiety runs in the family, or when the patient has had past episodes of depression or anxiety, this might increase the chances of developing antenatal anxiety or depression; unplanned or unwanted pregnancy; adverse events in life and high perceived stress such as a move to a bigger home in anticipation of the baby's arrival, divorce, or job loss, financial problems can contribute to anxiety or depression". HIV/AIDS patients are also prone to a great deal of anxiety in relation to the baby and their well-being (Lee et al., 2007). Present or past pregnancy complications and pregnancy loss have also been shown to impact on anxiety and depression (Lee et al., 2007). As discussed, mental illness can be understood through different conceptual models. As discussed here, the majority of contributing factors can be attributed to social factors (other than the bio-medical explanation of triggering from a prior diagnosis of mental health issues).

As shown, explanations of anxiety and depression have gravitated towards understanding biomedical symptoms and the psycho-social context. The contribution of my study is to explore mothers' perceptions and experiences of anxiety and depression as a lay perspective. This is based on a few mothers who have been clinically diagnosed as well as mothers not formally clinically diagnosed but who deem their experiences 'significantly different' from their usual experience and sense of self during previous pregnancies

## 7) Obstetric Violence

Before unpacking the concept of obstetric violence, it is important to shed light on the notion of medicalisation because it will locate and contextualise this discussion. Busfield (2017: 66) defined medicalisation as "the process of making medicine and the labels 'healthy' and 'ill' relevant to an ever-increasing part of human existence". The connection between medicalisation and expectant mothers' experiences of pregnancy particularly mental health is the "power doctors exercise over women in relation to matters such as birth control, pregnancy, abortion and child birth" (Busfield, 2017: 69).

The law in Venezuela highlighted that obstetric violence is one of nineteen punishable acts of violence. It was defined as:

> the appropriation of the body and reproductive processes of women by health personnel, which is expressed as dehumanized treatment, an abuse of medication, and to convert the natural processes into pathological ones bringing with it a loss of autonomy and the ability to decide freely about their bodies and sexuality negatively impacting the quality of life of women (Chadwick, 2016: 423).

The core argument put forward is the use of the word 'mistreatment'. The concept obstetric violence challenges the conventional use of 'mistreatment'. Obstetric violence problematises and debates the many ways in which the notion of 'mistreatment' is used (Chadwick, 2016). Chadwick (2016) points out that obstetric violence is the mistreatment used against women and girls when they experience humiliation and disrespectful treatment during pregnancy and labour, which is an injustice and a grave violence towards their being. Initially, the 'mistreatment' is experienced on an individual level but it is also experienced on a structural and systemic level. This study will explore whether the women in the study experience this and whether these are in fact connected for the women in this study.

Chadwick (2016: 423) suggests the best route to tackle this form of violence and abuse in maternal healthcare is by adopting more rigorous legal routes that recognise the results of the failure of the existing medical establishment. This should then confront the existing issues and therefore hold healthcare professionals and institutions accountable for unacceptable practices.

Chadwick (2016) argues that the constant experiences of mistreatment, in South Africa, should be acknowledged as a form of gender violence. One that devalues and normalises violence against women. This is particularly worse, for marginalised and impoverished women and girls. This form of violence is not of a simplistic nature. It is complicated and multi-layered due to the fact that it entails both individual acts of abuse and structural components. There is a need for the acknowledgement of both obvious forms of violence, by individual 'perpetrators' and structural forms of violence.

Chadwick (2018) emphasises there is a great need for feminist engagement and conceptualisation where obstetric violence is explored to a point where it offers space for women's response and resistance in the face of power and coercion. It is equally important to point out that this form of violence is not restricted, as presumed, to the public sector, but there is also a lot of 'mistreatment' in the private sector. Hence, the importance of acknowledging obstetric violence when looking at the experiences of pregnancy and labour (Chadwick, 2018).

This is particularly important because this study seeks to understand expectant mothers' experiences and perceptions of anxiety and depression across socio-economic backgrounds.

## 8) Social Support

According to Bowsher, Langford, Lillis and Maloney (1997), there are two broad descriptions of assistance or social support given to those in need. The first being tangible support i.e. financial aid. The second being intangible support i.e. emotional support. Before acknowledging the social support attributes, it is important to unpack the theoretical foundations of social support itself. The theoretical foundations of social support entail; social comparison theory; social exchange theory; and social competence (Bowsher et al., 1997: 96). Social comparison theory emphasises that the individual develops "their self-concept by equating themselves to others in their chosen reference groups" (Bowsher et al., 1997: 96). Second, the social exchange theory, unpacks human behaviour as a conversation of equally rewarding activities where the one supplying reward is contingent on favours returned. Third, social competence defines competence as the capability to effectively interact with the environment (Bowsher et al., 1997).

According Bowsher et al., (1997) there are several social support attributes that provide specific types of support for those in need. Emotional support allows for support that is empathic, caring, loving and trusting. It is said that this form of support is most prevalent as opposed to the other types of support. Then there is instrumental support which is centred around tangible goods and services or tangible aid. Even though instrumental support shows acts of care and love, it is distinguishable from emotional support as it is tangible in nature (Bowsher et al., 1997: 96). For example, providing financial help or performing assigned work for others. Following that there is informational support which refers to information being given to an individual during a time of stress or ill health. Informational support is particularly known for assisting in problem-solving (Bowsher et al., 1997: 96). Lastly, there is appraisal support which entails communication that is relevant to self-evaluation as opposed to problem-solving (Bowsher et al, 1997: 97). These forms of support will be used to later evaluate the support provided to mothers by their immediate context and health care practitioners, when discussing whether they experienced anxiety and depression (or not) and what helped them through the experience. As well as what their perceptions regarding that were.

## Conceptual Framework

In order to fully understand the importance of maternal mental health. It is paramount to unpack what maternal mental health entails and the struggles experienced during pregnancy. The literature review discussed this at length so the conceptual framework will briefly highlight the focus and context of the study.

Internationally, according to the American Psychiatric Association (2018) mental illness is understood as a set of health conditions and changes experienced involving a shift in emotions, thinking and behaviours. In the South African context, mental illness is understood as a psychological or emotional condition which hinders a person from functioning normally, over a period of time. Mental illness is often associated with distress and/or difficulties in relation to functioning in a social context, work or family activities (Parekh, 2018). This is how mental illness is understood in this study. According to SADAG, one in six South Africans suffer from anxiety and depression. Furthermore, research shows that 40% of people living with HIV in South Africa have a diagnosable mental disorder (http://www.psychiatry.uct.ac.za/).

Before restating the importance of maternal mental health, it is firstly important to understand what this is. Maternal mental health refers to mental illness that occurs during pregnancy or the first year after childbirth (www.bettercare.co.za). In South Africa, mental illness during as well as after pregnancy is extremely common. It is particularly high in South Africa because of the stresses associated with poverty, violence, abuse, HIV/AIDS and unintended pregnancies (www.bettercare.co.za). A focus particularly on antenatal anxiety and depression is particularly important because not enough research has been conducted on the topic, despite how common it is for women to experience mental ill health for the first time during pregnancy.

A number of women experience great distress over long periods of time during their pregnancy because they feel a great deal of shame, guilt and even embarrassment because of the lack of joy they feel in a time presumed to be a joyful time in their lives. As a result, women go through their whole pregnancy with this anguish, not knowing that they have been experiencing some form of mental illness (www.thewomens.org.au). This is extremely problematic because untreated mental illness can have a long term effect on the health and wellbeing of both the mother and the baby. As a result, it is important to get the right treatment. There are effective forms of treatment that will not affect the baby or the mother while breastfeeding. This study was broadly located within the field of maternal mental health.

As this study specifically aimed to highlight expectant mothers' experiences and perceptions of antenatal depression, antenatal anxiety and antenatal mental healthcare in the South African context, it is important to unpack key concepts at the heart of the research and that informed the research and are absolutely core to the findings. The analysis therefore centred around the emerging concept of social support and particularly what this means to mothers.

Bowsher, Langford, Lillis and Maloney (1997: 95), truly encompass and unpack the different forms of social support. This is firstly highlighted as assistance that can be understood broadly in two ways: tangible support and intangible support. Tangible, for example, being financial

support or aid and intangible being emotional help. Bowsher et al., (1997) then go on emphasise the attributes of social support.

The first attribute is emotional support which entails the delivery of care, empathy, love and trust. Then there is instrumental support which involves the delivery of tangible goods and services or tangible assistance as a whole. Following that there is informational support which refers to information provided to another during a time of stress. This attribute assists one to problem solve (Bowsher et al., 1997). These attributes were found to be really helpful in setting the foundation in understanding and analysing the findings and experiences of the participants.

In conclusion, this chapter unpacked and engaged key issues and ongoing debates around mental health. It engaged classic theorists that shaped the way mental health is understood. It further unpacked contemporary emerging theories that have shaped the way mental health is understood to date. In addition, it shed light on the existing literature that is particularly relevant to maternal mental health thereby highlighting the concepts and discourses at the fore front of maternal mental health and some of the gaps that have come up. This literature review provided a summarized discussion of the approaches to mental health care in South Africa; discussed the role culture plays; reviewed mental health policies and processes; it unpacked what anxiety and depression means as well as how it is understood from a range of perspectives, unpacked what is meant by antenatal anxiety and depression specifically; discussed how support is understood within this context; and lastly discussed the significance of obstetric violence within this field. The chapter ended with a summary of key concepts as used in this study. Following on from this, the next chapter, will unpack exactly how the study was executed, and is provided in the Methodology.

# Methodology

## Introduction

This research study aimed at understanding the perceptions and experiences of expecting mothers. Pregnancy is a stressful time for most women. As a result, this research aimed to explore and understand mothers' perceptions and experiences of antenatal anxiety and depression, as well as the factors that potentially influenced this. Due to the sensitivity of this study, it was important that the chosen method accommodated this. This research used a qualitative approach for a greater understanding of human and social interaction from the perspective of the insiders i.e. participants in the research: mothers and healthcare practitioners.

## 1) Context and Location

The basis of this research study is the experience of pregnant mothers with antenatal anxiety and depression. Before interviewing first time mothers, I first interviewed two health care professionals from a maternity clinic in Johannesburg who are obstetricians/gynaecologists (OB/GYNs) who are medical specialists in their field and had encountered some cases where mothers experienced maternal antenatal anxiety and depression under their care. This was done so I could gain further knowledge and insight on maternal mental health from the 'experts' perspective. A psychiatrist with expertise in the field was also interviewed. My intended sample included women participants who were recent mothers, having given birth within a year to four years previously. My initial plan was for all mothers to have been formally clinically diagnosed with depression and/or anxiety during their pregnancy. The first mother met this criteria and was referred from the psychiatrist. However, following that I had great difficulty in regard to accessing such participants. It proved more difficult than expected to find additional participants who were clinically diagnosed and willing to participate.

As a result, I had to use other sampling methods. I had to broaden the inclusion criteria beyond mothers with a formal diagnosis. Then I used 'word of mouth' e.g. WhatsApp messaging friends and family about my study and requesting that they please share the message to anyone they think might be interested. As a result, this assisted me in attaining my remaining seven mother participants. The participant pool then included mothers who had experienced anxiety and depression according to their own judgements, perceptions and evaluations of their experiences during pregnancy. It is important to note that my sample was also not restricted to participants who had been previously clinically diagnosed with anxiety and/or depression before their pregnancy. The sample was not restricted by marital status (both married and single moms were included). This was done to broaden the sample and highlight the various aspects that can contribute to the overall experience of pregnancy.

When it came to whether or not the sample was restricted to planned or unplanned pregnancies, I decided to also omit this criteria because I felt that asking this question itself, would already potentially bring about distress to participants. However, it came up organically within discussions about the pregnancy experience and thus I considered the effects thereof as a

strength or limitation in the specific interview process. Lastly, I conducted interviews with participants of various socio-economic statuses.

## 2) Methodological Approach

The approach used is a Qualitative Approach. A qualitative approach "is grounded on wanting to further understand human and social interaction from the perspective of the insider and participants in the interaction" (Neuman, 2006: 149). Due to the fact that this research aimed at understanding experiences, the qualitative approach was ideal as it aimed to attain an in-depth account and understanding of 'the perceptions and experiences of mothers in relation to anxiety and/or depression'. As mentioned, a key feature was understanding the perceptions and experiences of a topic that was of an exploratory nature (Maxwell, 1998). This exploratory nature gave room to uncover issues around antenatal anxiety and depression that other approaches may have missed or ignored (Maxwell, 1998). The qualitative approach also allowed for participants' views, lived experiences and accounts to be expressed and understood (Maxwell, 1998). As qualitative studies generally focus on relatively small samples or situations, they maintain the participant's individuality (Maxwell, 1998: 108). This was true for this research as rich themes were generated and detailed insight into mothers' ante-natal anxiety and depression was gained through the approach taken.

## 3) Research Method

### a) Primary Sources:

This consisted of in-depth interviews that were conducted with mothers (eight in total) and experts (three in total) on the topic.

### b) Secondary Sources:

Data was gathered and compiled from previous research on topics like this and I used applicable methods of gathering qualitative data for my literature review and thus to analyse my primary sources.

## 4) Research Instrument

Qualitative research instruments assisted in finding and collecting data needed. Once I had progressed to the interview stage, I conducted in-depth interviews using a semi-structured interview guide (see appendix). For the interview process, to ensure that I had core ideas and questions available on hand to guide me through the interview. These interviews were semi-structured interviews. Semi-structured interviews 'involve a clear list of issues to be addressed and questions to be answered, but there is flexibility in the sequence in which they are asked' and as the interviewer this allowed my participants to speak more broadly about the topics discussed (Greenstein, Roberts, Sitas, 2003: 76).

There is a huge gap when it comes to understanding the mental health experiences of pregnant woman and their use of mental health care. Now, having actually interviewed the mothers, my research conceptually and empirically assists in documenting mothers' experiences through their pregnancies. This could be useful for future research and scholarly literature on the topic as well as future mothers who may be assisted by the findings of this research, to navigate

through their pregnancies in a way that is most healthy for them psychologically and mentally. The findings could also be beneficial to society in that it creates awareness around maternal mental health care and will hopefully improve the existing healthcare structures.

## 5) Sampling

I sought out potential participants from the people around me. Subsequently, mothers that were interested in being interviewed and sharing their experiences, contacted me to set up an interview. The limitations of this research were that due to time constraints, I was only able to focus on a small sample in urban Johannesburg. During the research period there was not enough time to adequately research a wider set of experiences, such as the perceptions and accounts of mothers in socio-economically disadvantaged areas. I was also not able to study mothers' experiences post-pregnancy in relation to their antenatal experience.

## 6) Profile of participants

| Participant No. | Participant Description | Race | Place of birth | Partner Status | Public or Private | Where interviews took place | Language spoken when conducting the interviews | Length of interview |
|---|---|---|---|---|---|---|---|---|
| 1 | OB/GYN (HCP) | Indian | N/A | N/A | Private | Parktown | English | 17:52 |
| 2 | OB/GYN (HCP) | White | N/A | N/A | Private | Parktown | English | 12:24 |
| 3 | OB/GYN (HCP) | Indian | N/A | N/A | Private | Parktown | English | 21:09 |
| 4 | Mother | White | JHB | Married | Private | Rosebank | English | 51:02:00 |
| 5 | Mother | Black | Zim | Married | Private | Parktown | English | 15:05 |
| 6 | Mother | Black | JHB | Single | Private | Sunninghill | English | 30:34:00 |
| 7 | Mother | Black | Lim | Single | Public | Germiston | English | 20:18 |
| 8 | Mother | Black | Zim | Single | Public | Randburg | English | 11:54 |
| 9 | Mother | Black | JHB | Married | Private | Randburg | English | 16:12 |
| 10 | Mother | Black | JHB | Dating | Private | Germiston | English | 21:20 |
| 11 | Mother | Black | Lim | Married | Private | Telephonic | English | 15: 23 |

## 7) Interpretation of the data

Once all data had been collected. The interviews were transcribed verbatim and then analysed using Thematic Analysis. Thematic Analysis is a method of identifying, analysing and reporting themes within data (Braun, Clarke, 2006: 79). It minimally organises and describes the data set in immense detail. The core aim when constructing themes within thematic analysis was to capture important data that relates to the research question and that represents a particular level of constructed meaning within a data set (Braun et al., 2006).

I followed the following procedural steps suggested by Braun et al., (2006: 87), I familiarized myself with data, after all the transcribing was done, I read and re-read the data, and noted down initial ideas at this time. Second, I generated initial codes. These codes are ones that presented as interesting features of the data in a systematic fashion across the entire data set, I then collated data relevant to each code (Braun et al., 2006). An example of this would be support received. Third, I searched for themes. This entailed collecting codes into potential themes gathering all data relevant to each potential theme. For example, Healthcare professional support, Family support, Partner support, Financial support and Workplace support. Forth, I reviewed the themes to observe if these worked in relation to the coded extracts and the entire data set. The mothers continuously emphasised various forms of support and the impact that support had on them during their pregnancy and as a result how it shaped their experiences. Thus, I generated a thematic story of the analysis. Fifth, defining and naming themes. This involved an ongoing analysis to refine the specifics of each theme. Lastly, producing the report. This was the final opportunity for analysis of the selected extracts, relating back to the research question and literature thus producing a scholarly report of the analysis.

As emphasised by Braun et al., (2006: 77), thematic analysis is advantageous because it offers an "accessible and theoretically flexible approach to analysing data". It is also useful and a flexible method for qualitative research. However, there are pitfalls that I had to be cognisant of when applying thematic analysis. First, I had to be cautious of failing to adequately analyse data, it was important to remember that I had to do more than just string together extracts. I had to make sure that those I put together had meaningful analytic narratives. Second, it was important to properly construct themes, i.e. I had to be aware of not using the data collection questions as themes. Third, I had to be wary of themes not co-existing or working around the central concept. Fourth, I had to avoid a mismatch between the data and any analytic claims. Lastly, I had to make sure that my interpretations of the data were consistent with the theoretical framework (Braun et al., 2006). For example, I had to ensure that all interpretations contributed to understanding the importance of maternal mental health.

## 8) Methodological Lessons Learned

The lessons learned from conducting the research, and especially the fieldwork, were that there is a real intricate skill that comes with probing what? I assume you mean probing questions in interviews, but without context it's not clear. Once going over and reading through the transcripts, I realised that there were a couple of opportunities where I could have probed a bit more. For example, especially to get the entire picture of mothers' experiences 'of during and after the pregnancy', I could have asked more follow up questions. I was mostly focused on and thus asked questions on their experiences during pregnancy. Whereas I have now seen, if I had asked more questions about before and after the pregnancy, I could have generated a comparison and contrast of what happened during different phases of the pregnancy and this also would have enriched my understanding of my specific topic. I also think it could have helped to constantly remind myself, during the interviews, of the actual research question, to truly cement the direction I took during my probing. If I had done so, I could have been afforded the opportunity to better understand the full effects and aftermath of support or the lack thereof.

The positive lessons that were learnt from the research, were that people are very open about sharing their experiences and that those experiences really assist in understanding how complex human beings are; and that our environment has a significant impact on our lives. If anything, such experiences further emphasise that we are only human. One's environment does impact the way one responds to life's experiences and that impact is bound to have a positive or negative effect on one's overall mental well-being, especially during a significant time of change, such as pregnancy.

The prevalence of support or lack thereof really impacts on one's experience and one's perceptions of anxiety and depression. This was evident when listening to the experiences of the mothers. As a result, this raised questions around what is anxiety and depression? How they are experienced and perceived? Which the research allowed me to understand and unpack. Focusing on expectant mothers' perceptions and experiences about anxiety and depression proved necessary because it shed light on people that have fallen through the system. For example, new mothers that felt as though they were experiencing severe feelings of anxiety and/or depression in relation to their pregnancy or baby but were not necessarily having their mental wellbeing monitored because they were not previously clinically diagnosed with anxiety and/or depression. There is an outstanding strength that comes from sharing experiences and being able to truly listen. As a result of the qualitative method that I chose I feel I was able to understand meaning from human action (Badenhorst, 2017: 20)

## 9) Ethics

I applied and was granted Research Ethics Clearance by the School of Social Science. In accordance with this, I made sure that all participants received information about the study, agreed to participate through formal informed consent (see appendix) this was to ensure that there were no blurred lines when it came to giving consent. This was particularly important for me as the researcher because it allowed me to gain permission and it also provided my participants with the knowledge to make an informed decision (Ogletree, Kawulich, 2012). By the time I conducted my interviews, I had the details of a psychologist that my participants

could contact, if the need had arisen. I have also attached my participant information sheet, informed consent, interview schedule and ethics clearance, as Appendices to this report. In discussing my findings, I have not disclosed the names of the maternity clinic, the healthcare professionals nor the participants to ensure anonymity.

# Findings and Analysis

## 1) Context and Background

This research engaged mothers' experiences during pregnancy and the impact social support has on those experiences. It sought to understand and unpack the various events and experiences that unfold during pregnancy and how these then impacted the mothers' overall mental well-being. In regard to their socio-economic background they could be described as middle to lower class. This is a particularly important aspect to indicate because it provides context to the type of help, they were able to receive. Their ages varied from 18 to 45 years.

It is important to note that all the mothers who were interviewed, were familiar with terms such as anxiety and depression. These terms did not have cultural strain. Mothers understood and showed an awareness of these terms and articulated that "growing a baby is particularly tough". Worth noting is that, 6 out of the 8 interviewed women did not initially expect or plan their pregnancies, and 3 out of the 8 women had really complicated pregnancies.

The findings presented below focus on the mothers' narratives which speak to their understanding of maternal well-being, the support or the lack thereof available to them during their pregnancy, and how that impacted their maternal mental well-being. As well as discussing an array of sources of social support, mothers spoke of experiences in both the public and private health sector as unpacked further below.

## 2) Contributors of Anxiety and Depression

As this research is centred around the experiences of pregnancy and co-occurring experiences of mental ill health, be they feelings of anxiousness or depression. It is therefore equally important to highlight what healthcare professionals and mothers attributed to be the causes or contributors of such experiences.

According to the interviewed healthcare professionals (HCPs), there are various contributors to anxiety or depression during pregnancy. For some patients it is: unexpected pregnancies, unexpected diagnoses such as HIV, preeclampsia (which is a pregnancy complication in relation to high blood pressure), heart murmurs, or cysts (to mention a few) that induce some anxiety or even depression for the expecting mother. When experiencing such anxieties HCPs are expected to counsel expectant mothers or direct them to places where they can draw further assistance. However, the first gynaecologist interviewed, highlighted that:

> The mother's environment also plays a huge role in terms of counselling women, making them feel comfortable and warranted in the pregnancy. Mothers often also worry about whether or not they're going to be able to cope with the new infant. Financial anxiety and fragmented families such as fathers or partners not being in the picture are also a major contributor of anxiety and depression during pregnancy. Lack of support from extended families; judgments received at antenatal clinics especially when the mother's a teen and in poverty. [Or] living in communities where they're stigmatized, for example, experiences of xenophobia (Int01).

Whereas for the mother's contributors of anxiety and depression range from: the news of being pregnant; health as a huge determining factor of their mental well-being; family support;

partner support; financial support; and healthcare professional support. They all emphasised experiencing so many hormonal changes that each of their experiences has a massive impact on their mental well-being. The forms of support received or the lack thereof really have a huge impact on their maternal mental well-being. For example, this was greatly emphasised when interviewee 5 discussed her experience and what would have improved her situation:

> …definitely getting a therapist [giggles] because damn I mean I can't change the situations that happened so, uhm, just having a bit more professional help. Uhm, I think, also, because in the private sector… doctors [are] very expensive. I know that at most government clinics and stuff they have, uhm, free, uhm, what do you call them, free session, or uhm or like, they have psychologists there that can assist you because it is, uhm, it is a government clinic but, uhm, because first of all we didn't have… I live very far I live in Dainfern so, we have no free clinic, even then at that point I actually didn't know that they had… psychologists that, that were there specifically for that, uhm, I think also maybe like having my parents speak more deeply on it (Int 05).

She went on to further express how during her pregnancy she was emotional and at her lowest moment. This account (Int 06) sheds light on the perspective of finding value even in the illness-narratives unpacked below:

> There were days where I literally couldn't get out of bed, I was just so depressed I think my thing was I hated myself because I felt cheated out of my first time having a baby and obviously you have like these ideas in your mind and let, you know, the first time you have a baby you're going to be with somebody that you love and all of that and also like that I threw my whole life away, you know, kind of thing because now I have a baby that I [have] to take care of, and these responsibilities. Uhm, a lot of fear I was not, I did not know how to be a mother it is one thing to be an auntie because you give the kids back at the end of the day but being a mom it was just like I was scared I was very very scared.
>
> Uhm, I don't know if this is something that's okay to share but I kept thinking, is it too late for me… There was even a certain point where I felt suicidal. I will never forget this one day where was literally I was in the kitchen I don't know what I was doing it is one of my low, lowest, lowest days, I was there and I just wanted to get some spices and the spices are next to the medicine cabinets and then I opened the medicine cabinets and in my mind I was just thinking literally just want to take every single pill in this cupboard and just like I'm done I don't want this, so yeah, there was a lot of ups and downs. But yeah, I was by myself a lot I was working from home so also that you just have too much time to think…(Int06)

Another mother expressed how initially she felt very negatively about the pregnancy especially because she was going to be a teenage mother:

> I knew nothing Tessa…all I could remember with my first pregnancy is being a teenager and pregnant… I was terrified. I was in the rural areas, really terrified. But, uhm, I think my interests was just giving birth and go to university because I was just about to start university (Int07).

Although she had feelings of extreme terror and anxiousness, she emphasised that receiving extra assistance and constant guidance did somewhat ease her concerns:

> I remember the maternal clinic was at Germiston hospital and getting to learn about pregnancy, you know, I was given the pamphlets and really, I started to sort of embrace the experience at that time I started to become excited and anxious. I couldn't wait now. You know, being a teenager, I had to equip myself with the knowledge I was getting from the clinic and that really helped (Int07).

Although the feelings of anxiety were still present, she was able to feel more excited as opposed to terror due to the assistance she received from the HCPs. The comfort that came with the

support of HCPs was further emphasised by a mother who was gravely ill from the very beginning of her pregnancy. This particular mother (Int 11) noted that:

> …from my experience going through pregnancy without support, can drive you off the cliff, or into depression or way worse. So I would say, I would recommend if you have a support system, appreciate it and if you don't have a great support system, I would advise women who don't have a great support system, great support systems should be given often…whether support groups, uhm, you know, uhm, in government institutions, motivate families to support because it is not an easy thing to go through alone. You know, I look at myself and I see if I had gone through what I had gone through alone, I don't think I would have made it you know, so I would emphasise on support. You know, government and health institutions should offer such support structures, especially for the less privileged. I remember one of the nurses in the ward even gave me her numbers and told me that if ever, I felt overwhelmed, if ever I felt sad, I could call her and that's the extent of the support that I got (Int11).

Although seven out of the eight mothers were not formally diagnosed by a HCP with anxiety or depression during their actual pregnancy there were tell-tale signs that I as the researcher interpreted that the mothers' experience was more than your typical pregnancy worries. As a result, participants noted by looking back on their pregnancy experience, that greater emphasis on HCP's support was needed:

> I think what I needed at that time was to talk to a professional from a psychological point of view, health professional you can name them I mean. I think someone would have just, uhm, would have counselled me at that time. So, I would support that, I mean I think now the services are free in government hospitals. One can just see a psychologist if you're in that position and hear about that options that you have. If you decide to keep the baby that would be a good option, you know, [for] you [to be] advised into proper channels.

This recommendation from patients themselves then opens up the discussion to the role HCPs feel they themselves play when it comes to supporting their patients' mental well-being during their pregnancies.

**3) Healthcare professional support from the perspective of healthcare professionals**

When interviewing the healthcare professionals about maternal mental wellbeing, a lot was shared in relation to the support they provide to patients or conversely the lack of support given to patients.

In an interview with an Obstetrician and Gynaecologist (OBGYN) (Int01), it was highlighted that when she deals with patients, it is important for her to separate the high-risk patients from the patients that do not fall into a high-risk category. This is done through patient profiling with the result being that a mother could be informed that "she has a very strong chance she may lose the pregnancy because she's got severe preeclampsia for example" (Int01). The OBGYN would then involve a social worker in the patient's care, before delivery. In this particular instance, this OBGYN provided the mother with informational support, about her health condition and instrumental support by ensuring that referral avenues are there for the mother to make use of, if need be, as unpacked by Bowsher et al., (1997).

It was further emphasised that it cannot solely be left to HCPs to support expectant mothers. Therefore, a mother definitely needs added support from friends, family, partners, etc. This is particularly important because when looking at best case scenarios, a mother only has one scheduled session with the HCP once a month in both the public and private sector, where after they return to their family environment or social circumstances.

It is paramount to acknowledge that despite being a HCP, this OBGYN had herself first had an experience of the type of lack of support mothers often experience when they are pregnant.

> I am a postpartum depression survivor, so that's why you've come to the right person. And for whatever reasons I didn't get the antenatal support that I should have been given, uhm, from the time of being diagnosed with intrauterine growth that restricted baby to the point where I was admitted for steroids to the point where I had a foetal distress emergency caesar, my baby was in ICU. And it is just that whole concept of feeling inadequate and the subtle things like people telling me 'oh your baby was so small in the ICU because you work so hard'. It is that constant bashing and bashing that every woman needs to prove herself and if she's a mother she needs to step up and be the strong one, and when you feel as though there's no one supporting them in that aspect, and you feel inadequate, someone needs to be able to say it is okay, and the other thing I want to mention to you is, 'it takes a village to raise a child' and if you don't have a support structure other than a psychologist and a psychiatrist and someone who acknowledges what the problem is then it is a massive disservice so you need everyone on board to be able to support.
>
> One mom said to me 'snap out of it, you're being difficult'. So, I didn't have the support from that point of view. I have been in psycho-therapy seeing a psychologist for three years, my sons will be almost three, who I love, and every time I go to her she cannot believe the improvement I have made. Then I was also on anti-depressants which I've stopped now for more than a year and I'm coping well off them and I've taken this to basically help whoever I see not in a safe place and that is why I was late to see you because the two people before you have got signs that I had that I needed to sit and counsel and be able to get them to the right spaces so for me this is a topic very close to my heart and I really think that it is under studied because people only look at evidence-based they don't look at experiences and for me that's a huge default, why would we read what we need from textbooks when people are telling you how they feel and try make a difference from that perspective. (Int01)

This account of her experience is particularly disheartening because it takes a lot to seek help especially "where the experience of pain is at times valued and/or disvalued, to the point where in some cultural groups pain is deliberately kept silent as cultural influences play a role (Helman, 2007: 107)".

This is why she prides herself in ensuring that there is a support structure readily available in her patients' lives because the frequency of first time mothers who experience antenatal anxiety and depression is more common than one would think and often goes unnoticed:

> …I think it is one in eight or one in six but it is frequent, hey. Especially when a mother that's never experienced having or giving birth, going through the delivery process then you also have to assume that everything is normal and most time it isn't. You move from a completely independent life [where you] only need to focus on yourself to having a little child that completely dependent on you and will not survive without you and there's also that anxiety of getting it. There's an anxiety of being judged by the community or family for not getting it right and there's also the lack of sleep component which no one realises has huge hormonal implications. So, it is really very prevalent. It could even be more frequent like one in three mothers. I can't remember off the top of my head. It is something that's terribly under diagnosed but is very, very relevant (Int01).

Having had this personal experience makes this HCP more connected, understanding and less intimidating. Whereas in a second interview with another OBGYN (Int02), a very different perspective on support was shown. Int02 noted that very little was done for mothers in regard to their mental health during pregnancy. Of particular significance, is that Int02 stated "there's nothing compulsory done for the mother to monitor their mental health". This was emphasised to the point where it was stated that "so you're lucky [as the patient], if you ask questions".

As opposed to Int01, Int02's response in relation to how much is done for expectant mothers' maternal well-being acknowledged not much is done for expectant mothers with responses such a 'probably very little, so we don't [monitor] as a routine', 'I think it is poorly addressed by gynaecologists' (Int02). Following that when asked if she was aware if there are any resources that are available to manage maternal mental health in South Africa… the response provided was 'I do not' (Int02) which highlights the shortages of patient-centred approaches to care (WHO-AIMS, 2007). How would a patient feel hearing such responses? It raises questions around whether or not the patient would feel comfortable engaging further to find the assistance they feel they need at the time.

However, this HCP (Int02) acknowledged that monitoring mental health during pregnancy is important but noted that there is nothing [in terms of services] available for mothers during pregnancy. This point is reinforced with the HCP's statement: 'there's a post-natal depression society and self-help group but not an antenatal one' (Int02). This is problematic because if a patient was to ask assistance during pregnancy, information could not be provided but would only be made available after the birth of a child. The seventh interviewee (Int07) noted that:

> [HCPs] don't really ask how YOU are doing. It is always you in relation to the baby. Like 'how you guys doing'. Never is there anything we can do to make it better for you and because of that you start to look at yourself in relation to the child. You end up even feeling selfish for putting yourself first (Int07).

She went on to highlight that it also spills over into a mother's post-natal experiences:

> [putting yourself first] is really important because people really try making you feel bad for the things that aren't the norm or if you're being selfish. If you chose that right now, I want to be alone you end up overwhelming yourself with things you can sort out with just taking a break. Also, everyone's experiences are different. I mean I have a partner that doesn't live with me so it is almost like single parenting. You have to really cut yourself some slack and do the best that you can. That's why I keep saying you have to cultivate it within yourself that I'm doing the best that I can and uhm yea. It can get better but at the moment I'm doing the best I can.

As a result of the above mentioned it was concluded that mothers do need all sorts of social support, even more so because the HCP's acknowledge that such structures are not availed to mothers during pregnancy, at the point of need. Furthermore, the situation "is even worse in the public sector because after eight hours post-partum, a mother is released to go home" (Int 02); and if she had a Caesarean-section she is sent home two days post-partum. Thus, there is a minimum time for post-partum mental health conditions to be observed.

The third interview (Int03) was also with a HCP although one who works as a psychiatrist, who elaborated on the forms and channels of support put forth to mothers. When asked about resources availed to mothers, it was pointed out that there was an organisation called Post-Natal Depression Support Association (PNDSA) as well as the South African Depression and Anxiety Group (SADAG). Although PNDSA as an organisation no longer exists, there is still a website where you can access information. However, due to a loss in funding, it no longer exists as an organisation creating a gap of instrumental support. In addition, Int03 spoke of Rhahima Moosa's Antenatal Clinic, a public healthcare initiative, but did note that information such as pamphlets or brochures are not necessarily available. Such gaps and incomplete information, instrumental and emotional support are more missed opportunities where

assistance could be provided to mothers in need (Bowsher et al., 1997). Thus, to some extent, the channels exist and/or are present but do not entirely provide the full support that mothers need. For example, with interviewee 4 (Int04), it was concluded that she was in need of that full support as she was unable to cope mentally on her own but there were many hurdles that came in place when help was being sought out:

> I needed a psychiatrist and my psychologist managed to get me into seeing [a psychiatrist] on an emergency appointment so from that point of view, yes they acted quickly…but then there was a whole issue around medical aid payments and money. How am I going to pay for it because I have already got such a huge burden, so eventually we got things off it took a while like a month or two months get that process going (Int04).

Not only are there issues of urgency and medical aid support and assistance, there are even worse forms of mistreatment and lack of support in the public sector as highlighted by one of the OB/GYNs interviewed:

> I can tell you that it is probably diabolically diverse in the private sector compared to the public sector patients [who] get nothing. They don't even get seen post-delivery in the government sector. So how do you pick up post-natal depression? You hamba ekhaya [Zulu for go home] for eight hours after a normal delivery two days after a caesar never to be seen again. (Int02).

According to Davis (2013: 6) "fifty percent of post-partum major depressive episodes actually begin prior to delivery" hence placing a sense of importance on truly understanding the experiences and perceptions of antenatal anxiety and depression will provide crucial diagnostic and treatment guidance.

**4) Healthcare professional support from the perspective of the mothers**

Whilst HCPs have diverse views, they are generally aware of the types of needs expectant mothers have and that there are gaps in the delivery of such. However, it is crucial to also hear from mothers themselves as to what their experiences have been.

One of the interviewees (Int04) expressed that she went through a lot during her pregnancy. She had been continuously trying to have a child through In vitro fertilisation (IVF) and when she finally fell pregnant, she soon afterwards found out she was having twins. In addition to that already very overwhelming news, she then also found out her mother had been diagnosed with cancer. As a result, the time was very stressful and the pregnancy proved very overwhelming.

For this interviewee (Int04), maternal well-being meant having her mother's support:

> I'm the youngest of my brothers and sisters and they all had the benefits of my mom helping them with their kids. My mom had just sold her place she was moving in with me to help me take care of the babies and then she got sick and suddenly I felt insecure and I felt alone like there was nobody to help me, there was nobody to be with me, so yes [I felt] very alone. Very scared and alone.

She placed particular emphasis on the fact that for all her siblings, her mother was there to support them in navigating parenthood and with that support being taken away from her she experienced even more distress than that which ordinarily comes with pregnancy. Hence, the importance and increased reliance on instrumental and emotional support from a HCP was even more important, for her, at an earlier stage of her pregnancy. Especially since 17 weeks into

the pregnancy, she expressed that she was suffering from anxiety and was living in constant fear that something would happen to the babies.

When she voiced that "she was not okay", her then GYNAE replied with "I'll give you a name and number". She experienced this as not very beneficial, for her in that moment as she expected more urgency whether it was in the form of a referral. Furthermore, there was not much continuity between her HCPs: which suggests that good communication and continuity between HCPs is needed earlier on in the pregnancy, especially when an expectant mother expresses to a HCP that she is not well emotionally. Int04 also demonstrates the difference between HCPs' recognition and treatment of ante-natal mental conditions and post-natal anxiety and/or depression.

She was in need for dire assistance but because of medicalization and all the extra costs that come with healthcare she was only attended much later. There is great awareness and acknowledgement around the mistreatment experienced in the public sector but Chadwick (2016) highlights that this does not only occur in the public sector alone, and the private sector should not be overlooked. Chadwick (2016:424) raises a very important point when she states the importance of accountability on all levels: "in respect of the state, medical institutions, training programs and individual practioners".

As it was the paediatrician of her twins who was actually the one who got in touch with a psychologist for her, in conjunction with her GP. They then got her a psychiatrist via an emergency appointment. However, medical aid limitations and hospital bills got in the way. Regardless of the urgency of assistance needed, it subsequently took a month or two to get the mental health assistance needed. Although, it took longer than necessary, the structures in place to provide support ***after*** giving birth were better equipped to provide care and provided care that the patient herself deemed more beneficial.

Another interviewee (Int05) described how when going for your check-ups, it is all about the baby and for this particular mother, pregnancy was experienced as a sense of a loss in identity. She shared the example that when during one of her appointments, she expressed that she was experiencing a lot of pain in her hips, she was told: "well it is part of pregnancy" and that it would go away after the birth.

Such narratives are constantly being repeated to mothers, and these desensitised them from their everyday living and embodied experiences, as a result when they are not okay and they feel guilty for their feelings:

> It is tough, it is tough and nobody speaks about the hard parts of pregnancy and giving birth. You know people think that you're going to give birth and your face is going to be full of make-up you'll be holding your baby like – like it is not like that it is tough, you know. I had to have an emergency c-section when I gave birth and I mean that wasn't planned and I mean recovery from that was tough and it is difficult. You have to do all of that while taking care of a new born. It is tough, I couldn't sleep most of my pregnancy and there's certain positions you're not allowed to sleep in because the baby doesn't get oxygen. It is admin, it is a lot. Yeah, it is a lot so yeah people don't tell you that. They just tell you babycation, slay them, put on make-up. I mean when I was pregnant, I cut my hair uhm, I didn't wear any make-up, didn't wear lipstick. For nine months I didn't I just felt like it was a lot. Too much. So, I

> didn't do any of that and it is stuff I used to enjoy doing but I just felt like manufacturing a human is sufficient (Int07).

All the interviewed mothers stressed that if more emphasis was placed on their mental well-being, particularly from HCPs, it would have really made their experience more bearable. Especially for those for whom it was their first pregnancy, as a lot was new, a lot was happening and a lot can change from the first trimester to the last.

Despite not being diagnosed with ante-natal depression, three of the eight mothers that were interviewed were diagnosed with post-partum depression. Whilst, maternal mental well-being may mean different things for different women, it is significant that each mother felt it would have helped a great deal and been hugely beneficial if their maternal mental well-being was monitored throughout their pregnancy. Some acknowledged that they may not have felt it at the time of pregnancy due to going off of the narrative that "this is just how pregnancy is" but looking back they now did feel that the monitoring of maternal mental health was definitely needed. This was particularly emphasised when interviewee 6 (Int06) stated:

> There's not a lot of, there's not a lot of, uhm, understanding of or at least even, uhm, I don't think that people care that much of mental health when you're pregnant like they already assume that you're not… you know, but people need help. Even people that are in loving families and loving partners and all that like I think it is so important... of them to be aware of those kind of things because it is your body not you, it really isn't yeah I think just general awareness even when you get to the gynecologist they should really, uhm, advise it, uhm, because I think I would've done it if I had known (Int06).

Interviewee 7 (Int07) shared a similar sentiment:

> …I think what I needed at that time was talk to a professional from a psychological point of view, health professional you can name them I mean. I think someone would have just uhm would have counselled me at that time (Int07).

In addressing the improvements for support that need to be made by HCPs for mothers, it is also important to note the positive forms of support mothers felt they already received from HCPs during their pregnancies. There were two mothers that recalled their experiences as a teenage mother. The one mother (Int06) did not feel like she was being judged by HCPs for being a teenage mother. Instead she received a lot of help from HCPs, especially the nurses from the maternity clinic "… Even the nurses. I mean you go to clinics and you find nurses who are positive." She received informational, instrumental and emotional support in the form of being given pamphlets at the clinic, being introduced to other pregnant mothers who she could share experiences with, being given vitamins, meal ideas and exercising. Her overall recollection was that the nurses were very positive and supportive and that the support made her feel at ease about the pregnancy. She highlighted this by stating:

> …And you know they [the nurses] can also see that this one is just a teenager they were really supportive I remember. I was never judged that I must mention that I was never judged and that makes any young pregnant women feel comfortable'.

There was another set of mothers that experienced severe complications during their pregnancy. These complications were fortunately caught early during the pregnancy which meant the mothers needed and received a lot more support to get through a full-term pregnancy. Both mothers in this category felt as though their GYNAE was really there for them every step

of the way making sure that they had more appointments than usual. The one mother (Int11) would go for compulsory check-ups every month and had two GYNAEs, one close to her work and another close to home in case there was an emergency in either environment. The gynaecologists kept in constant contact with both the patient and her family. This form of immense support and guidance throughout really put her at ease because for her, maternal well-being was determined by her health. This was pointed out when she (Int11) said: 'You know I look at myself and I see if I had gone through what I had gone through alone I don't think I would have made it you know so I would emphasise on support' (Int11). So, knowing her health was in good hands and her family was there throughout the journey then made it all less overwhelming. She (Int11) went on to further highlight this when she said: 'I'd say they from my experience going through pregnancy without support can drive you off the cliff, or into depression or way worse. So, I would say, I would recommend you have a support system' (Int11).

**5) Partner Support**

The support of a partner during a pregnancy plays a major role in various ways. One of the interviewees looked to her husband for emotional support at a time when she was in a lot of emotional distress (Int04). Another mother also found her partner a source of comfort when she looked to him for strength in prayer (Int05). She was particularly excited about her pregnancy; he was equally excited about the pregnancy and was present throughout A third mother appreciated her partner showing his appreciation by surprising her and pampering her (Int06). This highlights how they valued the appraisal support they received from their partners because this support provided 'communication of information which is relevant to self-evaluation, rather than problem-solving' (Bowsher et al, 1997). It also includes affirmational support which is something these mothers appreciated. That one mom expressed: 'I was with my husband at the time he was just great whenever I needed anything he was just there' (Int05).

However, in mentioning how partners showed support, for some of the mothers it is also important to shed light on the experiences where mothers felt that partner support was absent. There were mothers who shared experiences of partners who were not supportive partners, on receipt of the news of the pregnancy (Int 06 and 07). The two mothers with this experience were teenage mothers at the time. The first expectant mother emphasized how 'scared and nervous [she was] because [she] was young, [she] was nineteen' (Int06). The second mother (Int07) highlighted:

> I had my first child when I was a teenager so, I knew nothing Tessa…all I could remember with my first pregnancy is being a teenager and pregnant was. I was terrified (Int07).

For the one mother (Int06), it was very disheartening because she expected more from her partner; at the very least, she expected him to support his child, given the costs that come with raising a child (Int 06).

> Emotionally, I think the expectations mostly towards the baby's father, I expected him to support me. I actually thought well, I'm pregnant now we might as well get married. So, there was that I thought I was going to move out start my own life (Int06).

This then introduces the experiences of financial support or lack thereof that mothers experience during their pregnancy.

### 6) Financial Support

When there is news of a baby being brought into a family, there are always conversations of the financial constraints that come with a child. One of the mothers who found out she was pregnant when she was nineteen and fresh out of high school, expressed how she was really concerned about the financial implications this would have on her family (Int 06). She stated:

> Money was a big thing for us, uhm, I come from a pretty good family. We're middle class and stuff but sometimes when you have something so big and unexpected happening…like we've had situations in our family where, you know, like we really going through some tough times. So, I felt like I was bringing a burden onto them. So yeah, I was very stressed about finances (Int 06).

Not only did this interviewee find financial constraints paramount during pregnancy but other teenage mothers spoke of the role of finance:

> …also remember finance plays a role. If you're working and you're financially stable, you don't worry where will I get the money, what will I buy the nappies with? Unlike my first pregnancy, it was all… it had to be my father that does all this (Int07).

Such financial constraints really create a lot of anxiousness around pregnancy and the help that is received.

> The cost is also something to consider I mean to see a psychiatrist these days is R2000 a session And I think it puts a lot of people off, you're about to have a baby so you don't want to use your medical aid because you want to save your medical aid for your babies so you kind of neglect yourself because you're trying to do everything you can to save money (Int04).

This account is particularly important to note because mental health care is often not equally regarded or prioritised as physical healthcare and subsistence needs and hence is often neglected; in the same way that mothers and HCPs often prioritise the baby's care over mothers.

### 7) Family Support

All interviewed mothers valued family support greatly and this was highly appreciated by them. Most mothers felt as though they had some sort of family support to get them through the pregnancy and that definitely helped, to a certain extent. However, as mentioned, there was one mother who felt as though at times she was left to fend for herself as her own mother had cancer and she could see that the rest of her family needed to focus on their ill mother:

> In my situation, I can see that my family they needed to focus on my mom so they, it was kind of like I have this inner strength, so they just thought I'd go off that. You know, there was no…From a family's perspective, there was no need to give me extra support or… I mean, I suppose, my mother tried to shelter me from things she didn't want my sister to tell me anything the doctors were saying or whatever diagnosis, it was to protect me from… (Int04).

However, in contrast to the above mentioned, all the other mothers drew immense strength from their families during their pregnancy. Some became more excited and less anxious about

their pregnancy, when they realised their parents were there for them and were understanding of the situation. Some mothers received a lot of strength and guidance from family members on what to expect when having a baby. For example, there was a mother who was able to open up a lot to her cousin when she would visit her extended family. This was highlighted when she stated:

> I loved being visited by my family, like my cousins…I've always had a good time with them, in my whole life since I was there also every time, they come visit me they would bring me like food to eat things that I was craving. It was all my aunties that came and they were quite real with me and they were like listen 'it happens and we just want you to know that like you shouldn't beat yourself up about it, if you want us to forgive you, we forgive you and we have, we love you and all of that'. It was just very overwhelming for me because I think I needed to get it from them, you know not just assume. Uhm yeah, they really showed it like they came through they all visited me in hospital they brought me like soup. Some of them even slept over after the baby was born like helping me with breakfast so there's a lot of family support a lot of it (Int03).

Other families provided a lot of emotional support as they expressed their excitement and happiness for the pregnancy. Therefore, most of the mothers received quite a lot of informational, instrumental and emotional support from their families. However, the support each mother values differs. Not only that but there is greater emphasis and expectations on various forms of support which will be unpacked further on.

### 8) Workplace Support

There were a few mothers that were really grateful for the support received from the workplace because the fact of being employed helped fund the livelihood of the family and the anticipated baby. The narratives expressed in regard to workplace support were of a positive nature. For example, when discussing whether adequate assistance was provided to the mother to be by HCPs, by family, friends or even sought out herself, interviewee (Int07) pointed out:

> Yes. From both families, healthcare professionals, even the workplace. Tessa, let's not leave that out. Yeah, even employers because that's very important. For you to go see a healthcare professional obviously, if you're full time employed now you have to be accommodated by your own employer. Let's not forget that, it also plays a critical role. Actually, they're all stakeholders in this case (Int07).

Another mother also expressed:

> I was hardly at work but, uhm, thank God, I had a very supportive boss that understood, my employers were very supportive. I stopped going to work earlier than expected. So, that was the good part of the pregnancy. So, even though I went through everything health-wise and my negative emotions. I had good support, you know (Int11).

Although the support of the workplace can be easily overlooked it is very important to acknowledge the impact that support has on a mother during their pregnancy. This type of support would be seen as instrumental and emotional support because it provided tangible aid as well as the provision of care, empathy and trust.

# Conclusion

This research report centred on exploring the perceptions and accounts of expectant mothers' experiences of anxiety and depression. It aimed to highlight mothers' illness-narratives as a gap that emerged in the existing literature on maternal mental health. This was done by firstly introducing the 'why' of the study as well as the importance of the research by putting forth the argument that there is not nearly enough literature on maternal mental health and specifically antenatal anxiety and depression. Hence, the importance of this study. Following that a literature review unpacked the central issues, debates and contemporary literature and key concepts that emerged throughout the report. Contemporary understandings of antenatal anxiety and depression were noted in order to better understand mothers' perceptions and experiences of antenatal anxiety and/or depression in relation to the existing literature.

Thirdly, the methodology chapter unpacked exactly how the study was conducted using an appropriate method best able to truly capture the accounts and experiences of the mothers, given the sensitive nature of the topic. The qualitative method of in-depth semi-structured interviews that maintained the organic nature of participant accounts was detailed. Following that, a findings and analysis chapter documented the experiences and accounts of the expectant mothers. This is where their real-life narratives were described and analysed. As a result, the intensity of the experiences mothers go through was highlighted. In addition, the various indicators of anxiety and depression, from mothers' perspectives, were brought to light. These accounts further emphasised the need for more research so that expectant mothers do not feel so alone during their pregnancy journey. There is still more to know and learn when it comes to the experiences of antenatal anxiety and/or depression and maternal mental health as a whole. However, this chapter brought to light the most current and pressing issues that need to be addressed when discussion maternal mental health.

Social support was central to the analysis and the findings showed the impact various types of social support, or the lack thereof, had on expectant mothers during their pregnancy, and in their lives. It made connections between support and feelings of anxiety and/or depression. These were also linked to obstetric violence and a claim made for additional measures and greater improvements and assistance from HCPs.

However, this study only focused on mothers' perceptions who in the majority had not been diagnosed… and experiences of their self-reported well-being. In the future, a study on mothers who have actually been diagnosed with antenatal anxiety and/or depression can stem from this; as there is still much research worth doing in this regard.

There is a lot said in the literature, about postpartum depression but not enough said about what is being done to monitor maternal well-being, during women's pregnancy. This was a central reason why this study stressed the need for more research on antenatal mental health care. Thus, it is paramount that policy implementation be encouraged. For example, expanding the assistance HCPs can provide to pregnant women and further equipping existing HCPs to deal with maternal mental health cases. This study suggests that it is not enough to only shed light on postpartum depression, but the healthcare sector needs to take seriously and do more

research to understand the indicators and triggers experienced during pregnancy that in turn impact maternal mental well-being. Monitoring and acknowledging mothers' experiences of anxiety and/or depression during pregnancy will assist in ensuring the mother is her best self and thus ensure a better experience for mother and child, when the baby does arrive.

This study does however answer the research question by showing the perceptions and experiences that mothers have about anxiety and depression, and how these experiences impact on their maternal mental health. It mostly confirmed that there is a gap when it comes to maternal mental health, especially antenatal anxiety and depression. As identified in the literature review, there is a fair amount said about postpartum depression but very little to none on the monitoring of expectant mother's maternal mental health throughout their pregnancy. More knowledge on issues of maternal mental health are needed so that there is a greater understanding of issues that arise during pregnancy and how such impacts on a mother's pregnancy journey.

So doing, the various illness narratives will speak to the number of things that impact a mother's maternal well-being and most importantly how there is a constant need for support and care as emphasised in the findings and analysis of this research report. The key concepts found in this study were social support and obstetric violence. This study showed the impact various forms of social support had on expectant mothers' journey: some good, some bad.

However, the impact of structural violence has a far greater effect on women and girls as a result more has to be done by healthcare policymakers and HCPs by applying pressure on associations and services to ensure that care is elevated. For example, training nurses to check in on mothers and to ask those more personal questions about how the mother is truly feeling themselves, irrespective of the baby and the baby's development.

Using the nurses, or other allied healthcare professionals, may take the burden off gynaecologists and general practitioners (GPs) who feel that their time is already limited as is. This could allow mothers to seek solace in and from the nurses. This may allow mothers to actually get responses to their questions of 'why haven't I felt the baby move' or 'why am I so anxious about what's going to happen next?'. These are normal questions that mothers have regardless of the fact that 'this is how pregnancy goes' or 'this is what you should expect when you're pregnant'. This research and the literature have shown that inappropriate responses by HCPs only further desensitise mothers and may actually result in them becoming more anxious and some may become depressed. If check-ups with HCPs could happen once a month or every trimester, it could really alleviate the anxiety mothers feel at having to carry on, especially on their own. The existing strain on staff could perhaps be addressed through the increased use of midwives to provide more assistance to mothers without adding more strain to existing staff and the healthcare system. Especially in a context where their environment may be unstable and experiences keep on changing, yet mothers have to "keep it together" for their unborn child, when they themselves need care and support which may be being neglected. As Chadwick (2016) emphasised mistreatment towards women and girls during pregnancy and labour should be viewed with a greater sense of urgency because mothers having to feel as though they are not receiving the full amount of support as they should be, is a grave form of injustice towards women and girls.

In discussing the different forms of social support that mothers' experienced, the presence or lack thereof of support contributes greatly to mothers' perceptions and experiences of anxiety and depression. From hearing and reading mothers stories, one can hear that they were experiencing anxiety and depression, although most were not formally diagnosed as such by HCPs. This requires us to truly grapple with the questions of "what is anxiety and depression?" and "how are these perceived and understood by expectant mothers"?

Seven out of the eight mothers did not have an established clinical diagnosis of ante-natal anxiety and/or depression but show the tell-tale signs as highlighted in the literature review. There are a range of indicators that need to be looked at more extensively when considering these cases. As such, this study shows that there are mothers with signs but without diagnoses; and there are likely to be a lot more undiagnosed cases in society. By focusing on these cases, and such similar, we can help catch people that are falling through the system.

When exploring the antenatal anxiety and depression literature it was evident that there was insufficient attention paid to antenatal anxiety and depression, especially within South Africa (Biaggi et al., 2016). Due to there being a struggle to keep up with the demand for mental healthcare, that has resulted in it being seen as a burden, there is even less care and attention for specialised cases (WHO-AIMS, 2007). However, according to Biaggi et al., (2016) developing countries such as South Africa do actually experience a high burden of antenatal anxiety and depression. Nettleton (2013) further highlighted the need to priorities management and services for mental health care. Whilst Stein (2014) emphasised that quality mental health could be established through responsive mental health approaches and community-based services.

In this study, expectant mothers' experiences were unpacked, in this study, within the overarching theme of social support along with how mothers did or did not receive support and how this in turn affected them. It was found that when certain forms of support were not received, this really had a negative effect on mothers' mental well-being. Although many mothers were not formally diagnosed, this study confirms that expectant mothers do experience the symptoms of anxiety and depression during their pregnancy. Through unpacking the various triggers and contributors of anxiety and depression amongst the women in this study, this study has elaborated on women's experience of antenatal anxiety and depression.

However, Chadwick (2016) further expanded this looking beyond the presence or absence of support; she argues that a lack of support is indeed mistreatment which in itself is actually a form of violence that is done unto a woman during her most vulnerable time i.e. pregnancy. She highlights this as a serious form of gender violence that must be taken very seriously, especially in the context of South Africa.

Having highlighted and unpacked the forms of support that are needed by pregnant women, we can see that delineating abusive treatment is complicated, However, "there is no excuse for failure to hold individuals and institutions accountable for practices that dehumanise, degrade and cause harm to women and girls in some of their most vulnerable moments" (Chadwick, 2016: 423).

This study has shown that the greatest improvements need to come from the healthcare system and these efforts should be primarily be led by policy makers, medical practioners, professional associations and institutional boards. This concurs with the recommendations made by Chadwick (2016). There is an overall lack of information when it comes to labour and birth experiences (Chadwick, Cooper and Harries, 2013: 4). This then raises questions around illness narratives and where they fall on the spectrum of healthcare. Looking at the experiences that have been discussed in this research report, seven out of the eight narratives were mothers expressing that additional professional help would have been beneficial, especially now that retrospectively look back on their experiences and realize that they did in fact experience anxiety and/or depression during their pregnancy. This realization was further backed by unpacking the impact support as on maternal mental health. This entailed unpacking various forms of support, such as emotional support, instrumental support, informational support and appraisal support.

Expectant mothers emphasised that there is a greater need for and emphasis on professional help that goes beyond the regular check-ups that make sure the baby is good and healthy. Truly focusing on providing expectant mothers with professional help to work through any indictors that might arise during their pregnancy will help catch and provide support to mothers who currently fall through the system.

When looking at what the existing literature means for mothers, to date, there is literature that: analyzes lay perspectives of depression and/or anxiety; as well as that which provides biomedical, psychosocial, and biopsychosocial analyses of anxiety and depression. However, not much is said about traditional approaches to mental health which could be explored further in the future and secondly there is a huge gap when it comes to portrayal of lived experiences and illness-narratives of expectant mothers. Mothers relayed that there was often no one to tell them that what they were experiencing was anxiety and/or depression or to share the experience with; hence they went through it all on their own. There was very rarely an opportunity, even at medical check-ups, that they were availed the opportunity to go into how they as expectant mothers were feeling. Regardless of the fact that all three HCPs acknowledged that more needs to be done for expectant mothers' mental well-being, they felt there is only so much they can do.

Moving forward my most significant recommendation is for HCPs to fully utilise the existing health care structures and the referral systems. For example, training nurses and midwives to check in on mothers and to ask those more personal questions about how the mother truly feels themselves, irrespective of the baby and the baby's development. According to O'Leary (2004:188) "lessons learned are likely to be applicable in alternative settings or across populations". As a result, it is highly recommended that this research should be expanded further: for example, incorporating previously clinically diagnosed patients and/or exploring mothers' experiences in different communities and countries.

There is definitely room for more research within this over-arching topic of antenatal depression and antenatal anxiety. Future studies can definitely go more in-depth and focus on specific illness-narrative with a smaller sample size to truly get those authentic narratives of expectant mothers. It is especially important to further deepen and expand our understanding

of expectant mothers' experiences and perceptions of their own health and of antenatal mental healthcare services. For example, more could be done to see if the new narratives are more generally held. Due to the lack of sufficient literature on antenatal anxiety and depression, especially in South Africa, more could be done to look into the indicators and measurement of such. Unpacking obstetric violence literature more in-depth would also be greatly advantageous because it gives room to explore otherwise overlooked concepts such as social support and enables greater emphasis to be given to real life, illness narratives from mothers themselves. Furthermore, the existing management of mental health care needs to be prioritised more, along with community-based methods and/or services. In future, a comparative study on evidence-based services compared to community-based initiatives in maternal mental health care would be interesting.

Lastly, healthcare professional associations could truly benefit from more use of existing healthcare workers. For example, providing training for nurses or midwives to identify indicators of anxiety and/or depression by having scheduled sessions to see mothers more often than Obstetric/Gynaecologists are able to. That way no mother feels as though they are falling through the cracks when they present with tell-tale signs of anxiety and/or depression. Such routine health care with empathetic maternal healthcare policies, systems and HCP associations would greatly reduce the likelihood that mothers feel neglected and could identify and alleviate anxiety and depression earlier.

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# Appendix

## 1. Participation consent form for Health Care Professional:

## Maternal Mental Health

## Name of Researcher: Tessa Nyirenda

I……, agree to participate in this research project. The outline of the research has been explained to me and I understand what my participation entails. Please circle relevant options below.

I agree that the interview may be tape recorded YES NO

…… (Signature)

…… (Name of participant)

…… (Date)

## 2. Participation consent form for Mothers:

## Maternal Well-being

## Name of Researcher: Tessa Nyirenda

I……, agree to participate in this research project. The outline of the research has been explained to me and I understand what my participation entails. Please circle relevant options below.

I agree that the interview may be tape recorded YES NO

…… (Signature)

…… (Name of participant)

…… (Date)

# 1. Participation Information Sheet for Health Care Professional:

*Cell: (076) 413-6937*

*Email : tessa.nyirenda@wits.ac.za*

*27 June 2019*

Dear Madam/Sir

**Re: request your participation in a research project**

My name Tessa Nyirenda and I am a Masters student in Sociology at the University of Witwatersrand in Johannesburg. In this research project I aim to understand the experiences of mothers during their pregnancy. More specifically, I hope to investigate mothers' experiences of mental health throughout their pregnancy.

I would appreciate your participation in this study. Your participation will provide me with an expert clinical perspective on maternal mental health and how it is understood in South Africa. The data gathered from your participation, will provide me with insight on the various mental health issues experienced during pregnancy.

Please note that your participation in this study is voluntary and there is no reward for participating or penalty for not participating. You will not be obliged to answer any questions with which you are uncomfortable and therefore have the option to decline to respond to any questions asked. You will also have the option of terminating your participation at any stage that you choose.

No one, apart from me and my supervisor will know about your involvement in the research. If you feel any distress or discomfort at any point in this process, we will stop the interview and resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details above. This research will be written up as a research report which will be available online through the university library website. If you have any questions, concerns or complaints regarding the ethical procedures of this study, you are welcome to contact my supervisor Dr Kezia Lewins, email: Kezia.Lewins@wits.ac.za.

Kind regards

*Tessa Nyirenda*

## 2. Participation Information Sheet for Mothers:

*Cell: (076) 413-6937*

*Email : tessa.nyirenda@wits.ac.za*

*27 June 2019*

Dear Madam

**Re: request your participation in a research project**

My name Tessa Nyirenda and I am a Masters student in Sociology at the University of Witwatersrand in Johannesburg. In this research project I aim to understand the experiences of mothers during their pregnancy. More specifically I hope to investigate mothers' experiences of mental health throughout their pregnancy.

I would appreciate your participation in this study. Your participation will give me insight and perspective on maternal well-being and how it is understood in South Africa. The data gathered from your participation, will provide me with more insight on the various mental health issues experienced during pregnancy.

Please note that your participation in this study is voluntary and there is no reward for participating or penalty for not participating. You will not be obliged to answer any questions with which you are uncomfortable and therefore have the option to decline to respond to any questions asked. You will also have the option of terminating your participation at any stage that you choose.

No one, apart from me and my supervisor will know about your involvement in the research. If you feel any distress or discomfort at any point in this process, we will stop the interview and resume another time.

If you have any questions during or afterwards about this research, feel free to contact me on the details above. This research will be written up as a research report which will be available online through the university library website. If any counselling is needed, you are more than welcome to reach out to FAMSA at (012) 460 0733/8 or you can contact SADAG at (011) 234 4837. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact my supervisor Dr Kezia Lewins, email: Kezia.Lewins@wits.ac.za.

Kind regards

*Tessa Nyirenda*

## 1. Mothers' research instrument

**A: Opening: [Administer informed consent during this time]**

Hi, how are you? How has your day been thus far? Are you comfortable for us to begin with the discussion?

**B: Emotional experiences:**

1) How did you initially feel when you found out you were pregnant?
2) What were your initial expectations about how the pregnancy would be?
3) Did those expectations ever alter (change) throughout your pregnancy?
4) How was your experience being pregnant for the first time?
5) How did you feel emotionally (how would you describe your overall emotional state) during your pregnancy?
   5.1 Did those emotions alter at all during your pregnancy? [How would you describe good times, bad times, their frequencies]

   5.2 What contributed to the emotions shifting? (Experiences, actions, behaviour, etc)

6) 4Do you feel there was enough emphasis placed on maternal well-being throughout your pregnancy? [Family, friends, healthcare team, society in general]
7) Was your maternal well-being monitored throughout your pregnancies? How/why/by whom?
8) Was any assistance provided to you? [Were you adequately supported / referred to services by HCPs / recommended by family and friends / sought help yourself]
9) What was the impact of this help/support/care?
10) What would have improved your experience/situation?
11) What would you recommend to women who find themselves in a similar position to yourself, during a first pregnancy?

**C: Closing**

12) Are there any questions you have for me?
13) Are there any last points that you may want to discuss or revisit?

Thank you very much for whole heartedly participating and for freeing time in your schedule to meet with me.

## 1. Ethics Approval

**SOSS Human Research Ethics Committee**

**Clearance Certificate**

| | |
|---|---|
| **Protocol Number:** | **SOCL20190503** |
| **Project Title:** | **"What are the experiences of mothers with antenatal anxiety and depression?"** |
| **Investigator's Name:** | **Nyirenda,Tessa (1076949)** |
| **Department:** | **Sociology** |
| **Date Reviewed:** | **June 20 19** |
| **Decision of Committee:** | **Approved / Unconditionally** |
| **Expiry Date:** | **May 2021** |
| **Date:** | |

**Head of School** _____

**Professor Mucha Musemwa**

**CC supervisor:** **Dr Kezia Lewins**

**Declaration of Investigator**

**To be completed in duplicate and one copy to be returned to Ms. Sarah Mfupa in the School of Social Sciences, Room 152, 1st Floor, Robert Sobukwe Block.**

**I fully understand the conditions under which I am authorised to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. If any departure from the research procedure as approved, I undertake to resubmit the protocol to the committee.**

_____ ____27/06/2019 _

**Student Signature** **Date**