Motherhood views on the effect of postpartum depression on the child

by

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PRETORIA

2017

DECLARATION

I declare that the dissertation, which I hereby submit for the degree Magister Educationis at the University of Pretoria, is my own work and has not previously been submitted by me for a degree at this or any other tertiary institution.

....

Lelanie Lisa van Rensburg

7 November 2017

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DEDICATION

I dedicate this research to those mothers who battled with postpartum depression. Always remember that it will pass and that you are not alone.

// ACKNOWLEDGEMENTS

To have achieved this milestone in my life, I would like to express my sincere gratitude to the following people:

- My Heavenly Father, who provided me the strength, knowledge and perseverance to complete this study. It made me realise that God has a bigger plan for me than I will ever have for myself. *Jeremiah 29:11 "For I know the plans I have for you", declares the LORD, "plans to prosper you and not to harm you, plans to give you hope and a future".*

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ABSTRACT

Postpartum depression can be defined as a major depressive disorder which usually occurs during the postpartum period within one month or more after giving birth. Literature shows that 35 to 47 per cent of South African women have been diagnosed with major depressive disorder during pregnancy and the postpartum period. Studies stated that the challenges in the South African context regarding the postpartum period includes detachment from care and lack of a support system.

Emotions are typically present in the context of relationships, in this case a mother and child relationship. However, research on early childhood has emphasised that the impact of the first five years of a child's life on his/her social and emotional development is crucial, since children must learn to communicate with emotional language. The role of the mother in a young child's emotional development is crucial, as the mother models certain behaviour to be imitated by the infant.

A phenomenological and multiple case studies research design were followed throughout this qualitative research study. As the aim of the study was to provide information and guidelines for mothers who suffer from postpartum depression, the sample selection focused on participants (mothers) who had experienced postpartum depression and who, in retrospect, could give information about their experience and their perceptions of the effect this syndrome had on the emotional development of their children. Three mothers who were diagnosed with postpartum depression were the participants of this study. In order to get rich in-depth data, they were each interviewed and had to compile a narrative describing their experience with postpartum depression and the effect it had on their child's emotional development. The three case studies provided a unique insight into the effect of postpartum depression on a young child's emotional development according to the mother's experience of postpartum depression.

The empirical part of the study revealed that postpartum depression has a severe effect on a child's emotional regulation and that support was an integral part in overcoming depression.

Key Terms: Postpartum depression; Emotional development; Young child

EDITING CERTIFICATE

Date: 10 October 2017

I, Berdine Smit, ID 7712190011083, hereby certify that the MAGISTER EDUCATIONIS dissertation by Lelanie Lisa van Rensburg:

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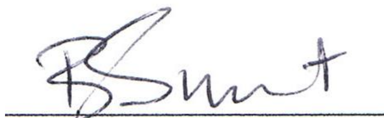

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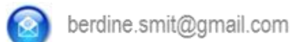

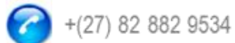

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CHAPTER 1
INTRODUCTION AND ORIENTATION

1.1 INTRODUCTION

In any society, the birth of a baby is considered a joyful event (Liebenberg, 2014:45). Becoming a mother is regarded a natural event that automatically implies the mother's unconditional love for her infant and the inherent ability to meet her child's needs. If a woman fails to experience joy and happiness, it is often frowned upon by friends, family and society in general. The truth is, it is very difficult for a new mother to come to terms with feelings of misery and anxiety after the birth of a baby. If she perceives herself to fail at the basic care of her infant, she understandably loses confidence and feel stigmatised as a poor mother who lacks affection and love for her child. While many women adjust to parenthood with accomplishment, Wylie, Hollins, Martin, Marland, Martin and Rankin (2011:54) suggest that postnatal mood disorders might not be as uncommon as is widely suspected. This is confirmed by Schober (2014:56), who reports that the prevalence of postpartum depression is significantly high, affecting as much as 15 per cent of new mothers. O'Hara (2013:1) identifies these feelings as postpartum (postnatal) depression (PPD) and describes this emotional state as a well-known and severe psychological mental health issue, as it is related to maternal anguish and various negative results for their children.

According to O'Hara and McCabe (2013:400), the prevalence of postpartum (postnatal) depression ranges worldwide from 13 to 19 per cent in mothers, which indicates a substantial public health concern. Thompson and Fox (2010:249) explain that maternal depression can be linked with various challenges in babies and young children, including emotional deregulation; decreased tolerance to frustration; higher rates of resistant behaviour and decreased emotional capacity; and diminished positive effect and capability to self-sooth.Flynn (2015:29) elaborates that bonding difficulties between the mother and infant can lead to the baby having problems to form an attachment with the mother, and that infants may experience behavioural problems and have higher levels of generalised anxiety in

childhood. The aim of this study was to explore motherhood views on the effect of postpartum depression on the child.

Postpartum (postnatal) depression can adversily affect a women's quality of life, close relations, maternal-newborn interaction patterns, baby attachement and child formative results from birth through to school age (McDonald, Wall, Forbes, Kingston, Kehler, Vekved & Tough, 2012:318). According to Paulson and Bazemore (2010:1962), it is known that maternal pre-birth and postpartum (postnatal) depression is common and has adverse personal, family and child developmental results. Flynn (2015:28) provides a detailed description of the symptoms that can occur during the postpartum (postnatal) period including very negative thoughts about the baby, thoughts of hurting the baby, thoughts of hurting themselves, not having any interest in the baby and thoughts of giving the baby away. Keeping these symptoms in mind, it does seem as if many women experience ongoing episodes of postpartum (postnatal) depression (McDonald et al., 2012:319), but due to stigmatisation, these mothers do not often want to talk about their feelings.

1.2 RATIONALE

Dealing with postpartum depression (postnatal) and caring for an infant can be overwhelming. Severe cases of postpartum depression (postnatal) can lead to the baby having difficulties to form an attachment with the mother (Flynn, 2015:30). Bowlby (1984:696) describes attachment with someone as the strong desire to seek closeness to and contact with an individual and to do so especially in certain conditions. Thompson and Fox (2010:251) state in their research that when infants' attachments with their mothers are unstable or insecure, they perceive other people as untrustworthy or rejecting, which may cause a low self-concept. DeGangi, Breinbauer, Roosevelt, Porges and Greenspan (2000:167) add that attachment problems may contribute to problems such as sensory hypersensitivity and high irritability, higher incidence of behavioural disturbances and attention deficit disorder with hyperactivity.

This study initially arose from my four years' teaching experience as a Grade R teacher in a classroom environment with young children dealing with emotional and social development challenges. This made me wonder what the reasons could be for emotional and behavioural problems in young children. In class, there was a boy who struggled with separation anxiety, which according to Murray, Creswell and Cooper (2009:1413), is common, but disabling. It is

often associated with the development of other disorders, such as depression, emotional regulation or attention deficit disorder and may accordingly influence the emotional and social skills development of the child. The boy mentioned above would not do anything unless sat with him and praised him continually. When I corrected or guided him in a different direction, he would scream and call himself dumb. He had difficulty controlling his emotions and also struggled with social skills.

During a parent meeting, I observed that the child's mother was distant towards him. She told me about her maternal experiences after the birth and that she was on anti-depressants because of "a bad case of baby blues"; she however, believed that she had recovered. This made me wonder about postpartum depression and the long-term effects it might have on a child. I was especially interested in the correlation between postpartum depression (postnatal) and the emotional development of the young child.

Based on parent meetings and classroom encounters, I started reviewing relevant literature. I realised that there is ample research available on predictors and the measuring of postpartum (postnatal) depression, as well as the impact of maternal depression on the child's language and cognitive development, but only a few studies specifically focus on the impact of postpartum (postnatal) depression on the emotional development of the young child. Although information on postpartum (postnatal) depression is freely available, Liebenberg (2014:44) notes that most mothers feel ashamed to admit that with the excitement of a new family member, comes a sad mood or anxiety in the postpartum (postnatal) period. Honikman, Van Heyningen, Field, Baron and Tomlinson (2012:222) report that in spite of the high prevalence of prenatal and postpartum (postnatal) depression, there is no standard screening for or treatment of maternal mental illnesses in essential care settings in South Africa.Therefore, Rochat, Tomlinson, Bärnighausen, Newell and Stein (2011:370) advise that culturally sensitive and accurate medical care is much needed.

Very little research on postpartum (postnatal) depression has been conducted in the South African context and the aim of this study is, therefore, to provide mothers who struggle with postpartum (postnatal) depression with information and guidelines on how to combat the negative impact of this syndrome on the emotional development of their children. Possible support groups may also benefit from these guidelines.

1.3 PROBLEM STATEMENT

Given the prevalence of maternal postpartum (postnatal) depression, and the negative implications it has for the health and well-being of women, their partners, families and also children, this disorder represents a mental public health concern (Mustaffa, Marappan, Abu, Khan & Ahmad, 2014:419). Risk factors are related to neurological, socio-emotional and cognitive functioning of the developing infant (Thompson & Fox, 2010:252). Ramchandani, Stein, Evans, O'Connor and Team (2005:2206) concluded their study by stating that there is an association between postpartum (postnatal) depression in mothers and the behavioural as well as the emotional problems of a child. To add to the long-term negative effect of postpartum (postnatal) depression on a young child, Field (2010:4) mentions that these negative effects include behavioural, emotional and health problems, which may lead to the disturbance of mother-infant interactions. In view of the above problem statement, this study was guided by the following research questions:

1.3.1 Primary research question

What are the views of mothers on the effect of postpartum depression on the child?

1.3.2 Secondary research questions

1. What role does the mother play in the emotional development of her young child?
2. How do mothers perceive the influence of postpartum depression on the emotional development their young child?
3. What guidelines can be developed for mothers who suffer from postpartum depression with relevance to the emotional development of a young child?

1.4 CONCEPT CLARIFICATION

For the purpose of this study, the core concepts will subsequently be explained.

1.4.1 Postpartum depression

Postpartum depression, also known as postnatal depression, is a non-maniacal depressive issue befalling women amid the postpartum period, which is the postnatal period after the birth of her child (McDonald et al., 2012:321). Flynn (2015:29) identifies the symptoms associated with this disorder as mood swings, feelings of anxiety or being overwhelmed, excessive crying, loss of appetite, or having trouble sleeping. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) determines that the side effects of postpartum depression must commence within a month after delivery. Many experts believe that women remain at increased risk for depression for up to one year after delivery (Gjerdingen & Yawn, 2007:83). In this study, the term “postpartum depression” will refer to mothers who were diagnosed by a general practitioner or psychiatrist with postpartum depression and who have been struggling with it for more than four weeks after giving birth.

1.4.2 Emotional development

Levine and Munsch (2011:G-6) define emotions as the body’s functional reaction to a situation, the cognitive interpretation of the situation, communication to another person, and actions. According to Ashiabi (2000:80), a child’s emotions serve two functions, namely motivational and communicative. As a motivator, emotions determine the behaviour of a child, while children use the communicative function of emotions to let others respond to their distress or needs. Emotional development can, therefore, be defined as the particular set of abilities the child brings to his or her emotional life to react to emotional situations in positive and efficient ways, that are mixed with natural reactions or learned tendencies from an example (Alegre, 2011:58). In this study, the term “emotional development” refers to the young child’s capability to increasingly control their emotions or to display their emotions appropriately.

1.4.3 Young child

An infant or a child is in the midst of becoming a person; seeking meaningful experiences relevant to their current needs and interests (Nelson, 2009:1). To give more meaning to the term young child, Bornstein and Tamis-LeMonda (2008:269) describe various characteristics by stating that from birth a child appears ready and motivated to communicate and share

meaning with others. The child starts by engaging in complex, highly interactive interactions with their mother or caregivers. Over time, they develop to a better level of social and cognitivel comprehension, including the advancement of social anticipations and assumptions about others' conduct with regards to themselves. In this study, the term “young child” will refer to a child between the ages of birth to four years.

1.5 LITERATURE REVIEW

To contextualise the study, the role of the mother in the development of the child will be explored, as well as the effect of postpartum depression on the mother and the child.

1.5.1 Introduction

The impact of depression is frequently underestimated and the majority of mothers often do not realise what is happening to them emotionally until they have no other choice but to start seeking professional help. During those weeks or months of struggling with postpartum depression (which could possibly have changed the mother’s personality for the time being), they scarcely realise the effect it will have on their infant. Literature confirms that the prenatal period, the time during pregnancy and the postpartum period, all have an important impact on Early Childhood Development (ECD) (Deave, Heron, Evans & Emond, 2008:1048). The exposure to chronic postpartum depression during infancy seems to be associated with problematic developmental outcomes for children, as postpartum depression interferes with the mother’s ability to respond adequately to her baby’s needs (Surkan, Kennedy, Hurley & Black, 2011:608). The problem, as briefly exemplified in the mentioned literature, has led to the purpose of the study, as well as the necessity to further consult the relevant literature.

1.5.2 The role of a mother in the development of the child

Poobalan, Aucott, Ross, Smith, Helms and Williams (2007:283) define the role of a mother as follows: “…she is the only parent guaranteed to be present at birth, who directly invests time and energy resources for *in utero* development and is equipped to provide initial postnatal feeding through lactation”. From a different perspective, Bornstein and Tamis-LeMonda (2008:269) state that meaningful mothering begins even before a baby’s birth and continues in some form throughout the life of the mother and child. Bornstein and Tamis-

LeMonda (2008:269) contend that the responsibilities of a mother are the most significant during infancy, when human beings are most dependent on receiving care and their ability to cope alone is minimal. Deave et al. (2008:1044) maintain that maternal characteristics have an influence on several aspects of a child, namely attachment styles, family experiences, and levels of stress. In this study, Chapter 2 will provide a more detailed description of the important role of a mother in the development of a child.

1.5.3 The impact of postpartum depression on the mother

Studies done by Field (2010:5) regarding the effects of postpartum depression on early interactions, parenting and safety practices have documented the negative health consequences of postnatal depression for women and their families. Child neglect or abuse and maternal and infant mortality are rare but real consequences (Dennis, Hodnett, Kenton, Weston, Zupancic, Stewart & Kiss, 2009:338). Leigh and Milgrom (2008:1) further state that depression during and after pregnancy can lead to the decreased ability to self-care, malnutrition and alcohol or drug abuse, which may compromise a woman's physical and mental health.

1.5.3.1 Safety and care-giving practises

Surkan, Kawachi, Ryan, Berkman, Carvalho Vieira and Peterson (2008:125) argue that the influence of postpartum depression on parenting behaviours could lead to negative responses during feeding practices, as well as for the duration of breast-feeding. Adewuya, Ola, Aloba, Mapayi and Okeniyi (2008:192) elaborate by postulating that depressed mothers stop breastfeeding earlier, with the result that those infants are more likely to experience various childhood illnesses than infants of non-depressed mothers. Furthermore, Elgar, Mills, McGrath, Waschbusch and Brownridge (2007:949) propose that the symptoms of maternal depression interfere with the behaviour of the parents, which reflects in the lack of nurturance, rejection of their child and poor monitoring of their child. Toth, Rogosch, Manly and Cicchetti (2006:1006) assert that unresponsive, insensitive and rejecting care-giving displayed in mothers, could lead to insecure attachment during the early years of the child.

1.5.3.2 Attachment with the infant

In most cases, the mother constitutes the infant's primary environment in the first postnatal months. Moehler, Brunner, Wiebel, Reck and Resch (2006:276) claim that this stage constitutes a very vulnerable phase for mother-infant bonding. Furthermore, Moehler et al. (2006:276) conclude that a crucial period exists for mother-newborn bonding amid the first month of life, cumulating from two weeks up to a six weeks and normally subsiding after four months of age. For more clarity regarding parent-child attachment, Feldman, Weller, Zagoory-Sharon and Levine (2007:957) conducted an assessment of maternal bonding from late pregnancy to three months postpartum periods. The results of the study suggest both anxious obsession and pleasurable attachment. Feldman et al. (2007:278) further explain that this specific touch can be caressing, holding and light stroking versus harsh, awkward and forced touch. Toth et al. (2006:1007) elaborate on this statement by stating that mothers with major depressive disorder can initiate an insecure attachment with their children, which may lead to future psychological problems. McMahon, Barnett, Kowalenko and Tennant (2006:665) found in their research that the history of care that the mother provided for her baby must be taken into consideration when the impact of maternal depression on the parent-child relationship is accounted for.

1.5.3.3 Interactions with the infant

In a study by Field, Diego and Hernandez-Reif (2009:242) on the effect of depressed mothers' interaction styles on the development of brain electrical activity in infants after birth, it was found that withdrawal and intrusiveness of the infants were present. Infants of depressed mothers exhibited significant withdrawal behaviours. Field (2010:3) distinguishes between two different maternal interaction styles, namely the intrusive, controlling and over-stimulating style; and the withdrawn, passive and under-stimulating style. Intrusive mothers have staccato-like movements. In contrast, withdrawn mothers have little or no play interactions with their infant, and they have detached and flat facial and vocal expressions. Field (2010:3) continues by comparing depressed mothers with non-depressed mothers. The depressed mothers tend to touch their infants less frequently in an affectionate manner. Ferber, Feldman and Makhoul (2008:366) agree with Field (2010:5) by stating that postpartum depressive mothers touch their infants less frequently and in a less affectionate manner. The significantly less sensitive, depressed mothers had repeatedly been found to show greater negative and

less positive affects during their interactions with their children. Forman, O'Hara, Stuart, Gorman, Larsen and Coy (2007:600) also mention that these mothers display poor discipline.

McLearn, Minkovitz, Strobino, Marks and Hou's (2006:278) findings suggest that postpartum depression symptoms reduce the mother's interaction with her baby, for example breastfeeding, playing and talking with their infants. Paulson, Dauber and Leiferman (2006:665) furthermore explain that these mothers are also least likely to read, tell stories or sing songs to their children.

1.5.4 Influence of postpartum depression on the young child

The negative effects of maternal depression on a child can be attributed to several aspects of the child's upbringing, such as the child's genes, attachments, emotional regulation and modelling of family environment and parenting (Elgar et al., 2007:947). Ramchandani et al. (2005:2202) report that their findings show that maternal depression has a particular and continuing damaging impact on children's initial behavioral and emotional development. The following aspects can be impacted, namely attachment, emotional regulation and vulnerability to future depression.

1.5.4.1 Attachment

Goecke, Voigt, Faschingbauer, Spangler, Beckmann and Beetz (2012:311) report that emotions related to attachment can be observed at the age of 10 weeks, and these emotions become more visible as the baby develops. Toth et al. (2006:1007) agree and warn that depressed mothers tend to be emotionally and physically unavailable, which may in turn cause an increased risk for developing insecure attachment relationships in children. McMahon, Trapolini and Barnett (2008:200) furthermore caution that children of depressed mothers may experience insecurity due to the lack of attachment, and may therefore overcompensate by displaying unacceptable defence strategies.

1.5.4.2 Emotional regulation

Morris, Silk, Steinberg, Myers and Robinson's (2007:378) research indicates that children who have been exposed to maternal depression, struggle to regulate their emotions and

consequently develop less effective strategies to manage emotions. Thompson (1994:27-28) defines emotional regulation as follows: “Emotion regulation as consisting of the extrinsic and intrinsic procedures responsible for monitoring, evaluating and modifying emotional reactions, especially their intensive and temporal features to accomplish one’s goals”.

Field (2011:8) notes in her research that studies show that children of depressed mothers sometimes inherit the development of problems such as ADHD and antisocial behaviour. Except for the fact that these children seem to have mood disorders, they also have more difficulty to adapt to their new environment, including expressing inappropriate emotions during development (Goodman, Rouse, Connell, Broth, Hall & Heyward, 2011:21). Furthermore, Elgar et al. (2007:949) mention statistics indicating that 18 to 22 per cent of children overall (who were experiencing emotional or behavioural disorders) were reported during a six months period in their study. These children experienced lower levels of positive effects and higher levels of negative effects in their interactions with their mothers (Forman et al., 2007:600).

McMahon et al. (2008) explain that if children do not have the appropriate strategies to regulate their emotions, it may compromise their ability to effectively handle stress from both internal and external circumstances. The important functions of early supportive relationships, including attachment, may impact negatively on the development of self-control in these children (Forman et al., 2007).

1.5.4.3 Vulnerability to future depression

The impact of postnatal depression on child development in early infancy, later infancy and early childhood have been the subject of various studies, such as the study done by Leigh and Milgrom in 2008 regarding the risk factors for prenatal depression, postnatal depression and parenting stress, where cognitive, emotional and social development are potentially being affected. The impact on child development is greater when postnatal depression is chronic and severe (Leigh & Milgrom, 2008). Deave et al. (2008:1045) state that children who are exposed to maternal depression may be disposed to direct vulnerability to depression. This also suggests that anxiety in the child could be substantial. According to Murray, Arteche, Fearon, Halligan, Goodyer and Cooper (2011:466), infants’ insecure attachments with their mothers can be a prediction of depression during adolescence.

1.6 THEORETICAL FRAMEWORK

Henning, van Rensburg and Smit (2004:25) explain that the theoretical framework of a research project serves as the viewpoint through which the research can be conducted. The proposed study intends to use John Bowlby's Attachment Theory (1982) as a framework to conduct the literature review, as well as for the interpretation of empirical data.

1.6.1 Bowlby's Attachment Theory

According to Bowlby and Ainsworth (2013:45), "the infant and young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment". Since the purpose of this study was to explore how mothers experience postpartum depression − and the impact it has on the emotional development of their children − the attachment between mother and child is important as described by Bowlby's Attachment Theory. Bowlby (1984) stresses the importance of an encouraging, supportive and stable parental figure during a child's early years of life, contributing to the young child's sense of attachment security and trust in significant others, as well as to the child's sense of self-esteem.

For the purpose of this study, John Bowlby's theory of attachment (1958:350), namely that the emotional attachments of young children can be assumed to be exhibited behaviourally in their preferences for particular familiar people, their tendency to seek closeness to those people and their ability to use the familiar adults as a secure base from which to explore the environment, was decided on. Bowlby (1988) further proclaims that the foundation of emotional attachments contributes to the development of later emotional and personality development. In the study of attachment and loss, Bowlby (1969) asserts that events that interfere with attachment (such as abrupt separation of the toddler from familiar people or the significant inability of carers to be sensitive, responsive or consistent in their interactions) have short-term and possible long-term negative impacts on the child's emotional and cognitive life.

According to Gold (2011:272), Bowlby's Attachment Theory emphasises interpersonal experiences and rejection. According to Goldberg, Muir and Kerr (2013:24), the evidence of Bowlby's research suggests that the influence of parental handling of an infant, and maternal

responsiveness towards their growing child’s affective state, can have an effect on the child’s adaptation to attachments.

1.7 RESEARCH METHODOLOGY

This section explains the rationale behind the specific methods selected for the proposed study. Accordingly, I will explain the research design and research methods, trustworthiness and ethical considerations of the study.

1.7.1 Research design

Creswell (2013:49) explains that the research design means the plan for conducting the study. Subsequently, the research paradigm, approach and type of research intended for the proposed study shall be discussed.

1.7.1.1 Research paradigm

The choice of paradigm determines the intent, motivation and expectation of the research being done (Mackenzie & Knipe, 2006:193). The research was situated within the interpretivist paradigm. Maree (2016:60) defines the aim of the interpretivist paradigm as “to offer a perspective of a situation and to analyse the situation under study to provide insight into the way in which a particular group of people make sense of their situation or the phenomena they encounter”. As the aim of the study was to explore how mothers experience postpartum depression, and the impact it has on the emotional development of their children, the interpretivist paradigm was regarded as the most appropriate for the study.

Tuli (2010:1) explains that the interpretivist paradigm is naturalistic, since it applies to real-world situations as they unfold naturally; more specifically, the interpretivist paradigm tends to be non-manipulative, unremarkable and non-controlling. Furthermore, Mackenzie and Knipe (2006:194) elaborate that this paradigm relies on the “participants' views of the situation being studied" and recognises the impact of their own background and experiences on the research. This can also be seen as one of the strengths of this approach, as it yields richness and depth of the descriptions from the participants (Maree, 2016:62).

1.7.1.2 Research approach

A qualitative research method was followed in order to explore the correlation between postpartum depression and the emotional development of the young child. Maree (2016:53) defines qualitative research as research that focuses on the social setting of individuals, as well as the individuals that inhabit the social setting. In the case of this study, the research focused on mothers who experienced postpartum depression in the past.

The qualitative research approach was decided on, in light of the fact that it enabled me to gather information in its natural environment where participants encounter the issue that is being inquired about (Creswell, 2013:50). The natural setting of the study was the mother-child relationship, and the experiences of both mother and child through the eyes of the mother.

1.7.1.3 Research type

Creswell (2013:76) defines phenomenological research as describing the experiences of numerous participants as a phenomenon, and to set aside the researcher's own experience in order to understand that of the participants (Creswell, 2002:13). The phenomenon in the study was postpartum depression as experienced by three different mothers, and the impact of this lived experience on a young child's emotional development. The reason for this was to collect data through detailed data collection methods to determine "what" these mothers experienced during the postpartum period and "how" they experienced postpartum depression with regard to their child's emotional development (Maree, 2016:78).

The benefit of phenomenological research is that it enabled me to study a limited number of subjects through intensive engagement with them, with the aim in mind to create relatonships and patterns (Creswell, 2002:13). Creswell (2013:82) furthermore notes that the challenges of using a phenomenological approach relate to the importance of selecting the participants, as they need to be carefully selected and also be individuals who have all experienced the same phenomenon.

In keeping with this phenomenological approach, the study utilised multiple case studies to describe different cases (phenomena) of experienced postpartum depression, in order to

create an in-depth understanding of the effects thereof on a child's emotional development (Creswell, 2013:98). Rule and John (2011:13) state that the identifying and choosing of a case necessitates important steps, since it involves choices about what to include or exclude in the study.

1.7.2 Research methods

According to Maree (2016:51), research methods are the tools used to collect data. This section explains the following: the role of the researcher, the planned research site and sample, data collection methods and the data analysis strategies.

1.7.2.1 The role of the researcher

The focus of the study was mothers who suffered from postpartum depression and the impact thereof on the emotional development of their young children. Due to the nature of this study, I took on the role of a participant observer during data collection, since I was recording the data as faithfully as possible (Creswell, 2013:167). While fulfilling the role of researcher, additional questions were raised to move deeper into the analysis of the phenomena, which were the effect of postpartum depression and the effects thereof on young children's emotional development (Maree, 2016:44).

Furthermore, I took on the role of interviewer and I interviewed the mothers through more in-depth interviews to gain information on the subject being researched (McMillan & Schumacher, 2006:346-350). During the interviews I aimed to stay objective by being a good listener, asking few questions and being respectful about participants' advice (Creswell, 2013:166).

The role of the researcher in conducting the interviews can be described as giving guidance and support while conducting the interviews, as well as giving guidelines in the topics of the narratives that the participants have to write. Lastly, the researchers role was to analyse and triangulate the data (Maree, 2016:44).

1.7.2.2 Research site and sample

With consent from the participants, the researcher I planned to interview the mothers in a neutral environment where they felt comfortable. The mothers were the participants, since they experienced postpartum depression which influenced their children. I believe that the mothers were able to give valuable insight on the children's emotional development during the postpartum period.

This study made use of purposeful sampling to select participants. Creswell (2013:156) describes purposeful sampling as selecting individuals and sites because they can purposefully form an understanding of the phenomenon. Participants were selected because of defining characteristics of their experience with postpartum depression that made them the holders of the data needed for the study (Maree, 2016:198). As the aim of the study it was to provide information and guidelines for mothers who suffer from postpartum depression, the sample selection focused on participants (mothers) who had experienced postpartum depression and who, in retrospect, could give information about their experience and their perceptions of the effect this syndrome had on the emotional development of their children. Criteria for the selection of participant mothers included that:

- They have been diagnosed with postpartum depression by a general practitioner or psychiatrist.
- They have been struggling with postpartum depression for a minimum period of a year.
- They were not suffering from postpartum depression at the time of the study.

The following was expected of the participants during the study:

- The participating mothers written a guided narrative about their experience of postpartum depression.
- The participants attended interviews at the arranged time and place.
- The participants voluntarily discussed their lived experiences during the interviews.

1.7.2.3 Data collection methods

Maree (2016:51) explains that methods are seen as the tools that are used to collect data. I used narratives and interviews to collect the data for this study.

(i) Narrative

Rule and John (2011:65) state that narratives provide opportunities for useful data, since they give the participants freedom in terms of content and the sequencing of their story. The advantage of narratives, described by Creswell (2002:179) as “data that is thoughtful”, is that participants pay careful attention to writing the narrative or story. However, this format can also be seen as a limitation because not all people are equally adept at expressing their feelings in written form.

I aimed to ask the participants to write a narrative of their experience of postpartum depression and the effect it had on their young child. They were given guidelines and topics to think about when they began writing their story. I decided on this method, since it provided rich, in-depth data about the participants’ thoughts, experiences and emotions.

(ii) Interviews

Interviews usually imply one-on-one discussions between the researcher and research participants, which Rule and John (2011:64) call “a guided conversation”. In this study, I conducted semi - structured interviews with the participating mothers. With permission from the participants, all the interviews were audiotaped and additional handwritten notes were used to support the recordings. All the notes were used to assist with the transcriptions for the purpose of analysis. Observations were noted during the interviews for the non-verbal prompts. Maree (2016:87) states that as an researcher, you should be mindful of the reactions of your participants with the goal of identifying new developing themes that are connected directly with the phenomenon being studied, and may proceed to investigate and examine these. To ensure that the semi-structured interviews were successful, I prepared a list of predetermined questions. While conducting the interviews, the mothers were allowed to determine the direction of the interview, since they were regarded as more informed about the phenomenon, and I endeavoured to make them experience the interview as an opportunity to tell their stories (Vos, Strydom, Fouché & Delport, 2005:352).

1.7.2.4 Data analysis strategies

According to Creswell (2002:238), qualitative research is interpretive research, in the sense of deciding which description or theme captures the main idea of the categories or information created. Furthermore, Vos et al. (2005:399) elaborate that qualitative research, with characteristics such as thinking and theorising, is a process of inductive reasoning. My aim during the data analysis steps was to interpret and to make sense of what is in the data (Maree, 2016:110). Maree (2016:109) explains that Seidel's model is useful to clarify the process of qualitative data analysis (see Figure 1.1.).

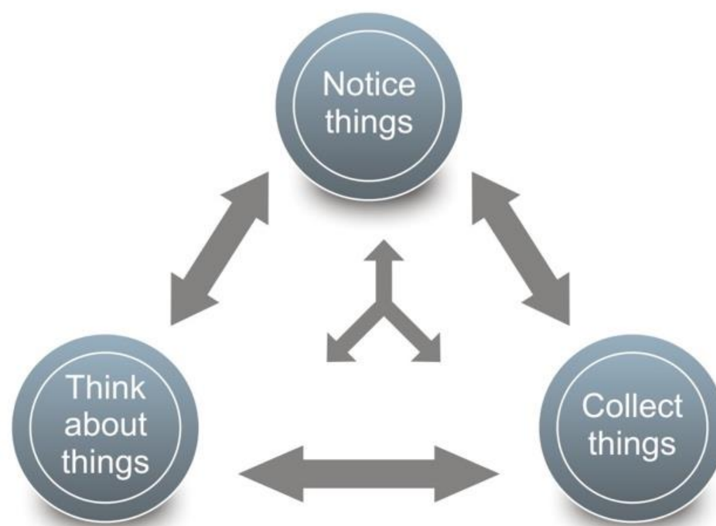

Figure 1.1: Seidel's (1998) interim data analysis model (Maree, 2016:110)

1.7.3 Trustworthiness

Maree (2016:121) maintains that trustworthiness is the most important part of qualitative research, since it is the critical test of data analysis, findings made and conclusions reached. Furthermore, Rolfe (2006:204) explains that trustworthiness is the extent to which the researcher persuades the reader that the research was done in a reliable manner, and that the findings are visible, which ensures that the research is being reckoned for. The elements of dependability, confirmability, credibility and transferability, as discussed below, illustrate the trustworthiness of this study (Maree, 2016:40).

1.7.3.1 Dependability

According to Tracy (2010:842) dependability involves determining whether the researcher's claims about knowledge correspond to the reality being studied. Furthermore, Maree (2016:124) states that dependability is demonstrated through research design and the implementation of it, data gathering and reflection on the project. To ensure that dependability is reached during this research, I aimed to employ member checking by discussing the identified themes during data analysis with the participants, thereby ensuring that the themes identified are dependable. In addition, I eliminated bias that might enter during the research period by constantly reflecting on the research process. The data collected during the interviews and the narrative analysis was triangulated to provide reliable findings. I aimed to keep a journal of all the decisions made during the research process and data analysis to ensure dependability.

1.7.3.2 Confirmability

Confirmability is reached when the findings of the study are shaped by the participants and not the researcher's bias, motivation and interest (Maree, 2016:40 & 125). The influence of the researcher's judgment should be minimised. The data and their interpretation are not figments of the researcher's imagination (Mertens, 2005:552). I aimed to conduct a confirmability audit by going back to review the original sources within the transcripts, documents and field notes made during observations. During informal meetings with the participants I asked the participants to verify the data collected from their cases to ensure that the interpretation of what they shared is correct (Maree, 2016: 40 & 125).

1.7.3.3 Credibility

Credibility refers to the trustworthiness, credibility and acceptability of the research findings (Tracy, 2010:843). Maree (2016:125) states that credibility can also be seen as internal validity, which means that the researcher describes an accurate image of a certain event or certain context. I strived to present findings that are believable and convincing, as well as presenting negative or inconsistent findings to add to the credibility of the study. The supervisor and co-supervisor assessed with the questions that were asked during the interviews, as well as the research diary kept to confirm that it was adequate for the research

to ensure content validity by thick and rich descriptions; member checking; crystallisation; narratives and interviews as well as triangulation.

1.7.3.4 Transferability

According to Tracy (2010:845), transferability (also known as generalisability) is achieved when readers feel as though the research identifies with their own situation and they intuitively transfer the research to their own lives. Maree (2016:300) agrees by describing generalisability as the generalisations that can be made from the data and context of the research to improve the wider community or setting. I aimed to use rich, thick descriptions by supplying a large amount of clear and detailed information about the data collected from mothers battling with postpartum depression, and the effect thereof on the young child's emotional development. Although transferability can occur, the aim of the study was not to generalise the findings of the study.

1.8 ETHICAL CONSIDERATIONS

I applied for ethical clearance at the Ethics Committee situated within the Faculty of Education at the University of Pretoria to conduct the study.

In keeping with the guidelines of Creswell (2013:58), the research upheld the following ethical considerations:

- Informed consent was obtained from the participants.
- I verbally and formally explained to the participants about the purpose and methods of this study.
- The consent letter was explained to them as well, stating that participating in this study is voluntarily and that the participant can withdraw from this study at any given time.
- To ensure anonymity and protect the identity of the participants, pseudonyms and/or code names was used when transcribing the data from interviews with the mothers and any other field notes.

During this study, I was working with mothers who have experienced a traumatic time in their lives. I dealt with this difficult life experience in a sensitive manner and refrained from

appearing judgemental or prejudiced. I also endeavoured to remain objective, acknowledging the possibility that emotional involvement by the researcher may compromise the findings of the study.

Maree (2016:298) maintains that, when working with young, under-age participants, written consent from their parents/caregivers will also be an importaint consideration. If this was the case, I considered the recommendations of Maree (2016:298).

Research confidentiality implies that unless otherwise decided upon, the participantds' identities ought to be protected so that the data gathered does not humiliate or in any way be detrimental to them (Einarsdóttir, 2007:2010). Since the mothers who participated in the study had experienced a traumatic time, confidentiality will be one of the main concerns for each of them to prevent harm or embarrassment. This was explained to each participant during the discussion of the consent form, which they were under no obligation to sign.

Punch and Oancea (2014:71) explain that not all harms connected to a study may be the full responsibility of the researcher. However, I intended to approach a psychologist to become involved in counselling the participants, if talking about their postpartum depression proves to be traumatic for any of the mothers.

1.9 BRIEF OVERVIEW OF THE STUDY

Below is a brief overview of what to expect in each chapter. Every chapter is discussed in detail according to this overview:

1.9.1 Chapter 1 – Introduction and orientation of the study

Chapter 1 provides a overview and introduction to the study. It explains the main problems as posed in the proposal. It will include the background of the study, rationale, literature review of the proposed structure of the study.

1.9.2 Chapter 2 – Theoretical framework and perspectives from literature

Chapter 2 consists of the theoretical framework as well as recent literature relating to the explanation of postpartum depression, the effects thereof and the impact on the emotional development of a young child. This literature created a foundation to understand the various concepts found in this study. It is followed by the attachment theory by John Bowlby, which served as a theoretical framework to support the research findings of this study.

1.9.3 Chapter 3 – Research methodology

As one of the most important chapters of this study, Chapter 3 maps out the procedures of research. The research approach, design and data collection methods are discussed in detail followed by ethical considerations. Lastly, the data analysis procedure and interpretation is provided.

1.9.4 Chapter 4 – Data analysis, and data interpretation

Chapter 4 presents the data after analysis. Interviews with the mothers and narratives allowed for very interesting and exciting data. The study followed a multiple case study design and therefore the data were also presented in that manner. The interpretation was conducted through the lens of literature which was presented in Chapter 2 as well as John Bowlby's attachment theory to interpret the research findings.

1.9.5 Chapter 5 – Summary, conclusions and recommendations

Concluding this research study, Chapter 5 provides a brief summary of the perspectives from the literature as well as the research findings and interpretations of this study. Conclusions were drawn by answering the main research question and the secondary questions. Finally, recommendations for health care providers, support systems, families, mothers and future research were posed.

1.10 CONCLUDING REMARKS

Chapter 1 introduced the research study. The background information, rationale, purpose of the study, the research questions and lastly, an overview of the chapters are given to provide an understanding of what is to follow in the upcoming chapters.

The next chapter, Chapter 2, provides the perspectives from maily recent literature.

CHAPTER 2
THEORETICAL PERSPECTIVES

2.1 INTRODUCTION

Chapter 1 provided an overview of the study by orientating the reader towards the context of the study, the problem that will be investigated, as well as the theoretical frameworks that will underpin the study. A short description of the research methodology was also provided. As the aim of this study was to explore the correlation between postpartum depression and the emotional development of the young child, this chapter consulted the literature on postpartum depression. This review includes a detailed discussion on postpartum depression as well as the symptoms and factors associated with this disorder. The available treatments were also investigated. Bowlby's attachment theory was elaborated on to highlight the importance of bonding between the mother and infant after birth. In conclusion, emotional development and the mother's role regarding the child's development was thoroughly explained.

Postpartum depression can adversely affect a women's quality of life, close relationships maternal-baby patterns of communication, newborn attachment and child developmental outcomes from infancy through to school age (McDonald, Wall, Forbes, Kingston, Kehler, Vekved & Tough, 2012:318). According to Paulson and Bazemore (2010:962), maternal prenatal and postpartum depression is common and has adverse personal, family and child developmental outcomes. Flynn (2015:28) provides a detailed description of the symptoms that can occur during the postpartum period, which include having very negative thoughts about the baby, thoughts of hurting the baby, thoughts of hurting themselves, not having any interest in the baby, and thoughts of giving the baby away. Keeping these symptoms in mind, it does seem as if many women experience ongoing episodes of postnatal depression (McDonald et al., 2012:319), but due to stigmatisation, these mothers do not often want to talk about their feelings.

Very little research on postpartum depression has been conducted in the South African context and the aim of this study was therefore, to provide mothers who struggle with postpartum depression with information and guidelines on how to combat the negative impact of this disorder on the emotional development of their children. Possible support groups for these women may also benefit from these guidelines.

In order to understand the extent of this disorder, it is necessary to discuss postpartum depression in detail.

2.2 POSTPARTUM DEPRESSION

Postpartum depression can be defined as a major depressive disorder which usually occurs during the postpartum period within one month or more after giving birth (Pearlstein, Howard, Salisbury & Zlotnick, 2009:57). The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM–5) specifies that a major depressive episode are classified when depression occurs during or within four weeks following the delivery, as stated by Stewart and Vigod (2016:2177).

Alici-Evcimen and Sudak (2003:210) postulate that postpartum depression is one of the most common difficulties associated with childbirth and contains considerable risk of illness. It has a substantial impact on the mother, the infant, and family. Furthermore, Hung, Tomlinson, Le Roux, Dewing, Chopra and Tsai (2014:74) report that 35 to 47 per cent of South African women have been diagnosed with major depressive disorder during pregnancy and the postpartum period. Studies done by Zlotnick, Tzilos, Miller, Seifer and Stout (2016:263) indicate that the challenges in the South African context regarding the postpartum period includes detachment from care and failure of health care. Furthermore, these authors state that proportions of women who suffer from postpartum depression do not receive treatment screening and regular follow-ups and note that the overall signing up for treatment is very low. Accordingly, Figure 2.1 provides an overview of the literature that will be discussed in this section regarding postpartum depression, the common symptoms and treatments available in South Africa (Kim & Swain, 2007:9).

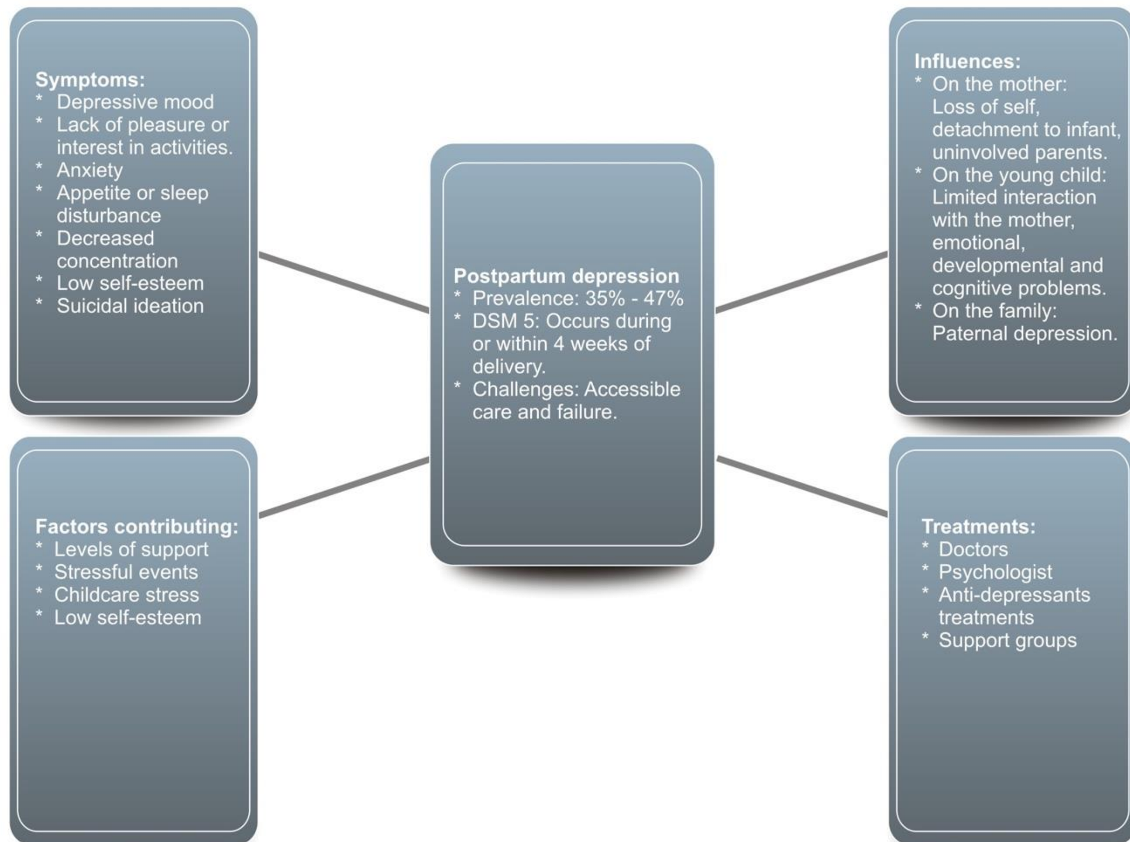

Figure 2.1 Overview of literature review *(Adapted from Kim and Swain (2007:39)*)

2.2.1 Symptoms of postpartum depression (diagnosis)

Pearlstein et al. (2009:357) state that the optimal screening time for postpartum depression ranges between two weeks to six months after giving birth. Shafak, (2011:238) in her memoir on her postpartum depression, refers to the intensity and duration of the symptoms when saying that "more than the symptoms per se, it is how strongly and persistently we suffer from them that matters". Differentiating between "baby blues", depressive symptoms and postpartum depression as well as the severity of the symptoms is important to consider during screening (Guille, Newman, Fryml, Lifton & Epperson, 2013:645). "Baby blues", as described by Hunt (2006:214), is a disorder which happens typically within the the first two weeks to delivery and could be overcome within those two weeks. 'Baby blues' befalls an estimated 50 to 80 percent of women with the most common symptoms as no more than by sadness, bad-temperedness, a low state of mind, nervousness and tiredness.

A clear indication of postpartum depression is when a woman experience five or more of the symptoms listed below most of the time and it's causing damage to her daily functioning during the same time period (Whooley, 2016:438). Table 2.1 explains the most common symptoms of postpartum depression as experienced daily by mothers around the world (Ege, Timur, Zincir, Geçkil & Sunar-Reeder, 2008; O'Connell & Dor, 2009:166; Guille et al., 2013:645).

Table 2.1 Symptoms of postpartum depression *Source: Adapted from Ege, Timur, Zincir, Geckil & Sunar-Reeder, 2008; O'Connell & Dor, 2009:166; Guille et al., 2013:645.*

Symptoms	***Discussion of symptoms***
1) Depressed mood (Ege et al., 2008)	Sad or depressed mood that persists daily for at least two weeks (Guille et al., 2013:645). Depressed mood (Lewis & Marais.2011:35): Fear of anything such as driving alone, Irritability and anger with people close by, tearfulness and acute sensitivity or vulnerability; overwhelming feelings (Beck, 2002:462)
2) Lack of pleasure or interest in activities (O'Connell & Dor., 2009:166)	Inability to derive pleasure from experiences or lack of interest in things that are normally enjoyable (Guille et al., 2013:645).
3) Anxiety (Ege et al., 2008)	Intense anxiety and feelings of panic (Beck, 2002:462). Anxiety disorders show a higher occurrence in the postpartum period compared to depressive disorders (Rochat, Tomlinson, Barnighausen, Newell & Stein, 2011:370).
4) Appetite and sleep disturbance (Ege et al., 2008)	During interviews conducted by Rochat et al., (2011: 373), participants reported that the most common thoughts and worries about their babies interfered with their ability to sleep. Guille et al. (2013:645) add that hypersomnia also contributes to the lack of sleep for a mother. The mother have no desire to eat and will eat what is available (Lewis & Marais, 2011:35).
5) Decreased concentration	Rochat et al. (2011:378) mention women most frequently described their concentration difficulties as

Symptoms	Discussion of symptoms
(O'Connell & Dor., 2009:166)	feeling 'easily distracted' or being 'forgetful'. Beck (2002:463) states that mothers minds seems to be filled with cobwebs and their ability to concentrate are diminished.
6) Low self-esteem (O'Connell & Dor., 2009:166)	Feeling of failing and worthlessness as a mother figure and letting everybody down (Guille et al., 2013:645).
7) Suicidal ideation (O'Connell & Dor., 2009:166)	She may feel an overwhelming sense of hopelessness. Reported to be plans to harm herself or in some cases even her baby (Rochat et al., 2011:370). Beck (2002:465) points out that due to the guilt these mothers carry, they seem to reason that dying will be better than to deal with the pain of never ending postpartum depression.

2.2.2 Factors contributing to postpartum depression

Postnatal depression can follow antenatal depression or depression during pregnancy. Some studies have shown that the level of depression experienced by women in the antenatal period was one of the main reasons for postpartum depression (Williamson & McCutcheon, 2004:12). Dennis and Chung–Lee (2006:324) mention in their research that the average woman's risk to develop postpartum depression is ascribed to approximately one-third genetic factors and two-thirds environmental factors. Furthermore, Vigod, Villegas, Dennis and Ross (2010:540) add that stressful events occur more commonly than that of personal and family histories of depression. In particular, a recent analysis of 84 studies indicated several risk factors for postpartum depression, which includes low levels of social support, stressful life events, childcare stress, low self-esteem, low income and marital satisfaction (Dennis & Ross, 2006:590), which is discussed in more detail below. The clarification of risk factors, according to Limlomwongse and Liabsuetrakul (2006:132), may help early detection which would result in early support and treatment which may reduce the severe mood disorders.

2.2.2.1 Levels of support

The level of support given to the mother by her partner after birth may present with significant risk factors (Milgrom, Gemmill, Bilszta, Hayes, Barnett, Brooks & Buist, 2008:148). Furthermore, the mother’s relationship with her parents and the availability of people to depend on during pregnancy and the early postpartum are also factors to consider. The absence of social care is an essential factor causing postpartum depression, as opposed to solid social ties that fill in as a safeguard against depression amid the postpartum period (Wang, Jiang, Jan & Chen, 2003:637).

2.2.2.2 Stressful events

High scores on “current life events” scales are associated with postnatal depression and may interact with vulnerability factors (Lee & Ching, 2007:148). Robertson, Grace, Wallington and Stewart (2004) explain that the death of loved ones, break up of a relationship or divorce, losing a job or moving home, are experiences which could trigger depressive episodes.

2.2.2.3 Childcare stress

Mothering or nurturing is a central value in our society, underpinning the lives of women with children (Mohammad, Gamble & Creedy, 2011:41). Feelings of inadequacy are the result of the supposed inability to meet the social ideal of a perfect mother (Highet, Stevenson, Purtell & Coo, 2014:180). “To be breast fed, fully vaccinated, sleep in the supine position and live in a smoke-free environment” are recommendations made by health care professionals to mothers. These recommendations could cause even more stress to a mother who are already anxious, reports Anderson, Jackson, Wailoo and Petersen (2002:391). In this regard McMahon, Barnett, Kowalenko, Tennant and Don (2001:582) suggest that prenatal depression and anxiety have an effect on a new-born baby, which cause irritability and excessive crying. Highet et al. (2014:181) report that most woman admit that infant care is perceived as overwhelming and in some cases ‘shocking’, making it difficult to cope with.

2.2.2.4 Low self-esteem

Maternal self-esteem includes, according to Farrow and Blissett (2007:519), a mother's assessment of her caretaking capacity, her estimation of her general capacity, her readiness for the mothering role, her acknowledgment of her infant, her normal association with her infant, and her sentiments in regards to her pregnancy, labour, and delivery. Scars, loss of muscle tone, stretch marks and gaining weight are usually associated with pregnancy, and adaption to a new body can be difficult to accept (Lewis & Marais, 2011:74). Furthermore, Highet et al. (2014:181) note that changes in physical appearance reinforce the experience of change; women often feel that not only their daily lives, but also their bodies were subjected to turmoil.

McMahon, Trapolini and Barnett (2008:201) found in their study that most women determined to have postnatal depression continued to encounter spells of depression after the inital postnatal year. Postpartum depression implies substantial and enduring health outcomes for women and their newborn children (Field, 2010). In the next section, the influences of postpartum depression will be discussed with regards to the mother, her child and spouse (life partner).

2.2.3 The influences of postpartum depression

Parental behaviour, cognition and feelings are influenced by depression, which in turn prompts emotional inaccessibility and thought patterns that adversely affect parent – child communications (Rosenblum, Mazet & Bénony, 1997:352). Furthermore, postpartum depression limits a women's capacity to successfully perform the maternal role: discouraged moms offer less responsive care, will probably cease breastfeeding early or have issues breastfeeding, are more prone to disagree with suggested safety practices, for example, the utilisation of car seats, and their youngsters have lower rates of preventive health services usage and innoculations (Field, 2010). Williamson and McCutcheon (2004:11) suggest that a depressed mother's ability to become involved in her child's life is weakened, and may even result in abusing or neglecting the child. Not only is the mother's life negatively impacted, but Oakhill (2016:532) also warns that family relationships are also distorted. Dennis, Janssen and Singer (2004:338) postulate that ladies who have experienced postpartum

depression are twice as liable to encounter future scenes of misery over a 5-year time frame, and caution that babies and kids are especially defenseless.

2.2.3.1 The influences of postpartum depression on a young child

A mother's ability to identify and respond to her infant's interactional cues and to communicate responsively with her infant during play, could be impaired due to the postpartum depression she is battling with, which accordingly leads to the strong relationship between postpartum depression and non-optimal interactions (Cornish, McMahon & Ungerer, 2008:142). Furthermore, Field (2002:26) did a comparative study on depressed and non-depressed mothers and their interactions with their infants and found that infants of depressed mothers displayed a passive/active coping behaviour pattern. The infants of the depressed mothers seemed to "mirror" their mother's behaviour while developing a passive coping, depressed style of interacting. "An alternative interpretation of these data is that depression or depressed affects may emerge in very young infants as a function of their early interactions with postpartum depressed mothers" (Field, 2002:27). Halbreich and Karkun (2006:98) agree that hostile cognitive, behavioural and emotional outcomes can be identified in these infants in accordance with long–term developmental disturbances due to poor interactions between mother and child.

According to Field (2002:29), attentional, emotional and behavioural problems have been reported more often in infants born to women who had depression, anxiety or stress. In this regard, Chong, Broekman, Qiu, Aris, Chan, Rifkin-Graboi and Kwek (2016:591) report on a study that highlights the direct effects of antenatal anxiety between 18 and 32 weeks of pregnancy on the behaviour and emotional problems of young children who are four years old. The study revealed that not only has antenatal depression an effect on a child's temperament and emotional development, but the persistence of the postpartum period may intensify the development of behavioural problems. In cases were the baby feels unnoticed or ignored, they tend to push back their feelings into the passive mother with accumilating vigour and fury, endeavoring to incite a reaction. This is frequently the origin of problematic attention-seeking conduct, which is labelled as Attention Deficit Hyperactivity Disorder (ADHD) (Emanuel, 2006:252). The child can also experience concentration difficulties leading to a negative effect on a child's ability to learn at school which, according to Cornish

et al. (2008:143) may be an indication of the early patterns of distraction experienced during the postpartum period.

2.2.3.2 The influences of postpartum depression on the marital relationship

It has been demonstrated that partners of postnatal depressed women are more likely to become clinically depressed and the married relationship can be tense (Halbreich & Karkun, 2006:98). The spectrum of influences that postpartum depression has on a woman's life is far more extensive than meets the eye. Goodman (2008:626) reports that partners of postpartum depressed woman describe their feelings as feeling overcome, disconnected, branded, afraid, perplexed, worried for their partner, frustrated, furious and vulnerable. Not only do they experience the mentioned feelings, but also uncertainty of what the future may hold, a feeling of sacrifice, unsetteled family social and leisure activities, loss of closeness, monetary issues, and a feeling that their world had collapsed. Goodman (2004:27) mention the concept "paternal depression" which explains these feelings of men when their female partners struggle with postpartum depression.

In qualitative studies, male partners of postpartum depressed women have described feeling overpowered, disengaged, disparaged, afraid, mistook and worried for their partner, disappointed, furious and powerless. They communicated doubt about the future, a feeling of sacrifice, unsetteled family social and leisure activities, loss of closeness, money related issues and a feeling that their world had collapsed (Boath, Pryce, & Cox, 1998; Davey, Dziurawiec & O'Brien-Malone, 2006; Meignan, Davis, Thomas & Droppleman, 1999). Maternal PPD appeared to contribute to paternal parenting stress (Milgrom & McCloud, 1996) and paternal disappointment with the couple relationship (Hock, Schirtzinger, Lutz & Widaman, 1995; Milgrom & McCloud, 1996).

2.2.4 Treatment

Pearlstein et al. (2009:358) maintain that since treatment will not necessarily mend the attachment bond between the mother and child or be sufficient for the development of the cognitive and socio-emotional development of the infant or toddler, it is still crucial to make an effort towards the prevention and treatment of depression during pregnancy and after the delivery. Effective treatments for postpartum depression do exist, yet current research

suggests that there is an estimated 75 per cent treatment gap for common mental disorders in South Africa (Baron, Field, Kafaar & Honikman, 2015:503). Hung et al. (2014:424) assert that in South Africa, much of postnatal care is focused primarily on the health of the new born, with little attention is paid to maternal well-being following delivery. Goodman and Santangelo (2011:278) agree when saying that very few depressed women are treated amid the postpartum period. Dennis and Chung–Lee (2006, p. 325) ascribe this phenomenon to two reasons: (1) not knowing where to get assistance or being unaware of treatment possibilities; (2) women's inability to unveil their feelings. Furthermore, the lack of proper screening, the shame associated with depression as well as the loneliness encourages women to rather hide their feelings. Women in South Africa who are depressed and financially underprivilaged should incorporate critical thinking in order to solve critical obstacles to care (Grote, Zuckoff, Swartz, Bledsoe & Geibel, 2007:3).

In some cases, postpartum depression often resolves spontaneously after four to six months, but can in some cases easily last (much) longer (Cuijpers, Brännmark & van Straten, 2008:104). Thus, the delivery of effective treatment is generally considered a priority. Gjerdingen and Yawn (2007:287) found that clinical treatment outcomes were enhanced when depression screening and response programs are combined with frameworks that guarantee precise diagnosis and viable treatment and aftercare.

According to Baron et al., (2015:503), a recent study reports that the barriers to treatment are not really structural, but attitudinal. In other words, attitudes towards depression are still characterized by stigmas by the general public (Grote et al., 2007:3). Peterson and Lund (2011:755) explains that traditional beliefs contribute to stigma and discrimination towards seeking treatment. Receiving a disability grant and unemployment are regarded as reasons for depression, which leads to the perception that people with depression are often perceived as incompetent, crazy, violent or out of control, "being responsible for causing their own condition" (Grote et al., 2007:3). A lack of health care awareness and training are also contributing factors for inequity in access to treatment for depression (Rochat et al., 2011:371). The following treatment mechanisms will be elaborated on, namely doctors, psychologists and support, as these are these are the first in line when women seek help.

2.2.4.1 Doctors

Struik (2013:3) mentions that in many instances a general practitioner (GP) will only casually enquire about a new mother's mental status and is of the opinion that screening takes too much effort. For these reasons, missed diagnoses have been found to be frequent in situations which lack structured methods for evaluating mental health status. A study by Turner, Sharp, Folkes and Chew-Graham (2008:453) indicated that the connection between a mother and her GP seemed, by all accounts, to have a critical effect on her choice to take medication, as some mothers referred to how they had remained concerned with taking antidepressants yet had chosen to trust their GP and follow his/her recommendation. A study assessing attitudes of doctors in the state of Washington investigated the recurrence of screening for depression and found that despite the fact that most specialists surveyed were worried about depression, just 44 per cent reported offering depression screening in their practices, regardless of indications (Breedlove & Fryzelka, 2011:20). As mentioned above the screening for postpartum depression and anti-depressant will be discussed briefly for a broader perspective.

(i) Postpartum depression screening

Beck (2002:24) developed a Postpartum Depression Predictors Inventory–Revised (PDPI-R) which is an assessment tool containing questions a health professional can use to assess each of the 13 risk factors such as maritial status, sosioeconimic status, selfesteem, prenatal depression, prenatal anxiety, unplanned/ unwanted pregnancy, history of previous depression, social support, maritial satisfaction, life stress, child care stress, infant temperament and maternity blues. Furthermore, Beck (2002:24) explains that including the PDPI-R there are two postpartum depression screening scales: Edinburgh Postnatal Depression Scale (EPDS) and the Postpartum Depression Screening Scale (PDSS).

Flynn, Sexton, Ratliff, Porter and Zivin (2011:131) explains that the Edinburgh Postnatal Depression Scale (EPDS) is a 10 item self-report depression measuring a one-week period. All the items in this screening assessment include four responses also containing reverse scores coded from 0 to 3. Items are then counted to develop a score of 0 to 27. The higher the score, the more severe are the symptoms. Referring to the Postpartum Depression Screening Scale (PDSS), Munoz, Agruss, Haeger and Sivertsen (2006:248) note that this

screening instrument comprises of 35 questions which includes the seven dimensions. The seven dimensions are as per the following: resting/eating disorders, nervousness/uncertainty, emotional liability, mental confusion, loss of self, blame/disgrace and self-destructive musings. The reactions are positioned on a Likert scale from one (strongly disagree) to five (strongly agree). A score of 60 to 79 indicates women with a positive screen for minor depression, and a score of 80 or above speaks to a positive screen for major PPD.

(ii) Anti-depressants treatments

Among women with mild to severe depression, antidepressant medication and therapy are sugessted (Guille, 2013:650). Dennis and Chung–Lee (2006:326) note that most women have a fear of addiction, thus they will rather keep on believing that their depression will resolve without any pharmacological treatment. In the cases that women decided to take the prescribed medication, Turner et al., (2008:453) explain that women usually prefer to be monitored frequently and were more willing to take a lower dose than prescribed. These prescribed antidepressants may benefit (therapeutic effects to the mother and producing breast milk) or harm (pharmacological effects in the milk) a child's development (Brummelte & Galea, 2016:62).

Lewis and Marais (2011:95) provide the following important information regarding the use of medication:

- The medication is not addictive as some of the studies shown that it's one of the most common fears of women.
- Most of the medication is safe to use during pregnancy and after giving birth while breast-feeding.
- The medication is not meant to be used on a permanent basis, only until the medical professional feels it's safe to stop using the medication.
- Medication is used to prevent depression and anxiety before it has major effects on the woman's life.

2.2.4.2 Psychologists or psychiatrist

Dennis and Chung–Lee (2006:326) found that most woman in a cross-cultural study incorporating 11 countries, resort to ‘‘talking therapies’’ with health professionals as a treatment preference, which refers to support groups, sessions with a psychologist or psychiatrist. These authors furthermore maintain that women with mild to moderate depressive symptoms in the postpartum period ought to be offered psychotherapy as a first line treatment alternative. Interpersonal psychotherapy (IPT), a interim effective treatment for MDD that tends to relational issues, (for example, role change, the conjugal relationship, social help and life stressors) is exceptionally important to the requirements of women amid the postpartum period (Pearlstein et al., 2009:6). Scope, Booth and Sutcliffe (2012:1910) found that the access for women to individual psychologicall treatment is constrained by cost, waiting times, and accessibility of therapists. Group treatment may offer a possibly successful substitute.

2.2.4.3 Support groups

Dennis and Chung–Lee (2006:327) take note of the potential negative characteristics of support groups, for example being overpowered by others' issues and involvement being overwhelmed by a particular ethnic group, which may prompt sentiments of not belonging. Turner et al., (2008:453) report on their findings of support groups saying that some of the participants who had received counselling had thought that it was useful however their state of mind stayed low.

2.3 THEORETICAL FRAMEWORK

The function of a theoretical framework, according to Anfara and Mertz (2006:192), is to interpret the empirical findings of a study. The role of John Bowlby’s Attachment Theory (1969) will be used as a framework to understand the relationship between the mother and the infant, which is the focus of this study, and will also be used to interpret the empirical data in Chapter 4.

2.3.1 Attachment theory

Bowlby studied the unknown territory of mother-infant's relationship and identified key elements in the attachment relationship, which may have instant and enduring effects on the developing individual (Bowlby, 1973:8). Bowlby (1980:1) also explored how youngsters react to a transitory or lasting loss of a mother-figure. The data that he collected through observations of how young children behave in defined situations, led Bowlby to postulate that the absence or loss of a mother-figure has far-reaching consequences for the young child's development. According to Bowlby (2005:154) attachment behaviour is considered as any type of conduct that results in someone obtaining or re-establishing closeness to some other distinguished and favored person, who is typically viewed as more grounded or more astute. A feature of attachment behaviour as presented by Bowlby (2008:4) is the intensity and the kind of emotion aroused by an individual depending on how the relationship between the individual and the attachment figure is progressing. Furthermore, Bowlby (2005:154) distinguished between the following features of the attachment theory:

a) Specify: Attachment behaviour is aimed at one or a couple of people in particular, usually as per inclination.
b) Duration: Early attachements are not easily surrendered and they normally continue.
c) Engagement of emotion: Intense feelings emerge amid the establishment, the maintenance, the interruption, and the reestablishment of attachment relationships.
d) Ontogeny: Infants attachment behaviour develops during the first nine months of life.
e) Learning: Figuring out how to recognize the common place and interesting is enter process in the advancement of a connection.
f) Organisation: From the finish of the primary year, it moves toward becoming encouraged by progressively refined behavioral frameworks composed through correspondence and utilizing their connection figure as a base to investigate their condition from.
g) Biological function: The mother is the preferred attachment figure which makes her function of attachment behaviour protection.

2.3.1.1 Phases of attachment development

First bonds form the corner stone of a child's personality (Bowlby, 1969:177). Poobalan et al. (2007:283) maintain that the mother is the only parent guaranteed to be present at the birth of her child and therefore the first significant person with which the infant bonds.

Postpartum depression is one of the many factors prohibiting a mother from forming the first attachment with her child. In this regard, Bowlby (1969:265) postulates that this primal bond between mother and child, which may seemingly be insignificant, have the potential to influence all future attachments. Attachments form because babies see their grown-up parental figures as places of refuge who illustrate – commonly on a repeated basis – an interest in the infant's survival by protecting the infant (Dykas & Cassidy, 2011:20). Furthermore, Bowlby (1969:265) explains the attachment development of an infant in four phases as explained in Table 2.2.

Table 2.2 Phases of attachment development *Source: Bowlby, 1969:265*

Phase	***Duration***	***Description***	***Behaviour***
Phase 1 Orientation and signals without discrimination of figure.	From birth to 12 weeks	The infant's ability to discriminate between different people is absent or limited.	Behaviour: tracking movements with their eyes; grasping and reaching; smiling and babbling.
Phase 2 Orientation and signals directed towards one discriminated figure.	Until six months of age	Discriminating between different bias stimuli to respond to. Auditory stimuli (four weeks of age): Human voices; Visual stimuli (ten weeks of age): Human faces	Infant behave in a friendly way with remarkable attention to the mother - figure.
Phase 3 Maintenance of proximity to a discriminated figure by means of locomotion as well as signals.	Six or seven months of age. Can be delayed to the 1st birthday with interaction with the mother-figure were limited	The attachment between mother and child are more noticeable.	Discriminating ways in treating people and different responses such as: following a departing mother,

Phase	*Duration*	*Description*	*Behaviour*
			greeting her on her return and using her as a base to explore from.
Phase 4 Formation of a goal-corrected partnership.	Any time from the second birthday towards the third birthday.	The child acquires insight into the mother's feelings and motives, also known as the groundwork for a more complex relationship. The infant's world becomes more sophisticated.	His behaviour more flexible.

Table 2.2 illustrates how the infant's attachment towards a mother-figure develops according to four phases identified by Bowlby (1969:265). These four phases are age related with regard to the healthy development of an attachment between the infant and the mother-figure. Since the infant's attachment development toward their mother-figure may vary due to various factors, the infant's attachment development phases will not always be consecutively. These phases set a guideline as to the age appropriateness and healthy development of attachment development towards this study, since the attachment between mother and infant will be questioned.

Even though the infant does not necessarily form an attachment with the mother-figure during Phase 1, the importance for the infant being aware of an existing mother-figure are highlighted (Bowlby, 1969:265). Field, Hernandez-Reif and Diego (2011:94) found in their study that infants of depressed mothers tend to express limited attentiveness and responsive to auditory, visual stimuli and tactile and kinaesthetic stimuli such as texture nipples, as seen in Phase 2 of the attachment development phases. Regarding Phase 3 and 4, Field (2011:9) holds that infants are less affected by a still–faced mother, which suggest that they adjusted to the behaviour of the mother-figure. Depressed mothers display emotions such as anger and anxiety as well as intrusive interaction styles. Based on the literature of a child's phases

of attachment development as well as the literature previously consulted, it is clear that from Phase 1 postpartum depression can have an effect on the attachment development of the infant.

2.3.1.2 Attachment classification

Co-founder of the attachment theory, Mary Ainsworth, Bowlby's fellow researcher, together with Rosmalen, Veer and Horst (2015:262) developed a laboratory procedure named Strange Situation Procedure (SSP) which was based on empirical evidence of Bowlby's research. This procedure was developed with the aim to allow classification of attachment security prompted by attachment behaviour in child. According to Bowlby's Attachment Theory, all infants become attached and insecure attachment may result in developmental problems. Figure 2.2 describes the classification of a child's attachment to their mother.

Youngsters' capacity to utilize a connection as a safe base likewise gives the self-administrative limits important to investigate and ace ordinary circumstances (Waters & Cummings, 2000:164). From this perspective, parents' roles are those of "external organizers" (Zimmermann, Maier, Winter & Grossmann, 2001:331), and parent–child relationships offer a meaningful context for emotion socialization, the product of which is emotion regulation abilities. Children learn about emotion and emotion regulation strategies in the interaction with their caregivers through a variety of socialization methods.

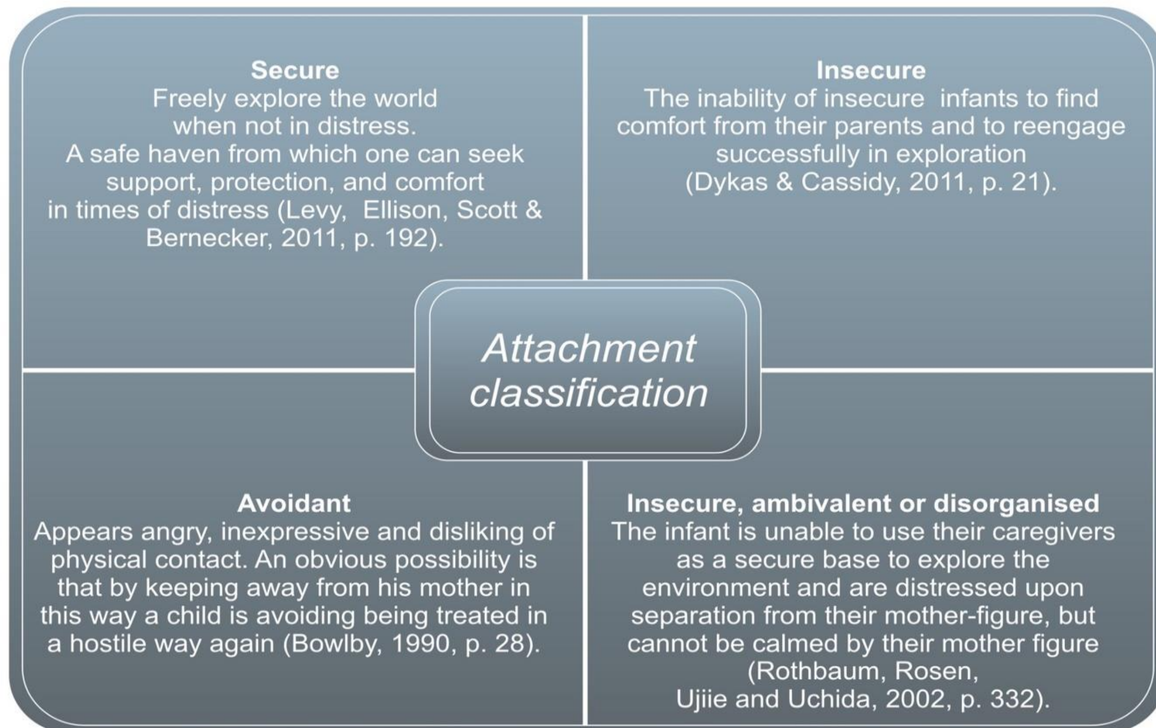

Figure 2.2 Attachment Classification *(Rosmalen, Veer & Horst, 2015:262)*

The secure base attachments between a mother figure and a child, provides the child with self–regulatory abilities to embrace and master everyday situations. Brumariu (2015:33) maintains that parent–child relationships offer context for sosio–emotional development including experiencing different emotions and the regulation of emotions. Furthermore, Lefkovics, Baji and Rigó (2014:359) confirm that infants of depressed mothers continually experience negative reactions due to insecurity, which fuels mutually bullying interaction patterns. Potential consequences of these types of attachment patterns may be the development of affecting problems in early childhood and future depression. On the other hand, Braungart-Rieker, Garwood, Powers and Wang (2001:265) found that young children who formed an avoidant attachment with their mother will easily use avoidance to suppress possible attachment-related emotions. The avoidant young child shows better emotion regulation when they were faced with a less sensitive mother from the age of four months leading to the young child, having an easier temperament. According to Kennedy and Kennedy (2004:256) children who experience disorganised/ambivalent attachments struggle to find successful ways of coping with separation from their parent figure, leading to behavioural problems during pre-school years, often displaying aggressive or disruptive

behaviour whilst being socially isolated from the others around him/her. A longitudinal study (Wan & Green, 2009:127) proposes that the enduring effect of maternal sorrow on connection relies upon the maternal gloom qualities and maternal affectability, as opposed to just the measure of melancholy introduction to the tyke. Groh, Roisman, van Ijzendoorn, Bakermans-Kranenburg and Fearon (2012:592) highlight that within the parent–child attachment relationship, children are believed to develop either adaptive or maladaptive emotion regulation strategies that serve either as their protective or risk factors for later psychopathology.

Literature indicates that there's a definite correlation between postpartum depression and the young child's emotional development, which is displayed in Table 2.3.

Table 2.3 Attachment style and the emotional effect on a young child

Attachment style	***Emotional effect***
Secure attachment *Sensitive caregiving gives escalation to secure attachment, which promotes optimal development (Wan & Green, 2009:129).*	Secure infants as described by Dykas and Cassidy (2011:21): • Use their parent as both a safe haven and a secure base • They seek closeness to or interaction with their parents when stressed and/or frightened, • Derive comfort from such interaction, and • Reengage in exploration once they have been comforted.
Insecure Attachment *Insecure attachment is determined mainly by shared environmental factors (Wan & Green, 2009: 129).*	Insecure infants show as described by Kennedy and Kennedy (2004:250): • Lower levels of coping competence. • Low social competence. • Lack of self confidence • Impulsive • Restless • Easily frustrated
Avoidant Attachment *The inability to derive comfort from their parents. Their parents*	Anxious–avoidant children: • Fail to develop trusting relationships with others,

Attachment style	***Emotional effect***
as unpredictable caregivers who should be kept nearby in order to increase the likelihood of gaining access to those attachment figures if needed (Dykas & Cassidy, 2011:21).	• Sees others as unable to provide emotional closeness and comfort, • Feeling socially and emotionally isolated. • Shows more externalizing and aggressive, antisocial behaviour, reflected by lying, bullying, and interpersonal insensitivity. (Kennedy & Kennedy, 2004:250)
Insecure Ambivalent/Disorganised Attachment *Disorganised attachment is understood to result from strange (rather than insensitive) caregiving behaviour and experiences of unresolved loss/ trauma (Wan & Green, 2009:124).*	Kennedy and Kennedy (2004:250) describes insecure disorganised infants as: • Aggressive and disruptive behaviours and social isolation • Under stress the disorganized child sees others as potential threats and might shift between social withdrawal and defensively aggressive behaviour.

The emotional development of the child will now be discussed to indicate the importance of a secure, loving attachment to the maternal figure.

2.4 EMOTIONAL DEVELOPMENT

Mayer, Salovey, Caruso and Sitarenios (2001:233) define emotion as an organised mental response to a happening that includes physical, experimental and cognitive aspects and mention that emotions typically occur in the context of relationships. Research on early childhood indicates that the first five years of a child's life is crucial in social and emotional development (Cooper, Masi & Vick, 2009:3). Explaining the importance of emotional development, Denham, Zinsser and Brown (2006:85) postulate that youthful youngsters must figure out how to send and get passionate messages, utilizing their insight about feelings and their capacities to direct feelings, with the goal that they may effectively arrange relational discussions, shape connections and keep up interest about and eagerness for their reality. Emotion, according to Dunn (2003:332), is the primary standard and the primary focus of communication in infancy. Subsequently, this section of the chapter aims to give a broader

perspective of the young child's emotional development by firstly discussing the emotional competence of the child as well as the mother's role in their emotional development. The relationship between a mother and her child will be further elaborated upon and lastly the influence of postpartum depression on the emotional development of the young child.

2.4.1 Emotional competence

Denham, Wyatt, Bassett, Echeverria and Knox (2009:42) defines emotional competence as being aware of your own and others' emotions and to act on this awareness to control the emotional experience. Furthermore, Eisenberg, Fabes and Spinrad (2006:250), Saarni (1999:4) and Denham et al. (2009:38) articulate the emotional related capabilities and abilities a child need to be able to adapt to the changing environments as they grow and develop. These capabilities and abilities are referred to as skills to emphasize the effective functioning that is contained in the concept of emotional competence. Table 2.4 list the eight skills of emotional competence as adapted from Eisenberg et al. (2006:250), Saarni (1999:4) and Denham et al. (2009:i38).

Table 2.4 Skills of emotional competence *Source: Adapted from Eisenberg et al., 2006:250*

Skills		***Developmental period***	***Description***
1	Awareness of emotions	Infancy (birth to 18 or 24 months)	Expression of basic emotions. Much assistance by adults.
2	Ability to discern and understand others' emotions	Toddler period (18–24 months through 3 years)	Expression of more social emotions (eg, guilt, shame, empathy). Begins to comprehend ‘‘good’’ and ‘‘bad’’ feelings. More independent emotion regulation.
3	Use of a vocabulary of emotion and expression	Preschool period through kindergarten (3 to 5–6 years)	Family dialogue about emotions, how to speak about feelings, and how to cope with emotion- overloaded situations.
4	The capacity for empathic and sympathetic involvement	Grade school	Capacity to empathise and sympathise with others during emotional experiences.

	Skills	Developmental period	Description
5	Skill in differentiating internal emotional experience from external emotional expression	Early adolescence (12–14 years)	More refined experience and expression of emotion. Ever more sophisticated understanding of unique emotional perspectives. Comprehensive selection of emotion regulatory strategies.
6	Skill in adaptive coping with aversive emotions and distressing circumstances	Middle adolescence (15–17 years)	Growing cognitive complexity, exposure to varied social models, and breadth of emotional-social experience contribute to their ability to generate more coping solutions to challenging situations.
7	Awareness of emotion communication in relationships	Late adolescence/early adulthood	Children recognize and express that emotion communication differs as a function of the nature of the relationship that they have with someone.
8	Capacity for emotional self-efficacy	Adulthood	The individual views her- or himself as feeling, overall, the way he or she wants to feel.

To summarise, Halberstadt, Denham and Dunsmore (2001:98) explain that the young children's conceptualisation of their own emotional experiences is most reliably produced in a familiar interactive context with regards to skills pertaining in skill one. When children are capable of expressing all the ''basic'' emotions (happiness, sadness, anger and fear) skill two of emotional competence are reached. They display a basic understanding of emotion understanding and regulation (although regulation needs to be supported by adults) (Denham et al., 2009:42). Furthermore, Saarni (1999:4) states that these youngsters develop a vocabulary of emotions in skill three that enable them to embody their own and others' emotional experience. The reviewed research by Halberst et al. (2001:98) as to skill four additionally shows that intricate, often secondary, connections exist between child rearing practices and children's empathic, sympathetic and prosocial conduct toward others. Maybe the first type of differentiation in skill five between internal state and external articulation is the exaggeration of emotional-expressive conduct to gain another's attention. Context has an influence on a young child's coping and emotion regulation with relationships in skill six, for example, which emotion is provoked under what kind of conditions and in what kind of relationship (Eisenberg et al., 2006:258). According to Asher and Rose (1997:196), related

issues in skill seven include how children and youth translate the relational outcomes of their emotional communication with the relationship for themselves and for those they communicate with and how they apply power and control in the relationship. Eisenberg et al. (2006:260) conclude that in their opinion, this feeling of emontional self-adequacy in skill eight is presumably not accomplished until adolescence. It is unquestionably reliant on congnitive development, including the ability to consider possibility and reality. The abilities of emotional competence are dynamic and value-based. Since these aptitudes are part of an interpersonal exchange that creates in a novel setting, for example, an emotional bond with a mother figure as an example of emotional capability.

2.4.1 The role of the mother in the child's development

Field (1994:209) explains the role of the mother in a young child's emotional development as being the person who models a certain behaviour to be imitated by the infant. Infants copy their mothers' emotions when the mother for instance simplifies and imitates the infant's behaviour, which in turn leads to reinforcement of the infant's behaviour. The quality of these emotional exchanges is conceptualized as an important sign of the developing child's ability to regulate his or her own emotions (Cole, Martin & Dennis, 2004:324). According to the research findings by Brophy-Herb, Horodynski, Dupuis, London Bocknek, Schiffman, Onaga and Thomas (2009:207), pre-schoolers' emotional development was the highest when their mothers used emotional language during interaction with their child and motivating their child to do the same. Furthermore, the mothers' use of desire language, such as "Mommy, feel sad if you behave in such a way", in associations with their 15-month-olds, anticipated these toddler's capacities to utilize mental-state dialect of their own and in addition to better perceiving others' feelings from facial and body articulations at two years of age. Children who display anger during parent-child interactions reflect the parents' negative emotion towards the child (Eisenberg et al., 2006:285).

Sroufe (1997:161) developed a structure (see Table 2.5) which depicts issues that may arise during the development of an infant and that are sequential, and describes the issues in infant emotional development as well as the role of the caregiver towards these issues.

Table 2.5 Issues on development Source: *Adapted from Sroufe, 1997:161*

Stage	Age	Issue	Role for caregiver
1	0 – 3 months	Physiological regulation (turning toward).	Smooth routines.
2	3 – 6 months	Management of tension.	Sensitive, cooperative interaction.
3	6 – 12 months	Establishing an effective attachment relationship.	Responsive availability.
4	12 – 18 months	Exploration and mastery.	Secure base.
5	18 – 30 months	Individuation (autonomy).	Firm support.
6	30 – 54 months	Management of impulses, sex-role identification, peer relations.	Clear roles, values; flexible self-control.
7	6 – 11 years	Consolidating self-concept, loyal friendships, effective same-gender peer group functioning, real-world competence.	Monitoring, supporting activities, co-regulation.
8	Adolescence	Personal identity, mixed-gender relationships, intimacy.	Available resource, monitor the child's monitoring.

Denham et al., (2009:38) mentiones that babies show interest in people and social interaction with adults and children.Toddlerhood marks the inception of peer interactions and relationships, along with developing prosocial behaviours and empathy. During Stage 1, important patterns begin to establish between the caregiver and the infant as they grow familiar with each other. It is the role of the caregiver to respond to the signals indicating the emotional state of the infant, and to provide smooth and harmonious routines for the infant (Sroufe, 1997:162). Kochanska (2001:474) states that infants who at 3 months experienced sensitive, harmonious, engaged interactions with their caregivers expressed less negative and more positive emotionality by 9 months of age (Stage 3). During the second stage, the caregiver guides the regulation of tension since the infant seems capable of learning strategies to deal with tension. Sroufe (1997:162) regards the issue of tension regulation as critical. The role of the caregiver can be perceived as assisting the infant to stay organised and effectively positive when faced with unusual stimulation (Sroufe, 1997:162). The role of the caregiver is to be available rather than dismissive during stage three. As the infant begins to be more mobile moving away from the caregiver, it's important that the caregiver will be

available when the infant is distressed or frightened (Sroufe, 1997:169). The caregiver takes on the roll as a secure base also known as home base in Stage 4 and the infant centres their exploration of the environment around this base. In a follow up study Sroufe (2005:350) found that in a temperately new setting, with the primary caregiver present, infants become eagerly involved with available toys, perhaps sharing their play, but not needing constant reassuranceThe firm support (also known as framework) is provided by the caregiver in Stage 5 by holding the infant's hands, with her eyes, with her voice and smile, and with changes within the infant's environment. This firm support teaches the infant how to contain him-/herself, how to control motor responses and how to hold on for longer and longer (Sroufe, 1997:165). According to Sroufe (1997:165) the caregiver acts as a source of stimulation when the young child communicates with them during Stage 6 and 7. As the young child realises that their actions have an effect, what the caregiver does in response further stimulates the infant to behave as well as regulating their own emotions. Furthermore, the simulation forms a foundation as the young child grows into the adolescence stage eight. Adolescences is not simply the span that bridges Stage seven to eight of intense involvement with attachment experiences. Rather, it is a period of profound transformations in specific emotional, cognitive and behavioural systems, as the adolescence evolves from being a receiver of care from parents to being a potential caregiver (Cassidy and Shaver, 2002:319).

2.4.2 The relationship between mother and baby

A social bond between a young infant and its primary caregivers is very important, simply because most infants cannot survive without the care of their caregivers or mother in particular (Lewis & Granic, 2002:324). According to Hazan and Shaver (1994), infants can form multiple attachments to others whom satisfy the criteria for attachments, especially proximity maintenance, safe haven and secure-base behaviour. Furthermore, Reck, Hunt, Fuchs, Weiss, Noon, Moehler and Mundt (2004:273) define the relationship between a mother and her baby as an adaptable process, in which there are recurrent changes between affective 'matches' and 'mismatches' ('intuitive mistakes'). 'Mismatches' are normally connected with a negative, and 'matches' with a positive articulation of affect. The interactional progress from a uncoordinated to a coordinated state is called 'intelligent repair'. In their research, Valiente, Eisenberg, Fabes, Shepard, Cumberland and Losoya (2004:911) looked at moms' and fathers' expressive style (self-reported) and their supportiveness toward their youngsters as they are coping with common place, daily stressors. Their discoveries

showed that moms who more frequently utilized the "negative dominant" expressive style, which included antagonistic and critical expressive conduct, had youngsters whose adapting was less constructive. Therefore, securely attached children (see Section 2.2.3.1) generally will have confidence in the availability of their mother and rely on her as a source of comfort and protection (Alink, Cicchetti, Kim & Rogosch, 2009:832). This is why the influences of the parent-child relationship is important, because these influences are unique, inclusive, universal, and potentially lasting.

2.4.3 The emotional influences of postpartum depression on the child

The mother assumes various roles in the interactions with her child, as does the infant, and together they develop atonement which can be explained as the dynamic emotional exchanges of the attachment relationship between parent and infant. Emotion dysregulation can occur when the mother is either physically unavailable or, even worse, emotionally unavailable, in the case of postpartum depression. Physical or emotional unavailability of the mother contributes to dysregulation because the mother can no longer act as optimal stimulator and a stimulation regulator for the infant (Eisenberg et al., 2006:258).

Depressed mothers, compared to non-depressed mothers, report a three-fold greater risk of serious emotional problems in their children and a 10-fold greater risk of having poor mother-child relationships (Gjerdingen & Yawn, 2007:286). Reck et al. (2004:275) mentions that the qualities of the connection between postpartum depression discouraged moms and their kids is an absence of responsiveness, by latency or nosiness, withdrawal and shirking, and in addition a low level of positive articulation of effect.

2.5 CONCLUSION

This research study focused on the influences of postpartum depression on the emotional development of a young child. Findings from the literature revealed the extent of the impact that postpartum depression has on the mother, the family as well as on the development of the young child. As the mother is the primary figure in the child’s life, her love, emotional and physical presence as well as care is crucial in the holistic development of the child, but specifically in the emotional growth of the child.

It was established that what happens to the child during the first years of life has a determining effect on all future relationships. John Bowlby's attachment theory, which served as theoretical framework, indicated the importance of the emotional bond between mother and child, and literature showed that postpartum depression can sever this bond. Therefore, it is of utmost importance that postpartum depression be reported and treated to ensure the well-being of both mother and child. The following chapter will explain the research design and the methods that were used in the empirical investigation.

CHAPTER 3
RESEARCH METHODOLOGY

3.1 INTRODUCTION

Chapter 2 provided an in-depth literature review regarding the different aspects related to postpartum depression as well as the effects thereof on the young child and close family members. The seven most common symptoms that are experienced by woman suffering from postpartum depression were described (see Table 2.1). Furthermore, the different treatment options for mothers experiencing these symptoms, as well as the information available for these mothers, were discussed. More literature was consulted to proof the importance of a caring mother in a child's development, especially the child's emotional development. To add to this, literature was also consulted on the mother's perceptions of her role in her child's emotional development.

In this chapter, the research methodology that was followed in conducting the empirical study is described, which involves the research design and methods that were used to investigate the correlation between postpartum depressions of a mother on her young child's emotional development.

I also justified my reasons for situating study within an interpretivist paradigm, followed by an overview of the qualitative approach to answer the research questions. Multiple case studies and phenomenology were used to gather the necessary data to draw conclusions according to the research questions. The discussion then focuses on the research methods I employed, which will include the research site, as well as the selection of participants. The data collection and methods of analysis are also explained in detail, as well as the elucidation on the maintenance of trustworthiness of the research. Ethical measures are also alluded to.

3.2 RESEARCH METHODOLOGY

Maree (2016:51) explains that methodology is a bridge that brings the philosophical standpoint and the methods used in the study together. According to Henning, van Rensburg and Smit (2004:36), the research methodology section of a dissertation is not only to set out the methods used, but to reason what the value of the methods were to the study and why they were chosen for the particular study. Throughout this section, the research design and the research methods used in this study is explained.

3.2.1 Research design

In accordance with Maree's (2016:72) definition of a research design, Vos et al. (2005:171) defines research design as the "plan, recipe or blueprint" of a study and provides guidelines for the selection of the data collection methods. In the following section, the paradigm in which the study was situated, the approach that was followed as well as the type of research that was used to gather the data are explained.

A paradigm as defined by Maree (2016:52) as "a set of assumptions or beliefs about fundamental aspects of reality which gives rise to a particular world view". Creswell (2013:18) adds to this statement by explaining that a paradigm shapes the formulation of the problem as well as the research question and how the data collection will be implemented to answer the questions. Since the aim of this study was to explore the correlation between postpartum depression and the emotional development of the young child, this study was situated within an interpretivist paradigm. Henning et al. (2004:20) confirm that the interpretivist paradigm is appropriate when the researcher wants to analyse interviewed data as well as the narratives to explore how people make meaning and what meaning they make of specific events or circumstances. The interpretivist paradigm also served as a set framework of reference by guiding me where to look for the answers, as were raised in the research questions (Vos et al., 2005:297).

According to Maree (2016:61-62), the interpretive paradigm is based on certain assumptions. Table 3.1 provides an explanation of how these assumptions were incorporated in this study. It was thus important to consult literature from other academics, but even more so to understood the participants and to realise that each mother who participated was a unique

individual with specific experiences of postpartum depression which resulted in different effect on her child.

Table 3.1 Interpretive assumptions and the relevance to this study Source: *Adapted from McMillan & Schumacher, 2010:315*

Assumptions	Relevance to the study
"Human life can only be understood from within."	During the interviews and narratives, the focus was on mothers' unique experiences of postpartum depression and the effect it had on their young child's emotional development. This helped to understand how these mothers interpreted and interacted within their social environment during their experience with postpartum depression and afterwards.
"Social life is a distinctively human product."	While collecting data through interviews and narratives, the participants were in a neutral environment of their choice. The participants felt safe and comfortable which created an opportunity to observe them while understanding perceptions on postpartum depression and the effect thereof.
"The human mind is the purposive source or origin of meaning."	The aim of using interviews and narratives was to collect rich, in-depth and complex data to gain insight into the experiences of participants and the meanings they constructed relating to postpartum depression and the effect of it on their young children.
"Human behaviour is affected by knowledge of the social world."	With the literature that was consulted regarding the research questions, gained understanding of the various contexts that could impact the mother's experiences of postpartum depression, and through the literature review I was also able to connect theory to the empirical research. The knowledge that was gained equipped me to make informed research decisions as to better understand the participants and their individual situations.

Assumptions	Relevance to the study
“The social world does not exist independently of human knowledge.”	I remained subjective during the interviews in order to ensure that they understood and described facts correctly through the eyes of the participants. My knowledge and experience were set aside as to ensure that it did not interfere with those of the participants.

Although the interpretivist paradigm can be extended to broader contexts (for example other places and other times), I chose to collect data through interviews and narratives which allowed me to understand the participants’ interpretation and interaction regarding their experience with postpartum depression, while each of them revealed their relevant information in a neutral environment where they felt safe and comfortable. Including interviews and narratives as research methods allowed me to collect rich data from the participants whilst observing and interpreting their actual feelings and interpretation regarding their experiences of postpartum. This interpretivist paradigm suited the research well because it allowed me to recognise each participant as a unique individual within a neutral environment of their choice.

3.2.1.2 Qualitative approach

Qualitative research is focused on studying real cases starting from people's expressions and activities in their known situation (Flick, 2014:21) whereas Creswell (2013:46) opines that qualitative research focuses on a phenomenon where the data are mostly obtained through the non-numerical means from the participants in the study. While investigating the correlation between postpartum depression and the emotional development of a young child, I decided to make use of a qualitative approach since it allowed me to understand and explain in argument this phenomenon by using evidence from the data and from the literature. By giving the participants the opportunity to share their views, I was able to provide an explanation of what the phenomenon is about in this study (Henning et al., 2004:5). McMillan and Schumacher (2010:320) note that educational researchers are more likely to use the term qualitative in a general logic as an approach that has certain characteristics.

These characteristics will be explained alongside the appropriateness to this study in the following table:

Table 3.2 Qualitative research approach characteristics and appropriateness

Characteristic	Appropriateness in this study
Natural settings Data gathering happens in the field where the researcher has face – to – face interaction over time while observing the participant within their context (Creswell, 2013:45).	• Three mothers who had experience with postpartum depression were the main participants for this study where they divulged information via interviews and narratives.
Direct data collection The researcher collects data directly from the participants (McMillan & Schumacher, 2010:322). Creswell (2013:44) explains that the researcher collects data by using instruments he/she designed themselves. Data collected, as stated by Maree (2016:76) can be through various methods as the researchers and the participants enter a collaborative relationship. These methods can include be the following: interviews, observations, journal records, and storytelling and field notes.	• I was a participant-observer during data collection since I recorded the data as faithfully as possible (McMillan & Schumacher, 2010:350). I was also an observer where I could jot down *observations* I made as field notes. • I conducted semi-structured interviews with three mothers. These interviews were scheduled before hand even though the participants weren't informed about the questions I intended to ask. Due to this reason, I never knew how they would react to the questions. I decided not to inform the participants about the questions since I wanted their real feelings and thoughts at that exact moment. • The participants also had to write a narrative according to stipulated guidelines.
Rich narrative description Every detail of the data collected is important towards understanding the behaviour of the participants. These descriptions recorded could be through pictures, photo's or words (McMillan and Schumacher, 2010:322)	• While interviewing, I made field notes as to things I observed which might have been important for the purpose of the study. The field notes were single descriptive words as to my understanding of what I saw. • The participants' narratives which were presented in written format were directed by specific guidelines, they could express their

Characteristic	Appropriateness in this study
	feelings and experiences with as much detail as possible.
Process orientation Henning et al. (2004:3) states that the researcher intends to find an explanation as to how human interaction takes place, what happens and why it happens. Furthermore, Maree (2016:53) adds that it the extracting meaning from data instead of just presenting the captured data.	• As I wanted to get insight into the experiences and meaning making of these mothers during their bouts with postpartum depression, the focus of the data capturing was to explain the effect of postpartum depression a young child's emotional development from a mother's point of view. • The data were collected to describe the unique experiences of mothers who were diagnosed with postpartum depression.
Inductive data analysis Interpreting data involves sorting, organizing and reducing them to more manageable pieces and then exploring ways to reunite them (Vos et al., 2005:399). Maree (2016:109) states "the main purpose is to allow research findings to emerge from the frequent, dominant or significant themes inherent in raw data, without the restraints imposed by a more structured theoretical orientation.	• Data were organised by assigning codes that cluster the data into categories, based on my reflections. • If gaps became evident in the data collected, more data were collected and added to the existing data. • Regarding reflecting about the current data, I used the following six steps to analyse the data: • Step 1: Transcription • Step 2: Organisation and preparation of data. • Step 3: Reading the data • Step 4: Coding procedures • Step 5: Identify themes and sub-themes • Step 6: Interpretation
Participant perspectives To understand a participant from their point of view, with their own voice (McMillan and Schumacher, 2010:323).	• Exploration of a phenomenon leads to the understanding of the phenomenon of the correlation of postpartum depression on the young child's emotional development. • One of the data collection methods I used to gain knowledge about this phenomenon was interviews where semi-structured interviews

Characteristic	Appropriateness in this study
	were held with mother's who experienced postpartum depression in the past. • During the interviews, I aimed to stay objective by being a good listener, asking few questions and being respectful about advice.

The characteristics portrayed in this table are seen throughout this research study and clearly indicate that a multiple case study design was best suited for this research.

3.2.1.3 Phenomenological research

Phenomenological study describes the common meaning of the lived experiences of several individuals (Creswell, 2013:76). Maree (2016:77) furthermore adds that phenomenological research aims to determine and describe the meaning of certain experiences for the individual. By using an interpretivist perspective throughout the study, I aimed to describe the experiences of three mothers who had experience of postpartum depression (lived experiences) in the past and the effect that postpartum depression had on their young children.

During data collection, the main goal was to describe the phenomenon as accurately as possible and remaining true to the facts (Vos et al., 2005:316). Semi-structured interviews were conducted with the participants to understand their perspective on their experience with postpartum depression (phenomenon) and the effect it had on their children's emotional development (McMillan & Schumacher, 2010:24). To ensure that the results from the data collected were truthfully reported, I made use of bracketing during the interviews, as stated in Chapter 1. Tufford and Newman (2012:81) explain bracketing in qualitative research as a method used "to lessen the potential harmful effects of misunderstood presumptions related to the research and thereby to increase the accuracy of the project". Furthermore, Hamill (2010:17) elaborates that the use of bracketing does not influence the participants' understanding of the phenomenon, as it is their reality. The researcher is presented with new knowledge and understanding in die determination of the meaning of the experience for each participant through the identification of essential themes for the data analysis process.

Enhancing the phenomenological study, I used multiple case studies (see Section 4.2) to describe different cases (phenomena) of experienced postpartum depression, to create an in-depth understanding of the effects thereof on a child's emotional development (Creswell, 2013:98). McMillan and Schumacher (2010:344) mentions that a case study is an "in-depth exploration of a bounded system". Therefore, the multiple case studies can be classified as a bounded system, since bounded refers to unique circumstances according to place, time and participant characteristics.

3.2.2 Research methods

Research methods are the tools used to collect data (Maree, 2016:1). Using these tools enables the researcher to gather the necessary data about social reality from individuals, groups, artefacts and texts in any medium. The following sections explain the methods used to gather the necessary information to answer the research questions. The following aspects will be dealt with: the role of the researcher, the participants and research site, as well as the instruments that were used to collect data. The data analysis approach used in this study is also described and the researcher indicated which measures were employed to ensure trustworthiness. The ethical considerations will also be discussed.

3.2.2.1 The role of the researcher

Maree (2016:44) states that the main role of a researcher is to create a mutual understanding between the researcher and participants to collect and analyse data. "In the field, those collecting data develop a role, which establishes the position of the investigator and his or her relationship with others in the situation" (McMillan & Schumacher, 2010:348). Since the focus of the study is on mothers who suffered from postpartum depression and the impact thereof on the emotional development of their young children, the researcher took on the role of a participant observer during interviews with the participants. Maree (2016:91) defines a participant as observer to be when the researcher engages in a chosen setting to gain an insider perspective of the setting. The researcher intended to capture the mothers' perceptions of their experience with postpartum depression, expressed in what McMillan and Schumacher (2010:352) identify as their actions and feelings. These perceptions resulted in an in-depth insight into the reality of the experiences of postpartum depression and the effect on young children (Vos et al., 2005:330).

The researcher also took on the roll of interviewer, they interviewed the mothers by making use of semi-structured interviews to gain information on the subject being researched. McMillan and Schumacher (2010:355) define semi–structured interviews as when the participants are asked the same predetermined questions in the same order. Interviews with the participants were conducted in a conversational manner, which according to Cohen, Manion and Morrison (2011:353) is a set of predetermined questions which are asked to the mothers during the interviews. All the participating mothers were asked the same questions in the same order to increase the comparability of the responses of the mothers. During the interviews, the researcher aimed to be objective by being a good listener, asking few questions and being respectful about advice regarding their depressive disorder (Creswell, 2013:166).

3.2.2.2 Participants and research site

Vos et al. (2004:391) mention that when deciding on participants for the study, the researcher will keep the purpose of the study, the credibility of the data, the time and available resources in mind. Choosing a research site is important since it must be a neutral setting where the participating mothers can exhibit their normal behaviour (McMillan & Schumacher, 2010:348). This section describes in detail where the research took place and what steps were taken to select the participants for the study whilst considering their vulnerability due to the experience they had with postpartum depression.

(i) Participants

Participants are the people who participate in a research study and from whom data are obtained in order to answer the research questions posed (McMillan & Schumacher, 2010:119). The aim of the study was to provide mothers who are struggling with postpartum depression with information and guidelines and to address the negative impact that the depression might have on the emotional development of a child, which possible support groups may also benefit from. Participants had to be selected based on the following criteria:

- They have been diagnosed with postpartum depression by a general practitioner or psychiatrist.

- They have been struggling with postpartum depression for a minimum period of a year.
- They are not suffering from post-partum depression at the time of the study.

Purposeful sampling was used to identify the participants for this study. All three of the participating mothers in this study were introduced to the researcher by colleagues. These three mothers' cases were chosen since it was information-rich cases ideal for in-depth studying (McMillan & Schumacher, 2010:325). The three case studies were selected to represent the phenomenon, which is postpartum depression (Maree, 2016:85). Each participating mother's case of postpartum depression was different. Each of these cases had one thing in common, being the phenomenon called postpartum depression. In these cases, it influenced their young children. A brief description of each case follows:

Participant 1 experienced postpartum depression six weeks after the birth of her baby. She consulted a psychiatrist who booked her into a psychiatric institute for the correct treatment. Participant 2 was diagnosed six weeks after the birth of her first born, she had an emotional breakdown where no one could calm her. With a psychiatrist's referral to a psychiatric institution, she was diagnosed with bipolar disorder after two years of treatment. Participant 3 is a surviving rape victim who fell pregnant at a young age. During the prenatal period she already showed signs of depression. Postpartum period it just progressed into a worse experience for her to care for the baby.

The ethical considerations are described in detail later in this chapter but briefly mentioned here for describing the selection of the participants: All the mothers had to sign a consent form (Appendix A) to state that they knew what was expected of them. A psychologist was contacted to be available if one of the participants felt too vulnerable during the interviews or narratives.

The participants were verbally and written informed (Appendix A) beforehand of following that were expected of them during the data collection period:

- The participating mothers will be expected to write a guided narrative about their experience of postpartum depression.
- The participants will attend interviews at the arranged time and place.
- The participants will voluntarily discuss their lived experiences during the interviews.

All the participants signed the consent form and were more than willing to take part in this study. Meetings were arranged beforehand to explain in detail all the aspects regarding this research and the necessity of it for a country like South Africa.

(ii) Research site

Saldaña (2011:27) defines a research site as a neutral setting, where research happens, which are shaped by the humans who inhabit them. Interviews often take place somewhere in the participant's daily world, which in this study was a place were the participants felt safe and comfortable (Seale, 2007:2). Maree (2016:36) explains the importance of the selection of a research site, and emphasized that it should be suitable and feasible to collect appropriate data for the study. Each of the three participants could choose a neutral place where they wanted to have the interview conducted. Due to the sensitivity of the research, it was important that the participants were in an environment where they felt comfortable and at ease and where they could talk freely about their experiences with postpartum depression.

The participating mothers lived in different areas of Pretoria and Johannesburg, South Africa, thus interview dates and times were scheduled to suit both the researcher and the participants. The participants preferred to conduct the interviews during a weekend or school holiday. Two of the three participating mothers are foundation phase teachers and understand the importance of having a peaceful environment away from young children demanding their attention. The third participant lived further away and was a busy career woman. We had to arrange a time to suite both of us between school responsibilities and family life. We met at in a neutral environment which the participant agreed on.

The semi-structured interviews ranged between one and two hours. The consent letters (Appendix A) which the mothers had to sign clearly specified that participation will require time from them to conduct interviews for data collection as well as the completion of narratives as part of the data collection. The time consumption of the narratives where each participant's choice and depended on their experience of postpartum depression. The mothers each had a different experience of postpartum depression and would compile the narrative according to the guidelines that were provided, but still from their own point of view. No time limit or word limit were set on the narratives since the narratives were used to fill any gaps in the

data that might have been missed during the interviews. The participating mothers where informed beforehand that there might be a follow-up meeting in order to discussed any unclear data or topics after the interviews has been conducted and narratives completed.

3.2.2.3 Data collection

The data collected can be perceived as bits of information that ranges from single and multiple sentences, facts, paragraph descriptions about a setting to widespread passages of text revealing understanding of the human experiences (Saldaña, 2011:26). As described by Creswell (2013:145) data collection involves more than just collecting data, it means gaining permission for the study and from participants, deciding and conducting a good qualitative strategy for sampling, developing methods for recording information, sorting the data and anticipating any ethical issues that may arise. Accordingly, the researcher decided on the following data collection methods for the study:

(i) Semi - structured interviews

This style of interviewing is more flexible since it involves a set of predetermined questions to start the discussion, but also allow space for any other questions which may arise from the discussions (Rule & John, 2011:64). Gibson and Brown (2009:7) elaborate that interviews are about the aim of the research and therefore the researcher should decide during the interviews what counts as relevant to prevent the interview from being side tracked. As mentioned earlier, the researcher gave the mothers the choice to decide upon the place, date and time for the interviews. The interview questions followed an interview guide approach (Appendix B) where, according to McMillan and Schumacher (2010:355), the researcher knew in advance what questions they would like to ask and the topics they addressed during the interviews. The sequencing and wording were decided upon during the interview. In order to put the mothers at ease and allowing them to be comfortable during the interview, the researcher introduced the questions while conversing with them. An example of one of the questions is: “Describe how you felt finding out you were expecting?”

The mothers were informed beforehand that the researcher would be recording the interviews on a voice recorder. This helped to ensure that each mother that was interviewed responded to questions and provided additional information that could be captured to increase the

researcher's understanding and interpretation of the information provided (Creswell, 2013:164). The researcher gave them the assurance that after the data was retrieved, the recorded interviews as well as the transcribed versions would be safe-guarded at the Early Childhood Development Department of the University of Pretoria for a period of 15 years.

The observations made during the interviews were in a semi-structured format since the researcher noted all observed behaviour and actions considered significant to the study (Rule & John, 2011:68). As Henning et al. (2005:82) stated, the researcher "observed" for a second time through their field notes made during interviews and the narrative data presented by the participants. These observations were data used as building blocks for the data collected.

(ii) Narratives

Saldaña (2011:127) classifies narrative inquiry designs as a story line of the participant's experiences to provide readers with an almost well-informed perspective about the participants' worldview. Furthermore, Flick (2014:179) elaborates that the main aim of the narrative is to provide background details and relationships necessary for understanding the story due to the limitation of describing. The researcher used narratives as a method to enrich the data collected through the interviews. Rule and John (2011:66) confirms that this method is best suited for this type of study since it provides richness and texture for a suitable case study. The researcher also had to keep in mind the warning of Creswell (2013:179) that narrative writing can also be a limitation towards data collection, because not all people are equally skilled at expressing their feelings in written form.

The researcher asked each of the participants to compile a narrative regarding their struggle with postpartum depression and how it affected their young child's emotional development. To ensure that even if the participants weren't skilled at capturing their feelings and viewpoints in writing, they were provided with guidelines to follow in writing the narrative (Appendix C). How and what were expected from the narrative data were discussed with each mother to clear any uncertainty that could've surfaced while compiling their narratives.

3.2.2.4 Data analysis

Analysis of data is a process to bring order, structure and meaning to the mass of collected data (Vos et al., 2005:397). According to McMillan and Schumacher (2010:367) the data analysis of qualitative research is an inductive process organizing the collected data into categories and identifying certain patterns and relationships among these categories. Taking note of the statement, Maree (2016:39) states that there isn't a right way of data analysis. The inductive method is the most appropriate for this study, since the researcher used phenomenology and case studies. Maree (2016:39) maintains that the inductive analysis is best suited in qualitative research, since themes emerge from the data itself. McMillan and Schumacher (2010:367) maintain that the process of inductive analysis is an ongoing process where the researcher can "double check" or go back to the previous stage to rectify or refine the analysis. According to Cohen et al. (2011:751) the most general characteristic of qualitative data analysis is that it is an ongoing and flexible process where the researcher is aware that it takes up a lot of time and effort to do.

The model in Figure 1 (see Section 1.7.2.4) illustrates the three essential elements of data analysis: noticing, collecting and reflecting. These elements are interlinked and cyclical (Maree, 2016:109). I made use of these inductive reasoning processes in the study. Data were organised by assigning codes that clustered the data into categories, based on my reflections. If a lack of information became evident in the data collected, more data had to be collected and added to the existing data, with regard to reflecting about the current data. I planned to use the following six steps to analyse the data:

Step 1: Transcription
The first step was to transcribe all the available data captured on the tape-recorded interviews. Non-verbal cues were included.

Step 2: Organisation and preparation of data
Creswell (2013:182) recommends that the collected data must be organised into different computer files, since the data may be voluminous. This step involves sorting and arranging data into different types, depending on the source of information (Creswell, 2002:185). After retyping field notes and interview responses, I arranged the data according to setting, situation, perspective, values and judgements.

Step 3: Reading the data

According to Maree (2016:115), quality data analysis depends on the understanding of the data, which means that the researcher needs to read and reread through the data. Following the organisation phase of the data analysis, I read and reread through the interviews and narratives to see the bigger picture before rearranging the data into smaller, different units/sections. According to Creswell (2013:182), "…writing notes or memos in the margins of field notes or transcripts or under photographs help in the initial process of exploring a database. These memos are short phrases, ideas, or key concepts that occur to the reader". In conducting the analysis process, I made field notes alongside the interview transcripts and wrote key phrases for certain statements contained in the participants' responses.

Step 4: Coding procedures

Working with the data collected and in conjunction with the notes, phrases and memos already completed, I started the process of coding. Creswell (2003:244) describes coding as the process of identifying text, words or phrases of importance within the data and assigning a code or phrases to it that best describe the meaning. Maree (2016:116) explains that the process of coding enables the researcher to quickly retrieve and collect all texts and other data. I reread the data and assigned codes to the interview transcriptions, notes and memos about the narratives. A list was made of all the codes with the aim to merge some of the codes.

Step 5: Identify subthemes and themes

Moving beyond the code, the next phase of classification begins, namely themes. Themes are the combination of several codes to form one common idea (Creswell, 2013:186). Since I used case study research design, the themes consisted of detailed descriptions of the cases.

Step 6: Interpretation

Vos et al. (2005:416) maintain that interpreting data involves making sense of the data. Accordingly, I organised all the different themes decided upon into larger categories of abstraction in order to make sense of the data collected. To get a deeper meaning of the interpretations of the data, I attempted to link the findings to earlier literature regarding the research topic.

Hahn (2008:5) recommends that working with a mass of collected data requires an organised system which will lead to the answer of the research questions. The data were analysed according to the steps mentioned by McMillan and Shumacher (2010:369) as seen in Figure 3.1. These steps will reflect throughout Chapter 4:

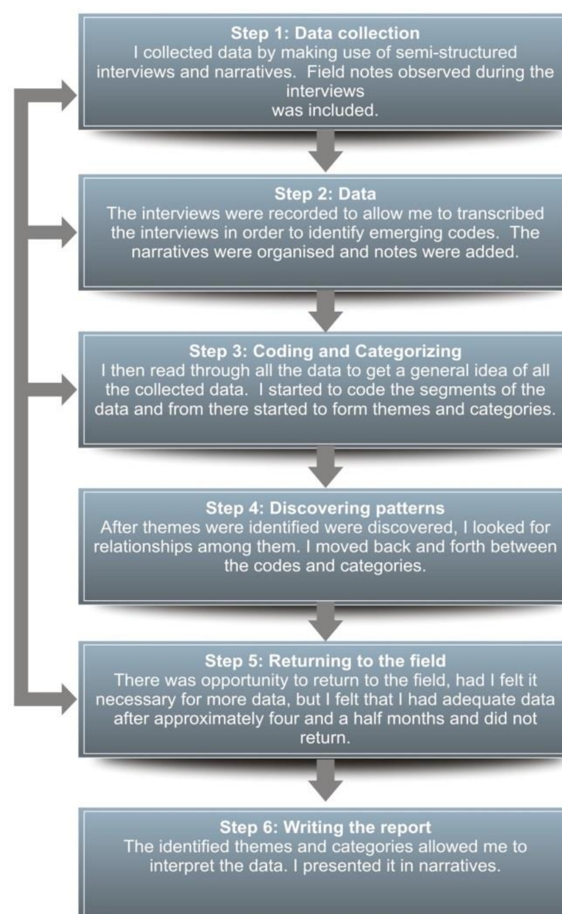

Figure 3.1 The data analysis process *(Adapted from McMillan & Schumacher, 2010:369; Creswell, 2013:183)*

As mentioned in Step 2, the organization of the data is important since disorganisation wastes time and degrades quality of the data (Hahn, 2008:11). The research produced better results when the researcher carefully planned, organized, and controlled the project and its data. Therefore, it was decided to invest in a good program to ensure that the organisation of the data was saved and stored in different files on the researcher's computer. Although at first it was time consuming, the researcher made sure that all the data was sorted according to each participant and ready to be categorized and coded. Furthermore, Creswell (2013:183) maintain that to read and reread data is to familiarise yourself with the detail of the data and

getting a sense of it before its coded and categorized. The captured data was read and reread as it was sorted and saved it. This process also included the adding of notes in the margins of interview transcriptions, narratives and field notes.

Different themes within the data were highlighted through codes, also seen as labels (Rule & John, 2011:77). McMillan and Schumacher (2010:370) maintain that one should look for repetitive ideas, meanings and information in the codes that could possibly form a category. All the codes were colour coded accordingly and after thorough investigation of these codes, the categories and themes in which to place the codes were discovered. A relationship among the categories was discovered and the researcher could therefore recognise distinctive patterns. Throughout this data analysis process, the researcher discovered whether they should return to the research site to gather more data, but was however convinced that they had acquired adequate data.

"Qualitative researchers use not only language but also illustrations to both analyse and display the phenomena and processes at work in the data" (Saldaña, 2011:133). The researcher made use of flow charts so as to make a show of classes that took into account associations with be visual. By showing the discoveries outwardly, the scientist endeavored to answer the examination inquiries and build a story exchange to clarify what had been gained from the information investigation.

Creswell (2013:187) defines interpretation of the data as a means to extract meaning beyond the codes and categories to develop an overall meaning out of all the data collected and analysed. Maree (2016:122) calls attention to that a definitive point of translating information is to make up determinations of the discoveries in light of the information gathered and just relevant to the members.

McMillan and Schumacher (2010:379) maintain that triangulation is a way of "cross-validating" the data by comparing the different data that was found through various data collection methods. The researcher made use of interviews together with field notes made during the interviews and the narrative process. The narratives which the participants written were also reflected upon. Through the interpretation of the data in Chapter 4, triangulation is evident. Since the researcher made use of different sources and methods, as suggested by Creswell (2013:251) the data was validated. According to Maree (2016:122), triangulation is

an important strategy in the production of findings. Figure 3.2 is a visual illustration of the various data collection methods used as triangulation throughout the study.

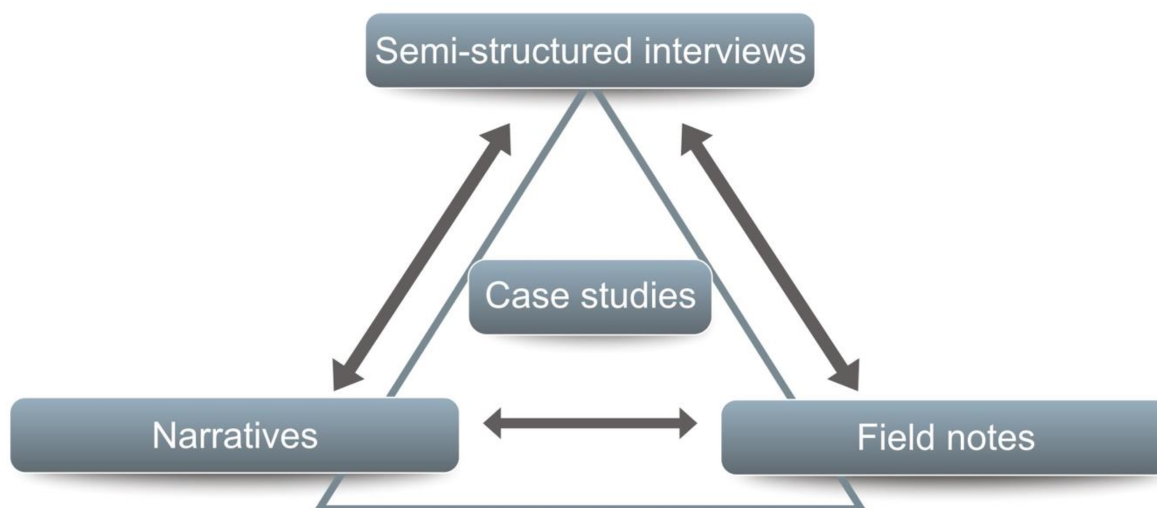

Figure 3.2 Multiple methods used for triangulation

3.3 TRUSTWORTHINESS

Rule and John (2011:107) point out that trustworthiness promotes values such as thoroughness, transparency and professional ethics to gain ultimate trust and reliability within the research industry. Furthermore, Maree (2016:123) adds that trustworthiness is very important in qualitative research and should be kept in mind throughout the study. To establish the trustworthiness of the research, Creswell (2013:246) use terms such as credibility, dependability, transferability and conformability. These terms, mentioned by Creswell (2013:246), will be discussed in relation to the study.

3.3.1 Credibility

Credibility refers to the believability of the researcher's work (Saldaña, 2011:135). By stating throughout the study whether the researcher were familiar with the participants, reasoning purposive sampling, detailed data collection methods and triangulation, credibility can be enhanced (Maree, 2016:123). According to Cohen et al., (2011:136), there are numerous

ways to ensure credibility, therefore a brief explaination of how these were followed in the research is provided:

- The researcher made use of semi-structured interviews with three mothers who experienced postpartum depression in the past. A four-month prolonged period in the research field for data collection ensured opportunities for provisional data analyses, refining ideas regarding the phenomenon and confirmation of evidence – based on categories and the participant's reality (McMillan & Schumacher, 2010:331).
- The researcher made use of various data collection methods in order to cross-validate the data. This means that the researcher compared the data (triangulation) that were gathered from interviews and narratives (Maree, 2016:122).
- The researcher made use of member checking to determine the accuracy of the qualitative findings (McMilllan & Schumacher, 2010:331). Creswell (2016:123) states that the course of member checking can be assumed by conducting a follow-up interview with the participants, providing them with the opportunity to remark on the outcomes, or it can be done through informal dialogues in relaxed situations (McMillan & Schumacher, 2010:332).
- During interviews and when completing the narratives, the participants spoke the language that they prefer and understood best. Two of the participants preferred speaking Afrikaans, which were their home language, as well as the researcher's. The third participant spoke English and preferred to be interviewed in this language. The researcher ensured that they were familiar with the jargon and sensitivities that may exist (McMillan & Schumacher, 2010:331).
- Concrete, precise descriptions were used in the field notes made during the interviews (Maree, 2016:123). The transcriptions of interviews were thick descriptions of the actual words used by the mothers that were interviewed. The guidelines to the narratives were such as to lead the participants to elaborate and describe as best as possible.
- The mothers were informed about the recording of the interviews beforehand and it was also noted in the participation letter signed by each of them. Eash of the participants was reassured that none of the answers they supplied me with or the stories they shared, that will be recorded, can be seen as the correct or incorrect answers. It will only add to more rich useful data. If any interference occurred, the researcher noted it in their field notes (Creswell, 2016:248).

3.3.2 Dependability

Atkins, Wallace and the British Educational Research Association (2012:15) maintain that the concept refers to that the same findings could be collected if another or the same researcher conducted a study using different data collection methods. From a different perspective, Rule and John (2011:107) mention that dependability is also concerned with the methodological methods used to generate findings and producing a research report which are acceptable for the research community. The researcher kept a journal of all the decisions made such as the categories chosen, to return to the field, conclusions made during the research analysis process as well as how the researcher came to the interpretations made from the data (Maree, 2016:124).

3.3.3 Transferability

Creswell (2013:246) maintains that thick descriptions ensure that the findings of the study are transferable between the researcher and the participants. Maree (2016:300) agrees by describing transferability as the generalisations that can be made from the data and context of the research to improve the wider community or setting. Thde researcher used rich, thick descriptions by supplying a large amount of clear and detailed information about the data collected from mothers battling with postpartum depression, and the effect thereof on the young child's emotional development. Although transferability can occur, the aim of the study is not to generalise the findings of the study.

3.3.4 Conformability

Conformability refers to the "objectivity of data and the absence of research errors" (Maree, 2016:125). To guarantee comparability of the information, an outside researcher who was not part of the investigation ought to survey whether the strategies and general systems of the study are depicted clearly. Conformability is when the researcher's data findings can be supported by readings and investigations of researchers who did similar studies (Cohen et al., 2011:148). Chapter 2 offers a broad selection of readings on all the particular facets of this study. The participation of an external auditor is another commendation made by Creswell (2010:192) in the course of authenticating a qualitative study. This involves the researcher requesting a person outside the project to review the study, and to provide

comments on its strengths and weaknesses. Such a review can be done either during the process, or at the close of the study (Creswell, 2010:253). Maree (2016:125) defines the role of an auditor as someone who authenticates the conformability of the data, through measuring whether the approaches and processes used in the study are defined clearly, and in detail, to allow for data confirmation. The role of an external auditor/experienced researcher was fulfilled by the supervisor, who directed the research process and reviewed the findings and interpretations to guarantee their dependability. The external examiner/s selected to review the dissertation at the end of the study will fulfil the role of the knowledgeable person/s on the theme of postpartum depression and the result of it on a young child's emotional development.

3.4 ETHICAL CONSIDERATIONS

Ethics reflects the norms and rules for acceptable behaviour that flows from a system of moral principles (John & Rule, 2011:111). McMillan and Schumacher (2010:338) state that conducting qualitative research is more probable to be personally invasive than a quantitative study, and therefore ethical guidelines like attaining informed consent, confidentiality and anonymity, privacy and caring must to be in place. According to Maree (2016:44), when working with individuals, it is important to understand and pay attention to the ethical policies of informed consent and voluntary participation, safety from harm and privacy, confidentiality and anonymity. In obeying these recommendations, the first step taken was to apply for ethical clearance from the Ethics Committee of the University of Pretoria (see Appendix D). Once the ethics application was accepted, the researcher could continue with the research process. Miller (2012:2) is of opinion that ethical considerations should form an ongoing part of the research. In the following sections, the ethical measures as applied in this research are alluded to: the permission to conduct research, the informed consent for the mothers, avoiding harm and maintaining confidentiality and privacy throughout the whole study. The participants were selected through a purposeful sampling method and had to meet the following criteria:

- They have been diagnosed with postpartum depression by a general practitioner or psychiatrist.
- They have been struggling with postpartum depression for a minimum period of a year.
- They are not suffering from post-partum depression at the time of the study.

3.4.1 Informed Consent

As Henning et al. (2004:73) explain, all the participants must give informed consent and they must be fully informed about the research in which interviews and narratives will be used. Furthermore, Creswell (2013:174) state that to receive support from the participants, the researcher should inform the participant of the purpose of the study and avoid engaging in deception about the nature of the study. After introducing themselves to the participants, the researcher revealed the purpose of the study to them, as well as the processes that would be followed, and the information necessary from them. The researcher read through the letter of informed consent (see Appendix A) and clarified participants' rights to them. The were also informed that their identity would be kept confidential and that pseudonyms will be used to safeguard their identities. Vos et al. (2005:116) furthermore states that informed consent should include the importance of voluntary participation. Informed consent also include that the participants should not be harmed and that their privacy and identity will be protected. All the participants signed the letter of informed consent, and the researcher could proceed with the interviews, after participants were reassured that they would not be obligated to participate in the study and could withdraw at any point of time.

3.4.2 Confidentiality and anonymity

Confidentiality indicates the handling of data or information in a confidential manner including agreements between the researcher and the participants that limit any outsider to access this private information (Vos et al., 2005:119). The consent letter, which the three the participants signed, stated that all the information gathered from them will be kept confidential and will be stored in a safe space at the University of Pretoria for 15 years. Due to the sensitivity of the research, the researcher approached a psychologist to be available if a participant might feel the need to talk to her. The psychologist had to sign a confidentiality agreement (Appendix E) regarding the use or share of any of the information from any of the participants.

Anonymity, according to Maree (2016:44), is the issue of protecting the participant's identities throughout the study. John and Rule (2011:112) further add to the above-mentioned statement that this principle translates into the need for the researcher to respect the participant's rights by fully informed them about voluntarily participation. The consent letter was verbally read and discussed in-depth with each of the participants informing them that

pseudonyms will be given to each case used in the study. All the participants' data and answers shared during the study were kept private and the results were presented in an unidentified manner in order to safeguard the identities of the participants.The participant's right to withdraw at any given time from the study or to refuse to answer the questions were read to them, as it's also compiled in the consent letter. The researcher constantly made sure that the participants understood that a psychologist were on call if necessary.

3.4.4 Caring and fairness

For the research to cause no harm towards the participants for the duration the study (John and Rule, 2011:112), a sense of caring and fairness must be part of the researcher's thinking, actions and personal mortality (McMillan & Schumacher, 2010:339). During the study, the researcher was honest, respectful and sympathetic towards all the participants in order to prevent harm. During the research, the researcher informed the participants that no information about them would be revealed. The participants knew that when writing their narratives, they had to avoid using names or choose a pseudonym that they preferred.

3.5 CONCLUSION

The purpose of this chapter was to give a detailed description of the research methodology used to explore the correlation between postpartum depression and the emotional development of the young child. A qualitative study allowed the researcher to make use of various data collection methods in order to collect data in order to answer the research questions. Multiple case studies and phenomenology placed focus on the phenomenon at hand, being the effect of postpartum depression of the mother on her young child. A detailed discussion of the analysis of the data and interpretation of the findings will follow in Chapter 4 and 5.

CHAPTER 4
DATA ANALYSIS AND INTERPRETATION

4.1 INTRODUCTION

The previous chapter provided a detailed description of the research methodology that was followed in order to investigate the impact of postpartum depression on the emotional development of the young child. It included a description of the criteria used to choose the three participants and provided information on the multiple case studies.

Chapter 4 provides the analysis as well as interpretation of the data. The duration of the fieldwork extended over two months. The researcher conducted semi–structured interviews with the participants and thereafter they had to compile a narrative regarding their experience of postpartum depression. The narratives were used for more in–depth information if any uncertainty arose from the interviews. The participation of three mothers who experienced postpartum depression in the past provided the data for the study. Their narratives enhanced existing knowledge and insight into the way postpartum depression affect the emotional development of the young child.

4.2 DATA ANALYSIS

This study followed a phenomological multiple case study design to answer the research questions. Purposeful sampling was used to select the three participants (see Section 3.2.1). Semi-structured interviews and narratives supported the data findings.

The researcher made use of inductive data analysis (refer to Section 3.2.2.4). The researcher read the transcripts several times in order to familiarise themselves with the data in its entirety

(Cresswell, 2013:183). This allowed the researcher to look for codes within the data that allowed for themes and categories to emerge (McMillan & Schumacher, 2010:367).
Each participant's case will be discussed separately, which involves the biographical information, interview data and narrative data. For the protection of the participants pseudonyms were used instead of their real names.

4.2.1 Case one: Louise (pseudonym)

Louise had a severe form of postpartum depression and narrated a very interesting story. Her case is described first, because she was the participant who experienced postpartum depression the most recently (five years ago) of the participants.

4.2.1.1 Biographical information

According to Louise she is a career driven mother who tries her best to excell in her career as well as be a good mother to her five-year-old daughter. With her first miscarriage still fresh in her memories, Louise described the second pregnancy as stressful. She was no stranger to depression since she was treated with this disorder before her and her husband decided to have a baby. She used prescribed anti-depressants until she fell pregnant. Even though Louise experienced stress throughout the pregnancy, she carried her baby to the full term. She gave birth to a healthy baby girl, who was five years old at the time of the study.

Louise struggled with postpartum depression and felt that she could not meet everybody's expectations of how she had to feel about her baby when she left the hospital after giving birth. Feelings of incompetency and "not loving her child enough" incapacitated her. During the first six weeks she could only convince herself to leave her house if a member of her support structure accompanied her. Her support structure consisted of her husband, family (especially her mother), friends and work colleagues. According to Louise, these people supported her through the "up" and "down" times. She felt they understood her emotional needs. Six weeks after giving birth, Louise's mother found her on her bathroom floor crying, because her baby would not stop crying. This made her mother realise that Louise might be battling with postpartum depression. Louise consulted her general practitioner who prescribed anti-depressants which she used for the rest of her maternity leave period (four months).

When Mari was two and half years old, Louise were diagnosed with Bipolar disorder since her depression never really got better, but rather worse. During the time of the interview, Louise's Bipolar disorder were under control. Her participation in this study was supported by her psychiatrist who she consulted before agreeing to participate. Louise received treatment at Vista clinic, a private psychiatric hospital that provides mental health services to people 16 years and older, by her current psychiatrist whom she still consults with once every two months for follow up visits regarding her Bipolar disorder and correct medication.

4.2.1.2 Interview data

All the interviews that were conducted were semi-structured interviews. This allowed for questions that arose from the original question, to be asked. Since Louise's home language is Afrikaans, the interviews were conducted in Afrikaans to eliminate unnecessary tension caused by explaining her story in English. The interview was translated from Afrikaans. Louise explained how she felt finding out she were pregnant and also why she felt the why she did.

Interview entry:

Researcher: How did you feel when you found out that you were pregnant? Can you describe your feelings?

Louise: I was very glad, I guess. I was pregnant once before, but had a miscarriage at five weeks. When I fell pregnant for the second time I felt that I could finally move on from the previous traumatic event. The pregnancy was very stressful from the start, because I was constantly afraid that I might be doing something wrong. I knew I weren't doing anything wrong, but I could not stop worrying.

Considering that Louise felt stressed throughout the pregnancy and that it can have an influence on her postnatal emotions, I asked her how she felt after giving birth. Louise stated that she felt "different". To be more specific, she did not feel the "unconditional love" that so many new mothers refer to:

Interview entry:

Researcher: Please describe your emotions after giving birth, did you feel the feelings over time or not? You said you were stressed before birth, and after that it just went on?

Louise: I think afterwards the thing that caught me, was that it felt as if I was not as fond of my child as other people were of theirs. Not that I knew how much you should love your child, but I think it must be ecstasy and total and all love and you cannot think you know how to be the same without the child, I did not feel like that.

With feelings as strongly as what Louise experienced after giving birth, the researcher was interested to know what made her realise that she might be battling with postpartum depression. This would also lead to finding out more regarding her emotional situation towards her baby after leaving the hospital and to coping alone at home. Louise elaborated on the question:

Interview entry:

Researcher: Was there a specific incident or feelings you experienced that were an indication that something is wrong?

Louise: I was terribly afraid I was doing something wrong. I feared so terribly that I never really went out and I thought I was doing something wrong and there was one particular day I just wished that she will stop crying. It was about 6 weeks and nobody was home except me, so when I called my husband, I told him you'd better come home now. Then he worked at Lonmin which was very far. He called my mother and she was in Brooklyn. By then my mom told me she thought I was depressed and that's why I'm taking everything completely wrong. I went to the doctor and they gave me pills. They gave me anti-depressants that lasted for the rest of my maternity leave, but yes I stopped drinking that again.

With emotions as strong as Louise's, the researcher asked her the question regarding the support she received during her battle with postpartum depression. Although Louise did not know about any support groups or supporting forums she could have joined, she was

fortunate enough to have her supportive husband and family there every step of the way to take care of her and her baby. She explained her everyday struggles and how her husband and family supported her when she was asked what support she had after giving birth.

Interview entry:

Researcher: What support did you have after the birth of your child?

Louise: I have a very supportive husband. So I gave up more or less at one stage. We made turns in the evenings and that worked very well because he goes to sleep late and I go to bed early and I get up early so we made turns. So I did not get up so much in the evenings as other mothers would, but he took over everything, everything, everything, everything. My mother-in-law stayed with us, I think she was there for half a week and she was there before Jack came home early from work for the first month or two. In the afternoons, I would call him and say you better come home, I'm tired now. So he took over my role. It is one of the things we have discussed, the fact that Mari is much closer to her dad than she is to me. So he literally fulfilled the mother's role and fulfilled the father's role and I was just there. I was the weird woman who sat there all the time and cried and tried to do something but felt so uncomfortable that nothing really worked. I think at this stage I'm really only in her life for the last year, a year and a half. I have not recovered, I'm just better. So the pills have kicked in. I'm no longer depressed. I'm now pretty on a normal level somewhere. What's normal, so now I really enjoy her and I start playing with her and she's starting to me choose over my husband.

Considering all the support that were available for Louise, the question still arose regarding the influence of external factors and internal factors which could have had an influence on Louise’s postpartum depression.

Interview entry:

Researcher: Were there any external factors that could have contributed to your depression? Such as stress at home, marital problems, financial problems? Were there any internal factors that could contribute to depression?

Louise: Yes, previous depression. I would say yes, that's the one and then I definitely think the miscarriage had quite effect.

Louise mentioned that her daughter formed a closer attachment with her father, since he took over the roles of both parents during that time. Even though her husband was there to fulfil parental love and attention that a baby needs, Louise's battle with postpartum depression did have an effect on her daughter.

Interview entry:

Researcher: What role do you think you play in your child's emotional development?

Louise: Well, her dad was very involved, Jack is terribly good with children so that's how it worked out very nice. I was terribly withdrawn, so it always seemed to me that I did not give her enough love. Thinking back, I gave her what I could, but I still think it wasn't good enough. Then the way I expressed myself when I had an emotional outburst. I would throw tantrums that would make three-year-olds look bad and she is currently performing the same way but not always, with us she's okay. Specifically, at school her tantrums are much bigger than any of her buddies. It's on a different level and I feel it's my fault although the psychologist says it's not necessarily my fault. In her case, she has been for three sessions at a child's psychologist, not an educational psychologist, a very pleasant woman. The teacher and the principal talked to us and you know if the teacher says you both have to come...

Louise stated that her daughter does have behaviour problems and sometimes display similar behaviour as to when she had emotional "break downs" in the past. Louise and her husband

decided to enrol their daughter in an expensive private pre-school to ensure that she received the individual attention she needed with the small classes the school offered, because they were aware of their daughter's emotional difficulties. After a meeting with the class teacher and principal of the school they became more aware of the behaviour and difficulties their child displays in class, leading to them seeking support from professionals. She is currently attending therapy sessions with an educational psychologist and in the past with a play therapist regarding her behavioural and emotional problems.

Interview entry:

Researcher: Please elaborate on your child's behaviour, especially at school. Have you ever received external support to help with your child's emotional development?

Louise: Yes, so they say now and then she throws tantrums, she's terribly emotional about everything and she's not concentrating at all. She just wants to do what she wants. She's going to Grade R next year, but they want her to only progress go to Grade R when she's sorted out. So, then we went to the psychologist. She says that Mari is looking for attention because you know, you have good attention and bad attention and then in our case specifically my tantrums, because then I will treat her like that. Well, that's how I explain it now, so I give her that negative attention she's looking for because it's attention. She is happy because that's what she knows, it's always the way it is. She does it at school too and she does it with her friends. Oh, what the psychologist says she has done now is she has regression so she sees herself not as a four-year-old, but she sees herself as someone younger. She acts like someone younger, she throws the tantrums of a three-year-old, and she handles certain things just as a three-year-old would handle it. So, we have to get her back from there. She sounds very positive that we can do it. So its the same with the concentration problems, she can concentrate for as long as a three-year-old can. It's very similar to when a second child is born, the oldest child is suddenly busy sucking his thumb and he wets his bed and that's

exactly the same thing that happened to her, but for other reasons.

Considering all the support that a mother can have and the support that Louise received in the past, what could have made a difference in Louise's situation? Knowing that Louise has been through a lot in the last five years, the researcher decided to ask her what support, according to her, would have made a difference in her case.

<u>Interview entry</u>:

Researcher:	What kind of support do you think could have helped you in the past?
Louise:	The correct diagnosis. When I went to the doctor for the first time because where else do you go if you cry 24 hours a day? Shame, she put the box of tissues in front of me. She is very nice. Doctors look at you and they decide okay you're depressed, you show that you're no longer longing for life and you do not want to work in the garden anymore because you do not like it anymore and blah blah blah. Well, that's my opinion, and then it's surely serotonin that's too low so they give you only those ones and the other two items, the other two chemicals in your brain, dopamine and I can never remember the other, I forget them. So you start feeling kind of better. Then keep on and on and on and go for refills but that's not really what was wrong with you. It's actually something else that's wrong and they've just never got it. They are not trained for it so one cannot really expect it's what they should do, but I do not know if they should refer to a psychiatrist after 6 months if you do not get better.

Knowing that Louise was diagnosed with Bipolar disorder two and a half years ago, the researcher needed to know what helped her to overcome postpartum depression. Could it be the medication, treatments, support given and the psychiatric therapy sessions? She went through all of them and some of it worked, while others were merely another something in her path to recovery.

Interview entry:

Researcher: What helped you to overcome the depression?

Louise: So what happened in my case were I went back to work, what he said was very true, my type of personality cannot sit at home, all day with a child. I have to do something, ticking tick boxes and keep my brain busy. So by the time I went back to work, I was so glad to be back at work between adults. I felt better so I stopped drinking the anti-depressants. I do not even think I finished the prescription for the six months. So I felt better for a while or I thought I felt better. Clearly I did not. Then I came to a point where everything more or less were white and black in my head. I cannot decide. I do white and black , that's how I've seen the whole future. Everything is planned for me and I do not want to do anything and that's when I went to Vista and then I got the right medication and started getting better because I was with my psychiatrist. As I said, I had her before the time If I got worse and worse and worse then I get a bang, then I start crying for it all the time and it's very annoying and then I was referred to a social worker and she looked at me like that and said "you are on the wrong medication". You must have something else, yes when I've been to the doctor for the third time, at least she sayd you're on the wrong medication. You have to see a psychiatrist, I thought you'd just not talk to someone else. I'm so tired to tell everyone everything and they cannot do anything and they do not understand. Anyway, my psychiatrist is absolutely awesome. So she prescribed pills for me now. Oh, I think I was with her for 6 months when I was taken to Vista and then she diagnosed me correctly and because I had it, it probably took 2 years until I felt better. I feel awesome now. It took her very long and a lot of tweaking but finally, I'm feeling better.

Looking back on her experience of postpartum depression, Louise had the following advice to offer to mothers who may be going through the same or similar experiences of postpartum depression:

Interview entry:

Researcher:	If you have that one mom before you, what would you tell her?
Louise:	Accept the support offered is good advice because I always feel I can do it myself and I cannot. I've just talked about it today and you're not the only person who feels like it's different. Not everybody, but there are definitely other moms who go through the same as you and if you do not talk to them or you do not read a book you will not know it. I think you're making it worse. You know, you do not go for treatment and you sink yourself deeper into that hole and then go for treatment. Seeing that you don't know, it's generally difficult to get into a psychiatrist, you really need to be referred and then it takes a great favour and you are put on the emergency lists and you will definitely see someone.

During the interview, Louise was calm and collected while sharing her story with the researcher. The interview provided in-depth insight regarding her experience of postpartum depression and how it affected not only herself, but her daughter as well. She has valuable information to share with others with the aim to help any other mothers who might be going through the same.

4.2.1.3 Narrative data

I do not know when I experienced the first signs of depression. I did not know what signs to look out for, but I was struggling from when the baby was born to understand what the fuss was about (about babies, and bonding and happiness etc). I didn't experience that unconditional love that everybody else talked about. I already felt like a bad mother before I left the hospital (how can I not love the bundle of joy?).

Everything was harder than expected and I felt that everybody had this expectation that I should do everything right. I felt like a disappointment and blamed my daughter. The whole time I was on maternity leave I wished I could rather be back at work. For at least the first month I phoned my husband at work around lunch time every day and asked him to come home because I wasn't coping. At first I did not leave the house, I didn't want people to see

how incompetent I was. All the failures and disappointments I experienced got bottled up until I had a breakdown one day. I phoned my husband and asked him to come home immediately. He said he would come immediately but that he was working about 120km away, so he phoned my mom and asked her to come and help. My mother said she is sure that I have postpartum depression and sent me to the doctors. He prescribed sertraline, an anti-depressant that would have the least effect on the baby (through breastmilk). I decided that I did not want any chemicals, especially mind altering drugs, to be consumed by my daughter at all and stopped pumping out breastmilk. (I finally had the reason I was looking for to stop pumping out breastmilk.)

At that stage I didn't feel anything towards my daughter except that she was a task that I had to do every day, like she was someone else's baby. I luckily had a wonderful husband that stepped up to the plate and raised her for the first 3/4 years. I did the things that mothers are supposed to do, birthday parties, visiting the school for mother's day etc. but it still felt like something I <u>had to</u> do. Not surprisingly my daughter formed a bond with her father instead of me and even now (she's 5), she still chooses him over me (that hurts). Currently our bond is something we work on actively; making stuff, going shopping, playing games etc.

I do feel that my postpartum depression influenced her development. She craved my attention and decided that excessive tantrums, not listening to her teachers at all, hitting her friends and acting like a much younger child would get my attention. It did, and also got the attention of her teachers who suggested an educational psychologist to help her work through these issues. And although the therapy is working I once again blame myself for the fact that she has to go in the first place.

4.2.1.4 Summary of the interview and narrative data

Louise felt no love towards her daughter except that she was a task that Louise had to do every day, like she was someone else's baby. Louise's husband had to step up and raise their daughter for the first three to four years. Although Louise did the things that mothers are supposed to do, such as birthday parties and visiting the school for mother's day, she still felt it was something she had to do. She noted that it was not surprising to her that her daughter formed a bond with her father instead of her, and even now, she still chooses him over her, which hurts her deeply. Currently their bond is something they work on actively; making stuff, going shopping and playing games.

Louise does feel that her postpartum depression influenced her daughter's development. She craved Louise's attention and decided that excessive tantrums, not listening to her teachers at all, hitting her friends and acting like a much younger child would get her mother's attention. It did, and also got the attention of her teachers who suggested an educational psychologist to help her work through these issues. Although the therapy is working, Louise still blame herself.

4.2.2 Case two: Nonni (pseudonym)

Nonni's tragic, but inspiring story regarding her experience with postpartum depression and how she overcame it motivated the researcher to include her in the study. She experienced postpartum depression 12 years ago, after the birth of her son.

4.2.2.1 Biographical information

Nonni was drugged and raped at the age of 17. According to Nonni she was not involved with anyone at that time and she felt it made it worse to process what happened to her. Devastated and unsure about what exactly happened to her, she only discovered after six months that she was expecting a baby boy. At that time, she was living with her grandmother and younger sister.

After the news that she's expecting a baby from someone unknown, she fell into a deep depression. Nonni did not have any knowledge of depression, what the signs and symptoms are and whom she could turn to for help. She stayed in her room as much as possible, withdrawing herself from everything and everyone around her. She even stopped eating all together.

She did not want to see him and even described hating the baby for what it reminded her of. While she had to cope with having a new born baby and her postpartum depression, her grandmother got very sick as well, which only made her feel worse.

Nonni never considered consulting a doctor or any other professional for the necessary support and treatment. After four years of struggling with postpartum depression on her own, she decided to confide in her pastor for help. Her pastor arranged sessions with a

psychologist. Only after receiving the treatment and support she needed, Nonni started to form an attachment with her son after five years.

Today Nonni work hard to reach her dreams and to provide for her son, who according to Nonni, she loves more than anyone else. According to Nonni, her son shows no signs of any emotional developmental problems or behavioural problems. He's an introvert and performs well in school.

4.2.2.2 Interview data

At the beginning of the interview, Nonni assured the researcher that she is emotionally strong enough to share her story. She preferred English for the interview since she does not understand or speak Afrikaans. Nonni did not elaborate on answers during the interviews, which lead to the researcher asking her more probing questions for clarification. She explained her feelings when she found out she was expecting as follows:

Interview entry:

Researcher:	How did you feel when you discovered for the first time you were expecting a baby?
Nonni:	Sad.
Researcher:	Sad?
Nonni:	Ja or confused. Let's say confused.

After admitting that she felt confused when she discovered that she was pregnant, the researcher was interested in why she felt this way. Asking her to elaborate more on feeling sad after she discovered she fell pregnant, she answered:

Interview entry:

Researcher:	Can I ask why?
Nonni:	Because I didn't know how I got pregnant.
Researcher:	But how so?
Nonni:	I was never in a relationship by then. I was seventeen years. And I got pregnant. It's like they drugged me and then he raped

me so I only discovered after six months.

Understanding her feelings better in context, she was asked if she experienced feelings of depression before giving birth. Since she found out about her pregnancy when she already in her third trimester of pregnancy.

Interview entry:

Researcher:	I would like to know if you have already experienced feelings of depression during the pregnancy?
Nonni:	I did. It was bad.

Taking into consideration that Nonni had no prior knowledge of depression and more specific postpartum depression, an incident or certain feelings must have made her realise that she was not herself as she used to be and that she needed help.

Interview entry:

Researcher:	Was there a specific incident or emotions that you experienced that were an indication that something was wrong before you were diagnosed, so were you ever diagnosed?
Nonni:	No.
Researcher:	So you never went to the doctor and said this is how you feel and they never…
Nonni:	Never.
Researcher:	but were there any emotions that you felt…
Nonni:	Ja. I couldn't eat. I was in my bedroom every day.

Regardless of Nonni's circumstances and prenatal depression, she carried her child for the full term (nine months) without any complications. Nonni experienced strong feelings of hatred and rejection towards her new born baby after giving birth. She stated it in perspective:

Interview entry:

Researcher:	Please describe your emotions after the birth of your child, did it change?

Nonni: I didn't want to see the baby. We couldn't even connect. I hated the boy.

As Nonni mentioned earlier on in the interview, that she could not bond with her baby. Knowing the importance of an attachment bond between a mother and baby, the researcher had to know if and when Nonni formed a bond with her boy.

Interview entry:

Researcher: Did you bond later with him?

Nonni: Ja after five years.

Processing what happened to her and coping with a new born baby, Nonni would have needed extensive support, but she was mostly alone.

Interview entry:

Researcher: What support system if any did you have after the birth of your child?

Nonni: My sister was at school. My grandmother was sick. So it was only me.

Seeking support after struggling by herself, Nonni mentions how she eventually turned to someone for support. Since she never consulted a doctor or even thought about using anti-depressants.

Interview entry:

Researcher: Did anybody help you?

Nonni: I went to my pastor. I told him everything. And then he booked an appointment at a psychologist. Then I started to attend. That's when I get helped. About after four years.

Asking Nonni about her perspective of a mother's role in the emotional development of her young child, she did not have anything to say, since she was unsure of what to answer. The researcher wanted to also know if her experience with postpartum depression had an effect on her son's emotional development. She shared the following:

Interview entry:

Researcher:	Do you think your depression influenced your child's emotional development?
Nonni:	Yes. He's able to sense it. Once he sees me down he loses focus.

Following on the previous question, the researcher needed to find out if Nonni did seek additional support for her son's development, since he is sensitive to her emotions.

Interview entry:

Researcher:	Did you ever get external support to assist your child's development? For example: psychologist. And did it help him?
Nonni:	Ja he's good. Ja it did.

Nonni explained that she took her son to a psychologist when he was nine years old. According to Nonni it helped him in such a way that he is coping well whenever she feels emotional or upset. Concluding the interview, the researcher wanted to know what advice Nonni will offer to others. Her advice:

Interview entry:

Researcher:	What advice can you offer to mothers who are suffering from postpartum depression?
Nonni:	Open up. Find somebody, tell them how you feel, cry it out. It helps. Keeping things to yourself will only damage you. You need to be brave, to go out there help others who are going through whatever you experienced.

For the duration of the interview, Nonni never really showed any signs of emotion indicating whether she is still sad or shy about her experience. She reassured the researcher that she is totally at peace with what happened to her and decided to make the best of what happened to her, by helping others. Nonni started helping other women in her community who struggle with depression and anxiety by supporting them emotionally and in their household.

4.2.2.3 Narrative data

I am a woman who went through what we call women abuse. I got raped at the age of 17 years. I was still a virgin by then. U was invited for a choir practise at some other church, after a church service, we had brothers to take us home. As we walked home, one brother offered to buy me juice. I agreed. As he gave e the juice I could only remember drinking it, don't know what really happened.

Four months down the line, begin to isolate myself. Spent time alone in the bedroom. I'll cry till I fell asleep. Couldn't eat, lost focus in the classroom, failed simple tests and couldn't submit assignments even.

Fell sick had a terrible flu with wonsils. Went to see the doctor. He told my granny that I was six months pregnant. For a moment I thought I didn't hear well. I could feel my heart beating faster. I was asked who's the father, and I was like "I don't know". Trying to convince myself that the doctor was only joking.

I wanted to die, I felt as if the world was reading everything in my eyes. I drank Pottasium trying to kill myself. I vormitted it out before it could ever reach my stomach.

I gave birth to ta baby boy on the 3rd of July 2004. The minute I saw him, anger, hatred arose within me. I didn't want to touch or look at him. He could cry whole night without me caring. I didn't want to connect with him. Looking at him reminded me that I don't know how he came to this world. How much I didn't plan for him. He suffered from Jaundice and dehydration. I had no time for him.

After four years, I went to my pastor and his wife. Sat down with them and told them what really happened. It was for the first time I spoke about what happened to me after four years. I have never cried like that in my life. That's when I realised that I was broken inside and I needed help.

He promised to book me for counselling and he did just that. I started with my sessions and I started to see my son with a different eye. Had to learn to love him no matter the past. I

came to realize he is a blessing. That I cannot change how I conceived him, but I can change how I raise him.
God opened my eyes and I recognised his talent. He started singing at the age of six years old. We could sing together, make some noise in the house. Took him for counselling when he was nine years old. He became a friend of mine to this day. He's now 13 years and very bright at school and he really loves music. He plays instruments and I sing. We make a strong and powerful team.

He loves the Lord and that alone gives me peace. We've became close you'll think that he is my brother since he's tall.

Honestly frim my families side, U didn't get any support. My granny got sick just after my son was three months , my twin sister was at school (adopted), my mom was living with my step dad. She passed on a week after we buried my granny.

When they died my son was only 11 months. Had to make sure my boy had clothes and everything which is one of the things that frustrated me when looking at him.
The only time I felt that I had someone on my side was after I disclosed to my pastor, by then I was already an orphan.

Today I look at life and smile. It shaped a strong woman within, who's able to stand and face all the challenges of life with confidence, knowing what there's always a morning after night. If you ever went ot fo through what I've faced, understand everything works together for those who love the Lord.

We sometimes fo through something, not because we're bad people or we derserve that, but because God allowed it to happen. So it can strengthen us within to able to testify to the broken hearted that God is able to mend anything.
Don't lock yourself in the house just because you were raped. Yes it hurts, it makes us to lose self esteem, it makes us to hate men, but you gonna feel sorry for yourself till when? Let's get up, go out to save broken women who are going through what we've experienced. There is still hope, life, love, success after rape. It doesn't end here.

God has got plans with our lives. Jeremiah 11:29

4.2.2.4 Summary of the interview and narrative data

The minute Nonni saw her baby boy she felt anger, hatred arose within her. She didn't want to touch him or even look at him. She would let him cry without caring. Nonni states that she didn't want to connect with him at all. Nonni felt that her baby boy was just another thing she had to do, like a task. Since she did not plan him or even remember how "he came to this world".

Only after confiding in her pastor, who arranged counselling for her, she started seeing her son through different eyes. She had to learn to love him and to work on bonding with him as a mother should. He started singing at the age of six and that was their bonding time, since Nonni loves to sing as well. They could sing together and make some noise in the house. He started with counselling at the age of nine. It helped him. As Nonni stated: "We make a strong and powerful team".

4.2.3 Case three: Elsabé (pseudonym)

Elsabé were diagnosed with postpartum psychosis more than 10 years ago after the birth of her first born. She was treated for postpartum depression and only later on her psychiatrist diagnosed her correctly with postpartum psychosis. The researcher decided to include Elsabé's case, since it met the criteria that were decided upon for the study.

4.2.3.1 Biographical information

Elsabé was still busy to complete her studies, when she found out that she was expecting a baby. At that time, it came as a shock to her and her husband since they did not plan on having a baby in the near future. Even though it was an unplanned pregancy, Elsabé embraced the experience of expecting a baby. She was not depressed during the pregnancy, but rather stressed due to not having a medical aid to cover the necessary cost of the pregnancy. The pregnancy overall went very well and this continued for few days after giving birth.

Elsabé only started feeling "strange", as she describes it once they were settled in a new home. Elsabé was unnaturally energetic and could go days without sleeping or resting. At

first Elsabé thought that’s just how it should be for a new mom, but she soon realised that it was not true at all. Two weeks after giving birth she consulted her gynaecologist regarding her “strange” behaviour. The gynaecologist admitted her to hospital for observation and a consultation by a psychiatrist. The gynaecologist could not find anything wrong with Elsabé and the psychiatrist never got around to her.

More or less two weeks passed before Elsabé’s sister visited from Bloemfontein and arranged a consultation with a psychiatrist she knew. The psychiatrist not only prescribed medication for Elsabé, but admitted her for three weeks to Weskoppies Psychiatric hospital. During this time Elsabé had a lot of support from her family, friends and especially her husband who stood by her through it all. He took over the role of mother and father for their baby girl. The psychiatrist initially diagnosed and treated Elsabé for postpartum depression. Eventually, after experimenting with different treatments, she was diagnosed with Postpartum psychosis and received treatment thereof.

Adjusting and coping well with her disorder, Elsabé enjoyed motherhood and finally bonded with her baby girl. Two years later, she had a relapse and was admitted to Vista Psychiatric hospital by her psychiatrist. Her psychiatrist advised her not to plan on having more children in the future since it may only worsen her disorder. Although Elsabé recovered well from the disorder, she still has relapses when she experiences major stress. She still needs to continue with her medication daily. Her husband and daughter understand and support her.

4.2.3.2 Interview data

Elsabé preferred to conduct the interview in Afrikaans since she felt more comfortable explaining herself in the language. She recovered from her disorder to such a degree that she can talk about her experience open heartedly. Firstly, she explained her emotions when she found out that she was expecting.

<u>Interview entry</u>:

Researcher:	Please explain your feelings when you found out you were expecting.
Elsabé:	I will say surprised.
Researcher:	Was this unexpected?

Nonni: Yes, a surprise.

Furthermore, Elsabé elaborated that even though she had no feelings of depression, she was stressed about the financial impact the baby might have on their life.

Interview entry:

Researcher: I would like to know if you felt depressed during your pregnancy?

Elsabé: Not at all. But very stressed... Yes, because at that stage we did not have a medical aid, you worry how are you going to pay for everything and then you visit the doctor and the doctor informs you that it's a big baby. Then we had to think of a C section you know, and a C section is so much more expensive.

Elsabé explains that her emotions after giving birth to her daughter had not changed during her stay in hospital, but it all changed after settling in at home.

Interview entry:

Researcher: Please describe your emotions after the birth of your child? Did your feelings change over time or not?

Elsabé: No, when she was just born, it went well, in the hospital, especially when you still have help and you know the nurses are there. If you feel here you're struggling, let's say to breastfeed, then you can just ask. They will not be able to help you later when you are alone at home and that makes you more stressed.

Researcher: So you were not as emotional or sleepy as you say, but actually had a lot of energy?

Elsabé: Yes, but then you know you cannot keep it up, I mean you cannot go without sleep so many days, then you get confused. Then my sister got here and she told me to seek help. I went back to the gynaecologist to tell him I do not feel right, something is wrong, maybe my hormones were mixed up. Even he did not pick it up. Yes, he sent me back to the hospital and said someone would see me, but it was also over a weekend and well, the guy never came

out to consult me. Then my sister was luckily there, she was from Bloemfontein. She then took me to someone. They admitted to a psychiatric hospital.

She mentioned that she consulted her doctor as soon as she realised that she had a "strange" feeling she felt was not normal at all.

Interview entry:

Researcher:	How long did you wait for a doctor to see you regarding your depression? If you have been waiting for more than 6 weeks?
Elsabé:	No, I did not wait that long, like I said, but it was hardly 2 weeks before I first saw the doctor, but he did not find anything and then there was another week or so and that's where the problem had evolved because so much time had passed, then it took another week. By then it was time for me to see the psychiatrist.

Elsabé has no negative feelings or thoughts regarding the use of anti-depressants. She explains:

Interview entry:

Researcher:	What is your opinion about anti-depressants or any other form of medication during the postpartum period?
Elsabé:	You're just so glad that there is something to help you because you feel like everything is dark as night for you and you have no energy or you're depressed. I'm not talking about someone who's moderately depressed, this is worse. You, I mean, just cannot get up when someone tells you to get up and get dressed. It's too much for you and if they tell you to comb your hair and to blow dry and so on, it's a huge task. Then, my husband's mother came to help look after the baby because it was too much for me.

Although, Elsabé never joined a support group, she had the support of others close to her.

Interview entry:

Researcher:	What support did you have after the birth of your child?
Elsabé:	My parents were there, my mother-in-law, they were there, actually I had a lot of support, but it does not matter, you just feel... you cannot, you cannot.

Elsabé believes that a mother plays a big role in her child's emotional development. The effect of her postpartum depression on her young child she describes as follows:

Interview entry:

Researcher:	Did your depression have an impact on your child's emotional development?
Elsabé:	I think so. Look later, yes, I think she cried a little more, but she is happy despite all that. My mother was there, my mother-in-law was there and they were very involved so they could take over my role to a great extent and it helped a lot ... Yes, and then, they still want to be with you, but they do not realise that you are totally absent. You know, my husband was understanding. To this day she has quite a close relationship with her dad, but I can hardly say more so than with me.

Elsabé recommended the following for other mothers:

Interview entry:

Researcher:	What advice can you give to other mothers who are battling with postpartum depression?
Elsabé:	Okay, because you cannot help them, the big thing is to pick it up early. I feel the nurses and the people working in the nursery rooms need to identify you...

Elsabé feels that mothers should be made aware of the disorder by hospital staff, in order to prevent it before it turns out for the worse.

4.2.3.3 Narrative data

My first awareness of depression was short after the birth of my child. While other mothers would rather take time to sleep, I would constantly stand to go look where my baby was and to ensure that the nurses looked after her.

For three tot four days I barely slept. I just couldn't get myself to go to sleep. I was afraid something might happen to her while I slept.

I was very concerned about her well-being, but felt that I wasn't capable of looking after her by myself, especially not able to bath her alone.

I tried breastfeeding, but skipped some of the feeding times. That's when I started to rather change to bottle feeding. Which made me feel more uncapable to look after my child. At that time I were admitted to hospital again.

I personally feel that me being in hospital and my depression had a influence on my attachment with my child, until today. I was admitted to a psychiatric hospital for three weeks and I could only see my baby during visting hours.

My family, friends and especially my husband supported me unconditionally throughout this experience. Always there to help when needed.

4.2.3.4 Summary of the interview and narrative data

From the start, Elsabé were fond and protective of her daughter, but she just felt like she could not look after her alone. Even bathing her felt like the biggest task that Elsabé couldn't manage by herself. Elsabé felt constantly incapable of looking after her daughter. She never left the confines of their house, because she was afraid others may notice that she's an incapable mother.

Being admitted in a psychiatric hospital for three weeks resulted in Elsabé only seeing her daughter for a few minutes during each visiting time. Her family and loving husband supported Elsabé throughout. She feels that the time she lost with her daughter meant that she was

never able to bond with her like she should have. Now that her daughter is a young adult herself, they still do not have a strong bond like her daughter and husband has.

4.3 THEMES AND CATEGORIES

Through various data collection methods (see Section 3.2.2.3), the researcher was able to gather rich and in-depth data. Inductive data analysis (see Section 3.2.2.4) allowed the identification of three very distinct themes as well as their categories, according to each participant's response.

The following table summarises the various themes and categories derived from the participants' individual semi-structured interviews and narratives:

Table 4.1 Themes and categories

THEMES	CATEGORIES	PARTICIPANTS RESPONSES		
		Louise	**Nonni**	**Elsabé**
Prenatal period	*Stress*	Previous miscarriage Doing something wrong Depression	In denial about pregnancy Teenager Rape	Unplanned pregnancy No medical aid
	Contextual factors	Miscarriage	Rape Grandmother illness Sister in foster care	Lack of finances No medical aid
Postpartum period	*Caregiving*	No feeling of unconditional love. Baby feels like a task. Baby constantly crying Bathing time was a terrible task to do.	Hate towards her child Resentment towards her child Feeding Baby crying	Lots of energy Excessive crying Felt more incapable during bathing time. Baby crying excessively Dressing her child
	Support	Husband Mother Mother-in-law	No one at home Pastor	Husband Parents
	Treatment	Anti-depressants Psychiatric hospital Monthly sessions with a psychiatrist.	Psychologist	Anti-depressants Psychiatric hospital

THEMES	CATEGORIES	PARTICIPANTS RESPONSES		
		Louise	**Nonni**	**Elsabé**
Emotional development of the young child	*Impact on the young child*	Tantrums Excessive crying Mood fluctuation Concentration problems Seeking attention from others.	Excessive crying Sensitive to mother's emotions/fluctuating emotions? Very aware of his mother's emotions.	Excessive crying
	Professional support	Play therapy Educational psychologist Accept support from others who want to help and support you.	Psychologist Confide in someone	None Early diagnosis of depression. Professional care from nurses and doctors.

Table 4.1 shows the three themes which featured clearly after data analysis. The first two themes divided the mothers' experience of depression into the prenatal period and postpartum period. The third theme takes the young child's emotional development into consideration. Each of these themes have additional categories which refer to the participants' experiences and feelings that had an influence on their children's emotional development as well as accounts of professional treatment. Each theme will be discussed separately in the data interpretation section to connect it with the literature that was obtained in Chapter 2.

4.4 DATA INTERPRETATION

Creswell (2013:187) maintains that nterpreting the data collected is to abstract a larger meaning from the codes and themes that were decided upon during data analysis. Maree (2016:120) explains that new meaning and understanding will be constructed using the codes and themes as a framework, after which the researcher will link their interpretation to the literature created by others (Creswell, 2013:187). The data was therefore interpreted in view of the research findings and the connection with other literature (see Section 2.2) as well as with the theory of John Bowlby (see Section 2.3).

Although each theme will be discussed separately, it will be noticeable that some of the categories will overlap with each other throughout the themes as well.

4.4.1 Theme 1: Prenatal period

The semi-structured interviews with each of the mothers gave the researcher considerable insight into their emotional experiences during the prenatal period. The main categories that could be distinguished were stress and contextual factors. Beydoun and Saftlas (2008:438) define worry as an occasion or circumstance that is seen differently by different people, and it is that perception as opposed to its objective nature that has the ability to impact wellbeing. Furthermore, Oberlander, Papsdorf, Brain, Misri, Ross and Grunau (2010:444) maintain that exposure to maternal mood disturbances and anxiety during pregnancy can be the first risk factors leading to postpartum depression and childhood behavioural disturbances.

Feelings of happiness, excitement, fear and most of all stress, were described by each of the participants. Each of the mothers explained that there was some factor regarding their life that caused them to stress about the unforeseen future prospects of giving birth to a baby. Louise mentioned that due to her previous miscarriage, she experienced continuous stress throughout her second pregnancy, because she was afraid of “doing something wrong”. Concerns regarding medical aid and all the unforeseen expenses were one of the reasons for Elsabé’s stress. Nonni not only had to stress about her unborn baby and how she will provide for him, but had to process the feelings connected to being raped and expecting the child of a stranger. One can argue that, according to Section 2.2.3.1, the stress that these mothers experienced had a direct effect on their unborn infants’ emotional and cognitive development.

One of the main reasons for postpartum depression can be ascribed to experiences of stress, anxiety or depression during the prenatal period (see Section 2.2.2). Elsabé explained that she felt “fine” during hospitalisation whereas Nonni revealed that she preferred not to see her baby since the day he was born. These three mothers explained the contextual factors which lead to the stress they experienced.

As Nonni was raped at the age of seventeen, she experienced a lot of anxiety whilst being pregnant with her son. Nonni found out about her pregnancy at a very late stage, whilst dealing with the emotions of her traumatic experience. She did not want the child, and had no one to confide in. She voiced her feelings by saying: “I didn’t want to see the baby. We couldn’t even connect. I hated the boy”. Furthermore, Nonni had to deal with her grandma’s illness and her twin sister being in foster care. Instead of having a confidante to confide in, she withdrew from everything and everyone around her.

Not only were tuition fees and exams one of Elsabé’s concerns, but also the realisation of an unplanned pregnancy with all the related finances connected to it. With no medical aid and only her parents to rely on, Elsabé stressed a lot about how they would manage with all the medical bills related to a pregnancy. Even though Elsabé and her husband were happy about the unexpected pregnancy, she still described the prenatal period as stressful.

Louise decided to rather stop drinking her prescribed antidepressant medication when they decided to try for a baby. With her first pregnancy resulting in a miscarriage, Louise felt stressed from the moment she found out that she was pregnant for a second time, trying hard not to do anything "wrong" for it to be a successful pregnancy. Louise voiced her feelings by saying: *"…so toe ek nou die volgende keer swanger word toe is dit soort van okay uiteindelik kan ons aangaan, maar dit was baie stresvol van die begin af want ek was die heeltyd bang ek doen weer iets verkeerd. Ek weet ek het niks verkeerd gedoen nie maar jy hou aan om so te voel."* [When I fell pregnant for the second time I felt that I could finally move on from the previous traumatic event. The pregnancy was very stressful from the start, because I was constantly afraid I might be doing something wrong. I knew I was not doing anything wrong, but I could not stop worrying]. Louise regards her previous depression and the miscarriage of her first pregnancy as one of the main reasons for her postpartum depression, resulting in her daughter's emotional and behavioural problems.

The contextual factors of each participant that caused stress and anxiety during the prenatal period, shows that each of the above mentioned factors are more personal than that of family history of depression (see Section 2.2.2). As the literature consulted in Chapter 2 concluded that these factors contribute to prenatal stress, anxiety or depression that could have had an influence on each of the participant's experience of postpartum depression.

4.4.2 Theme 2: Postpartum period

Pearlstein et al. (2009:357) state that depression during the postpartum period may occurr during pregnancy or only have an onset one month after giving birth. One of the participant revealed that she only had her emotional meltdown six weeks after giving birth to her daughter, leading her to seek professional treatment. Elsabé realised three weeks after delivery that her feeling "fine" was actually an experience which reached far deeper than what met the eye. Categories such as caregiving, support received by loved ones and treatment seeked will be discussed under this theme. Amid the transitional period, moms are expected to at the same time giving

self-care and caring for their newborn child while in the hospital and after that continuing these abilities at home, frequently in an unsupported situation (Leahy-Warren, McCarthy & Corcoran, 2011:174).

4.4.2.1 Caregiving

The attachment theory focuses on a parent's responses to a child's needs and emotional signals (see Section 2.3.1). According to Shaver and Fraley (2000:109), an infant arouse in parents more intricate thoughts and feelings about matters such as a child's needs for sustenance, for shelter from danger, for stimulating entertainment and for informative support and guidance, to which a parent respond to. Furthermore, Field (2010:5) stated that a depressed mother offers less responsive caregiving (see Section 2.3.3). It is known that one of the symptoms of postpartum depression is that the mother has an overwhelming sense of worthlessness and letting everyone, especially her baby, down by not fulfilling the mother role as expected of her (see Section 2.2.1). Each of the participants reported that they felt "strange" towards their infant and more often they felt incapable of providing care. Routine tasks namely feeding, bathing and nappy change, felt like a punishment to these mothers since they felt incapable of performing them. This lead to them rather withdrawing themselves from the task and their child.

Bowlby identified four phases during which an infant forms an attachment with a mother-figure (see Section 2.3.1.1). From the first phase (birth to 12 weeks), the infants start to form an attachment since they can discriminate between absent or limited parents. During two of the interviews, the mothers admitted that their daughters formed a closer bond with their fathers, since they, as mothers, were more absent and withdrawn. Due to their experiences with postpartum depression, these mothers lost the opportunity to form an attachment with their infants.

Bowlby's attachment theory identifies four classifications of a child's attachment to their caregiver (see Section 2.3.1.2). Depending on the child's attachment classification to the caregiver, it could lead to developmental problems. Louise and Elsabé's attachments can be classified as insecure, ambivalent and disorganised. The girls could not use their mothers as a secure base to explore their environment and were distressed upon separation, but in the same sense could not be calmed

by their mother. The young girls never percieved their mothers as a secure base, but rather their fathers since they took over the role of the mother for so long. It is evident that Nonni's boy formed an insecure attachment with his mother. His mother made him feel insecure of her. He displayed low selfconfidence and lower levels of coping competency since there was no other available support structure for him.

4.4.2.2 Support

The level of support given to a mother during and after a pregnancy could be considered one of the risk factors for postpartum depression (see Section 2.2.2.1). One of the mothers revealed that there were no family to support her emotionally. Only after four years she turned to her pastor and his wife for help to get through the depression she was struggling with. There was no one to fulfil the role as primary caregiver, with the result that her baby boy was more sensitive to her emotions. According to Leahy-Warren et al., (2012:395), contrasted with moms with elevated amounts of help, the chances of being discouraged was about twice that with medium help and almost four times higher in those with little help. In both the other two cases, the father and grandparents stepped in as primary caregivers when the mothers were not able to. This resulted in the young children forming a closer bond with their fathers. In these cases, unconditional support was given to the mothers, but it did not prevent postpartum depression.

4.4.2.3 Treatment

The most noteworthy factor in the span of postnatal depression has been observed to be the length of postponement of early acknowledgment and satisfactory treatment (Leahy-Warren et al., 2012:390). As proved by the participants and research done by Baron et al. (2015:503), a 75 per cent treatment gap exist in South Africa (see Section 2.2.4). Due to circumstances, all three of the participants received treatment either too late or inadequate to what their needs were at that given time. This resulted in them being separated from their young children for weeks in order to receive the correct treatment. Two of the three participants were admitted to a psychiatric hospital on two occasions. It was reported by one of the participants that her daughter cried more often than usual while she was admitted.

Even though the young children were too small to understand, the damage can be done by not forming an attachment with their mother. Only one of the participants went for counselling as her only treatment method. Although she was not physically away from her son, emotionally she was unavailable until the counselling she received had the necessary outcome for her. Furthermore, not one of these mothers' considered having another child due to their experience with postpartum depression. Elsabé's psychiatrist mentioned that if she were diagnosed earlier, she might have been able to consider having another child.

4.4.3 Theme 3: Emotional development of the young child

According to Vaish, Grossmann and Woodward (2008:3) the process of emotional development of a young child already begins prenatally when the unborn baby receives vocal emotional information, and continues with facial information from the moment they are born. They continue to receive these emotional stimuli in increasingly diverse methods throughout development. Depressed mothers are less likely to respond to their infant's emotional cues, leaving the infant without an emotional competency framework (see Section 2.2.3.1).

During the interviews, the researcher wanted to explore how the participants regarded their role as mothers in the emotional development of their children. Louise immediately made the connection between her daughter's tantrums and the way she herself behaves when having an emotional "break down". *"Ek sou tantrums gooi wat 3 jariges sal laat sleg lyk en sy tree huidiglik dieselfde op maar nie die tipiese, saam met ons is sy okay."* [I would throw tantrums that would make three-year-olds look bad and she [her daughter] is currently performing the same but not the typical, with us she's okay]. Louise explained that her daughter displays the emotional level of a three-year-old, even though she is already five years old, and it is clear that Louise feels responsible for her daughter's inability to regulate her emotions, even though the psychologist reassured her that she is not to blame. Research (see Section 2.4.1) indicates that the mother is mainly responsible for the emotional development of the child, which develops in an atmosphere of positive emotional interaction between mother and child. Expressing her emotions and in this way and setting an example for Mari is still a challenge for Louise. As a way to

manipulate those around her, Mari would cry for everything and seeks attention whether it is positive or negative. This is corroborated by research (see 2.2.3.1), which suggests that children would do anything to provoke a response – even if the result is negative attention, which Louise admitted seems to please Mari, just as long as she gets the necessary attention. Bowlby's Attachment Theory (2.3.1) also indicates that the intensity of emotion in the child is determined by the relationship between the child and the attachment figure, in this case the mother (see Section 2.4.3).

When the same question was posed to Nonni, she agreed that a mother does have an influence on her child's emotional development. She explained that her son's sensitivity to her emotions as well as his insecurity can be ascribed to the fact that she distanced herself emotionally from him from birth. Although Nonni's son never displayed any emotional and behaviour problems, he tends to "keep to himself". In this regard Bowlby's theory also postulates that the quality of the bond between mother and child, is significant in determining later attachments (see Section 2.3.1.1).

Although Elsabé acknowledged the impact that a mother has on her child's emotional development, she was of the opinion that her depression had minor effects on her daughter. According to Elsabé, her daughter cried more often, but overcame it quickly, especially when her husband stepped in to take care of her daughter (see Section 2.4.2 and 2.4.3).

Lastly, the researcher asked each of the participants what advice they could offer to mothers who are struggling with postpartum depression. Both Louise and Nonni referred to the value of support and the possible damage to their children's emotional development. Louise voiced her opinion as: *"Aanvaar die ondersteuning wat geoffer word, dis 'n nice een want ek voel altyd ek kan dit self doen en ek kan nie"* [Accept the support offered, I always feel I can do it myself and I cannot". Nonni's had the following advice to give: "Open up. Find somebody, tell them how you feel, cry it out. It helps. Keeping things to yourself will only damage you". Elsabé on the other side said: *"Goed ja want mens kan nie vir hulle, die groot ding is dat jy dit vinnig optel. Ek voel net die susters en die mense wat in die kraamsale*

werk hulle moet al jou kan pinpoint..." [The big thing is that to pick it up early. I feel that the nurses and the people working in the nursery rooms need to pinpoint you as a person ...]. These mothers disclosed that through participating in this study, their hope would be to help any other woman who might be struggling as they did.

4.5 CONCLUSION

The data obtained from the semi-structured interviews and narratives yielded insightful information regarding the impact of postpartum depression on a young child's emotional development. Although each of the three case studies was different from the others, the data analysed indicate a variety of common themes and categories according to each participants' experience of postpartum depression. Findings indicated that contextual factors before and during pregnancy determined to a great extent the experience of postpartum depression. It seems that support from family members and medical personal is crucial in coping with and overcoming postpartum depression.

Chapter 5 provides a summary of the research findings, the research conclusions and research and recommendations.

CHAPTER 5
SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In Chapter 4, the research findings of this study was analysed and interpreted in accordance with the research questions, relevant literature on postpartum depression and John Bowlby's Attachment Theory.

The prenatal period was presented against the backdrop of relevant literature on the exposure to stress and anxiety during pregnancy and the contextual factors that might play a role in postpartum depression (see Section 4.4.1). Thereafter, the postpartum period was discussed with regard to the caregiving relationship between mothers and their infants, the support they had during this period and the treatment received for their depression (see Section 4.4.2). Finally, the impact of the mothers' experience with postpartum depression on a young child's emotional development and the professional support that was sought to support the child's development, was eluded to (See Section 4.4.3).

The purpose of this chapter is to conclude the study by presenting a brief summary of the literature on postpartum depression (Chapter 2) and the empirical research results of this study (Chapter 4). Resemblances and possible inconsistencies between the literature and the empirical findings of this study, as discussed in Chapter 4, will be concisely summarised. Subsequently, assumptions are made by first answering the secondary research questions, and finally, the main research question that directed this study. Lastly, recommendations are made for health care providers, support programs, families, mothers and future research.

5.2 SUMMARY OF LITERATURE AND EMPIRICAL RESEARCH FINDINGS

This section contains a summary of both the literature that was consulted for this study as well as a summary of the empirical research findings.

5.2.1 Summary of key literature findings

Throughout the literature, it became evident that postpartum depression is no new concept but rather a common experience for new mothers. This depression not only has an effect on the mother, but also on her extended family as well as her social connections. For South African woman, the greatest challenge is ongoing health care and routine screening with postpartum follow–up sessions. Not only can the health care be an obstacle, but also the knowledge and stigma regarding postpartum depression (see Section 2.2).

Depressed mood, lack of interest, anxiety and low self–esteem are only a few of the symptoms experienced by mothers with postpartum depression (see Section 2.2.1). These symptoms can occur within four weeks after giving birth. Moreover, postpartum depression can follow from antenatal depression or depression during the pregnancy. Various factors contribute to postpartum depression, such as the levels of support the mother receive from health care professionals, spouses, family and friends (see Section 2.2.2.1). Furthermore, mothers experience stress after giving birth because of life changes and mostly caring for their new born baby (see Section 2.2.2). These symptoms hold great risks for the relationship between a mother and her child.

These influences have a broader effect on the present, but also the future of the child's development. According to the literature, children of depressed mothers tend to develop behavioural, emotional and attention problems later on. Whilst the research indicates that young children mirror their caregivers' expressions and behaviour and that their emotional developmental problems may emerge from their early interactions with depressed mothers (see Section 2.2.3.1). Postpartum depression also cause disruption in a marriage or relationship, since the mother withdraws herself from those around her. The treatment options available in South

Africa includes regular appointments with a general practitioner or a psychologist, a psychiatric assessment if anti–depressants are necessary and support groups.

John Bowlby's Attachment Theory supplied a broader perspective on the importance of the forming of an attachment between a caregiver (mother) and her young child. Bowlby and his cofounder classified attachment n four styles namely: secure, insecure, avoidant and ambivalent and disorganised. Each of these styles represent attachment behaviour in a child according to the bond they formed with their mother. Studies show that there is a definite correlation between postpartum depression and the young child's emotional development according to their attachment style (see Section 2.3.1.2).

Various literature studies were consulted to define emotional development and correlate it to the influence of a mother on a young child's emotional development (see Section 2.2.3.1). Emotional related capabilities and abilities (also called skills) a child needs to be able to adapt to changing environments as they grow and develop emotional competency were identified (see Section 2.4.1). These skills are part of an interpersonal exchange that develops in a unique context such as an emotional bond with a mother figure as an example of emotional competence. Literature shows that in young children of mothers who use more expressive language regarding how they feel when communicating with them, emotional development were the highest. Therefore, a mother plays an important role in a child's emotional development. Sroufe (1997:161) developed a structure (refer to Table 2.3) that depicts issues that may arise during the development of an infant and that are sequential, and describes the issues in infant emotional development as well as the role of the caregiver towards these issues (See section 2.4.1). Physical or emotional unavailability of the mother contributes to the emotional developmental problems since the mother are not there to act as an emotional stimulator for the young child.

5.2.2 A short overview of the empirical research findings of this study

The participants in this study were three mothers who struggled with postpartum depression. Semi-structured interviews were conducted with each of the participants

in a neutral setting. After each interview, the participants were asked to write a narrative reflection regarding their experience with postpartum depression. Through the interviews and narratives, the researcher gained sufficient data for this study to develop a deep understanding of the effect postpartum depression has on a young child's emotional development. Through inductive data analysis and interpretations, a number of findings were made.

First of all, postpartum depression had a major influence on both Louise's and Nonni's young children. Due to Louise's intense experience with postpartum depression, Mari [Louise's daughter] presented with various emotional developmental problems including behavioural problems, temper tantrums, emotional outbursts, concentration problems and excessive crying. According to the educational psychologist, Louise and her husband had to get professional support for Mari. Mari's pre-school also advised them to seek professional help. At the time of the study, Mari displayed behaviour typical for a three-year-old although she was already 5 years old such as crying for attention, short attention span and tantrums to get what she wants. The goal of the therapy was to help Mari to progress to the level of emotional competency of a five-year-old since she had to attend Grade R the following year and therefore had to be school ready (see Section 2.4.1). During the interview, Louise often stated that she felt responsible for Mari's developmental problems (see Section 4.2.1).

Louise was admitted to a psychiatric hospital at two different occasions, which caused long periods of absence from Mari's life. She also had repeated episodes of postpartum depression as mentioned by Dennis et al. (2004:338) (see Section 2.2.3), leaving Mari emotionally vulnerable. Louise and Mari had no attachment at first (see Section 2.3.1). This left Louise feeling incapable of caring for her young child. The empirical research and the literature consulted led the researcher to the conclusion that Louise and Mari formed an insecure, ambivalent and disorganised as classified by John Bowlby and Mary Ainsworth together with Rosmalen, Veer and Horst. Mari could not use her mom as a safe haven from where she could explore the environment around her as Louise mentioned that she was incapable of calming Mari when she felt in distress.

Jack, Louise's husband, had to compensate for the role of mother and father. He mostly made all the decisions on behalf of Louise as she was often indecisive and lacked interest in her baby, family and friends. Due to the fact that the father predominantly cared for Mari, she formed a closer bond with him than with her mother (see Section 4.2.1.2). Louise explained that she is working on improving her bond with her daughter, now five years old, by being more involved in her activities and showing more interest. When Louise experienced postpartum depression, her husband Jack was very supportive, as well as her parents and in-laws.

According to Nonni, her son did not show major developmental problems as was the case with Mari, however he was more focused on Nonni's feelings and emotional state. He often reacted in a sensitive manner when she was emotional. Nonni stated that her son would feel uncertain and get upset whenever she felt depressed or sad. When her son turned nine, she took him to a psychologist. Nonni revealed that the therapy sessions helped her son. Nonni first had to learn to accept her circumstance and learn to love and accept except her son, after four years of struggling with postpartum depression (see Section 4.2.2).

Nonni only confided in her pastor and his wife after four years of struggling with postpartum depression, which led to her attending psychology sessions. For four years, Nonni felt absent as a mother to her son. She struggled with the fact that her son was conceived due to her being raped at the aged of 17 (see Section 4.4.2.3). Since Nonni felt emotionally and physically absent for the first four years of her son's life, an insecure attachment formed between mother and son (see Section 2.3.1.2). Furthermore, Nonni's son had an inability to find comfort from his mother and to reengage successfully in exploration of his environment.

Nonni had no support system, since her grandmother fell ill and her sister was in foster care. She had to work through her depression alone. She had to take care of her son on her own, which added additional stress to the relationship (see Section 4.4.2.2).

The third participant, Elsabé, was the only participant who felt that her daughter showed no developmental delays due to her postpartum depression. She

elaborated that her child, as reported by her husband, may have cried more often during the time that she was admitted to a psychiatric hospital, Weskoppies, for the first time (see Section 4.2.3). Elsabé is also the only participant who was treated and diagnosed within a reasonable time, which could have been the reason that her daughter was not as affected by postpartum depression as Louise and Nonni's children. Elsabé had a relapse two years later and was admitted to Vista psychiatric hospital.

Elsabé's daughter formed a closer attachment with her father since he had to take care of her during the time Elsabé was admitted to Weskoppies. Elsabe's daughter is already a 27-year-old woman and to this day, has a closer bond with her father. Elsabe explained that her husband was very supportive along with her parents and parents in law (see Section 4.4.2.2).

From the empirical data it became clear that postpartum depression has a definite effect on a child's emotional development. Although all the mothers in this study aspired to do their best, it was evident in this study that it is difficult to prevent the effects of postpartum depression on a young child. External and internal factors significantly influenced postpartum depression. Additional support for the young children who is affected by their mothers' experience with postpartum depression, will be advised. It is also important to note that the findings were limited to the participants of this study. Any generalisations should be carefully considered.

5.3 RESEARCH CONCLUSIONS

In the next section, the research questions (see Section 1.3) will be answered in order to draw a final conclusion of the research study. The secondary research questions will be answered first as they lead up to answering the main question of the study:

5.3.1 Secondary research question 1:

What role does the mother play in the emotional development of her young child?

The literature that was consulted in Chapter 2 emphasises the importance of a mother as the one person who models certain behaviour that is often imitated by a young child (see Section 2.4.1). The mother's regulation of her emotions is noticed by the child and therefore the young child also learns from the mother to regulate their own emotions. Furthermore, all three the participants admitted that the mother plays a major role in the child's emotional development (see Section 4.4.3). Louise described that her daughter started to display the identical emotional tantrums as Louise did when she battled with postpartum depression. Nonni admitted that her son's insecurity and sensitivity towards her emotions could be the results of the time that she withdrew herself from him. Literature also indicated that mothers who spoke about their emotions and taught their children the importance of voicing their feelings, were capable to regulate their emotions and showed the best emotional development.

5.3.2 Secondary research question 2:

How do mothers perceive the influence of postpartum depression on the emotional development their young child?

From the start, Louise felt that due to her experience with postpartum depression, she was to blame for her daughter's emotional and behavioural developmental problems (refer to Section 4.2.1.2). Louise was of opinion that if she was diagnosed earlier and better informed, her daughter's development would have been more age appropriate and effected less (see Section 4.2.1.2 and 4.4.3). Louise also admitted that her daughter preferred her husband to herself. Mari, formed a closer attachment with Louise's husband due to Louise's experience of postpartum depression.

As mentioned before, Nonni felt that her son's insecurity and sensitivity towards her emotions could be the result of the time that she withdrew herself from him and neglected him. Due to Nonni's experience with postpartum depression, she had to learn to love and accept her son at the age of four. After both Nonni and her son received counselling, they formed a strong attachment (see Section 4.2.2.3).

According to Elsabé, her experience with postpartum depression had minor effects on her daughter. Excessive crying was the one of the effects she noticed during the time she was admitted in the psychiatric hospital. The only noticeable long-term emotional effect that Elsabé mentioned was that her daughter formed a close bond with her father (see Section 4.2.3.1).

5.3.3 Secondary research question 3:

What guidelines can be developed for mothers who suffer from postpartum depression with relevance to the emotional development of a young child?

Through studying extensive literature (see Section 2.4) and the empirical research findings (see Section 5.2.2) the following guidelines for mothers became clear:

- Remember that prenatal experiences of depression, stress and anxiety could have an effect on an unborn baby.
- Be informed about the warning signs, symptoms and treatment available for postpartum depression.
- Talk to others that might be in the same position as you. Accept support and advice given by others.
- Voice emotions from an early stage towards a young child to enable your child with the skill to regulation of his/ her emotions.
- Remember that the emotional behaviour a mother displays will be reflected by the young child.
- Even though overwhelming feelings are present, try to stay involved in a young child's life by completing small tasks.
- Forming attachments with a young child has a great influence on the child's emotional development, which is why early diagnosis and treatment are of utmost importance.
- Emotional and physical support from loved ones is important. These are the people that step in when you feel you are not capable to look after yourself and child.

5.3.5 Main research question:

What are the views of mothers on the effect of postpartum depression on the child?

Postpartum depression affects a mother's ability to react to her young child crying or communication and the mother's ability to think logically about certain situations. Furthermore, studies indicate that mothers who struggle with postpartum depression is more likely to be less loving and caring towards their children. Although any generalisations should be carefully considered, the researcher found in this study that three of the mothers admitted that caring for their young children were too much for them to handle. It is known that these mothers often have more emotional break downs and show less emotion towards their children. While these mothers continue to try to deal with their postpartum depression and the associated symptoms, young children may start to imitate their mother's facial expressions, emotional regulation and communication techniques as well.

The influence of postpartum depression is far-reaching with serious consequences, not only for the mother's health, but also for her relationship with her child and family. This is illustrated by the three participants who either withdrew themselves from their loved ones or having to be admitted to psychiatric hospitals. The attachment between mother and child is often compromised due to postpartum depression. In this study, the mothers often withdrew from their children and lost valuable bonding time with their children. In this study it was also apparent that the children of mothers who suffer from postpartum depression often felt insecure regarding their mother and their environment. According to Halbreich and Karkun (2006:98), various developmental problems occur when there is a weak attachment between a mother and her child. Behavioural problems such as anger and aggression to provoke a response, as well as emotional displays such as unnecessarily crying or screaming and concentration difficulties are the three most common problems. The findings in this study correlated with the literature as mentioned above, as informed by Louise and Nonni along with Elsabé.

Furthermore, in this study the researcher found that the impact of postpartum depression was not as big due to the support of the loved ones of the mothers. This

finding of the study was not found in the literature consulted in Chapter 2. Both Louise and Elsabé had their husband's, parents and parents-in-law who supported them during their troubled times. Nonni had her pastor and his wife who supported her and ensured that she received the treatment she needed. Any generalisations of the findings of the study should be carefully considered.

The following recommendations could guide parents, teachers and medical institutions to support mothers who struggle with postpartum depression. This can also assist children who have developmental problems due to their mother's postpartum depression. Further research might find more solutions and prevention methods for those who battle with postpartum depression and the young children influenced by it. It is also important to note that the findings were limited to the participants of this study. Any generalisations should be carefully considered.

5.4 RECOMMENDATIONS

With reference to the findings of the research, the following recommendations are made to health care providers, support programs, families, mothers and further research:

5.4.1 Recommendations for health care providers

The following recommendations are directed at health care providers for the promotion of young children's emotional development with relation to their mother's health:

Recommendation 1

Postpartum depression awareness sessions could be held with the mothers and their families during the prenatal period to ensure that the mother as well as those around her has the necessary knowledge of what symptoms to look out for and the effect it can have on the child. These sessions can promote awareness of postpartum depression and possibly overcome the stigma associated with it.

Mothers can feel more empowered to know what to expect and how to help their child if it happens to them or other mothers around them.

Recommendation 2

A mother's wellbeing is just as important as the young child's health and development. During regular follow-up consultations with the mother and child, health care professionals must take intense interest in the mother's mental and physical wellbeing to try and prevent or control the effect of postpartum depression on the mother and her child. The mothers will be more assured that how they are feeling is just as important as their child and that they have someone to talk to and receive advice from.

Recommendation 3

Health care professionals can keep mothers informed of the available support programs to them by providing the mothers with information pamphlets when they are discharged from the hospital. These pamphlets can contain more information about the services provided by psychologist, psychiatrists and support groups meetings in the neighbourhood.

5.4.2 Recommendations for support programs

The following recommendations are focused on support programs for the support of mother's who were diagnosed with postpartum depression and the promotion of emotional development of their children:

Recommendation 4

From the literature it is evident that most mothers feel intimidated by big groups of people taking about their programs and experiences. Rather have smaller groups with no more than 10 mothers. Within the smaller groups, these mothers will feel more comfortable and safer to share the experience as well as advice. At least one professional per group, to lead the support group and give a more professional input,

should be available. This will ensure these mothers that there is someone with knowledge of postpartum depression and the influences thereof to give them the support and advise they need and want.

Recommendation 5

Providing individual support sessions to the mothers who need it, will help especially the mothers who cannot afford therapy by psychologists or psychiatrists. By providing this service, more mothers could be reach out to, which will lead to less children with emotional developmental problems. These sessions can be empowering to these mothers to ensure that they form an attachment with their young child and the proper emotional development of their child.

Recommendation 6

Relevant topics to be addressed during the support group sessions could be:

- Adjusting to new routines in the home environment with a new baby around.
- Coping strategies for days when mothers feels incapable.
- Feelings towards the new baby, partners, husband and family.
- Accepting support from others.
- Activities and ways to form an attachment with a young child.

5.4.3 Recommendations for families

The following recommendations are focused on the families of mother's who struggled with postpartum depression and the promotion of emotional development of their children:

Recommendation 7

Families could ensure that they are informed about postpartum depression, the associated symptoms and treatments available for the mother during the prenatal period. Not only will they know what signs to recognise, but how to respond in a

situation or incident of postpartum depression if they suspect that the mother might be struggling with postpartum depression.

Recommendation 8

The support of family and friends is important to ensure that the mother feels loved and completely supported by those who love her without overwhelming her with constant advice. The mother needs to know that she can talk to her loved ones without any judgement. Giving her time to talk, cry or ask advice if she feels like it, whenever suits her. Instead of constantly asking, phoning or doing house visits, rather let her know you are there to help with what she needs. Just knowing there is someone looking out for her might make her feel more secure umongst those who love her.

Recommendation 9

Complete small tasks for the mother such as washing the dishes, doing the laundry or tiding up the house. Mothers feels overwhelmed with their new responsibility, and stressing about regular house chores just add to it. Ensure that the mother feels like she is in a partnership instead of the mother who has to do everything, because that it is what is expected from her. Tasks such as bathing and feeding the new baby can also be shared or done together to make it more enjoyable and less stressful for the mother.

5.4.4 Recommendations for mothers

The following recommendations are focused on the mothers for the promotion of emotional development of their young children:

Recommendation 10

Develop a routine along with a loved one or friend to help with the baby. This routine can include the following activities to ensure emotional development of the young child:

- Reading a story aloud.
- Singing short songs.
- Talking in a calming manner to the young child.
- Soothing touching the young child.
- Sharing emotions with the young child.
- Spending time with the child.
- Taking short walks.
- Join a “mommy and me” group.
- Encourage family time.
- Activities which can be done with the young child.

Recommendation 11

Set weekly goals for both the mother and child and try to keep to it. These goals can be developmental activities for the young child, relaxation activities or exercise for the mother and later on for the young child. These goals can be increased as the child grows and develops. Later on, the child can have a say in some of the goals to be completed. Some examples of goals: walking for 15 minutes outside daily, exploring new age appropriate toys or easy activities for the development of the young child. Having goals for each week and trying to complete it, gives the mother something else to focus instead of just her child. Furthermore, the goals that are chosen should be easy to complete and enjoyable for both the mother and her baby.

5.4.5 Recommendations for further research

The following recommendations are made for further research:

Recommendation 12

While the findings of this study are important and provide valuable insight into the connection between postpartum depression and the emotional development of the young child phenomenon, it was is without limitations. There are several avenues for future research that can build upon the results of this research endeavour,

therefore, the recommendations for further study to provide more insight into the extent of the influence of postpartum depression on a young child phenomenon:

- Other research studies must contain bigger groups of participants to be able to compare the results to other studies and to ensure more reliable results.

- The research should go beyond the current situation into an intervention research, where participants will be given some form of intervention and support to mitigate them in their present experience. Thus, results from this study should be used to develop informed and practical strategies to promote child development whilst battling with postpartum depression.

- Studies to follow up on children older than four years old with regards to their attachment to their mothers after the monther's battle with postpartum depression and coping with the challenges of school performance will be beneficial for teachers in the Foundation Phase, in order to understand a child better.

- Further research should be carried out to broaden the knowledge base of the postpartum depression effects on young children. This will allow for policy or programme development to be focused on supporting and assisting mothers and families with no means to attend follow up doctor's consultations or closer health care facilities in certain parts of South Africa.

- Future studies should focus on the role of the father figure in a young child's development in circumstances where the mother is battling with postpartum depression. This will moving the focus from the mother's experience to the effect it has on a father figure and how they deal with it.

5.5 CONCLUDING REMARKS

The purpose of this study was to explore the motherhood views on the effect of postpartum depression on the child.

Through conducting an in-depth literature study on postpartum depression and emotional development, the researcher discovered the importance of knowledge regarding postpartum depression and the impact thereof on the attachment between mother and child as well as effect on the emotional development of the child. The empirical part of the study revealed that postpartum depression has a severe effect on a child's emotional regulation and that support was an integral part in overcoming depression.

Even though the research findings cannot be generalised, it was an in-depth qualitative study of the experiences of mothers and findings indicate that there is a definite correlation between postpartum depression and the emotional development of the young child. As a mother is present from the first day of a child's life, the child depends on the mother to teach him/her about emotions and handling them in an appropriate manner. Therefore, the researcher argues that all mothers should be informed about postpartum depression, as well as their role in their child's emotional development. Mothers should also be guided in promoting optimal emotional development for their child. The sincere advice of the three participating mothers should be taken to heart as to assist mothers who are struggling to overcome postpartum depression.

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ANNEXURES

ANNEXURE A – Consent form

October 2016

Dear Madam,

INVITATION TO PARTICIPATE IN RESEARCH STUDY

I am currently a MEd student at the University of Pretoria, in the Faculty of Education, Department of Early Childhood Education. I am conducting a research study, titled: "The correlation between postpartum depression and the emotional development of the young child". The aim of my study is therefore to explore the connection between post-natal depression and how young children develop emotionally.

As you have experience with postpartum depression I request your participation in this study which will involve writing down your experience with postpartum depression in a narrative form as well as granting me an interview afterwards. The following explanation will provide you with the necessary information to make an informed decision:

I shall be providing you with a prompt to guide you with the writing of a narrative and it will focus on your experience with postpartum depression and the effect it had on your young child. An interview will then be conducted, where I shall ask you specific questions to gain more clarity on some aspects of postpartum depression and the impact on your child's emotional development. This interview will last for about two hours and be audio-recorded to make enable me to revisit the conversation.

All the information will be treated with strict confidentiality and anonymity which means that I will not make use of your name anywhere in the course of my fieldwork and writing. Information that is collected during the course of this research project will be stored safely even after the task is complete. You may choose to withdraw from the research process at any stage should you deem this necessary. There will also be a psychologist available to allow for debriefing, should you wish to talk to a professional on your experiences with postpartum depression.

The research is conducted under the auspices of the University of Pretoria's ethic committee and as research all participants will remain anonymous.

The findings of the study may provide mothers who struggle with postpartum depression with information and guidelines on how to combat the negative impact of this syndrome on the emotional development of their children. Possible support groups may also benefit from these guidelines. Information garnered may continue to enrich the body of knowledge in a way to finding solutions to this phenomenon.

I trust that you will review my request favourably as to enable me to conduct my research in an ethical manner. I shall greatly appreciate your response at the end of this letter.

Yours sincerely,

Lelanie van Rensburg
Signature ……………………
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Dr. M. G. Steyn
Signature ……………………...

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Ms. M Moen
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ANNEXURE B – Interview questions

1. How did you feel when you discovered for the first time you were expecting a baby? Probe: Can you describe your emotions?

2. As you know we are interested in your specific experiences of post-partum depression. I would like to know if you already experienced feelings of depression during your pregnancy?

3. Was there a specific incident or emotions that you experienced that were an indication that something was wrong before you were diagnosed?

4. Please describe your emotions immediately after the birth of your child. Did you emotions change after the first few months? If yes, how?

5. When did you realise you are battling with postpartum depression? How did you handle it?

6. How long did you wait before you consulted a doctor about your depression? If you waited more than 6 weeks, why?

7. What were your thoughts about anti-depressants or any other forms of medication?

8. Did you ever join a support group or any other form of support besides your family and friends? Explain your answer.

9. What support systems, if any did you have after the birth of your child?

10. What role do you think a mother plays in the emotional development of her young child?

11. Do you think your depression influenced your child's emotional development? If yes, how?

12. Did you ever get external support to assist your child's development in general/with his/her emotional development? If yes, did the support help? Explain your answer.

13. Were there any external factors that could have triggered your postpartum depression? How did you deal with these factors? (e.g. stress at home, marriage difficulties, financial problems)

14. Were there any internal factors that you were battling at that stage that could have triggered or contributed to your depression? (maybe depression from an early age, other psychological factors, low self-esteem)

15. What type of support could have helped you at that stage to overcome postpartum depression?

16. What helped you eventually to overcome the depression? Or are you still battling with the symptoms of depression?

17. What advice can you offer to mothers who are suffering from postpartum depression?

18. Do you want to add anything?

ANNEXURE C – Narrative guidelines

The purpose of the narrative is to “tell your story” as part of the data collection for my study. Through your “voice, viewpoint” I will be able to collect more rich and in-depth data to answer my research questions. When writing this narrative, please be as descriptive as possible.

The following are only guidelines to help you with the writing of your narrative:

With regard to your experience of postpartum depression:

- Earliest signs of your depression.

- The symptoms that you experienced.

- The feelings that you had towards your baby.

- The influence your experiences could have on your baby (crying, sleeping problems, feeding problems etc.).

- The bonding/ attachment that formed between you and your baby and which influenced your relationship with your child - as baby and also currently.

- The support you received (loved ones/friends/spirituality/institutions etc._,

Thank you for your participation.

ANNEXURE D – Ethical clearance certificate

Ethics Committee
23 February 2017

Dear Ms LL van Rensburg

REFERENCE: EC 16/11/01

We received proof that you have met the conditions outlined. Your application is thus approved, and you may continue with your fieldwork. Should any changes to the study occur after approval was given, it is your responsibility to notify the Ethics Committee immediately.

Please note that this is not a clearance certificate. Upon completion of your research, you need to submit the following documentation to the Ethics Committee:

- Integrated Declaration Form (Form D08),
- Initial Ethics Approval letter and,
- Approval of Title.

Please note:

- *Any amendments to this approved protocol need to be submitted to the Ethics Committee for review prior to data collection. Non-compliance implies that the Committee's approval is null and void.*

- *Final data collection protocols and supporting evidence (e.g.: questionnaires, interview schedules, observation schedules) have to be submitted to the Ethics Committee before they are used for data collection.*

- *Should your research be conducted in schools, please note that you have to submit proof of how you adhered to the Department of Basic Education (DBE) policy for research.*

- *Please note that you need to keep to the protocol you were granted approval on should your research project be amended, you need to submit the amendments for review.*

- *The Ethics Committee of the Faculty of Education does not accept any liability for research misconduct, of whatsoever nature, committed by the researcher(s) in the implementation of the approved protocol.*

- *On receipt of the above-mentioned documents you will be issued a clearance certificate. Please quote the reference number: EC 16/11/01 in any communication with the Ethics Committee.*

Best wishes

Prof Liesel Ebersöhn
Chair: Ethics Committee
Faculty of Education

ANNEXURE E – Psychologist consent form

October 2016

Dear Sir/Madam,

INVITATION TO ASSIST IN THE CONDUCT OF RESEARCH

I am currently a MEd student at the University of Pretoria, in the Faculty of Education, Department of Early Childhood Education. I am conducting a research study, titled: "The correlation between postpartum depression and the emotional development of the young child". The aim of my study is therefore to explore the connection between post-natal depression and how young children develop emotionally.

As you have knowledge of postpartum depression I request your participation in this study which will involve that you will be available for any of the participants if it happens that they might need counselling, when talking about their postpartum depression proves to be traumatic for any of the participating mothers. The following explanation will provide you with the necessary information to make an informed decision:

I shall be provide the participants with a prompt to guide them with the writing of a narrative and it will focus on their experience with postpartum depression and the effect it had on their young child. An interview will then be conducted, where I shall ask the participating mothers specific questions to gain more clarity on some aspects of postpartum depression and the impact on their child's emotional development. This interview will last for about two hours and be audio-recorded to make enable me to revisit the conversation.

All the information will be treated with strict confidentiality and anonymity which means that I will have to require for you to complete a declaration form to ensure that all participants' information will stay confidential during and after this study. You may choose to withdraw from the research process at any stage should you deem this necessary.

The research is conducted under the auspices of the University of Pretoria's ethic committee and as research all participants will remain anonymous.

The findings of the study may provide mothers who struggle with postpartum depression with information and guidelines on how to combat the negative impact of this syndrome on the emotional development of their children. Possible support groups may also benefit from these guidelines. Information garnered may continue to enrich the body of knowledge in a way to finding solutions to this phenomenon.

I trust that you will review my request favourably as to enable me to conduct my research in an ethical manner. I shall greatly appreciate your response at the end of this letter.

Yours sincerely,

Lelanie van Rensburg
Signature ……………………
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