CHAPTER 5

A CULTURAL APPROACH TO PERINATAL MOOD DISORDERS

5.1   Chapter Preview

Comparative and cross-cultural researchers are faced with deceptively simple questions that need to be considered. Do given syndromes exist in all cultures? If so, then are the syndromes as common in every setting? Are the clinical features the same? Are there any major differences in etiology, course, and outcome? And is there any difference in how they are managed and treated?

Childbirth is a universally similar physiological event for women. It does, however, occur in a socio-cultural context causing the experience to be filtered, mediated, and directed, at an individual as well as a social level, by culturally constituted frameworks. The transition to motherhood is therefore experienced and conceptualized according to a person's specific beliefs, values, and attitudes.

Most of the research on PPD has considered the biological and psycho-social etiologies such as hormonal changes, maternal age, psychiatric history, and level of support. Although these are important contributing factors, the impact of socio-environmental factors, the cultural patterning of childbirth, and the post-partum period as an etiology in PPD also need consideration. This chapter will also discuss some cultural approaches to the understanding of childbirth and related mental disorders as well as how these impact on adapting a postpartum depression screening measure cross-culturally.

5.2 Paradigms of Mental Illness

Biological, psychological, cultural, and sociological theories have all sought to explain the onset of mental illness. The Universalist approach regards mental illness as a disease that has the same set of symptoms, the same diagnosis and treatment, and the same prognosis across the world. This approach is based on the medical model which regards factors like organic brain disease due to either genetic, biochemical or physiological causes as the contributor/s in the onset of mental illness, with pharmacotherapy as a main treatment option. The medical model is a leading approach in psychiatry in Western societies. This paradigm, which regards mental illness as a biological or disease model, is the way in which mental illnesses in the United States of America is categorized and classified (Goldbort, 2006).

The paradigm that regards culture or environment or society as the core contributor/s in the onset of mental illness is the sociological or environmental model. This model views mental illness as violations of, or deviations from certain norms in society. Treatment for an individual from this perspective would require changing societal issues contributing to the individual's stress, such as poverty or sexism.

Mental illness should, however, be viewed as a multifaceted illness that requires the philosophical underpinning of both these paradigms. The exclusion of either one in seeking to understand the impact of mental illness does a disservice to improving the outcome for individuals with mental illness.

A number of studies have indicated that the etiology of PPD lies in multiple factors – psychological, familial, hormonal-biological, social, and cultural (Beck, 2001; Clay & Seehusen, 2004; Halbreich, 2005; Kruckman & Smith, 2006; Leung, 2002; O'Hara & Swain, 1996). Kirmayer, and Lazarus and Folkman, emphasized that cultural factors have a significant impact on one's emotional state (as cited in Bina, 2008, p. 569). Some cultural practices and beliefs can significantly influence PPD, either positively or negatively (Bina, 2008). Cultural factors, along with social, psychological, and biological perspectives, must be taken into account in order to fully comprehend PPD (Bina, 2008; Cox, 1999; Harkness, 1987; Leung, 2002). It is also important to consider all the correlates of PPD across different populations to determine whether PPD is a universal experience or a condition that is specific to Western cultures, and to determine how the illness is expressed in other cultures.

5.3   Prevalence of PPD Across Different Cultures

Research about PPD has mostly been carried out in Western cultures (Affonso et al., 2000). Furthermore, the reported prevalence of PPD in non-Western cultures is variable, with prevalence rates varying from 0% to 40%. The reason for the discrepancy in PPD prevalence is uncertain, but researchers believe that it may be due to any of the following factors: that PPD manifests differently in different cultures, low prevalence rates in some cultures may be due to cultural protective factors, the diagnosis of PPD may be more unacceptable in some cultures or not used at all, or that the clinical criteria documented in the DSM-IV-TR is not sufficient to incorporate cross-cultural diagnostic

standards (APA, 2000; Fitch, 2002; Kleinman, 2004; Miller, 2002; Posmontier & Horowitz, 2004; Yoshida, Yamashita, Ueda, & Tashiro, 2001). Attempts to investigate the relationship of postpartum traditional practices with PPD amongst non-Western and Western cultures are made more difficult in light of the factors suggested above.

Stern and Krukman's review (1983) of the cultural aspects of PPD advocates that the phenomenon "postpartum depression" is a culture-bound Western syndrome that is not likely to occur in a non-Western society. They maintain that a significant contributing factor to the onset of PPD in Western societies is a lack of organized social support. More recent publications (e.g. Affonso et al., 2000) indicate that PPD does, however, cross cultural boundaries and is not a culture-bound illness. Posmontier and Horowitz (2004) comment that Stern and Kruckman (1983) failed to address the possibility that expressions of PPD may vary according to culture.

The birth of a child, especially the first child, is arguably a significant life event for any women – or man – regardless of their cultural background. A new baby in a household also impacts on the family's financial budget and on the work load of the mother. Hormonal changes are dramatic during pregnancy and shortly after delivery, and their contribution to depressive symptoms postpartum has been indicated (Ahokas et al., 1999; Altemus et al., 2004; Bloch et al., 2000; Bloch et al., 2003; Epperson et al., 2006).

Halbreich and Karkun (2006) state that "if a comprehensive bio-psychosocio-economic model is applied to the postpartum period (as it should), then it is difficult to explain how such a significant life event would not result in distress in at least some mothers in any culture." (p109). Despite evidence of the psychological, socio-ecomonic,

and hormonal impact of childbirth on women, the question whether PPD is specific to certain cultural contexts and whether it is influenced by cultural factors has often been raised.

In an attempt to answer this question, numerous researchers have sought to determine the prevalence of postpartum psychiatric illness in various cultures and countries and explored the socio-cultural factors associated with childbirth. Epidemiological studies and survey results from a variety of different cultures across the world report increasingly high rates of PPD (Rahman et al., 2003). Some examples include studies from India (Patel et al., 2002), Turkey (Inandi et al., 2002), United Arab Emirates (Ghubash & Abou-Saleh, 1997), China (Wang, Jiang, Jan, & Chen, 2003), Hong Kong (Chan & Levy, 2004; Lee, Alexander, Yip, Leung, & Chung, 2004), and Latina and African American women (Yonkers et al., 2001). For the most part, these studies show no substantial difference in the rates of PPD and that the risk factors for PPD are similar.

Researchers agree that PPD is a universal experience, even though it may be referred to by a different name by various cultures. Cox (1999), for instance, maintains that PPD is not limited to certain cultures and states that PPD is readily identified in traditional African cultures too. Cox (1999) points out, however, that there is a paucity of research and literature on postpartum mental disorders in African countries. This may be due to the lack of resources and also possibly due to an attitude that these disorders are of no serious consequence and occur infrequently.

Halbreich and Karkun's (2006) review of the literature on the prevalence of PPD and depressive symptoms in a variety of countries found that PPD was prevalent in 40 countries – although in some countries there were very few reports while other countries, including South Africa, had high prevalence rates. They attribute the variability in reported PPD due to a multitude of cross-cultural, socio-economic, and environmental variables, along with biological vulnerability factors.

The Transcultural Study of Postnatal Depression (TCS-PND) was done across several cultures simultaneously to determine the universality of the concept of postpartum depression. This study also examined and compared the correlates of PPD, its prevalence, the psychosocial origins, as well as the consequences of PPD (Asten, Marks, & Oates, 2004). In the initial phase of the study, Oates et al. (2004) explored the understandings, views, and beliefs regarding what constituted happiness or unhappiness antenatally and during the postpartum period. A common theme emerged across all centres in the 11 countries that participated in the study which revealed that a morbid state of unhappiness occurred after delivery with similar characteristics and attributes. Not all centres, however, recognized it as a specific illness with a definite name – like postpartum depression. Participants described characteristics that met the criteria for diagnosing PPD and attributed the unhappiness to family and marital problems, as well as practical and emotional support. Oates et al. (2004) concluded that new mothers from non-Western societies may be protected from becoming depressed due to the role of social support present in their communities.

Gorman et al. (2004), in keeping with the goal of the TCS-PND study (to develop, translate, and validate PPD research measures for use in different countries and cultures),

used and adapted the SCID (Structured Clinical Interview for DSM-IV Disorders) and the EPDS to determine whether the rates of PPD vary across different cultures. They concluded that the overall estimated rate of major depression in the postpartum period – 12.3% - was almost identical to the rate reported by O'Hara and Swain (1996) – 12% - in a meta-analysis of 59 PPD studies conducted across several European, Western, and non-Western countries over the preceding 20 years.

Goldbort's (2006) literature review on the transcultural analysis of PPD also examined women from various cultures to determine whether PPD is a universal experience. This review demonstrates that, although it may be labeled another way in different cultures, PPD is a universal experience. Non-Western cultures tend to use the term 'unhappiness' for PPD. An Ethiopian study found that postpartum mental distress was explained in terms of social adversity and was not considered to constitute a specific mental health illness afflicting postpartum women despite recognizing depressive symptoms (Hanlon, Whitley, Wondimagegn, Alem, & Prince, 2009).

The risk factors for PPD were similar cross-culturally, and included factors like a history of depression or mood disorders, an unplanned or unwanted pregnancy, significant stress in the previous year, child care stress, low social support, marital problems, and fatigue. One notable exception found which impacted on PPD was the sex of the infant. Indian, Turkish, and Chinese cultures favoured a male infant over a female infant. Goldbort (2006) further reports that non-Western cultures do not typically attribute the cause of PPD to biological or medical reasons, but rather to social and environmental reasons, such as lack of support, financial concerns, poverty, and lack of

support – factors that have also been found to contribute to PPD in Western societies (e.g. Horowitz & Goodman, 2005; Logsdon, Birkimer, Simpson, & Looney, 2005).

The majority of studies reviewed by Goldbort (2006) utilized the EPDS to screen for PPD, and the prevalence rates found corresponded to PPD prevalence rates in Western cultures. Halbreich and Karkun (2006) point out that the prevalence estimates have been reported to be greater in studies where self-report measures were used compared to interview-based studies (Ghubash & Abou-Saleh, 1997; Gotlib, Whiffen, Mount, Milne, & Cordy, 1989; Wickberg & Hwang, 1997). Samples and sampling methods also often differ across cultures and studies. This may contribute to the variation in prevalence rates (Eberhard-Gran, Eskild, Tambs, Samuelsen, & Opjordsmoen, 2002). Researchers have also investigated whether women from different cultures respond to self-report questionnaires in a different manner as reporting biases may impact on prevalence rates (Halbreich & Karkun, 2006; Yoshida et al., 1997). It was thought that women's cultural context, perceptions, and beliefs, and also whether there is a stigma associated with mental health in their culture may cause women to overestimate or underestimate their responses to self-report questionnaires (Dankner, Goldberg, Fisch, & Crum, 2000; Stuchbery, Matthey, & Barnett, 1998).

5.4   Environmental and Cultural Influence on PPD Prevalence

Differences across cultural and environmental norms may explain some of the variance in PPD prevalence rates (Halbreich & Karkun, 2006). The range of psychosocial experiences that are involved in childbirth is not likely to be the same in different

countries and cultures. Any number of socio-economic and environmental factors that are subject to culture-specific standards may impact on reporting styles across groups, and marked differences have been found across cultural groups (Dankner et al., 2000; Kumar, 1994). These include, amongst others, antenatal and postpartum access to healthcare, procedural differences, nutrition, religious customs, gender roles, organization of family structure, variations in the nature of marriage, quality of care available, actual or perceived levels of social support, social responses to a new birth, stress and adverse life circumstances like poverty or the perception of poverty, attitudes concerning pregnancy, motherhood, and mental illness, childrearing practices, and biological vulnerability factors. It is therefore possible to assume that there will be substantial differences between cultures in the incidence of depression, how soon after childbirth depressive symptoms occur, and other factors associated with childbirth.

Edge, Baker, and Rogers (2004) found no differences in the levels of depressive symptoms between White British women and Black Caribbean women. They did, however find clear indications that the psychological and social correlates of depression differed between these ethnic groups. This has implications for the theoretical models concerning the causes of perinatal depression, as these were predominantly constructed from studies of White women.

PPD was found to be less prevalent within certain traditional cultural settings (Halbreich & Karkun, 2006). Many non-Western societies have certain rituals and proscriptions that accompany the transition to motherhood and offers guidance and support as the mother adapts to her new role and responsibilities. Some researchers believe that this reinforces the maternal role transition and assists in relieving the new

mother of psychological and physical burden which may protect her from depression (e.g. (Cox, 1996, 1999; Dankner et al., 2000; Seel as cited in Oates et al., 2004).

Stern and Kruckman (1983) regard the lack of organized social support in Westernised cultures as a significant contributing factor to the onset of PPD. Bina's review (2008) of the impact of cultural factors on PPD concludes that not having cultural traditions may lead to an increase in PPD and that cultural rituals and traditions may lessen the impact of PPD. Furthermore, cultural rituals may potentially have a negative effect on a mother's postpartum mood if she does not perceive the rituals as helpful to her.

In certain eastern cultures, for example, a postpartum woman rests in bed for the first 3–6 weeks after childbirth while her mother or mother-in-law takes care of the infant and household chores (Huang & Mathers, 2001). Pillsbury suggests that this emotional and material support may boost a mother's self-esteem and help protect her from the stressful and demanding period of early motherhood (as cited in Lee et al., 1998, p. 436). Halbreich and Karkun (2006) warn, however, that there may be a delay in the onset of depression to later during the postpartum period, despite these supportive practices. Depression at around 2 or 3 months postpartum may therefore be a reaction to receiving very little postpartum support relative to the early postpartum period and being confronted with the harsh realities and demands of motherhood.

Certain Eastern and West-Asian cultures, and the Japanese culture in particular, differ considerably from Western cultures regarding attitudes towards childbearing, marriage, and social support for new mothers (Halbreich & Karkun, 2006). In some

Asian cultures a depressed mood is regarded as self-indulgent. The interest of one's family has a higher priority than individual interests. Self-definition is defined in terms of relationships and social roles, and a person's self-esteem relies on properly fulfilling these roles rather than cultivating individual potential. Therefore, an Asian woman who fulfils her role in her family and society is typically regarded as healthy. This perception of identity is contrary to the westernized concept of encouraging individualism, introspection, self-actualisation, and other self-notions (Furnham & Malik, 1994).

According to Morsbach, Sawaragi, Riddell, and Carswell (as cited in Halbreich and Karkun, 2006, p. 108) a Japanese woman's status is increased when she delivers a healthy baby and she may endure more psychological and physical discomfort for the sake of her infant's well being. This, coupled with the prohibition on crying in the first month after delivery, may result in mothers restricting emotional expression and underreporting symptoms of PPD (Halbreich & Karkun, 2006). Personal difficulties and emotions – which are considered a weakness – are encouraged to be suppressed as there is a heavy stigma attached to the diagnosis of a mental disorder. It has been suggested that the Japanese people's reluctance to express emotion and their reputed stoicism may account for the low prevalence rate of PPD in Japan (Kumar, 1994; Hau & Levy, 2003; Yoshida et al., 2001).

The stigma attached to mental illness is not limited to the Japanese culture. In other cultures females with symptoms of depression also did not seek support from healthcare services. Chandran, Tharyan, Muliyil, and Abraham (2002) argued that this may not only be due to the stigma associated with mental illness, but also the belief that a mother's

symptoms of depression are a "normal" experience associated with childbirth, or that they reflect a temporary period of maladjustment that will subside.

African cultures, like some Asian cultures, are known to place an emphasis on collective values and interests of the group as well as extended community support. This is in contrast to the Western societies' focus on promoting individual well-being and interest (Fouche et al., 1998).

The Transcultural Study of Postnatal Depression (TCS-PND) also revealed that, in the 11 countries that participated in the study, treatment by healthcare professionals for "morbid unhappiness" in the postpartum period was not necessitated (Oates et al., 2004). Widespread difference in the availability and utilisation of services for postpartum mothers and their infants has been reported (Chisholm et al., 2004; Huang & Mathers, 2001). This is another significant cultural factor that may influence reports of PPD prevalence rates as it puts mothers at increased risk for developing PPD (Halbreich & Karkun, 2006). The availability of health care professionals like psychiatric nurses, psychologists, social workers, and others who may provide care and support for women with PPD varies between countries – and even within countries. A study in a poor and over-crowded per-urban settlement in South African led researchers to conclude that there is a need for interventions aimed at preventing or ameliorating PPD and the associated consequences of PPD in the relationship between mothers and their infants (Cooper et al., 1999).

Patients from some cultures are also likely to seek assistance from traditional healers first before consulting someone from the medical profession. African[1] women who live predominantly in rural communities have a high regard for traditional beliefs and customs as they tend to have limited contact with Westernised medicine and methods of health care. These traditional cultural practices have a strong supportive function in these communities (Fouche et al., 1998). According to Rahim and al-Sabiae, mothers who have a long and difficult labour who do not have medical attention may also be at increased risk for PPD (as cited in Halbreich & Karkun, 2006, p. 109).

Cox (1999) describes some facets of perinatal psychiatry that require a specific socio-cultural perspective which are based on the reviews by Kumar (1994), O'Hara (1994), and Cox (1996) on cross-cultural issues within this field. In addition to the particular attitudes, knowledge, and skills that practitioners require when working in the field of perinatal psychiatry, the following facets also need consideration when working with people from different cultures (Cox, 1999, p. 105):

- Perinatal rituals, for example, the postpartum check-up, routinely taking iron tablets, socially sanctioned `lying in period'.
- Rites of passage including the separation, liminal, and reincorporation phases.
- Changing family structures: impact of, and reasons for, increase in single parenting, divorce, and separation.

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[1] The term 'African' as used herein, refers to those people of the African continent who share a philosophy of life termed 'African', as opposed to 'Western' or 'Eastern'.

- Kinship systems: the family and grandparents acquiring new roles.

- Naming and other religious ceremonies, for example, baptism, churching, other traditional ceremonies to declare legitimacy.

- Civil and religious understandings of the commitment implied in a long-term relationship – such as a marriage or cohabiting.

- The status of child bearing in society – dubious in the West, highly regarded in Africa and Asia.

- The structure of the family and in particular its support systems and kinship networks, like the availability of co-wives, peer support, and grandparents – especially the availability of the mothers' mother.

- Folk or popular names for perinatal mental health problems, such as blues, PPD, and psychosis.

- Choice of presenting symptoms of a perinatal mood disorder, for example, a headache, palpitations, feeding problems, not coping, and fatigue.

- Choice of healer (obstetrician for hormones; psychiatrist for antidepressants; general practitioners or health visitors for advice about baby, feeding, and sexual problems).

5.5   Symptom Definition and Expression Across Cultures

Symptom definition and symptom expression accounts for one of the foremost problems in studying PPD across different cultures (Reichenheim & Harpham, 1991; Wolf et al., 2002). In order to fully comprehend postpartum mood disorders certain

cultural factors must be taken into account together with social, biomedical, and psychological perspectives (Cox, 1999, p.103). Kruckman and Smith (2006) point out that the way a woman experiences non-psychotic PPD may be both cushioned and exacerbated by a number of socio-cultural factors. In different social worlds the manner in which a woman's depression is confronted, discussed, and managed varies. Furthermore, the course of the depression is influenced by cultural meanings and practices.

Several writers have indicated that culture determines what constitutes an illness as well as the appropriate response to that illness (e.g. Furnham and Kuyken, and Prince as cited in Furnham and Malik, 1994, p.107). Therefore, a person's cultural background, with its taboos and expectations, influences the way in which psychological factors and biological changes are perceived and acted upon. Culture influences the manner in which symptoms are experienced as well as the idioms used to describe them. This in turn has an impact on how that person responds to it, how the illness is described to a health practitioner, the decisions about treatment and the likelihood of certain outcomes like suicide (Furnham and Bochner, and Rack as cited in Furnham and Malik, 1994, p. 107; Kleinman, 2004).

Littlewood, a cross-cultural psychiatrist states that "current evidence suggests that the somatic symptoms of endogenous depression do seem to be universal" (as cited in Furnham and Malik, p. 107). Bashiri and Spielvogel (1999) argue to the contrary and claims that dysphoria and depressive illness manifest and are interpreted differently in non-Western and Western societies. Cultural attitudes, beliefs, ways of thinking, and cultural norms for behaviour and emotional responses have an impact on how an

individual experiences depression and seeks help. Furthermore, the languages of some cultures do not have as many words to describe depressive experiences as others.

It seems clear that PPD is not a culture-bound Western syndrome. It should therefore not be assumed that the method for evaluating it is culture-free. If broad or unstandardised diagnostic categories are used it creates uncertainty about the boundaries for a syndrome or illness and may also lead to observer error.

Understanding postpartum experiences, how depressive symptoms are expressed, and how it is assessed across different cultural groups are important considerations when screening for PPD as these may vary across cultural groups. Some cultures have their own indigenous definitions of PPD along with explanations of what causes PPD that are not outlined within the Western DSM-IV classification system (Bashiri & Spielvogel, 1999). Using standardized Western diagnostic classification systems and methods may be culturally insensitive as it increases the risk that some signs or symptoms which are prevalent in non-Western cultures will be missed (Okano et al., 1998). This may even be the case when the examiner is a local, but is more Westernised than the individual being assessed (Ghubash & Abou-Saleh, 1997).

People from Western societies tend to describe their distress in symptoms of depression whereas in non Western societies, it is expressed in somatic complaints. Asian, African and Hispanic cultures are more likely to express depression through somatisation (Bashiri & Spielvogel,1999; Park & Dimigen, 1995). Chang found that the difference in depression ratings across different cultures was mainly attributed to somatisation (as cited in Furnham and Malik, 1994). The Black classification group in his

study was characterized by a mixture of affective and somatic complaints, the White classification group by cognitive and existential concerns, and the Chinese group by somatic complaints. Chinese people do not report feeling sad, but rather complain that their hearts are being squeezed and that they feel weighed down and exhausted (Kleinman and Good, as cited in Bashiri and Spielvogel, 1999, p.82) or they express boredom, discomfort, and symptoms of dizziness, pain, and fatigue (Kleinman, 2004). Lee, Yip, Chiu, Leung, and Chung (2001) add that Chinese women tend to mention physical symptoms of depression like "wind illness", "wind inside the head", or head numbness. Japanese women are not inclined to express their depressed feelings, but rather express emotional complaints by referring to concerns about childcare or physical problems and symptoms (Yoshida et al., 1997; Yoshida et al., 2001).

Somatisation and hypochondriasis are typical of how depression is expressed in African cultures (O'Hara as cited in Bashiri and Spielvogel 1999, pp. 82-83). Nigerians typically describe symptoms of depression by referring to nausea or vomiting and feeling "hot in the head" (Jinadu and Daramola as cited in Halbreich and Karkun, 2006, p. 107). Nigerians suffering from depression may also describe their symptoms as ants that keep creeping in parts of their brain (Kleinman and Good as cited in Bashiri and Spielvogel, 1999, p. 82). North American and Europeans are more likely to emphasize affective symptoms (Park & Dimigen, 1995). In Western research "Have you ever felt that life isn't worth living?" is a common screening question but one which had no meaning for mothers from Bengali who could not conceive of such a possibility (Watson and Evans as cited in Halbreich and Karkun, 2006, p. 107).

The cultural variation of depressive symptomatology can be found in the frequency of appearance of certain symptoms. Jablensky, Sartorius, Gulbiant and Ernberg (as cited in Bashiri & Spielvogel, 1999, p. 83) found that guilt feelings were more prevalent in a Swiss sample (68%) than in an Iranian sample (32%), who had more somatic symptoms (57%) with only 27% of the Canadian sample reporting somatisation. Suicidal ideation was more prevalent in a Canadian sample (70%) than in a Japanese sample (40%).

5.6   Cultural Factors, Beliefs, and Rituals Associated With Pregnancy and Childbirth in South Africa

Numerous studies across different countries have indicated that PPD is a universal experience. It is expected that there will be very little difference, if any, between the White population of English and Afrikaans-speaking South Africans in their beliefs about, and rituals associated with childbirth as they have essentially experienced the same social knowledge due to being socialized in the same culture. The same may be said for the Coloured population with a westernized upbringing. Some of the Black participants in this study come from areas of adverse circumstances in urban townships where traditional African customs and upbringing may be more prevalent, but not likely as prevalent as in rural areas.

Poverty, unemployment, unwanted pregnancy – often due to rape – and AIDS remains a problem amongst many South Africans – particularly the Black population. Private health care is expensive and free medical care is not always easily accessible even though it is available. These factors are an additional burden to these mothers. South

Africa is also affected by extreme and violent crime. Antenatal exposure to extreme societal stressors, like attempted murder or witnessing a violent crime, is indicated as one of the strongest predictors of PPD in an urban South African cohort (Ramchandani et al., 2009).

Antenatal rituals for White South African women, both English and Afrikaans speaking, are similar to those of North American women and other Western countries. Rituals include baby showers with gift giving to celebrate the imminent arrival of a new baby, regular visits to a general practitioner or obstetrician for antenatal check-ups, antenatal classes in preparation for childbirth, and a 6 week postpartum visit to an obstetric practice. Childbirth most often takes place in a hospital and the mother typically remains in hospital for 3 to 4 days after delivery while nursing staff assist her with recovery and with her baby. The mother's return home from the hospital seems to be a time when she is most vulnerable in the role transition of becoming a mother. Many mothers find themselves feeling isolated and lack support from family members which is common practice in some other cultures. It is customarily regarded that a mother is ready to resume full domestic and marital responsibilities at 6 weeks postpartum. Financial pressure forces more and more families to rely on a double income and working mothers are expected to return to work after 3 months of maternity leave, or sooner if no maternity leave is granted.

Collective responsibility and interdependence are fundamental beliefs of African cultures. Grandmothers play an important role, but generally the entire family and even those who are not biological relatives may all participate in a number of child-rearing

functions (Wile & Arechigo, 1999). Hence the African proverb: It takes an entire village to raise a child.

A culturally specific action which is adhered to by some African parents when their unmarried daughter becomes pregnant, is to demand both "umgezo" (cleansing of ritual impurity and bad luck thought to be caused by premarital pregnancy) and "inhlawulo" (the payment of damages) from the family of the man responsible for impregnating their daughter. This requires the payment of money, cattle or goat, as recognition of responsibility and of good faith on the man's behalf (Preston-Whyte & Zondi, 1989).

In traditional Zulu culture, men have not been allowed to be present at childbirth as it has always been the concern of women alone. The midwives are older women of the "umuzi" past child-bearing age. Mothers and children are isolated until the baby's umbilical cord falls off – usually for a period of 5 to 10 days. During this time the mother is considered unclean and potentially harmful to their husband's ancestors in the homestead. The mother may only eat food prepared by the midwife using a special spoon and dish, and may not touch ordinary utensils. After the period of isolation the mother is purified through a sprinkling of "intelezi" and can then resume her normal life and the father may see his child for the first time (Klopper, 1998).

Literature about the beliefs and rituals associated with pregnancy and childbirth in other African cultures of South Africa is scarce. The author could also not find any relevant research regarding how PPD manifests in the different South African cultures. It has, however, been indicated that the traditional African cultural value system is fading in

the more cosmopolitan areas of Africa compared to the rural areas (e.g. Owoeye, Aina, & Morakinyo, 2006).

5.7   Use of PPD Screening Measures Across Different Cultures

Comparative cross-cultural research that uses a measuring instrument developed in one culture and subsequently translated to a different language for use in another culture should never assume that the measuring instrument is tapping the same construct(s) in exactly the same manner for each cultural group. Byrne and Campbell (1999, p. 571) argue that in this type of research, the principal psychometric issue should focus on:

- The extent to which the conceptual notion of the construct being measured (e.g., depression) is portable across the cultures of interest; and
- The extent to which the operationalisation of the construct, as measured by the items of the selected instrument (e.g., the BDI), is portable across cultures.

Byrne and Campbell (1999) recommend that researchers and practitioners not only look beneath the surface of item scores, but also always question how appropriate the conceptual and philosophical aspects of the assessment measure is when utilised in a different culture.

The instrument that has been used most frequently in international research into PPD is the Edinburgh Postnatal Depression Scale (EPDS; Cox et al., 1987). The EPDS

has been translated into numerous languages and has been used to screen for PPD in many countries. Many studies where the EPDS was used to screen for PPD indicate a significant variation in the level of depressive symptoms within and between countries, and recommend that different cut-off scores are warranted for different cultural groups.

Halbreich and Karkun's (2006) review of the literature on the prevalence of PPD and depressive symptoms in a variety of countries found that cut-off scores ranged from 9 to 13. The EPDS developers recommended culturally sensitive cut-off points with a range of 9–10 to 13–14 for different populations. The Western standard cut-off score is 12 or 13. Researchers have determined optimal EPDS cut-off scores for various cultures in order to improve the instrument's specificity or sensitivity, or both (e.g. Affonso et al., 2000; Cryan et al., 2001; Yoshida et al., 1997; Yoshida et al., 2001). The inconsistency in estimated EPDS specificity and sensitivity may explain the variances in the prevalence of PPD (Eberhard-Gran et al., 2002). Barnett et al (1999), for instance, concluded that a higher cut-off score (14 or 15) on the EPDS was recommended to identify women with PPD for a Vietnamese-speaking sample in Australia compared to English and Arabic-speaking samples, for whom a cut off score 9 or 10 was indicated (as cited in Boyd et al., 2005, p. 147). Yoshida et al. (2001) found that the EPDS was useful for Japanese women but recommend a much lower cut off score of 8 or 9 due to their reluctance to express depressed mood on self-report questionnaires.

Halbreich and Karkun (2006) regard the EPDS to be an excellent instrument for detecting the dimension of depression for which it was developed. It has, however, been recommended that more culturally sensitive and flexible measures are needed for the range of postpartum mental disorders as the EPDS has not proven to be a valid screening

tool across different cultural groups (Bashiri & Spielvogel, 1999; Gibson et al., 2009; Halbreich & Karkun, 2006). Goldbort (2006) suggests that the PDSS be used in proposed PPD multicultural studies in the United States.

Gibson et al. (2009) offer various explanations for the wide range of values for sensitivity and specificity of the EPDS at all cut-off points across samples drawn from various countries with different cultures and socio-environmental conditions in the studies that were reviewed. The methods utilized as well as the populations varied significantly between the studies. The samples were drawn from urban and rural areas, from both poor and affluent women, and from countries with diverse cultural attitudes to the expression of feelings and distress. Screening was performed at different times in the peripartum period, in different clinical settings and countries, and was administered in different languages.

Further important factors to consider that would contribute to the heterogeneity of results is that the diagnostic interviews and criteria used were different. In addition, the screening and diagnostic instruments used in the studies were developed to detect depression according to how the condition is understood and expressed in Western societies and do not accurately screen for the presence of significant distress in other cultural settings (Evans et al., 2001; Gibson et al., 2009). A number of researchers have doubted the validity of applying a Western-based diagnostic system to a world population composed of around 80% non-Western people (Bashiri & Spielvogel, 1999). The close-to zero incidence of PPD reported in some cultures may therefore only be a reflection on a westernised concept of PPD or its EPDS representation. A culturally specific reporting style should also be considered (Halbreich & Karkun, 2006).

Applying the EPDS to cross-cultural samples has resulted in some difficulties. In some contexts difficulties have been reported in the way items are understood by respondents. For example, difficulty in understanding the meaning of items which, according to the researchers, required introspection, were reported in a study conducted in India with a Hindi translation of the EPDS (Banerjee, Banerjee, Kriplani and Saxena as cited in De Bruin, Swartz, Tomlinson, Cooper, & Molteno, 2004). Furthermore, languages differ in their range and differentiation of words to denote mood symptoms. Icelandic researchers recognized this problem when they had to revise 2 of the 10 items of the EPDS as Icelandic women had difficulty understanding the differences between four EPDS items (O'Hara, 1994).

Parry (1996) describes two significant threats to the validity of psychiatric instruments when applied in Africa. Firstly, psychopathological states and culturally distinctive behaviour must be differentiated to avoid confusion. Some behaviour which may be deemed acceptable and is tolerated in one culture may be unusual or unacceptable in another (Sartorius as cited in Parry, 1996, p. 178). Gillis, Elk, Ben-Arie, and Teggin argue that in some African cultures, for instance, "delusions" and "hallucinations" are not unusual occurrences among normal people and are thought to result from encounters with ancestors (as cited in Parry, 1996, p. 178). Secondly, the content of a psychiatric instrument may impact on responses culturally. Items on the instrument which refer to actual life experiences or particular objects, such as watching television or riding a rollercoaster, may lead to biased responses as respondents may not be familiar with or have access to the objects referred to (Buntting and Wessels, as cited in Parry 1996, p. 178). Thirdly, the format of the psychiatric instrument may impact on responses. Gillis et

al. also point out that most standardised instruments have an interrogative style which may be foreign to the practice of many Africans, especially in sub-Saharan Africa (as cited in Parry 1996, p. 178).

Strategies have been proposed to deal with these types of problematic issues. Both Kirmayer and Kleinman suggest that an anthropological study may be conducted prior to undertaking an epidemiological study to explore how the population under study understands mental illness as well as investigate their cultural forms of expression and classification of illness (as cited in Parry 1996, p. 178). Based on the above, instruments may be supplemented by the addition of questions that may be analysed separately which enquire about specific cultural phenomena or the somatic expressions of mental illness (Swartz, Ben-Arie, & Teggin as cited in Parry 1996, p. 178). Interviewers or interpreters familiar with the subtle cultural nuances may be used to ask respondents to explain responses (Kortmann, as cited in Parry, 1996, p. 178-179). In some cultures culturally-sensitive interviews are essential when self report instruments do not elicit positive responses. Halbreich and Karkun (2006) recommend that 'such interviews should also include inquiries on complaints and symptoms pertinent to the local culture even if they initially do not fit current westernized molds, are time consuming, and thus more expensive' (pg 109).

In order to develop and harmonise PPD research instruments for use in various countries and cultures, it is necessary to understand the various cultures' beliefs, attitudes, and customs about pregnancy and childbirth. To enable direct comparisons of the incidence of postpartum disorders and possible manifestations thereof that are unique to some cultures, the same procedures should be utilized across samples and sample sizes

should be adequate. Only then can meaningful comparisons be made (Halbreich & Karkun, 2006).

Understanding the nature of postpartum disorders across different cultures around the world will help to clarify the underlying mechanisms and differences between culture specific and universal aspects of postpartum disorders. Understanding these will assist in the identification of specific risk factors for certain cultures and thereby help to identify women who are at risk (Halbreich & Karkun, 2006). Furthermore, it will facilitate the development of culture specific preventative and treatment interventions.

5.8   Conclusion

Childbirth takes place in a socio-cultural context. It is therefore important to consider how cultural factors, beliefs, taboos, and rituals contribute to the understanding of childbirth and perinatal mental illness. It must also be given due consideration in the adaptation of screening measures for cross-cultural use. It is clear the PPD is a universal concept, even though it may have different names and manifestations in different cultures. The main purpose of this study was not to discuss the anthropological nature of PPD in different cultures. This chapter has, however, provided an overview of the cultural patterning of childbirth, which, considering South Africa's cultural diversity is likely to influence the assessment of PPD.

CHAPTER 6

AFRIKAANS-SPEAKING SOUTH AFRICANS

6.1 Chapter Preview

The naming of the diverse peoples who have populated South Africa in the past and present is often a difficult and delicate matter. The term "Afrikaner" has come into use with the passage of time and the development of a separate identity since the arrival of the first European settlers in South Africa. This chapter focuses on the history of the Afrikaans-speaking people, the development of the Afrikaans language, and demographic features of the Afrikaans population in South Africa today.

6.2 Definition of Terms

6.2.1 Afrikaner.

The term Afrikaner has often been used interchangeably with that of "Boer", which literally meant farmer, but then came to characterize a particular species of the genus Afrikaner. English South Africans often refer to the Bantu population as Africans. However, the translation of African is Afrikaner, a word which Afrikaners were not prepared to use generically. More recently, the favoured term to describe the Bantu-speaking population has been "Blacks" or "Africans" (Le May, 1995; Giliomee, 2003).

Le May (1995) states that anyone who is rash enough to attempt to interpret the Afrikaner people is perplexed at once by difficulties of definition. The definitive Afrikaans dictionary published in 1950 defines an Afrikaner as "One who is Afrikaans by descent or birth; one who belongs to the Afrikaans-speaking population group". Defining the Afrikaner by language alone is too broad as it would include, for example, the Cape Coloured people. The Shorter Oxford English Dictionary defines an Afrikaner as a White native of South Africa. Giliomee (2003) states that the term Afrikaners for Whites was first used in the early eighteenth century, but it had to vie with designations like burgher, Christian, Dutchmen, and Boer. It was not until the mid-twentieth century that the term was reserved only for White Afrikaans-speakers. From the 1980's the term started to become racially inclusive.

There are people who are classified as belonging to one of the Black groups who speak Afrikaans as a first language. However, they comprise a very small fraction of the Afrikaans-speaking population.

The term Afrikaner has been used to discuss the history of the Afrikaans-speaking people, but has otherwise deliberately been avoided in this thesis. This is because the term has many emotional and political connotations, and has been used by White Afrikaans-speakers as an exclusive term to distinguish themselves, not only from White English-speakers, but also from Coloured Afrikaans-speakers.

For the purposes of this study, the Afrikaans-speaking population will be those who have Afrikaans as their first home language and consider themselves to be Afrikaans-

speakers, regardless of which population group they belong to. It is expected however, that they will typically be members of the Coloured or White classification groups.

6.2.2   Culture.

Human beings are social creatures (Baron & Byrne, 1994). They generally live out their span as members of groups. Countless studies in social psychology have shown that the groups which individuals belong to greatly affect their attitudes, values, perceptions of the world, and ultimately the person's very identity of who they are. Cultural, racial, and ethnic groups are social definitions that may be used to categorise people. Science Daily (n.d.) points out that ethnic groups are defined substantially by distinctive cultural attributes, behavioural, linguistic, or religious practices. Members of an ethnic group typically maintain a strong cultural continuity over time.

Culture consists of interrelated components of material artifacts, social, and behavioural patterns, and mental products. Cushner and Brislin (1996) refer to culture as

A set of human-made objective and subjective elements that in the past have (a) increased the probability of survival, (b) resulted in satisfaction for the participation in an ecological niche, and thus (c) become shared among those who communicate with each other because they had a common language and lived in the same time-place. (p. 10)

6.2.3   Cultural group.

The term "cultural group" refers to the common philosophical tenets, which underlie the intellectual collective functioning of the group and includes such things as religious beliefs, traditions, historical folktales, language, and rituals. White (1959) describes culture as

An extrasomatic, temporal continuum of things and events dependent on symboling. Specifically and concretely, culture consists of tools, implements, utensils, clothing, ornaments, customs, institutions, beliefs, rituals, games, works of art, language, etc. All peoples in all times and places have possessed culture; no other species has or has had culture. (p. 3)

6.2.4   Ethnic group.

Ethnic group refers to perceived cultural characteristics, specific to a particular group. These characteristics commonly include nationality, religion, and dress. Ethnic groups are usually subgroups of racial groups rather than vice versa (Kinloch, 1974). Pogge (1997) states that to constitute an "ethnic group", a set of persons must satisfy three conditions, namely: commonality of descent, commonality of continuous culture, and closure. Pogge (1997) elaborates that

Members of the set must understand themselves as descendants of members of an historical society (in a broad sense, including tribes, principalities, and the like, as well as systems of interacting tribes or principalities). They must share a common

culture, or partial culture, which they take to be connected, through a continuous history, with the culture of their ancestors (however different from the latter it may have become in the process). And the group must contain all, or nearly all, of the persons who, within the relevant state, are taken to share the descent and culture definitive of the group. (p. 193-194)

Pogge (1997) points out that the first condition is necessary to distinguish ethnic groups from mainly religious and from mainly linguistic groups. The second condition is necessary to distinguish ethnic groups from mainly racial groups, and the third is necessary to distinguish ethnic groups from subgroups.

6.2.5   Racial group.

Shillington (1988) refers to the term "racial group" as perceived physical characteristics, specific to a particular group. She points out that pigmentation differences are the most commonly utilised, and that the consequences of such a social definition include awareness of subordinate group differences by the race group itself and their utilisation by the elite to rationalise prejudice and discrimination.

The Coloured/White dichotomy can be described to some extent by any of the above terms. However, none of these terms refers to the legal distinction that is made between the terms "Coloured" and "White" in South Africa.

6.2.6   Classification group.

According to Omond (1985) the term "classification group" refers to "a racial group defined by law" (p. 21). The term "classification group" is often preferred over "ethnic group", "racial group" or "cultural group" in South Africa. The reason for this is that membership of the White as opposed to the Coloured group is not determined only or necessarily by membership of an ethnic, racial or cultural group. It is determined by present day law and as such is uniquely South African (Shillington, 1988).

6.3   Historical Overview

In 1488 Bartholomeu Dias, a Portuguese sailor, was the first recorded European to traverse the South African coast in his desperate search for a sea-route from Europe to the riches of the East. A permanent settlement was soon established on the southern tip of the continent by the Dutch while many hundreds of ships – Dutch, French, British, Portuguese – called on this coastline for fresh supplies of water, wood, and food en route to the East (Rissik, 1994).

The South African history of the Afrikaans-speaking people began in 1652 when Jan van Riebeek, a member of the Dutch East India Company (DEIC), arrived at the Cape of Good Hope with some ninety men to establish a permanent base, a fort, and a foothold on the southern tip of Africa. Most of these early settlers were immigrants from Western Europe most of whom were Dutch but also included French, German, Swedish, Danish, and Belgian immigrants. They were sent to the Cape of Good Hope to establish a

refreshment station from which they could supply Dutch sailors with fresh vegetables to prevent scurvy.

Most of the European immigrants came from the lower rungs of society and many were illiterate or semi-literate peasants, artisans or laborers employed by the Company as sailors or soldiers. For the first three decades most of the immigrants were single Dutch males. In 1688 a party of fewer than two hundred French Huguenots arrived to join the DEIC settlers (Le May, 1995). They had fled from religious persecution in France and were composed mostly of families. Religion was, in fact, a binding force among the early white-skinned settlers and placed them in contrast with the heathen, dark-skinned indigenous people (Giliomee, 2003).

The Dutch-speaking settlers made an effort to prevent the French immigrants from speaking French and from forming a cohesive group. They were forced to speak Dutch in public places such as schools and churches "so that they could learn our language and morals, and be integrated with the Dutch nation" (Böeseken, as cited in Giliomee, 2003, p. 11). Some authorities took a more lenient stance toward the French immigrants and permitted them to form a church congregation but a tougher policy was imposed in 1701. This policy instructed that the necessary measures be taken to ensure that the French language would gradually become extinct and disappear. This policy of forced cultural assimilation was largely successful and by 1750 no one under the age of forty could still speak French.

Apart from the French women, the female European immigrants were Dutch. During the eighteenth century the German language also made an appearance on the Cape

scene with the arrival of single male Germans immigrants. A typical German immigrant of these times had been driven to Holland in search of employment through poverty and the absence of other means of help and waited to be recruited as a soldier or a sailor by the VOC. The Germans were largely single males, spoke diverse dialects, and married Dutch of French women. The language of their children was Dutch, or what the German traveler Henry Lichtenstein, early in the nineteenth century, called "an abbreviated forcible Afrikaans Dutch" (Trapido, as cited in Giliomee, 2003, p. 12). No effort was made this time to accommodate the immigrants' religious sensibilities. Permission for a Lutheran Church was not granted until 1780 by which time the principle of one language and one church for the European community had become well established (Giliomee, 2003).

Colonization was never the Company's policy, yet colonization was made necessary by the exercise of strict economy. The colony therefore expanded largely in spite of, rather than because of, the policy of the DEIC who began allocating land to settlers and permanent farms were being established. The settlers made the new land their own and cut most of their family and community ties with Europe. Their numbers started increasing through immigration, through starting their own families, and some mixed with the local Khoisan people (also known as Hottentots). Mixing continued and was diversified by the arrival of slaves from Madagascar, Mozambique, West Africa, Angola, Malaysia, Indonesia, and Java as shortage of labour proved to be a major problem.

During the first seventy-five years of Company rule there was no rigid racial division. Fenwick and Rosenhain (1991) report that in the early days of the colony several White men married Black women and that Coloured or mixed race slaves were

born within the company, often to a free White father and a slave mother. People of mixed racial origins were prominent both as burghers and free Blacks, and did not appear to suffer any racial discrimination. The frequency of racial mixing was due in the first place to the huge gender imbalance in the White population. By 1700 there were twice as many men as women in the adult burgher population in the Cape district. In the interior, the ratio was three to one. Marriages between White men and fair-skinned non-White women were common during the first seventy-five years. Sexual liaisons outside of wedlock and casual sex were common, especially in the slave lodge where local European men as well as sailors and soldiers satisfied their sexual urges. Sailors from various Western European countries were allowed ashore to "relax" and, according to an early Dutch writer quoted by Venter (1974), "Female slaves are always ready to offer their bodies for a trifle, and towards evening one can see a string of soldiers and sailors entering the company's slave lodge where they misspend their time until the clock strikes nine" (p. 20).

In 1685, High Commissioner Hendrik Van Reede of the DEIC visited the Cape Colony and noted that there were approximately 57 mixed race children in the colony (Fenwick & Rosenhain, 1991). He prohibited marriages between Europeans and "heelslag" or full-blooded slave women (of pure Asian or African origin). He permitted marriages with "halfslag" (meaning that the father was White) women with the intention of assimilating such half-castes into the European population. The ban was, however, never enforced. These children were brought up with a knowledge of the Dutch language and Dutch customs, which made it easier for the colonists to train them as servants.

Giliomee (2003) writes that it was through the relationships with these slaves and semi-free servants that the Dutch language was turned into Afrikaans.

By the middle of the 18th century, liaisons between the settlers and other racial groups were strongly frowned upon by the White public who were concerned about the mixing of races. The predominant language was Dutch until the British took over the administration of the troubled Cape Colony in 1795 following the French capture of Holland during the Napoleonic Wars. This gesture was made to keep open the strategic sea-route to Britain's vast, valuable Indian territories. It was returned to the Dutch government in 1803, but Britain recaptured it in 1806 and administered it in various geographic shapes and political forms until union in 1910.

Giliomee (2003) commented that, at the time of the British conquest of the Cape, all the ingredients for the development of a new group were present. These ingredients were: a specific spoken language, a particular religious doctrine, identification with Pan-Dutch traditions and an awareness of the "differences" between people of different races. These ingredients differentiated the earlier settlers not only from the indigenous people and slaves, but also from the British settlers. The Afrikaners – the name now more common than in the eighteenth century – became a colonized people in a different sense. They were now British subjects, enjoying the rights that went with the status but ruled by a foreign nation.

According to Le May (1995) by 1806, the year of permanent British occupation, the White population was estimated at 18 000, of which the majority were Dutch. In 1820 nearly 5000 British immigrants landed at the Cape Colony where Port Elizabeth is today,

having been promised portions of land to farm. Rissik (1994) reports that they endured years of poverty and hardship as their farms were on the frontier and they were effectively the buffer between the Colony and the Xhosa tribes. The battle for land between the two groups led to a number of wars and skirmishes – and large doses of ill will.

Despite their difficulties the 1820 Settlers, as they were called, made their mark as craftsmen, traders, and farmers. Their cultural contributions soon became firmly embedded in the nature of South Africa. They also played a major role in the administration of the Cape as the British style of governing changed from autocratic colonial power to an ever more representative system in the 1850s. The British influence was strong, not only in government, law, and administration, but also in the broader social and cultural sense (Rissik, 1994).

A move that was introduced by the British, which finally led to the official abolition of slavery in the Cape in 1834, caused great discontent among the Dutch-speaking settlers. They objected and moved away in small, separate groups in what was to be known collectively as "The Great Trek".

The Great Trek, the first mass migration of immigrant South Africans, began in 1835 and only ended in 1848. This was a deliberate and premeditated exodus from British rule. Those who took part in it became known as the Voortrekkers, the pioneers. At that time they also referred to themselves as emigrant farmers or "trek Boers".

They eventually formed communities in what was known the Transvaal, Orange Free State, Northern Cape, and Natal. The communities were still somewhat discrete

units and it was only after the discovery of gold and diamonds and the concomitant influx of "uitlanders" or foreigners, that a real sense of nationalism was felt. The early Voortrekkers tended to band together to prevent too much contact with the non-farming newcomers. The Anglo-Boer War further strengthened the feelings of cohesiveness among the Boers, as they have become known. During the early part of the 20th century these feelings developed into a pride in the past, to the formation of a specific culture based on religious teachings and to the birth of a new African language, Afrikaans.

6.4   The Development of Afrikaans

6.4.1   The history of the Afrikaans language.

The ground for the beginnings of a new language, Afrikaans, were set in 1652 when the DEIC established a halfway house at the Cape. Those first Dutch settlers came into contact with the languages spoken by the indigenous Khoi people and those of the later settlers. High Dutch may have been the official language, but as the settlement grew and the settlers dispersed a new language developed. High Dutch became mingled with loan words from French, German, English, Malay, and Portuguese-Creole, and was constantly influenced by the dialects of the indigenous inhabitants (Le May, 1995; Rissik, 1994).

The transformation of Dutch at the Cape seems to have been quite rapid, although not as rapid as those who previously sought to explain Afrikaans as a Creole language would have had us believe. At the beginning of the twentieth century it was argued that the process was completed in a period of about thirty years after the initial settlement. Not many people agree with that school of thought anymore, as documentary evidence

has been found which proves that, although all the salient features of Afrikaans which demarcate it from Dutch were present by the middle of the eighteenth century, many of them continued to compete with the original Dutch structures until the late nineteenth century (Mesthrie, 1995).

Linguistics believed that by 1850 Afrikaans had developed in most part into the language it is today (Rissik, 1994). What is now Afrikaans was, according to Mesthrie (1995), in the 1860s an unstandardized language of hearth and home, with various designations. Le May (1995) states that in the 1870s serious attempts were made to transform this new language into a literary language. Furthermore, he adds that it took another half-century before Afrikaans replaced High Dutch as an official language in South Africa (Mesthrie, 1995).

Afrikaans struggled against the English and Dutch languages – the early colonial powers – for recognition as a medium of cultural expression. General Hertzog remarked that the Afrikaners had to wage a language struggle in an attempt to stop considering themselves as "agterryers" (standing in the back line). Dutch and English speakers would look down upon Afrikaans speakers as Afrikaans was merely considered a dialect and language of the poor Whites. Consequently the Afrikaners developed feelings of inferiority and persecution in the early days of their culture and language development. General Hertzog insisted that a sound sense of White nationhood in South Africa would have to be based on the recognition of both English and Afrikaans cultures. He also encouraged the Afrikaans-speaking community to establish a separate identity to overcome the relative social, cultural, and economic backwardness they experienced. The outcome of political battles in South Africa succeeded in shaping a more exclusive

Afrikaner identity (Giliomee, 2003). By the beginning of the 20th century Afrikaans was generally recognized as a cultural language and vernacular (Rissik, 1994). Furthermore, there was a strong identification with Afrikaans as a public symbol of nationality with South Africa – its only home – and with indigenous or local forms of cultural expression – such as adherence to the Reformed faith (Giliomee, 2003).

Towards the end of the 19th century and the beginning of the 20th century there was much debate about whether Afrikaans was a language in its own right. D.F. Malherbe, who had studied linguistics, maintained that Afrikaans, with its simple and regular structure, was not a dialect, but indeed a language unto its own. D.F. Malan was also a key figure in the promotion of Afrikaans. He 1904 he remarked that Afrikaners would only become strong if they were united. He further stated that Afrikaners needed to realize they had their own heritage, based on their nationality, character, religion, and language (Booyens, as cited in Giliomee, 2003, p. 366). In 1908 Malan took the first step in his public career when he issued this ringing call: "Raise the Afrikaans language to a written language, let it become the vehicle for our culture, our history, our national ideals and you will also raise the people who speak it" (Pienaar, as cited in Giliomee, 2003, p. 366).

By 1907 a number of language associations had been established in Bloemfontein, Cape Town, and Pretoria to promote Afrikaans. The language battle was not over yet and Afrikaans was still opposed. A loyalist section in the English press, "The Star", questioned, with reference to call for English-speakers to become bilingual, whether Dutch or Afrikaans was meant – "Any man who knows the real Dutch language is painfully aware of what a truly stupid patois this South African "taal" is, and it must be a

source of surprise and astonishment to the serious inquirer why such a degenerated branch of an originally sound language is so stubbornly maintained in its provoking ugliness" (The Star, 30 September 1910, as cited in Giliomee, 2003, p. 367). The *Cape Times* frequently published letters from Readers in which Afrikaans was denounced as "kitchen", "degenerate", "hotch-potch", "decaying", and "a mongrel" language which was only fit for "peasants and up-country kraals" (*Cape Times*, 4 May, 1901, and Zietsman, as cited in Giliomee, 2003, p. 367).

It was at around this time that Cornelis Jacob Langenhoven made a great effort to win the argument that Afrikaners should use Afrikaans for all purposes. He maintained that the fight to maintain Dutch was futile because of its complexity and the simple grammatical structure of Afrikaans, as opposed to Dutch, offered a better alternative to English. He challenged those who argued that it should not be taught at schools and universities and cried

It [Afrikaans] is our highest honor, our greatest possession, the one and only White man's language which was made in South Africa and which had not come ready made from overseas … [it is] the bond which joins us as a nation together, the expressed soul of our volk. (Kannemeyer, as cited in Giliomee, 2003, p. 369)

He blundered, however, by calling it a White man's language instead of recognizing its multiracial origins also spoken by Coloured people.

Eugene Marais, editor of "Land en Volk" in Pretoria, advocated the use of Afrikaans as a written language and used Afrikaans and Dutch in the paper. Marais's path later crossed with Gustav Preller at the Pretoria-based De Volkstem, a newspaper that

was started by the Boer Generals. Preller had a passion for Afrikaans. As a language activist he fought against the view that depicted Afrikaans as a low-class tongue. He insisted that a distinction be made between the language of the street and servants, and the language of civilized Afrikaans. He called for a new identity for Afrikaners as modern, increasingly urbanized people and strongly supported the use of Afrikaans as a written language, which also served to develop a distinctive nationality among Afrikaners in South Africa (Giliomee, 2003). The aim was nothing less than "to build a nation from words." (Hofmeyr as cited in Giliomee, 2003, p. 372)

In 1914 Langenhoven successfully proposed that Afrikaans be used as an alternative to Dutch for instruction in primary schools (Giliomee, 2003). In the mid-1920s a re-created Afrikaans had become a fully standardized national language and it was generally recognized as a cultural language and vernacular (Mesthrie, 1995).

The Bible was translated into Afrikaans in 1933. This was a major step towards standardizing the language and also served to enhance its credibility among the many Boers, Coloureds, and others who spoke it.

6.4.2 The influence of other languages.

The majority of the Afrikaans vocabulary, according to Rissik (1994), is derived from Dutch, but changed quite substantially, especially in pronunciation. Although there are strong grammatical similarities between Afrikaans and Dutch, it has a far less complex structure, making it a fairly easy language to learn. Mesthrie (1995) reports that it is estimated that about 90-95 per cent of the present-day Afrikaans vocabulary

originated from 17th century colloquial Dutch as opposed to contemporary or even from 19th centuryDutch. Words of English, German, French, Portuguese, and Malay origin are also liberally sprinkled throughout Afrikaans. The Coloured population had considerable influence in shaping the Afrikaans vocabulary as it is used today due to their mixed backgrounds (Rissik, 1994). The Afrikaans language borrowed words from almost all of South Africa's diverse cultures as a result of the mixed racial origins of the Afrikaner. Numerous Afrikaans words were coined – particularly for local plants and animals. There are words from African languages like "mampara", which means "an untrained or stupid person" and most often is used as a form of gentle rebuke, or "babelas" from the Nguni language which means "hangover" (Rissik, 1994).

Mesthrie (1995) comments English has had a great influence on Afrikaans and that Afrikaans has, in many ways, developed in a similar direction to English in its degree of analysis, for example, the loss of gender. This grammatical change had, however, started long before the arrival of the English at the Cape in 1795. The two languages also share many structures and vocabulary as both English and Dutch are closely related Germanic dialects.

The absence of Cape Dutch written texts prior to 1830, when the British were in possession of the Cape Colony for about 30 years, makes studying the origins of Afrikaans a difficult task. Examining the effect that English was having on Afrikaans in the 19th and early 20th centuries was an equally arduous – if not impossible task. At that stage, Afrikaans speakers were not in the position they are in today to provide written evidence of the inroads that English was making into their language (Mesthrie, 1995). Only two nineteenth-century works exist which acknowledge that English had an effect

on Dutch at the Cape. One was written by A.E. Changuion, which dates from 1844, and the other by N. Mansvelt, which dates from 1884. Both authors were schoolteachers from Holland. When they arrived at the Cape they were appalled at the state of their language as spoken in the Colony and set about trying to purify the Dutch language of their colonial brethren.

It has been stated that Afrikaans had come into being as a new tongue by the late eighteenth century (Raidt, 1989) and all that occurred thereafter was a settling of the dust on this new reality. Mesthrie (1995), however, argues to the contrary. He asserts that the linguistic transformation that would take place after the British occupation of the Cape in 1795 was to be as great as – if not eventually greater than – all the changes that had previously taken place. He describes the English influence on Afrikaans as a story without end, as follows:

> It is taking place now to a degree that is perhaps without precedent in the history of European languages. Such an argument may not be regarded favorably by many in South Africa because, I contend, Afrikaners refuse to see the many inroads that English had made and is making into their language, in terms of language change (or language change in progress), and persist in regarding them as mere interference phenomena which can and should be removed by education. (p. 223)

According to Mesthrie (1995) the mutual influence of the two languages is inevitable. However, the influence was greater in one direction than the other and occurred to such and extent that it eventually passed from the realm of interference into

that of true language change, producing a hybrid that is a unique product of South African society. Afrikaans as it is now spoken is a true reflection of the reality of present-day South Africa. It is both the overwhelming influence of English on Afrikaans, and the traditional differences between Afrikaans and Dutch, that serve to demarcate Afrikaans from Dutch and enhance its character as a separate language. The Netherlands, the Dutch people and their language have become a foreign country, people, and language to Afrikaans-speaking South Africans. Their English-speaking compatriots have inadvertently assimilated Afrikaners, culturally and to an ever-increasing degree linguistically.

6.4.3   Landmarks in the extension of the functions of Afrikaans.

Afrikaans had achieved certain landmarks, which include its adoption as a language of instruction in schools from 1914. English had become the official language in 1910, but this made the Boers so unhappy that by 1925 they had seen to it that Afrikaans had become the second and equal official language. Further landmarks include the publication of the first complete Bible in Afrikaans (1933). A remarkable proliferation of governmental vocabulary began when virtually all state publications had to appear both in English and in Afrikaans. Somewhat later language activists fought to establish Afrikaans as a language of technology and specialized disciplines. By 1985, at least 250 technical dictionaries covering a wide range of fields had been produced.

Today numerous South Africans use either English or Afrikaans, or both, as a means of cross-cultural communication. Afrikaans is also used extensively on radio and

television, and has become a language of religion, education, and science. There are Afrikaans language newspapers across a broad political spectrum, as well as many famous Afrikaans authors of all races.

6.5   Linguistic Diversity in South Africa

South Africa is certainly a land of linguistic and cultural diversity and the nation's people are often talking across a language and cultural barrier. South Africa's language situation is characterized not only by the number and variety of African, Asian, and European languages that coexist, but also by alternative varieties of these languages – including the Afrikaans of the Coloured population (Mesthrie, 1995). South Africa has eleven official languages, namely, Afrikaans, English, Ndebele, Northern-Sotho, Southern-Sotho, Swazi, Tsonga, Tswana, Venda, Xhosa, and Zulu.

Zulu is the most common home-language and is spoken by 23.8% of the population. Xhosa follows and is spoken as a home-language by 17.6% of the population. Afrikaans is spoken by 13.4%, Sepedi by 9.4%, and English and Swazi are each spoken by 8.2% of the population (Lehohla, 2009).

Some of South Africa's linguistic characteristics are similar to those of other developed nations despite the high degree of linguistic diversity in the country. English is South Africa's language of wider communication and is widely spoken throughout the country – by members of virtually all the different ethno-linguistic groups, and is also taught in schools. Furthermore, there is a high level and degree of bilingualism and even

multilingualism. This reflects the extensive intergroup contact that continues, in spite of the legacy of apartheid, to characterize South African society. The literacy rate in South Africa is considered impressive by third world standards. It is still low, though, and is skewed disproportionately toward certain groups at the expense of others Mesthrie (1995) further adds that "the notion of South Africa as a fourth world society (i.e., one in which elements of both the first and third worlds coexist) clearly makes a great deal of sense from the perspective of the country's linguistic situation." (p. 321)

The future of South Africa's language situation is likely to remain essentially unchanged, according to Mesthrie (1995). Linguistic changes that do occur will fall into one of four well-documented linguistic processes: language change, language spread, language emergence, and language death. Mesthrie (1995) further emphasizes that regardless of the nature of political change in South Africa, it is virtually certain that linguistic diversity will remain a feature of social life for generations to come, and that bilingualism and multilingualism will remain commonplace for many, if not most, South Africans well into the future.

As indicated earlier, Afrikaans represents the third largest language group in the South Africa. Contrary to many foreigners' beliefs, a large number of Afrikaans speakers are not White. A large percentage of the Coloured population speaks Afrikaans as a first language. Although it is accepted that the Afrikaans language is common to many Coloured and White people, there is some controversy as to whether the people belonging to these classifications groups are similar.

6.6   Afrikaans-Speaking People: The Coloured – White Dichotomy

The Coloured person has been defined by The Population Registration Act number 30 of 1950 (Omond, 1985) as someone who is not a Bantu and also not a White person. Similarly, according to the Population Registration Amendment Act, Number 64 of 1967 (Omond, 1985), a White person has been defined as someone who

In appearance obviously is a White person and is not generally accepted as a Coloured person, or is generally accepted as a White person and is not in appearance obviously not a White person. [Furthermore]… his habits, education, and speech and [his] deportment and demeanor shall be taken into account. (p. 22)

This description still does not give much clarity concerning the differences between Coloured and White people (if, in fact, there are differences) or what their identities are (if they have them). According to Venter (1974) points of view vary from the assertion that Coloured and White people have largely the same genetic base to an absolute refusal to believe that Coloured people have any White origins. The latter group presumes that Coloured people originate solely from Hottentots, Khoisan people, and slaves. Mason states that it became the trend in the Western Cape to refer to people of mixed descent as 'Coloureds' or 'Cape Coloureds' (as cited in Giliomee, 2003, p. 110).

The Afrikaans language is common to many Coloured and White people. Their membership to these subgroups will be addressed in more detail below.

6.6.1 Classification and identification of Coloured and White Afrikaans-speakers.

The myth of the Coloured identity was explored by Van der Ross (1979):

It is claimed by some that there is a special identity, peculiar to the Coloured people. They have, according to this claim, an identity, which they share with no other population group, and this sets them apart in a very special sense. (p. 2)

He refutes the assumptions that Coloured people all have the same origin, are necessarily easily recognizable, and that they have their own specific culture. He also asserts that the mixed nature of the Coloured person's composition precludes him from having a separate identity.

The heterogeneity of the Coloured people is further emphasized by the *Theron Report* (1976). This report discusses the common bonds that may hold Coloured people together:

The most important positive binding element between Coloureds is probably their being South African. The most negative binding element is probably the biological typing of Coloureds in terms of biological characteristics, for example variations in skin pigmentation, hair texture, and facial features in so far as these are perceptible and are used by other groups as criteria for exclusion from their own ranks. (par. 21.4)

White Afrikaans-speaking people may be classified according to four broad identification patterns (Giliomee, 1975):

1. The first viewpoint is held by those who see Afrikaans-speaking Whites "as a distinct White volk, membership of which is clearly defined" (Giliomee, 1975, p. 32).

2. A second viewpoint is that the Afrikaans-speaking White belongs to a larger White population group into which he is increasingly being assimilated. The identity of Afrikaans-speaking Whites is seen to be tied up with the identity of the White population group as a whole.

3. A third viewpoint attempts to redefine the Afrikaans-speaking White person in terms of cultural attributes Afrikaans-speakers are seen as a cultural group which seeks to express its cultural heritage through its language. Furthermore, this cultural group is seen as a political entity existing in a plural society, with its members believing in values which transcend communal interests.

4. The last major viewpoint states that the Afrikaans-speaker should see himself as belonging to a number of different groups within the broader community, one of which is cultural. Membership of this classification group is not seen as being linked to a particular political position.

The concern with "identity" appears to be particularly marked in some sections of the White Afrikaans-speaking community, which is a contrast to the Coloured people who appear to de-emphasize or even disregard the notion of identity.

The Afrikaans-speaking Whites' identity becomes a reality in so far as it can be distinguished from their identities of other groups. The diversity of opinion presented above does not enable a definitive statement to be made in terms of the identification of Coloured or White people. It does, however, indicate the ambiguity of the situation and therefore it would seem to be appropriate to explore possible implications of classification for Afrikaans-speaking people.

6.6.2   Implications of classification.

The position the Coloured people have been in has perhaps been the most difficult of all the South African cultural groups. Yet, Coloured people do not see themselves as having a separate identity. Most Coloured people subscribe to the Western culture, although many align themselves with Black people and even consider themselves to be Black. This ambivalent position is described by Mann (2007) as being 'marginal'. A marginal personality is characterized by feelings of insecurity, hypersensitivity, and self pity which develop due to someone who desperately wants to be accepted by a privileged group but who is excluded from finding membership within that group (Mann, 2007).

The ambivalent position of the modern Coloured person is to some extent due to attitudes on the part of White and Coloured people to themselves and each other. However, the attitudes of Coloured people to Black people are also complex. Generally, relationships with Black people have been cordial. Despite this Coloured people do not completely identify with Black people.

A few decades ago, Lison (1977) studied Afrikaans- and English-speaking students – both Coloured and White – and found that the development of certain personality characteristics stems from the ambiguous position of the Coloured people:

> The Coloured students are by no means at home within the society. Their personality strongly reflects a person (sic) whose position within society is uncertain, and their severity of social maladjustment is greater. The Coloured female is untrusting of others, is introverted, socially insecure, and has difficulty in establishing close, meaningful relationships. Her male colleague too, is struggling. He is a person with feelings of inferiority and inadequacy, low self-esteem, and a disorganization of thought processes. (p. v)

Opinions on the position of the White Afrikaans-speaking population are also complex. In the 1980's, De Klerk believed that the Afrikaans-speaking White population was moving towards a greater feeling of cohesiveness within the South African community as a whole (De Klerk, 1984). Archibald (1969) described them as an emergent minority. Historically, Afrikaans-speaking Whites have largely lagged behind their English-speaking counterparts in terms of social status and economic dominance. This has changed, but it has to a large extent shaped the Afrikaans-speaking White population of today. According to Archibald (1969), the minority status experience of the Afrikaans-speaking White has been morally disabling and has had a profoundly negative effect on their personality development.

Schlemmer (1974) disputed Archibald's (1969) view. Schlemmer (1974) points out that the Afrikaans-speaking White group has largely emerged from the minority position and from traditional ties and has instead become "a bureaucratically organized White elite" (p. 204).

It is believed that the still-conservative orientation of the young Afrikaans-speaking White population has had an effect on the personality development of the Afrikaans-speaking White youth (Archibald, 1969; Orpen, 1970; Viljoen & Grobler, 1972). Orpen (1970) makes the point that Afrikaans-speaking Whites have, to a great extent, internalized the authoritarian norms that prevail in South African society, and have accepted them with little question.

In order to conclude the discussion on Afrikaans-speaking people, pertinent statistical data relating to demographic variables is presented in the next section.

6.7   Demographic Features

Presenting an accurate demographic picture of the Afrikaans-speaking people of South Africa is difficult, as the statistics available from the Central Statistical Services are presented in terms of classification group rather than language group.

6.7.1 Geographical region.

According to mid-year population estimates in 2009, there were 4 433 100 Coloured people in South Africa The largest concentration of Coloured people was found in the Western Cape province (61%), followed by the Eastern Cape Province (12%), and the Northern Cape (10%; Lehohla, 2009). Whites in South Africa as a whole was estimated at 4 472 100 people (Lehohla, 2009; Stats SA, 2009), with the majority living in the Gauteng province (41%) followed by the Western Cape (19.4%) and Kwazulu Natal (11%).

6.7.2 Language.

The distribution of home languages in South Africa, as recorded by the last major census in 2001, indicates that 13.35% of the total population spoke Afrikaans, of which 53% are Coloured and 42.4% are White. Afrikaans is the third most predominant language in South Africa, preceded by 23.8% who spoke Zulu and 17.6% who spoke Xhosa (Stats SA, Population census, 2001, as cited in Lehohla, 2009, section 2.18).

6.8 Conclusion

This chapter has addressed the Afrikaans-speaking people by providing a historical overview of the Afrikaner in South Africa. The development of Afrikaans was discussed which focused on the history of the Afrikaans language and the influence other languages had on the development of Afrikaans. Linguistic diversity in South Africa was addressed

as well as the Afrikaans-speaking classification groups. This led to a discussion of the Coloured and White classification groups in South Africa as well as a brief outline of their geographical and language distribution. It is hoped that this chapter has provided the reader with a more comprehensive understanding of the Afrikaans-speaking population. The next chapter details the methods and procedures that were utilized in this study.