THE EXPERIENCE OF MOTHERHOOD FOR HIV POSITIVE WOMEN SHOWING SIGNS OF POSTPARTUM DEPRESSION

BY

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Abstract

Motherhood appears to be an expected role that most women take on and embrace. This role takes place in the context of the woman's life. For some, the context is the reality of HIV infection and related mental health issues. With the estimated large number of people living with HIV residing in South Africa, attention has also been paid to the prevalence among pregnant women attending antenatal care. In this study, the experience of motherhood for HIV positive mothers showing signs of postpartum depression was explored from a phenomenological point of view. The researcher aimed to understand the mothers' perceptions of their role and to understand the factors shaping their experiences. In the findings, it became evident that motherhood is a complex phenomenon. In addition to this, the presence of a medical condition further interplays with the views that the mothers take about themselves and the kind of care they have to provide for their babies. Issues of disclosure were also evident as the mothers fear social judgment. For the mothers issues of mental health are linked closely to HIV illness reactions and the implications thereof for psychological functioning.

Keywords:

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Declaration

I declare that the work on **the experience of motherhood for HIV positive women showing signs of post partum depression** is my own work and all sources used have been duly acknowledged.

_____   14 APRIL 2016

   K. S Tsebe   Date

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CHAPTER 1: Introduction

This chapter provides an overview of the research study conducted. The researcher proposed that the experience of motherhood for HIV positive women who show signs of postpartum depression be understood from a phenomenological point of view. The background information, research question and aims of research are discussed. In addition to this the objectives as well as justification for the study are provided. Lastly the structure for the paper is outlined.

1.1 Description and Statement of Research Question

In this paper, the findings of a study on the experience of motherhood for a select group of HIV positive women showing signs of postpartum depression are presented. The intention was to explore the experience from a phenomenological perspective focusing on the lived experience of this select group of women.

The research question: How do HIV positive women who show signs of postpartum depression experience motherhood?

1.2 Research Problem

HIV/AIDS is a psychological, social and medical issue that is prevalent in the South African context. It is linked to various mental health conditions such as depressive disorders. Literature on mental health of those infected with HIV reveals that HIV positive individuals are at a greater risk of developing mental disorders than those who are not infected (Freeman, Nkomo, Kafaar, & Kelly, 2007; Moosa & Jeenah, 2007). This relationship is multilayered and the relationship is not unidirectional. Therefore various factors are linked to the development of depressive symptomatology, and depressive symptoms have an impact on physical health status (Moosa & Jeenah, 2007; Thom, 2009).

In 2011, 28.7% of women attending their first antenatal care at public health clinics in Gauteng between the ages 15-49 were HIV positive (Department of Health, 2012). In the Tshwane district the prevalence for the same group was 24.4% (Department of Health, 2012). Thus a significant number of pregnant women are HIV positive and this has implications for not only their physical wellbeing but also mental wellbeing.

Understanding how HIV and depression interact in the postpartum period may have implications for how motherhood is experienced and thus the research aimed to explore the experience of motherhood for a select group of women. This included allowing women to give their personal accounts of the lived experience of motherhood in the presence of HIV and a possible diagnosis of postnatal depression.

Before the next section is presented it may be useful to define and clarify the concepts central to the study, these include; HIV positive, motherhood and postpartum depression signs.

An individual is considered to be HIV positive when the HI virus enters his/her body, replicating, attacking and weakening the immune system (Abdool Karim, Abdool Karim, & Baxter, 2010; Barnett & Blaikie, 1992). For the purpose of this study, the women should have tested positive for HIV.

The conceptualisation of postpartum depression (PPD) as defined by the Diagnostic and Statistical Manual (DSM) of diseases will be used. PPD is a mood disturbance that has an onset of symptoms within four weeks postpartum (DSM-IV-TR, 1994). The current classification system covers both antenatal and postnatal mood symptoms within the same category, namely; peripartum depression (DSM-V, 2013). This research will make use of the conceptualisation of PPD as defined in the DSM-IV-TR because that is more useful for the present research. For the purpose of this study signs of postpartum depression refer to the

presence of symptoms that are of severity or quantity that is detectable enough to warrant a possible diagnosis of postpartum depression using the screening measure described in later sections of this paper.

Motherhood in this case will refer to a phase that a woman enters after she has given birth to a child (Long, 2008; Nicolson, 1998). In addition to have given birth to the child, the mother should also be involved in child rearing in order to be considered for the study. How a woman then comes to take on this role and understand it will refer to the experience of motherhood.

1.3 Justification, Aim and Objectives

Aim:

- To explore how HIV positive women who show signs of postpartum depression experience motherhood

Objectives:

- To try to identify and understand those factors involved in shaping the participants' experiences
- To gain an understanding of the participants' role experience and perception

Literature shows that HIV and PPD affect how women describe their identity as mothers, therefore gaining an in-depth understanding of the experiences of a select group of women presenting with the above conditions will extend the literature in the field. In addition to that, it will have implications in terms of designing preventative and supportive programs that can potentially provide for the mothers' needs.

1.4 Structure of the Paper

Chapter 1

This provides the introduction to study and outline of the paper. This is as provided here.

Chapter 2

This chapter provides an overview of the literature review and the key theoretical approach that informs the study. As such, previous research on motherhood, HIV and postpartum depression is discussed. Furthermore, the phenomenology is overviewed, this reference as the pragmatic point of departure for the current study.

Chapter 3

This chapter focuses on the methodological considerations for data collection. The qualitative research method is discussed, together with the research design for the study. In addition to this particular modes of data collection and ways in which the data was analysed is provided. The ethical considerations adhered to in the current study are discussed. The issues of reliability and validity relevant to the study are also provided in order to allow the reader to make decisions about the validity of the current research.

Chapter 4

This chapter reports on the findings of the study. In that regard, the researcher reports on the themes that emerged from the data analysis and the relevant quotes from the transcriptions that coincide with the themes.

Chapter 5

In this chapter, the research findings are discussed in relation to the literature in the field. As such an integration of the data, research findings and literature is provided.

Chapter 6

This chapter provides a review of the study. Conclusions are made and the limitations of the study are discussed. Furthermore recommendations for future studies and considerations for health care provisions are provided. Lastly, the researcher provides a reflection on the study conducted.

CHAPTER 2: Literature Review

This chapter outlines the literature around the subjects of motherhood, HIV/AIDS and postpartum depression. The discussion begins with available studies on motherhood, postpartum depression and HIV/AIDS. This is followed by a discussion on how these variables link to each other. The usefulness of social support is also discussed. Lastly, the theoretical point of departure for this study is examined. This review of literature serves as both the background and foundation of the current study.

2.1 Motherhood

Motherhood is frequently defined as a phase that a woman enters when she becomes a mother. This role is linked to an adult feminine status and it demands that a woman takes on a complex identity (Nicolson, 1998). When searching for a definition of motherhood, one finds that it is usually not clearly defined in research studies. Furthermore, there has been an evolving discussion on motherhood and some authors have argued that this role is often defined as a function rather than an experience (Long, 2008; Phoenix & Wollet, 1991). This denotes that the subject of motherhood becomes the child receiving the mothering rather than the mother herself (Long, 2009; Phoenix & Wollet, 1991). As such, motherhood and how women experience this phase needs to be given a voice in research.

Walker (1995) has conceptualised motherhood according to three domains: *the practice of motherhood; discourses of motherhood; and motherhood as a social identity*. This attempt to delineate motherhood in various domains and definitions by Walker (1995), has been found to be useful in this study. Firstly, the practice of motherhood involves the acts of care that a mother undertakes, her involvement in childbearing and/or childrearing. This would constitute the functions that are performed by mothers. Secondly the available discourses of motherhood speak to the societal ideas about motherhood and the gender role

thereof. Lastly, motherhood as a social identity refers to the self-image associated with being a mother , it also speaks to how women who are mothers feel and think about their role as mothers, that is, it speaks to women as agents; how they subjectively take on the role, construct and narrate it (Walker, 1995).

Bearing these domains in mind, one comes to understand the complex nature of this role and the identity that women come to undertake with reference it. This makes it difficult to clearly and uniformly define motherhood. Motherhood must be understood as more than just the act of mothering, or as socially constructed but also in terms of the individual attribution women make in terms of their experience and understanding of the role.

Moreover, motherhood is concerned with a change in identity that becomes self-actualised through child rearing, it is a criterion by which women are defined by others and it is linked to their perceptions of themselves (Mamabolo, Langa, & Kinguwa, 2009; Phoenix & Wollet, 1991). By virtue of this, it has become a role by which women come to judge themselves and are judged in society. An understanding of this role thus has to be done with an acknowledgement of the context in which women live.

In the South African context, Motherhood remains an expected role for women (Segalo, 2003). It then appears that motherhood is a role that is significantly linked to womanhood, from this it can be inferred that women may feel pressurised to become mothers not only to fulfil a societal expectation but to also attain a status in society. The pressure is evident when looking at some of the reasons why HIV positive and HIV negative women have chosen to become mothers. Motherhood is idealised in society, culturally celebrated and expectations are made on the mother to take on its demands without major difficulty (Long, 2008; O'Hara, 2007). Due to the status given to mothers in society, women find that their

reproductive capacity becomes their source of power which in turn defines their identity and status in society (Segalo, 2013). Fertility has come to define womanhood (Segalo, 2013).

Womanhood and motherhood have become synonymous (Segalo, 2013; Walker, 1995). Thus the extent to which these two roles have come to be synonymous should be questioned further. Feminists have advocated that the notion of motherhood should be problematized (segalo, 2013), As such it should not be a given to determine womanhood. It appears motherhood has become a norm for womanhood and with that societal expectation influences how women perceive themselves.

Looking at the work of various authors on the topic, it is evident that this role is not clear-cut and with that, societal perceptions define what it should be and how a mother becomes. Thus how a woman comes to experience this role is linked to societal expectations and the individual perceptions she comes to define herself by.

Various SA authors have now called for researchers to give women an opportunity to give meaning to their own experiences (Long, 2008; Segalo, 2013).The current research focused on women's understanding and experience of their role a priority in research. It is interested in how women have come to take on this role. However, it does not ignore the societal influences and expectations as these may inform to different degrees the judgements and perceptions of individual women about themselves.

2.2 Postpartum Depression

During pregnancy and birth of children, the emotional wellbeing of mothers is an assumed norm (Manikkam & Burns, 2012; O'hara, 2007). Women are expected to celebrate the birth of children and undertake child rearing demands without great difficulty, but for mothers who are depressed this is not the case (O'Hara, 2007). The depressive mood

symptoms which will be discussed below makes it hard for women to undertake the practice of motherhood, to take on the societal expectations of motherhood and they also influence how they feel and think about their identity as mothers. This section outlines depression (PPD), Major Depressive Disorder (MDD), and Maternal Blues (MB), which will be followed by a contrast of these conditions, especially how they differ. Lastly, the prevalence and aetiology for PPD will be discussed.

2.2.1 Diagnosing Postpartum Depression

A depressive disorder is diagnosed when an individual presents with symptoms that cause clinically significant distress or impairment in occupational, social or other important areas of functioning. The symptoms of a depressive mood disturbance, include the presence of a depressed mood, lack of pleasure, weight loss or gain, insomnia or hypersomnia, fatigue, feelings of worthlessness or guilt, recurrent thoughts of death as well as a reduced ability to plan (DSM-IV-TR, 1994). Moreover, Postpartum depression is diagnosed based on the time frame within which symptoms are present i.e. it is diagnosable when the mood disturbance is noticed and persistent within four weeks postpartum period (DSM-IV-TR, 1994).

A diagnosis is made with the use of the above outlined criteria and a considerably thorough clinical interview (Manikkam & Burns, 2012). When screening for PPD, you are alerted of a possible presence of a disorder and further investigation is warranted to diagnose. Although further investigation to diagnose PPD is necessary, the current study will however focus on screening thereof. Screening is important as it allows for the possible detection of PPD, thus it is instrumental in identifying women who may require further examinations and interventions. Various screening measures are used to detect the possible presence of PDD, these include among others the Beck Depression Inventory (BDI), Inventory of Depression symptomatology (IDS), Edinburgh Postnatal Depression Scale (EPDS), and Postnatal Depression Screening Scale (PDSS). A discussion of these various measures falls beyond the

scope of this paper. The current study will make us of the EPDS as it was specifically developed to measure PPD and attempts have been made to validate its use with various groups of women in the SA context.

2.2.2 Major Depressive Disorder, Post Partum Depression and Maternal Blues

It may be useful to briefly contrast MMD, PPD and maternal blues as stated earlier. MDD and PDD symptoms are the same but they are differentiated by the time of onset and aetiological basis when diagnosing. The four week after birth specifier or time of onset helps differentiate MDD from PPD as PDD is diagnosable around that time period while general MDD is not limited to the postnatal period and only requires about two weeks at any given time (DSM-IV-TR, 1994). Furthermore, these symptoms are set to be indicative of PPD when the feelings and thoughts of the mother are a result of being a parent; they may therefore involve guilt and worthlessness about being an inadequate mother. This is in contrast to an individual who generally has an inadequate sense of self not limited to being a parent which may be more indicative of a MDD.

Maternity blues are considered to be a relevant risk factor for PPD, the symptoms experienced includes fatigue, lack of sleep, irritability, tearfulness and sadness within 2 weeks after delivery (Reck, Stehle, Reinig, & Mundt, 2009). These symptoms are transient and do not impair functioning while those present with both MDD and PPD impair it. Furthermore, maternity blues are not considered a disorder and are sometimes said to be a normal response following child birth (Reck et. al, 2009), even though the symptoms present may be alarming for a mother, they are not severe enough to warrant a diagnosis.

2.2.3 The Prevalence of PPD

The prevalence of PPD in S.A is unclear, however some authors have attempted to provide estimates of the prevalence rates in different S.A regions. Rochat et al. (2011) found that the prevalence of antenatal depression in the rural Hlabisa district was 47.1%. In this study, 109 women formed part of the sample and had symptoms of depression, 27 of these were HIV positive and 24 were HIV negative. Clinical interviews were used to reach the conclusions about the diagnoses, however the extent to which the findings can be generalizable may be questionable and limited because of the small sample size.

Another study by Manikkam and Burns (2012) found that 38,5% of women in an urban Kwa-Zulu Natal setting suffered from depression. This study sampled 387 women and they were screened for depression and thoughts of self-harm. Nonetheless, that study made use of a screening measure to arrive at the conclusions, and attempts were not made to validate the results diagnostically.

What is evident from the available statistics on the prevalence of PPD is that a significant number of women experience symptoms of depression after giving birth. The reasons for such a presentation after giving birth vary, and the next section aims to elucidate this phenomenon.

2.2.4 Aetiological Basis of PPD

The development of PPD is associated with various factors ranging from social contexts to both biological and psychological perspectives amongst others. These factors are not limited to but include the following: history of depression, hormonal changes due to child birth, individual reactions or thoughts about childbirth, lack of both social and financial support, unplanned pregnancy and unwanted pregnancies (Kathree & Petersen, 2012; Kong et.al, 2012; Mbatha, 2012; O'Hara, 2007). These factors interact in various ways and

exacerbate the development of PPD. For instance, women with a history of MDD are prone to PPD than those who do not have a history of MDD; and HIV infected woman are susceptible to both depression and PPD than their HIV uninfected counterparts. Additionally, those who fall pregnant and give birth are at risk of developing postpartum depression.

PPD should not be understood as a mere reaction to childbirth, but it is also linked to the way an individual makes sense of and copes with circumstances surrounding motherhood and environmental stressors (Kathree & Petersen, 2012; Nicolson, 1998). For some mothers, motherhood may regarded as challenge or anxiety provoking while for others it may be perceived as something pleasant. As such, it influences a mother's coping abilities and the amount of support that she may need. It can be useful for researchers to consider how the experience of PPD occurs in the context of the mothers' life situations.

2.2.5 Cultural Considerations in Depression

The importance of culture and context in the expression of psychological symptoms has been considered in research (James & Phrillelstensky, 2002; Massakowski, 2008). Most findings show that an individual's context influences the severity and type of symptoms communicated (James & Phrillelstensky, 2002; Massakowski, 2008). The manner in which depression is experienced and expressed is thus influenced by culture and context.

2.3 Human Immunodeficiency Virus

SA has been affected by the HIV and AIDS epidemic more than any other country in the world (Department of Health, 2012), and still remains a prevalent issue in this country. South Africa is estimated to have the largest number of people living with HIV/AIDS, and this has been noticeable from a long time ago (Adbool Karim et.al, 2010; Barnett & Blaikie, 1992). In 2011, an estimated number of 5 600 000 South African residents were living with HIV (Department of Health, 2012). In the same year, the prevalence of HIV among pregnant

women in SA was estimated to be 29.5 % (Department of Health, 2012). With such high rates, the social and medical understanding (links) is briefly discussed below.

The link between HIV and AIDS has been established, and the former has been explained as a cause of the latter (Adbool Karim et.al, 2010; Barnett & Blaikie, 1992). HIV destroys the body's defence mechanism and compromises the immune system which opens a way for other infections, and thus leading to death indirectly. As an illness, HIV/AIDS makes infected individuals dependent on other people, which calls for various forms of adjustment for those infected and affected.

HIV is diagnosed when an individual's blood has tested positive, indicating that the virus has entered the body and has potential to replicate and eventually weakening the immune system. This far, no cure has been found for HIV. Individuals diagnosed with HIV are treated with antiretroviral therapy medications which boost immune status and suppress the HI virus. This further prevents opportunistic diseases as the level of immune functioning is improved (Abdool Karim et al., 2010).

HIV/AIDS has profound social effects and impacts on communities (Adbool Karim et al., 2010; Barnett & Blaikie, 1992). HIV has come to also partake in ways that people are defined and viewed by others. It is at the level of the community that the understanding of this pandemic is built. HIV is a stigmatised disease which does not only affect the body, but also affects the relationships between people (Adbool Karim et al., 2010; Barnett & Blaikie, 1992), whereby the stigma attached to those affected will eventually lead to forms of rejection and marginalisation. The next paragraph will briefly explore stigma in light of HIV/AIDS further.

Stigma is a complicated phenomenon described as a social conception that leads to discrediting social label created on a basis of deviation from an ideal that influence how

people see themselves and are viewed by others (Clum, Chung,. Ellen and The Adolescent Medicine Trials Network for HIV/AIDS Interventions, 2009). Bearing the presence of stigma, issues around disclosure are implicated. One way to receive the desired support for those infected with HIV is to disclose their status to their social network, but they often find it hard to disclose because of the negative connotations and implications that come with the stigma attached to the disease (Frohlich, 2010; Thom, 2009; Sanders, 2008). The fear of stigma becomes an additional source of stress and anxiety. On the one hand, if those infected by the virus choose to disclose their status, they face the possibility of being rejected and not receiving the required support. On the other hand, if they choose to not disclose, then they do not stand the chance of receiving the necessary support required to deal with the disease (Thom, 2009; Sanders, 2008). In addition, for some, the option may be to suffer in silence, while others may choose to disclose in the hope of receiving the necessary help.

2.4 Mental Health of Those Infected with HIV

For some people being diagnosed with HIV has implications for their psychological functioning. When examining literature on mental health of those infected with HIV one finds that HIV positive individuals are at a greater risk of developing mental disorders than those without such a diagnosis (Freeman, Nkomo, Kafaar, & Kelly, 2007; Moosa & Jeenah, 2007). Individuals living with HIV/AIDS have been found to have high levels of depressive symptoms; furthermore depression is a common psychopathology in those living with HIV/AIDS (Govender, 2012; Thom, 2009). This comorbid diagnoses may be a significant problem as these illnesses then come to influence the individual's life and perception of the life they live contributing to a deterioration of life quality.

Various studies have looked at the relationship between HIV and depressive disorders. In a study by Olagunju, Addeymi, Erinfolami and Aina (2012) 30% of HIV

positive individuals reported experiencing psychological distress. In another study conducted by Peltzer and Shikwane (2011), 45.1% of HIV positive women reported having a depressed mood. These studies inform us of the relationship between mental health and physical health of those infected with HIV. This should be taken into consideration in treating individuals who are HIV positive. Care should not only be focused on physical health but emotional wellbeing as well.

It should however be noted that factors related to the development of depression in HIV positive individuals are multilayered and include the presence of a number of stressful life conditions that interact in complex ways (Olagunju et al., 2012). Societal and personal factors include high levels of unemployment, inadequate social services, lack of family support, being single and poverty to name a few (Freeman et al., 2007; Olagunju et al., 2012). These then interact leading to further deterioration and perpetuation of difficulties experienced.

The relationship between HIV and depressive disorder is not unidirectional. Depression is related to the quality of physical wellbeing in those infected with HIV/AIDS and treating it has an effect on the immune system status (Moosa & Jeenah, 2007; Thom, 2009). Depression often increases with the stages of the HIV illness (Andersen & Seedat, 2009; Moosa & Jeenah, 2007; Thom, 2009). An awareness of this link has implications for the immune system's ability to fight the infection and preserve health and life. It further means that they should receive services that cater for possible physical and psychological ailments.

Contradictory reports are found with regards to the association between depression and adherence to antiretroviral therapy. Research by Kitshoff, Campbell & Naidoo (2012) found that there was no association between depressive symptoms and non-adherence to

antiretroviral treatment. On the other hand Bangogo & Govender (2013) found that untreated and undiagnosed depression in individuals infected with HIV/AIDS leads to poor adherence to medication and lower quality of life. Furthermore, others have reported that depression that is untreated is associated to decreased tolerance to antiretroviral therapy (Andersen & Seedat, 2009; Moosa & Jeenah, 2007; Thom, 2009).

The exact link between the depression and its effects on physical health are not clear at this point it time, however both these diagnoses impact on the immune status and quality of life in those diagnosed. Thus for an individual who is HIV positive, becoming depressed compromises the quality of the immune system and threatens the quality of their health/lives. Thus there is a relationship between physical deterioration and mental deterioration and this in turn influences life quality and functioning.

2.4.1 The link between HIV and PPD

The following factors are associated with the development of antenatal and postpartum doeression in HIV positive women; discrimination, lack of social support, low income and stigma (Kong et al., 2012; Pletzer & Shikwane, 2011; Rochat et al., 2011). These factors are similar to those present in depressed people as discussed previously with the exception of stigma and discrimination due to being diagnosed with an infectious disease.

Some researchers have attempted to establish the prevalence of PPD among populations of women infected with HIV and high rates have been reported. Rochat et al. (2011) found that a significant number of HIV positive women were depressed. In addition to this, Kapetanovic et al. (2009) reported that the prevalence of perinatal depression among HIV positive women was found to be 30.8%. Thus, it will be of benefit for qualitative researchers to study the relationship between HIV and PPD as it will provide textured data from which to understand this link further.

2.5 The Transition to Motherhood

2.5.1 HIV Positive Pregnant Mothers

As evident in the previous sections, a significant number of pregnant women are HIV positive. Though HIV is a generalised epidemic in South Africa, the highest prevalence is among pregnant women (Department of Health, 2012). This denotes that the psychological functioning of pregnant women may require attention from health care workers. Research indicates that HIV infection may place mothers at an additional risk for depression during pregnancy (Manikkam & Burns, 2012).

HIV potentially affects different dimensions of women's sexual and reproductive health i.e. it influences the desire to reproduce, fall pregnant, mode of childbirth and the decision to breastfeed or not Phaweni, Pletzer, Mlambo, & Phashwana-Mapuya, 2010). It is often considered when women choose to have children, and the decision making that follows conception.

Like other women, HIV positive women also have a desire to have children. They too are influenced by societal perceptions of womanhood and motherhood. When looking at the reasons why some of the women have chosen to become mothers in light of their infection, one finds that they have chosen to do so because they view motherhood as signifying a certain purpose in their lives. Motherhood is perceived as a transition that completes what it means to be a woman (Cooper, Harries, Myer, Orner & Bracken, 2007; Sanders, 2007). Thus the belief that motherhood is definitive of womanhood is present as HIV positive women negotiate their status in society.

In addition to that the desire to experience pregnancy, rear children, the belief that children signify normality and the expectation from families and communities are also

motivating factors in the decision (Cooper et al., 2007). The desire to have children is linked to fewer children; partner knows status and family planning discussed (Phaweni et.al, 2010).

HIV positive women who choose to fall pregnant are often not free from the stigma that the society has placed on HIV/AIDS. These women have reported that they have been judged negatively for their decision to fall pregnant (Cooper, Harries, Myer, Orner, & Bracken, 2007; Sanders, 2007). Health care workers usually do not support such women who chose to fall pregnant as excepted and thus limiting their role as information givers only.

One would expect health care workers to be a source of not only information but also support when a woman makes a decision to have a baby, however, this is not the case. Such judgments expressed seldom, usually from health care professionals who made comments that displayed their disapproval of the HIV positive women's decisions to have a child (Cooper et al., 2007; Sanders, 2007). For instance, they are perceived to be placing innocent children at risk of contracting the HI virus (Sandelowski & Barosso, 2003). The negative connotations attached to their desires and decisions to have children become an additional source of distress as they negotiate their way to motherhood.

The state of health of the women as well as the possible health status of the baby is an issue that HIV positive women also have to battle with when they either make the decision to fall pregnant or when they are already pregnant. Emotional distress with regards to falling pregnant is also evident seeing that HIV positive women who are pregnant report that they experience the fear that they will infect their unborn children (Cooper et al., 2007; Sanders, 2007). In addition to fear of infecting the unborn baby they worry about the possibility of their own health deteriorating as a result of the pregnancy (Cooper et al., 2007; Sanders, 2007). These health concerns may or may not inhibit the need to have a baby.

From this one can infer that for a woman who is HIV positive falling pregnant is a decision that is not easily made, they have to rise above not only the stigma they receive from those around them but they also have to overcome the health fears they encounter about their health and that of their baby. The next section focuses on the experiences of women who have chosen to become mothers.

2.5.2 HIV positive motherhood

HIV positive motherhood is multifaceted, just as the definition of motherhood is not clear cut, there is no unified definition or experience of a universal HIV positive mother. However, research into the topic provides some useful conceptualisations. Long (2009) argues that two contradictory identities co-exist in HIV positive mothers; on one hand they have a degraded and feared identity because of being HIV positive while on the other hand they have an idealised identity of motherhood. This is understandable in terms of the stigma around HIV and the idealisation of motherhood as previously discussed. The mother is thus faced with the task of attempting to reconcile these two identities. The coexistence of these two identities thus calls on perceptions of self that may be difficult to integrate. One then wonders how this interaction is managed and understood in terms of their role and perceptions that they then come to have about themselves and potentially how that influences them and the identity they take on as mothers.

These women also have to live with and manage the fear they would infect their children and the fear that they could die, prematurely leaving their children to be raised by other family members (Long, 2009; Sandelowski & Barosso, 2003). Furthermore, there is also a paradox between a diagnosis of HIV as a mortal infection and that of pregnancy signifying an affirmation of life (Sandelowski & Barroso, 2003). Thus child bearing has significance for bringing hope for these women. On the other hand the diagnosis of HIV as an incurable disease may bring about despondent feeling. Motherhood in the context of

maternal HIV infection therefore introduces different and somewhat contradicting emotions that these women have to cope with and possibly attempt to reconcile or at least find a way to live with them.

In terms of role perception, the primary goal of HIV positive mothers is to protect their children and preserve a positive maternal identity (Long, 2009; Sandelowski & Barosso, 2003). This is linked to the extent to which they are ill or not (Plach, Stevens, & Heidrich, 2006; Sandelowisi & Barroso; Sanders, 2007). The more symptoms of ill health present at a time, the more diminished the positive view of self in relation to her role. Plach et al. (2006) state that there is a significant relationship between the amount of HIV symptoms a woman is experiencing and the degree of self-acceptance and role perception. Some of the ill health symptoms experienced include fever, cough, pain and weight loss (Plach et al., 2006). These limit physical functioning and thus limiting the extent to which mothering tasks are completed. From this it can be inferred that the more symptoms present at a time, the more diminished the positive view of self in relation to her role as a mother.

Women who are HIV positive perceive their role as a mother to be of poor quality and this negative perception interferes with the satisfaction in their status/role as mothers (Plach, et al., 2006; Sanders, 2007). This denotes that they have ideals of what a mother ought to be and in their view they may not meet the ideal.

2.5.3 Motherhood in the context of PPD

Women who have postpartum depression experience the transition into motherhood differently than those who do not have the psychological disorder. Women report that they experience a delay in adjusting to motherhood and learning tasks associated with the role as a result of PPD (Barr, 2008; Darvill, Skirton, & Farrand, 2010; Kathree & Peterson, 2012). Having taken on the role of being a mother, they also have to identify as such but they

struggle in this regard. They report that they have to re-adjust their self-concepts in order to adapt to the needs of their new born baby (Barr, 2008; Darvill et al., 2010; Kathree & Peterson, 2012). Maternal identity in this context is thus characterised by dissatisfaction with one's role and perceptions of being a mother as often defined or normalised.

These women also have found that the symptoms of postpartum depression interfered with learning the tasks and the role that is associated with being a mother (Barr, 2008; Darvill et al., 2010; Kathree,& Peterson, 2012;). These means that the tasks of mothering such as managing multiple tasks, taking care of the baby, decision making and housework become difficult for them to complete. Motherhood thus presents the women with a challenge of having to change their lives and identity but the psychological disorder interferes with this and in turn may be a source of additional frustration and distress.

Barr (2008) maintains that when comparing themselves to other mothers, women who have Post-partum depression viewed their adaptation to motherhood as delayed. When women with PPD compared themselves to other mothers, and societal role expectation, they view their experience as different. They therefore had a diminished self-esteem as a result of this comparison and this further resulted in lack of confidence in themselves and their abilities to be mothers (Barr, 2008; Darvill et al., 2010; Kathree & Peterson, 2012). Mothers who have postpartum depression therefore do not view their transition as occurring at the rate that it should, and this impairs their ability to mother their child as they are under the impression that they do not have the necessary skills.

Mothers who have postpartum depression also experienced anxiety and depressive symptoms and these impair their attachment to their infant, in addition to that they struggle to find a sense of love for their infants, and express mothering as mere task completion (Barr,

2008). This denotes that parenting or mothering is done not because of the love that they have for their children but because it is something that has to be done.

Mothers who have PPD are also stigmatised. This can result in underreporting as they also expect themselves to be happy after childbirth, thus experiencing the opposite may mean that there is something wrong with them. This will be important to consider in terms of early identification and intervention at a primary health care level.

2.6 Social Support as a Potential Buffer

Social support is a recurring theme when considering the development of mental disorders in both HIV positive and negative individuals as observed in the above discussions. It refers to the support received from family member, peers, professionals, etc. The social group is an important reference point and support network for the individual in defining and consolidating their identity (Walker, 1995). It not only defines expectations but it is also a means through which a potential ill can be brought back to a state of equilibrium.

Lack of social support is a source of stress in HIV positive pregnant women, and that makes it one of the aspects that are risk factors for developing depression and postpartum depression, alternatively having social support is one of the elements that can potentially cushion against developing these mental disorders (Ogalunje et al., 2012 ; Pletzer & Shikwane, 2011; Thom, 2009). Pregnancy, childbirth and a diagnosis of HIV can be an emotionally stressful event for women and they need the support of their social structure in order to counteract these stressful emotions (Mbatha, 2012; Rochat et al., 2013). Social support helps women to not only able to cope with the changes that come with motherhood but to also adapt their behaviour to these changes (Mbatha, 2012).

Thus the issue of social support alerts us of the context in which motherhood, HIV and mental health occur. Providing social support therefore can help women who are at risk of developing postpartum depression cope. Motherhood occurs in the context that women live in and thus a definition of their role as a mother is subject to their perceptions, views and the environments in which they live. Support of these women can be in the form of providing education on parenting skills and the reality of motherhood, in addition to this mothers who have recovered from PPD can act as mentors (Barr, 2008).

2.7 Theoretical and Paradigmatic Point of Departure

This study is situated in a phenomenological paradigm. Phenomenology has been described essentially as the study of lived experience (Laverty, 2003).This perspective has its roots in philosophy and has extended to different disciplines including psychology. In addition to this diversification, different standpoints are also taken.

In psychology, the two main approaches to phenomenological research are descriptive and interpretive phenomenology (Willig, 2008). Furthermore, different methods for collecting as well as analysing data associated with these approaches are found (Willig, 2008). Heidegger and Hursell are among others the founders of phenomenology as way to understand the world and acquire knowledge (Willig, 2008). However, there are differences between the kinds of knowledge that the phenomenology can produce according to these authors. Hursell proposed a more descriptive analysis while Heidegger argued for an interpretive stance. Both these are discussed below.

Descriptive and interpretive phenomenological studies share certain epistemological and ontological assumptions. Epistemology refers to the kinds of knowledge that our research endeavours produce while ontology refers to the kinds of questions the researcher seeks to ask and truths that research aims to bring about (Willig, 2008). A researcher working from

the phenomenological perspective seeks to attend to things, experiences and situations as they are (Smith, Flowers, & Larkin, 2008; Willig, 2008). Value is given to the subjectivity of human experience as knowledge. It asserts that there are multiple realities and there is a relationship between the known and the knower (Laverty, 2003).

In relation to the current study, the multi-layered experience of motherhood is explored further; the women's understanding of this phenomenon is treated with respect. Phenomenology thus emphasises an understanding of the world as experienced by the person and not reality as something separate from the individual (Laverty, 2003). Phenomenologists focus on the phenomena as experienced by the research participant, the current study focuses on the experiences of the women sampled. The current study is phenomenological because it is concerned with the lived experience of the women in the study.

The knowledge produced by phenomenological studies does not offer causal explanations about the existence of phenomena but instead offers knowledge on what is experienced as well as how it is experienced by the participants (Smith et al., 2008; Willig, 2008). This further entails a move from the natural scientific way of studying phenomena which searches for objective truths. There are also distinctions between descriptive and interpretive phenomenological approaches which are discussed next.

2.7.1 Descriptive phenomenology

Descriptive phenomenological research can be used to provide fundamental truths about the existence of phenomena. The aim of research then is to study an event or experience and describe it in terms of its essential concepts or governing essence (Smith et al., 2008; Willig, 2008). This denotes that an attempt is made to find the unique characteristics that make the phenomena under study what it is. A researcher working from this perspective is required to bracket their past knowledge and report on the objective

accounts of participants as they present themselves (Willig, 2008). In this way, the biases a researcher might bring to the research are put aside in understanding the phenomena.

2.7.2 Interpretive phenomenology

From an interpretive perspective, phenomena are interpreted to uncover their hidden meaning (Dowling, 2004 1996; Smith et.al, 2008). The assumption therefore becomes that the meaning of a phenomena can be uncovered through a process of interpretation (Dowling, 2004; Smith et.al, 2008). In addition to that it assumes that it is through understanding that we come to know the world and interpretation is the critical process of understanding (Laverty, 2003). Through the process of interpretation, the researcher engages with reality as presented by the participants and this brings about an understanding of the phenomena under study.

2.7.3 Theoretical Assumptions

Phenomenology subscribes to subjectivist and relativist epistemology. The subject matter in this form of research becomes the meaning of being, which is contextual. This paradigm concern itself with experiences and meanings (Willig, 2013). Certain assumptions are central to this way of thinking. These include the assumption that individuals attribute meaning to events and that then shapes their experience of the events (Willig, 2013). It is through questioning that the possibility of meaning opens up.

In interpretive phenomenology inquiry, the presuppositions of the researcher are not bracketed and the researcher's bias is used in further understanding the subject matter under study (Smith et al., 2008). The researcher's role in meaning making is acknowledged, through questioning and understanding the phenomena under study.

The role of language in this type of research endeavour warrants attention Language viewed as a means by which participants communicate their experiences and understanding

occurs and it thus understood as a tool in research (Willig, 2013). This theoretical stance is thus criticised for not taking a critical stance towards language (Willig, 2008).

2.7.4 An interpretive Turn to the Study

Interpretive phenomenology is the theoretical point of departure for this study. An interpretive stance further denotes that the phenomenologist will be concerned with discovering and recording the women's accounts of the experience rather than preconceived hypotheses. Thus phenomenology as prescribed by this stance will be used to understand how a select group of HIV positive women who have signs of postpartum depression experience motherhood. With that the researcher aims to explore the women's experiences, how they interpret it in terms of their personal characteristics and the context that they find themselves. In using this theoretical view, women were allowed to share their personal experiences with the researcher. The complexity of the experience researched.

2.8 Conclusion

In this chapter, literature linked to the current research topic was examined. From the literature it becomes clear that the relationship between physical and mental health has implications for the holistic wellbeing of individuals. It is thus useful to understand the experience of those infected with HIV and it's implications in the postpartum period. literature shows that HIV and PPD affect the nature of mothering, therefore gaining a richer (in-depth) understanding of the experiences of women presenting with the above conditions has implications in terms of extending literature in the field and designing preventative and support programs to cater for their needs. The theoretical underpinning of the study was introduced. In this way, it allows for the rich experience of motherhood to be studied and understood.

CHAPTER 3: Methodology

3.1 Introduction

This chapter discusses the methodological considerations that informed this study. The research process, the method of research and the research design are given. The methods used to locate participants and data collection are discussed with an inclusion of how the both the processes unfolded. The research setting for the study is then outlined. A brief reflection of the researcher's position is also provided. Furthermore, the data analysis method undertaken is explained in detail. This is followed by a discussion of issues pertaining to the quality (i.e. validity in quantitative studies) of the current qualitative research endeavour. Lastly, the ethical principles considered and relevant to the current study are discussed.

3.2 Qualitative Research Method

A qualitative approach was used which is concerned with exploring, describing and interpreting personal and social data (Smith, 2004). This approach allowed the researcher to study the phenomenon in its complexity and for meanings to emerge. The purpose of research from this perspective is to understand reality from the participant's frame of reference (Smith, 2004). Thus an idiographic approach that puts emphasis on understanding the individual is followed (Thompson & Harper, 2012; Willig, 2008). Moreover, it is considered to be concerned with the quality of experience as well as its context and it can be regarded as a holistic approach to the material the researcher is investigating (Hayes, 1997; Willig, 2008).

A qualitative researcher collects data from participants in naturally occurring settings and does not aim to predict events and experiences but rather to describe and explain them (Willig, 2008). A qualitative methodology therefore allowed the researcher to gather rich and

quality data from the women and provided for an exploration and understanding of experience for the mothers in the study. Based on this exploration and data collected idiographic understandings were explored, which will be explained more in the chapter that follows.

3.3 Research Design

Interpretive phenomenological analysis (IPA) was employed as a research design. It is a qualitative research method that explores in detail the personal lived experiences of people (Smith et.al, 2008; Willig, 2008). This method has risen from phenomenology, hermeneutic philosophy and subjective experience (Shinebourne, 2011; Smith & Osborn, 2007). It is detailed exploration of how participants are making sense of their personal and social world (Smith & Osborn, 2007; Smith, 2004). This method is argued to be phenomenological in the sense that it examines the participant's life world (Smith & Osborn, 2007). The concern is with the individual's account of an object or event as opposed to providing objective statements. It is also concerned with how meanings are constituted by individuals within both a social and personal world (Smith & Osborn, 2007). With the use of this method the researcher aimed to uncover and understand how a select group of women experience motherhood. A rich description of these experiences will be represented in the results chapter.

A double hermeneutic is involved in the process of understanding; on one hand, the participants are trying to make sense of their reality, and on the other, the researcher is trying to make sense of the participants trying to make sense of their world (Smith & Osborn, 2007; Smith et.al, 2009). The researcher therefore tries to gain an insider perspective, but this cannot be achieved completely because the researcher has his/her own conceptions of the phenomena (Smith & Osborn, 2007). The role of the researcher in interpretation and thus in the formation of meaning is acknowledged. The presuppositions of the researcher are not

discarded but are used to help in interpreting and thus understanding phenomena. However, since this may be an obstacle to the truth (participant's experiences), priority is given to the truth as provided by the participants in the study, not the researcher's biases (Shinebourne, 2011; Willig, 2008).

Thus the way that the researcher understands the experiences of motherhood for these women will be based on how she interprets the information that the participants share based on how they have come to understand their experience. According to Willig (2008) personal reflexivity involves both a reflection on how the researcher shapes the research and how the researcher is influenced by the research process.

3.4 Researcher's Position

This will start with my reflection on the interest in the topic, which started when I worked during my honours year as part of my academic demands I worked at Kalafong Hospital with parents living with HIV, those with infected babies as well as adolescents living with HIV. In my personal capacity, I also happen to live in a rural area where HIV is not talked about, people die, assumptions are made but an atmosphere of open communication and education surrounding HIV is not created. My interest was informed by the above.

A reflection on the research process will be provided in the last chapter. Another aspect of note here is that the researcher is a childless woman in her mid 20s. The researcher is a black African and of Pedi ethnicity. The extent to which this may have or may have not influenced the extent to which the mothers shared their life world with the researcher will be explored in a later chapter. Based on ethnicity and gender, the mothers may find it easier to talk to and related to the researcher. In addition to this, as a childless woman, I am not in a

position to claim expertise on motherhood; this may also facilitate openness from the mothers.

3.5 Research Setting

Two primary health care clinics in Mamelodi were selected. These clinics serve communities around them for various medical presentations including for postnatal follow ups. The area was chosen for purposes of locating the study. It should then be noted here that the area in which the data was collected is a township on the outskirts of Pretoria. The two clinics are government run and serve a multitude of people on a daily basis most of which cannot afford to pay for consultations at privately owned institutions and thus they patiently wait on the long queues to be served.

3.6 Selection of participants

Purposive sampling was used to gather participants for the study. Purposive sampling implies that participants are chosen because they meet a certain criteria and have characteristics that are of concern to the research topic (Shinebourne, 2011). In light of these an inclusion criterion was established. For the purposes of locating the study, African women 20 years and above attending postnatal care at primary health care two clinics in Mamelodi were targeted. The race was chosen for reasons of locating the study and not with racial discrimination at its roots. These women had undergone an HIV test and should be HIV positive and in addition to this they must have babies between 5 and 12 weeks old. It is commonly during this period that PPD can be manifest although it can occur even after this time period.

3.6.1 Locating Potential Participants

In locating participants, the nursing staff working at the community clinics were consulted in order to acquire assistance in recruiting the potential participants. They were briefed about the study and asked to ascertain their willingness to help locate participants. Thereafter, they were asked to refer women who meet the criteria for the study.

During the data collection stage, challenges were experienced, for instance, some of the nursing staff declined reasoning that due to the overpopulated nature of clinic, they would not be able to check accordingly the criteria with each woman they meet and thus refer to me. At this point, pessimism set in on the part of the researcher. However, at the end two sisters agreed to help, one at each clinic.

Three participants were recruited from the two primary health care clinics. The sample size was kept small as it was hoped that this will be sufficient and manageable for in-depth exploration. At the end, the ages ranged from 28-33. Biographical information such as parity, marital status, sex of child and social class formed part of the background context from which the life world of the participants may be captured. For the sake of making the sample homogenous the nurses were asked to refer the age group that fitted the targeted group. The nurses referred the above, with the exception of one woman who was slightly older the proposed age group, however, the sample remained homogenous in terms of age and the women were not much older than each other.

3.7 Data Collection Methods

Data was collected through the use of a postnatal depression screening measure as well as semi-structured interviews. Both methods are explained below. It should be noted here the screening measure was administered first then followed by the interview depending on the mother's score.

3.7.1 Screening for PPD

Data on signs of depression was collected using the Edinburgh Postnatal Depression Scale (EPDS). The EPDS is a self-report measure that consists of 10 multiple choice questions with four possible answers with score ranging from 0-3 and thus resulting in a maximum score of 30 and a minimum of 0, (Lawrie, Hofmyer, Jager, & Berk, 1998; Zubaran, Schumacher, Roxo, & Foresti, 2010). The questions asked the respondent about presence and severity of symptoms they have had in the past seven days and score indicates the probability of depression (Lawrie et al., 1998; Zuraban et al., 2010).

This measure has been validated for verbal administration in South Africa and the procedures as outlined in the validation study will be followed (Lawrie et al., 1998). A threshold of 11 is applicable for identifying women with depression (Lawrie et al., 1998), and this threshold was used in this study. The potential participants had a level of English that allowed them to understand the contents of the informed consent sheet and take the EPDS as the instructions that were read out in English, while reading I also provided them with the question so that they can see them and keep up with me as the questions were read them.

The data collection stage took much longer than expected; it took four months to locate the three women who made up the sample. The reasons for this varied, other times the women at the clinic couldn't be referred because when the nurse screened, they didn't meet the criteria, thus they never reached the researcher. Consecutive visits to the clinic were met the unavailability of participants.

At the end, the researcher had contact with six women, they were seen individually and the purpose of the study was explained to them. The mothers read the informed consent and were asked to voluntarily take part in the study. One of them declined to take part in the

study, two of which didn't score on the required range when given the EPDS measure. The remaining three made up the study sample.

3.7.2 Interviews

Data was collected using semi-structured interviews and these were conducted with the help of an interview guide. This form of interviewing assists in facilitating an interaction and allows for the dialogue to be open-ended (Shinebourne, 2011; Smith et al., 2008). It gives participants freedom to tell their stories and the researcher freedom to follow up on topics of interest that may have not been included in the interview guide (Smith et al., 2008; Willig, 2008). The aim of the interviews was to gather in-depth information from participants. The interview included the basic topics a researcher would like to gain insight into and it helps keep the questions within the scope of the research topic (Shinebourne, 2011), this was kept in mind when designing the interview guide.

The interview guide questions were informed by the research question, theoretical framework and the focus will be on motherhood. Moreover, the interview schedule was constructed with the aim of letting participants express their experiences of being a mother. The mothers were interviewed individually. Each woman was interviewed once for 45-60 minutes. However, the first interview was the exception, as it lasted 29 minutes, this was be attributed to interruptions at that stage, agitation with the mother standing throughout the interview to comfort the baby, thus it was important to get through themes as quick as possible.

These interviews took place at the interviewees' place of preference. It seemed most women preferred to be interviewed at the clinic on the day that the screening measure was scored. It seemed this provided them not only an opportunity to partake in the study quickly but also the familiar environment provided a sense of safety. As they queued, they trusted

that the nurse will call them when their time comes and thus they found it better to be helpful while waiting on the queue. Another interview took part in the researcher's car at the mall as a suitable location could not be found at the clinic on the day, the participant suggested a nearby mall as she said she also wanted to buy medication there on the day.

These interviews were audio-taped and transcribed by the researcher. Observational notes were also taken during the interview which will be incorporated in the understanding of the experiences represented. Although a room was provided for the researcher depending on the availability at the time, the private space was not free from disruptions by the nursing personnel reporting that they needed objects from the room. In addition to this there was constant background noise as the patients at the clinic communicated and cars driving around in the parking lot. The babies were also present during the interviews, at times the mothers also had to comfort them when they cried or became restless which was a distraction at times.

3.7.3 The process of transcribing data

The interviews were conducted primarily in Sepedi, Setswana and English. These audio-taped interviews were transcribed verbatim and translated for analysis. In transcribing the interviews, they were firstly transcribed in the language of the interview (mixed Sepedi, Setswana and English). Secondly, the interviews were also transcribed and directly translated to English (used in results presentation as extracts). The interviewer relied on her competency in the above languages in order to transcribe and translate the interviews.

3.8 Data Analysis Method

The steps of the IPA analytic process as outlined by Smith et al. (2009) will be used to analyse the data. The focus of the analytic process guides the attention towards the participants' efforts to make sense of their experience (Smith et al., 2009). Six steps are suggested in analysis of data.

The first step involves reading and reading the transcribed data and recording initial thoughts and observations one transcription at a time (Smith et al., 2009). This is done for the intention of ensuring that the participant's voice and data provided is the focus. Smith et al. (2009) state that this initial step involves the researcher immersing oneself in the original data as it was provided by participants. During this stage, the researcher read and listened to the transcripts continually as this phase required that one actively engages with the data. This stage is completed individually for each participant.

Secondly, the ways in which the participant talks about and understands the issue are noted. This involves making comments on the data and is the initial level of analysis and it is repeated for all the transcripts (Smith et al., 2009). There are ways that guide this process, for instance it is suggested that the researcher can make descriptive and conceptual comments at this time as well as comments on how the participant makes use of language (Smith et al., 2009). Descriptive comments focus on describing the content of what is said by the participant at face value, while conceptual comments focus on engaging the data on a more interrogative level, searching for provisional meaning and understanding of how participants are making sense of their world (Smith et al., 2009). The researcher noted here the ways in which participants communicated their experiences and the understandings that were emerging. These notes were made on the printed transcribed interview.

Thereafter, themes that emerged for each participant were written down. The aim of this is to identify interrelationships and patterns in the notes. During this phase, the primary role for the researcher was to organize the comments that were made in the previous stage and to find connections between them. Looking for emergent themes allows for the data to be manageable and represents an attempt to reduce the volume of detail (Smith et al., 2009). This was once again noted on the printed transcription as they occurred.

In the fourth step, the researcher searches for connections across the themes that emerged in the previous stage while discarding some if necessary (Smith et al., 2009). To complete this stage possible, the researcher found two methods useful, namely; numeration and abstraction. These are discussed below.

Numeration involves taking note of the frequency with which the theme occurred (Smith et al., 2009). The number of times the identified themes occurred were therefore noted and this helped the researcher to identify the dominance of certain themes in the data.

The abstraction method also appeared useful at this point, it is explained as a basic form of identifying patterns between emergent themes by putting together 'like with like' and developing a new name for the cluster (Smith et al., 2009). This was done by grouping the emergent themes as much as possible to arrive at overarching themes. Thus using these two methods allowed the researcher to identify patterns among the themes and to identify themes that dominated the data.

For the next stage, the researcher then moved to another case and performing the above mentioned steps for the unique case. It is argued that it is important to treat each case on its own terms and bracketing the ideas emerging from the previous case (Smith et al., 2009). It was important for the researcher to take some time off the analysis to allow for this to happen. This was important to ensuring that the idiographic commitment is kept and for new themes to emerge for each unique case.

Lastly, the researcher looks for themes across the cases. The themes that are relevant to the experience under study are noted. Thus through the analytic process, there is an integration of idiosyncratic meaning making by the participants and shared qualities (Smith et al., 2009). At this time, the researcher searched for patterns across three cases, identified them and later re-organised and sometimes renamed them.

Thus from the themes that emerged in the process, a narrative account of the findings is written. The interplay between the interpretation on part of the researcher and the participant's meaning making through their descriptions comes are incorporated. The participant's voices are retained and interpretive comments by researcher are made. This is illustrated in the next chapter.

3.9 Issues of Quality in Qualitative Research

To ensure quality in the research, certain issues and principles were considered and efforts were made to adhere to these measures. These include transparency, rigour, transferability to context and reflexivity. These are discussed below with detail on their applicability in the current study.

To ensure transparency, the researcher kept an account of the process of research through recording the interviews and transcribing them with accuracy. Transparency was kept in the manner in which data was collected, analysed and interpreted. Transparency involves providing the reader with information about decisions made in the course of research, the data gathering, analysis as well as interpretation methods; this allows the reader to judge the accuracy of conclusions reached (Roberts, Priest, & Traynor,2006 ; Meyrick, 2006). In terms of the data collection, information was provided in this chapter on pitfalls experienced along the way, location of participants as well as the whole process.

Rigour speaks to the meticulousness of the study (Smith et al., 2009). To maintain rigour, the researcher paid attention to ensure that complete analysis of interviews was conducted and that the homogenous sample helped answer the research question. The emergent themes are discussed in the next chapter and attempts are made to make use of extracts in order to link them to the data as provided by the research participants.

In addition to that the extent to which the findings of the study are applicable need to be explained. Transferability refers to the extent to which the research findings are applicable while contextualising individuals and locating them within situations to assist the reader in judging the credibility of findings (Creswell & Miller, 2010; Chamberlain, 2000). Thus information on the research setting is provided to help the reader make conclusions about the applicability of the results obtained during the research process. The data gathered and the inferences made thereof are to be understood in context and applicability limited to the background similar to that provided by the mothers in this study.

To maintain the quality of the results obtained the researcher tried by all means to minimise bias, and a process of reflexivity was adopted. Reflexivity requires that the researcher is aware of his/her own biases and assumptions and self-discloses them, the researcher reports on own presuppositions, this process then makes the researcher self-aware and at the same time it allows the reader to be aware of the researcher's position in the research and how the researcher's context and the data that is obtained have resulted in certain understandings and interpretations (Creswell & Miller, 2010; Willig, 2008). The role of the researcher in the research process is made visible and reflected upon. Information on the researcher's position was provided on one of the previous sections in this chapter and a further reflection will be provided on the last chapter of this paper.

3.10 Ethical considerations

The study adhered to the ethical principles stipulated by University of Pretoria. Ethical principles relevant to the study include; obtaining permission to conduct study, voluntary participation, acquiring informed consent from research participants, right to withdraw, keeping the data confidential as well as anonymous, minimising harm as well as making opportunities for debriefing available for participants, correctly citing sources and

acknowledging authors whose measure were used in the study. The applicability of these to the present study is explained below.

Permission to conduct the research was obtained from the ethics committee of the University of Pretoria and the Department of Health responsible for primary health care clinics in Mamelodi. In addition to this, permission was obtained from the clinic managers that were responsible for the two clinics from which participants were recruited.

Participation in the study was on a voluntary basis and the participants that took part in the study and the nursing staff that helped with recruiting participants did so willingly. Informed consent entails that potential participants are provided with information on the nature of the research and procedures to be followed before they agree to take part in the study (Salkind, 2009; Willig, 2008). To acquire informed consent a form was be given to the mothers outlining the nature of the research and procedures which they can sign to give consent. The consent form was also explained to the mothers verbally.

Confidentiality of the data is maintained and information about participants acquired through the research process will not be disclosed. In terms of anonymity, pseudonyms are used to ensure that the results are not linked to the research participants (Salkind, 2009; Willig, 2008).

Opportunities for debriefing after the interviews were made available. In addition to this, the participants were given an opportunity to be provided with contact details of an institution in Mamelodi that would provide psychological counselling at no cost if they need it as a result of distress caused by material talked about in the interview. None of the mothers took this up even though the first participant showed interest, she opted to think about it further before deciding, she was therefore provided with the researcher's contact details should a need arise. This is in line with the principle of minimising any harm that may occur

as a result of psychological distress. The debriefing provided would be at no cost to the institution.

The participants were also informed of their rights to withdraw from the study at anytime that they see fit. Awareness of the right to withdraw from the study denotes that the research participants are aware that they may excuse themselves from continuing with the study should reason to do so arise (Willig, 2008).

3.11 Conclusion

This study takes a qualitative approach to research and knowledge acquisition. Interpretive phenomenological method is introduced as a research design and its assumptions and techniques are used for data analysis. The research process undertaken was also discussed in detail and with the issues surrounding the quality of the results obtained through the research inquiry. Details surrounding the research process and unfolding are provided. The ethical implications and considerations that were undertaken prior and throughout the research process were also discussed.

CHAPTER 4: Research Findings

4.1 Introduction

In this chapter, the results from the data collected are presented. The chapter begins with a brief introduction to the mothers that took part in the study in order to provide an understanding of the context of the sample. It is important to note that *pseudonyms* are used to refer to the participants. Following the description of the sample, the themes that emerged from the interpretive phenomenological analysis will be presented and corroborated with extracts from the transcribed data.

4.2 Description of the Sample

Three mothers made up the study sample. These women were sampled in a township on the outskirts of Pretoria. The two clinics are government run and serve a multitude of people on a daily basis, most of who cannot afford to pay for consultations at privately owned institutions and thus they patiently wait on the long queues to be served. All the mothers were Black, from the Pedi ethnic group. The first participant the researcher met will be referred to as *Sonti*. She is a mother of three and she is currently co-habiting with her partner. She is unemployed and she found out that she is HIV positive while pregnant with her lastborn baby. She is 33 years of age and her EPDS score was 15.

The second mother was *Lebo*. She is a mother of two and she is single and not living with the father of her child, however she reports that they are still in a relationship. She is employed and she has already returned to work. She too found out about her HIV positive status during her most recent pregnancy. She is 28 years old and her EPDS score was 11. The third mother was *Tima*. She is a mother of one and she is customarily married to the child's

father. She reported that she found out that she is HIV positive while pregnant. She is employed but currently on maternity leave. She is 30 years old and her EPDS score 12.

Table 1 below provides a brief summary of demographic information of the three mothers interviewed in the study.

Table 4.1: Demographic information of the mothers sampled in the study

Pseudonyms	Age	Race	Ethnicity	Employment Status	Marital Status	No. of Children	EPDS Score
Sonti	33	Black	Pedi	Unemployed	Co-habiting	3	15
Lebo	28	Black	Pedi	Employed	In a relationship	2	11
Tima	30	Black	Pedi	Employed	Customary marriage.	1	12

EPDS = Edinburgh Postpartum Depression Scale

4.3 Description of the Emergent Themes

Main themes were identified from the data analysis performed and are presented in a summary table below (Table 4.2) followed by an interpretive discussion of each theme. It is acknowledged that these themes were not the only themes that emerged, but those that the researcher found to be dominant in communicating the lived experience of the mothers in the study. The themes are as follows:

Table 4.2: Themes emerging from HIV positive mothers with signs of post-partum

depression

Master Theme: Living with and Coping with the Diagnosis of a General Medical Condition

Constituent Theme	Sonti	Lebo	Tima
Initial reactions to diagnosis	it was very difficult, I couldn't believe it, I asked myself but why...	...after I was told, I was scared a little because when I got back home, I was not feeling okay...	...the first day I found out I said that it was not true...
Acceptance of the health condition	I have accepted	I was tested and told that I am positive and I didn't have a problem because the matter was discussed before and I accepted because they explained to us.	I pray and that it what has helped me cope with this,
living in interpersonal relationships: the avoidance of locating blame	I don't want to think bad things...	From the beginning I didn't have a problem because I didn't ask myself where I got it,	I on the other hand have no reason to blame another person, sometimes I blame myself that I should have been responsible , had I

			been responsible I wouldn't have been infected..
Living with HIV: perceptions employed	I feel sad yes, it is making me realise that at the end of it all I will be emaciated and I will be seriously ill	As long as I am like this, I am going to raise my children, I am going to live.	when I look at this HIV, you can live even longer than a person that does not have it if you choose to live right

Master Theme: Becoming a Mother

Reactions to pregnancy and motherhood	I didn't have a problem with the baby, and I told myself that I will raise the baby	I was happy that I have a child	I was happy I had a baby
The importance of baby wellbeing	he doesn't have a problem	I am not supposed to let me child suffer	... I was worried about whether the baby would be okay after what had been said and they baby turned out okay..
Maternal functions	I wake up, I clean	sometimes I just	then the baby wakes

- daily tasks completed	and I make food for my baby food and after that I eat as well, and then I sleep.	wake and do the laundry, and then clean, and then make the baby food	up, he does not eat, I breastfeed him , bathe him and then when he is sleeping I study
Maternal functions - impressions of their abilities to complete the tasks	I do it normally, the way that I am used to doing it and the way the way that I was doing it before, I don't have a problem	No, when it comes to fatigue no , being tired or sick I would be lying, I don't have that, I am just okay	
Identity and perceptions as mothers	"bana ke ba mosadi" (children belong to the mother)	I can't explain it to you because what has made me happy is the fact that I am called mama *Rine* or mama *Gali* (pseudonyms) is what has made me happy, the fact that I am someone's mother, that is what makes me happy in life	You have to be responsible and sacrifice some things…

| *The role of social comparison stemming from status as a mother* | | …it is part of being a woman, it is impossible, not to want to have a baby. | I think every woman wishes to be a mother, to have a child that is your own |

Master Theme: Knowledge and Social Support

Empowering and educating oneself: sharing and acquiring knowledge	they explained to me that they are stopping the medication and that if my CD4 count was low	Sometimes when you are with other mothers you, they share their concerns and things they have experienced	I did research, I am person who likes to be informed
Disclosure difficulties and expected social judgement	it is like, it is not time yet, when the time comes I will tell them	No I have not told them, many of them talk too much	I can't tell them because it depends on the kind of person you are disclosing to and how they will handle it and how you are
The role of social support	I needed an outlet, where I could cough it out so that it		I think the issue of disclosing helps

doesn't stay with me,

Master Theme: Psychological Wellbeing		
Implications for *mental health*	if I didn't trust God, maybe I didn't trust him I would have done like others or I would have killed myself when I was pregnant	maybe had it been another person they would have been more miserable than the way that I was

4.3.1 Coping with the diagnosis of a general medical condition.

All the mothers found out while they were pregnant that they are HIV positive. This means that after this, considerations had to be made in terms of how they reacted to the news as well as efforts to reach a stage of acceptance. Thus the discussion here moves from their initial reaction to the diagnosis of HIV to how they attempted to accept and cope with the news, thus integrating it into their experience of being.

4.3.1.1 Initial reactions to diagnosis.

It seems at hearing the news disbelief was the first reaction. This was following by attempts at meaning making and to a certain extent integration and understanding of the illness into their life world. For instance *Sonti* stated that "I never thought that I would have that thing". A struggle is identified in terms accepting the diagnosis. They also describe it as something that happened to them, something that they now have to accept and plan for the implications thereof. *Tima* reports;" I was worried and as time went by I told myself to accept the situation because by not accepting, I will cause myself depression, I won't be able to

concentrate and will not be able to perform at work and at exams that were approaching...".
Lebo speaks of it in the following way; ... "God knows I didn't choose to fall into a pit and I didn't think that it would happen to me thus when it happens I have to bear it"

For the mothers, acceptance was not an easy thing to arrive at, from *Sonti*, there is a provision of reasons why it doesn't make sense for her to be told she is HIV positive. For *Lebo*, is sounds like a terrible thing that happened to her and she now faces the battle of making sense of it and she makes use of religious beliefs to achieve this. For *Tima*, at first it was unreal and accepting meant prevention of ill mental health. The essence of the mothers' reactions is that being HIV positive was something initially inconceivable to them, something that they never thought would be part of their life world but now that it is, they had to attempt to reconcile it into their lived experience.

A sense of sadness and shock reactions are also expressed in relation to this. For instance *Sonti* says; "... I cried that day shem, I cried, and when my husband came back from work. The sad thing is that he doesn't have it, he's negative and I've got it."

4.3.1.2 Acceptance of the health condition.

Through the data runs a theme for the women to accept the situations in which they find themselves in. For *Sonti* it became hard to accept because of her behaviour, which should have protected her from infection.

It seems *Sonti* is conflicted in terms of acceptance and feelings of disbelief. She appears to be in a stage in which she is trying to reconcile these two conflicting points, and this mental work has implications for her psychological wellbeing. She concludes with expressing a need to accept in order to prevent stagnation, similar to the avoidance of ill health expressed by Tima in the previous section.

Sonti "Therefore I don't understand it, I have never been one to run around and even him, I have been thinking, even him as well, I don't want to think bad things", on another instance she reports the following " I have accepted. Sitting in the house crying will not help me with anything, it will not amount to anything."

It seems Lebo doesn't engage much in questioning how she came to be diagnosed, perhaps due to the religious defence already adopted in the initial reaction or the medical explanations provided upon testing. She expresses her acceptance in the following way:

Lebo: "I didn't have a problem because the matter was discussed before and I accepted because they explained to us."

Tima brings in her religious beliefs in order to maintain acceptance of being HIV positive and drawing in internal strengths to understand that she can cope with the diagnosis given. She expresses this in the following way;

"I pray and that it what has helped me cope with this, when I found out how I was and understanding that it isn't the end of the world..." in terms her attributes she reports that "maybe had it been another person they would have been more miserable than the way that I was"

It seems acceptance comes to be related to reinvesting back into their life world instead of wallowing on the difficult situation emanating from being diagnosed with HIV. There is a need for life to continue despite this or rather in light of this and acceptance is the gateway to that. This then raises the question of whether they have truly accepted the diagnosis or if they are providing a superficial account in order to be able to continue with life.

4.3.1.3 Living in interpersonal relationships: the avoidance of locating blame.

Lebo reports "I just accepted that it was the way things were and I didn't want to blame someone else". The avoidance of blame is expressed in various ways; in explicit attempts to deny blaming another (relational partner) as well as in distancing oneself from bringing the virus into the relationship. *Tima* reported that she cannot blame another as she did not take the responsibility to prevent infection, however she also expressed that her good behaviour warrants that she did not infect her partner. Related to this, was the impressions that the mothers also have about their good behaviour and the reasons they were not infected outside the current relationship. *Sonti* "Therefore I don't understand it, I have never been one to run around and even him, I have been thinking, even him as well,"

They express these impressions almost as though they do not fit the schemas of the people who get infected. Good behaviour is closely conceptualised as a preventative measure. *Tima*: "it is not my mistake, to tell the truth I was well behaved, most people think that it is those who go around, sleep around and I am not like that, I have never been like that"

What is interesting is that by virtue of distancing themselves, they are implicitly blaming their partners even though they don't overtly state it, it is communicated. *Tima*: "…let me say that I didn't take the responsibility as an individual, taking responsibility means that you go testing together and you get to verify and be sure and not have it that another person says that I have tested, or use a condom until, make a good decision before you sleep with another person without a condom, therefore I can't blame another person that I failed to take the responsibility

Avoiding blame seems to be a method of maintaining harmony in the relationship. In this manner the women continue living in relationships with their relational partners.

4.3.1.4 Living with HIV: perceptions employed.

This theme, linked to that of acceptance, speaks to the realisation that life has to go on. It also speaks to the efforts of these women in attempting to maintain hope for the future as well. They make use of their understanding of their health condition in order maintain hope. *Lebo* states "you do as you are told and people will not see how you are, you will be fine and you won't show that you are sick, you thus see that you can live a life as others live it". To an extent an impression is given that due to the invisibility of the diagnosis, one can still attempt to lead a normal life. *Tima* speaks to this in the following manner; "other people smoke and have other diseases or you find that their situation is not good at all, because yours is not visible"

They also bring into play existential issues of tragedy being a part of human living. *Lebo*: "I will die in my own time, other people die and there were not even sick". Embedded in this could also be a resistance to focusing on the struggles experienced and instead defending by stating that 'life goes on'.

However, *Sonti* brings in a degree of difference and speaks to an awareness of physical symptoms not as a means to maintain hope but rather as affirmation for her frail health condition. In contrast to the two women, she is already entertaining the possibility of her health deteriorating drastically as a result of HIV infection. She speaks of this in the following manner:"ya.. ya... I am okay, it is just that now I have been realising that I am losing weight. I used to fat"

"yes and I don't like it, I feel sad yes, it is making me realise that at the end of it all I will be emaciated and I will be seriously ill, eish,"

4.3.2 Becoming a Mother

4.3.2.1 Reactions to pregnancy and motherhood.

The mothers reported that they were happy when they received the information that they were pregnant. The following expresses the various reactions: Sonti "for the first time I was happy that I am pregnant" Lebo: "I am always in a state of happiness that I am also a mother, Tima: "…on the other part I was happy that I am pregnant because I was told that I can't get pregnant".

Although the pregnancies were not planned, the mothers wanted and welcomed the possibility of having children. For *Tima*, the reality of her religious beliefs set in and became an additional stressor concerning right and wrong, she expressed this in the following manner "It was not something we planned or prepared for because I wanted us to receive the blessing from church". For *Lebo*, she wanted a baby and she is happy that she was having one at that point in time. For *Sonti*, the problem was not the baby she states; the problem must have been something else then, the HIV status.

4.3.2.2 The importance of baby wellbeing.

The mothers expressed with relief and pride that their babies are well and do not have the infection that the mothers have been diagnosed with. Sonti: "I was like eish, lucky enough that my child doesn't have what I have". Tima: "...So my worry was the baby because I didn't want him to be positive…"

Related to this is also the issue of continuing to protect the baby from infection. This was expressed in the following words from the mothers: *Lebo*: "when they are sick I have to take them to the doctor, or if something is not well to attend to it to make sure s/he is well". *Tima*: "I saw that he is okay, and every time we have a follow up they check him to ensure that he is growing well and all". Thus from the mothers, there was a worry that they would

infect their children with the HI virus. Receiving the news that their children were HIV negative was received with relief by the mothers.

A need to rear their own children was also expressed and this seems to be related to ensuring the wellbeing of the babies. This is especially communicated by *Sonti*: "imagine me dying whilst my baby is still small". For *Tima* an additional issue was trusting people to look after her baby in her absence and trusting that they will respect her feeding decisions even though she has not disclosed that it is related to her being infected with HIV.

"I don't want to leave him alone with anybody until 1 year 6 months and they have seen that he is okay because you don't know what another person will do to the baby and you will find that there is damage caused and you just come and breastfeed and you know they say breast milk had an infection, but when I ask the nursing sisters and doctors they say that if you drink your medication well, it is rare for the baby to be infected, I don't know if they are trying to give me hope or what but I don't want to just relax and tell myself that it is rare, I am drinking it as prescribed and I have an alarm and when it goes on, I drink"

4.3.2.3 Daily tasks completed.

Mothers expressed continued completion of mothering tasks, which are of importance for them. They report no difficulties in being able to complete the required tasks for these mothers. *Sonti*: "I do it normally, the way that I am used to doing it and the way the way that I was doing it before, I don't have a problem". Attached to their maternal functions is also the need to be responsible and responsive to the baby's needs. *Lebo*: "What I did was comfort him until he was tired of crying and he went to sleep". *Tima*: "…if you go to the clinic, you will find that it is filled by mothers who have brought children to the clinic even though the baby belongs to both the mother and father".

4.3.2.4 Impressions of their abilities to complete the tasks.

The mothers communicated the need for things to remain as they were prior to the diagnosis of the medical condition. The following extracts from the interview speak to the expression of this need in relation to the tasks of mothering that they have had to complete: *Sonti*: "it has been the same, the same way it was with my first child and second, it is still like that". What the mothers are communicating is their adequacy to mother their children regardless of their diagnosis. *Lebo*: "No, when it comes to fatigue no, being tired or sick I would be lying, I don't have that, I am just okay".

4.3.2.5 Identity and perceptions as mothers.

There's a theme of motherhood as a privilege that emerges as mothers compare themselves socially and tell life stories on womanhood (status). Perceptions of self as a good mother come out. *Lebo*: "I am an mother who is alright, I don't have a problem, when the baby cries I will try to breastfeed, if he continues crying I will put him on my back and comfort him. *Sonti:* "I am a good mother". *Tima:* "I perceive myself as a good mother"

Motherhood as an identity, a way of seeing oneself and being seen by others is also communicated. *Lebo:* "when I pass in the street and they see me, I am someone's mother, and when I go home and I am called out mama risha, I get happy, happy that I am someone's mother and they know my child and that I am the mother". *Sonti:* ""bana ke ba mosadi"(children belong to the mother), I am the one that takes care". *Tima:* "if you go to the clinic, you will find that it is filled by mothers who have brought children to the clinic even though the baby belongs to both the mother and father". Motherhood as a social identity associated with caring for the child, expected that you should be able to do so.

Issues of change as a result of taking on this role also came about, as women now take this role and the traits that are associated with it. *Lebo:* "it shows that a person has grown up .

You are a mother when you take care of your children and you see that in terms of maturity in thinking. *Tima*: "yes there are changes and you should be willing to be responsible so that you can adjust to the changes"

4.3.2.6 The role of social comparison stemming from status as a mother.

The theme of social comparison came about in terms of the health status (already discussed) of the mothers as well as the appreciated role of motherhood that they have been able to undertake.. The social expectation of motherhood is also prevalent in their communications. *Tima:* "there is a difference between a person who doesn't have a child and the one that does, even though it is not much. Lebo "is important that a woman has a baby, it is important for a woman to have a baby, it is not desired for you to be a woman but not want to have a child".

4.3.3 Knowledge and Social Support

4.3.3.1 Empowering and educating oneself: sharing and acquiring knowledge.

The importance of acquiring knowledge and information in relation to mothering and one's health is also expressed. *Sonti*: "they told me that they were stopping the medication and after and my blood was drawn and sent to the laboratory and after that when the results came back I was told that my CD4 count was still okay ". *Tima*: "maybe it is because he is my first child I rush to the doctor and sometimes they tell me that he is not sick, I google, I ask around, tell them I see this or that on my child what is it and even though it is just people's opinions". As mothers use various media modes to acquire that, it proves as a way to ease experienced concerns and anxieties. *Lebo:* "I listen to doctors talking, to people talking about how they are and how they live and they don't have problems".

Hearing about people in similar situations also seems to calm the mothers and reassure them that they too should be fine. *Lebo*: "…then we share and we are able to give

each other advice". *Tima*: "I was watching a programme on Tshwane TV last week and they showed a lady there who said that she has disclosed to people that she works with".

4.3.3.2 Disclosure difficulties and expected social judgement.

Women expressed difficulties disclosing their HIV status to significant others. They expressed how interactions with various individuals in their lives have influenced whether or not to disclose. It also seems disclosure to their partners was the first line of communication for them. Thus it seems there are fears around disclosure due to expected judgment. *Tima*: that sometimes I become scared and worry about what other people will say. Lebo "I can hear with the way that they talk about others when they are like this (HIV positive), I can hear how harmful it can be"

For them it could also be a means of maintaining normality for as long as possible, ensuring those interactions remain the same and are not perturbed by the news of the status. Sonti "but I didn't want them to know when (illustrates weakness), I want them to know when I am still strong ". *Tima*: "my bother doesn't understand people who are HIV positive, that is why it is not easy for me to disclose to him because I hear the way he talks about them and I see that he doesn't know that this thing is present in his family but one day I will tell him".

Tima: "the only person that I have disclosed to is my mother". My mother is not judgemental and she has worked for love life and she is informed.

The importance of disclosing is acknowledged even though not achieved. *Tima*: "I think the issue of disclosing helps, I hope that one day I will stand before people and tell them that I am like this, but at the moment I am not in that position. I think that it helps a lot, you don't feel shame, even if they want to gossip about y u, what's there to talk about because you have stood before them and told them".

4.3.3.3 The role of social support.

After disclosing to limited people, it seems the mothers have benefited from ongoing support from those around them. *Sonti:"* I thought that if I cough it out it will not eat me up, and it was so". In this way she shared the difficulty with the people in her life in order for them to help her bear the diagnosis. *Tima:* "and if we want to continue with our relationship let us forget about who brought it in and who didn't, instead we should rather be supportive of each other". Thus for Tima, the relationship with her husband also depended on them being supportive of one another.

4.3.4 Psychological Wellbeing

4.3.4.1 Implications for Mental health.

When looking at the mental health of the mothers in the study, the results are complicated by the diagnosis of HIV during pregnancy. *Lebo:* if I didn't trust God, maybe I didn't trust him I would have done like others or I would have killed myself when I was pregnant. That's why I told myself to trust God and pray, and get guidance and accept that

It seems that even though the measure screens for the presence of depressive symptoms during the postnatal period, their sad feelings seem to be related to the infection. *Tima:* "I told myself to accept the situation because by not accepting, I will cause myself depression, I won't be able to concentrate and will not be able to perform at work". In addition to this, difficulties seem to also be related to issues of disclosure and social support.

4.4 Conclusion

From the results above, it is clear the experience of motherhood in the context of HIV and symptoms of PPD is a complex phenomenon. Themes that emerged and are discussed

centre around the lived experience of the mothers. The mothers express a concern about their health and that of their babies as a result of the HIV positive diagnosis. The implications for their social relationships and the issues around disclosure and social support emerged. When the mental health of the mothers is considered, the results are linked to the medical condition diagnosis rather their PPD symptoms reported.

CHAPTER 5: Discussion of Findings

5.1 Introduction

This chapter is a presentation of the discussion of the results in relation to the literature on the topic. It begins with a brief summation of chapter 4, thereafter the results are meaningfully discussed in conjunction with the literature to enable the understanding of the lived experience of the mothers that took part in this study.

5.2 Summary of Results

As presented in the previous chapter, three mothers took part in the study. Their scores on the postpartum depression scale fell in a range that suggested the presence of PPD symptoms. In addition to this they were all HIV positive and following up for postnatal care at two primary health care clinics on the outskirts of Pretoria. . Mothers in this study were not expecting to be pregnant or HIV positive and found out about this upon consultations at the clinics, however, it was easier for them to accept the possibility of motherhood than the diagnosis of a HIV. Even though their pregnancies were unplanned, they welcomed it and report that they have been able to fulfil the functions that come with that.

From the results chapter, it became evident that the roles that mothers take vary, thus making the understanding of motherhood a complex phenomena. In addition to this, the presence of a medical condition further interplays with the views that the mothers take about themselves and the kind of care they have to provide for their babies. Mothers are not only concerned about their health but that of their babies as well.

When it comes to issues of disclosure it appears that the mothers have thus far disclosed to people in their lives that they anticipated would not judge them. They are cognisant of the benefits of disclosure, however they also express that they are not ready to

disclose to other people. The theme of disclosure is interlinked with implications for social support and in this chapter these two topics are discussed within the same focal point.

The issues of mental health are also briefly considered and the implications thereof for psychological functioning. For the mothers this appears to be linked closely to illness reactions. They speak of a need to accept the diagnosis and anticipate that this acceptance will be good for their mental functioning.

5.3 Motherhood as a Complex Multi-faceted Role

Mothers in this study described their role mostly in relation to their children. They also described their own experiences in terms of the feelings that they have, but somewhat linked to their ability to mother. The mothers judged their impressions of motherhood in relation to their ability to provide for and mother their babies. This confirms the literature defining the experience of motherhood to be linked to the acts of care that a mother undertakes and her involvement in childbearing and/or childrearing. This would constitute the functions that are performed by mothers and falls within the practice of the motherhood domain (Long, 2009; Walker, 1995). In a sense there is truth to the statement that in as much as there is no baby without a mother, there is no mother without a baby.

It also becomes clear here that the domains of motherhood are interlinked. It is not easy to separate the identity of the mothers from their practice of motherhood and how this is informed by societal ideas. Mothers in the study explained in various ways how mothers are the primary caregiver for children, thus speaking to their social responsibility towards their offspring. This role and responsibility as they take it on may be perceived as a contextually and social defined belief that influences their mothering. Thus this is consistent with literature arguing that societal ideas about mother and the female gender shape the experience of motherhood (Walker, 1995).

5.3.1 Motherhood as Social Identity

Motherhood, for the mothers who took part in the study, is a role that comes with being responsible for another, thus adjusting the perception of oneself to not just be responsible for yourself but another individual too. They narrate stories of personal changes that motherhood required them to make. Authors speak to this dimension and argue that motherhood is concerned with an identity that becomes self-actualised through child reading, and it is linked to perceptions mothers come to form of themselves (Mamabolo et al., 2009; Walker, 1995). For *Lebo*, this change is also manifested in how one carries oneself after they have become a mother and the limitations in self-needs acquisition. For *Tima* too motherhood meant sacrificing her own needs and old habits for the benefit of the baby.

In literature, motherhood as a social identity refers to the self-image associated with being a mother, it speaks to how women who are mothers feel and think about their role as mothers; it speaks to women as agents; how they subjectively take on the role, construct and narrate it (Mamabolo et al., 2009; Walker, 1995). From the narratives of the mothers, it becomes evident that they are taking on the role as they understand it and adjusting their behaviour to fit the constructed image. All the mothers in the study perceived themselves as good mothers and this perception was related to their ability to nurture to their children. It has come to be perceived as a role that requires one to be responsible as well as readjust the being in order to be able to mother effectively. The experience is also one that is taken with pride and privilege by the mothers hence speaking to its significance for them.

The mothers also take this role as a privilege, as they compare themselves to other women, they communicate appreciation for the opportunity to mother. From this it can be inferred that this is an important role for them to fulfil, this is consistent with the report by Segalo (2013) that mothers are given an important position which comes to define their identity and status in society.

5.3.2 The Social Expectation of Motherhood

The social expectation of motherhood as a norm is also prevalent in the mother's narratives. They speak of how it is desired of women to be mothers and expectations of motherhood. This confirms notions in the literature that in the South African context, motherhood remains an expected role for women (Segalo, 2003; Walker, 1995). Motherhood is idealised in society, culturally celebrated and expectations are made on the mother to take on its demands without major difficulty (Long, 2008; O'Hara, 2007). Interestingly, the mothers expressed they welcomed the news that they were pregnant even though the babies were not planned.

5.3.3 Maternal Functions

Mothers in the study experienced no difficulties in terms of fulfilling maternal tasks which contributed to their positive identity and regard of their identity. In terms of role perception, the primary goal of HIV positive mothers is to care for their children and preserve a positive maternal identity (Long, 2009; Sandelowski & Barosso, 2003). This may be due to various factors; they are currently not experiencing any ill health which reinforces hope for them and the symptoms of postpartum depression reported seem to not be impairing their current functioning. Literature posits that PPD often interferes with tasks of mothering and leads mothers to adopt a negative self-concept to due difficulties fulfilling tasks (Barr, 2008; Darvill et al., 2010; Kathree & Peterson, 2012). Perhaps this was not evident in the current study because efforts were not made to investigate whether the symptoms reported are of severity to warrant a diagnosis and to impair the mothers' functioning.

The protection of the baby from infection was important for the mothers in the study and mothers responded with relief when they were told that their children were HIV negative. It was therefore of importance for them to have healthy babies. These women also have to live with and manage the fear they would infect their children and the fear that they could die

prematurely, leaving their children to be raised by other family members (Long, 2009; Sandelowski & Barosso, 2003). For *Sonti*, this is evident in her report that she still wants to be around to raise her baby; she doesn't want to leave her children. For instance, *Tima* lives not only the fear of infecting her child, but the management and avoidance of infection thereof. After she chose to only breastfeed, she justified this decision in terms of health benefits for the baby; however, she is hypervigilant to the possibility of infecting the baby and wants to ensure that that does not happen. Emotional distress associated with falling pregnant is evident in reports by HIV positive women that they experience the fear that they will infect their unborn babies (Cooper et al., 2007; Sanders, 2007), this concern is expressed by the mothers in this study.

5.4 HIV: Disclosure and Social Support

The women in the study found it difficult to disclose their status to individuals they are in contact with including family members. They spoke of the kind of judgement that they anticipated should they disclose. For them, they spoke of not being ready as another reason for non-disclosure.

Fears of stigma in relation to contracting HIV are also present, the women felt the need to share with the researcher how well behaved they have been, this already speaks to the notions in society concerning what kind of people contract HIV and views concerning promiscuity, as a result they distanced themselves from this commonly held beliefs about the people who contract HIV. Bearing the presence of stigma, issues around disclosure are thus complex. For individuals diagnosed with HIV, one way to receive the support that they need is to disclose their status to their social network, but they often find it hard to do this due to the stigma attached to the disease (Frohlich, 2010; Thom, 2009; Sanders, 2008).

From what the mothers communicated concerning sharing their status with those who can potentially provide support, it seems they benefited from disclosing. They spoke of the cathartic nature of disclosure when sharing with those who didn't judge them based on their HIV status. The social group is an important reference point and support network for the individual in defining and consolidating their identity (Walker, 1995). For *Lebo*, disclosure nearly cost her a relationship and she has not disclosed to anyone except her partner due to fears of social judgement and stigmatisation. HIV has come to also partake in ways that people are defined and viewed by others. It is a stigmatised disease and thus it not only affects the body but the relationships between people (Adbool Karim et al., 2010; Barnett & Blaikie, 1992), to maintain harmony and perceptions of one within the relationship, these women have chosen not to disclose, this is one way to maintain homeostasis in the relationship.

5.4.1 Implications for Social Support

Support for the mothers is not only received from family members but also peers and health care professionals. This was evident with the mothers in the study; they reported that they have benefited from acquiring information through various means. The nurses they are in contact with, doctors, other mothers, other people living with HIV and the media. Their reports of the beneficial nature of this support literature that speaks to social support as reducing the effect of stressful life events and enhancing coping (Mbatha, 2012).

There also seems to be in their narratives a need for further psycho-education for the mothers. They can benefit further from information about ill health, medication and immune functioning. *Sonti* for instance still fears health deterioration despite advice from health professions that she doesn't need medication due to adequate immune functioning. For Tima, fears concerning infecting her baby persist despite reassurance that should she take the medication as prescribed, the baby should be protected.

5.5 Mental Health

For the purpose of this study, it was not clarified whether or not the women's presentation on the EPDS warrants a diagnosis of PPD. However from what has been gathered, the diagnosis of HIV had implications for the psychological functioning of the mothers. Initial reactions therefore also included sadness and shock. Although the mothers had unprotected sex they were surprised when they found out that they are HIV positive. The exploration of this is beyond the scope of this paper. However, if the issue of avoiding blame is considered here, it became prevalent in the results that the women did not want to locate blame even though they were distancing the infection from themselves; perhaps they were of the assumption that their partners were HIV negative.

Mental health functioning in the study was closely linked to issues concerning acceptance of the diagnosis. *Lebo* for instance reports that if it was not for religious beliefs she would have killed herself. *Tima* speaks of the misery she found herself in. In addition to this, *Tima* reports that she had to accept what has happened to avoid depressive symptomatology which could have impacted on her function. They therefore acknowledge the importance of acceptance as having implications for good mental health functioning.

When screening, you are alerted of a possible presence of a disorder and further investigation is warranted to diagnose. The current study focused on screening for PPD for the purposes of alerting of the presence of symptoms however unlike most research on this, efforts were not made to confirm the diagnosis. It can't be ignored that mothers who have PPD can be stigmatised. As discussed in the literature review section, this can result in underreporting of symptoms as they expect themselves to be happy after child birth. When comparing themselves to other mothers, depressed mothers view their adaptation as delayed (Barr, 2008; Darvill et al., 2010; Kathree & Peterson, 2012). The mothers in this study preserved a positive maternal identity in terms of caring for their children and they did not

report impairments in functioning. This could mean that their symptoms were not severe enough to impair their current functioning.

Linked to this, perhaps the reporting of the impact of postpartum depression for the mothers is linked to their context as well. Literature reports that in the social setting, motherhood is expected to be culturally celebrated and expectations are made on the mother to take on its demands without major difficulty (Long, 2008; O'Hara, 2007). In addition to this, culture influences the expression and severity of symptoms of depression (James & Phrillelstensky, 2002; Massakowski, 2008). In that regard perhaps that could also explain why the expression of psychological difficulties is more linked to the medical condition than the role of mothering and the demands thereof. Thus, the extent to which the mothers made sense of their role and the depression symptoms is influenced by the context they find themselves in. For them it may have been easier to admit the psychological difficulties experienced more in relation to their physical health rather than the demands of the role they have undertaken.

5.6 Conclusion

In this chapter, the experience of motherhood for the women who took part in the study was discussed in relation to existing literature on related topics. As demonstrated, motherhood is a complex multi-faceted role that women undertake. It comes with changes in identity and requires one to take on the tasks of caring for another.

Even though their pregnancies were unplanned, the acceptance of motherhood came easier than the diagnosis of being HIV positive. This can be understood in relation to the fact that, motherhood is celebrated and a normative expectation for women in society while HIV is a stigmatised disease that people sometimes feel the need to hide due to fears of judgement as revealed in the literature and confirmed by the experiences of the mothers in this study.

This has implications for the degree of social support they receive as well as mental health. Accepting the diagnosis is paramount for the mothers as that is linked to psychological functioning. Disclosing too is linked to this some mothers reported that after disclosing there was catharsis as well as support from the individuals spoken to.

CHAPTER 6: Conclusions, Limitations and Recommendations

In this chapter, limitations of the study are provided. Thereafter, recommendations for future research and implications for service delivery and provision are discussed. Lastly, conclusions of the study are provided and the researcher provides a reflection in relation to the current study.

6.1 Limitations of the Study

The findings are limited by the qualitative nature of the study and sample size and are not generalizable. The study aimed to provide a detailed account of the mothers' experiences. The sample was kept small in order to make it manageable for a dissertation; perhaps a bigger sample could have enriched the data in a different manner. In addition to that, all the women were diagnosed with HIV while pregnant; the experience could be different for those who fall pregnant after they know their diagnosis.

Efforts were not made to investigate whether the reported symptoms were also present prior to the pregnancy. Furthermore, a single screening measure was used with no attempts to confirm the diagnosis of PPD.

6.2 Recommendations

From the study conducted, various recommendations are made. Firstly, a similar study can be conducted with women who have known of their HIV diagnosis prior to falling pregnant. It can be assumed that their experience of pregnancy and motherhood may be different compared to those that find out about their HIV status while they are already pregnant.

Secondly, future research and interventions can also focus not only screening for PPD but to undertake a more thorough assessment by trained clinicians in order to diagnose and

track mothers struggling and thus intervene appropriately. Conducting such research will enhance the understanding of having a diagnosis PPD in the context of motherhood.

Thirdly, the use of support groups can further be beneficial, it is clear that the mothers appreciate the interactions that they have come to have with others, thus formalised support group intervention can prove useful for them to share their experiences with each other. In this way, mothers can benefit from ongoing social support.

Lastly and linked to this, the need and importance of psycho-education is also raised, not only on PPD but also coping and living with HIV in relationships. Despite the reported counselling received by the mothers from health care professionals, it seems they still had worries and concerns about their health deteriorating and possibly infecting babies. Thus mothers can then acquire the necessary knowledge and skills to understand their diagnosis and implications thereof.

6.3 Conclusions

This study aimed to study the experience of motherhood from a phenomenological point of departure. An in-depth exploration of the experience as it is lived by the mothers who took part in the study was provided. As demonstrated, motherhood in the context of HIV and PPD is a complex phenomenon. For the participants, although their pregnancies were unplanned, they gave an impression that it was easier to accept the role of motherhood than the diagnosis of HIV. This was understood in the sense that motherhood is celebrated and a normative expectation for women in society while HIV is a stigmatised disease that people sometimes feel the need to hide due to fears of judgement as revealed in the literature and confirmed by the experiences of the mothers in this study.

Issues of stigma limited the extent to which the mothers disclosed their HIV positive status to significant others which limited the amount of social support received. At times that the mothers were able to disclose, it seems they benefited from sharing their experience as well as learning from those in a similar situation to them.

Thus motherhood is the context of the diagnoses of HIV and possible PPD is an intricate phenomenon to understand. The current study attempted to clarify the above phenomenon for a select group of mothers and found that the experience of motherhood unified on the following identified broad themes; living with and coping with the diagnosis of a general medical condition, considerations on becoming a mother, the role played by knowledge and social support and lastly; implications for psychological wellbeing.

6.4 Researcher's Reflection

As stated in chapter 3, my interest in the topic started when I worked at Kalafong Hospital with parents living with HIV and infected babies and adolescents. My training during my MA in clinical psychology has further exposed me to the prevalent nature of mental ailments experienced by those living with HIV.

The research process impacted on me in various ways, I had read on motherhood and HIV and PPD, and now I was about to partake in the reality, I soon realised my need to heal, to see mothers well despite this, mothering well despite the above and I wanted to hear that. I saw how I was also led by the participants and the way they spoke, the use of words such as positive, my inhibition at times in that regard.

I can't help but wonder about my impact on the participants, I am slightly younger than all of them, in addition to this am a childless young woman with whom they were asked to share their experience of motherhood. In addition to this the position I found myself in was

difficult, as expecting the researcher to share their life world with a stranger, which they welcomed.

I appreciated the manner in which they openly communicated and shared their world with me. Despite knowing very little about me except that I was a student researcher and as it became apparent through the interaction that I am of the same ethnic and racial group as them, they spoke, and they shared their life experiences with me. Perhaps my gender as well helped in rapport building as well as with their openness and honesty in the narratives that they provided.

In terms of IPA, as a novice research working within that paradigm, reaching for the in depth left me unsure at times what to follow up on, I had to remind myself of the mandate, the research topic, but also allow the participants to lead, balancing this was a difficult task to complete. In addition to this, the data analysis stage that required of me to be more interpretive was the most anxiety provoking analysis stage and time consuming for the researcher, as a novice researcher using IPA, it became difficult identifying issues of to note. I found myself overly relying on participant's descriptions and I had to caution myself from taking it all at face value. It was also at this time that supervision was of importance in assisting organise the analysis completed.

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APPENDICES

Appendix 1: Informed Consent letter

Faculty of Humanities
Department of Psychology
10 July 2014

Consent Information letter

I am currently completing my MA in clinical psychology; part of the course requirements is to conduct research.

You are invited to take part in a study that explores the experiences of motherhood for HIV positive women showing signs of postpartum depression. As part of the study, you will be required to complete two interviews which will be audio recorded and notes will taken during the interviews. During the first interview you will be required to answer questions on depression symptoms you have experienced, this will take 10-15 minutes. If your score meets a set standard, you will then be requested to take part in another interview that will take 45-90 minutes. These interviews will occur at a place that is suitable to you.

Participation in this study is voluntary and you may at any time choose not to participate and withdraw. This will not be held against you in any way. If you do decide to withdraw any information you have provided up to that point will not be used in the study. If some questions make you uncomfortable, you may also choose not to answer them. Please note that confidentiality will be maintained and the discussion of the study results will not be linked to you. Should participation in the study cause you psychological distress, you are required to alert the researcher who will then refer you to an appropriate person to receive help.

The information gathered in the study will be stored in a safe and secure place in the Department of Psychology for 15 years. It may be used at a later stage for further research. The data will be stored in a way that it will be possible to link it to you personally in any way as your name will not be used in the collection of information.

If you have concerns or questions about the study please contact:

Khomotjo Tsebe 0736890268/ khomotjotsebe@yahoo.com

Linda Blokland 082 202 2099/ linda.blokland@up.ac.za

Consent form

I _____ have read the information sheet and I have understood the information it contains. I voluntarily agree to take part in the study described above.

Signature: _____

Date: _____

Appendix 2: Interview Guide

Biographical information:

- Age:
- Ethnic group:
- Parity:
- Marital status:

Questions:

- Could you describe your typical day as a mother?
- How do you describe yourself as a mother?
- How did you feel about your pregnancy?
- Can you tell me about how being a mother has been for you?
- What were some of the reasons you decided to be a mother?
- What does motherhood (being a mother) mean to you?
- What were your expectations about motherhood (being a mother)?
- How did you feel after giving birth?
- To what extent has being a mother lived up to your original expectations?
- What is the best thing about being a mother?
- What is the worst thing about being a mother?
- Do you have any concluding remarks on your experience of being a mother?

Appendix 3: Edinburgh Postnatal Depression Scale (modified)

As you have recently had a baby, I would like to know how you are feeling. I am going to read some statements to you and give you a choice of four responses.

For example, I have felt happy:

Yes, all the time

Yes, most of the time

No, not very much

No, not at all

Please choose an answer that comes closest to how you have felt in the past seven days, not just how you feel today. In the past seven days:

1. I have been able to see the funny side of things:
   As much as I always could.
   Not quite so much now.
   Definitely not so much now.
   Not at all.
2. I have looked forward with enjoyment to things:
   As much as I ever did.
   A little less than I used.
   Much less than I used to.
   Hardly at all.
3. I have blamed myself unnecessarily when things went wrong:
   Yes, most of the time.
   Yes, some of the time.
   Not very much.
   No, never.
   No, not at all.
4. I have been worried for no good reason:
   No, not at all.
   Hardly ever.
   Yes, sometimes.

Yes, very much.

5. I have felt scared or panicky for no good reason:
   Yes, quite a lot.
   Yes, sometimes.
   No, not much.
   No, not at all.
6. Things have been getting on top of me:
   Yes, most of the time I haven't been managing at all.
   Yes, sometimes I haven't been managing as well as usual.
   No, most of the time I have managed quite well.
   No, I have been managing as well as ever.
7. I have been so unhappy that I have had difficulty sleeping (not because if the baby):
   Yes, most of the time.
   Yes, sometimes.
   Not very much.
   No, not at all.
8. I have felt sad and miserable:
   Yes, most of the time.
   Yes, quite a lot.
   Not very much.
   No, not at all.
9. I have been so unhappy that I have been crying:
   Yes, most of the time.
   Yes, quite a lot.
   Only sometimes.
   No, never.
10. The thought of harming myself has occurred to me:
   Yes, quite a lot.
   Sometimes.
   Hardly ever.
   Never.

Source: Lawrie, T. A,, Hofmyer, G. J., De Jager., M & Berk, M. (1998). Validation of the Edinburgh postnatal depression scale on a cohort of South African women. *South African Medical Journal*, 88(10),1343-134