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Title: Creating capabilities through maternal mental health: a case study at Hanover Park

Abstract

Almost 50% of South African women living in poverty experience mental illness during pregnancy. This is more than three times the prevalence in developed countries. The poverty-mental-illness cycle is well-documented. In sub-Saharan Africa, MDG4 outcomes (reduce mortality of children under five years) have worsened, and MDG5 outcomes (improve maternal health by reducing maternal mortality per 100 000 live births by 75%) have not improved. The primary causes cited for these failures in development correspond with the outcomes of untreated maternal mental illness.

The capabilities approach to development, pioneered by Amartya Sen and Martha Nussbaum, attempts to highlight how poverty and gender inequality combine to lead to the failure of capabilities which development goals attempt to address. Applying this approach to a case study, this paper will (a) explore the deprivational impacts of maternal mental illness, (b) describe the Perinatal Mental Health Project intervention in Hanover Park, Cape Town and (c) argue that maternal mental health interventions may enhance resilience and facilitate the conditions necessary to rise out of poverty.

Of women recruited into the study (n= 327), 55% of women were unemployed and 53% were diagnosed with Major Depression. Of women who attended counselling (n=49), 69% reported problems with their primary support system, which could result in capability deprivations related to emotion, affiliation and material control over one's environment. Other capability deprivations were related to bodily health and bodily integrity. The PMHP therapeutic counselling interventions included: containment, grief counselling, trauma debriefing and psycho-education.

The Hanover Park descriptive data confirm the high prevalence of both economic deprivation and mental illness in pregnant women. The capabilities approach provided a nuanced understanding of the *ways* in which women's central functional capabilities are compromised within the cycle of poverty and mental illness. Preliminary data suggests that maternal mental health interventions may act as strategic entry points for capability formation and sustainable development.

Keywords: poverty, maternal mental health, gender, mental illness, capabilities approach, Millennium Development Goals

Introduction

The World Health Organisation estimates the incidence of depressive symptoms among women in developing countries to be between 15% and 57% (Surkan et al. 2011). Almost 50% of South African women living in poverty experience a mental illness during pregnancy (Hartley et al., 2011; Rochat et al., 2011). This is more than three times the prevalence in developed countries (Mark Tomlinson et al. 2009) The poverty-mental-illness cycle is well-documented in low and middle-income countries (Lund et al., 2010). The cycle indicates that there is an increased risk of mental illness for those living in poverty and an increased likelihood that those living in poverty will drift into, or remain in, poverty (Lund et al., 2011).

The aim of this paper is to locate maternal mental illness in a development framework to highlight its significance for development outcomes. Mental illness, and maternal mental illness specifically, poses one of the most significant threats to development (Miranda & Vikram Patel 2005). The associations between female gender, poverty and common mental disorders are located in a capabilities framework to evince the consequences of untreated maternal mental illness.

1. The Capabilities Approach

Capabilities emerged as an alternative to purely economic approaches to human development. It was pioneered by economist and Nobel laureate Amartya Sen. The approach sees beyond economic resources for measuring quality of life and wellbeing, and considers what people are able to do or to be, as a result of having resources.

Sen argues that development requires the removal of obstacles to create free and sustainable expression of one's agency. The approach provides an understanding of poverty and related 'deprivations' (Sen 1999). Nussbaum (2011) expanded on Sen's framework to propose a comprehensive assessment of how personal, social, environmental, political and economic factors act together, and not independently, to limit capabilities (Giullari & Lewis, 2005; Sen, 1999). Taking gender into account, she argues that 'poverty combined with gender inequality leads to the acute failure of central human capabilities' (Harcourt 2001). The capability approach is an evaluative framework for gender inequalities, capable of distilling the economic, political, social and epidemiologically disabling environment (Robeyns 2004; Harcourt 2001). It provides a framework for assessing human development, and a tool for advancing it (Hill 2003). From a gender perspective, the capabilities approach provides 'a more grounded analysis of the problems women face because of their gender ... [and] looks at what is needed to enable poor women to function fully within society' (Harcourt, 2001: 4).

2. Poverty, Gender and Common Mental Disorders

A multi-country study in low and middle-income countries, found that women are disproportionately affected by mental health problems (Vikram Patel et al. 1999). In addition, it found that low-income groups are more vulnerable to suffer from common mental disorders, 'irrespective of the overall state of development of the society they live in' (Patel et al., 1999: 1468). Relative poverty is a risk factor for mental illness. In 2012, South Africa was upgraded by the World Bank as an upper middle-income country. However, the World Bank acknowledges that South Africa is one of the most unequal countries in the world, with a Gini coefficient of 0.7 in 2008 (World Bank 2012). The top 10% of the population accounted for 58% of South Africa's income. The bottom 10% accounted for just 0.5% of income and the bottom 50% less than 8% (World Bank 2012).

Female gender and poverty increases vulnerability to mental illness, and the prevalence of major depressive disorders in women is highest during the childbearing years (Kessler et al. 2003). In addition, pregnancy is a time when women experience an increased rate of onset of depression (Buist et al. 2002).

Based on the literature, and preliminary evidence emerging from research conducted by the Perinatal Mental Health Project (PMHP), the time of pregnancy, especially for women living in contexts of poverty and relative poverty, can be a time increased deprivations and compromised capabilities.

3. Common Mental Disorders and Capability Deprivation

Both poverty and mental illness can be framed as capability deprivation because they interfere with a person's functioning, that is, their ability to make valued decisions, access services and opportunities, and participate fully in society (Hopper 2007). Development interventions that tackle poverty without addressing the high prevalence of mental illness may fail to address all the factors that influence a women's functioning, and her ability to engage with economic opportunities. Sustainable development interventions require more than making opportunities available; people need to be in the material position to bring opportunities to fruition.

Research shows that common mental disorders are causes, rather than merely correlates, of impaired functioning, especially with regard to low earnings (Levinson et al. 2010). In addition to economic deprivations, the primary causes cited for failures to achieve key development targets correspond with the outcomes of untreated maternal mental illness (Meintjes et al. 2010). Specifically, in South Africa, MDG4 outcomes (reduce mortality of children under five years) have worsened, and MDG5 outcomes (improve maternal health by reducing maternal mortality per 100 000 live births by 75%) have not improved (Chopra et al. 2009). The capabilities approach to development highlights how poverty and gender inequality combine to lead to the capability deprivations which these failures represent (Meintjes et al. 2010; Harcourt 2001).

3.1 Functioning

The World Health Organisation reports that mental illness affects more people and gives rise to a greater loss of human resources than all other forms of disability (Levinson et al. 2010). Mental illness can dramatically impair one's capacity to work and to earn a living. It can be regarded as a mechanism whereby an individual's capacity to self-determination may be seriously compromised (Davidson et al. 2009). This leads to impoverishment, which can worsen mental illness. More working days are lost per year as a result of mental disorders than physical conditions (WHO 2000). Depression is the leading cause of disease burden globally for women between 14 and 44 years of age, which by 2020, will account for 8.62 Disability Adjusted Life Years (DALYs) (Mayosi et al. 2009).

The perinatal period is a time of increased physical and emotional demands on woman, and the disability associated with depression is likely to interfere with many essential functions related both to the mother and the infant (UNFPA 2008). Depressed mothers are more disabled and less likely to care for their own needs (Miranda & Vikram Patel 2005). The recent Report on Confidential Enquiries into Maternal Deaths in South Africa found that mental illness is increasingly contributing to maternal mortality (South African Department of Health, 2007). Depression in mothers may also lead to increased maternal mortality, both through adverse effects on physical health as well as more directly through suicide. Suicide is a leading cause of maternal mortality in developed countries (Oates 2003). This evidence shows that mental health has an integral role to play in achieving many of the Millennium Development Goals (Prince et al. 2007).

3.2 Maternal mental illness in South Africa

Prevalence rates for maternal mental illness in South Africa are high. In a Khayelitsha study, 39% of women were diagnosed with antenatal depression (Hartley et al. 2011). A study in rural Kwazulu-Natal showed 47% of pregnant women had diagnosable antenatal depression (Rochat et al., 2011). In 2012, the PMHP study in Hanover Park, a low-income community in the Cape Flats, shows that 53% of women attending the

maternity facility are diagnosed with depression. The rate of maternal mental illness in South Africa is therefore more than three times that of developed countries, where prevalence ranges between 10 to 15% (Warner et al. 1996).

The Mental Health Care Act of 2002 legislates the integration of mental health services into the primary health care system, yet this has been difficult to realise due to: enormous burden of disease, lack of political will, stigma, lack of knowledge regarding the prevalence and nature of mental illnesses, under-resourced health facilities, poorly trained nursing staff, lack of appropriate screening tools, and insufficient skilled counsellors, psychologists and psychiatrists to provide effective treatment. Only 7% of psychologists in SA work in the public sector (Breier, Wildschut, & Mgqolozana, 2009; Health Systems Trust, 2011).

3.3 Maternal mental illness and specific deprivations

Mental illnesses are proven risk factors for physical health problems such as HIV infection (Prince et al., 2007). Physical health problems may, in turn, exacerbate mental illnesses (Repetti, Taylor, & Seeman, 2002). Women suffering from depression may experience low energy, fatigue, reduced problem-solving abilities, concentration, and low self-esteem. These symptoms interfere with treatment seeking (Grote, Zuckoff, H. A. Swartz, Bledsoe, & Geibel, 2007).

Studies indicate that depression is associated with a disturbance in cognitive performance, particularly with executive function, memory and processing speed (McDermott & Ebmeier, 2009). Women suffering from depression often experience difficulties in participating in social and family life and in maintaining job performance levels. This leads to feelings of frustration, low self-esteem and feelings of worthlessness. A cycle is thus set up where negative feelings enhance depressive symptoms (Hammar & Ardal, 2009).

In South Africa, pregnant women are routinely tested for HIV infection and learn of their HIV status during this time. The presence of a mental illness is significantly associated with the non-adherence to antiretroviral regimes (Mellins, Ph, Kang, & Leu, 2003). Depression in particular is associated with poorer HIV treatment outcomes (Hartzell, Janke, & Weintrob, 2008). Local research shows that women with HIV are more likely to experience abuse, and those that are abused are more likely to contract HIV (Dunkle et al. 2004).

A South African study showed a 35% prevalence of domestic violence during current pregnancy (Mbokota & Moodley, 2003). Research indicates that the incidence of domestic violence may escalate during pregnancy (Mezey & Bewley, 1997). Suffering from a mental illness may impair a woman's ability to address situations of harm (Roberts et al. 1998).

Depression during pregnancy may influence attachment to the foetus and be the basis for poor mother to infant bonding (McFarland et al. 2011; Rochat et al. 2008). In addition, postnatal depression is associated with less optimal mother-infant interactions and insecure infant attachment (Carter et al. 2001)). A review on the long-term effects of maternal mental illness found the following risks among mothers experiencing depression or anxiety: increased likelihood of self-medication with alcohol or drugs; reduced sleep and appetite; poor antenatal weight gain; increased risk of pre-term birth and low-birth weight and increased risk of emotional and behavioural problems in the child (Surkan et al. 2011; Talge et al. 2007).

4. The PMHP Intervention: Enhancing Agency toward Capability Formation

Evidence shows that the impairments and deprivations of common mental disorders can be reversed with best-practice interventions (Levinson et al. 2010; Stewart et al. 2006) The PMHP model is informed by evidence from low-resource settings showing that integrated maternal mental health services may provide support necessary to enhance agency, build resilience to challenging life circumstances, and facilitate the conditions necessary to rise out of poverty. Mental wellbeing among mothers forms a range of capabilities

that have shown to mediate the link between poverty and negative child health outcomes. One of the most striking benefits of improving maternal mental health is a significantly reduced health gap between rich and poor children (Propper et al. 2007).

4.1 The PMHP intervention

In South Africa, over 90% of pregnant women attend antenatal care at least once, and 73% have up to four visits (UNICEF, 2008). Therefore, the antenatal period presents a unique opportunity to provide mental health care for women in need. The Perinatal Mental Health Project (PMHP) maximises on this opportunity by integrating mental health care into obstetric services at 4 public facilities in Cape Town, in partnership with the Department of Health.

The primary objective of the PMHP is to work toward achieving universal maternal mental health services by developing, evaluating and optimising interventions and tools through service provision. This includes mental health screening for pregnant women and free, on-site counselling within maternity services. Its secondary objective is to prepare the environment and enhance scalability of maternal mental health services through 3 complementary programmes. The PMHP trains health practitioners and provides in-service professional development for health workers in the maternity setting. It also conducts pragmatic research, which is imbedded within the clinical setting, to develop, evaluate and optimise maternal mental health service models. Research uptake is ensured through the PMHP's advocacy programme (Honikman et al. 2012).

4.2 The PMHP intervention at Hanover Park

Hanover Park is a peri-urban settlement outside Cape Town. It has a history of gang violence, often involving the drug trade. Women who live in this setting frequently experience threatening life events, exposure to multiple forms of interpersonal and community violence (emotional, physical, and sexual violence as well as witnessing violence) and chronic stressors.

The PMHP Project is situated on the grounds of the local Community Health Clinic (CHC) which operates a day hospital and a 24 hour emergency service. The Midwife Obstetric Unit (MOU) is run by midwives and provides an antenatal service and a labour ward. The PMHP partners with the MOU to provide a mental health service for pregnant women.

In Hanover Park*:

- 61% of adults have no income
- Only 11,4% of adults have a monthly income more than R1600
- Less than 20% of adults have completed high school

**Community Action for a Safer Environment (CASE), a community-based organisation in Hanover Park. Data available at www.case.za.org*

Women are screened for mental illness at their first antenatal visit and referred to an on-site PMHP counsellor if necessary. Counselling appointments are made to coincide with antenatal visits in order to increase access for women with scarce resources. The counsellor refers women to the psychiatric nurse or to the social worker for further intervention as appropriate. The PMHP also links in with referral networks to non-governmental organisations in the community providing additional support.

In order to overcome some of the deprivations faced by women with mental illness, creating an environment that is sensitive to women's feelings and needs is important. The PMHP provides training to health workers to create an environment of empathic client engagement. Coordinating counselling sessions with antenatal and postnatal visits, and offering telephonic counselling sessions, are strategies used to try and overcome some of the logistical barriers that women in low-resourced settings face. These facilitate continuity of care and follow-up. The PMHP has an 'open-door' policy to encourage women who default appointments to access care when needed. The integration of mental health care into maternity care may also reduce stigma associated with counselling or mental health services.

4.2.1 Description of the study population (n = 327)

Screening data from 327 pregnant women showed the mean age to be 26 years. Of women included in the research (n= 327), 95% had a partner, with 90% reporting that they were married, or in a stable relationship. Approximately 37% lived separately from their partner.

The mean level of education amongst the study population was Grade 10. The unemployment rate was 55%, and 57% of those generating income made under R1000 a month. The average household size was 4.9 people per household, with 67% of households living on less than R5000 a month. 40% reported food shortages. 38.7% lived in a shack or an informal dwelling.

Of women screened, 53 % were diagnosed with Major Depression and 34% were currently suicidal.

Problems reported amongst counselling attendees (n=49)*

- 69% primary support system (deprivation in emotion)
- 43% social support system (deprivation in material control over one's environment)
- 29% physical health problems (deprivation in bodily health, bodily integrity)
- 45% lifestyle transition difficulties (deprivation in thought and practical reason)
- 76% past or present psychiatric problems (deprivation in emotion, bodily health)
- 92% problems in more than one category noted above

*Average 2.2 counselling sessions each.

4.2.2 Interventions

The PMHP counselling intervention has been adapted using components from existing psychological approaches. During therapeutic counselling sessions, the counsellor actively listens to the client in order to validate and reflect her feelings. Such “containment” creates a safe therapeutic space, allowing the client to express her feelings, and build the capacity to internally manage the troubling thoughts, feelings and behaviours that arise as a consequence of stress.

Simultaneously, the counsellor engages in dialogue to allay fears and provide information around pregnancy, labour and birth, parenting, mental health, substance misuse, sexual education and HIV. This “psycho-education” assists an individual to better understand what affects her mental health, while reinforcing her strengths, resources and coping skills. As the discussion will argue, this process activates women's capabilities enabling better decision making and choices for themselves and their babies (Dowrick et al. 2000).

Where clients have experienced recent or past losses (which could present as miscarriage, neonatal death or the death of a close person), a combination of debriefing and containment is used. Grief counselling (32% of sessions) assists the individual to process the loss in a healthy way, adjust to the loss and prevents the onset of more serious mental health problems (Maglio 1991).

Through problem solving (27% of sessions), the counsellor acts as a facilitator, enabling women to process problems and work towards solutions. Using this technique, problems are defined and clarified, and an attempt is made to solve the problems in a structured way (Dowrick et al. 2000). This enables the individual

to create a cognitive framework for approaching problems in their lives, building self-efficacy and enhancing resilience (Malouff et al. 2007).

Activity scheduling (34% of all sessions) is a behavioural approach whereby clients learn to monitor their mood and increase the number of pleasant activities and positive interactions within their environment (Cuijpers et al. 2007). These positive experiences build and reinforce self-efficacy, and build resilience and coping strategies. Through focus on the cognitive function in daily life, the counsellor enhances skills, resilience and coping techniques and aims to break the cycle of negative feedback associated with the inability to function adequately (Hammar & Ardal, 2009).

Through relationship counselling (25% of sessions) around dysfunctional and problematic relationships, the counsellor assists the individual to develop healthier interactions with their partner, as well as identifying supportive social networks.

A Cochrane review of psychological and psychosocial interventions for postpartum depression found that, compared to routine care, these interventions were associated with a 30% reduction in relative risk for depressive symptomatology (Sockol et al., 2011). When women are listened to and validated in a safe and therapeutic environment, they may begin to restore their self-esteem and locus of control (Sockol et al., 2011). Improved mood increases energy levels and motivation. Women may then be better empowered to identify what actions they can take to overcome their deprivational and challenging life circumstances.

4.2.2 Evaluation data

PMHP data indicates that mental health care may provide the necessary support to empower vulnerable women to identify resources and personal capabilities. This could enhance their resilience to negotiate difficult life circumstances, and support them to nurture their children optimally.

The following analysis pertains to the Hanover Park research project described above. Here, the PMHP collected socio-economic demographic data to use toward exploring clients' overall wellbeing and functioning. Counselling occurred during pregnancy and assessments were conducted with each client at 6 weeks postpartum. At this time, the client's mood, functioning and her experiences of counselling, birth and motherhood were investigated using a questionnaire. The study commenced in November 2011, and this paper offers a preliminary analysis from a sample of the first available postnatal assessments. This is a qualitative content analysis of 5 representative cases. The table below summarises the socio-economic data from these cases. Names of the clients have been removed to preserve confidentiality.

Table 1: Summary of PMHP Hanover Park study client socio-economic data

Client	Age	Gravidity	Parity	High school	Employed	Partner	Partner high school	Partner employed	Dwelling type	People residing in dwelling	Monthly household income in Rands (ZAR)
Z	27	4	2	No	No	Yes	No	Yes	Backyard dwelling	3	1001-2000
R	27	4	3	No	No	Yes	No	No	House	7	Unknown
C	26	4	3	No	No	Yes	Yes	Yes	Backyard dwelling	7	Unknown
G	21	2	1	No	No	Yes	Yes	No	Council house	6	Unknown
H	29	4	3	No	No	Yes	No	Yes	Council house	7	2001-5000

4.2.3 Findings & Analysis

Sen and Nussbaum's capabilities approach was applied to the preliminary data. The following discussion outlines some of the deprivational experiences vis-à-vis pregnancy and mental illness, and describes the therapeutic intervention engaged in each case.

Client Z was in an emotionally and physically abusive relationship. Her partner's abusive behaviour worsened when he had been drinking. Z had previously been stabbed by her partner, and was frequently kicked and beaten. During counselling, she expressed severe anxiety. She had experienced a previous stillbirth and birth complications, and was concerned about her foetus' wellbeing because of the physical abuse.

Client Z had met the criteria for current Major Depressive Episode and post-traumatic stress disorder. She declared a problem with substance abuse at the time of counselling. Interventions explored by the PMHP counsellor included containment, psycho-education, birth preparation and problem solving.

At the time of the postnatal assessment, Client Z reported improvement with respect to her presenting problems. She indicated that the physical abuse by her partner had stopped. She had managed to avoid the more extreme bouts of conflict with her partner by walking away and exercising other mechanisms of conflict avoidance. Her partner was, however, still abusing her emotionally when he had been drinking.

She had been able to contain her anxiety about her pregnancy and childbirth and reported enjoying motherhood. She was no longer drinking or using substances. She has been able to improve communication with her husband, and feels that there has been a change in his attitude and that he is more supportive. Client Z reported feeling depressed on the occasions that her partner argued with her, but could not continue with counselling owing to the challenge of arranging childcare and transport. The gang violence at the time in Hanover Park was also a deterrent to attending further sessions. At the time of the assessment, the PMHP counsellor arranged for on-going telephonic counselling to overcome this obstacle.

Client R had experienced a major traumatic event. Her home had burnt down and she had lost all her belongings, including her identification documents. The latter made it impossible for her to claim the grants that were her primary means of support. At the time of the intervention, Client R was experiencing a great deal of conflict in all her primary relationships. Her ex-husband refused to provide maintenance. The pregnancy was unintended and her current partner was unsupportive. She had to move to her mother's home after her dwelling burnt down. Her mother accused her of abusing drugs, and the home was over-crowded. Client R was very anxious about a fourth child under these circumstances, particularly as she had hoped to find work at the time of becoming pregnant.

Client R met the criteria for current Major Depressive Episode, and posed a medium suicide risk. The PMHP counsellor pursued containment, psycho-education, birth-preparation, and problem-solving modalities in the counselling sessions, focusing on trauma debriefing. Linking Client R to support services was also central to the intervention.

At the time of the postnatal assessment, Client R had, with the support of the PMHP counsellor, secured a place at a shelter for mothers and children. She reported that her situation had improved, and that she was 'feeling happy'. She had made friends at the shelter. She was able to pursue a range of opportunities there, including life skills and work skills courses.

Client C was abandoned by the father of her child when he found out about the pregnancy. Her other primary support relationships were contentious. She lived in a backyard dwelling on her grandmother's

property. Her grandmother was verbally and physically abusive towards C's children. The property was overcrowded, and her grandmother was inappropriately intrusive in her life. Client C met the criteria for Major Depressive Episode with melancholic features, and was a high suicide risk. She was deeply unhappy with her living arrangements but felt that she had no alternatives. She had been a previous drug user.

The PMHP intervention included containment, psycho-education, problem-solving and behavioural activation. At the time of the postnatal assessment, Client C reported that her situation had improved. She had established contact with the father of her elder child and secured financial support. At the time of the assessment, she described this relationship as one of 'friendship'. Client C had also identified her aunt as another source of support, and had moved to live with her. Although the situation is not ideal in terms of space, the environment is more stable and secure, and her aunt is supportive of her and her children. She reported less anxiety, and that she was coping. In the postnatal assessment, Client C indicated that she had left her partner, the father of her new-born, as he was abusing drugs.

Client G was experiencing conflict with her husband at the time of the counselling intervention. He had become extremely argumentative and very unsupportive. Due to financial difficulties, her 2-year old son stayed with her parents, which caused Client G anxiety. She felt that he would 'forget her'. At the time of the counselling intervention, she met criteria for current Major Depressive Episode and posed a medium suicide risk. She also experienced instances of social phobia.

The PMHP counsellor incorporated containment, psycho-education, problem-solving, behavioural activation, relationship counselling and cognitive behavioural elements in the therapeutic sessions. At the time of the postnatal assessment, Client G reported some improvement in her relationship with her husband. They were communicating with each other more and trying to talk about the future. She felt less anxiety about her 2-year old son as she had been able to make arrangements to see him regularly during the week and every weekend. She felt that she had a stronger bond with him now. While she still had days where she felt depressed, she had developed coping mechanisms and felt that her mood had improved. She had requested to continue with counselling postpartum as she felt it was beneficial and helped her manage conflict and improve her relationships.

Client H was diagnosed with generalised anxiety disorder, and was dependent on alcohol. She was in an extremely abusive relationship with her boyfriend of eight years. She reported that he physically and sexually abused her, and that he frequently beat her in front of their children. At the time of counselling, she reported that her partner regularly used methaqualone (mandrax) and methamphetamine (tik), and did not supportive her or their children.

The PMHP intervention included containment, psycho-education, cognitive behavioural interventions, bonding interventions and birth preparation. At the time of the postnatal assessment, Client H reported that she had thought of leaving her partner, but that he had then proposed marriage. At the time of the assessment, she was living with him, and while she was not getting as much support as she would like, the abuse had stopped. Her partner was providing for her and the children financially. He was employed, and used drugs less frequently. These circumstances had reduced her anxiety, and she felt happy about motherhood. She was enjoying breastfeeding and had bonded successfully with her son. She felt counselling had helped her negotiate the conflict in this relationship.

4.3 Discussion

The following discussion presents a preliminary assessment of the potential for capability formation through maternal mental health interventions. Using Nussbaum's capabilities set (2011), specific capabilities emerging from the findings include: bodily health, bodily integrity, thought, practical reason, material control over one's life, emotions and affiliation.

- ***Bodily health & bodily integrity***

These capabilities refer to the ability to have good health, including reproductive health, to be adequately nourished, to have adequate shelter, and to be able to exercise freedom of movement, to be secure against violent assault, including sexual assault and domestic violence and for choice in matters of reproduction.

The benefits of the therapeutic engagement vis-à-vis self-esteem and agency formation potentially translate into more active health-seeking behaviour. For instance, Client Z and C had made choices to stop using drugs and alcohol. Client G had requested to remain in counselling. Client R had actively engaged with the PMHP counsellor to secure safe accommodation at a shelter, and had pro-actively taken advantage of a range of beneficial support services on offer at this facility. After a period of despondency, Client C was also able to move into a more secure environment. Clients Z and H were able to bring about a change to the levels of abuse in their intimate relationships. The way in which Client H was able to negotiate her relationship with her partner enabled her to reduce her anxiety considerably, and be better prepared for birth and motherhood.

- ***Thought, practical reason and material control over one's environment***

Being able to think and reason, to be able to form a conception of the good and to engage in critical reflection about the planning of one's life, and being able to have property, employment and economic rights on an equal basis with others, comprise these particular capabilities.

The data provides evidence that the individual therapeutic space allows a time for women to engage in critical reflection about their lives. They are able to think about their problems, assess their options and choices, and identify possible solutions and resources. Counselling enables women to identify solutions when no alternatives seem to exist, which shows the value of a calm space to think about one's situation.

Women are able to identify their own 'conception of good', such as Client C, who identified that a life with her partner was not the kind of life she 'wanted to go back to'. She reported that counselling had given her the space to talk about these issues, and given her the coping skills to make better decisions. She wanted to be drug-free and healthy for herself and her children.

The opportunity to connect women with resources forms a critical part of the intervention. Client C was able to explore her options, and able to identify resources she may already have - such as a supportive aunt. After working on a plan in her counselling sessions, she felt confident enough to approach her aunt and ask for support. Client R secured accommodation at a shelter, which made a significant impact on her being able to take substantive control over her life. R had felt overwhelmed by her situation, isolated and without options. The therapeutic modalities employed by the counsellor enabled her to identify solutions. Her sense of empowerment has since resulted in her actively exploring a range of activities that could improve her opportunities. She expressed a feeling of pride in her achievements.

Client G was able to make substantive changes in her life to ensure that she bonded with her son. The skills she acquired in counselling also benefited her family as a whole, as she was able to work on her relationships with her partner and start planning for the future, something they had not done before.

The social environment in Hanover Park, with respect to poverty and gang violence, pose significant challenges to taking material control over one's life. However, maternal mental health interventions activate coping mechanisms, enabling women in some instances to negotiate generalised situations of distress. Client Z, for example, was unable to continue counselling sessions at the Hanover Park facility due to heightened gang violence, but was able to recognise the benefit of counselling to her current situation, and negotiated alternative ways of continuing the therapeutic relationship, in this instance, via telephonic counselling.

- ***Emotions & Affiliation***

Mental health interventions may promote the formation of attachments necessary for human wellbeing and development, and also the capabilities to ensure that one's emotional development is not restricted by fear and anxiety. Nussbaum argues that supporting this capability means supporting forms of human association that can be shown to be crucial in their development (Nussbaum 2011). The mother-infant bond is just such an association, as are primary support relationships, whether these are with a partner or a parent (Wilhelm et al. 2010). Affiliation is defined as 'having the social bases of self-respect and non-humiliation; being able to be treated as a dignified being whose worth is equal to that of others' (Nussbaum, 2011: 34). In the cases noted in this preliminary assessment, women's emotions and affiliations are closely linked. They may be in relationships (affiliations) which break down their self-respect or which humiliate them through abuse. The inflicted emotional damage may diminish women's confidence in their caregiving capacity and their ability to ensure overall wellbeing for themselves and their children.

The PMHP experience evinces that, in being empowered and able to take a degree of material control over their lives, women are able to re-orient their relationships to earning the support and respect they may not have previously had. Through the therapeutic engagement, being heard – often for the first time – validates women's feelings and needs, and contributes to a sense of self-worth. This, in turn, forms the foundation on which other therapeutic modalities can build to enhance women's self-esteem and agency within their interpersonal relationships.

An example of this is the healthy emotional bond between mother and infant, which is critical not only for infant wellbeing, but for infant survival as well as the mother's own emotional health. Bonding is important to establish successful and longer breastfeeding, for example, which in turn prevents diarrhoeal episodes, malnutrition, dehydration, and hospital admissions (Rochat et al. 2008; Clemens et al. 1999).

In all cases presented here, mothers expressed anxiety during their pregnancy, and all were experiencing symptoms of depression or current major depressive episode. Yet, PMHP data shows that counselling may support a positive birth experience, successful bonding, and breastfeeding. For example, Client L reported a positive birth experience and was enjoying exclusive breastfeeding. Client H and Z had experienced a great deal of antenatal anxiety, which they reported to be resolved. At the time of the postnatal assessment, both were enjoying motherhood and had bonded successfully with their infants.

The examples of capabilities discussed here overlap: a woman's sense of self-worth (affiliation) will enhance her ability to form positive attachments, such as bond with her infant (emotions). She may also be able to make better decisions under challenging circumstances for the health and wellbeing of herself and her children, such as leaving an abusive relationship and securing safe alternative accommodation (thought, practical reason and material control over one's environment; bodily health and integrity). In addition, this particular analysis shows that it is not only the mother who benefits from therapeutic

interventions. Being able to bond with her infant, breastfeed, to make sound decisions about health, living arrangements, safety and relationships, and to plan for the future, are clearly integral to the infant and child's wellbeing and on-going development.

By applying Sen and Nussbaum's capabilities approach to this preliminary data, the argument is made that mental health promotion is integral to building the functional capabilities required to ensure that women are able to pursue a life of dignity and value, which has the commensurate positive outcomes for their children and families.

Taking note of the socio-economic conditions of the PMHP clients discussed (see Table 1), interventions which promote resilience and capabilities are apposite. All clients were unemployed and living in either a backyard dwelling or a council house. All were dependent on a partner for financial support at the time of counselling, with 3 out of 5 not aware of their partner's income. This dependency points to the limited control women have over their own future. At the time of the postpartum assessment, however, all women had a greater sense of control over their situations, felt more empowered to deal with conflictual relationships and stand up for their - and their children's needs. Coping, or adapting, is an act of agency, a way of exercising one's capabilities to greatest effect in one's circumstances (Austen & Leonard 2008).

Conclusion

Maternal mental illness affects functioning, which impacts on women's capability to take up development opportunities. Overcoming developmental challenges requires an understanding of the debilitating effects of common mental disorders.

The capabilities approach shows that maternal mental health interventions can address the major developmental challenges posed by poverty in South Africa and the sub-Saharan region with respect to infant and maternal health. Cross-cutting and empowering, these interventions offer development and health practitioners a solution for positive outcomes for women and their children. Patel et al. (1999) state that the prevalence of maternal mental illness cannot be considered in isolation from social, political and economic issues: 'when women's position in society is examined, it is clear that there are sufficient causes in current social arrangements to account for the surfeit of depression and anxiety experienced by women' (Patel et al., 1999: 1466). As there can be no health without mental health, there can be no development without addressing women's capability deprivations through exploring opportunities to activate women's adaptive capabilities in contexts of poverty.

In settings of poverty and adversity, where women and children face enormous developmental challenges, it makes sense to also invest in maternal mental health interventions rather than only financially-focused developmental solutions. Even in resource limited settings, mental health interventions can break the cycle of poverty and mental ill-health. Treating mental illness, particularly among women living in poverty, can increase resilience, agency and productivity, reduce health-care expenditure and facilitate the conditions necessary to rise out of poverty.

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