

CREATING CAPABILITIES THROUGH MATERNAL MENTAL HEALTH INTERVENTIONS: A CASE STUDY AT HANOVER PARK, CAPE TOWN

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Abstract: In South Africa, approximately one third of resource-poor women experience mental illness during pregnancy. Prevalence is higher in low-resource settings than in developed countries. The poverty–mental illness cycle is well documented. Through the capabilities approach, this paper locates maternal mental illness in a development framework and explores the deprivational impacts of mental illness. It describes a counselling intervention in South Africa as a case study and applies a qualitative content analysis to descriptive data of a sample of five typical clients. Findings suggest that integrated maternal mental health care may act as a strategic intervention for capability formation and sustainable development. Copyright © 2015 John Wiley & Sons, Ltd.

Keywords: maternal mental health; gender; poverty; capabilities approach; Millennium Development Goals; Perinatal Mental Health Project; South Africa

1 INTRODUCTION

The World Health Organisation (WHO) estimates the prevalence of depressive symptoms among women in developing countries to be between 15 and 57 per cent (Surkan, Kennedy, Hurley, & Black, 2011). Approximately 40 per cent of South African women

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living in poverty experience a mental illness during pregnancy (Hartley *et al.*, 2011; Rochat *et al.*, 2011). The poverty–mental illness cycle is well documented in low-income and middle-income countries (Lund *et al.*, 2010). This 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).

Mental illness, and maternal mental illness specifically, poses one of the most significant threats to development (Miranda & Patel, 2005). In this paper, the relationships between female gender, poverty and common mental disorders¹ (CMDs) are explored within the capabilities paradigm (Sen, 1999; Nussbaum, 2011) to assess the consequences of untreated maternal mental illness. The aim of the paper is to locate maternal mental illness within a development framework in order to highlight its significance for development outcomes. The paper will also describe the Perinatal Mental Health Project's counselling intervention in Hanover Park, Cape Town, South Africa, to illustrate an approach to capability formation and sustainable development.

2 DEVELOPMENT AND COMMON MENTAL DISORDERS

As development philosophy responded to critiques related to 'abstracting the economic from the social' (Razavi, 2007), a more people-centred approach to development emerged in the late 1990s and early 2000s. This shifted focus towards interrogating whether economic growth afforded people the means to pursue a life of value. Traditionally, the market was seen as a source of material growth and individual freedom. Contributions of contemporary development scholars such as Sen highlight the primacy of individual agency. Sen's concept of 'development as freedom' requires a focus on removing the factors that may impede a person's agency, or ability, to participate in the market economy. There is an imperative to evaluate contextual dynamics—social, environmental, economic, political or biological—which impede individual development (Sen, 1999; Nussbaum, 2011).

Nussbaum (2011) built on this theoretical foundation, crafting an approach to assessing people's comparative quality of life and what they are 'able to do and to be'. The focus is less on providing people with an income and more on how to advance their capabilities to 'lead the kind of lives they have reason to value' (Sen, 1999). The corollary to identifying capability formation is identifying the ways in which people are deprived of their capabilities. Sen and Nussbaum elaborate on how poverty, gender inequality, violence, marginalisation and discrimination limit capabilities and contribute to a 'disabling environment' (Giullari & Lewis, 2005; Sen, 1999).

2.1 Poverty, Gender and Common Mental Disorders

Nussbaum 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, allowing for the distillation of economic, political, social and epidemiologic factors within the disabling environment (Harcourt, 2001; Robeyns, 2004).

¹Common mental disorders include depressive and anxiety disorders.

A multicountry study in low-income and middle-income countries found that women are disproportionately affected by depression (Patel *et al.*, 1999). In addition, it found that people in low-income groups are more vulnerable to suffering from CMDs, 'irrespective of the overall state of development of the society they live in' (Patel *et al.*, 1999). Relative poverty is a risk factor for mental illness. In 2012, South Africa was upgraded by the World Bank to an upper middle-income country despite data showing the country to be one of the most economically unequal in the world. At the time, the Gini coefficient was reported as 0.7, with the top 10 per cent of the population accounting for 58 per cent of South Africa's income and the bottom 10 per cent accounting for just 0.5 per cent of income (World Bank, 2012).

Female gender and poverty increase vulnerability to CMDs, and the prevalence of major depressive disorders in women is highest during childbearing years (Kessler *et al.*, 2003). In South Africa, women have a two times greater 12-month prevalence of mood disorder than men do (Williams *et al.*, 2008). There is a documented increased rate of onset of depression during pregnancy (Buist *et al.*, 2002).

There are high levels of gender-based violence (GBV) against women in South Africa with the mortality rate from intimate partner violence being the highest reported globally (Norman *et al.*, 2000) and twice that which is reported in the USA (Abrahams *et al.*, 2009). During pregnancy, 35 per cent of women in a hospital antenatal clinic sample had experienced GBV (Mbokota & Moodley, 2003), and in a community-based antenatal clinic sample, 56 per cent reported physical or sexual partner violence (Dunkle *et al.*, 2004). The association between GBV and mental illness is well established, particularly for depression, anxiety, post-traumatic stress disorder, somatisation and self-harm (Patel *et al.*, 1999). In Brazil, partner violence was shown to be associated with postpartum depression (Ludermir *et al.*, 2010), whereas in South Africa, the strongest predictors of depressed mood in mothers were shown to be intimate partner violence and household income of less than ZAR2000 per month (Hartley *et al.*, 2011). The association with poverty is further described in a study of pregnant, rural South African women. Here, high rates of psychological violence (49 per cent) and physical violence (36 per cent) were associated with higher levels of unemployment and lower education (Hoque, Hoque, & Kader, 2009).

2.2 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 value 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 significant factors that influence a woman'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 and psychological position to bring opportunities to fruition.

Research shows that CMDs are causes, rather than merely correlates, of impaired functioning, lower earnings and poverty (Levinson *et al.*, 2010). The social drift theory postulates that mental illness increases the chance of drifting into or remaining in poverty because of increased costs in health care, reduced productivity, stigma and loss of employment (Lund *et al.*, 2011).

Untreated maternal mental disorders correspond with failures in South Africa's development goals, particularly related to Millennium Development Goals (MDGs) 4 (reduce mortality of children under 5 years) and 5 (improve maternal health by reducing maternal mortality per 100 000 live births by 75 per cent) (Chopra *et al.*, 2009). Skeen, Lund, Kleintjes and Flischer (2010) document evidence to link mental health and the MDGs and make recommendations to include mental health on the development agenda. The capabilities approach to development highlights how poverty and gender inequality combine to lead to capability deprivations, which these failures represent (Meintjes *et al.*, 2010; Harcourt, 2001).

2.3 Functioning

The WHO 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). More working days are lost per year as a result of mental disorders than physical conditions (ILO, 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 (Mayosi *et al.*, 2009). 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, Ridgway, Wieland, & O'Connell, 2009). This leads to poverty, which can, in turn, worsen mental illness.

The perinatal period is a time of increased physical and emotional demands on women, and the disability associated with depression is likely to interfere with functioning related both to mothers and their infants (UNFPA, 2008). Depressed mothers are less likely to care for their own needs than non-depressed mothers (Miranda & Patel, 2005). The 2007 *Report on Confidential Enquiries into Maternal Deaths in South Africa* found that mental illness increasingly contributes to maternal mortality (Pattinson, 2007). Depression in mothers may lead to increased maternal mortality, both through adverse effects on physical health and more directly through suicide. Suicide is a leading cause of maternal mortality in developed countries (Oates, 2003), and suicidality, thoughts of suicide or self-harm, occurs in up to 20 per cent of mothers in low-income and middle-income countries (Rahman *et al.*, 2013). Mental health thus has an integral role to play in achieving many of the MDGs (Prince *et al.*, 2007).

2.4 Maternal Mental Illness in South Africa

Prevalence rates for maternal mental illness in South Africa are high. In a Khayelitsha study, 39 per cent of women screened positive for antenatal depression (Hartley *et al.*, 2011). A study in rural KwaZulu-Natal showed 47 per cent of pregnant women had diagnosable antenatal depression (Rochat *et al.*, 2011). These rates contrast with lower rates of maternal mental illness of 10–15 per cent in developed countries (Warner, Appelby, Whitton, & Faragher, 1996) and reflect similarities indicated in rates from other developing countries such as the 36 per cent reported in Pakistan (Husain *et al.*, 2006) and 37 per cent reported in Chile (Rojas *et al.*, 2007).

The South African Mental Health Care Act (2002) legislates the integration of mental health services into the primary healthcare system, yet this has been difficult to realise.

Many factors contribute to this: the burden of disease, a lack of political will, stigma, a lack of knowledge regarding the prevalence and nature of mental illnesses, under-resourced health facilities, poorly trained nursing staff, a lack of appropriate screening tools and insufficient skilled counsellors, psychologists and psychiatrists to provide effective treatment. Only 7 per cent of psychologists in South Africa work in the public sector (Day, Gray, & Budgell, 2011; Breier, Wildschut, & Mgqolozana, 2009).

2.5 Maternal Mental Illness and Specific Deprivations

Mental illnesses are proven risk factors for physical health problems such as HIV, tuberculosis and malaria (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 and concentration, and low self-esteem. These symptoms interfere with health-seeking behaviour and adherence to treatment (Grote *et al.*, 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 and exacerbates low self-esteem and feelings of worthlessness. A cycle ensues where negative feelings enhance depressive symptoms (Hammar & Ardal, 2009).

In South Africa, pregnant women are routinely tested for HIV infection. The presence of a mental illness is significantly associated with non-adherence to antiretroviral regimes (Mellins *et al.*, 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 physical and sexual abuse, and those with violent intimate partners are more likely to contract HIV (Jewkes, Dunkle, Nduna, & Shai, 2010). The incidence of domestic violence may escalate during pregnancy (Mezey & Bewley, 1997), while suffering from a mental illness may impair a woman's ability to address harmful situations (Roberts, Lawrence, Williams, & Raphael, 1998).

Depression during pregnancy may influence psychological attachment to the foetus and be the basis for poor mother–infant bonding (McFarland *et al.*, 2011; Rochat, Mitchell, & Richter, 2008). Post-natal depression is also 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 associations among mothers experiencing depression or anxiety: increased likelihood of self-medication with alcohol or drugs, poor antenatal weight gain, increased risk of preterm birth and low infant birthweight and increased risk of emotional and behavioural problems in the child (Surkan *et al.*, 2011; Talge, Neal, & Glover, 2007).

3 CASE STUDY: COUNSELLING IN PREGNANCY AND CAPABILITIES DEVELOPMENT

Evidence shows that the impairments and deprivations of CMDs can be reversed with best-practice mental health interventions (Levinson *et al.*, 2010; Stewart, Ashraf, & Munce,

2006). Mental well-being among mothers forms a range of capabilities that may mediate the link between poverty and negative health outcomes for mother and child. One of the most striking benefits of improving maternal mental health (MMH) is a significantly reduced health gap between rich and poor children (Propper, Rigg, & Burgess, 2007).

In South Africa, the District Health Information System reports that over 99 per cent of pregnant women attend antenatal care at least once, attending on average between three and four visits before birth (Day & Gray, 2013). Therefore, the antenatal period presents a convenient opportunity to provide mental health care for women in need.

3.1 Objective

The objective of this paper is to illustrate how antenatal counselling for depressed and/or anxious women living in poverty may enhance their capabilities towards positive development outcomes.

3.2 Method

This is a qualitative content analysis of five cases of clients who received counselling. The sample was chosen to illustrate typical problems, deprivations and capability formation. Counsellors' data-recording logs and case notes were analysed thematically by a researcher who was external to the counselling service.

3.2.1 Site

Hanover Park is an urban area of Cape Town, previously designated as a 'coloured township'. It has a history of gang violence, often involving the illicit drug trade. As of September 2012, Community Action towards a Safer Environment website (CASE's) (www.case.za.org) reported that less than 20 per cent of adults have completed high school and 61 per cent of adults have no income. Women in this setting frequently experience life-threatening events, exposure to multiple forms of interpersonal and community violence (emotional, physical and sexual violence as well as witnessing violence) and chronic stressors related to poverty.

The Perinatal Mental Health Project operates at the local Community Health Centre, working in partnership with the Midwife Obstetric Unit to provide a mental health service for pregnant and post-natal women. The project is described in some detail elsewhere (Honikman *et al.*, 2012). Women are screened for mental illness at their first antenatal visit and referred to an on-site counsellor, if they meet the cut-off score of 13 or more on the Edinburgh Post-natal Depression Scale (Cox, Holden, & Sagovsky, 1987). Counselling appointments are made to coincide with antenatal visits in order to facilitate access for women with scarce resources. The counsellor refers women to the psychiatric nurse or to the social worker for further intervention, as appropriate. Referrals may be made to a network of nongovernmental organisations in the community who provide additional support.

3.2.2 Participants

Five participants were selected as part of a larger group of women who received psychological counselling at the Hanover Park Midwife Obstetric Unit. Between September 2011 and August 2012, 84 pregnant, adult women received counselling from

the Perinatal Mental Health Project service and signed informed consent for their information to be used for research purposes. Ethics permission for this study was granted by the University of Cape Town (HREC number: 131/2009).

Descriptive data of the women who received counselling are summarised in Table 1.

3.2.3 Description of the counselling intervention

Counselling occurred during pregnancy, and follow-up assessments were conducted with each client at 6–10 weeks postpartum. At this time, the client's mood, functioning and her experiences of counselling, birth and motherhood were investigated, using a standardised questionnaire.

The counselling intervention incorporated components from existing psychological approaches. During therapeutic counselling sessions, the counsellor actively listened to the client in order to validate and reflect her feelings. This process of containment built the capacity to internally manage the troubling thoughts, feelings and behaviours that arise as a consequence of stress.

Additionally, the counsellor engaged in dialogue to address fears and provide information around pregnancy, labour and birth, parenting, mental health, substance misuse, sexual education and HIV. Psycho-education and health promotion assisted individuals to better understand what affected their mood, while reinforcing their strengths, resources and coping skills.

Through problem solving, the counsellor acted as a facilitator, enabling women to process problems and work towards solutions. By using this technique, problems were defined, prioritised and clarified, and plans developed to solve these problems in a structured way (Dowrick *et al.*, 2000). This enabled the individual to create a cognitive framework for approaching problems in their lives, building self-efficacy and enhancing resilience (Malouff, Thorsteinsson, & Schutte, 2007). These positive experiences build and reinforce self-efficacy and build resilience and coping strategies. Using a cognitive behaviour therapy (CBT) approach, counselling focused on reframing or shifting away from negative thoughts. This was linked to activity scheduling whereby clients learn to monitor their mood and increase the number of pleasant activities and positive interactions within their environment (Cuijpers, Van Straten, & Warmerdam, 2007). This approach aims to break the cycle of negative feedback associated with the inability to function adequately, which has been shown to enhance skills, resilience and coping techniques (Hammar & Ardal 2009). CBT has been used effectively for maternal depression, paternal child engagement and improved child outcomes in a low-income setting in Pakistan (Rahman *et al.*, 2008).

Table 1. Descriptive data of the counselled women ($n = 84$)

Mean age	27 years
Married/stable relationship	87%
Live separately from partner	29%
Mode level of education	Grade 11
Average household size	4.8
Unemployment rate	64%
Live in a shack/informal dwelling	45%
Of those generating income, make <ZAR1000/month (US\$102 ^a)	60%
Households living on <ZAR5000/month (US\$510)	70%

^aExchange rate of US\$1: ZAR9.8 on 23 October 2013.

Through relationship counselling for dysfunctional and problematic relationships, the counsellor assisted individuals to develop healthier interactions with their partner, as well as in identifying supportive social networks. Where clients experienced recent or past losses (such as miscarriage, neonatal death or the death of a close person), a combination of debriefing and containment was used. Grief counselling assisted the individual to process the loss in a healthy way, adjusting to the loss and preventing the onset of more serious mental health problems (Maglio 1991).

A recent meta-analysis demonstrated that a range of psychotherapies, such as those employed earlier, is effective in the reduction of depressive symptoms during the perinatal period, noting that ‘reductions in symptoms from pretest to post-treatment are large’ (Sockol, Epperson, & Barber, 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.

On assessment, the counsellor records clients’ problems into problem categories. These are presented in Table 2 with the corresponding capability deprivations.

Table 3 summarises socio-economic data from five cases selected for analysis for this paper. The names of the clients have been removed to preserve confidentiality.

Table 2. Presenting problems and corresponding capability deprivation (*n* = 84)

Primary support (emotion)	79%
Social support (material control over one’s environment)	43%
Physical health (bodily health and bodily integrity)	27%
Life cycle transition (thought and practical reason)	41%
Past/present psychiatric problems (emotion and bodily health)	78%
Problems in more than one category	94%

Table 3. Summary of socio-economic data (*n* = 5)

	Client				
	Z	R	C	G	H
Age	27	27	26	21	29
Gravidity	4	4	4	2	4
Parity	2	3	3	1	3
Has partner	Yes	Yes	Yes	Yes	Yes
High school education completed	No	No	No	No	No
Partner completed high school	No	No	Yes	Yes	No
Employed	No	No	No	No	No
Partner employed	Yes	No	Yes	No	Yes
No. of people residing in dwelling	3	7	7	6	7
Dwelling type	Backyard dwelling	House	Backyard dwelling	Council house	Council house
Monthly household income in ZAR	1001–2000	Unknown	Unknown	Unknown	2001–5000

3.3 Findings and Analysis

Sen and Nussbaum's capabilities approach was incorporated into the content analysis of data obtained from counsellor logs and notes. Table 4 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 a violent, abusive relationship. The counsellor enabled Z to identify how the cycle of violence unfolds in her relationship. The sessions assisted her to identify behaviours in herself and her partner that frequently preceded conflictual situations. She learnt practical skills to avert arguments and to ensure her own safety when violence became inevitable. Use of these skills was commended and reinforced.

R lost her home and all her possessions in a fire. She was overwhelmed by her problems and circumstances: 'even money for the children is just enough for food, can't really buy clothes and anything else'. The counsellor provided stability in these uncertain circumstances and enabled R to explore options and prioritise the actions she needed to take in order to make progress with processing social grant support, networking with supportive women in the community and seeking income-generation activities.

C had three children and was unemployed with no social support, and during the counselling process, her partner left the relationship. She was evicted from their home and found temporary refuge in a shelter for women. The counselling enabled her to focus on her strengths, affirming her ability to secure her children's safety and shelter. Through a stepwise problem-solving approach, priority problems were identified, and potential solutions explored. In this way, several sources of support were activated.

G experienced a conflictual relationship with her husband. She was frequently ruminating about this and was highly anxious that the relationship would end. The process of counselling gave her the opportunity to voice concerns, reconsider some of her assumptions and activate certain healthy behaviours for engaging her husband and child. As she felt more agency in these relationships, her anxiety diminished. She indicated that she 'learnt a lot like how to manage conflict and talk properly with her husband'.

H's partner was a drug abuser and was physically and emotionally abusive towards her. She had very limited support and had thoughts of 'not wanting the baby, and would throw herself and the children under a train'. H had accepted her partner's addiction and was not willing to leave the relationship; however, she was able to identify when his mood was dangerous to her and remove herself and the children from harm at those times. As she felt stronger and more in control of her situation, her mood improved, and she no longer felt suicidal or anxious.

4 DISCUSSION

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

Table 4. Presenting problems and therapeutic interventions (*n* = 5)

Client	Problems presented	Psychiatric diagnosis ^a	Therapeutic interventions	Client-reported assessment outcomes at 6 weeks post-natal
Z	Emotional and physical abuse by partner	Major depressive episode	Containment	Physical abuse stopped
	Previous stillbirth and birth complications	Post-traumatic stress disorder	Psycho-education	Learned avoidance techniques
	Substance abuse		Birth preparation Problem solving	Improved communication with partner No longer drinking/using drugs Unable to continue counselling because of gang violence—but negotiated continued telephonic sessions
R	Traumatic life event—house burnt down	Major depressive episode	Containment	Social grant accessed
	Loss of access to social grant		Psycho-education	Housing secured at shelter
	Unsupportive primary relationships		Problem solving	Made new friends
	Overcrowded living conditions		Trauma debriefing	Pursuing opportunities for skills development and jobs
C	Unintended pregnancy		Referral to social support services	
	Tenuous primary support relationships	Major depressive episode	Containment	Contact established with father of eldest child and financial support secured
	Abandoned by partner		Psycho-education	Identified aunt as source of support—moved to live with her
	Overcrowded living conditions		Problem solving	Would not resume relationship with partner as he was a drug user
G	Previous drug user		Behavioural activation	
	Conflictual relationship with husband	Major depressive episode	Containment	Better communication with husband
	Financial difficulties		Psycho-education	Regular contact with 2-year-old
H	2-year-old son staying with grandparents— <i>anxious that he would ‘forget her’</i>		Problem solving	Improved mood
	Emotionally and physically abusive relationship with partner	Generalised anxiety disorder	Behavioural activation	Counselling continued to assist management of conflict and improve relationships
	No financial support		Cognitive reframing	
			Relationship counselling	
			Containment	Still living with partner—but physical abuse stopped
			Psycho-education	Partner providing financial support

(Continues)

Table 4. (Continued)

Client	Problems presented	Psychiatric diagnosis ^a	Therapeutic interventions	Client-reported assessment outcomes at 6 weeks post-natal
	Alcohol dependence		Birth preparation	Anxiety reduced
	Partner is a drug user		Problem solving Behavioural activation Cognitive reframing	Conflict better managed and negotiated

^aDiagnoses were made according to criteria on the MINI-International Neuropsychiatric Interview Plus diagnostic interview version 5.0.0, which contains 26 modules for the major axis 1 psychiatric disorders in the *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (Sheehan *et al.* 1998). The interviews were administered by a trained B. Psych counsellor registered with the Health Professionals Council of South Africa.

4.1 Bodily Health and Bodily Integrity

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

The benefits of the therapeutic engagement vis-à-vis agency formation potentially translate into more active health-seeking behaviour, self-care and improved self-esteem. For instance, clients Z and C had made choices to stop using drugs and alcohol. Client G had requested to remain in counselling. Client R had actively secured safe accommodation at a shelter and had proactively 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 relationships. The way in which client H was able to negotiate her relationship with her partner enabled her to reduce her anxiety considerably.

4.2 Thought, Practical Reason and Material Control over One's Environment

These capabilities comprise being able to think and reason, form a conception of the good and 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.

The cases show 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 initially seemed to exist, which shows the value of a facilitated opportunity to reflect on one's situation. Client G indicated that counselling 'helped a lot, opened her eyes to a lot of things'.

Women are able to identify their own 'conception of good' (Nussbaum 2011), 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 enabled her 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 external 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. Client R had felt overwhelmed by her situation, isolated and without options. After developing a plan in her counselling sessions, she felt confident enough to take up a referral to sheltered accommodation. Her sense of empowerment 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 could enhance her relationship with her son. The skills she acquired in counselling also benefited her family as a whole, as she was able to work on her relationship with her partner and start planning for the future, something that they had not previously carried out.

The social environment in Hanover Park, with respect to poverty and gang violence, poses significant challenges to taking material control over one's life. However, MMH 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 because of 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 via telephonic counselling.

4.3 Emotions and Affiliation

Mental health interventions may promote the formation of attachments necessary for human well-being 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 to one's development (Nussbaum, 2011). The mother–infant bond is 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). In the cases noted in this assessment, women's emotions and affiliations are closely linked. They may be in relationships (affiliations) that undermine their self-respect or that humiliate them through abuse. The inflicted emotional damage may diminish women's confidence in their caregiving capacity and their ability to ensure overall well-being for themselves and their children.

The case study evinces that, in being empowered and able to take a degree of material control over their lives, women are able to reorient their relationships towards earning the support and respect they may not have previously had. The therapeutic engagement, which includes empathic listening and a validation of women's feelings and needs, 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.

The healthy affiliation between mother and infant is strongly associated with infant well-being, infant survival and the mother's own emotional health. Bonding is important to establish successful and longer breastfeeding, for example, which in turn prevents

diarrhoeal episodes, malnutrition and dehydration and reduces hospital admissions (Rochat *et al.*, 2008; Clemens *et al.*, 1999).

In all the cases presented here, mothers expressed anxiety during their pregnancy, and all were experiencing symptoms of depression. Yet, counselling may support a positive birth experience, successful bonding and breastfeeding. For example, clients H and Z had experienced a great deal of antenatal anxiety, which they reported to be resolved. At the time of the post-natal assessment, both were enjoying motherhood and felt bonded with their infants.

The examples of capabilities discussed here overlap: a woman's sense of self-worth (thought) 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 well-being 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). This analysis also shows that it is not only the mother who benefits from therapeutic interventions. Being able to bond with her infant, to breastfeed, to make sound decisions about health, living arrangements, safety and relationships and to plan for the future is integral to the infant and child's well-being and ongoing development.

By applying Sen and Nussbaum's capabilities approach to these 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 commensurate positive outcomes for their children and families.

Taking note of the socio-economic conditions of the clients discussed (Table 1), interventions that 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 three out of five not being aware of their partner's income. This dependence 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 and felt more empowered to deal with conflictual relationships and to exercise their agency towards meeting the needs of themselves and their children. Coping, or adapting, is an act of agency, a way of exercising one's capabilities to the greatest effect in one's circumstances (Austen & Leonard 2008).

5 LIMITATIONS

The data presented in this paper are taken directly from counsellor notes as a primary source; verbatim transcripts were not collected during counselling. Thus, potential limitations include counsellor bias. However, counsellors were not aware of the study questions explored in this paper; therefore, bias pertaining to the conclusions of this study is not affected by counsellor's opinions *per se*. Furthermore, the counsellor received weekly individual supervision by a clinical psychologist as well as fortnightly peer supervision, which further mitigated against bias.

6 CONCLUSION

Maternal mental illness affects functioning, which impacts on women's ability to take up development opportunities. The capabilities approach highlights the benefits of MMH interventions in addressing the developmental challenges posed by poverty in South Africa

and other low-resource settings. Patel *et al.* (1999) states 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’ (p. 1466).

Just as the WHO proposes that there can be ‘no health without mental health’ (Prince *et al.*, 2007), there can be no development without addressing women’s capability deprivations. This paper argues that MMH interventions can improve developmental and health outcomes for women and their children. Social determinants of women’s mental health, such as poverty and gender-based violence, must be addressed on a systemic level, but in the interim, activating women’s adaptive capabilities through mental health care can increase resilience, agency and productivity, reduce healthcare expenditure and facilitate the conditions necessary to alleviate poverty.

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