WOMEN ON FARMS: DISCOURSES OF DISTRESS

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DECLARATION

I, the undersigned, hereby declare that the work contained in this thesis is my own original work and has not previously in its entirety or in part been submitted at any other university for a degree.

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ABSTRACT

The primary goal of this cross-cultural study was to determine how low income female farm workers in the Winelands region of the Western Cape (South Africa) talk about and express their psychological distress. The language these women used to articulate their psychological distress (verbal and non-verbal communications) were analyzed to determine whether it is possible to identify certain 'discourses of distress'. Data was generated by interviews (consisting of semi-structured and open-ended questions, and implementation of - amongst others - the Beck Depression Inventory) with six participants. With grounded theory, a specific way of doing qualitative analysis of interviews and questionnaire data, an attempt was made to capture the idioms of distress used in this culture. It was possible to identify six 'discourses of distress', namely, i.) silence, ii.) reporting and describing behaviour, iii.) 'body talk' / somatization, iv.) narrativation, v.) metaphorical and idiomatic speech, and vi.) psychologization. The possible ways in which these discourses function were discussed (with the existing literature as background) in order to come to an understanding about what the choice of discourse communicates about the experience of psychological distress. Drawing on this theory building attempt, directions for the development of accurate theory on female farm workers' ways of expressing psychological distress, the possible implications thereof, and suggestions for appropriate assessment and provision of mental health care to them, were explored.

OPSOMMING

Die primêre doel van hierdie kruiskulturele ondersoek was om die wyse(-s) vas te stel waarop lae inkomste vroulike plaaswerkers van die Wynlandstreek van die Wes-Kaap (Suid-Afrika) hulle sielkundige distres uitdruk en daaroor praat. Die 'taal' wat deur hierdie vroue gebruik is (verbaal en nie-verbaal) om hulle sielkundige distres uit te druk, is ontleed om vas te stel of sekere 'diskoerse van distres' geïdentifiseer kon word. Data is gegenereer deur *oop* onderhoude (bestaande uit semi-gestruktureerde en oop-einde vrae) en die implementering van die Afrikaanse weergawe van die Beck Depression Inventory. Met grond- ('grounded') teorie, 'n spesifieke manier om kwalitatiewe analise van onderhoude en vraelys-inligting te doen, is gepoog om die sogenaamde 'idiome van distres' wat in hierdie kultuur gebruik word, vas te stel. Dit was moontlik om ses diskoerse om sielkundige distres uit te druk, te identifiseer, naamlik i.) stilte (onvermoë / weiering om te antwoord); ii.) rapportering en beskrywing van gedrag en simptome; iii.) 'liggaamstaal' / somatisering; iv.) narrativasie / storievertelling; v.) metafore / idiome en vi.) *sielkundige spraak*. Die moontlike wyses waarop hierdie diskoerse werk, is bespreek (met die bestaande literatuur as agtergrond), om sodoende tot 'n beter begrip te kom van wat die spesifieke keuse van diskoers oor die ervaring van sielkundige distres kommunikeer. Op die basis van hierdie teoriebou-poging, is rigtings vir die ontwikkeling van akkurate teorie oor die maniere waarop vroulike plaaswerkers distres ervaar en oordra, die moontlike implikasies daarvan, en voorstelle vir gepaste assessering en die verskaffing van geestesgesondheidsdiens aan hulle, geëksploreer.

CONTENTS

WOMEN ON FARMS: DISCOURSES OF DISTRESS

Introduction:

In the United States depression is the most prevalent major mental health problem and the most frequent diagnosis associated with psychiatric hospitalization (Dean, 1985). Also in South Africa, depression has been and continues to be a major health problem (Swartz, 1998). A community-based prevalence study of psychiatric morbidity on adult South Africans (restricted to a coloured population) found an overall psychiatric morbidity of 27,1%, with the majority of cases (24%) identified as either depressive or anxiety related disorders (Rumble, Swartz, Parry & Zwarenstein, 1996). This finding is consistent with international studies which indicate that depression and anxiety, but particularly depressive disorders, are the two most common disorders detected at a community level (Hollifield, Katon, Spain & Pule, 1990; Parry, 1996). Furthermore, studies in the United States and England have determined that *women* (Ashurst *et al.*, 1989; Nolen-Hoeksema, 1990; Weissman & Klerman, 1985), and especially *low-income mothers of young children* (Guttentag, Salasin & Belle, 1980; Ross & Huber, 1985), constitute the section of the population most at risk for mood disorders such as depression and *dysthymia* (Goldberger & Veroff, 1995). The positive association between low income or poverty and depression are particularly relevant for women, especially women of color (Kessler & Neighbors, 1986).

Given the fact that international studies have postulated such clear associations between gender, income and depression, it is interesting that little research in this regard has been conducted in South Africa. South African research has typically focussed on psychological distress in general and not specifically on depression (for instance, Spangenberg &

Pieterse, 1995). According to this study done in South Africa by Spangenberg and Pieterse (1995), a low family income was the only demographic variable that was significantly correlated with psychological distress. In the light of existing international and local research about the vulnerability of low-income women for psychological distress and depression, one can assume that women on farms are particularly at risk for these problems. In terms of poverty, female farm workers can be identified as one of the most vulnerable, marginalized and disadvantaged groups in South Africa (Moeller, 1998; Salgado, 1994). In South Africa farm work has been characterized historically by extremely poor living conditions, including poor wages, inadequate housing, poor sanitation, inadequate water supplies and paternalistic and coercive labour relations (Du Toit, 1992; Farmworkers Research and Resource Project, 1997; Segal, 1991; Whittaker, 1987). In a survey done by Te Water Naude, London, Pitt and Mahomed (1998) on farms in the Winelands Region of the Western Cape (South Africa), it was found that, in comparison to the men's wages (which were very low already), women were paid significantly less than men. Not only do these farmworkers face particular forms of discrimination and exploitation, they also live in particularly stressful conditions (see for instance, Naidoo, 1997). Regarding health issues, women on farms still seek to secure elementary conditions that have already been secured for so many others in South Africa. Kisting, Stevens, Gwagwa and Burton (1996) stress however, that many of the mental health problems that women on farms experience are not yet recognized or made visible. While international studies suggest that we can expect female farm workers to be at risk for depression, as of yet we know very little about the mental health problems of these women - it is not even clear whether the term *depression* is appropriate for conceptualizing the mental health problems that they experience. (Therefore, in this context, the term 'psychological distress' will be used.) It seems imperative then that mental health

researchers should pay attention to the mental health needs of this sector of the population. Such research may also illuminate psychological distress of low income women in general.

To address the general psychological distress of this group of women we need to understand the nature, impact and etiology of their distress. However, such research proves to be extremely problematic. Western psychiatry uses the Western diagnostic systems (e.g. the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 1994) as the standard. Implicit in this approach is the belief that Western psychiatry has discovered the core syndromes, and different manifestations in different parts of the world are unusual versions of these syndromes (Swartz, 1998). As Kleinman, Eisenberg and Good (1978) put it, the modern Western doctor's view of clinical reality assumes that biologic concerns are more basic, *real*, clinically significant, and interesting, than psychological and sociocultural issues. In other words the so-called medical model of distress exaggerates biological dimensions and de-emphasizes the cultural dimensions of ill health. As Fabrega and Silver (1973) point out, the medical perspective assumes that diseases are universal in form, progress and content, and that they have a *recurring identity*; that is, it is assumed that the same disease will always have the same cause, clinical picture, treatment, and so on, in whatever culture or society it appears. In other words, psychiatry's way of doing research and diagnosing represents one very particular way of looking at and interpreting someone's experience - it leaves out other aspects of the person (Swartz, 1998). Such an approach may lead to the neglect of the development of an understanding of the subjectivity of the illness experience for the patient (Petersen, 1998). Similarly, within Western medicine, diagnoses are limiting in the sense that it is based on an individualistic view of the person (Swartz, 1998).

Furthermore, these standard diagnostic methods are themselves dependent on cultural / social assumptions about normality and abnormality (Swartz, 1998). Even though the fourth edition of the DSM (APA, 1994) pays more attention to cultural factors than the preceding editions (for instance, Petersen, 1998), the extent to which the DSM can begin to deal with a diverse world, is still uncertain (Mezzich, Kleinman, Fabrega & Parron, 1996).

Cross-cultural psychiatry has emphasized the idea that "culture does considerably more than shape illness as an experience; it shapes the very way we conceive of illness" (Kleinman, 1977, p 4). This implies that it is necessary to keep in mind that culture is an important dimension that influences the clinical presentation of distress (specifically also depression), the relation thereof with the local idioms of distress, the names given to it, the models used to explain the condition, the patterns of help seeking as response to it and the course thereof (Swartz, 1998). It is argued then that, according to the literature, culture may place differential emphasis on particular emotions and can also assign unique attributions as well as expression to the intensity of an experience. It seems that such variation in the phenomenology as well as the language of emotion suggests that cultures selectively emphasize and elaborate these experiential domains (Kleinman & Good, 1985). By extension, people may have difficulty understanding how emotions (which are so much part of our own cultural experience), are experienced and articulated by other people from other cultures (Swartz, 1998). Different cultural groups exposed to similar stressors and conditions experience distress differently and may display different types of stress response, as may men and women within the same cultural group (Kirmayer, 1984).

In the seventies the analysis of the cross-cultural medical and psychiatric research emphasized the importance of the two interdependent aspects of 'sickness', namely *disease* and *illness.* According to Kleinman (1977), *disease* can be described as "...malfunctioning or maladaption of biological or psychosocial processes ..." (p 9). The same author describes *illness* as the personal, interpersonal and cultural reaction to *disease.* In later years the same author (Kleinman, 1988) added another dimension to these definitions by refering to *disease* as the mental health practitioner's objective description of the disorder, and to *illness* as the respondent's psychological experience of pain, suffering and distress - more specifically, the way in which such symptoms are subjectively conceived, evaluated and acted upon by the respondent herself. Even though the etiology and course of the *disease* can either be or not be influenced by social and cultural factors, *illness* is always influenced by these factors. In other words, *illness* per definition is a cultural construct. The focus of cross-cultural psychiatry is mainly on mental *illness* - rather than on mental *disease.* That is, it is concerned less with the organic aspects of psychological disorders than with the psychological, behavioral and sociocultural dimensions associated with them. The focus on the illness experience is of crucial importance in that it determines the sufferer's behaviour, choice of treatment and compliance (Swartz, 1998). To focus only on the disease side, is to strip the question of culture and depression of its chief significance (Kleinman, 1977). Cross-cultural psychologists and psychiatrists subsequently argue that illness, rather than disease, should be the focus of research.

If illness rather than disease becomes the focus of mental health research and interventions, the language (the various verbal and somatic idioms) within which distress is articulated inevitably also assumes central importance. Our feelings are affected and

shaped by the words we use and the vocabulary and sentence construction we have available to us (Swartz, 1998). According to this (hermeneutic) approach to language described by Swartz (1998), language plays a central part in the construction of meaning. By implication, researchers and clinicians have to pay very careful attention to the ways in which subjects who experience hardship and psychological disturbance, talk about and express their distress (Gureje, Simon, Ustun & Goldberg, 1997). According to Migliore (1993), these modes of expression represent the culturally acceptable language of distress and operate in two ways. First, it enables individuals to express their personal suffering to others. Second, it ensures that significant others and health care providers are in a position to recognize and interpret the meanings encoded in the messages they receive (Migliore, 1993). Thus language can and should be considered the basis of most assessments in mental health care, and central to almost all forms of treatment.

Language diversity occurs not only across languages, but also across usages within the same language - even when the same words are used by individuals, the terms may have different meanings for them (Swartz, 1998). The term *discourse* is used to refer to the different ways in which language is used by different groups and individuals. Discourses that have been identified most often in the available literature are somatization, psychologization and narrativation: Somatization, or 'body talking' distress (in the sense of somatic presentations of distress), psychologizing distress, or 'psychologically talking' distress (the tendency to perceive and articulate distress in psychological terms), and narrativation (story-telling) have been reported in diverse cultural groups in Asia, Africa, North and South America, and Europe (Hydén, 1997; Katon, Kleinman & Rosen, 1982; Kirmayer, 1984; Kleinman, 1982; Marsella, 1981). Somatization is conventionally associated with anxiety disorders and depression, and has been reported "in the absence

of psychopathology as an expression of and means of coping with social stress and personal distress" (Kleinman, 1982, p 129). Somatic symptoms are possibly the most universal expression of distress worldwide (Mukherji, 1995) and it seems as if psychological distress almost always is accompanied by reported physical discomfort. The systems model of somatization described by Katon and colleagues (1982) provides an insight into how the emergence and maintenance of functional somatic symptoms are intricately linked with the patient's social and cultural milieu. In other words, as communicative acts, somatic symptoms are tightly woven into the fabric of culture (Kirmayer, 1984). Somatization has been found wherever it has been sought (Crandell & Dohrenwend, 1967; Kirmayer, 1984; Singer, 1975) and, worldwide, somatic symptoms are more common than emotional complaints as a way of presenting psychological distress (Mukherji, 1995; Swartz, 1998). Psychologization can be described as the tendency to perceive and articulate distress in psychological terms and to seek psychosocial treatment (Kirmayer, 1984). According to Kirmayer (1984), women (in contrast to men) are socialized to display a more emotional language of distress - such as the various forms of 'nerves' described by anthropologists in different parts of the world. As third discourse *type*, the narrative concept only first began to appear in studies of medicine and illness at the beginning of the 1980's and has come to be used in a variety of ways (for instance, Mishler, 1995) and contexts (for instance, Somers, 1984). According to Kleinman (1988), the narrative concept can broadly be defined as the form in which people (patients) shape and give voice to their suffering. A number of writers (for instance, Frank, 1995) have shown how narratives not only articulate suffering, but also give the sufferer a voice for articulating the illness experience apart from how illnesses are conceived and represented by biomedicine. Narratives have undisputedly gained importance in the study of illness as

a means for understanding the attempts of people to deal with their life situations (Hydén, 1997).

The way people define or label (articulate) their illness experience vary according to demographic factors such as race (Raczynski *et al.*, 1994), gender (Furnham & Kirkcaldy, 1997) and cultural background (Furnham & Malik, 1994; Kleinman *et al.*, 1978). In conclusion then, language usage may differ across many divides, and there may be different discourses for different social and racial groups, different ages and classes, and the different genders (Swartz, 1998). While this is obvious when the languages spoken are different, this is not always clear when the same language is used in different ways. At this stage, however, if one examines the relatively recent international and the South African literature (for instance, Swartz, 1998) on culture, social class, gender, and mental health, using (amongst others) the computer retrieval programme PsycLIT (1988 - 1999), the language issue is not given much (enough) prominence.

In thinking about mental health and illness in terms of *culture* specifically, it is necessary to be sensitive to the fact that language usages - both in terms of vocabulary and sentence construction - may have different meanings for different speech communities (Swartz, 1998). The articulation of psychological distress in diverse cultures is one in which many other clinicians are also specifically interested - not only to get an idea of the appropriateness of current psychological assessments and (by implication) the adequacy of health care provision to them, but also because these phenomena seem to incorporate some of the determinants of health care utilization (Gureje *et al.*, 1997).

The primary goal of the current study then was to determine how low income female farm workers in the Winelands region of the Western Cape (South Africa) talk about and express their psychological distress. The language these women used to articulate their psychological distress (verbal and non-verbal communications) were analyzed to determine whether it is possible to identify certain 'discourses of distress'.

Thus, the focus of this cross-cultural study is mainly on the expression of psychological distress and possibly mental *illness*, that is the personal, interpersonal and culturally specific ways in which this specific group of low income women talk about their psychological distress.

Methodology:

i.) Design

The current project was one component of a large ongoing project (Kruger, 1998) concerned with the often-ignored psychological distress and resilience of female farm workers. This project is aimed at (amongst other things) generating knowledge that will be useful in the development of policies concerning welfare services and mental health services for low-income women.

In the larger study each participant was interviewed by the same interviewer at least five times. All interviews were conducted in approximately the same year (July 1998 to September 1999) so that the broader social, economic and political context were relatively constant across participants. These interviews covered a range of topics on life experiences and life styles (such as their psychological distress and wellbeing, history of

possible mental illness and substance abuse, their (and their families') physical health, their personal development history, family roles and rules for interaction, resilience and ways of coping, their eating habits and rituals, their sexual history and current sexual functioning and their experience of pregnancy and motherhood). The questions were aimed at exploring how the women themselves interpret and make sense of their experiences.

In the current study the focus was on the first of the five interviews. The terminology used by them, their unique expressions, and also possibly the bodily symptoms reported to convey their distress, were studied in order to come to an understanding of the way in which they articulate their psychological distress. This was done by focussing on these women's answers given during an open-ended interview consisting of semi-structured and open-ended questions.

ii.) Participants

For the larger study between 40 and 50 women, living on farms, are being recruited. Purposive sampling is used so that the final group of women will represent the range of circumstances faced by women living on farms in the Western Cape. Specific sectors of the population are targeted in order to maximize the variation. Respondents are recruited mainly through community organizations (such as the Vroue Regte Groep), non-governmental organizations (such as the Women on Farms Project) and by word of mouth.

To be able to explore the illness experience of heterogeneous populations (i.e. to generate hypotheses and to plan suitable research and intervention strategies) purposive sampling

is a more appropriate sampling procedure than random sampling. It is also important to note here that female farm workers are by no means a homogeneous group: farm workers in different industries, in different regions and different employment situations live in very different conditions and may therefore also have very different mental health issues.

For the current study, the first six participants of the larger study were used. Although this was in the first place a sample of convenience, this sample includes *non-cases* (not depressed) as well as different kinds of cases of depression, namely extreme cases, typical cases, and critical cases. (The importance of inclusion of different types of cases is emphasized by Skinner and Van der Walt (1987)).

Demographic details of the respondents who were included in the current study are provided in Table 1 (p 16). Interviewers' ratings of the participants' mood status, as well as their scores obtained by means of the structured measure of mood, namely the Beck Depression Inventory (BDI), are also included in Table 1.

Diagnoses were made on the basis of participants' responses given and behaviour shown during the open-ended clinical interviews (see Table 1). The respondents often clarified or described their choices - specifically regarding the items of the BDI. These specific responses were considered for analysis.

iii.) Measures

The first interview basically follows the format of a standard clinical psychiatric interview (Kaplan & Sadock, 1994; Morrison, 1995; Othmer & Othmer, 1994). (See Appendix 1 for the interview schedule.) Specific attention was paid to the women's current psychological

functioning, (family/) history of mental illness, substance abuse, their physical health and mental status.

During the first interview the following structured questionnaires were also administered: the Afrikaans version of the Beck Depression Inventory (BDI) (Moller, 1990), the General Health Questionnaire (GHQ - 20) (Goldberg, 1972), and the Satisfaction With Life Scale (SWLS) (Diener, Emmons, Larsen & Griffen, 1985). (Also see Appendix 1 for these questionnaires.) As the BDI (a structured instrument used to detect and measure the presence and severity of depressive symptoms) has not been validated for this population, it was mainly implemented to assess its usefulness as a diagnostic measure for this population. Interviewers were also asked to rate the participants as either (mildly / moderately / severely) depressed or not depressed. These scores and ratings are also provided in Table 1.

iv.) Procedures

All interviews were conducted by qualified clinical psychologists or advanced students in clinical psychology. For the current study, the first interviews (each approximately 90 minutes to 2 hours long) were transcribed verbatim. (For an example of one of these transcribed interviews, see Appendix 3.)

v.) Data analysis

If one is to understand the illness experience and the idioms in which psychological distress is articulated, it is necessary to rely to a large extent on qualitative analysis. Many psychiatric epidemiologists, struggling with finding appropriate ways to define and measure disease / illness in non-Western contexts, have recommended this approach

(Draguns, 1984; Miller & Swartz, 1992; Parry, 1996; Parry & Swartz, 1997). Grounded theory (Strauss & Corbin, 1990), a specific way of doing qualitative analysis, seemed to be particularly relevant for the current study. According to Charmaz (1990), grounded theory can provide alternative understandings of patients' beliefs and actions than those readily available in clinical settings. This perspective also leaves room for inclusion of subjective experiences, values and priorities. Another major strength of the grounded theory method is its open-endedness and flexibility (Charmaz, 1990) - rendering this method particularly useful for theory building. By studying the data from the lived experience of the participants, it was attempted from the beginning to attend to how they construct their worlds. This open-endedness of grounded theory allowed the pursuit of leads and ideas as they developed.

Analysis was done, firstly, by carefully reading through each of the lengthy transcribed interviews. These interviews provided rich, detailed data, revealing thoughts, feelings and actions, with which to work. Secondly, each sentence or utterance was coded, line by line, so that all of the possible themes could later be identified systematically. Thirdly, initial coding was done by examining each line of data and defining the actions or events that were seen as occurring in it or as represented by it. Fourthly, this line-by-line coding process was followed by focused coding, referring to taking earlier codes that continually reappeared in the initial coding and using those codes to sift through the large amounts of data. Categories were then developed from these 'focused codes' in accordance with the process suggested by Charmaz (1990) and constantly recurring themes were selected and analyzed further by referring to both the interview material and the existing literature. Once a set of categories was developed, it was compared with concepts in the literature in order to place this study appropriately within it. All the quotes from the interviews that

could fit in with (and thus confirm) these identified themes, were selected. In other words, in order to see how the participants actually go about making sense of their worlds, their language was taken seriously in analysis, for "in large part it is through language that we create our realities" (Riessman, 1990, p 17). By constantly going back ('staying close') to the actual words and phrases used by each of the participants, and discussing it with the entire research team (busy with the large ongoing project), it was attempted, in true grounded theory tradition, to affirm, check, and refine developing ideas and not to be "locked into preconceived conceptual blinders" (Charmaz, 1990, p 1163), i.e. limited by preconceived hypotheses or ideas.

vi.) Validity

Interviewers clinically evaluated every participant interviewed, using a standard clinical evaluation form. As was mentioned previously, these interviewers are either qualified clinical psychologists or advanced clinical psychology students. By implication, they have been trained to conduct clinical interviews and are experienced in detecting central issues and making valid diagnoses.

By offering a set of systematic procedures, grounded theory enables qualitative researchers to generate ideas that may later be verified through traditional logico-deductive methods (Charmaz, 1990). Nonetheless, grounded theory qualitative methods can stand on their own (i.e. are valid) because they: (1) explicate basic processes in the data; (2) analyse a substantive field or problem; (3) make sense of human behaviour; (4) provide flexible, yet durable, analyses that other researchers can refine or update; and (5) have potential for greater generalizability than other qualitative works (Charmaz, 1990). Furthermore, apart from using this well-established data analysis strategy, many validation

strategies have been built into the research schedule (for example, the enhancement of construct validity by asking similar questions, but in different ways, of the same individual over time).

In a review of research studies focussing on the psychometric properties of the BDI with psychiatric and non-psychiatric samples for the years 1961 through June 1986, Beck, Steer and Garbin (1988) indicated that the concurrent validity of the BDI with respect to other measures of depression is high. It was also found that the BDI is related to clinical assessments of depression (Steer & Garbin, 1988). However, as some of the scores obtained from this structured measure of mood (Moller, 1990) were paradoxical or significantly different to the diagnoses made by interview, these scores were considered invalid. In other words, when / if the BDI is used with this population, it should be applied and interpreted with caution as the usefulness thereof as diagnostic measure could not be confirmed by the data of this particular study.

The other two structured measuring instruments (GHQ and SWLS) have been used in South Africa and have been shown to be reliable and to have validity (Diener *et al.*, 1985; Swartz & Miller, 1992).

Table 1

Demographic detail of participants

Participant	Language	Age	Marital status	Children	Mood	
					Interview	BDI-score
1. Rita	Afrikaans	35	Married	3	Adjustment disorder with anxiety and depression	11 - 14 (Mild depression)
2. Roos	Afrikaans	25	Single	1	Mild depression / Adjustment disorder	30 - 41 (Severe depression)
3. Evie	Afrikaans	45	Married	3 (own) 3 (foster)	Euthymic / Normal	7 - 10 (Normal)
4. Marianda	Afrikaans	61	Separated	3	Euthymic / Normal	43 (Severe depression)
5. Belinda	Afrikaans	32	Single	2	Euthymic / Normal	7 (Normal)
6. Nicole	Afrikaans	28	Married	2	Severe depression	34 (Severe depression)

Results:

By means of the method of grounded theory, it was possible to identify six possible 'discourses of psychological distress', namely i.) silence (refusal / inability to answer),

ii.) reporting and describing behaviour,

iii.) body talk / somatization,

iv.) narrativation,

v.) metaphorical and idiomatic speech, and

vi.) psychologization.

A detailed discussion of each of these categories, illustrated by examples (firstly in Afrikaans, and then roughly translated into English) from the transcribed interviews, will follow.

(For transcription guidelines, see Appendix 2.)

i.) Silence (refusal / inability to answer)

The five women who were interviewed first reported that they frequently remain silent when distressed. However, even when telling about their misfortune in life or their stressful relationships, they seldom, if ever, demonstrated this 'silence behaviour' during the interviews. Silence seems to be their 'conscious' choice, a strategic informed choice within a particular context - in this case, their culture.

On the other hand, participant 6 who was severely depressed, mostly remained silent during the interview - especially when asked about her mood and wellbeing, for example:

Interviewer: "En (1.5) dit is nou vandag se hartseer of gaan dit nou al lank aan?"
["And (1.5) now it is today's sadness or has it been going on for a long time?"]

Participant 6 (P6): "Ek dink nou (2.0) net vandag omdat ek weer nou (5.0)"
["I think now (2.0) only today because again I (5.0)"]
(she did not complete her answer / silence)

She often replied that she did not know (possibly meaning that she did not know *how to respond*, or *what it is that she felt*, or that she struggled to put these feelings into words):

P6: "Ek weet nie."

["I don't know."]

This *struggling* attempt to put feelings into words is illustrated by the fact that she repeatedly and literally said "I cannot say".

ii.) Reporting and describing behaviour

As mentioned in the previous section, participants 1, 2, 3 and 5 *reported* that they often chose to remain silent when distressed, for example:

P1: "Ek gee hom nie meer antwoord nie."

["I don't answer him anymore."]

P2: "( ) dan bly ek stil (1.0)"; "ek gat hom nie antwoord nie"; "Ek praat ook nie by die huis nie"

["( ) then I remain silent (1.0); "I will not answer him"; "I don't even talk at home"]

P3: "Toe kan ek haar nie antwoord nie"; "Stilbly is 'n antwoord"

["I couldn't answer her then"; "Silence is an answer"]

P5: "om stil te wees (2.0)"; "om aan niemand niks te sê nie"; "ek het nie spraak gehad nie"

["to be quiet (2.0)"; "to say nothing to no one"; "I didn't have words"]

Participant 2 and 5 *reported* that they prefer not to complain even when they believe they have enough reason to feel discontent:

P2: "Ek sal *nooit* kla nie"; "( ) dan bly ek stil"

["I will never complain"; "( ) then I remain silent"]

P5: "Ek pla nie ander mense nie"; "om niemand te pla nie"

["I don't bother other people"; "to bother no one"]

In the past participant 3 communicated her psychological distress by shouting, but at this stage she *said* that she articulated her distress by just being quiet:

P3: "Stilbly is 'n antwoord."

["Silence is an answer."]

According to participant 5 her children know that she is experiencing and expressing distress when she is quiet, for example:

P5: "Die gouste wat hulle (.5) sien ek antwoord nie vir hulle nie, (.5) of ek kyk nie vir hulle nie, (.5) dan weet hulle ek het probleme of ek voel nie lekker nie"

["As soon as they (.5) see that I don't answer, (.5) or when I don't look at them, (.5) then they know that I have problems or that I don't feel well."]

Participants 3, 5 and 6 cried during the interview. Their crying was alternated by deep sighs. Sad expressions (participants 2, 3, 5 and 6), slumped posture (participant 6) and passive demeanor (participants 2 and 6) were also documented in the journals written by interviewers.

Most of the participants *reported* that they usually cry, shout or use abusive language when they express their distress. Participants 1, 2, 3 and 5 mentioned that they often cry when in distress, for example:

P1: "En andersins huil ek maar (3.0)"; "dat die trane ook nou gekom het"

["And otherwise I just cry (3.0)"; "that the tears also came"]

P2: "Ek net gesit en gehuil"; "raak *moeg* gehuil"

["I just sat and cried"; "tired of crying"]

P3: "dan sit en huil ek net"

["then I just sit and cry."]

P5: "Dan huil ek net."

["Then I just cry."]

Participant 1 also *said* that she usually use abusive language frequently to express her dysphoria (especially anger and unhappiness):

P1: "As hy skel, (1.0) dan gee ek nou vir hom woorde terug (2.0)"

["When he scolds me, (1.0) then I give him words (2.0)"]

Participant 1 *reported* that apart from crying and the use of abusive language, she even uses physical violence to communicate her needs and ultimately her psychological distress:

P1: "En andersins huil ek maar (3.0) en sommige kere dan (2.0) baklei ek terug"; "Maar die baklei gebeur baie min. Dis meer *skel*."

["And otherwise I just cry (3.0) and sometimes then (2.0) I fight back"; "But the fighting seldom happen. Rather it is scolding."]

Abusive language and physical violence also seem to be participant 2's way of expressing her distress and communicating her needs to others:

P2: "Dan sal ek ook slegte woorde sê ( )"; "dan sal ons eerder handgemeen raak"; "die ding uit*baklei* "

["Then I will also use bad words ( )"; "then we will physically fight"; "*fight* about the issue"]

Participants 3 and 5 refrain from physical violence, but they admitted that they shout at everyone when in distress. Whether *abusive* language *per se* is used in these contexts, is unclear, for example:

P3: "Ek was (.5) *lelik* (1.0)."; "ek het geskree op almal ( ) (2.0) Ek (.5) Iets was miskien nie so erg nie (1.0) ( ) Dan vaa:r ek uit."

["I was (.5) *ugly* (1.0)."; "I shouted at everyone ( ) (2.0) I (.5) Maybe something was not even that bad, then I would carry on."]

P5: "daar kom tye (.5) wat ek net in woorde seermaak"; "Ag, dan raas ek op hulle albei."

["there come times (.5) that I only hurt others with words"; "Oh, then I scold them both."]

Participant 2 *reported* that she isolates herself from others when she is feeling distressed:

P2: "ek wil net weggaan dat dit kan beter wees"; "dan stap ek in die wingerd. Dan gaan sit ek daar alleen (1.0)"; "ek loop maar eerder net weg"; "ek gat sit daar eenkant daar langs die pad".

["I just want to leave so that things can be better"; "then I walk in the vineyard. Then I sit there on my own (1.0)"; "I prefer to walk away"; "I go sit on my own next to the road"]

When distressed, she also smokes constantly - she *reported* that she smokes the whole day when she feels unhappy:

P2: "'n PAKKIE 'n DAG as my as my dag so begin, dan rook ek heeldag. Ek eet nie, ek rook net."

["a PACKET a DAY when my day starts like this, then I smoke the whole day. I don't eat, I just smoke."]

She also *reported* frequent coffee drinking as a way of coping with (and in effect, communicating) her psychological distress:

P2: "Ek drink net koffie"

["I just drink coffee."]

iii.) Body talk / somatization

All the women that were interviewed spoke of psychological distress in terms of "senuwees" or "maagsenuwees" (nerves or stomach nerves). The stomach appears to be the primary site for nerves. According to participant 1 of the current study, this condition ("maagsenuwees") seem to have a course or shows progression: she talked about the onset of the condition, and she also said that if it is treated early, the prognosis improves:

P1: "Toe was dit ook net die beginstadium van *maagsenuwees*"; "en toe't ek ook (1.0) begin maagsenuwees kry, (.5) maar ek het gou genoeg dokter toe gegaan."

[At that stage it was also just the beginning of *stomach nerves*"; "and I also started (1.0) to get stomach nerves, (.5) but I went to the doctor soon enough."]

Participant 1 also talked about a burning sensation in her stomach, that 'feeling' in her tummy when she is upset.:

P1: "die maag het nou nie meer so (2.0) uh vreeslik uh gebrand"; "dan kry ek ook daai (.5) gevoel op die maag"

["the stomach did not (2.0) uh burn so uh much"; "then I also get that (.5) feeling in the stomach"]

She also described a "gnawing at the stomach" to communicate her distressed state of being:

P1: "Jy kan sommer daai gevreet voel aan die maag."

[You can just feel that gnawing at the stomach."]

Participant 2 also described this unpleasant state of being in terms of a turning stomach.

She becomes aware of her nerves or dysphoria when she feels her stomach turning:

P2: "[draaimaag"; "my maag my maag gee net die heeltyd so (1.0) draaie"

["turning stomach"; "my stomach my stomach gives such (1.0) turns the whole time"]

And so, when she complains to others about her stomach pains, she actually (presumably subconsciously) is telling them more about her psychological distress. The term "maagsenuwees" was also used by participant 4 to talk about a dysphoric mood state. She referred to this condition as a "sickness in the stomach" or as a feeling of discomfort of the stomach:

P4: "dan lyk dit vir my asof ek 'n soort siek (.5) het in my maag."

["then it seems to me as if I have a type of illness (.5) in my stomach."]

Participant 5 also mentioned that she 'gets on her nerves' when she finds a situation difficult or stressful. The stressful effect that other people, in this case, the father of her first child, has on her, was described with:

P5: "dan (1.0) is ek so op my senuwees, (2.0)"; "(.5) werk hy eintlik op my senuwees"

[then (1.0) I am so nervous, (2.0)"; "(.5) he is making me nervous"]

Besides the term 'nerves', two of the participants (participant 3 and 4) used the term "kortgespanne" to describe feelings of distress. However, this term was also used by participant 4 when she talked about her mother's temperament - implying that she was a short tempered, often unhappy lady:

P3: "Die tye van my siekte, ek was (.5) *lelik*. (1.0) Ek was kortgespanne"

[At the time of my illness, I was (.5) *ugly*. (1.0) I was short tempered"]

P4: "sy was baie kortgespanne gewees en hy was baie (sag)"

[she was very short tempered and he was very (soft)"]

Headaches, experienced during distressful times, were also described by almost all of the participants. These headaches typically persist for a long time, sometimes even for a few

days, despite trying to sleep it off, or taking medication for it. Headaches and the stomach seem to be the main foci for all of the participants' complaints or reports of distress. These 'focus points' were prioritized by some of the women: Participant 1 described both stomach problems ("maagwerk") and headaches, but she said that headaches are the biggest and most frequent problem:

P1: "kry ek net hoofpyn van die more tot die aand (.5). As ek vanaand gaan slaap met hoofpyn, more-oggend staan ek daarmee op."; "die maag het nou nie meer so (2.0) uh vreeslik uh gebrand as wat ek die hoofpyn gekry het nie. Die hoofpyn is die grootste probleem."

[I just get headache from morning until night time (.5). If I go to sleep with a headache at night, tomorrow morning I wake up with it."; "the stomach did not burn (2.0) so much as having the headache. The headache is the biggest problem."]

When participant 2 told of her unhappiness and her stressful relationships, she talked about a headache ("kopseer") that persisted for a week despite taking medication:

P2: "Ek het laas week so 'n kopseer gehad (2.0). My kop het begin Maandag (1.0). Hy't *hee:l wee:k* aangehou. Ek het pynpille gevat. Dit help net niks."

[I had a headache like that last week (2.0). My head started on Monday (1.0). It continued the *who:le wee:k*. I took pain killers. I didn't help at all.]

When participant 3 talked about the events that led up to her being diagnosed with depression, she related the events of her admission to hospital, her physiological diseases (heart, diabetes and asthma), but when asked what the matter was, she chose to tell the medical personnel that her head was sore:

P3: "Toe sê ek my kop is seer"

["Then I said my head is sore."]

Most of the participants (all except participant 2) articulated their psychological distress by complaints of being tired ("moeg") or feeling weary ("lam"). Participant 1 explained this state in a very unique way: she said that her tiredness comes from 'inside' even at times

when she hasn't worked hard:

P1: "dan raak ek net so MOEG (1.0)"; "= so van *binne* af"; "en ek weet ek het nog nie eers baie gewerk vandag nie, (.5) dan is ek *moeg*"

[then I only get so TIRED (1.0)"; "= from the *inside*"; "and I know that I haven't even worked that much today, (.5) then I am tired."]

Even though participant 4 did not mention tiredness, she did refer to herself as being weary ("lam") and shaky ("bewerig") when experiencing distress. When she is in a conflict situation, participant 5 also communicates her feelings by refering to her legs as being weary:

P5: "dan word my bene lam"

["then my legs get weary"]

Apart from the aforementioned similarities in the articulation of distress, other more idiosyncratic ways of communicating or expressing distress that are not shared were also documented. For example, participant 1 spoke about her hair growth that stops when she is worried or distressed:

P1: "die laaste tyd my hare wil nie eers groei nie (2.0)"

["in recent times my hair doesn't want to grow (2.0)"]

Another very unique way that participant 1 used to express her distress, is when she said that she menstruates twice in a month when she's upset:

P1: "somtyds vloei ek sommer twee keer in die maand"; "en as ek my baie ontstel, dan (.5) *vloei* ek sommer."

["sometimes I even flow twice in a month"; "and when I get very upset, then (.5) I simply flow."]

iv.) Narrativation

Most participants in this study also used narratives / story-telling as a way of expressing their distress. Quite a few examples could be found where the participant told a story (e.g.

he did / said this, then I did / said that, and then ...), but refrained from disclosing the emotion *behind* the event or describing the distress they experienced.

Participants 1, 2, 3 and 4 typically used this 'style' of discourse and it is almost as if they expect the interviewer to know how they felt and how they experienced it - just by narrating the incident, for example:

P1: "Oor uh (3.0) die omstandighede waarin ek nou is. (1.5) My man is werkloos (1.0) en dis net my inkomste en ek het vier kinders om te onderhou (1.0) en (2.0) die geld is min. Daar's baie dinge (2.0) wat moet reggemaak word met geld."

["Because of uh (3.0) the circumstances I am in at this stage. (1.5) My husband is unemployed (1.0) and it is only my income and I have four children to support (1.0) and (2.0) the money is limited. There are many things (2.0) that need to be taken care of with money."]

Participant 1 also described her concern about her children's future by relating an incident that happened that specific morning:

P1: "[Soos byvoorbeeld vanoggend het ek die uh uh kind 'n *goeie* pak gegee (1.0) omdat hy nou (2.0) meer as R3-iets uit my beursie uit gesteel het. Ek het hom *dadelik* 'n goeie pak gegee (1.0) en vir hom gesê as hy nou al in die *huis* steel, (.5) kan hy *later* (.5) *buitekant* steel en (.5) dan beland hy in die tronk. Die kleintjie, [ja. Ek het my *belt* gevat gevat en hom 'n paar houe gegee."

["[For example this morning I gave uh uh the child a thorough hiding (1.0) because he (2.0) stole more than R3-something out of my purse. I *immediately* gave him a good hiding (1.0) and I told him that if he already steals at *home* at this stage, (.5) then he probably will steal (.5) *outside* of home *later on* and (.5) then he will land in jail. The small one, [yes. I took my belt and gave him a few lashings."]

In other words, she chose to express her distress about her children's 'criminal' tendencies through the narration of this particular incident.

Participant 2 expressed her distress with stories about her relationships with her significant others (such as her parents, her boyfriends and her friends). She gave an account of what happened, how they treated her and the way she responded to them in these specific situations, for example:

P2: "Dit is vandat uh uh uh (1.0) die probleem in die kerk begin het ( ) dat dit so gaan. Want kyk ons ek en die (1.0) apostel (apostel) ons het uh uh uh altyd ook so saam gebid en so (1.0) en toe begin die mense mos nou te praat, (2.0) jy weet? Toe sê ek net so maar (2.0) ek ek ek was nie daar nie, OK, toe gee sy mos nou (1.0) haar man vir my, maar voor sy dit gedoen het, het hulle seker onder mekaar gepraat"

[It is since uh uh uh (1.0) the problem started in church ( ) that things are like this. Because see, we the (1.0) apostle (apostle) and I, we uh uh uh always prayed together in this way and so (1.0) and then the people started talking, (2.0) you know? Then I just said but (2.0) I I wasn't there, OK, then she indeed gave me (1.0) her husband, but before she did that, they probably talked among themselves"]

She seemed to be concerned more with narrating what happened chronologically than she was with introspective remarks and with disclosing emotions.

Like participant 2, participant 4 often articulated her distress in terms of events (e.g. the day her son seriously injured his wife by beating her with a brick):

P4: "dan dink ek net altyd aan daai Sondag"

["then I always think about that Sunday"]

what people did or said, for example:

P4: "En nou daai laaste keer wat sy geloop het en sy gesê het sy kom nie weer terug nie"

["And that last time that she went away and she said that she is not coming back"]

and what her own reactions were:

P4: "ek het so gebid (.5) ek het op my knieë gegaan ( ) en vir die Here gevra die Here moet help".

["and I prayed and prayed (.5) I went on my knees ( ) and I asked the Lord that the Lord must help me"].

Participant 4 also told entertaining stories about her childhood, especially about incidents where she probably felt mistreated or victimized, for example:

P4: "Nou nou {laughter} en dan sal sy dit vat en gaan toesluit (1.5) dan vertel sy vir ons (1.5) 'n mens eet nie alles op *een* dag nie (1.5), daar's 'n volgende dag. JA: Die ander kinders kry *al* hulle goeters, maar ons kry nie ons goeters nie (2.0) en dan kom my pa nou weer (2.0) (en sê) 'n mens eet nie alles op 'n slag nie, dis nie kos nie, dis vrugte (2.0) (Julle) mae raak seer en dit raak aan die werk. Hy't ons altyd so bang gemaak ="

["Then then {laughter} and then she will take it and lock it away (1.5) then she tells us (1.5) a person

does not eat everything in one go (1.5), there is a tomorrow. YE:S. The other children get *all* their stuff, but we don't get our stuff (2.0) and then my dad comes again (2.0) (and says) a person does not eat everything in one go, it isn't food, it is fruit (2.0) (Your) stomachs get sore and it starts working. He always scared us so much ="]

Severely limited eyesight (due to a disease) is causing impairment in this participant's general functioning. She expressed this distressful state of affairs by narrating how good her life has been in the past (when she could still see properly):

P4: "Want ek het (.5) hoe kan ek nou sê (.5) dit was vir my lekker daai tyd toe ek alles kan gesien het en so (.5) Ek weet nie eens of ek nou half die huis uitvee of (1.0) half miskien skottelgoed was of so of half afstof nie ="; "Dan vra ek altyd Let sy moet kom kyk of ek dit skoon gedoen het. Dan sê sy: Nee, dis oraait"

["Because I (.5) how can I say (.5) it was very nice at that time when I could see everything and so on (.5) I don't even know if I only sweep the house by halves or (1.0) wash the dishes by halves or so or dust by halves ="; "Then I always ask Let to come and see whether I have done things properly. Then she says: No, it is all right."]

Participant 3 also told descriptive stories frequently to express her psychological distress:

P3: "Ja, vanmiddag wat ek so gevoel het seker maar nou omdat ek nou koud gekry het en my voete het gepyn en die taxi kom nie uit nie en toe voel ek so (.5)"

["Yes, this afternoon I have felt like this probably because I was cold and my feet ached and the taxi didn't come and Then I felt like this (.5)"]

Other similar examples could also be found - for instance, where she told about the distress she experiences when the rights of children are violated:

P3: "Dat 'n kind regte het. 'n Kind is geregtig ( ). Nou hy het twee meisiekinders (1.0). Die oudste een is sestien en die ander een is nou elf (1.0). Hulle se ma is toe nou daar weg, (2.0) toe was die een 'n babatjie (1.0), toe was sy 'n jaar en twee maande (1.0) .hhh En hy't daai kind na my toe gebring en ek het vir hom grootgemaak ( ) (1.0). Hulle ken nou nie 'n ander pa nie, hulle ken net vir hom, hulle ken nie 'n ander ma nie, (as hulle praat van) 'mamma', dan is dit nou ek."

["That a child has rights. A child has the right ( ). Now he has two daughters (1.0). The eldest is

sixteen and the other one is eleven at this stage (1.0). Their mother had left, (2.0) the one was a baby still (1.0), she was a year and two months (1.0) .hhh And he brought that child to me and I raised her for him ( ) (1.0). They do not know another father, they only know him, they do not know another mother, (when they speak about) 'mom', then it is me."]

v.) Metaphorical and idiomatic language

Apart from silence, narratives and reporting behaviour to speak the language of psychological distress, other very interesting metaphorical and idiomatic ways of expressing psychological distress can be found in some of the interviews. (Because of their unique and *language bound* nature, these phrases were also the most difficult of all the discourses to translate.)

Participant 1's legs are weary when she is in this state of psychological distress. Taking the context into consideration, one can assume that this phrase was meant metaphorically:

P1: "Maar (.5) my bene is maar altyd (.5) lam. Uh uh uh ek het maar altyd sulke lammerige bene."

["But (.5) my legs are always (.5) weary. Uh uh uh I always have such weary legs."]

Participant 2 described her reaction to an unpleasant event with the following words:

P2: "ek haak so 'n bietjie uit daar"

["I lose control there"]

"Swartgallig" and "omgekrap" were other idiomatic terms used by participant 3 to describe her "black" or distressed mood. Another idiom used by participant 3 to describe a stressful situation makes mention of the devil - indicating exactly how bad it was for her:

P3: "Oe:, toe't die duiwel los geraak"

["O:h, then the devil was loose"]

She also uses the terms "swaarkry" and "omgedraai wees" to vividly describe the 'heaviness' and 'disruptive' nature of her distress.

Participant 4 reported that her 'heart breaks' when she experiences serious psychological distress:

P4: "en dan *breek* (.5) *my* (.5) *hart*"

[and then (.5) my (.5) heart breaks"]

Participant 1 also referred to this proverbial 'heart' when describing her friend's display or expression of psychological distress:

P1: "Sy't nou sy't nou haar hart uitgepraat saam met my (1.0) oor oor die probleem van *haar* nou."

["She she emptied her heart while talking with me (1.0) about about her problem."]

When participant 3 told of her worries, she said that her 'heart feels tired':

P3: "dat ek so MOEG is en (.5) dit voel amper of my hart moeg is"

["that I am so TIRED and (.5) it feels as if my heart is tired"]

Participant 5 said that she didn't have the heart to do something - meaning that she didn't feel up to it, or that she found it very difficult (distressing) to do something:

P5: "maar ek voel nie altyd gelukkig om hulle te slaan nie, (.5) want ek het nie die hart daarvoor nie."

["but I don't always feel happy to beat them, (.5) because I don't have the heart for it."]

Other 'metaphorical' expressions used by participant 5 when she talked about articulating psychological distress, were:

P5: "met 'n lang gesig"; "gesiggies hang"; "met 'n verkeerde voet opgestaan"; "dan is dit altyd (.5) donderstorms (.5) is nou net los"

["with a long face"; "hanging faces"; "gotten out of bed with the wrong foot"; "then it is always (.5) thunderstorms are loose"]

vi.) Psychologization

As mentioned previously, 'psychologization' refers to the ability to speak in psychological terms. For example, to psychologize one's psychological distress (from a Western or biomedical perspective), words such as 'depressed', 'worried', 'dysphoric' and 'anxious'

would be used.

Participant 1 was able to express her emotions in this way during the interview. She was able to say what she feels in psychological terms and used phrases such as:

P1: “is ek ’n bietjie *upset*”; “baie bekommerd”; “[Van al die [spanning wat ek ondervind”; “dit maak my baie ongelukkig”; “as ek my baie ontstel”; “as ek *baie ontsteld* is”; “die frustrasie"

["am I a little bit *upset*"; "very worried"; "[because of all the [tension that I experience"; "it makes me very unhappy"; "when I get very upset"; "when I am *very upset*"; "the frustration"]

Participant 3 is the only one of the participants that has had experience of psychiatric treatment and she is well acquainted with so-called 'psychological terminology'. Phrases such as:

P3: "wat ek so hartseer is"

["that I am so sad"],

P3: "seerkry"

["feeling hurt"] and

P3: "bekommerd"

["worried"]

are examples of the discourse of psychologization used by her. Participants 4 and 5 were also able to articulate their distress in terms of emotions and other 'abstract' terminology. For instance, words such as 'sad', 'upset', 'feels bad' and 'I am afraid' can be considered examples of the ways in which they psychologized their distress:

P4: "bitter treurig gevoel"; "so bang"; "daarvoor voel ek sleg"; "so hartseer"

["felt terribly sad"; "so scared"; "therefore I feel bad"; "so sad"];

P5: "*irriterend*"; "wat my seermaak"; "terneergedruk"

["*irritating*"; "what hurts me"; "depressed"].

Creating theory: Discussion of results:

In the previous section, six different ways of articulating psychological distress were identified. While it is not the object of the current study to determine or to speculate about how common these discourses are, it is important to discuss the possible ways in which these discourses *function*. In order to come to an understanding about what the choice of discourse communicates about the experience of psychological distress, a discussion of each of these discourses, with the existing literature as background, will follow. In this way, it is attempted to shed light on the importance of gaining knowledge about, and insight into the specific content of each of these discourses, the contexts in which they are used and the implications thereof - not only for cross-cultural psychology / psychiatry as a discipline, but more specifically for assessment of mental status and the provision of mental health care.

i.) Silence (refusal / inability to answer)

Very few of the participants demonstrated this communication pattern, and unfortunately, cross-cultural studies done on silence are also very scarce (Goldberger, 1996). However, the findings of this study clearly echo Goldberger's (1996) conclusion that silence, as a way of communication, is very complex. In this discussion then, the complexity of silence and the functioning thereof (specifically as discourse of distress) in particular contexts will be illustrated. In this way it was attempted to come to a conclusion about what the relevance and implications of this particular discourse of distress can be.

Participant 6, diagnosed with severe depression, effectively conveyed her distress to the interviewer through silence. She was quiet, one can even say *speechless*, and this silence (or 'loss of voice') communicated her distress and her 'loss of self' (as Jack (1991)

describes depression) quite strikingly. Looking at participant 6's immediate context (as victim of seriously abusive marital relationship), it is quite obvious that silence is / was the safest and thus her only option (according to her) in dealing with the situation.

Even though Goldberger (1996) argues that learning when to and when not to speak is basic to the production of culturally appropriate behavior, this woman seemed to be 'silenced', not because of her culture, but rather by her living conditions, her fear and thus, her experience of severe psychological distress. She seemed to be without words, without the choice to either speak or not to speak, and therefore powerless. Goldberger (1996) says that "it is only those who are silenced by oppressive and demeaning life conditions who feel powerless, mindless, and truly without words ... (p 346)". The sense of choice about whether to speak or not to speak is missing for this woman. The importance of understanding both the immediate (familial, community) and the distant (cultural, political) context for silence and speech is also confirmed by research done by Goldberger (1996).

It can be concluded from this that silence, as a discourse of distress, is communicating much more than just a loss for or an absence of words. A person's preference for silence is important - as this choice may either be culturally endorsed, or / and it may be because of individual factors (such as the intensity of distress or temperament) (Matsumoto, 1994). The complexity of silence as a way of communication can be confusing and / or limiting - especially in the mental health care context where the practitioner firstly has to notice the silence, and secondly, has to decide what is communicated by the patient's silence in a particular context so that the appropriate response (and treatment) can be provided.

ii.) Reporting and describing behaviour

This second discourse of distress identified will be discussed in the following section. It will be shown that even though people's (patients') reports, or speech patterns, have traditionally been accorded a somewhat ambiguous status in modern biomedicine (Hydén, 1997), this way of expressing distress is very common indeed. How patients spoke about their illness was traditionally regarded at best as a pale reflection of the language of the organs and tissues and their pathological changes (Armstrong, 1984). But, as clinicians have to depend on these reports in order to investigate and diagnose the disease, it was attempted in this discussion to give prominence to the content thereof and the probable reasons they have for choosing this particular discourse. In short, the ways in which this discourse function within this particular context will be explored.

Silence, crying, shouting, the use of abusive language and physical violence were reported by the participants of this study and can be considered (amongst other things) their ways of communicating distress. In other studies done in the Western Cape (for instance, London, Nell, Thompson & Myers, 1998), high levels of interpersonal violence have also been reported. In the study done by London *et al.* (1998) on the health status among farm workers in the Western Cape, high levels of alcohol intake and smoking (described by some of the participants of this study), were also reported. In other words, the specific ways in which these women report and describe certain behaviours as a way of 'speaking the language' of distress, are confirmed by existing (South African and international) literature.

Reports and descriptions of behaviours and symptoms are probably the easiest discourse of psychological distress to identify and thus, to attend to. Looking at the Western

diagnostic manuals and similar instruments (such as the DSM-IV) at our disposal, it seems obvious that this is the discourse used most often. By implication, it would also be this discourse of distress that would be attended to most effectively. In other words, the choice for reports / descriptions of behaviours can thus be seen as an effective way of communicating distress, and seeking help.

To conclude, the fact *that* this discourse is used, the contents thereof and the reasons for choosing it (subconsciously or not), seem to fit into a Western framework of thinking about detection and treatment of psychological distress.

iii.) Body talk / Somatization

In the following section it will be attempted to show how distress can be 'body talked' or communicated by the body as the ultimate instrument of all our external knowledge (Goldberger, 1991). Furthermore, it will be explored how this particular discourse functions as a way of expressing distress and what the importance thereof is for theory and practice.

To complicate matters, recent research suggests the possibility of three forms of somatization in primary settings. These have been identified as functional somatization, hypochondriacal somatization and presenting somatization (Kirmayer & Robbins, 1991). In this case, presenting somatization is the focus point as it refers to the somatic presentation of anxiety or depressive illnesses (Kirmayer & Robbins, 1991). The somatic presentation of psychological distress in the community as well as in primary health care settings (in South Africa) is well documented (Bhagwanjee, Parekh, Petersen & Subedar, 1998).

According to the 'culturally informed' approaches to thinking about women, distress and social interaction, it can be said that the body or *soma* is understood as an organism that is thoroughly immersed in culture, a medium of culture, rather than 'brute matter', neutral with respect to sociocultural influences (e.g. Stoppard, 1998). Social scientists and laypersons alike have long recognized that people of different cultures can, and do, display different ways of 'body talk' in order to express their emotions (Matsumoto, 1994). For example, the results on somatization of this study echo the pattern of articulating distress employed and reported by *coloured* people receiving primary health care in another Western Cape village (Rogers, 1992). (For instance, headaches appear to be a feature of nerves - for the participants of Rogers' study as well as the women in this study.) Wiener and Marcus (1994) suggested that 'somatic presentations' (Kirmayer & Robbins, 1991) such as these can be considered to be outward manifestations of possibly an underlying depressive disorder, and can also be understood as forms of bodily communication guided by shared social 'scripts'.

An extension of the view that distress can be 'body talked' or communicated by the body as the ultimate instrument of all our external knowledge (Goldberger, 1991), is the idea that an inability for, or social suppression of verbal emotional expression has a direct effect on the production of physical symptoms (Kirmayer, 1984). Whether these dynamics are at work here, is unlikely, as embodied expressions of distress such as these were often accompanied by other 'discourses', such as narratives (telling the story) and metaphorical language.

In South Africa these somatic presentations have been found to be explained largely in terms of social and psychosocial problems such as poverty and interpersonal problems

(Petersen & Parekh, 1996; Swartz, 1998). In thinking about the existing South African and international literature, for example the study by Rogers (1992), as well as the data obtained from these women on somatization, it is important to consider somatization as a language, a way of seeing the world, and as a way of negotiating with the world (Swartz, 1998). Goldberger (1996) considered these 'body metaphors' as a powerful tool for organizing, articulating and communicating human experience. As such, at the most basic level, it is necessary to consider this discourse as one of the ways in which distress is communicated and help is seeked.

To conclude then, having knowledge about and by paying attention to the ways in which distress is expressed by the body, the identification of underlying problems associated with the somatic presentations will possibly be facilitated. In this way the appropriate services can be offered and rendered to the relevant persons. However, as misinterpretation is more likely to be prevalent amongst this third form of somatization (presenting somatization) (Petersen, 1998), it seems fitting to caution against making assumptions about this particular way of articulating distress, the intentions behind it, and what the implications thereof may be.

iv.) Narrativation

In this section, the discourse of narrativation (story-telling), the meaning (-s) thereof, and the way in which it functions to communicate the experience of distress, will be discussed. It will be shown how the content of these stories is determined and influenced by factors closely connected to life style and conditions. The implications thereof within the context of mental health care will be explored.

Narrative can be defined as talk that includes some notion of temporal ordering or temporality (Preece, 1992) with the chronology serving to make sense of scattered events (Labov, 1972). Depicting illness in the form of narratives is a way of contextualizing illness events and illness symptoms by bringing them together within a biographical context (Hydén, 1997). The stories people tell are important - not only because they offer an unmatched window into subjective experience (Ochberg, 1988), but also because it is one of several cultural forms available to us for conveying, expressing or formulating our experience of illness and suffering (Early, 1984; Hydén, 1997). According to Hydén (1997), a central aspect of this narrative concept is that, besides being an important knowledge form, it is able to represent and reflect illness experiences in daily life. By weaving the threads of illness events into the fabric of our personal lives, physical symptoms are transformed into aspects of our lives, and diagnoses and prognoses attain meaning within the framework of personal life - what Early (1984) calls the 'customisation' of the illness. According to Ochberg (1988) these narrative self-representations shape how we conduct our lives, how we come to terms with pain, what we are able to appropriate of our own experience, and what we disown - at the familiar price of neurosis. Just as narratives gradually come to occupy an increasingly centralized position in social science generally, so also has their importance in *illness* research grown (Hydén, 1997).

In this way, people's (patients') narratives shape and give voice to suffering (Kleinman, 1988) in a way that lies outside and beyond the domain of the biomedical voice (Hydén, 1997). Hydén (1997) concludes that the narrative should also, amongst other things, be considered a medium for conveying shared cultural experiences.

Looking at the results of this study and specifically the findings on narrativation, the stories

that were told often seem long and vague and often without much *direction* or purpose. Therefore, one may hypothesize about the different possible reasons why people would choose to use this particular discourse of distress, but what is certain, is that with narrativation, in whatever context, the interviewer and the interviewee are co-constructors of (the interviewee's) reality. That is to say, both are looking for a way to understand and articulate the illness and the illness events as a meaningful whole (Hydén 1997). It is through narrativity that she / they come to know, understand and make sense of the social world (Somers, 1994). In other words, narrativation, can (should) be understood as a very complex way of making meaning, not only giving symptoms or describing feelings, but also a way of exploring causes, consequences and implications of these symptoms within a specific culture.

In terms of theory building and the practice of mental health care, this information emphasizes the importance of allowing a person (patient) to tell their stories as a way of making sense of, 'giving voice to', and thus, looking for help to relieve their suffering. By extension, physicians are encouraged to attend to patients' stories as ways of providing their concerns and understanding of their illnesses (Clark & Mishler, 1992). It is imperative then that physicians should attend to the stories of their patients, even when no obvious psychological or physical symptoms are reported. It should be assumed that the patient tells a story to her doctor for a reason or, in other words, that every story within a clinical encounter is meaningful. This entails that the physician will have to play a much more active and interpretive role in looking for the reasons or the meaning of a particular narrative. However, it is often up to the physician to determine what these reasons or intended meanings are as the patient her- (/ him-) self may not offer this explicitly in her (/ his) narratives.

By improving the ability of mental health professionals to identify these narratives as a way of expressing distress and to interpret it as such, the understanding and care of patients may be improved significantly. However (unfortunately), as of yet little research exists on how storytelling actually is accomplished in the context of clinical encounters.

v.) Metaphorical and idiomatic language

The functioning of this discourse of distress, i.e. the specific use (-s) and content thereof, the contexts in which it is used and, by implication, the possible reasons for *not* using this discourse, will be explored in the following section. Prominence will be given to speculation about what this choice of discourse communicates about the experience of psychological distress and what the implications thereof for mental health care are.

According to Stoppard (1998) a metaphoric link may be drawn between some terms used to describe depressed mood and embodied aspects of experience. For instance, being *low*, *down* or *flat* (e.g. participant 4: "dan gaan ek af ...") represents bodily positions associated with sickness, defeat or an effort to conceal the body from view. To say one is feeling 'down' or 'low' therefore implies not only a quality of mood, but also a way of positioning oneself in relation to others, a having conceded or given up.

None of the participants has their own means of transportation, and often has to walk great distances from and to work / town. Thus complaints about 'heavy', 'tired' or 'weary' legs contribute to the idea of being powerless, maybe even incapacitated and thus, by implication, in distress.

Like so many other cultures (e.g. Hamilton, 1986), these women also communicated their

experience of extreme distress by referring to 'blackness', the 'heart' or the 'devil'. This emphasizes the fact that even though some discourses of distress are typical of specific cultures, there are instances where these discourses are similar in or shared by different cultures. By implication, by using these 'shared' discourses of distress, (cross-cultural) understanding is facilitated.

The metaphors and idioms that people use can thus also be seen as a reflection of the specific cultural idiom (Stoppard, 1998). The failure of some individuals (for example participants 2 and 4), to reveal a rich emotional and fantasy life, expressed with idioms and metaphors specifically, may reflect neither biological incapacity nor preoccupation with somatic concerns, but rather a culturally supported suppression of open displays of feeling (Hsu, 1949; Rainwater, 1970) or possibly merely an idiosyncratic preference for the other discourses of distress. Whatever the case may be, the content of most of these metaphors very effectively conveys a person's mood - especially how it is experienced, and, by implication, what is needed or expected from the interviewer. By implication, and in conclusion then, apart from noticing *the use* (or absence) of certain metaphors within a particular population, we also need to pay close attention to the *content* of the metaphors used.

vi.) Psychologization

In this part of the discussion, the use, content and functioning of psychologization, (a traditionally Western discourse of distress,) within the context of the Winelands region, are discussed.

Even though participant 3 was able to communicate in terms of emotions, (i.e. the

discourse of psychologization) she used the other discourses more often to convey her feelings of distress. Also, in the case of participant 1, the whole body, from head to toe, from the inside to the outside, is used to convey her feelings, especially her distress. Even though her ability to psychologize can be seen as adequate, she articulated her distress mostly through descriptions and reports of somatic symptoms. A complete lack of psychologization was noticable in the case of two of the six participants despite the fact that the interviewers often used Western *psychological* terms such as "bedruk" and "terneergedruk" (i.e. 'depressed' or 'distressed') during the interviews.

Surprisingly, psychologization seemed to be one of the discourses of distress used least by these women. The relative absence thereof is significant as it influences clinical impressions and diagnoses. Mental health professionals, the majority who have been trained in the dominant Western biomedical discourse (which characterizes the current (mental) health care services in South Africa), use the discourse of psychologization. They expect *feedback* or response from their patients in a similar 'emotional' or 'psychological' discourse. In other words, it is probably mainly the discourse of psychologization that would be heard by these professionals. The other discourses are very likely to be ignored or missed in this context - leading to serious misinterpretations or mistakes regarding diagnoses.

vii.) Conclusion of discussion

In conclusion, the possible ways in which the identified discourses of psychological distress function, were explored in this discussion of the results. It was attempted to come to an understanding about what the choice, context and content of each discourse communicate about the experience of psychological distress. Drawing on this theory

building attempt, directions for the development of accurate theory on female farm workers' ways of expressing psychological distress, the possible implications thereof, and suggestions for appropriate assessment and provision of mental health care to them, were explored.

The symptoms or behaviour that these women reported and displayed can be considered as conscious communicative acts aimed at informing, influencing or controlling others - especially the members of their families and community (Swartz, 1998). This and the other discourses of distress can then be considered as these women's ways of communicating, and it can, by implication, be considered as their ways of seeking help. The reasoning behind a person's choice for a specific discourse of distress is important as these choices can be determined by either social factors, such as her / his culture, or individual variables, such as the intensity of his / her distress and personality. In other words, the context within which a particular discourse is employed, as well as the content thereof play an important role. The importance of considering the content of a discourse is illustrated by (for instance) the discourses of somatization (e.g. "maagseer", "kopseer") and the use of metaphorical language (e.g. "dan gaan ek af", "swartgallig"). The content of phrases such as these is important as it renders information about how the distress is experienced in the first place, secondly, reveals more of the person's framework of reference, and thirdly, by implication, renders information about where the focus of treatment should be.

One can hypothesize that the different discourses identified would elicit different responses from different people. For instance, one may hypothesize that descriptions and reports of symptoms / behaviour and 'body talk' are given priority as these ways of

articulating distress (rather than psychologization) elicits the desired response within a community such as this. While displaying and reporting somatic symptoms provide the most common expression of distress worldwide, psychological and sociomoral idioms are often employed concurrently (Swartz, 1998). However, one can possibly propose that the Western diagnostic systems (e.g. the DSM-IV) give preference to observable signs and reportable behaviours / symptoms, and the perception and articulation of distress in psychological terms (psychologization) in the first place. In other words, it is mainly these discourses that would bring the person into contact with the right (mental health care) professionals. However, in this population some signs are not observable and some symptoms not reported. In other words, the discourse of symptoms and signs is a very particular one and not the one always used by this population. By implication, some of the discourses of distress would actually not be heard. This could partially explain the discrepancy between the (depression-) scores obtained by the BDI and clinical impressions - the clinical judgment of a qualified and sensitive psychologist probably would not ignore the other discourses. The other discourses - hitherto seemingly underestimated ways of reporting illness - would probably have different, less effective (curative / healing), if any, 'results' in the current Western mental health care system. One can also say that the discourses (other than reporting behaviour and psychologization) that are employed, are 'limited' in terms of their ability to communicate its true message accurately, and to elicit the appropriate responses from the appropriate agencies.

It seems obvious at this stage that the Western perspective of psychological distress is limited and does not give equal weight and value to all ways of seeing the world. It is suggested that research approaches need to be expanded to encompass those that allow women's (subjective) accounts of their experiences of depression or distress, and

'displaying' those, to be foregrounded, rather than being distorted to fit formulations conceived from the standpoint of experts coming from a traditional Western perspective.

These findings clearly have important implications for assessment and the provision of services to female farm workers in the Western Cape. Not only is it important for mental health professionals and other health care providers to know *that* women on farms use these discourses to express their distress, they have to know the *contexts* in which it is used, and they also have to be familiar with the *contents* of these 'expressions'. Only with this knowledge and understanding can the appropriate help be offered. In South Africa, most health care personnel at the primary level of care have not been trained in the identification and management of psychological distress and (minor) psychiatric disorders (Bhagwanjee *et al.*, 1998). Therefore, practitioners (primary health workers including doctors and nurses) should be trained to notice, to listen to, and to interpret the meaning of silences, metaphors, bodily symptoms and stories while doing assessments - so that they can understand the causes, consequences and implications thereof. In other words, they have to be able to detect and possibly cure the *disease* but also not miss and attend to the *illness*. Practitioners should be flexible and adaptive, and not simply rely on their DSM-IV (APA, 1994) as framework. Interviewing and diagnostic skills of professionals can and should be improved (Gask, Goldberg, Lesser & Millar, 1988; Bowman, Goldberg, Millar, Gask & McGrath, 1992) and it is hoped that such improvement would lead to improvement of his / her ability to identify emotional distress and / or disorders (Goldberg, Steel, Smith & Spivey, 1980) and to respond in appropriate and effective ways.

To conclude, the importance of sensitizing primary health care personnel to the complex and culturally specific ways in which psychological distress is experienced and articulated,

and by implication, the ways in which help is seeked, are emphasized by the results of this study. By extension, the urgent need for a *new* approach to assessment and the training of primary health workers is implicated by this study.

Conclusion:

The primary goal of the current study was to determine how low income female farm workers in the Winelands region of the Western Cape (South Africa) talk about, and express their psychological distress. The language these women used to articulate their psychological distress (verbal and non-verbal communications) were analyzed to (determine whether it is possible to) identify certain 'discourses of distress'.

The goal of this study was achieved by focussing on these women's answers given during an open-ended interview consisting of semi-structured and open-ended questions as well as the implementation of structured measuring instruments (the BDI, SWLS and the GHQ). The terminology used by them, their unique expressions, and also possibly the bodily symptoms reported to convey their distress, were studied in order to come to an understanding of the way in which they articulate their psychological distress. The current project was one component of a large ongoing project (Kruger, 1998) concerned with the often-ignored psychological distress and resilience of female farm workers. The first six participants of the larger project were used in the current study.

Through qualitative analysis of interviews and questionnaire data (and with grounded theory in particular) an attempt was made to capture the idioms of distress used in this culture. It was possible to identify six possible 'discourses of psychological distress',

namely i.) silence (inability or refusal to answer), ii.) reporting and describing behaviour, iii.) body talk / somatization, iv.) narrativation, v.) metaphorical and idiomatic speech, and vi.) psychologization. The possible ways in which these discourses function were discussed (with the existing literature as background) in order to come to an understanding about what the choice of discourse communicates about the experience of psychological distress.

The findings of this study suggest that while some women do articulate their psychological problems in ways that sound like the westernized ideas of depression, there are other symptoms and signs that will not fit the diagnosis. One of the fundamental questions of this study, but also of cross-cultural studies on depression, remains whether these variations in the reported symptoms suggest that this is simply a cultural specific form of depression (or of psychological distress) or whether these other symptoms and signs may indicate the existence of a different psychiatric syndrome altogether.

Drawing on this theory building attempt, directions for the development of accurate theory on female farm workers' ways of expressing psychological distress, the possible implications thereof, and suggestions for appropriate assessment and provision of mental health care to them, were explored. It was proposed that the Western diagnostic systems (e.g. the DSM-IV) give preference to observable signs and reportable behaviours / symptoms, and the perception and articulation of distress in psychological terms (psychologization) in the first place. In other words, it is mainly these discourses that would bring the person into contact with the right (mental health care) professionals. By implication, some of the discourses of distress would actually not be heard. These other discourses - hitherto seemingly underestimated ways of reporting illness - would probably

have different, less effective (curative / healing), if any, 'results' in the current Western mental health care system. It is imperative then that health care workers should attend to these different discourses used by patients, even when no obvious psychological or physical symptoms are reported. This entails that these workers will have to play a much more active and interpretive role in looking for the reasons or the intended meaning of a particular discourse. The existence of these differences in the discourses of distress obviously has potential then for problems of diagnosis and treatment. Problems of diagnosis and treatment can possibly be overcome by awareness and experience of the existence of the discourses and their differences.

These findings obviously have implications for training of adequately skilled mental health personnel and other primary health care workers (nurses and doctors). Not only is it important for mental health professionals and other health care providers to know *that* women on farms use these discourses to express their distress, they have to know the *contexts* in which it is used, and they also have to be familiar with the *contents* of these 'expressions'. Only with this knowledge and understanding can the appropriate help be offered. The importance of sensitizing primary health care personnel to the complex and culturally specific ways in which psychological distress is experienced and articulated, and by implication, the ways in which help are seeked, are thus emphasized by the results of this study. Interviewing and diagnostic skills of professionals can and should be improved and it is hoped that such improvement would lead to improvement of their ability to identify emotional distress and / or disorders and to respond in appropriate and effective ways. Furthermore, it is clear that traditional depression indexes are not useful with these women in particular, not only because of different signs and symptoms, but also and more importantly, because of different ways of communicating or articulating distress. The

discrepancy between the (depression) scores obtained by the BDI (a traditional diagnostic instrument) and clinical impressions also illuminates the possible danger of using these so-called traditional diagnostic instruments and standardized interview schedules haphazardly or at random, or even in non-Western populations or populations for which these instruments have not been validated. The findings of this study also emphasize the fact that the medical model and Western diagnostic systems, such as the DSM-IV, are limited where it pertains to psychological distress and this culture in particular, and do not give equal weight and value to all ways of seeing the world.

Despite the existence of a considerable amount of critique on the use of qualitative research methods, the benefits of using qualitative analysis in this particular study seem to outweigh the potential costs. By offering a set of systematic procedures, grounded theory enabled this qualitative researcher to generate ideas that may in future be verified through traditional logico-deductive methods. Furthermore, while it was not the object of the current study to determine or to speculate about how common these discourses are, it is suggested that the commonality or generalizability of these results be the focus of attention in future studies.

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APPENDIX 1

DIE EERSTE ONDERHOUD

(Week 1)

Lewenstyl en daaglikse roetine:

1. Vertel van jou lewe op die plaas: jou tipiese dag. Bv.: Hoe het jou dag gister gelyk?

2. Wat was gister vir jou lekker / sleg? (d.w.s. probleme en bekommernisse vs. genietinge). Wat is in die algemeen vir jou lekker / sleg?

ONDERHOUD EEN

Kliniese evaluasie:

A. Huidige funksionering:

1. Hoofklagtes / Probleme (In subjek se eie woorde, maar sal afhang van interpretasie van onderhoudsvoerder)

2. Geskiedenis van die huidige klagtes / siekte (simptome, duur, frekwensie, presipitante, gevolge, gevoelens oor siekte / probleme)

3. Hoe hanteer jy ("cope" jy met) hierdie dinge?

4. Het jy al ooit voorheen in 'n hospitaal beland / was jy behandel vir "senuwees"?
   (Psigiatriese geskiedenis: vorige episodes, eerste episode, hospitalisasies, medikasie, ander behandeling, diagnoses):

5. Gewelddadigheid (ander en self):

6. Hoe gaan dit met jou gesondheid? / Hoe dikwels gaan jy kliniek toe, en waarvoor? (Mediese geskiedenis: siektes, oiperasies, mediese hospitalisasies, allergiee, rook, kaffeien, kopbesering, vigs-risiko, somatisering?)

   Algemene praktisyn / kliniek: _____
   Telefoonnommer: _____

7. Huidige medikasie (psigiatries en ander, dosis, frekwensie, newe-effekte):

8. Substansgebruik (soorte, eerste gebruik, huidige gebruik, behandeling):

9. Familiegeskiedenis van sielkundige siektes / substansgebruik:

_____

_____

_____

_____

_____

_____

_____

_____

_____

B. Kliniese Beeld

1. Algemene beskrywing:

Voorkoms:

_____

_____

_____

Psigomotories: (mannerismes, tics, stereotipie, rusteloosheid, traagheid, rustig):

(Beskryf)

_____

_____

_____

Houding: (samewerkend, negatiwisties, aggressief)

(Beskryf)

_____

_____

_____

2. Gemoed en affek:

Gemoed: Subjektief:

_____

_____

_____

_____

_____

Affek: (eksterne uitdrukking van 'n onmiddellike emosie: toepaslik / ontoepaslik; afgestomp / afgeplat; beskryf):

_____

_____

_____

_____

_____

Anhedonisme: (verlies van belangstelling in en geniet van aktiwiteite):

_____

_____

Nihilisme: (negatiewe of donker belewing van self en toekoms):

_____

_____

3. Neurovegetatiewe simptome

Slaap (insluitend herhalende drome / nagmerries)

Gewig / Eetpatroon:

Energie:

Seksuele funksie: (vra uit na libido, seksuele disfunksie):

4. Angstigheid

Gevoel van angs: (voel gespanne en kan nie ontspan nie; oordrewe bekommernisse): (Ja / Nee):

Somatiese simptome van angs: (hoofpyn, duiseligheid, sweterigheid, hartkloppings, drukking op die borskas, bewerigheid, frekwensie van urine en ongemak op die maag, warm gloede, lam swaar bene): (Ja / Nee):

5. Kognitiewe funksionering:

(spesifieke geheue, konsentrasie)

a. Gedagte-inhoud:

b. Gedagte-vorm (beredeneerd, logies, tangensiaal, wollerig, ens.)

c. Persepsie (Abnormaal: Hallusinasies)

d. Insig (erkenning van probleme, self-insig):

6. MAAK NOU JOU DIFFERENSIëLE DIAGNOSE (VOORDAT JY AANGAAN NA DIE VOLGENDE FASE VAN DIE ONDERHOUD):

"Satisfaction with Life Scale (SWLS)" - (Tevredenheid-met-leve-skaal)

Die volgende sal aan deelnemers voorgelees word:

"Hieronder is vyf stellings waarmee jy dalk saamstem of verskil. Gebruik die onderstaande skaal en dui aan in watter mate jy met elke item saamstem of verskil, deur die toepaslike nommer op die lyn na daardie item te plaas. Wees asseblief oop en eerlik met jou antwoorde."

1 = **Verskil sterk**
2 = **Verskil**
3 = **Verskil effens**
4 = **Stem nie saam nie en verskil ook nie**
5 = **Stem effens saam**
6 = **Stem saam**
7 = **Stem sterk saam**

1. My lewe is wat die meeste dinge betref na aan my ideaal. _____
2. My lewensomstandighede is uitstekend. _____
3. Ek is tevrede met my lewe. _____
4. Tot dusver het ek die belangrike dinge gekry wat ek in die lewe wil he. _____
5. As ek weer my lewe kon leef, sou ek amper niks verander nie. _____

BECK VRAELYS

Op hierdie vraelys is groepe stellings. Lees elke groep stellings noukeurig deur. Kies dan uit elke groep die een stelling wat die beste beskryf hoe jy die afgelope week, INSLUITENDE VANDAG, gevoel het. Trek 'n sirkel om die nommer van die stelling wat jy kies. As meer as een stelling in die groep van toepassing is, omsirkel elkeen. Maak seker dat jy alle stellings in die groep lees voordat jy jou keuse maak.

On this questionnaire are groups of statements. Please read each group of statements carefully. Then pick out the one statement in each group which best describes the way you have been feeling the past week, INCLUDING TODAY! Circle the number beside the statement you picked. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice.

1. 0 Ek voel nie swaarmoedig of teneergedruk nie.
   I do not feel sad..
   1 Ek voel swaarmoedig of teneergedruk.
   I feel sad.
   2 Ek is gedurig swaarmoedig of teneergedruk en kan die gevoel nie afskud nie.
   I am sad all the time and I can't snap out of it.
   3 Ek is so swaarmoedig of ongelukkig dat ek dit nie kan verduur nie.
   I am so sad or unhappy that I can't stand it.

2. 0 Ek is nie besonder pessimisties of ontmoedig oor die toekoms nie.
   I am not particularly discouraged about the future.
   1 Ek voel ontmoedig oor die toekoms.
   I feel discouraged about the future.
   2 Ek voel ek het niks om na uit te sien nie.
   I feel I have nothing to look forward to.
   3 Ek voel die toekoms is hopeloos en dat dinge nie kan verbeter nie.
   I feel that the future is hopeless and that things cannot improve.

3. 0 Ek voel nie soos 'n mislukking nie.
   I do not feel like a failure.
   1 Ek voel ek het meer as die gewone mens misluk.
   I feel I have failed more than the average person.
   2 As ek op my lewe terugkyk, sien ek net mislukkings.
   As I look back on my life, all I can see is a lot of failures.
   3 Ek voel ek is 'n algehele mislukking as mens.
   I feel I am a complete failure as a person.

4. 0 Ek kry soveel bevrediging soos voorheen uit dinge.
I get as much satisfaction out of things as I used to.

1 Ek geniet dinge nie soos gewoonlik nie.
I don't enjoy things the way I used to.

2 Ek kry nie werklike bevrediging uit enigiets meer nie.
I don't get real satisfaction out of anything anymore.

3 Ek is ontevrede of verveeld met alles.
I am dissatisfied or bored with everything.

5. 0 Ek voel nie besonder skuldig nie.
I don't feel particularly guilty.

1 Ek voel 'n groot deel van die tyd skuldig.
I feel guilty a good part of the time.

2 Ek voel die meeste van die tyd taamlik skuldig.
I feel quite guilty most of the time.

3 Ek voel altyd skuldig.
I feel guilty all of the time.

6. 0 Ek voel nie ek word gestraf nie.
I don't feel I am being punished.

1 Ek voel ek mag gestraf word.
I feel I may be punished.

2 Ek verwag om gestraf te word.
I expect to be punished.

3 Ek voel ek word gestraf.
I feel I am being punished.

7. 0 Ek voel nie terleurgesteld in myself nie.
I don't feel disappointed in myself.

1 Ek is terleurgesteld in myself.
I am disappinted in myself.

2 Ek het 'n teensin in myself.
I am disgusted in myself.

3 Ek haat myself.
I hate myself.

8. 0 Ek voel nie ek is slegter as enigiemand anders nie.
I don't feel I am any worse than anybody else.

1 Ek is krities teenoor myself oor my swakhede en foute.
I am critical of myself for my weaknesses or mistakes.

2 Ek blameer myself altyd vir my foute.
I blame myself all the time for my faults.

3 Ek blameer myself vir alle slegte dinge wat gebeur.
I blame myself for everyting bad that happens.

9. 0 Ek het geen gedagtes aan selfmoord nie.
I don't have any thoughts of killing myself.

1 Ek dink aan selfmoord, maar sal dit nie uitvoer nie.
I have thoughts of killing myself, but I would not carry them out.

2 Ek wil myself graag om die lewe bring.
I would like to kill myself.

3 Ek sal selfmoord pleeg as ek die kans kry.
I would kill myself if I had the chance.

10. 0 Ek huil nie meer as gewoonlik nie.
I don't cry any more than usual.

1 Ek huil nou meer as gewoonlik.
I cry more now than I used to.

2 Ek huil nou gedurig.
I cry all the time now.

3 Ek kon vroeër huil, maar nou kan ek nie al wil ek ook.
I used to be able to cry, but now I can't cry even though I want to.

11. 0 Ek is nie nou meer geïrriteerd as gewoonlik nie.
I am no more irritated now than I ever am.

1 Ek word makliker ergelik of geïrriteerd as voorheen.
I get annoyed or irritated more easily than I used to.

2 Ek voel nou gedurig geïrriteerd.
I feel irritated all the time now.

3 Ek word glad nie geïrriteer deur dinge wat my gewoonlik geïrriteer het nie.
I don't get irritated at all by the things that used to irritate me.

I have not lost interest in other people.

1 Ek stel minder belang in ander mense as voorheen.
I am less interested in other people than I used to be.

2 Ek het die meeste van my belangstelling in ander mense verloor.
I have lost most of my interest in other people.

3 Ek het al my belangstelling in ander mense verloor.
I have lost all of my interest in other people.

13. 0 Ek neem besluite net so goed soos gewoonlik.
I make decisions about as well as I ever could.

1 Ek stel meer uit om besluite te neem as voorheen.
I put off making decisions more than I used to.

2 Ek neem besluite moeiliker as voorheen
I have greater difficulty in making decisions than before.

3 Ek kan glad nie meer besluite neem nie.
I can't make decisions at all anymore.

14. 0 Ek voel nie dat ek slegter as gewoonlik lyk nie.
I don't feel I look any worse than I used to.

1 Ek is bekommerd daaroor dat ek oud of onaantreklik lyk.
I am worried that I am looking old or unattractive.

2 Ek voel daar is blywende veranderinge in my voorkoms wat my onaantreklik laat lyk.
I feel that there are permanent changes in my appearance that make me look unattractive.

3 Ek glo ek lyk lelik.
I believe I look ugly.

15. 0 Ek kan byna net so goed soos tevore werk
I can work about as well as before.

1 Dit vereis meer inspanning om te begin om iets te doen.
It takes an extra effort to get stared at doing something.

2 Ek moet myself forseer om enigiets te doen.
I have to push myself very hard to do anything.

3 Ek kan geen werk doen nie.
I can't do any work at all.

1 Ek slaap nie so goed soos gewoonlik nie.
I don't sleep as well as I used to.

2 Ek word 1-2 ure vroeër as gewoonlik wakker en sukkel om weer aan die slaap te raak.
I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 Ek word etlike ure vroeër as gewoonlik wakker en kan nie weer slaap nie.
I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 Ek word nie moeër as gewoonlik nie.
I don't get more tired than usual.

1 Ek word makliker moeg as gewoonlik.
I get tired more easily than I used to.

2 Ek word moeg van omtrent enigiets wat ek doen.
I get tired from doing almost anything.

3 Ek is te moeg om enigiets te doen.
I am too tired to do anything.

18. 0 My eetlus is nie slegter as gewoonlik nie.
My appetite is no worse than usual.

1 My eetlus is nie so goed as wat dit was nie.
My appetite is not as good as it used to be.

2 My eetlus is nou baie slegter.
My appetite is much worse now.

3 Ek het glad geen eetlus meer nie.
I have no appetite at all anymore.

19. 0 Ek het nie onlangs veel, indien enige, gewig verloor nie.
I haven't lost much weight, if any, lately.

1 Ek het meer as 2½ kg (5 pond) verloor.
I have lost more than 2½ (5 pounds).

2 Ek het meer as 5 kg (10 pond) verloor.
I have lost more than 5 kg (10 pounds).

3 Ek het meer as 7½ kg (15 pond) verloor.
I have lost more than 7½ kg (15 pounds).

(Ek probeer doelbewus gewig verloor deur minder te eet. Ja ☐ Nee ☐
I am purposely trying to loose weight by eating less. Yes ☐ No ☐

1 Ek is bekommerd oor liggaamlike probleme soos pyne of 'n omgekrapte maag of hardlywigheid.
I am worried about physical problems such as aches and pains or upset stomach or constipation.

2 Ek is baie bekommerd oor liggaamlike probleme en dit is moeilik om aan iets anders te dink.
I am very worried about physical problems and it's hard to think of much else.

3 Ek is so bekommerd oor my liggaamlike probleme dat ek aan niks anders kan dink nie.
I am so worried about my physical problems that I cannot think about anything else.

21. 0 Ek het nie onlangs enige verandering in my belangstelling in seks opgemerk nie.
I have not noticed any recent change in my interest in sex.

1 Ek stel minder in seks belang as gewoonlik.
I am less interested in sex than I used to be.

2 Ek stel nou baie minder in seks belang.
I am much less interested in sex now.

3 Ek het heeltemal belangstelling in seks verloor.
I have lost interest in sex completely.

Authorized translation by A T Möller (1990)

General Health Questionnaire (Algemene Gesondheidsvraelys)

Die volgende sal aan deelnemers voorgelees word:

"Antwoord deur ja of nee te se, na elke stelling wat aan u voor gelees word."

1. In die laaste tyd kon jy konsentreer op wat jy ook al doen? _____
2. In die laaste tyd het jy baie slaap verloor weens bekommernis? _____
3. In die laaste tyd het jy gevoel day jy 'n nuttige rol in dinge speel? _____
4. In die laaste tyd het jy in staat gevoel om besluite te neem oor dinge? _____
5. In die laaste tyd het jy die heeltyd gevoel day jy onder druk is? _____
6. In die laaste tyd het jy gevoel dat jy nie jou moeilikhede te bowe kon kom nie? _____
7. In die laaste tyd kon jy jou normale dag-tot-dag aktiwiteite geniet? _____
8. In die laaste tyd kon jy jou probleme in die gesig kyk? _____
9. In die laaste tyd het jy ongelukking en depressief gevoel? _____
10. In die laaste tyd het jy vertroue in jouself verloor? _____
11. In die laaste tyd het jy aan jouself gedink as 'n waardelose persoon? _____
12. In die laaste tyd het jy redelik gelukkig gevoel, as alles in aanmerking geneem word? _____
13. In die laaste tyd het jy dit reggekry om jouself besig en bedrywig te hou? _____
14. In die laaste tyd het jy soveel as gewoonlik uit die huis gekom? _____
15. In die laaste tyd het jy oor die algemeen gevoel dat jy dinge goed doen? _____
16. In die laaste tyd was jy tevrede met die manier waarop jy jou take uitgevoer het? _____
17. In die laaste tyd het jy dinge swaar opgeneem / gevoel dat dinge swaar is? _____
18. In die laaste tyd het jy gevind dat dinge te veel vir jou word? _____
19. In die laaste tyd het jy die heeltyd senuweeagtig en gespanne gevoel? _____
20. In die laaste tyd het jy gevind dat jy soms niks kon doen nie omdat jou senuwees te sleg was? _____

APPENDIX 2

TRANSCRIPTION GUIDELINES

(Based on Silverman, (1993) and Riessman (1993)):

Symbol	Explanation
[	Left brackets indicate the point at which a current speaker's talk is overlapped by another's talk.
=	Equal signs, one at the end of a line and one at the beginning, indicate no gap between the two lines.
(.5)	Numbers in brackets indicate elapsed time in silence in tenths of a second.
What's *up*?	The use of italics indicates some form of stress, via pitch and / or amplitude.
Lo:ng	Colons indicate prolongation of the immediately prior sound.
WORD	Capitals, except at the beginning of lines, indicate especially loud sounds relative to the surrounding talk.
.hhh	A row of h's prefixed by a dot indicates an outbreath; without a dot, an inbreath. The length of the row of h's indicates the length of the in- or outbreath.
( )	Empty brackets indicate the transcriber's inability to hear what was said.
(word)	Words in brackets are possible hearings.
{laughter}	Parentheses contain transcriber's descriptions

rather than transcriptions.

Sources:

Riessman, C. K. (1993). Narrative Analysis. Qualitative Research Methods Series 3.0. USA: Sage Publications, Inc.

Silverman, D. (1993). Interpreting Qualitative Data. Methods for Analyzing Talk, Text and Interaction. London: Sage Publications, Ltd.

APPENDIX 3

Example of transcribed interview:

Rita (participant) and Marian (interviewer)

(64 pages)

THE FIRST INTERVIEW

Rita and Marian

M: "Oraait. (1.0) Hm (1.0) Ek wil nogals graag van jou hoor (1.0) Ek gaan hierdie (.5) hierdie onderhoud gaan ek net (1.0) vrae vra oor jou gesondheid en jy weet, sulke dinge (1.0) en hoe gaan dit met jou en (1.5) daai tipe van ding (1.0) en dan gaan ek 'n paar vrae vra van vorms wat ek wil invul, (1.0) maar volgende keer gaan dit meer oop vrae wees. Dit gaan meer wees oor hoe jy oor jouself dink en (1.0) oor jou (.5) familie en hoe jy grootgeword het (1.0) en dan gaan dit meer spesifieke vrae wees. (1.0) Oraait? En jy moet vir my vra soos ons aangaan of jy hoe jy voel en of jy lus is en (.5) of jy iets nie verstaan nie. (.5) Oraait? (.5) OK. Is jy (.5) gemaklik?"

R: "Ek is gemaklik ja."

M: "OK. {Both giggles.} Nou toe (1.5) Vertel my 'n bietjie (.5) van jou lewe op die plaas. Jou tipiese dag soos gister (1.5) Wat gebeur wat doen jy?"

R: "Hm (2.0) die tipe werk?"

M: "Ja."

R: "My algemene (1.0) werk op die plaas (.5) wat ek doen (1.0) Uh seisoen-tyd pak ons vrugte (2.0)."

M: "Hm."

R: "Na die (.5) uh vrugteseisoen dan uh (1.0) snoei ons boom."

M: "OK? 1.0 [*Hm.*"

R: "[Wat 'n bietjie vir my (1.5) 'n ingewikkelde werk was moeilike werk was ="

M: "= Is dit?"

R: "Dit was my eerste (1.0) ondervinding van daai (1.5) sn- snoeiwerk."

M: "OK, ja."

R: "Maar ek het dit vinnig geleer."

M: "Watse ure werk jy? (.5) Wanneer staan jy op (.5) en ["

R [{Starts to laugh}: "Man, die afgelope tyd het ek so geslaap!"

{Both Rita and Marian laughs.}

M: "Is dit?"

R: "Opstaan-tyd is 6 uur 2.0 en ons val half-agt in"

M: "OK 2.0 En tot wanneer werk julle gewoonlik?"

R: "Halfses 1.0 halfses. Die vroue tot halfses."

M: "OK (1.0) En dan na die tyd, (.5) wat doen jy?"

R: "Na die tyd en dan (1.5) is ek mos nou vry van die werk."

M: "Ja."

R: " Enne (2.0) as ek nou niks (1.5) het nie, dan (.5) doen ek my huiswerk."

M: "Hm."

R: "Kyk 'n bietjie TV (.5)."

M: "Hm?"

R: "Kook (.5) kook kos."

M: "Hm?"

R: "Tot slapenstyd toe (1.0)."

M: "OK."

R: "Tot wanneer ek nou (.5) gaan slaap."

M: "[Ja."

R: "[En sommige aande het ek nou vergaderings (3.0)."

M: "OK. (3.0) Jy's mos (.5) die leier? Is jy nie die leier van die vroue nie?"

R {Confirms}: "Hm."

M: "O, ek sien. So jy het baie van daai goed om te organiseer."

R {Confirms again}: "Hm."

M: "En in die oggende *voor* jy gaan werk (.5) Wat alles moet jy *dan* doen (.5) [gewoonlik?"

R: "[Soggens dan (2.0) *prepare* ek nou die (.5) die babatjie die sesjarige kind (1.0) maak *brekfis* (3.0) en (1.0) sorg vir hom vir sy skoolbrood (.5) die grotes sorg vir hulleself."

M: "Hm-m."

R: "En (2.0) Dan gaan ek werk."

M: "OK (.5) Oraait. .hhh Wat is vir jou lekker in 'n dag? (.5) Is is daar dinge wat vir jou (.5) lekker is (.5) in so 'n tipiese dag soos gister?"

R: "Hm (.5) wanneer ons vrouens bymekaar is, die kommunikasie (1.5)."

M: "Hm."

R: "Daai is vir my lekker."

M: "Hm (1.0) Het julle goeie (.2) goeie vriende (.2) vriendinne en so op die plaas (.5) of. "

R: "Ja, bedags dan (1.5) gaan dit goed, maar nou saans ek eintlik is ek meer (1.0) 'n rondloper nou (by die huis kan stil wees nie)."

M: "Hm."

R: "Wanneer ek in die werk is, dan (1.0) geniet ek my (.5) saam met (.5) my [( ) "

M: "[Ja (.5) ja (.5) En slegte dinge? Wat hou jy nie van nie (1.0) van so 'n dag nie?"

R: "Uh {sighs} (3.0) wanneer die die die die (.5) nie die eienaar nie die (1.0) of die wanneer die plaas (.5) die werkgewer (1.0)."

M: "Hm?"

R: "Wanneer hy (.5) vir ons (.5) nie lekker behandel nie ( )"

M: "Gebeur dit baie?"

R {in a soft voice}: "Ja (1.0) dit gebeur baie "

M: "Hm. Soos hoe? (1.0) Wat?"

R: "Wat ons geld moet betref (1.0) hulle betaal nie vir ons (1.5) na ons wense nie (.5) vir die werk wat jy doen nie. (.5) ( ) is *in a bad condition.*"

M: "Hm. Hm. (1.0) OK. (.5) Is daar iets wat jou (1.0) wat jou *vandag* pla (.5) of of is daar dinge wat jou nou op hierdie stadium pla?"

R: "Op die oomblik (.5) is ek nog baie bekommerd."

M: "Hm?"

R: "Oor uh (3.0) die omstandighede waarin ek nou is. (1.5) My man is werkloos (1.0) en dis net my inkomste en ek het vier kinders om te onderhou (1.0) en (2.0) die geld is min."

M: "Hm?"

R: "Daar's baie dinge (2.0) wat moet reggemaak word met geld."

M: "Hm. [Hm."

R: "[En (2.0) wat my pla is (2.0) ( )"

M: "Hm."

R: "(3.0) En die boer wil die huis leeg hê."

M: "So julle moet julle moet *waai*?"

R: "Ons moet waai, ja, die 15de November verwag die boer die huis leeg (1.5)."

M: "Sjoe (2.0) OK."

M: "(Dit was my 'n bietjie [bekommerd maak.)

M: "[Ja. Ja."

{Tea is brought in. They continue with the interview while they are having tea.}

M: "Sê vir my hoe lank gaan die ding al aan dat jy bekommerd is oor waar jy moet heen gaan ? Hoe lank is jou man werkloos?"

R: "Is maar nou 'n week."

M: "Is dit?"

R: "Ja, uh verlede week (1.5) 'n week en 'n half."

M: "Hm?"

R: "Week en 'n half."

M: "(1.5) Maar hoe't dit gebeur? Wat het [gebeur?"

R: "[Hy het nie (.5) hy's nie weggeja nie (.5) van die werk nie (.5) hy's nie afgedank nie. Hy't net so gevoel (1.0) hy uh wil weggaan van die plaas af (3.0). Die boer het nou nie vir hom geld betaal volgens sy werk nie."

M: "Ek sien ="

R: "= En hulle wil nie ag *slat* op die (.5) plaaswerkers se behoeftes nie."

M: "Hm."

R: "(2.0) En (1.0) die uitbreiding van die huise."

M: "Ek sien."

R: "Daai was nou ons probleme."

M: "Ja."

R: "Nou ons bly in 'n baie *bekoekte* huisie ="

M: "= Hm ="

R: "= Met vier kinders. Daai vier kinders moet in een vertrek slaap."

M: "Sjoe, ja dit is (2.0) [.hhh"

R {In a soft voice}: "[Dis baie klein (2.0)."

M: "Ja. (2.0) Maar sê vir my hoe voel jy daaroor dat jou man (.5) klaar dit gedoen het?"

R: "(2.0) Uh (2.0) (eintlik) (.5) is ek 'n bietjie *upset* omdat hy haastig en vinnig (.5) sonder my medewete (.5) besluit om bedanking in te dien (.5) sonder om dit met my te bespreek."

M: "O, so jy't glad nie geweet daarvan nie?"

R: "Ek het op die *tippie* kom hoor."

M: "Ja, (1.0) ja."

R: "En (1.0) ons het nie eens die saak deeglik bespreek nie."

M: "Ja."

R: "En die boer het toe *ook* van my verwag (1.0) om (.5) die geskrewe brief te teken wat sê dat (.5) teen 15 November sal (.5) hy die huis (.5) met sy huisgesin ontruim."

R: "Hm (1.5) OK. (2.0) Nou hoe gaan julle maak? Het julle 'n idee hoe hoe (.5) hoe *cope* jy met daai tipe van (1.0) *worry* wat jy het?"

R: "(3.0) *Hy* is op die oomblik (.5) op soek nou na werk en 'n plek."

M: "Hm? ="

R: "= En hy *hou* nie van my voorstelle nie. (4.0) En (2.0) hy het 'n idee om by sy familie te gaan bly (1.0) en ek hou nie daarvan nie. (.5) Die kinders hou ook nie daarvan nie. (1.0)"

M: "[Hm."

R: "[Ons is gewoond op ons eie van die begin af."

M: "[Ja."

R: "[En dit sal 'n groot aanpassing wees (1.0) vir my en die kinders (.5) om by (1.0) vreemdelinge te kan bly."

M: "Ja. (1.0) ja."

R: "En my bekommernis is (1.0) my kinders (1.0) my twee meisiekinders veral (.5) die dogters (.5) hou van was en aantrek en hare moet ge-*blow* word (.5) en hulle hou van aanmekaar {Marian laughs} aantrek en stryk en dis elektrisiteit en water (.5) wat mens in ag moet neem en dan (.5) mense gaan *complain* een of ander tyd."

M: "Hm hm ja (1.0) nou hoe hoe maak jy = "

R: "= En ek staan in die werk bedags."

M: "[Ja.

R: "[Ek weet nie wat die kinders aanvang nie. Vanaand kom ek uit die werk uit en dan hoor ek dit en dit en (.5) *daai* klagtes.

M: "Ja, ja. (1.0) Hoe maak jy, (.5) Rita met hierdie (1.0) met hierdie hele ding? (1.0) Veral dat dat um (.5) lyk my nie jy (.5) jy kan praat daaroor nie (1.0) of jy kan nie jou voorstelle *gee* nie of (.5) hoe werk jy?"

R: "Wanneer ek 'n kans kry, dan (2.0) *vat* ek die kans om met my man te praat oor hierdie goed."

M: "Hm."

R: "Andersins (1.5) *leef* ek nou net (1.0) dag in en dan dag uit en so (1.0) kry ek net hoofpyn van die more tot die aand (.5) as ek vanaand gaan slaap met hoofpyn, more-oggend staan ek daarmee op."

M: "Yho."

R: "Ja, en (1.5) ek het nou al agtergekom die laaste tyd my hare wil nie eers groei nie (2.0)."

M: "[Hm?"

R: "[Van al die [spanning wat ek (.5) ondervind."

M: "Hm. .hhh Is die hoofpyne nou al die laaste paar weke vandat jy hierdie slegte nuus gehoor het?"

R: "Is al 'n geruime tyd (.5) behalwe die af (.5) uh uh bedanking is (.5) kry ek die hoofpyne ="

M: "= Hm."

R: "Oor ek bekommerd is."

M: "Ja."

R: "(2.0) Oor my man se *gedrag* ook."

M: "Hm (.5) Wat is dit? (.5) Wat gebeur?"

R: "Die verhouding tussen ek en my man ="

M: "= Hm?"

R: "Is nie so goed nie (2.0) Nie dat dit nie so goed is nie. Dis nie *altyd* so goed nie. (1.5) Hy's 'n drinker en dan sê hy altyd negatiewe dinge."

M: "(2.0) Soos wat? Kan jy [noem daarvan?"

R: "Jaloesie (1.5) jaloesie (1.5) lelike skeltaal op my en die kinders."

M: "Hm."

R: "En dit maak my baie ongelukkig."

M: "Hm."

R: "Somtyds (1.0) gebeur dit (.5) tot op die *punt* van baklei."

M: "Hm?"

R: "En dit uh is 'n (.5) swaar proses (.5) vir my en die kinders om deur te maak."

M: "Ja. (1.5) Kom dit al lank aan?"

R: "Nie die bakleiery nie. (1.0) Die jaloesie (.5) obsessie (.5) is nou al 'n *siek* (.5) by hom."

M: "Hm (1.0) So is dit nou al jare al?"

R: "Jare."

M: "Hm. (3.0) Wat maak *jy* (1.0) as dit gebeur? (.5) Hoe hoe hanteer jy dit?"

R: "(2.0) As hy skel, (1.0) dan gee ek nou vir hom woorde terug, (2.0) want hy (.5) ek *kalmeer* hom ="

M: "= Hm."

R: "Maar dit kan (2.0) somtyds dan baat dit niks nie."

M: "Hm."

R: "En andersins huil ek maar (3.0) en sommige kere dan (2.0) baklei ek terug (1.0) wanneer dinge woes gaan en dit (.5) kom op die baklei-stadium dan (.5) baklei ek terug (1.0) want andersins sit ek more met 'n vreeslike blou oog."

M: "Hm. So julle baklei fisies?"

R {Confirms}: "Hm."

M: "Hm. (1.0) Hm."

R: "Maar die baklei gebeur baie min. Dis meer *skel*."

M: "Hm."

R: "So."

M: "(3.0) OK. (2.0) Is daar ander dinge ook wat jou ook pla? Is daar ander .hhh"

R: "Ja, daar is ander dinge wat vir my pla. Byvoorbeeld (1.5) my oudste kind van sestien (.5) raak groot."

M: "Hm?"

R: "Hy's 'n man. (1.0) Hy raak uit die hand uit."

M: "Hm?"

R: "En (1.0) ek as ma (.5) as vrou (.5) is nie altyd sterk genoeg om (.5) die situasie te hanteer nie. (1.0) *DAAI* het ek nou weer die hulp van die pa nodig en die pa staan nie vir my by nie."

M: "Hm. (1.0) Kan jy bietjie vir my vertel hoe hoe is dit vir jou moeilik? Wat wat gebeur wat vir jou moeilik is?"

R: "(2.0) Die seun uh uh uh (1.5) se vriende (2.0) hy kommunikeer met met met verkeerde vriende (1.0) en (2.0) hy kom nou 'n bietjie laat in die huis (2.0) en (2.0) die teëpratery (1.0)."

M: "Hm."

R: "Miskien miskien is is is is ek vandag (2.0) soos kinders nou meen 'Mamma is outyds' (1.0) en ek vat dit (1.0) ek het nie die voorreg gehad om vir my ouers tale terug te gee nie. Ek moes net gedoen het ="

M: "= Hm."

R: "Wat hulle uh uh uh (1.0) verwag het, wat hulle gevra het, waar hulle my gestuur het."

M: "[Hm.

R: "[En (1.0) ek *het* dit gedoen. (1.5) So was ek (1.5) omdat ek het so grootgeword (.5) met uh uh uh baie ondervindings (1.0) en (.5) ek het baie geleer in daai proses. (1.5) Enne (.5) ek verwag ook dat my kinders (1.0) vir my as ma respekteer en waardeer (1.0) en ek (1.0) dit is elke ouer se se se *wens* (.5) om nie 'n ongehoorsame kind te hê nie."

M: "Hm (.5) hm."

R: "En ek *hou* nie van die teëpratery van hom nie."

M: "Hm. (1.0) Hoe laat dit jou voel?"

R: "(3.0) Dit laat my ongelukkig somtyds voel. (1.0) Woedend. (1.0)"

M: "Hm."

R: "En ek praat *baie* met met *al* my kinders in die huis. Ek sê vir hulle: 'As ek die dag nie meer daar is nie, dan gaan julle *swaarkry*, (1.0) want dan is daar nie meer 'n ma wat saam met julle praat nie, wat julle uh uh kan *verdedig* nie. Dan sal julle julle man moet staan."

M: "Hm."

R: "So voel ek."

M: "Ja. (1.0) Ja. (2.0) .hhh Dit lyk my jy jy (1.0) *cope* eintlik op jou eie (1.0) jy (.5) Dit klink asof *jy* die hele ding (1.0) die huis en die kinders en so (1.0) moet moet hanteer."

R: "Ja. Ek is ma én pa (.5)."

M: "Hm-m?"

R: "Al is daar 'n pa."

M: "Hm. (2.0) Um, (.5) Rita, was jy al ooit in 'n hospitaal vir (.5) behandel vir iets soos senuwees of (1.0)."

R: "Nee."

M: "Geen van daai dinge nie?"

R: "Geen van daai dinge nie."

M: "Dat jy depressief is of baie huil of (1.0)."

R: "Nee, ek het een keer behandeling gekry, maar dis jare terug."

M: "Hm?"

R: "Toe was dit ook net die beginstadium van *maagsenuwees*."

M: "Hm-m."

R: "En dit was toe my (2.0) 12-jarige dogter 'n babatjie was en toe was die man ook so onbeskof saam met my (1.0) en toe't ek ook (1.0) begin maagsenuwees kry, (.5) maar ek het gou genoeg dokter toe gegaan."

M: "Ja. (1.0) Was jy gehospitaliseer (.5) of (1.0)."

R: "(2.5) Verduidelik 'n bietjie van 'hospitaliseer'?"

M: "O, moes jy hospitaal toe gaan om daar te bly oor nag (1.0)?"

R: "Nee."

M: "Of het hulle vir jou (1.0) pille gegee?"

R: "Hulle het vir my medisyne gegee."

M: "Hm. (2.0) OK."

R: "En vandag nog as ek (2.0) van daai (1.0) as ek vir my (2.0) baie *upset* of as ek ="

M: "= Hm?"

R: "*Skrik* skok, en (.5) somtyds vloei ek sommer twee keer in die maand. So daai (1.0)."

M: "Is dit?"

R: "My maag. (1.0) Jy kan sommer daai gevreet voel aan die maag. (1.0) So."

M: "Hm, hm. (.5) So is is dit soos in (1.0) soos dingetjies [wat rond(-trek) hierbinne."

R: "[Ja, soos my maag wil nou *werk*."

M: "OK."

R: "Vir as ek op my senuwees is (1.0) of uh uh uh (.5) ek is nou hier oor (.5) oor die straat en hier kom die karre. Oe, dis nou net 'n *maagwerk.* So [(vertoon dit)"

M: "Ja ja."

R: "So kan ek die gevoel kry (.5) of as ek geskrik het, (.5) dan kry ek ook daai (.5) gevoel op die maag (1.0) en as ek my baie ontstel, dan (.5) *vloei* ek sommer. So."

M: "O."

R: "Baie *sensitief*."

M: "Gebeur dit baie, Rita?"

R: "Die afgelope tyd het ek nogals (3.0) die v- die die die vloei nou baie gekom."

M: "Hm?"

R: "En die (1.5) die die die maag het nou nie meer so (2.0) uh vreeslik uh

gebrand as wat ek die hoofpyn gekry het nie. Die hoofpyn is die grootste probleem."

M: "Hm. (2.0) As jou maag so brand, moet jy ook kry jy ook diarree dat jy baie moet badkamer toe gaan?"

R: "NEE!"

M: "Of nie? Is dit net die gevoel? Dis net die gevoel dat dit gebeur?"

R: "Dis net die gevoel. Ja."

M: "OK."

R: "En bewerig."

M: "OK. Gebruik jy enige medikasie op hierdie stadium? Neem jy enige pille (.5) of medisyne?"

R: "Nee, ek is nie op medikasie nou nie."

M: "Niks nie. (.5) OK. (1.0 Oraait. .hhh um Was jy al ooit het al ooit dinge soos stemme gehoor wat ander mense nie hoor nie of of (.5) hm (.5) dinge onder jou vel miskien gevoel wat wat nie eintlik wat jy nie kan sien nie of miskien dinge gesien wat jy nie wat ander mense nie raaksien nie?"

R: "Hm-m."

M: "OK. Geen daai. Niks daarvan gekry nie. .hh OK. Het jy al ooit (.5) gevoel jy wil jouself seermaak? Dat jy dat jy iets aan jouself wil doen?"

R: "NEE MAN. Ek het net (1.0) Al wat altyd so in my gedagte kom as ek *baie ontsteld* is, (3.0) ek kry net 'n gedagte - ek het dit al baie kere vir my kinders ook gesê. (2.0) Ek is net lus en LOOP."

M: "Uh-h?"

R: "Sonder om om te kyk."

M: "Ja."

R: "(2.0) Dis net so nou en dan dat ek daai gevoel kry."

M: "Hm ="

R: "= Maar (1.0) in die werklikheid (1.0) dink ek nie ek kan nie die kinders so los nie."

M: "Hm. Is daar 'n plek waarheen jy sou wou loop? (1.5) Is daar 'n plek waar jy anders sou wil wees?"

R: "So 'n bietjie (.5) wegkom van die probleme af na die vriende toe na familie toe en (.5) en (1.0) so."

M: "OK. Het jy al ooit vir iemand anders iets iets leed aangedoen? Wat jy hulle seergemaak het soos (.5) jou kinders of iemand waar jy regtig (.5) vir hulle seergemaak het fisies?"

R: "(2.0) Verduidelik 'n bietjie 'leed'?"

M: "Um (1.0) Soos om iemand (2.0) Soos sê nou maar (.5) om iemand baie hard te slaan of met 'n of met 'n mes te wil dreig of as jy baie kwaad of iets raak en jy wil iemand anders seermaak. Het jy dit al ooit gevoel dat jy dit wil doen of .hhh dat jy dit miskien wel gedoen het?"

R: "(3.0) Uh dit (1.5) wanneer my kinders byvoorbeeld nou iets gedoen het wat hulle nie moet doen nie, dan sal ek nou vir hulle tug ="

M: "= Hm ="

R: "= Verstaan?"

M: "Hm."

R: "Maar (.5) ek sal nou *nie* (1.0) die f- die frustrasie van ek en my man op die kinders uithaal nie."

M: "Hm."

R: "Verstaan?"

M: "Hm. Hm. [Hm"

R: "[Soos byvoorbeeld vanoggend het ek die uh uh kind 'n goeie pak gegee (1.0) omdat hy nou (2.0) meer as R3-iets uit my beursie uit gesteel het. Ek het hom *dadelik* 'n *goeie* pak gegee (1.0) en vir hom gesê as hy nou al in die *huis* steel, (.5) kan hy *later* (.5) buitekant steel en (.5) dan beland hy in die tronk."

M: "Hm [hm."

R: "[So iets."

M: "Hm. Is dit die kleintjie dan?"

R: "Die kleintjie, [ja."

M: "[OK. Met die hand of hoe hoe?"

R: "Ek het my *belt* gevat gevat en hom 'n paar goeie houe gegee. {Both laughs quietly.}"

M: "OK. .hh Oraait. Um. Vertel my bietjie van jou (.5). Ons het netnou gepraat oor oor senuwees en sulke goed, maar fisies Jy't al vir my gesê jy't jy't hoofpyne, nè?"

R: "Hm."

M: "En daai gevoelens wat jy daar het in jou maag en die vloei."

R: "Hm."

M: "Het jy ander fisies siektes of probleme enigsins (3.0) Um (1.0) miskien wat jou in jou bene miskien anders voel? Of jou kop of jou maag of jou hart is nou enige siektes?"

R: "NEE, daar is nie enige siektes nie."

M: "Hm."

R: "Ek is sommige dae (3.0) dan het ek nou (1.0) lank gelede (1.0) um dan is dan raak ek net so MOEG (1.0)"

M: "Hm ="

R: "= so van *binne* af (1.0) dan is ek nie lus (1.0) vir niks of niemand lus het nie (1.0) en ek weet ek het nog nie eers baie gewerk vandag nie, (.5) dan is ek *moeg* (1.0) en so iets (1.0) Daai gevoel (.5) daai."

M: "Hm. (1.0) Daai ding van jy is net (1.0) net nie lus nie."

R: "Ja."

M: "Lus vir niks nie. OK. (.5) Ja (.5) Was jy voorheen (.5) ooit baie siek dat jy miskien moes (.5) hospitaal toe gaan en daar gaan bly en operasies gehad het (1.0) um?"

{Both laughs when Rita hiccups.}

R {Sighs when she says}: "Nee, (1.0) ek (.5) ek het nou nie (.5) (net klein operasies gehad)"

M: "Soos wat?"

R: "Soos sterilisasie (die melk het 'n klont geword en) abses gehad in my bors."

M: "O, ek sien."

R: "Daai was op neëntien."

M: "OK. (2.0) Wanneer was die sterilisasie, [Rita?"

R: "[Die sterilisasie was nou ses jaar terug."

M: "OK. (2.0) Hoe dikwels gaan jy dokter toe of na 'n kliniek toe?"

R: "Net wanneer dit nodig is. Wanneer ek nou (1.0) *regtig* waar (1.0) voel, maar ek kan dit nie meer hou nie."

M: "Hm. (.5) OK. Het julle enige hm familiesiektes (3.0) wat jy van weet?"

R {Means 'No'}: "Hm-m."

M: "Niks nie? Geen epilepsie? Of (1.0) ooit baie seer op jou kop gekry?"

R{Means 'No'}: "Hm-m."

M: "Niks? Motorongelukke?"

R (Means 'No'}: "Nee."

M {Laughs}: "Gelukkig. OK. (1.0) Um (2.0)."

R: "Uh. Gepraat van seer. Ek het ="

M: "= Ja?"

R: "(2.0) Ek weet nie of dit belangrik is nie. Ek het nou (.5) al 'n paar *HOUE* op my kop weg, ja =

M: "= Hm?"

R: "Met sy slanery."

M: "Is dit?"

R: "Hm."

M: "Ja. (1.5) OK. (Oopgemaakte) houe? Of of dat dat dat daar knoppe kom?"

R: "Ja."

M: "Hm-m? (1.0) Wat doen jy gewoonlik dan?"

R: "(2.0) Die een een keer het ek (.5) twee keer (1.0) Ek het net nooit dokter toe gegaan nie, maar self behandel."

M: "OK. Met salf en daai tipe van goed."

R: "Hm."

M: "OK. (1.0) Oraait (1.0) .hhh Um wat se tipe is daar enige substanse wat jy het jy ooit dagga gerook of uh (1.0) nie nie rook jy sigarette?"

R: "Nee."

M: "Glad nie?"

R: "Glad nie."

M: "OK (1.0) Um Kafeïene? Koffie? Drink jy baie [koffie?"

R: "[Nee, ek drink glad nie koffie nie."

M: "*O.* (1.0) OK. Um wat van gewone alkohol?"

R: "So nou en dan as ek miskien nou na 'n dans toe gaan of 'n partytjie, dan sal ek 'n *bier* vat."

M: "Hm."

R: "En dit is al (1.0) niks *wyn* nie (2.0) ( )"

M: "OK .hh Um (.5) Het jy ooit iemand in jou familie gehad wat (.5) verskriklik met senuwees gely het of (.5) wat stemme gehoor het (.5) of of um ="

R: "= Ek het 'n suster my oudste suster sy (1.5) is ook so 'n senuweelyer."

M: "OK. (.5) Word sy behandel?"

R: "Ja, sy (.5) is nou op behandeling."

M: "Hm. Weet jy waar?"

R: "Um, ek het gehoor sy is onder Dr. Malgas in Cloetesville."

M: "O (3.0) Hoe lyk daai senuwees? (1.0) Weet jy (.5) hoe dit lyk (.5) haar senuwees?"

R: "As sy (1.0) soos (.5) die suster wat na my kom sê vir my sy (2.0) raak

sommer net soos (1.0) VAS in die IN die geselskap aan die slaap."

M: "Is dit?"

R: "Senuwees."

M: "Hm."

R: "En dan (1.0) Partykeer as sy net so siek word, (1.0) maar haar persoonlikheid (bly nog dieselfde)."

M: "OK. (3.0) Oraait. (2.0) Um is jy nog (.5) by? (.5) Is jy al moeg?"

R: "Nee [( )"

M: "[OK. (1.0) Oraait."

(Clinical picture:)

M: "Kan jy vir my vertel *vandag* (1.0) hoe hoe voel jou gemoed? (1.0) Hoe voel jy binnekant (1.0) jou hart?"

(3.0)

R {First few words inaudible; possibly just an introductory statement}: "Ek voel goed (.5) én bekommerd."

M: "Hm."

(3.0)

M: "Is daar tye wat jy net sit en huil (.5) miskien of wat jy hartseer voel (1.5) onlangs?"

R: "(2.0) Ja, daar is tye wat ek nou hartseer voel, maar (1.0) ="

M: "= Hm."

R: "ek *huil* nou nie graag nie."

M: "Hm."

R: "Ek sal nou (1.5) veral as as my man vir my nou slaan of (1.0) lelike woorde gee, dan sal ek nou (.5) somtyds (1.0)"

M: "Hm."

R: "En soos vanoggend het ek nou so saam met uh die vroutjie wat ek mee saamgekom het ="

M: "= Hm? ="

R: "= Ek het nou so hartseer gevoel saam met haar dat die trane ook nou gekom het."

M: "Vandag?"

R: "Vanoggend, [ja."

M: "[Hm. Toe jy toe jy met haar gesels?"

R: "Ja, sy het vir my gebel (1.0)."

M: "Uh?"

R: "En vir my gesê sy weet nou nie moet sy nou saam- (1.0) kom met my om julle te kom sien (1.0) of *wat* moet sy nou maak."

M: "Hm."

R: "Sy het nou 'n uh probleem met die man en die huwelik."

M: "Ek sien."

R: "So."

M: "Ja. Wat het wat het gebeur toe jy met haar begin huil het? (1.0) Waaroor het julle toe gesels?"

R: "Sy't nou sy't nou haar hart uitgepraat saam met my (1.0) oor oor die probleem van *haar* nou."

M: "Hm. Het jy vir *haar* hartseer gevoel?"

R: "Sy't nou gehuil aan die ander kant ="

M: "= Ja ja ="

R: "= En toe raak dit nou ook vir my."

M: "Hm."

R: "Verstaan jy?"

M: "Ja."

R: "Dis nie asof jy nou (1.5) byvoorbeeld 'n program op TV sien en daar's nou 'n sterfte of daar's 'n ongeluk en die mense huil (1.0) jy raak ook aan die huil."

M: "OK, ja."

R: "Sien. Daai soort."

M: "Ja, jy voel so half *saam* met ="

R: "= Ja, saam met ="

M: "= hulle. (1.0) OK. Ja. (1.0) Is (.5) voel jy (1.0) as jy in die dag (.5) as jy opstaan (.5) in die oggend (.5) voel jy beter in die oggend of in die aande? Wat is vir jou die lekkerder tye van [die dag?"

R: "[In die oggend voel ek (1.0) beter. Kyk, as ek nou gisteraand 'n *hewige* aand gehad het, dan (.5) more-oggend is *alles* weer weg. Ek ek ek weet van dit wat plaasgevind het, maar ek voel net weer beter na (.5) 'n slaap."

M: "Hm. Hm. OK. (2.5) En jy sê (.5) daai die dinge waarin jy gewoonweg in belangstel, is jy stel jy nog steeds daarin belang (1.0) soos jou kinders en (1.0) hierdie (1.0) hierdie groep vrouens wat jy wat jy het en so (1.0) Um (.5) is jou belangstelling daar?"

R: "Ja, my belangstelling is nog daar."

M: "Hm. (2.0) OK. (2.0) .hhh As jy moet vir my sê as jy nou (1.0) toekoms toe kyk, hoe lyk dit? (1.0) Hoe lyk die toekoms vir jou? Hoe voel jy daaroor?"

(3.0)

R: "Om die waarheid vir jou te sê (2.0) Ek het nou die dag (1.0) hier in die week, (1.0) het ek en my man weer so 'n vreeslike rusie gehad. (1.0) 'n Argument oor die (1.5) verblyf-probleem en sy jaloesie-probleem."

M: "Ja?"

R: "Toe't ek vir myself gesê ek weet nie (.5) of ek nog 'n toekoms saam met die man kon opbou nie."

M: "Hm."

R: "(2.0) Want ek het nou uitgesien (1.5) hoe ons nou dinge saam gaan doen en waar hoe't gaan ons nou saamlewe op die nuwe uh uh woonplek, (1.0) maar toe hy nou weer so alles wat ek in gedagte gehad het of af kom breek, toe's alles sommer net verlore vir my."

M: "Hm (.5) hm (2.0) Dis 'n groot slag vir jou, dié?"

R: "Ja, dis 'n groot slag."

M: "Hm (2.0) OK. (1.0) .hh (.5) Jou slaap in die aande (1.0) Hoe slaap jy?"

R: "Ek slaap swaar (1.0) Net in die begin (1.0) slaap ek swaar, maar as ek nou eers slaap vas aan die slaap (is), dan slaap ek nou (1.0) goed."

M: "OK. (1.0) Raak jy deur die nag wakker baie kere?"

R: "Nee."

M: "OK. En in die oggende? Wanneer raak jy wakker?"

R: "In die laaste tyd (.5) soos veral dié week eintlik so (1.0) voor 7 (.5) wakker geskrik (het nie 'n man wat ons wakker gemaak het nie en die) wekker was nie gestel nie {laughter}. En dan stel ek nou die wekker nou dat ek kan wakker skrik."

M: "Ja ja. OK. So so jy raak nie vroeg sê nou maar wakker en (1.0) probeer om aan die slaap te raak en jy kan nie. Jy raak met die (1.0) wanneer jy moet wakker word, raak jy dan (.5) skrik jy dan wakker?"

R {Confirms}: "Hm."

M: "Hm. OK. Het jy nagmerries ooit of of slegte (.5) drome?"

R: "Die afgelope tyd verlede week het ek baie slegte drome gehad."

M: "Hm."

(4.0)

M: "OK. As jy as jy wakker word in die oggend, hoe voel jy uitgerus? Voel jy dat jy (1.0) energie het vir die dag?"

R: "Somtyds dan (2.0) voel ek nou weer goed. Dan (1.0) staan ek op met 'n lekker gemoed, maar sodra ek my voet daar in daai werk gesit het, dan voel ek nie meer lus nie."

M: "Hm."

(3.0)

M: "Wat van eet? Hoe lyk jou aptyt? (1.0) Voel jy nog lus vir kos? (1.0) [Eet jy?"

R: "[Ek het 'n goeie eetlus sover."

M: "Is dit?

R: "Hm-m."

M: " Dit het nie verander in die afgelope paar weke nie? Is dit maar dieselfde soos gewoonlik?"

R: "Ja, dis dieselfde soos gewoonlik."

M: "OK. (1.0) Oraait. (1.0) En energie? Jy't netnou vir my gesê jy's nie (1.0) baie lus vir goeters nie, nè? Partykeers raak jy net (1.0) net half lusteloos. Is dit omdat jy nie fisies energie het nie of is dit hierbinne wat jy voel: 'Maar ag' (2.0) Um (2.0) Het jy nog dieselfde energie soos gewoonlik dat jy (.5) Raak jy gouer moeg (1.0) of is dit maar dieselfde soos altyd?"

(3.0)

R: "Ek het nog energie."

M: "Hm?"

R: "Om baie dinge te doen (1.5) Kyk byvoorbeeld as ons nou (.5) in 'n groep is, (1.0) dan pak ons mos nou verskillende take aan. Dan het ek die energie daarvoor. (1.0) Nou kom ek nou (1.0) by die huis. (1.5) Daar speel nou weer 'n musiek, (1.0) dan het ek nou weer energie. Die energie, dink ek, is soos gewoonlik."

M: "Hm."

R: "Dis nou net (1.0) so nou en dan (1.0) wat ek nou op een plek weer dink (oor my probleme) dan sal ek lank so sit en dink en dink."

M: "Ek sien."

R: "Somtyds dan kyk ek TV, maar dan's die gedagte nie daar nie. Dan maal die 'Waar *gat* ons bly?' in my kop."

M: "Ja [Ja."

R: "[So."

M: "OK. Oraait. (.5) En seks? Is jy nog lus daarvoor?"

R: "Nee, man. Die seksgevoel is nie (1.0)"

M: "Hm (1.0) nie daarso nie?"

R: "Nie van die beste nie."

M: "OK. Hoe lank is dit al? (1.0) Kan jy (.5)"

R: "Man, ek (2.0) ek is nie 'n warm mens nie. Ve- veral nou na die sterilisasie."

M: "Hm."

R: "(2.0) (waar ons altyd (1.0) kan gaan (1.0) kwaad slaap)

M: "Hm."

R: "So."

M: "Hm. Hm"

R: "En somtyds dan somtyds dan is dit nogals 'n probleem."

M: "(1.5) Hm? [Vertel vir "

R: "[Tussen ek en my man."

M: "Hm."

R: "Wanneer hy nou voel vir seks dan voel ek nie vir seks nie."

M: "Hm. (1.0) Wat maak julle dan?"

R: "Dan's hy nou net kwaad, dan lê hy met sy rug (1.0) na my of hy *SKEL*."

M: "O, ek sien. Hm. (1.0) Hoe voel jy dan? (.5) Wat maak dit aan jou (1.0) as dit nou gebeur?"

R: "Dan (.5) sê ek nou vir hom: 'Maar ek voel nie daarna nie. Ek het nou nie lus nie.' (1.0) En dan skel hy my bla- hy beskudig my en dan (1.0) waai ek net. Ek gee hom nie meer antwoord nie."

M: "Hm."

R: "Solank ek net kan slaap!"

M: "Hm."

{Laughs with Marian.}

M: "OK. OK. (1.0)"

{Marian checks whether recording is still running smoothly.}

M: "Jy't netnou vir my gesê dat dat eintlik (.5) dis nie so hartseer wat jy voel nie. Dis meer dat jy angstig voel, nè? Dat jy ge-*worried* is oor dinge."

R: "Hm."

M: "OK. Hm (.5) Ek gaan vir jou 'n paar (.5) dinge vra. Jy't vir my gesê jy kry hoofpyne. Voel jy ooit duiselig (1.0) [dat jy?"

R: "[Ja. Ja. My kop *gat* so."

M: "Uh-hu?"

R: "So."

M: "OK. Is dit ook in die afgelope tyd (1.0) nou?"

R: "Dis al 'n hele lang tyd (1.0)."

M: "Hm?"

R: "'n Hele lang tyd."

M: "Soos hoe hoe lank al omtrent (.5) maande of (.5)?"

R: "Maande."

M: "Maande?"

R: "Hm."

M: "Maande. OK. En sweterig? (.5) Raak jy sweterig dat jy voel jy (1.0) jou handpalms (.5) of onder jou arms dat jy meer as gewoonlik sweterig raak?"

R: "Oor die algemeen my hande."

M: "Jou hande. OK. (1.5) Hartkloppings? Wat daarvan? Dat jy (.5) dat dit skielik begin (.5) vinniger gaan?"

R: "Somtyds, maar nou nie so (.5) dikwels nie."

M: "OK. (.5) Druk- Wat van drukking op die bors? Wanneer 'n mens voel (1.0) Jy weet daai gevoel as iets swaar vir jou is? As jy nie kan asemhaal as-asof iemand jou DRUK."

R: "Ek het gisteraand (.5) so 'n vreeslike pyn hier gehad."

M: "Hm?"

R: "Hier. So. (.5) Maar ek weet ek is nie geSTAMP teen die bors nie (.5) en ek het nou gewonder (1.0) maar hoekom voel ek so?"

M: "Hm. Was dit die eerste keer?"

R: "Nee. Gisteraand was dit nogals -s pynliker (.5) seerder as (1.0) die vorige kere."

M: "OK."

R: "Die vorige kere dan (1.0) voel ek die drukking hier (1.0) so op my bors."

M: "Hm. (1.0) .hhh Het al die dinge erger geraak vandat jy nou hierdie slegte nuus gekry het (.5) oor jou man en (1.0) is dit of is dit dinge wat voor dit al aankom?"

R: "Die die die die borsdrukkings [is so nou en dan."

M: "[Hm?"

M: "Hm?"

R: "En die (2.0) die hoofpyne is eintlik die die die die ding wat die dikwels wat die meeste gebeur."

M: "Ja ja. OK. Wat van bewerigheid? Dat jy half (1.0) dat jy bewerig voel?"

R: "(2.0) So nou en dan voel ek bewerig."

M: "En (1.0) dat jy meer moet toilet toe gaan (.5) dat jy miskien (1.0) um"

{Rita answers inaudibly, but means 'No' to the last question.}

M: "dit nie gebeur nie? (.5) OK. (1.0) Warm gloede? Wanneer jy daai gloede kry wanneer jou wange en alles so warm word?"

R: "Dis net so nou en dan dat ek (.5) net benoud kry, veral as my kop so duiselig word."

M: "OK ="

R: "= Dan begin ek sommer hoofpyn te kry."

M: "Ja. Ja. (1.0) Hoe voel jou bene? Voel hulle ook swaar en lam? (2.0) Die res van jou liggaam (1.0) of dit baie swaar voel?"

R: "Ek weet nou nie of dit maar nou (1.0) 'n (1.0) *liggaamsboustruktuur* is nie."

M: "Ja?"

R: "Maar (.5) my bene is maar altyd (.5) am. Uh uh uh ek het maar altyd sulke lammerige bene."

M: "OK."

R: "*Val gou.* "

M: "Uh-hu."

R: "Dit het nog nooit by my gekom dat dit (1.0) miskien (1.0) 'n probleem is wat ek nog nie agtergekom het nie. (1.0) Soos 'n ou wat eintlik 'n oorsaak van iets nie."

M: "Jy bedoel jy jy ="

R: "Ek het nog nie dit besef nie (2.0)"

M: "OK."

R: "Miskien kan die lam- die lompheid (.5) DIT (1.0) kan [miskien die oorsaak wees. Ek het nog nie daaraan gedink nie."

M: "[Ja ja."

M: "Ja. Ja. Kom dit nou al 'n lang pad?"

R: "Ja."

M: "Hm. (2.0) OK."

R: "En nou het ek ook die enkel van my (1.5) was mos nou gebreek en nou is nou nog (1.0) probleemagtig."

M: "Hm. (1.0) Is dit ook 'n lang tyd wat dit gebreek het?"

R: "Is *in* die jaar."

M: "*In* die jaar?"

R: "Hm. In Maart. Maart. En in April het hy begin (.5) herstel-herstel. ( )."

M: "Het jy gevoel of?"

R: "Ja, ek het gevoel hy't ge*breek*."

M: "Hm."

R: "Ek het gevoel."

M: "Sjoe. OK. .hhh Um. (.5) Is daar tye ooit tye waar jy (1.0) *skielik* baie benoud raak en jy voel jy moet net uitkom? (1.5) Dat dat jy um (1.0) Gewoonlik kry mense dit (1.0) dis so 'n tyd wanneer jy regtig *paniek* (1.0) paniek is. Dat jy net (1.0) bang raak en jy wil net uitkom. Jy wil hardloop en wegkom. Het jy ooit daai gevoel?"

R: "*Dit* kry ek nou in die tyd wanneer ek en my man nou (2.0) skel of (1.0)

baklei."

M: "OK. Hoe voel dit? Kan jy vir my sê? Hoe is daai tye?"

R: "Dan is ek net bang."

M: "Hm."

R: "Verstaan?"

M: "Ja."

R: "Dis net daai bang gevoel."

M: "Ja ja. Voel jy dat jy gaan doodgaan of dat jy nie kan asemhaal of enige van daai dinge nie. (.5) Dat jy gaan flouval? .hh Het jy sulke gedagtes dalk of nie?"

R: "*Nee*. Ek (.5) Al- (1.0) Ek dink net altyd (1.5) hy *kan* my doodmaak. Dis altyd van drank (1.0)."

M: "OK."

R: "Op die manier hoe hy (1.0) uh die (.5) situasie hanteer."

M: "Ja ja."

R: "Verstaan? Somtyds as hy my nou *wurg* (1.0) dan kan ek mos nou nie asem kry nie."

M: "Ja ja."

R: "So."

M: "*Is* jy bang vir jou man, Rita?"

R: "(2.0) Vir baklei (1.5) ja. Want ons vrouens sal tog maar nooit 'n man kan wen nie."

M: "Hm."

R: "Maar om my sê te sê is ek nou nie bang nie!"

{Marian laughs.}

M: "OK. (1.0) Um (1.0) Het jy (.5) gevoel in die afgelope tyd dat jy miskien (.5) meer um dat jy sukkel om te konsentreer op jou werk of wat mense sê op die televisie? (1.0) Dat jy sukkel om (.5) om lekker by te hou wat (.5) wat aangaan?"

R: "Nee, by die werk het ek nie so 'n probleem nie, maar somtyds as ons (1.0) uh uh groep nou (.5) besig is uh dan (1.0) uh (1.0) konsentreer ek (2.0) somtyds 'n bietjie stadig."

M: "OK. [Ja."

R: "[Dan moet ek nou eers weer *inkom*"

M: "Ja."

R: "Jy moet nou eers weer verduidelik voor ek die ding vat, verstaan?"

M: "Hm."

R: "Dit verstaan."

M: "Ja. (1.0) Is dit iets wat jy onlangs opgetel het?"

R: "Ja, kyk (1.0) die gedagte is nou by jou en dan gaan dit weer weg."

M: "Hm."

R: "Jy jy (.5) ons kyk na mekaar toe, maar jy weet nie wat hierbinne aangaan nie."

M: "Hm hm."

R: "Verstaan?"

M: "Hm Hm."

R: "Daai tipe van ding."

M {Confirming that she understand}: "Hm hm. (1.0) OK. (.5) En jou

geheue? Het jy gevoel is daar 'n verandering in jou geheue dat jy miskien vergeetagtig (1.0) is of (1.0) of het dit nie by jou gebeur nog nie?"

R: "Somtyds vergeet ek somtyds (.5) oor die algemeen (.5) vergeet ek somtyds baie ="

M: "= Hm."

R: "Maar dan (.5) ek sal nie sê dat ek nou (2.0) as gevolg hierdie (.5) omstandighede = "

M: "= Ja?"

R: "Dat vergeetagtigheid dit die probleem [is nie veroorsaak is nie."

M: "[Ja. OK. Oraait. Um (2.0) OK, ek dink dit is al vir hierdie (.5) hierdie stuk nou. Nou gaan ek (.5) Is jy nog (.5) oraait? Wil jy 'n bietjie rus of is jy (1.0)?"

R {Laughs when she says}: "Nee, ek is nog oraait."

M: "Kan ons nog aangaan? OK?"

R: "Ja, net 'n bietjie teetjies drink."

M: "Ja."

{Marian says something about drinking the tea before it gets cold. She pours the tea. She then asks Rita whether the tea is still warm enough for her.}

M: "OK."

R: "Kan ek gou iets vra?"

M: "Ja."

M: "As hierdie kassette nou geluister word ="

M: "= Hm?"

R: "*Waar* gaan dit nou geluister word? Op 'n plek waar mense my *nie* ken

nie?"

M: "Ja, dit gaan nie deur (.5) dit gaan nie deur 'n klomp ander mense geluis- Dit gaan nie deur 'n groep geluister word nie. Wat wat gaan gebeur is dat um (1.0) ons gaan hierdie goed (1.0) op band hê sodat elke een wat (.5) daarin belangstel - daar is mos nege van ons ="

R: "= Hm."

M: "Gaan die *tape* kan kry (1.0) en sal kan neerskryf die inligting wat hulle soek ="

R: "= Hm?"

M: "Vir hulle spesifieke ding wat hulle doen. (.5) So, dit gaan net hulle nege mense wees."

R: "Hm-m."

M: "En daar mag miskien een of twee junior mense wees wat glad nie weet van wat ons doen nie, (1.0) maar wat gaan help om dit neer te skryf jy sien maar hulle gaan glad nie vir julle ken nie. Hullle gaan glad nie. (.5) Dis hoekom ons ook op die *tapes* julle kodename inskryf sodat niemand (1.0) dit gaan weet nie."

R: "Hm."

M: "Maar dit gaan nie vir groot groepe mense gegee word nie (2.0)."

R: "OK."

M: "Voel dit maar snaaks? Dit voel seker maar [snaaks."

R: "[Dit voel nie snaaks nie. Dit stel my nou weer (.5) gerus."

M: "Uh-hu. (1.0) Ja."

R: "Baie keer wil mense nie hulle name bekend gemaak word nie, verstaan?"

M: "Ja ja."

R: "Want baie kere dan's mense so bang (1.0) om op te staan vir hulle regte. Bang die boer gat (.5) hoor."

M: "Ja."

R: "Daai tipe ding."

M: "Ja."

R: "Ek wil net seker (.5) [maak."

M: "Ja. Nee, dit sal definitief nie (.5) Um. Niemand sal weet (.5). Veral nie die boere of (.5). Dit sal nooit op televisie of so persoonlik met 'n persoon gekoppel word nie. Nooit nie."

R: "Hm."

M: "OK, so jy hoef nie daaroor (1.0) te bekommer nie. Dit is hoekom julle hierdie ding teken, want (1.0) um Jy weet, julle (1.0) dis jou reg om hierdie privaat te hou. So as as ek byvoorbeeld enigsens jou informasie gaan uitgee, dan kan jy my hof toe vat. Ek mag dit glad nie doen nie. So (1.0) dis definitief .hh Die volgende ding (1.0) is nou 'n paar meer spesifieke vrae.

{SWLS}

M: "So, ek gaan baie meer spesifiek (.5) Dis sulke vraelyste wat ek graag wil doen (2.0). So wat gaan gebeur, is ek gaan vir jou 5 stellings gee (.5), 5 sinne lees (1.0), en by elke sin (.5) wil ek hê jy moet vir my jy dit luister en dan moet jy vir my sê (.5) of jy daarmee saamstem of nie. (1.0) OK? En dis sinne oor jou eie lewe. (.5) OK. Nou wat ek het hierso is (1.0) ek wil hê jy moet vir my 'n nommer gee, (1.0) as jy glad nie saamstem nie met wat ek vir

jou lees nie, dan (.5) gaan dit 'n 1 wees. (1.0) Dit beteken jy (.5) stem glad nie saam nie en as jy baie saamstem, dan gaan jy 'n 7 daarvoor gee. (1.0) OK? As jy absoluut niks daaroor voel nie, is dit 4. Dan's dit in die middel. Dan beteken dit nie veel nie. (1.0) OK? En die 2 en die 3 en die 5 en die 6 is (.5) sê nou maar jy verskil, maar jy verskil nie *so baie* nie (1.0) dan kan jy miskien 'n 2 of 'n 3 gee. (2.0) OK? En sê nou jy stem saam, maar jy stem nie *sterk* saam nie, dan kan jy of 'n 5 of 'n 6 gee."

R: "Hm-hm?"

M: "Maak dit maak dit vir jou sin?"

R: "As jy nie saamstem nie, dan's dit 1 en 'n 7."

M: "Dan's dit (.5) Nee, as jy *nié* saamstem nie, dan's dit die 1."

R: "[Hm-hm?"

M: "[As jy *baie* saamstem, dan's dit die 7."

R: "Ek sien."

M: "OK. Dié in die middel is dit so (.5) Ag, jy *worry* eintlik nie. (2.0) OK?"

R: "Hm-m."

M: "Ek sal vir jou (.5) Kom ons lees een dan dan oefen ons dit gou-gou. (1.0) Die stelling is: 'In die meeste opsigte (1.0) is *my* lewe (.5) dit beteken *jou* lewe (.5) *baie* naby (.5) aan dit wat ek as die ideale lewe beskou.'"

(3.0)

M: "Moet ek dit weer lees?"

R: "Ja, lees weer."

M: "OK. 'In die *meeste* opsigte (.5) is *my* lewe (.5) baie naby aan dit wat ek as die ideale lewe beskou.' (1.0) Sou jy sê jy stem (.5) saam baie sterk (1.0)

of stem jy glad nie saam nie (.5) of val dit hier iewers in die middel?"

(3.0)

R: "Is dit net die een *copy*? Net die een?"

M: "Ja, wil jy dit lees?"

R: "Hm."

M: "Hm-m. (2.0) Daai eerste is nommer 1."

{Silence while Rita reads. The silence continues for approximately 15 seconds.}

M {giggling apologetically}: "Sou jy sê jou lewe is die ideale lewe vir jou? (1.0) Of sou jy iets anders gekies het?"

(10.0)

R: "Nommer 2."

M: "(2.0) OK? (1.0) Bedoel jy jy kies nommer 2?"

R: "Nee, ek bedoel."

{Rita and Marian speak simultaneously. It seems as if Rita doesn't understand what is expected of her. She gave the statement that describes her the best. Marian quickly grasps what Rita means.}

M: "OK OK. So so jy voel nie jy jy verskil dit is nie jou ideale (1.0) Dit is nie jou ideale lewe nie (1.0) wat jy nou het nie?"

R: "Uh. Wag. Kan (1.0) kan uh ons na die volgende vraag toe gaan?"

M {Sounds relieved and accommodating}: "Ja! Die volgende een is: 'Die omstandighede van my lewe is uitstekend.' (1.0) Stem jy *saam* of *nie*?"

R: "Nee, ek stem nie saam nie."

M: "OK. Stem jy *stérk* nie saam nie? (2.0) Verskil jy *sterk* (.5) of net so 'n

bietjie? (2.0) Stem jy *glad* nie saam nie?"

R: "Ek stem (1.0) [*glad* nie saam nie."

M: "[Glad nie saam nie. OK. So dis 'n nommer 1."

{Marian adds a few inaudible words. It doesn't seem significant.}

M: "OK, nommer 3 sê: 'Ek is tevrede met my lewe.'"

R: "Nee, (1.0) ek stem nie saam nie."

M: "Glad nie?"

R: "Glad nie."

M: "OK. (1.0) .hh Nommer 4 sê: 'Tot dusver het ek (.5) die (.5) belangrike dinge gekry wat ek in die lewe wou gehad het'."

(3.0)

R: "Uh. (3.0) Halfpad."

M: "Halfpad. (1.0) Sou jy sê (1.0) 4?"

R {Confirms}: "Hm."

M: "OK. (2.0) En nommer 5: 'As ek my lewe kon oorhê, sou ek feitlik niks verander nie'."

R: "Ek sal feitlik *baie* verander. Hoe sal ek nou daar sê?"

M: "OK, so jy verskil eintlik?"

R: "Hm, ek verskil."

M: "So jy sou baie (.5) *baie* dinge verander het?"

R: "Ja."

M: "OK. (2.0) OK. Kan ons teruggaan na daai eerste een toe? (1.0) Die eerste een sê: 'In die meeste opsigte is my lewe baie naby aan dit wat ek as die ideale lewe beskou'."

(3.0)

M: "Dit beteken dis die lewe wat jy wou gehad het. Dis 'n ideale tipe lewe wat jy het."

R: "Nee, dit is nie (1.0) Ek (.5)"

M: "Uh?"

R: "Ek stem nie s- (.5) baie daarmee saam nie."

M: "OK. Sal ons vir jou (.5) So, dan is dit bietjie stem jy bietjie (.5) Sal jy sê jy verskil *totaal* daarvan jy stem glad nie saam nie (1.0) of (2.0) nommer 2 of 3?"

R: "Ek sal nommer 2 daar sit."

M: "Nommer 2? OK. (2.0) Oraait. Goed."

{Part on BDI}:

M: "Nou die die volgende ding wat ek gaan doen (2.0) dis *weer* 'n klomp vrae wat ek vir jou gaan lees. (1.0) OK? (1.0) Um. Dis *weer* 'n groep sinne (1.0) daar's vier sinne in elke groep. (1.0) En dan (.5) ek gaan vir jou die vier sinne lees, (1.0) OK? En dan wil ek hê jy moet kies uit (.5) elke sinnetjie of jy daai met daai s- met daai sin saamstem of nie. (2.0) OK? En ek wil hê jy moet (.5) beskryf watse sinnetjie beskryf beste hoe jy die afgelope week en vandag voel. (2.0) OK? (1.0) En jy kan meer as een (1.0) um jy kan meer as een van die (.5) van die sinne kies. So jy kan twee of drie sinne kies as hulle as jy met hulle almal saamstem. (2.0) OK? Sal ons gou probeer, dan sien jy ="

R: "= Herhaal gou wat is die eerste (.5) verwagting?

M: "OK. Ek gaan vir jou (.5) vier sinnetjies (.5) lees.

R: "Hm?"

M: "Ek gaan dit eers almal deurlees en dan wil ek hê jy moet vir my kies (.5) watter van daai sinne beskryf vir jou (.5) hierdie week en vandag (1.0) En jy kan meer as een kies. (1.0) OK? Kan ons gou probeer, dan sien ons gou hoe werk dit."

1.) M: "Die eerste een: {Reads the four items}."

(5.0)

M: "Moet ek weer vra?"

R: "Hm "

M: "OK, die eerste een: {Repeats all four items}."

(5.0)

R: "Um, (die tweede een) lees gou weer?"

M: "'Ek voel swaarmoedig of terneergedruk'."

R: "Ja."

M: "OK? (1.0) En die volgende een is (1.0) {reads item 3} en die vierde een is {reads item 4}."

(5.0)

R: "Um (3.0) Nommer 3."

M: "OK. Dis die een 'Ek is gedurig swaarmoedig of terneergedruk en kan die gevoel nie afskud nie'."

R: "Man, ek sal nou vir *gedurig* (2.0)."

M: "Hm."

R: "Sal ek nou iets (uit sal kan)?"

M: "OK. (2.0) So jy wil sê: 'Ek is swaarmoedig en kan nie die gevoel afskud nie?'"

R: "Hm, (1.0) reg (2.0) hm."

M: "OK. OK. (1.0) Is jy gereed vir die volgende een?"

R {Confirms}: "Hm-m."

M: "OK."

2.) {Marian reads items 1-4.}

(2.0)

R: "Uh, ek sal (1.0) uh verkies dat uh (1.0) uh (1.0) *you can give me an explanation about* ="

M: "= Hm? Die eerste moet ek dit weer gou-gou doen?"

R: "Wat is daai woord daar?"

M: "Ontmoedig."

R: "Ontmoedig?"

M: "Dit (1.0) OK. Dis dis as jy ="

R: "= Pessimisties."

M: "OK. 'Pessimisties' is as jy (.5) as jy (.5) donker voel oor dinge (.5) en jy voel dinge gaan nie regkom nie as jy (.5) as jy die *swart* kant van die lewe sien - *dis* pessimisties."

R: "Hm-m?"

M: "En die 'ontmoedig' (1.0) is (1.0) in Engels sê jy 'discouraged'. (1.0) Dis jy's um (1.0) jy voel nie lus om aan te gaan nie. (.5) Jy't nie meer

moed nie. (1.0) Dis om om jou moed weg te vat. (3.0) Kan ek hulle weer vir jou lees?"

R {whispers}: "Asseblief?"

M: "OK."

{Marian reads items 2-4.}

R: "(2.0) Um (2.0) Nommer 1 en 2."

M: "OK. Nommer 1 is {reads 1} (1.0) en nommer 2 is {reads 2}."

R: "Ja, *my* verduideliking ="

M: "= Uh?"

R: "Sal ek nou (1.0) sal ek graag wil verduidelik. Daai twee."

M: "Hm?"

R: "Um, ek voel ontmoedig op die oomblik, maar (1.0) ek het ook daai *moed* (1.0)."

M: "Uh?"

R: "En daai (1.0) krag om (1.0) die toekoms vorentoe ek sien uit na die toekoms om die toekoms op te bou ="

M: "Hm."

R: "Al gebeur wat ookal wat vir my *upset* ."

M: "Hm."

(3.0)

R: "Verstaan?"

M: "Ja [ja."

R: "[Dis wat ek nou."

M: "Ja. So dis twee emosies wat jy het: (1.0) die een is dat jy jy voel dit

is vir jou 'n slegte tyd, maar jy weet jy gaan (1.0) [aan die ander kant uitkom?"

R: "Ja. En ek het hoop daarop."

M: "Hm."

R: "Verstaan?"

M: "Ja ja. (1.0) En jy's reg. Dit dit gee nie vir jou daai (2.0) jou opsies is moeilik."

R: "Hm."

M: "So OK. Nommer 3."

3.) M: "Dis nou die volgende klomp sinne: {Reads item 1.}"

R: "Definitief nie."

{With these words Rita means that she agrees with item 1, i.e. that she definitely doesn't feel like a failure.}

M: "Moet ek hom vir jou sirkel nommer 2?"

{Marian reads items 2 – 4.}

(3.0)

M: "Moet ek hulle weer vir jou lees?"

R: "Ja. Lees weer vir my nommer 2, 3, en 4."

M: "OK. {Reads items 2 – 4}."

(5.0)

R: ".hhh een het ek nog watter een verkies ek nou? (2.0) Nommer 2 (1.0) Sal ek nou so (2.0) *in-between* saamstem. (1.0) Want uh somtyds dan (.5) as ek en my man ook nou (.5) woorde het, dan sê ek vir hom

altyd: 'Ek het nog nooit 'n goeie huwelik saam met jou gehad nie'. Verstaan? [So."

M: "[Hm."

M: "Hm."

R: "Want jy moet so (1.0) in die (1.0) huweliksjare moet jy so (.5) wonder: (1.5) *Wat nou*? As jy kan as jy die jare kan tel (1.0) goeie jare dié kant en slegte jare dié kant. Op die ou end dan dan lyk dinge vir jou daar's meer die slegte jare (1.0) oorskry die goeie jare, verstaan?"

M: "Ja ja. (1.0) OK. (1.0) OK. Kan ons aangaan?"

R: "Hm-m."

M: "OK. (2.0) Um."

4.) {Marian reads the four items of number 4.}

R: "Lees weer?"

M: "OK."

(4.0)

R: "Ek stem nog ek stem nie saam met die (1.0) vier punte nie."

M: "OK. (2.0) So jy's jy voel *nie* ontevrede met alles nie, nè?"

R: "Nee."

M: "OK. En (1.5) Ged- (1.0) Ek gaan hulle gou-gou (.5) weer lees ="

R: "= Of uh (.5) hoe sal ek sê (.5) verduidelik elke punt (.5) vir my."

M: "OK."

R: "Net op meer'n eenvoudiger manier."

M: "OK. {Reads item 1 and explains}: "Dit beteken jy (.5) geniet dinge

net so baie soos jy altyd dinge geniet het."

R: "Ja. Ja, ek stem saam met daai punt "

M: "OK. OK. Moet ek die anders doen? [Of wil jy daai een kies?"

R: "[Ja."

M: {Reads item 2 and explains}: "Dit beteken (1.0) um gewoonlik geniet ek dinge baie, maar op die stadium (.5) is is dit nie so lekker soos dit aityd was nie."

(3.0)

M: "OK."

R: "Ek stem nie saam nie "

M: {Reads item 3 and explains}: "Dit beteken jy geniet niks meer nie."

R: "Hm-m. Ek stem nie saam nie."

M: {Reads item 4 and explains}: "Niks is vir jou lekker nie. OK."

R: "Nee, dis net nommer 1."

5.) {Marian reads all the items once.}

(5.0)

R: "Laat ek hulle weer "

M: "Wil jy hulle kyk? Die vyfde een."

{Rita reads the items herself. Approximately 10 seconds go by.}

R: "Uh. Ek sal nommer (5.0) kies ek voel nie besonder skuldig nie."

M: "OK. (1.0) Is dit vir jou makliker as jy dit self. Ek moet dit vir jou lees, maar dink jy dit sou vir jou makliker gewees het as jy dit (1.0) *self* gelees het (1.0) en *self* ingevul het?"

R {Agrees}: "Hm. Hm."

M: "OK. (1.0) Ek besef dit, hoor. So jy moet maar sê as ek moet herhaal."

6.) {Marian reads the first two items.}

R: "Ek stem saam met die eerste een."

M: "OK. Moet ek die ander lees of [is jy (.5)"

R: "Ja, lees die anders."

{Marian reads the rest of the items.}

(10.0)

R: "Jy weet somtyds (2.0) dan dink 'n mens, (1.0) jy *sê* altans: Ai, wat het ek gesondig (.5) om *dit* te kan verdien?"

M: "Hm."

R: "Wat het ek gedoen dat ek al die dinge oorkom? Daai kom (2.0) *baie* dikwels by (2.0) ons vroue (1.0) wat met sulke probleme te doen kom."

M: "Hm."

R: "Kom baie dikwels vra ons vir onsself daai vraag af."

M: "Hm."

R: "Wat het jy (1.0) verkeerd (.5) of jy nou NIKS verkeerd gedoen het nie, verstaan? Somtyds dan as die die die die (1.0) dan as hy te veel drink, dan vra jy: Wat het ek ge*doen* om dit te kan verdien?"

M: "Hm."

(5.0)

R: "Lees weer vir my die laaste paar."

{Marian repeats the last three items.}

{Rita chooses the first item; asks that the first item be repeated. After hearing the first item again, she doesn't agree with it anymore. In the end she chooses the last item.}

M: "So jy bedoel eintlik (1.0) die eerste een {reads item 1}. Jy jy so jy sê eintlik vir my partykeers voel jy so, maar ander kere voel jy weer (1.0) daar is (.5) dit moet 'n straf wees (.5) die lewe."

R: "Ja."

M: "Hm."

R: "Die eerste een: 'Ek voel (.5)?

M {repeating the first item}: "'Ek voel *nie* ek word gestraf nie'."

R: "(2.0) Nee, nee. (1.0) (Ek voel nie so nie)."

M: "Moet ek hom uitkrap?"

R: "Hm."

M: "OK. (3.0) OK."

7.) {Marian reads the four items.}

(8.0)

R: "Lees weer die een vòòr 'Ek voel ek haat myself'."

{Marian reads item 3.}

R: "Verduidelik dit vir my, asseblief?"

M: "Um. Dit is as dis nie haat nie, maar (.5) jy (1.0) hou nie baie van jouself nie. Jy voel ="

R: "= Nee, ek het nog nie ek (1.0) kry nie daai gevoelens teenoor myself

nie."

M: "Hm."

R: "Nie een van hulle nie."

M: "OK. So, die eerste een: 'Ek voel nie teleurgesteld in myself nie'."

(7.0)

R: "Weet jy, nogal somtyds, verstaan jy?'

M: "Hm hm."

R: "Ja. (1.0) Ek dink ons (1.0) elkeen van ons (1.0) het maar (.5) ons uh swak bede (1.0) en dan dink jy: Ai, (1.0) hoekom het ek dit gedoen (1.0) en dan sou ek nie *dit* bereik het nie of sou nie *dit* gedoen het nie of ek sou nie *dit* oorgekom het nie."

M: "Hm."

R: "Ja."

M: "En vandag? As jy moet sê *vandag* (1.0) voel jy teleurgesteld in jouself of nie?"

R: "(3.0) Wat is daai punt voor ons verder gesels daai eerste ene."

M: "'Ek voel nie teleurgesteld in myself nie'."

R: "Ek voel nie teleurgesteld in myself nie. Waar's ek nou?"

{Rita laughs, and Marian joins in.}

(5.0)

M: "As jy dit vir *vandag* moet antwoord?"

(4.0)

R: "Ek is teleurgesteld in myself (3.0) (eintlik)"

M: "OK."

11.)M: "As dit moeilik is om te antwoord (.5) as jy nie kan dink nie, dan (.5) probeer om vandag te om van- vir vandag jy weet want dit verander mos (1.0) van tyd tot tyd. So probeer om vandag se gevoelens (1.0) OK? (1.0) te antwoord. OK. Die volgende. Is jy nog by? {laughs apologetically}"

R: "Ja, ek is nog by. .hhh hhh."

12.)M: "OK, (.5) dis nog nie meer lank dink ek nie. OK, die volgende klomp: {reads items 1-4}."

(6.0)

R: "Ek stem *nie* saam met enige van hulle nie, (1.0) want my belangstelling is (1.0) in mense is nog steeds (2.0) {Marian and Rita speaks simultaneously. Words inaudible on tape.}

M: "Wat van nommer 1: 'Ek het *nie* belangstelling in ander mense verloor nie'?"

R: "*Nee*, ek het nie belangstelling verloor in ander mense nie."

M: "OK."

13.) M: "Die volgende klomp: {Reads items 1-4.}"

R: "Ek neem besluite moeiliker."

M: "OK."

14.) M: "Die volgende klompie: {Reads items 1 and 2}."

{Rita interrupts Marian before she can go on to items 3 and 4.}

R: "Ek voel dat ek slegter as gewoonlik lyk."

M: "OK. {Laughs together with Rita.} Kom ons sien of hy inpas 'Ek is bekommerd daaroor dat ek oud (.5) of onaantreklik lyk'."

R: "Ek is nogals bekommerd."

{Both laughs.}

M: "OK, {Reads items 3 and 4}."

R: "Nee, ( )."

M: "OK. (1.0) Wil jy jy't nommer 2 (.5) 2 gekies?"

R: "Uh (1.0) lees *weer* gou vir my almal?"

M: "OK."

R: "Want ek het dan nou so (1.0) saamgestem. Ek dink ek het saamgestem met twee dinge."

M: "OK, {Reads all four items}."

(4.0)

R: "Ek het nommer 2 gekies, nè?"

M {Agrees}: "Hm-m ."

R: "Lees weer vir nommer 2?"

{Marian repeats item 2.}

R: "Ja."

M: "OK."

15.)M: "Die volgende klomp: {Reads all four items}."

R: "Nommer 1? (2.0) Lees hom net weer vir my?"

M: "Ek kan byna (.5) net so goed soos tevore werk."

R: "Ja."

M: "OK."

M: "Ek dink ek en jy snap nou die ding! Ons gaan goed hierdeur."

{Laughs with Rita.}

16.) M: "Die volgende klomp: {Reads items 1-4}."

R: ".hhh hhh. Lees weer vir my van die begin af?"

M: "Goed. {Repeats all the items of number 16}."

R: "Die middelste een. Van bo af die tweede een."

M: "Ek slaap nie so goed soos gewoonlik nie?"

R: "Ja."

M: "OK."

17.) M: "Oraait. Die volgende klompie: {Reads items 1-4}."

R: "Ek word nie moeër as gewoonlik nie."

M: "OK."

18.) M: "Oraait. Die volgende klompie: {Reads item 1}."

R: "Hm."

M: "Moet ek hom doen?"

R: "Ja."

M: "OK. Ek sal die ander lees: {Reads items 2-4}."

R: "Dis net daai een punt wat ek gesê het."

M: "OK. My eetlus is nie slegter as gewoonlik nie."

19.) M: "OK. Die volgende klompie: {Reads items 1-4}."

R: "Nommer 1."

M: "Ek het nie onlangs enige gewig verloor nie?"

R: "Hm."

M: "OK (1.0) Um (1.0) OK. Nou moet jy vir my 'Ja' of 'Nee' sê: 'Ek probeer doelbewus gewig verloor deur minder te eet'."

(5.0)

R: "Nee."

M: "OK. (1.0) Nog net die laaste stuk."

20.) {Marian reads items 1 and 2.}

R: "Ja."

M: "OK. {Reads items 3 and 4 as well}."

R: "Ek moes 'Ja' of 'Nee' geantwoord het, nè?"

M: "Um (.5) Jy moet weer. Nee, jy moet weer een kies (.5) soos voorheen. Jy moet weer een van daai kies of of meer as een kies."

R: "O."

M {in a very discouraged voice}: "Ja, moet ek hulle weer lees?"

R: "Ja, 'seblief?"

M: "OK."

R: "Want ek dog toe ek moet 'Ja' (1.0) of ['Nee' "

M: "[Ja, want ek het mos nou net gesê van die 'Ja' 'Nee' (1.0) Ja-nee. Dit was net vir daai een vraag."

R: "Dit was net vir daai een vraag."

M: "So hierdie is weer soos die voriges. OK."

R: "Hm-m."

M: "OK, ek gaan hulle weer lees: {Repeats items 1 en 2}."

R: "Ja."

M: "OK. {Reads items 3 and 4 as well}."

R: "Ek stem ( )"

M: "OK. Daai een. Oraait."

21.) M: "Nou die laaste klompie: {Reads all the items of number 21}."

(4.0)

R: "Ek moet nou (2.0) iets soek (1.0) hierso wat weer wat wat *MY* antwoord gaan (1.0) wat wat gaan sin maak op die einde van die dag. Ek kan net vir jou sê: Jong, (1.0) my gevoel is nou net *in-between* ="

M: "= Uh."

R: "Verstaan jy?

M: "Uh."

R: "Nou met ons weer 'n sin soek wat nou (1.0) "in-between" gat {Laughs} wat gelyk is aan *in-between*. {Laughs together with Marian}"

M: "JA."

R: " Verstaan jy nou?"

M: "Ja. Kan ek dit weer vir jou lees en dan sien ons gou. {Repeats items 1 and 2}."

R: "Ja."

M: "OK, (1.0) nommer 3: {Reads item 3}."

R: "Daai vorige een."

M: "Ek stel minder in seks belang as gewoonlik?"

R: "Hm."

M: "OK. (1.0) Oraait. So daai een is ook nou klaar. (2.0) Daar's nou nog net hierdie enetjie wat ek wil doen. Wil jy net so 'n paar minute net rus?"

R: "Ja, (1.0) so 'n paar sekondes."

M {laughing}: "OK."

R{Rita yawns heartily!}: "Kyk hoe gaap ek nou!"

M: "Wat doen jy gewoonlik op op op 'n Saterdagmiddag?"

R: "As ek nie vergaderings het nie, dan (1.0) maak ek skoon en (1.0) en kuier ek 'n bietjie (1.0) by my buurvrou of ek gaan uit na my vriende toe buite op die plaas."

M: "Ek sien, ja. (1.0) Dis maar 'n opoffering om hierso te kom. Ek is baie baie dankbaar dat jy dit dat jy jou Saterdagmiddag."

R {Laughing}: "Ek is so ingespanne (1.0) om weg te wees van die huis af. Die kinders het gesê: 'Mamma is *nooit* by die huis nie!'"

M {Laughing with Rita}: "Is dit?"

R: "Mamma bly weg! {Rita then provides her answer to their accusation without introducing it first:} Nee, toe maar, ek slaap nie uit die huis nie!"

M: "Hm-m."

R: "Ja."

M: "OK."

R: "Somtyds as dit koud is, dan slaap ek nou 'n bietjie. Ek en die ou (1.0)

seuntjie."

M: "Hm hm."

R: " Maar nou sal dit baie laat wees (1.0) (en vervelig miskien)."

M: "Ja."

R: "Dan slaap ek in die middag."

M: "Speel hy nou (1.0) alleen daar?"

R: "O, hy is 'n *buitekant-kind*. (1.0) Ek het vir hulle gesê hulle moet hom in die huis hou vandag."

M {Laughs}: "Shame!"

R: "Hy's (.5) baie (1.0) hiperaktief."

M {Still laughing}: "Ag, moeder!"

R: "Ja. Dit sukkel maar om vir hom by die huis te kry!"

M: "Is dit? Is dit lekker op die plaas vir kinders? Is dit 'n lekker plek om te speel en groot te word, dink jy?"

R: "Ja (1.0) Daar is 'n speelpark vir die kinders, maar (1.0) dis 'n bietjie (.5) somtyds is dit 'n bietjie (1.0) gevaarlik."

M: "Hm?"

R: "Met die valslag hy het die een van my het met 'n gaatjie in die kop huis toe gekom."

M: "O, jinne, ja."

R: "Maar dink jy hy gaan wegbly? (1.0) Hy gaan net weer!"

M {Laughs}: "En Ma moet maar *worry*!

R: "Hm."

M: "OK. (2.0) Hoe voel jy? Sal ons hom klaarmaak? Dan kan ons (.5) vir

Lou-Marie gaan kry."

R: "Ja, ons kan maar klaarmaak."

M: "OK. (1.0) Ek moet dit nou vertaal terwyl ek dit vir jou gee. (1.0) So, ek gaan nou 'n bietjie stadiger wees. OK? Al wat ek wil hê jy moet vir my sê (.5). Dis 20 vrae en ek wil net hê jy moet sê 'Ja' of 'Nee'. (.5) So dis baie makliker as al die ander. Die eerste een is: (2.0) Was jy oor die afgelope tyd (1.0) Um kon jy konsentreer op wat jy gedoen het?"

R: "Ja."

M: "OK."

(3.0)

M: "Nommer 2: Het jy oor die afgelope tyd um slaap verloor oor jy so baie ge-*worry* het of bekommer het?"

(5.0)

R: "Soms dan het ek nogals um later gaan slaap as gewoonlik. Van *net dink.*"

M: "Hm."

R: "Verstaan?"

M: "Hm hm."

R: "En dan is daar niks lekker op TV nie. Dan sit en ek kan nie. Ek *voel* maar ek gaan nie slaap nie, (1.0) nou sit ek maar nou net so voor die TV."

M: "Hm, ja. So jy sal sê 'Ja'. Jy hét nogals ="

R: "= Ek sal sê 'Ja'."

M: "OK. Nommer 3: Um Het jy onlangs gevoel (1.0) dat jy 'n (3.0) dat jy 'n bydrae (1.0) lewer in dinge (1.0) dat jy 'n belangrike rol speel in dinge?"

R: "Ja."

M: "OK. Nommer 4: Het jy onlangs gevoel dat jy kan besluite neem oor dinge?"

R: "Ja."

M: "OK. Nommer 5: Het jy onlangs gevoel dat jy konstant onder druk is?"

R {Asks about the meaning of the question}: "(Explain?)"

M: "Um onder druk soos dat dat jy stres. Dat jy (1.0) dat baie druk op jou is dat jy (1.0) um."

R: "Ja."

M: "OK. (1.0) Nommer 6: Het jy onlangs gevoel dat jy nie oor jou probleme kan kom nie?"

R: "Nee, ek het nie daai gevoel gehad nie."

M: "OK. Nommer 7: Um (1.0) Het jy onlangs gevoel dat jy normale daaglikse dinge en aktiwiteite kan geniet?"

R: "Ja."

M: "OK. Nommer 8: Het jy onlangs gevoel dat jy (.5) um dat jy jou probleme in die gesig kan staar dat jy kan =?"

R: "= Ja ="

M: "= kan konfronteer."

R: "Ja."

M: "Nommer 9: Um Het jy gevoel dat jy ongelukkig of depressief is?"

R: "Ja."

M: "OK. (.5) Nommer 10: Het jy onlangs gevoel dat jy besig is om vertroue in jouself te verloor?"

R: "Nee."

M: "Nommer 11: Het jy onlangs gedink (1.0) van jouself gedink as 'n persoon wat nie waarde het nie?"

R: "Nee."

M: "Het jy onlangs gedink um of gevoel dat jy (1.0) dat jy eintlik nogals gelukkig is as jy nou alles bymekaar moet (1.0) moet tel en (1.0) Het jy gelukkig gevoel?"

R: ".hhh hhh. Ja, (1.0) ongeag alles het ek (1.0) weer eens vergeet van die hartseer en weer die moed in die lewe gekry ( )."

M: "OK."

R: "Uh wag! Lees gou weer?"

M: "Het jy onlangs gevoel dat jy, (1.0) as jy nou alles moet optel (.5) dat jy eintlik maar redelik gelukkig is?"

R: "Ja."

M: "OK. Nommer 13: Het jy onlangs gevoel um dat jy dit regkry om jouself (1.0) betrokke en besig te hou?"

R: "Ja."

M: "OK. Die volgende een (1.0) um Nommer 14: Het jy onlangs gevoel dat jy (1.0) soveel as soos gewoonlik uit die huis uit kom dat jy net soveel as gewoonlik uit die huis uit kom?"

R: "*Repeat*?"

M: "OK. Het jy onlangs gevoel dat jy net soveel as gewoonlik uit die huis uit kom?"

(6.0)

R {Asks if they can go on to the next question}: "( )"

M: "Hm-m. OK. Nommer 15: Het jy onlangs gevoel (1.0) dat oor die algemeen jy dinge nogals goed doen?"

R: "Ja."

M: "OK. Nommer 16: Het jy onlangs gevoel dat jy (.5) tevrede is met die manier waarop jy dinge doen (1.0) en jou (.5) jou take doen?"

R: "Ja."

M: "Nommer 17: Um Het jy onlangs gevoel (1.0) um dat dinge vir jou (1.0) dat jy gevoel het dat dinge nogals vir jou *hard* is in die afgelope tyd?"

R: "Ja. Ek het nogals so gevoel."

M: "Hm-m. (1.0) Nommer 18: Het jy onlangs gevoel um dat alles eintlik maar te veel vir jou begin word?"

(8.0)

R: "Nee."

M: "OK. Nommer 19: Het jy onlangs gevoel dat jy die heeltyd (1.0) um senuweeagtig en bekommerd is? (1.0) En *tense*. Jy weet, as jou liggaam (1.0) [*tense* is."

R: "[Ja."

M: "Nommer 20: Het jy onlangs gevoel (1.0) um dat daar tye is dat jy net niks kan doen nie omdat jou senuwees te erg is?"

R: "Nee."

M: "OK. Ek gaan net terugkom na daai ander een toe."

R: "Hm-m."

M: "OK? Um (1.0) Nou watse nommer was hy?"

M & R: "Nommer 14."

{Laughing together.}

M: "Jy onthou goed. OK. Um Het jy onlangs gevoel dat jy net soveel as gewoonlik uit die huis uit kom? (1.0) Met ander woorde dat jy net soveel soos ander kere uit die huis uit gaan?"

R: "Nee."

M: "OK. Dis klaar. (1.0) Kan jy kan jy vir my sê (.5) um (1.0) hoe hoe dit was vir jou?"

R: "Dit was (1.0) interessant."

M: "Hm-m? OK."

R: "Dit was vir my asof dit nou weer lekker soort van medikasie (2.0) om 'n bietjie weer uit te bring."

M: "Hm."

R: "En gesels. (1.0) Al was dit net vrae wat jy moes geantwoord het, (1.0) maar dit het weer gehelp."

M: "Ja."

R: "Gewig van jou skouers af."

M: "Ja. Ja. (1.0) Kan jy vir my (.5) Wat het jy verkies? Die die begin toe ons meer (1.0) Ons het meer mos net gepraat, nè? En toe die laaste helfde moes jy al hierdie vrae beantwoord. Wat was vir jou Wat het jy verkies? Watse deel van hierdie (.5) sessie met saam met my het jy verkies?"

(4.0)

R: ".hhh Jy weet, niks was nogal vir my moeilik nie."

M: "Hm."

R: "Niks was nogals vir my moeilik nie."

M: "OK."

R: "In die begin (1.0) toe ek hier aangekom het in die gebou {Laughs} Toe ek van die *toilet* af kom, (1.0) toe ek daai *tape* sien, toe begin ek {Marian and Rita laugh together} toe begin my senuwees te werk en ek dink ek gaan niks praat nie!"

{Marian laughs.}

R: "Verstaan, maar toe ek nou weer (1.0) die moed geskep het ="

M: "= Ja."

R: "En weer in die ding is, toe's alles weer 'n *big ball*!"

{Laughter from both.}

M: "OK. Ek is bly!"

{Again, laughter.}

R: "Ja."

M: "En nou? Is jy nou gemaklik met die *tape* wat?"

R: "Ja, ek is gemaklik."

M: "OK, ek is bly."

{Rita laughs again.}

R: "Toe ek kom van die *toilets* af (1.0) en die groot ding is op die tafel en ek het net so gekyk, {laughter from both} toe dink ek ek gaan niks praat nie ( )"

M: Jy't vir my gelyk asof jy dit baie goed hanteer, so."

{Again, laughter.}

{Rita then talks about the way the women handle a group meeting and how they sometimes find it difficult to start a discussion. They then discuss how Rita prefers to be adressed by Marian. The arrangements for their next

interview are finalized.}

THE FIRST INTERVIEW

Rita and Marian

Journal

I had heard of the respondent before and had imagined her to be a large, perhaps even imposing person. The short, spontaneous woman I met surprised me tremendously. My immediate awareness was of not knowing at what level to meet her. Because I could assume very little of the things one so easily assumes when conversing with someone of the same social group as you, interest, education, ability, etc. Typical of me, a lot of effort goes into 'saving' or accomodating the person. To save the person, I often assume as subordinate role. And in this interview I was soon uncomfortable that the chair I was sitting on was higher than the couch she had, and sat on the floor at her feet, as it were. I wondered, fleetingly as I did so, whether the less professional position might make her even more uncomfortable? She seems a really strong and adaptable person, though, and warmed to whatever was transpiring quite easily. I like her and think we established a basic rapport on which we can build.

The clinical interview went off easily, although I am not sure I spent enough time on the presenting problems. I felt rushed to finish and yet finished well ahead of time. I hated doing the Life Satisfaction Questionnaire and the Beck. My subjective experience of time was much longer than it actually was, but it felt awfully clumsy. I felt that reading it instead of letting her read it

was disempowering her and that she was forced to struggle on something she could have probably handled easily on her own. She did not understand many words, nor the 7-point scale, and found the Beck options limiting. The stories she insisted in including were much more substantial. The General Health Questionnaire was easy to administer.

I find myself wondering why on earth she is doing this project with us. Even though she told me it was helpful to her.