A Feminist Phenomenological Description of Depression in Low-Income South African Women

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ABSTRACT

A review of the past decade of literature on the subject of depression in South African women revealed a paucity of research that documents the perspectives of low-income women who have been diagnosed with depression. Informed by this and recent feminist critiques of the concept of depression, this study aimed to bring traditionally overlooked perspectives to the fore by providing rich descriptions of the subjectively lived experience of depression, as recounted by low-income women themselves. This feminist phenomenological study took place in a poor, rural community in the Western Cape Province of South Africa. Semi-structured in-depth interviews were conducted with ten low-income women who had been diagnosed with depression. The transcribed interviews were analysed using Interpretative Phenomenological Analysis. A number of important findings emerged. Firstly, participants were seen to express somatic complaints ahead of (and more frequently than) disclosures of sadness. Secondly, participants often described experiencing their psychological distress as anger, anxiety and a changed sense of self. Thirdly, participants generally attributed these experiences (and their overall distress) to a history of childhood trauma, the loss of important relationships, being physically, sexually or emotionally abused, feeling under supported and overburdened by multiple responsibilities, living in dangerous communities, and/or the various consequences of poverty. Finally, it was observed that while symptoms of suicidal ideation and intent were present in many of the women interviewed, strong religious and cultural norms existed and generally functioned to silence and deny the subject. Overall, the women's subjective experiences, understandings and descriptions of depression allowed a more complex picture to emerge than that which is currently offered by mainstream biomedical models. Consequentially, the current conceptualisation of the term "depression" was deemed to be inadequate, specifically because it does not fully capture low-income women's experiences of distress, and also because it tends to obscure the possible impact of socio-economic and political contexts on their mental health. Implications of these findings include firstly, that not only does the diagnosis of depression serve to medicalise women's misery, but it may simultaneously serve to obscure their feelings of anger, anxiety, sadness, hopelessness and other symptoms of distress that are intrinsically linked to their disadvantageous social and living conditions. Secondly, the findings indicate that the use of traditional diagnostic and suicide assessment interviews may be unhelpful or even irresponsible in some South African contexts. Finally, many of the study findings warrant further investigation and psychological research. Recommendations to this end are thus included and stress the need to use theoretical perspectives and research methodologies that are sensitive to the multilayered, complex psychological experiences of depression in low-income women.

Key words: Depression, women, low-income, rural, South Africa, feminist, phenomenology, subjective experience, Interpretative Phenomenological Analysis.

OPSOMMING

’n Oorsig van die afgelope dekade se literatuur oor depressie by Suid-Afrikaanse vroue dui op ’n gebrek aan navorsing oor die perspektiewe van vroue uit lae-inkomstegroepe wat met dié toestand gediagnoseer word. Na aanleiding hiervan sowel as onlangse feministiese kritiek op die konsep van depressie, was hierdie studie dus daarop toegespits om tradisioneel miskende perspektiewe na vore te bring deur middel van ’n ryke beskrywing van die subjektiewe ervaring van die lewe met depressie soos vroue uit lae-inkomstegroepe self daarvan vertel. Hierdie feministiese fenomenologiese studie is in ’n arm, landelike gemeenskap in die provinsie Wes-Kaap, Suid-Afrika, onderneem. Semigestruktureerde diepte-onderhoude is gevoer met tien vroue in die lae-inkomstekategorie wat met depressie gediagnoseer is. Die getranskribeerde onderhoude is op vertolkende fenomenologiese wyse ontleed. ’n Aantal belangrike bevindinge is gemaak. Eerstens het die meeste deelnemers somatiese klagtes gehad voordat (en meer dikwels as wat) hulle oor hul neerslagtigheid en terneergedruktheid gepraat het. Tweedens het heelwat deelnemers hul sielkundige nood as woede, angs en ’n gewysigde selfbeskouing beskryf. Derdens het die vroue merendeels hul ervarings (en hul algehele nood) aan ’n geskiedenis van kindertrauma, die verlies van belangrike verhoudings, fisiese, seksuele of emosionele mishandeling, ’n gebrek aan ondersteuning tesame met ’n oormaat verantwoordelikhede, hul gevaarlike woonbuurte en/of die verskillende gevolge van armoede toegeskryf. Laastens is waargeneem dat hoewel die ideasie en voorneme van selfdood wél as simptome by baie van die respondente opgemerk is, daar terselfdertyd sterk godsdienstige en kulturele norme bestaan waarvolgens dié onderwerp oor die algemeen doodgeswyg en ontken word. In die geheel skets die vroue se subjektiewe ervarings, begrippe en beskrywings van depressie ’n meer komplekse prentjie as wat hoofstroom- biomediese modelle tot dusver gebied het. Dus blyk die huidige konseptualisering van die term ‘depressie’ onvoldoende te wees, veral omdat dit nie die ervarings en nood van vroue uit lae-inkomstegroepe ten volle vasvang nie, en ook geneig is om die moontlike impak van sosio-ekonomiese en politieke kontekste op dié vroue se geestesgesondheid te misken. Die implikasies van hierdie bevindinge sluit eerstens in dat die diagnose van depressie nie net hierdie vroue se nood ‘medikaliseer’ nie, maar terselfdertyd dalk ook hul gevoelens van woede, angs, hartseer, hopeloosheid en ander simptome van nood wat ten nouste met hul minderbevoorregte maatskaplike en lewensomstandighede verband hou, verberg. Tweedens dui die bevindinge daarop dat die gebruik van tradisionele diagnostiese en selfdoodevalueringsonderhoude in sekere Suid-Afrikaanse kontekste nutteloos en selfs onverantwoordelik kan wees. Laastens regverdig baie van die studie se bevindinge verdere ondersoek en sielkundige navorsing. Aanbevelings in hierdie verband word dus ingesluit, en beklemtoon onder meer die behoefte aan teoretiese perspektiewe en navorsingsmetodologieë wat gevoelig is vir die meervlakkige, komplekse sielkundige ervarings van depressie by vroue uit lae-inkomstegroepe.

Trefwoorde: Depressie, vroue, lae-inkomste, landelik, Suid-Afrika, feministies, fenomenologie, subjektiewe ervaring, vertolkende fenomenologiese ontleding.

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My utmost respect and gratitude to my friends and family, particularly Avril, my parents and step-parents, for their continued interest in my personal and professional development. I would neither have been able to begin, nor complete this project without their unwavering support. The content of my work repeatedly reminds me of how immensely fortunate I am to have the life, friends and family that I do.

Finally, to the women who agreed to participate in this study: Thank you.
There is no guaranteed relationship between telling one's story and being healed by telling it, and there is much in these narratives that is not easy to tell, which makes the telling all the more generous and brave. Several women recalled the horrors of their physical and sexual abuse. Others recalled facing the death of their children and loved ones. These stories are important yet often go unheard. How fortunate that this research was organised, and that despite their complicated and demanding lives, these women made time to participate in a project that asked them to reveal so much of their deeply personal and painful histories. I will forever feel grateful to each of them for sharing their stories with me.

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Night brings out stars as sorrow shows us truths.

Philip James Bailey

CHAPTER 1: INTRODUCTION

1.1 Background

Major depressive disorder is the single most commonly occurring mood disorder in the world (Mazure, Keita, & Blehar, 2002; Schlimme, 2013). It exacts considerable personal and social costs (Hugo, Boshoff, Traut, Zungu-Dirwayi, & Stein, 2003; Kupfer, Frank, & Phillips, 2012) and has become one of the largest social and health problems of our time (WHO, 2006). Indeed, as described by Kazdin and Rabbitt (2013), "mental disorders are more impairing than common chronic medical disorders, with particularly greater impairment in the domains of home, social, and close-relationship functioning" (p. 171). The burden of depressive disorders (e.g., years of good health lost because of disability) has been ranked third in the list of mental and physical diseases (World Federation for Mental Health, 2011), and it has been projected that by 2030, depression will be the number one cause of disability, ahead of HIV/AIDS, traffic accidents, and cardiovascular and chronic pulmonary diseases (WHO, 2008).

The fact that there is a twofold greater prevalence of depressive illnesses in women than in men is similarly one of the most widely documented findings in psychiatric epidemiology (Kessler, 2003; Kohen, 2000; McMullen & Stoppard, 2006; Moultrie & Kleintjies, 2006; Ngcobo & Pillay, 2008; Noble, 2005). This gender difference is typical of South African populations too (Moultrie & Kleintjies, 2006; Olley, 2006; Stein, et al., 2008; Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009; Tomlinson, Swartz, Kruger, & Gureje, 2007). Highlighting the magnitude of the problem, the World Health Organisation (2006) has cited depression as the leading cause of disease-related disability among women in the world today. Research aimed at understanding depression in women seems therefore to be of utmost importance.

1.1.1 Women, poverty and depression

It has been estimated that women and children represent up to 70% of the world's poor (UNIFEM, 2010). The feminisation of poverty persists globally, as well as in South Africa, where women are more likely than men to be unemployed (Statistics South Africa, 2013), and when employed, generally earn less than men. While South Africa was categorised as a middle-income country in the United Nations Human Development Report (2006), it remains an extremely unequal society (de Villiers, 2011), in which a large proportion of the population exists in low-income communities. This is due mainly to the lasting effects of apartheid, which greatly contributed to the high levels of poverty among black, coloured[1] and Indian South Africans (Seekings, 2007).

Women in low-income communities are more likely to develop depression than women in middle- and high-income communities (Burdette, Hill, & Hale, 2011; Elliot & Masters, 2009; Havenaar, Geerlings, Vivian, Collinson, & Robertson, 2008; Levy & O'Hara, 2010). Poverty is thought to contribute to depression via its association with low self-esteem and agency, an increased number of stressful life events and chronic social adversity (Belle & Doucet, 2003; Moultrie & Kleintjes, 2006). The existing international and South African psychological literature strongly suggests that poor black and coloured women in particular are especially vulnerable to developing depression, with additional factors such as gender, race, class and motherhood all apparently increasing the risk of depression (Belle, 1990; Belle & Doucet, 2003; Kagee, 2008; Kehler, 2001; Kruger, van der Straaten, Taylor, Dukas, & Lourens, in press; Levy & O'Hara, 2010; Pillay & Kriel, 2006; Ramchandani, Richter, Stein, & Norris, 2009; Seekings, 2007; Stein et al., 2008; Tomlinson, Swartz, Cooper, & Molteno, 2004; Tomlinson et al., 2009; de Villiers, 2011).

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[1] I am mindful of the fact that the use of racial categories in South African scholarship is controversial. However, such categories are socially constructed and carry important social meanings. As such, I believe that it is impossible to conduct a meaningful analysis of my study findings within the context of post-apartheid South Africa without making reference to previous racial classifications, since these still inform existing power relations. In this paper, then, the category of "black" will be used to refer to those designated as African under apartheid racial classification, and the category "coloured" will refer to South Africans said to be of mixed racial origins.

1.1.2 Existing literature: Contributions and criticisms

Given the magnitude of the problem of depression, particularly for low-income women of colour, it seemed important to establish what researchers were doing in their attempts to conceptualise and understand the problem of depression in South African women. Thus, my Clinical Psychology Master's dissertation consisted of a critical literature review of the past decade of research on the topic of depression in South African women (Dukas, 2009). The South African literature on this topic was seen to be largely consistent with the international literature. Two theoretical models emerged as prominent in the current literary discussion of depression in women: the medical model and the psychosocial model.

Where medical models consider biological factors, social models consider social factors to be the cause of pathology (Mauthner, 1998). The diathesis-stress and biopsychosocial models move towards combining these two dominant perspectives by postulating that a person who is vulnerable to depression (via their biology, cognitive style or personality) may become depressed in response to stressful or unfavourable environmental or social conditions (Accortt, Freeman, & Allen, 2008). However, although these "combined" models were created with the intention of giving equal consideration to the different aspects of experience, in practice, they often prise biological over social or psychological aspects (Lafrance & McKenzie-Mohr, 2013). Such models therefore tend to remain "medical" because of their privileging of biology (Ussher, 2010). Overall, then, in literary discussions on the subject of depression, biological (specifically hormonal) explanations dominate.

Having reviewed the existing body of research on depression in South African women, a number of important problems pertaining to that research were identified (Dukas, 2009), as outlined briefly in the following paragraphs.

First, the vast majority of the research is situated within the medical framework and classifies itself as epidemiological. Epidemiology is the study of the distribution and determinants of health-related states or events in populations (Green, Freedman, & Gordis, 2000). While a plethora of epidemiological research on depression in women exists (see Table 1), only *one* nationally representative study (Stein et al., 2008) has recorded the lifetime prevalence of major depression (9.8%) in South Africa.

Second, it is difficult to determine the actual extent of the problem, because the smaller studies define and measure depression differently and thus report diverse prevalence rates (e.g. Bhagwanjee, Parekh, Paruk, Petersen, & Subedar, 1998; Cooper et al., 1999; Cooper et al., 2002; Cooper et al., 2009; Hamad, Fernald, Karlan, & Zinman, 2008; Manikkam & Burns, 2012; Naidoo & Mwaba, 2010; Nel & Kagee, 2013; Ngcobo & Pillay, 2008; Pappin, Wouters & Booysen, 2012; Peltzer & Phaswana-Mafuya, 2013; Peltzer & Shikwane, 2011; Pillay & Kriel, 2006; Rochat et al., 2006; Rochat, Tomlinson, Bärnighausen, Newell, & Stein, 2011; Stacey, 1999; Storkey, 2006; Theron, 2005).

Third, the language used in these epidemiological studies is typically misleading. For instance, researchers claim that they aim to "understand depression in African women" (Ngcobo & Pillay, 2008, p. 133) by describing prevalence rates or retrospectively studying patients' clinical evaluations – that is, by investigating the opinions of other health professionals rather than those of depressed women themselves. Their statement of intent thus blurs the distinction between a qualitative understanding of depression and a mere quantitative description of diagnostic categories and rates. Upon closer analysis, it appears that these epidemiological studies only achieve the latter.

Fourth, the majority of South African epidemiological research is conducted on low-income black women, usually during the postpartum period (e.g. Cooper et al., 1999, 2002, 2009; Tomlinson et al., 2004). This implies that these factors (poverty, race and/or the postpartum period) are implicated in the aetiology of depression, although studies are never designed to test such hypotheses. Further, due to insufficient research on other races/classes of South African women, it is impossible to know whether some populations of women are more depressed than others.

Fifth, whether measurement instruments have been validated for South African populations is often unclear. Indeed, measurement and conceptual inconsistencies create problems even within the framework of traditional epidemiology. It is problematic to assume that depression (as a construct) is transparent, experienced similarly, and measurable in the same way, irrespective of culture. Even if one assumes that depression exists globally, ample cross-cultural evidence suggests that it manifests differently in different cultures (Ngcobo & Pillay, 2008; Tomlinson et al., 2007). Additionally, some authors have suggested that the use of traditionally Western psychological approaches in South Africa is inappropriate (Ahmed & Pillay, 2004; Foster, 2008; Gilbert, 2006; Mkhize, 2008). They attest that psychological theories that were developed in first world contexts are unhelpful in our third world position of inequality, poverty and disempowerment. Lochner's (1999) study of depression in low-income South African female farm workers supports this argument, by showing that Beck Depression Inventory scores (i.e. professional opinion) do *not* always capture participants' subjective experiences and articulation of depression (as elicited through qualitative, semi-structured interviews). Lochner thus concludes that depression may manifest differently in different populations, and that the conventional medical model may not be relevant for the low-income South African population that she worked with.

Although frequently mentioned, these vital points are often disregarded in research designs. That is to say, that South African researchers often acknowledge the fact that different studies define and measure depression differently, that measurement instruments are not always validated for South African populations, and that it is possible that depression may manifest differently here. However, such acknowledgements do not seem to translate into how research is conducted and different types of (or potentially more appropriate) research designs are seldom used. Collectively, these multiple assessment and reporting problems make comparing South African and global depression rates impractical, and the resulting literature is likely to contribute to precarious definitions and knowledge production, and therefore may be constraining our understanding of depression in women. Criticisms such as these call for South African research to become more suitable by providing understandings of depression that are more contextually specific.

Table 1: Summary of the past decade of South African studies on the prevalence rates of depressive disorder, with analysis by race and gender where available, arranged in order of study size

Authors	**Population**	**Construct purportedly measured**	**Measures**	**Findings**
Stein et al. (2008)	4351 adults: Black 76.2% Coloured 10.4% White 10% Other 3.4%	"MDD"*	WHO Composite International Diagnostic Interview	Overall prevalence: 9.8% Prevalence female to male (1.78:1)
Peltzer and Phaswana-Mafuya (2013)	3,840 adults over age 50 (55.9% women): Black 74% White 9.3% Coloured 12.8% Indian or Asian 3.8%	"Depression"	WHO Composite International Diagnostic Interview	Overall prevalence: 4.0% No analysis by race or gender
Stacey (1999)	2100 patient records (50% female) from three public psychiatric hospitals	"MDD; Dysthymia; BMD"**	Archival/retrospective study	Women: MDD 17% Dysthymia 3.7% BMD 20.5% Men: MDD 2.5% Dysthymia 0.7% BMD 11%
Pappin et al., (2012)	716 HIV+ adults (75.7% female) Black 98.4%	"Symptoms of anxiety and depression"	Hospital Anxiety and Depression Scale	30.6% anxiety 25.4% depression No analysis by race or gender
Peltzer and Shikwane (2011)	607 postnatal, HIV-positive women: Black 98% Other (2%)	"MDD"	Edinburgh Postnatal Depression Scale	Women: 45.1%
Cooper et al. (2009)	449 women at 6- & 12-months postpartum	"MDD; Postnatal Depression"	Structured Clinical Interview for DSM-IV diagnoses and Edinburgh Postnatal Depression Scale	Women: 18% No analysis by race
Pillay and Kriel (2006)	422 female outpatients: Black 38.6% Indian 31.8% White 16.4% Coloured 11.8%	"MDD"	DSM-IV checklists	Women: 19% No analysis by race
Manikkam and Burns (2012)	387 pregnant women	"MDD"	Edinburgh Postnatal Depression Scale	Women: 38.5% No analysis by race
Hamad et al. (2008)	257 adults	"Significant elevation in depressive symptoms"	Centre for Epidemiologic Studies Depression Scale	Women: 64.5% Men: 50.4% No analysis by race or gender

Table 1: Continued

Rochat et al. (2006).	242 pregnant women (undergoing HIV testing) during antenatal & postnatal periods	“Depressive symptoms”	Edinburgh Postnatal Depression Scale	Women: 41% No analysis by race
Naidoo and Mwaba (2010)	166 adults with TB (84 women, 82 men)	“MDD”	Beck Depression Inventory	Overall: 64.3% No analysis by race or gender
Cooper et al. (1999)	147 women at 2-months postpartum	“MDD”	Structured Clinical Interview for DSM-IV diagnoses	Women: 34.7% No analysis by race
Rochat et al. (2011)	109 “low-income” pregnant women	“MDD”	Clinical interview (DSM-IV checklists	Women: 47% No analysis by race
Nel and Kagee (2013)	101 HIV+ adults (83 women, 18 men) Language (no racial) classification: Xhosa 55.4% Afrikaans 31.7% Other 12.9%	“Depression and anxiety”	Beck Depression Inventory Beck Anxiety Inventory	40.4% depression 28.7% anxiety No analysis by race or gender
Bhagwanjee et al. (1998)	65 women; 16 men	“MDD; Dysthymia; MDD plus dysthymia”	Clinical interview (DSM-IV checklists)	Overall: MDD 4.8% Dysthymia 7.3% MDD + dysthymia 8.2% Weighted prevalence of MDD: Women 16.8% Men 6.3% No analysis by race
Theron (2005)	61 women attending clinics	“MDD”	Archival/retrospective study (DSM-IV criteria)	Increasing prevalence of depression recorded
Ngcobo and Pillay (2008)	54 inpatients’ (81% female) records: Black 94% Indian 4% White 2%	“MDD; Dysthymia; MD plus psychotic symptoms”	Archival/retrospective study (DSM-IV criteria)	MDD 42.5% Dysthymia 16.6% MDD plus psychotic symptoms 5.5% No analysis by race or gender
Cooper et al. (2002)	32 women at 6-months postpartum	“MDD”	Structured Clinical Interview for DSM-IV diagnoses	Women: 19% No analysis by race or gender
Storkey (2006)	30 women during & after pregnancy	“Depressive symptoms”	Beck Depression Inventory	Women: 60% (No difference in rates of depressive symptoms during and post-pregnancy)

*MDD – Major Depressive Disorder

**BMD – Bipolar Mood Disorder

Source: Carla Dukas

While most research on depression does not closely attend to the precise voices and lived experiences of people who have been diagnosed with the condition (Allan & Dixon, 2009), some studies do. A small number of international researchers have sought to augment their "clinical" understanding by conducting phenomenological studies with individuals who have a lived experience of depression. Rhodes and Smith (2010), for instance, recently conducted a phenomenological case study with one man who had been diagnosed with depression. Themes of negative memories, failures and catastrophic views of the present and future were prevalent. Hedelin and Jonsson (2003) similarly used a phenomenological approach to collect experience-based and person-centered descriptions of depression from 21 elderly women. They found that the women's experiences of mental health or depression were heavily influenced by their sense of value and self-esteem in relation to themselves and others. In particular, the experience of mutuality, which the authors defined as "interdependence and influence in the relationships with others and the view of self" (Hedelin & Jonsson, p.318) was central to their findings and thus new understanding of depression. Allan and Dixon (2009) also conducted a phenomenological investigation into the experience of depression in elderly women and similarly found that depression was implicated in a sense of failure and self-loathing, which causes one to withdraw from relationships and consequently feel alone and isolated. Likewise, Jack (1991) and Leibrich (1997) previously conducted research on the experience of depression from the perspective of women and found that negative self-evaluation by women caused a drop in self-esteem, social isolation as well as anger that was directed at the self. The phenomenological study by Powell, Overton and Simpson (2013) showed yet another perspective of the lived experience of depression. Along with themes of hatred, anger, shame and sadness, the female participants in their study spoke about a sense of self-disgust as being intrinsic to their overall experience of depression. The findings of each of these international phenomenological studies on depression suggest that there is more to the experience and understanding of depression than traditional clinical descriptions suggest. Further still, they highlight the dire lack of South African studies of the same nature.

Like phenomenological studies, feminist studies on the subject of depression in women have contributed entirely different perspectives to those provided by mainstream or epidemiological researchers. In agreement with numerous feminist authors, Lafrance and McKenzie-Mohr (2013) write: “The Diagnostic and Statistical Manual of Mental Disorders (DSM) offers a biomedical framing of people’s experiences of distress and impairment, and despite decades of criticism, it remains the dominant approach” (p. 119). These authors attribute some of the DSM’s dominance to the powerful pharmaceutical industry, noting that medical and psychological research into depression is often funded by pharmaceutical companies who stand to benefit from the popularisation of the idea that depression is a biological condition which can be treated with medicine. Unsurprisingly then, the vast majority of South African and international psychological studies on depression are informed by the tenets of the medical model (and thus subscribe to the DSM), which has, in turn, caused both professional and public opinion on depression to focus largely on biological explanations (Johansson, Bengs, Danielsson, Lehti, & Hammarstrom, 2009; Lafrance & McKenzie-Mohr, 2013). International authors, McMullen and Stoppard (2006) similarly attribute this world-wide phenomenon to clinical psychology’s reliance on individualist conceptions and the recent demands for evidence-based health care. In the same vein, Fee (2000) argues: “the pervasive viewpoint is that the only way that mental illnesses can be recognised as ‘real’ – and hence worthy of funded research, insurance coverage, rigorous study… is when they are anchored in the language of bio-physiology” (p. 1).

As a result, context-specific and feminist-informed understandings are almost completely absent in mainstream accounts of depression in women, both internationally (Stoppard, 2010) and in South Africa (Dukas, 2009; Rapmund & Moore, 2000). In particular, there is a lack of socio-political analyses and no exploration of the power relations within which depression in women might occur. A paper by Ussher (2010) published in the influential feminist journal, *Feminism & Psychology*, states: “We do need to question the increasing medicalisation of misery in the West, in particular the way in which women who experience mild distress or understandable problems with everyday life are defined as having a mental disorder ‘depression’” (p. 24). That is to say, feminist writers contend that when depression is located only within women’s bodies and hormones, it is less likely that other explanations are considered, such as the effects of social, economic and political contexts on women’s mental health (Hornstein, 2013; Kruger et al., in press;

LaFrance, 2009; LaFrance & Stoppard, 2006; Lafrance & McKenzie-Mohr, 2013; Liebert, 2010; Stoppard, 2000; Ussher, 2010).

The fact that these critical perspectives are seldom heard or heeded does not imply that they are new. On the contrary, feminist informed perspectives on women's mental health emerged in the 1960s (Evans, Kincade, Marbley, & Seem, 2005). For instance, a feminist paper written over twenty-five years ago (Rose, 1988) criticised the biological preoccupation that surrounds the discussion of women's mental health, and argued that the process of medicalisation has a two-fold consequence: economic growth through health-seeking actions (the demand for anti-depressant medication increases) and the silencing of women.

Today, the primary relational and discursive feminist critique remains that the medical focus in women's mental health research serves to divert attention away from the actual lived experience of depression and the different social contexts within which women become depressed (Lafrance & McKenzie-Mohr, 2013). These authors therefore choose to explore women's lived experiences of depression and highlight the shortcomings of reductionistic, biological explanations (Jack, 1991; Lafrance & Stoppard, 2006; MacKay & Rutherford, 2012; Stoppard, 2000; Stoppard & McMullen, 2003). In so doing, they draw attention to the contextual factors that permeate women's stories of their experiences of depression.

Although the abolition of apartheid in South Africa did much to improve the social standing and morale of the population, black and coloured women in particular still bear the scars and continue to face double oppression in a patriarchal society by being both female and black (Field & Kruger, 2008). This increases their vulnerability to mistreatment, neglect or abuse, and increases the likelihood of their continued silence. Unsurprisingly then, and as previously stated, most published South African literature on the topic of depression in women concentrates on expert perspectives and opinions, with a predominant focus on postnatal depression (Dukas, 2009). Few published studies in South Africa consider depression in women from the perspective of depressed women themselves (Rapmund & Moore, 2000), and even fewer consider the perspectives of low-income women. As a result, low-income women living with depression in South Africa have seldom had the opportunity to have their voices heard or their opinions considered in published studies. By extension, these women have not been afforded the opportunity to partake in decision-making processes regarding the treatment and prevention strategies that are aimed at alleviating the problem of depression in women. That is, they have not been afforded a role in the decision-making procedures that concern them. As succinctly stated by P. Reid (1993), poor women are usually “shut up and shut out” of mainstream psychological research and theory. In agreement with critical feminist researchers, I contend that hearing what these women have to say about their lives and experiences is of utmost importance, and further, that they ought to be given a voice in representing themselves, particularly in the literature and policies that are written about or directed at them.

1.2 Study context

The current study forms part of a larger multi-site, longitudinal research project that is concerned with low-income women’s mental health. The Women’s Mental Health Research Project was launched in 2001 by Professor Lou-Marie Kruger of the Psychology Department at the University of Stellenbosch. While this project was initially concerned with the subjective emotional experiences of low-income South African mothers in general, the focus shifted to depression in 2009. Similar to the study presented here, a number of other researchers (e.g. see Appelt, 2006; de Villiers, 2011; Kruger et al., in press; Lochner, 1999; Lourens & Kruger, 2013; Spies, 2001; Storkey, 2006; Taylor, 2011) have worked under Professor Kruger’s supervision to complete Honours, Masters and Doctoral dissertations based on interviews with low-income women from various communities in the Western Cape Province of South Africa. The entire project is built on the belief that the subjective experiences of low-income women who have received psychiatric diagnoses need to be documented and analysed more frequently in the literature, and further, that researchers ought to attend to the contexts within which these women are seen to become distressed.

At this juncture, it might be helpful to provide some more information about how it came that I embarked on this particular research project. In 2011 I was stationed as Community Psychologist for the Cederberg Municipality of the Western Cape Province. The Cederberg Municipal area covers 8,007 square kilometers (Cederberg

Municipality Draft, 2012), and contains a number of small rural and semi-rural communities, most of which are poor and suffering from a vast array of social problems. I was assigned to service five rural government clinics in this area. While people of all ages, genders and problems came to the clinics for psychological help, the majority were low-income women who presented with either a current or previous diagnosis of depression.

Having previously argued for the need for feminist and phenomenological studies of depression in low-income South African women (Dukas, 2009), I began to think that it would be hypocritical of me – as someone who was equipped and able to carry out such research – to ignore my own call for research on the types of South African communities that I was now involved with on a daily basis. Additionally, meeting so many women with diagnoses of depression reminded me of the magnitude of the problem. Increasingly I began to realise the vital necessity and potential value of research that investigated and highlighted these women’s problems and concerns. I thus consulted with my previous supervisor, Professor Kruger, who subsequently agreed to supervise the current research project.

1.3 Problem statement, goals and research questions

1.3.1 Problem statement and study rationale

According to mainstream psychology, depression is easily diagnosed with the use of checklists and basic clinical interviews. However, ample evidence indicates that there is more to a depressed state of mind than is typically detected by these somewhat superficial approaches, especially from the experiencing person's perspective (Hornstein, 2013; Schlimme, 2013; Stoppard, 2000; Ussher, 2010). It is therefore probably both unwise and problematic to continue to subscribe to the existing conceptualisation of depression, without at least testing its veracity and applicability to different populations and contexts.

It is also particularly problematic that many studies do not carefully consider the impact of social context or listen and give credence to women’s own accounts of their lived experiences of depression. Seekings (2007) wrote that rural black South African women are regarded as the population group that is most susceptible to poverty and its corresponding mental health problems. However, it would appear that the psychological research on this group of women is limited. Specifically, there is a marked paucity of research that focuses on the complexity of poor women's lives by considering how the contextual factors of age, race, gender and social class might influence and shape their experiences. The lack of research on these aspects of experience results in a psychological knowledge base that is grossly inadequate.

Therefore, this thesis is built on the assumption that the current conceptualisation of the medical diagnosis "depression" may not fully capture low-income women's emotional experiences of distress, and further, that such partial or misguided conceptualisations may actually serve to pathologise individual women while simultaneously obscuring the possible impact of socio-economic and political contexts on their mental health. It therefore seems necessary to acquire more fine-grained descriptions of the lived experience of depression, considered in the context of gender, race and class, particularly from the perspective of low-income South African women themselves. Such research is sorely needed in order to improve our knowledge base so that we can make more valuable and helpful contributions to future policies, research strategies and interventions.

1.3.2 Goals and research questions

Given the above, one of the primary ambitions of the current study is to respect the original intention of phenomenological investigations (see Husserl, 1970; Merleau-Ponty, 1962) by gathering data that pays attention to how women who have been diagnosed as "depressed" personally describe and make sense of their own lived experiences. A second, (though no less important) ambition of this study is to draw attention to the contextual factors that permeate the women's stories.

The study will therefore endeavor to provide a phenomenological *description* of the findings pertaining to the subjective experience of depression in low-income women, and not a deep *analysis* thereof. Achieving a broad overview or description of depression is both a necessary and logical place to start if we are earnest in our ambition of moving towards new understandings and conceptualisations of the phenomenon.

In more concrete terms, the first goal of this study is to carefully describe the experience of depression from the subjective perspectives of one group of low-income, rural South African women who have been diagnosed as depressed, while remaining cognisant of the contexts within which they became distressed. The second goal of this study is to consider the findings in light of both the extant feminist and epidemiological literature on the subject of depression in women.

Inherent to these goals is the resolve to make low-income women and their diverse experiences visible in scientific literature. Similarly, in line with most qualitative and feminist research studies, this project also has "empowerment as research goal" (McLeod, 2003, p. 72). This necessitates an awareness of the "social and political implications of the research, accompanied by a commitment to using the research process to benefit the research participants" (McLeod, 2003, p. 72).

Towards achieving these goals, the central research questions being asked are:

- How does one group of low-income South African women who have been diagnosed with depression subjectively experience, describe and make sense of their emotional distress?

- How might these descriptions be considered in the light of the existing epidemiological and feminist literature on the subject of depression in women?

It has been argued that a counter hegemonic perspective on the topic of depression in low-income women is imperative. Thus, this study aims to bring traditionally overlooked perspectives and subjective experiences of depression to the fore. This ambition is facilitated by a feminist phenomenological approach, a qualitative research design, a semi-structured interview schedule, and Interpretative Phenomenological Analysis (IPA) methods of data analysis. It was thought that this research strategy will enable me to acknowledge the women's cultural and social situatedness while giving primacy to their personally lived experiences.

1.4 Organisation of the dissertation

This study forms part of an ongoing investigation that began with a review of the current psychological literature on the topic of depression in South African women (Dukas, 2009). The research document presented here is comprised of five chapters. Chapter 1 commences with an introduction for the present study. This is followed by a description of the study context, problem statement, rationale, research goals and questions. A brief outline of the subsequent chapters then ensues.

Chapter 2 provides the theoretical framework of the study. Phenomenology is first explained and presented as one of the study's guiding theoretical perspectives. A discussion on feminisms ensues, before describing the study's ultimate adoption of the feminist phenomenological perspective. The chapter will contain a brief overview of feminist phenomenological perspectives on psychiatric diagnoses in general and the concept of depression (as it is used in this study) in particular.

Chapter 3 reiterates the aims of the current project and then details the methods employed towards achieving those aims. Information on the study's methodological positioning, design, participants, data collection and analysis will be discussed. Special focus will be given to the IPA methods of data collection and investigation. Finally, ethical issues and matters of personal reflexivity will be considered.

After a brief introduction to the study participants, a presentation and discussion of the data will be presented in Chapter 4. Specifically, the major themes that emerged from the raw data will be described and then discussed in light of the extant literature in the field.

Chapter 5 provides a brief summation of the study's findings. The limitations and challenges of the study will be considered before offering possible suggestions for future research and intervention. Finally, concluding remarks and my reflections as the researcher in this study will be shared.

CHAPTER 2: THEORETICAL FRAMEWORK

2.1 Introduction

Epistemologists remind us that all research is conducted (that is, all knowledge is produced) via a particular theoretical framework or point of departure. Specifically, theoretical frameworks act as lenses that influence the knowledge that is created, by simultaneously attending and not attending to different aspects of the phenomena under investigation (Terre Blanch & Durrheim, 1999). This chapter documents the theoretical perspectives that influenced my thinking about the current research study, from my choice of topic and methodology, to my ways of understanding and presenting the findings.

The theoretical framework of feminist phenomenology was chosen for this study. Both feminism and phenomenology are considered influential in the psychological study of women (Cosgrove, 2003). It is impossible to provide a comprehensive review of these theories here, owing to their complexity and volume. Rather, the basic concepts and assumptions that have particular application to the current study will be considered. The chapter therefore begins by providing broad introductions to the fields of phenomenology and feminism, including their respective theoretical influences in the field of psychology. A more detailed discussion of feminist phenomenology ensues. The chapter concludes after attending to feminist critiques of psychiatric diagnoses as well as the practical and theoretical implications of the use of the diagnostic term “depression” in this study.

2.2 Phenomenology

Edmund Husserl is considered to be the founder of phenomenology, which arose in Western Europe during the 20th century as a philosophical orientation that was concerned with elucidating the purely subjective aspects of conscious experience (Finlay, 2008; Giorgi, 2012; Kendler, 2005). Husserl considered consciousness to be the “medium between a person and the world” (Giorgi, 2012, p. 9), and believed that phenomenological questions should include “What is this kind of experience like?” and “What does the experience mean?” (Finlay, 2008). Through such questions, the phenomenological researcher would endeavour to provide a rich and nuanced description of a particular lived experience. The researcher's task, according to Husserl (1970), was to "return to the things themselves", where "things" referred to the world of lived experience.

Today, phenomenology is still identified primarily as a philosophical movement, but it has evolved to include many theoretical and research approaches, including sociology, ethnology, philosophy and psychology (Fisher & Embree, 2000). Consequently, there are many different branches of phenomenology, and as such, it is best thought of as a set of guiding ideas and principles rather than as one specific outlook or method. Some general concepts that are central to phenomenology (including life-world, intentionality, perspectivity and bracketing) will be briefly expanded upon, for the purposes of better understanding the theoretical perspective as it pertains to the current paper.

One of the key concepts of phenomenology is life-world – Husserl's (1970) *Lebenswelt*. The life-world consists of the world around us, as we perceive it, as well as our qualitative experience of our self and our personal encounters. Husserl described the life-world as pre-reflective, as it takes place before we think or speak about it. The term life-world is thus used to direct attention to a person's lived experience and real social context, rather than to their inner world of introspection (Finlay, 2008). As explained by Merleau-Ponty, "There is no inner man [sic], man is in the world, and only in the world does he know himself" (1962, xi). The overall aim of life-world (i.e. phenomenological) research is thus to describe and explain the lived world in a way that increases our understandings of human experience.

A second key concept and focus of phenomenological investigation is intentionality. Husserl (1962) was of the opinion that consciousness is intentional; it is always conscious of something other than itself. When we become conscious of something (an object), it takes on meaning and we are positioned in relation to it. Thus, subject (us) and object are united in mutual co-constitution. The term for this phenomenological concept is "intentionality" (Finlay, 2008). The phenomenological researcher aims to explain this intentionality because it pertains to what the participant is experiencing and how. In other words, attention is paid to the intentional relationship between the participant and her evaluation of the thing she is focusing on or experiencing. For example, one significant finding in the current paper on women's lived experiences of depression, was that many of the participants were concerned about the impact that depression had on their relationships with others. The intentional, embodied relationship between the women and their partners, peers and children was thus highlighted.

Traditionally, pure phenomenology sought to describe rather than explain, and aimed to start from a perspective that was free from preconceived ideas (Husserl 1970). Husserl later revised this idea, stating that although a large part of phenomenology is descriptive, there are phases where interpretation also takes place. As described by Giorgi (2012) "Phenomenology does not dictate to phenomena but rather it wants to understand how phenomena present themselves to consciousness and the elucidation of this process is a descriptive task" (p. 6). This is in agreement with the beliefs of critical and feminist researchers who absolutely refute the possibility of working without preconceptions or bias, and claim that researchers should rather view themselves as interested and subjective actors in their projects, and disclose how various interpretations and meanings are positioned within their research (Lester, 1999). Thus, another central concept in Husserl's phenomenology is perspectivity, which speaks to the fact that we as researchers never have a "bird's eye view" of anything; we always conduct our investigations or analyses from a particular point of view. It is for this reason that researchers should remain reflexive and aware of their own perspectives and biases (Giorgi, 2010; Husserl, 1970; Røseth et al., 2011).

Perspectivity, however, does not negate the phenomenological practice of "bracketing". Husserl (1962) and Merleau-Ponty (1962) advised withholding existential consent. This means that researchers should refrain from automatically assuming that the phenomenon under their investigation exists. Today, this practice in phenomenology has come to be known as bracketing, and is performed in order to reduce bias and to allow new meanings and understandings to emerge. In practice, bracketing involves consciously attempting to suspend taken-for-granted assumptions when studying a specific experience or phenomenon (Finlay, 2008; Giorgi, 2012; Røseth et al., 2011). While gathering and analysing phenomenological data, the phenomenological researcher adopts an open stance and tries to see the world differently – freshly – while attending closely to the participants' views (Finlay, 2008). The intention is to allow the phenomenon to emerge, without imposing preconceived ideas on it. As elegantly summarised by Wertz (2005): "Phenomenology is a low-hovering, in-dwelling, meditative philosophy that glories in the concreteness of person-world relations and accords lived experience, with all its indeterminacy and ambiguity, primacy over the known" (p. 175). This practice allows phenomenological approaches to yield new ways of understanding subjective experience while gaining insights into people's behaviours. Bracketing therefore helps researchers to cut through the hegemony of taken-for-granted assumptions (Lester, 1999). In the current paper, this implies that we disregard our previously learned theories and preconceptions of depression in favour of remaining open to discovering women's lived experiences of emotional distress.

"The phenomenological method is generic enough to be applied to any human or social science—sociology, anthropology, pedagogy, etc. The only difference is that one assumes the attitude of the discipline within which one is working" (Giorgi, 2012, p. 11). Thus, a number of diverse phenomenological methods exist in the dynamic field of phenomenology today (Finlay, 2008; Schlimme, 2013). Finlay (2008) briefly explains the variants of the phenomenological research method, including: the heuristic approaches (which focus on the researcher's role in self-reflection towards producing an understanding and explanation of lived experience); the relational approaches (which focus on how data develops out of researchers and co-researchers' dialogical encounters); and the hermeneutic approaches (which highlight the researcher's role and interpretations, for example, IPA, which is used in the current study). What all these variations of phenomenology have in common is a focus on *describing* lived experience and acknowledging the importance of one's intersubjective life-world. They all therefore aim to gather "deep" information by using inductive qualitative research methods, and then represent that information from the perspectives of the research participants themselves (Finlay, 2008).

2.2.1 Phenomenology and psychology

Mainstream psychology was originally heavily influenced by phenomenology (Giorgi, 2010). Ludwig Binswanger (1881-1966, as cited in Schlimme, 2013) for instance, became one of the founding fathers of phenomenologically informed psychopathology and psychiatry, and produced meticulous descriptions of depressed ("melancholic") states. Binswanger was deeply influenced by Edmund Husserl (1859-1938), Martin Heidegger (1889-1976) and Sigmund Freud (1856-1939). While his descriptions of melancholy were influential in the 1960s and 1970s, they have not been used in recent years (Schlimme, 2013). Thus, although the phenomenological approach was once part of the development of mainstream psychology, it is now "perceived to be a minority movement; [and] as a marginalized perspective it is, in fact, rarely properly understood" (Giorgi, 2010, p. 147).

While phenomenology and psychology have influenced each other for well over a hundred years, it still remains unclear as to exactly how the two disciplines concern each other. Giorgi offers "part of the problem is that both disciplines have developed complexly with competing, not easily integratable perspectives" (p. 145). Furthermore, although the term "phenomenology" originally reflected the early psychiatrists' desire to gain an understanding of a disorder from the patient's point of view, it has come to be associated with the symptoms as seen from the professional's perspective, namely the clinical manifestations of an illness (Tomlinson et al., 2007). This is confirmed by Lupton (1995), who argues that many medical researchers pay scant attention to the subjective experiences of people affected by illnesses:

> The ways in which people dealt with illness or disease, how they felt about their body and its ills, their relationship with the medical profession and other healthcare givers, their experience of treatment, were aspects of the medical encounter which were little explored. (p. 80)

Today, although reduced to a minority perspective in the vast field of psychological research, *true* phenomenological psychology remains primarily concerned with fully capturing first-person accounts in order to determine the essential features of a lived experience (Langellier, 1994; Schweitzer, Griffiths, & Yates, 2012). The two main challenges for today's phenomenological researchers are: how to facilitate participants' direct expression of their experiences, and how to present those expressions in valid and useful research documents (Finlay, 2008). This challenge is met in part by the researcher's attempt to bracket or put aside her prior assumptions, so that she remains receptive to the phenomenon however it presents itself. As discussed above, this bracketing process is often misconstrued as being an attempt to be totally unbiased, when in fact it is simply an attempt to be open to new ideas and understandings.

It should be noted that the phenomenological approach to psychology does not exist without criticism. As phenomenological researchers deliver verbal reports in their attempts to describe the phenomena under their investigation, most objections centre around this and the question of reliability (Giorgi, 2010). It becomes a convoluted discussion with advocates on both sides of the dispute. As explained by Giorgi (2010), in psychology:

> The issue comes down to the fact that when one describes one's own mental processes, no one else can check the description. With the description of a transcendent object, others are able to check the validity of the description. But of course, they check the description of the transcendent object with conscious processes. However, since the object is public, there is acknowledgement that agreement is in principle possible. Reflection on one's own mental processes is available only to the experiencer. This is the basis of most objections. (p. 171)

Another, perhaps lesser problem with the phenomenological approach to psychological research is that it generates a large quantity of data (from audio recordings, interview notes, observations etc.), all of which have to be transcribed, coded and analysed. The analysis itself is also necessarily chaotic, as phenomenological data does not usually fall into neat categories (Lester, 1999). This makes phenomenological studies time-consuming and labour-intensive.

On the other hand, there are many clear advantages to using a phenomenological approach in psychological research. Giorgi (2012) explains his proclivity towards this approach as being based on his desire for a non-reductionistic way of studying "the whole person and not fragmented psychological processes" (p. 3). Finlay (2008) adds that good phenomenological research emphasises the intricacy and ambiguity of participants' experiences. Additionally, and as previously mentioned, phenomenological methods are particularly effective in capturing and documenting the subjective experiences of people, and therefore in challenging structural or normative assumptions (Lester, 1999). Specifically, by adding an interpretative dimension to phenomenological research and using it in the creation of theory, phenomenology can inform, endorse or contest existing policies and knowledge (Lester, 1999). IPA is employed in the current study towards this end, and will be discussed in greater depth in Chapter 3.

Despite the obvious value that phenomenological methods offer to psychological research, the South African literature shows a marked paucity of phenomenological studies in general, and a lack of phenomenological studies of depression in women in particular. This implies that the meaning and experience of depression from the female standpoint has been largely neglected in the past decade of South African literature (Dukas, 2009; Lochner, 1999; C. Newman, 2005; Ngcobo & Pillay, 2008; Rapmund, 1999; Tomlinson et al., 2007). Hence, one of the primary ambitions of the current study is to respect the original intention of phenomenological investigations by carefully observing and constructing a representation of the experience of depression from the subjective perspectives of depressed women themselves. However, due to my own subscription to feminist ideals and to the fact that the study participants emerged from one of the most disempowered sectors of the population, it was decided that the most appropriate theoretical orientation for the current project would be both phenomenological and feminist. The central tenets of feminist phenomenology will thus be considered in the following sections.

2.3 Feminisms

A plurality of meanings and definitions has been applied to the word “feminism”, leading theorists and scholars to rather refer to the term “feminisms” (Campbell & Wasco, 2000). In its broadest sense, however, feminism can be considered an intellectual and political movement that is committed to challenging the socially and politically entrenched positions of gender inequality which disempower and subordinate women via traditional practices and attitudes (Russell, 1996; Shefer, 2008). More specifically, feminism is concerned with changing perceived patriarchal, racist societies into those that are egalitarian, founded on mutual respect and collaboration and the fair distribution of power, resources and responsibilities (Evans et al., 2005; Finchilescu, 1995).

2.3.1 Feminisms and psychology

The basic premises of feminist psychology are that the personal is political (Hanish, 1970); that psychological suffering is linked to social, economic and political contexts; and that there is no lasting individual change without social change (Evans et al., 2005; Marecek & Gavey, 2013). Feminist-informed psychological counselling and research strategies emerged from the social change movements of the 1960s (Evans et al., 2005). In particular, impetus for feminist-informed research strategies came from the observation that studies on women tended to evaluate their characteristics and abilities “against the male norm and differences were constructed as deviant or deficient in comparison” (de Villiers, 2011, p. 23). Early feminist researchers in psychology began to rethink the guiding assumptions and methods involved in their research. While many different types of feminist psychological research have evolved, all are essentially designed to “seek social justice, to enhance women’s voices and influence in society, and to explore alternative ways of understanding the world through women’s experiences” (Harding, 1987; Baker, 2006, as cited in Gergen, 2008, p. 280). Feminism is thus better understood as a perspective on research rather than as a research method per se.

The different varieties and styles of feminist research are due in part to the theoretical variations contained under the umbrella term “feminist”. For instance, the two polarised positions on feminism, feminist empiricism and feminist standpoint theory, contain fundamental epistemological differences, which in turn guide the nature and type of feminist research that is performed (Cosgrove, 2003). Research conducted from the feminist empiricist approach, for example, tends to be quantitative in nature, as it employs traditional, positivist assumptions, designs and methods (Gergen, 2008). This approach attempts to prove that there are no essential differences between the abilities or experiences of men and women, and thereby aims to support the value of equality between the sexes. Although there are advantages to the feminist empiricist approach (see Cosgrove, 2003), it has been criticised for not studying people in context, for not solving "real life" problems, for objectifying research participants, and for not actually being successful in its attempts to change gendered stereotypes.

The feminist standpoint theory, in contrast, is informed by a postmodern epistemology. It therefore challenges the validity of traditional, scientific, positivist research methods and prefers to use a variety of qualitative methods to study individual experiences and reflect on personal subjectivity (Gergen, 2008). The current study's feminist phenomenological orientation has been influenced by the same postmodern epistemological perspective as standpoint feminism, as will be illustrated in the following section.

2.4 Feminist phenomenology

The potential significance and compatibility between phenomenology and feminism has only recently begun to be explored. Fisher and Embree (2000) believe that this is due to the assumed incompatibilities between the two schools of thought. For instance, feminists are critical of many of the philosophical schools of thought and resulting theories (including phenomenology) that were originally developed by male thinkers, claiming that those ways of thinking are guilty of male bias. However, Fisher and Embree (2000) point out that this "sense of fundamental incompatibility often precludes any exploration of a potential relation" (p. 18) and go on to argue that the feminist charges that phenomenology contains a male bias can be easily disarmed. Other authors similarly attest that there is in fact tremendous scope for the two perspectives to join in an advantageous union, in the form of feminist phenomenology. To quote Langellier (1994):

> Phenomenology and feminism mutually inform and enrich each other. Feminism encourages the situation of phenomenological analysis of women's lived experiences within the social differences unavoidable in a society built upon inequalities. Phenomenology cautions against merely imposing feminist interpretations on women's lived experience. (p. 72)

In more recent work that is directly applicable to the current study, Fisher (2010) provides a concise answer to the question "Why use phenomenology and feminism to study depression in women?"

> Each component contributes something vital, which enhances the possibilities of both. Phenomenology can provide the style for an analysis which retrieves and retains the immediate, vibrant, tangible, and compelling lived experience, and enables our understanding of the phenomena and meanings of this lived experience and situation; while feminist thought and analysis can expand and deepen phenomenological investigation by recalling and insisting on the importance of the lived context, and the multiple aspects, particularities, and dynamics of the social and cultural world, of social and political being in that world, and the necessity of a phenomenological analysis and framing of these phenomena. In this manner, the enhanced presence and timbre of the feminist voice in phenomenology, and the phenomenological voice in feminism, can bring forth the clear and distinctive tones of the feminist phenomenological voice. (p. 94)

Similarly, Garko (1999) highlights a number of reasons why phenomenological studies (particularly those involving female participants) are methodologically compatible with the salient values and principles that underpin feminist theory. Specifically: investigating and understanding the everyday world of women's lived experiences is paramount to feminist and phenomenological studies alike; both feminist and phenomenological orientations are committed to openness, description, and understanding; and both denounce the assumption that absolute objectivity is possible, or that a true subject-object dichotomy can exist.

My adoption of a feminist phenomenological position in the current study was due in part to my personal alignment with the many feminist researchers who suggest that the uncritical acceptance of individualistic, biomedical explanations of depression tends to dismiss inconsistent findings and gaps in knowledge while simplifying the complexity of women's experiences (Jack, 1991; Lafrance & Stoppard, 2006; Stoppard, 2000; Stoppard & McMullen, 2003). These researchers point out that in the field of psychiatry, women are commonly regarded as more susceptible to mental disorders during times of hormonal change, such as menstruation, after childbirth and around menopause, despite the lack of conclusive evidence to this end (White, 2002). Ussher (2010) labels such research “reductionistic” because it positions women as victims of their biology and detaches them from other possible political, economic or social explanations for their illnesses (Hare-Mustin & Marecek, 1990; Inhorn & Whittle, 2001). Similarly, Greenspan (1993) argues that the traditional medical model tends to encourage women to seek individual solutions to many health problems that might be better solved by social or collective means, and in that way, subtly maintains their socially disempowered status.

From its inception, feminist phenomenology has been dedicated to basing a new area of study on women’s own understandings and interpretations of their experiences (Fisher & Embree, 2000). Feminist research conducted from this position seeks to understand a phenomenon (for example, depression) from the perspective of the individual rather than from that of the medical or social “expert” (Gergen, 2008; Stoppard, 2000). By deviating from the traditional methods of thinking about and conducting research, the present study therefore intends to contribute to the existing body of knowledge of depression in low-income South African women by seeking out different perspectives and understandings of the topic.

The research project presented here involves a population group that is subject to the third-world contextual challenges of poverty, sexual discrimination, disempowerment and gross socio-economic and racial inequality (Field & Kruger, 2008; Kaminer & Eagle, 2010; Russell, 1996). As has been explained, the feminist perspective acknowledges power differentials and pays close attention to culture, context and language (P. Reid, 1993), while the phenomenological perspective is sensitive to each person’s unique lived experience (Langellier, 1994). Together, feminist phenomenology concerns itself with starting from women’s lived experiences while offering contextually sensitive mechanisms for understanding South Africa’s unique social environment. As such, feminist phenomenology is particularly well suited to the ambitions of the current study; that is, to exploring the subjective, lived-experiences of low-income women who have been diagnosed with depression.

2.5 A feminist critique of psychiatric diagnoses

Feminist psychologists and researchers have cited numerous reasons for eschewing traditional psychological assessment and diagnostic procedures (Lafrance & McKenzie-Mohr, 2013; Marecek & Gavey, 2013; Swartz, 2013), the most fundamental of which will briefly be summarised here.

Firstly, feminist writers point out the fact that there exists a long history of traditional theoretical orientations pathologising femininity and diagnosing "difficult" women (Swartz, 2013; Ussher, 2013). That is, the assumption that women's physiology increases their vulnerability to mental illness has persisted throughout time. Kohen (2000) and Ussher (2013) form part of a lineage of authors who have examined the way in which early medical descriptions locate women's illnesses and/or "deviant behaviours" in the uterus, starting with the early philosophers, where the writings of Plato and Hippocrates suggested that all hysteria in women stemmed from the uterus (named *hysteron* in Greek). Whether "hysteria", "nymphomania" and "frigidity" in previous years, or "premenstrual dysphoric disorder" today, "feminists have shown that many diagnoses are suffused with the dominant ideologies of their time and place and (are) used to regulate problematic behavior" (Marecek & Gavey, 2013, p. 5). Feminist psychologists thus argue that much of what is passed off as scientific knowledge is merely the subjective beliefs of a masculine society, packaged and delivered as objective truth (Marecek & Gavey, 2013). While it is not within the scope of this thesis to fully investigate the historical views on women, their reproductive cycles and psychological illnesses, it is important to remain aware of the fact that these ideas have inserted themselves into modern-day doctrine (Swartz, 2013; Ussher, 2013).

Secondly, feminist writers contest that psychological assessment and diagnostic procedures, as traditionally practised, tend not only to exacerbate the power differential between the clinician and patient, but also to reflect only the dominant culture's definition of mental health and illness (Garko, 1999; MacKay & Rutherford, 2012). Thus, "health" is typically measured against what is normal for a white, young, middle-class, Christian, heterosexual, able-bodied male, to the exclusion of women and other races' and classes' opinions of wellbeing.

A third substantial criticism leveled at psychiatric diagnoses pertains to diagnostic systems in particular. Specifically, it is argued that diagnostic systems such as the International Classification of Disease (ICD) and Diagnostic and Statistical Manual (DSM) remain “mute about the conditions in people’s lives that might understandably and predictably give rise to symptomatic behavior” (Duffy et al., 2002, p. 371, as cited in Lafrance & McKenzie-Mohr, 2013). This is especially problematic when diagnosing people who live in oppressive circumstances. Some limited effort to consider the contextual aspects of people’s distress has been made by the DSM, by including Axis IV, where clinicians can note “psychosocial and environmental problems”. In practice, however, this usually only affords a restricted (and often superficial) consideration of the contextual influences on a person’s distress (Lafrance & McKenzie-Mohr, 2013).

Finally, feminists such as Guilfoyle (2013) have pointed out that the DSM tends to facilitate diagnoses becoming “I am” conditions. It is not, for example, that “I experience extreme feelings of sadness”, it is that “I am depressed”. Guilfoyle thus argues that formal diagnostic systems force people to “subsume self-understanding within the terms of this or that particular diagnostic lens” (p. 86).

However, the fact that feminist psychologists and psychological researchers are so critical of mainstream diagnostic systems does not imply that they eschew diagnosing entirely. Some, for instance, suggest that a “feminist sensitivity” can be adopted, by carefully considering the social meanings and repercussions of diagnosis, so as not to replicate patriarchal and ethnocentric assumptions (L. Brown, 1994; Georgaca, 2013). They claim that feminist-informed assessments and diagnoses can embody the feminist values of egalitarianism, collaboration and phenomenology, and thereby allow the clinician and client to construct hypotheses *together* about the origin and nature of the client’s distress (L. Brown, 1994).

Similarly, other writers, including Hornstein (2013) and Swartz (2013), have recently argued that it is not categorisation or diagnoses per se that are problematic. Rather, both authors accept the utility of having criteria that distinguish one type of suffering from another, particularly when doing so aides treatment. Salient to the current paper is Hornstein’s argument that in order to be meaningful, diagnostic categories must stem from lived experience. She contends that the biggest problem with the DSM-5 is not that it includes or excludes any particular category of disorder, but rather that it "continues unchallenged the tradition of adding to a profusion of diagnoses that are already so far away from lived experience as to have little clinical use" (p. 30). She therefore advocates the use of a phenomenological approach, which allows one to view "extreme states and unusual perceptions, thoughts, actions, and feelings with fresh eyes – from the perspective of the distressed person's own categories and explanations" (p. 29) – a process which, by extension, causes one to notice the complex ethical and political realities that might otherwise be overlooked.

Thus, feminists assert that when diagnostic labels are applied in isolation, the "problem" tends to be seen as residing exclusively within the body or psyche of the individual (Cosgrove, 2005; Stoppard, 2000; Ussher, 2010). This, in turn, precludes the consideration of past and present interpersonal relations and experiences, as well as the impact of socio-economic and political contexts as contributing factors to individual distress and dysphoria (Hare-Mustin & Marecek, 1990; Ussher, 2010).

From a feminist phenomenological perspective, adopting a Western worldview in terms of diagnoses may be inappropriate within a South African context. Mkhize (2008) reasons that Western psychological theories hold little relevance in a social context of poverty, inequality and disempowerment. Indeed some of the terms used in the DSM to describe depression (including "poor self-esteem" and "depressed mood") make use of a discourse that is common in traditionally Western, developed contexts, but that may not be relevant to the subjective experience or manifestation of distress in the South African context, especially when considering the influence of language on the construction of social realities (Ward, 2002). It has already been repeatedly demonstrated that South African patients and health professionals can perceive the same set of symptoms in completely different ways (Lochner, 1999; Lorber, 1997). It is therefore important that researchers and healthcare professionals begin to pay special attention to the intricacies of the presentation of depression. One way of achieving this – certainly one of the primary ambitions of the research presented here – would be to gather data that pays attention to how women who have been diagnosed as depressed personally discuss and make sense of their own lived experiences.

2.6 A critical consideration of the concept "depression" and the use of the term in this study

In addition to the feminist critique of psychiatric diagnoses in general, a specific consideration of the term "depression" must be made here, firstly because of its obvious relevance to the current study, and secondly because the concept of depression has become a topic of continuous debate in mental health circles (Kruger et al., in press; Ussher, 2010).

Used in the context of healthcare professionals, the DSM stipulates that the two primary symptoms of depression are a depressed mood (e.g. feeling sad or empty) and loss of pleasure or interest in daily activities. However, it is stated that before a diagnosis of depression can be made, there must be at least five additional symptoms that persist for a period of fourteen days or more. These additional symptoms include: changes in body weight or sleeping patterns, psychomotor agitation or retardation, fatigue or loss of energy, feelings of inappropriate guilt or worthlessness, diminished ability to concentrate or process information, and recurrent thoughts of death or suicide (APA, Diagnostic and statistical manual of mental disorders: DSM-5, 2013). It is this conceptualisation of the term "depression", however, which many feminists find problematic.

Ussher (2010), for example, discusses the historic progression of medicine that led to the establishment of "depression" as a legitimate entity. She writes that the term only came into common use at the start of the 20th century, when it was translated into Major Depressive Disorder in the DSM, which thus positioned it as a "scientific truth". Ussher reminds us that depression remains "very much a western cultural concept, as there is no word for 'depression' in many non-western cultures" and that "many so called 'symptoms' of western depression are not expressed, or positioned as signs of distress, in non-western contexts" (p. 10). She attributes the endurance of the concept of depression (particularly as a biomedical condition) to the unassailable influence of western psychiatry and the pharmaceutical industry, and cites Japan as an example,

> where there wasn't even a term for mild depression before SSRIs were promoted by a pharmaceutical company in 1999. Experiences such as melancholia, sensitivity and fragility were accepted as part of life, not deemed to be pathological conditions to be alleviated. (p. 11)

Even in mainstream literature, where the concept of depression is uncritically accepted, it has been pointed out that the term itself is problematic, in that it can refer to a mood, a symptom, or a disease, and the relationship between these three is vague (Rapmund, 1999). Adding to the confusion that surrounds the definition and usage of the word, is the fact that while the DSM-5 delineates between a significant elevation in depressive symptoms (usually measured by self-report questionnaires such as the Beck Depression Inventory), Major Depressive Disorder, Persistent Depressive Disorder (Dysthymia), Premenstrual Dysphoric Disorder and other specified and unspecified disorders (all typically diagnosed using standardised diagnostic interviews), these theoretically different terms are often used interchangeably in the literature (see Chapter 1, section 1.1.2). That is to say, researchers and clinicians alike have thus far been unable to reach a definitional consensus on the construct of depression. One should therefore remain aware that any definition is partial – each reflects and omits different standpoints – and overall, that there is no consistent, trans-historical and transcultural definitional consensus on the construct of depression.

While there may not be a definitional consensus on the construct of depression, there is general agreement that the term inevitably carries clinical connotations (Lewis, 1996). As pointed out by Marecek and Gavey (2013), the DSM has employed a medical metaphor to organise the meanings of psychological suffering since 1980. This medical metaphor renders psychological problems as analogous to physical diseases, and uses the vocabulary of biology and medicine to describe them. They comment further: "the medical metaphor has assumed the status of fact, even though scientific evidence for a biological basis of most psychiatric problems remains limited" (p. 4).

One major problem in carrying out this research on the subjective experiences of depression then, was the unavoidable use of the term and thus the implication of a medical state. As the interview transcripts will show, it is difficult to talk about one's experiences of depression without at least occasional reference to a clinical discourse, whether this manifests as acceptance or rejection of that discourse. While I remain largely in agreement with the feminist criticisms of psychiatric diagnoses in general, and of the term "depression" in particular, for the purposes of this paper, the term will continue to be used to aid general comprehension. More specifically, it will be used to identify women who have met the DSM diagnostic criteria (i.e. women who experience the required number and type of symptoms that are deemed to represent "depression") and more specifically, women who regard their own mood states as negatively altered and/or "different" from their "normal", emotionally healthy selves. However, it will nonetheless be held in mind that the term may simply represent a psychological construction of distress, and probably does not fully capture the entirety of an individual's lived experience. Moreover, this study stands in agreement with Ussher's (2012) argument that while there may be some advantages to the use of the term "depression" (for instance, in helping to communicate the extent of a woman's distress and/or to validate her subjective experiences), it needs to be "conceptualised outside of a medical model that positions it as pathology within the woman" (p. 24).

2.7 Conclusion

The ambition of this chapter was not to provide a comprehensive account of the complex theories that were named therein, but rather to showcase the central ideas that informed the current study's design, execution and presentation of results. Thus, the theoretical tenets of both phenomenology and feminism were presented first, before discussing the merits of using them in the combined approach that is feminist phenomenology. Following the arguments presented by Fisher and Embree (2000), it was reasoned that feminist and phenomenological theory have much to offer each other, and it is at these points of mutual enhancement that the current study is theoretically situated.

My adoption of a feminist phenomenological approach constitutes a deviation away from the traditional positivist methods of thinking about and conducting research. In so doing, this study intends to contribute to the existing body of knowledge of depression in low-income South African women by seeking out different perspectives and understandings of the topic. Specifically, feminist phenomenological perspectives and methods of doing research are employed, as these perspectives give credence to women's experiences and understandings of their own lives within their specific cultural and political contexts. By focusing on how low-income women who have been diagnosed with depression make sense of their own lived experiences, new perspectives and meanings can emerge, which may, in turn, lead to new knowledge and possibilities for corrective and preventative strategies. To this end, like Greenwood and Levin (1998), I hope that this research project will empower its participants by validating and documenting their views, while simultaneously contributing towards a process of "social change as well as the creation of valid social knowledge" (p. 3).

CHAPTER 3: RESEARCH METHODOLOGY

3.1 Introduction

Epistemological reflexivity – how the research design and methodology define what can be found – is necessary in all qualitative research studies (Willig, 2001). Decisions about research methodology are influenced by a number of factors, including the research goals and objectives, practicability, and the study's theoretical orientation. This methodological chapter will therefore begin by briefly revisiting the study's theoretical orientation, goals and questions. The remainder of the chapter will be devoted to a discussion of the constituent parts of the overall research design and its practical implementation. Specific focus will be given to the IPA methods of data analysis and validation. The chapter concludes with a discussion of the ethical matters attended to during the course of the research, including a section on researcher reflexivity.

3.2 Theoretical perspective: Feminist phenomenological research

As detailed in Chapter 2, this is a feminist phenomenological research study. Consequently the perspective of the study can be considered feminist, while its methodological orientation is both feminist and phenomenological. Although the field of psychology was historically shaped by research methods that prized *quantification*, many of today's psychological researchers claim that the source of good theories lies in *qualitative* accounts of action and experience (Banister, Burman, Parker, Taylor, & Tindall, 1994). The objectives of the current research study together with its theoretical perspective strongly motivated my choice of a qualitative research design, as will be described in section 3.4.

3.3 Research goals and questions

The previous chapters in this document have argued that the current conceptualisation of the medical diagnosis "depression" may not fully capture low-income women's emotional experiences of distress, and further, may actually serve to pathologise individual women while simultaneously obscuring the possible impact of socio-economic and political contexts on their mental health (Hare-Mustin & Marecek, 1990; Ussher, 2010). It was also argued that there is a dire need for research that respects the subjective, lived-experiences of low-income South African women who have been diagnosed as depressed.

With this in mind, the first goal of the present study is to provide a phenomenological description of the lived experience of depression, from the subjective perspectives of one group of low-income, rural South African women who have been diagnosed as depressed. Special attention will be paid to the contextual factors that permeate the women's stories regarding their experiences of depression. The second goal is to consider the descriptions in light of the extant feminist and epidemiological literature on the subject of depression in women.

Consistent with this study's phenomenological, inductive (bottom-up rather than top-down) approach to research (K. Reid, Flowers, & Larkin, 2005), it does not aim to test hypotheses. Rather, the research questions have been formulated to explore, flexibly and in detail, the lived experiences of low-income South African women who have been diagnosed as depressed. In line with qualitative studies, the research questions are framed broadly and left open-ended (Smith & Osborn, 2008). The research questions which initiated the enquiry are:

- How does one group of low-income South African women who have been diagnosed with depression subjectively experience, describe and make sense of their emotional distress?

- How might these descriptions be considered in the light of the existing epidemiological and feminist literature on the subject of depression in women?

In line with qualitative and feminist phenomenological research in general, a third goal of the current study is empowerment of its participants. As stated by McLeod (2003), this necessitates an awareness of the "social and political implications of the research, accompanied by a commitment to using the research process to benefit the research participants" (p. 72). It is hoped that the women involved in this study will experience the research process as personally meaningful, and further, that having their opinions heard and validated may be experienced as empowering.

In summary, the ultimate goal of this feminist phenomenological study is to bring traditionally overlooked perspectives and subjective experiences of depression in low-income South African women to the fore, while simultaneously facilitating the validation and empowerment of the women who contribute to the achievement of this goal. This ambition is facilitated by a qualitative research design, a semi-structured interview schedule, and IPA methods of data analysis, as will be described and discussed in the following sections of this chapter.

3.4 Research design

3.4.1 Qualitative research

As explained above, this study was situated within feminist phenomenology, and was therefore designed as a qualitative study (Willig, 2008). Qualitative research is especially conducive to gaining an understanding of complex psychological processes, to describing and clarifying research participants' complex meanings and lived experiences (Banister et al., 1994), and to working on projects that could ultimately contribute to social change (Denzin & Lincoln, 1994). Additionally, while qualitative research acknowledges the contextual factors that shape enquiries, it does not adhere to a distinct paradigm or theory, nor does it privilege any method of enquiry above another (Willig, 2008).

According to Marecek (2003), three intertwined elements rest at the heart of the movement toward qualitative enquiry in psychology. Firstly, qualitative enquiry positions the study of psychology in the context of history and society. Secondly, it re-situates the people who are studied in their life worlds, which means it attends to their social positioning. Finally, it regards those who are studied as reflexive, meaning-making, and intentional actors. That is to say, in most qualitative studies, central importance is given to research participants' stories that are particular, contextual and timely, rather than universal, general and timeless (Appelt, 2006). Given the feminist principles that the personal and the political are intrinsically linked, and that participants' stories and voices are of paramount importance in any research document, qualitative research methodologies are therefore particularly well suited to studies that are conducted from feminist perspectives (Evans et al., 2005).

In summation, while quantitative research is represented by "practices such as experimentation, objectivity and accurate measurement of variables" (McLeod, 2003, p. 41), qualitative research involves attempting to understand the complexity of people's lives by investigating individual perspectives in context through "exploration, elaboration and systematisation of the significance of an identified phenomenon" (Banister et al., 1994, p. 3). The goal of qualitative research is not generalisability or quantifiability (as it is in quantitative research), but rather to capture some part of human experience and to reflect upon it in a way that offers a deeper, more complex view of personal subjectivity (Denzin, 2009; Hollway & Jefferson, 2000). This makes qualitative research particularly suitable to the goals and ambitions of feminist phenomenological studies, such as the one documented here.

3.4.2 Participants

3.4.2.1 Sampling

Phenomenological studies usually employ purposive and convenience sampling techniques in order to recruit a closely defined group for whom the research questions will be significant (Smith & Osborn, 2008). For the purposes of this study, participants were recruited according to the following inclusion criteria:

- Gender: Female participants only.
- Age: Adults over the age of 20.
- Socio-economic status (SES): Participant's socio-economic status was defined with the Living Standards Measure (LSM) (Golding & Murdoch, 1992). The South African population is divided into ten LSM groups, from one (lowest) to ten (highest). Individuals who fall into groups five and below are unlikely to have had higher education, usually earn minimal to no income and/or may live in informal housing. Only individuals in LSM brackets one to five were included in the study.

- Language: Afrikaans is the primary language spoken in the area where the research was conducted. However, owing to my own limited proficiency in that language, only potential participants who were comfortable with speaking English were included in the study. See section 5.3.3 for a further discussion on this point.
- Psychiatric diagnosis: Women who had been diagnosed as "depressed" by a healthcare worker (medical doctor, psychiatric nurse, social worker, psychologist or psychiatrist) were invited to participate in the study during a screening interview. (See section 2.6 for a discussion on the use of the term "depression" in this study.)

While a high rate of co-morbidity of other mood and substance abuse disorders was expected and allowed for, participants with psychotic disorders were excluded from the study. Finally, while there were no racial inclusion/exclusion criteria, given the social demographics of the areas under investigation, it was anticipated that the majority of the participants would be coloured or black.

Phenomenological studies are conducted on small sample sizes, as they aim to say something specific about the experiences and opinions of their study participants, rather than hastily making conclusions about people or phenomena in general (K. Reid et al., 2005; Smith & Osborn, 2008). For this reason, ten suitable and willing participants were chosen to make up the sample for the current study.

3.4.2.2 Recruitment

The healthcare staff from four rural clinics within the Western Cape Province of South Africa were informed about the goals, methods and inclusion criteria of the research project (see Appendix B). These staff members were then invited to refer women who they believed were suitable for the study. It was made clear that they did not have to refer any clinic attendees if they did not wish to, and equally clear that each clinic attendee had the right to decide whether or not she was willing to accept the research invitation and attend the study screening interview and/or to continue to participate in the research project thereafter.

All suitable study participants gave their written informed consent to partake in the study (see Appendix C). Each was made aware that should she decide not to take part in, or to withdraw from, the study, her routine care and treatment at the clinic would continue unaffected. Nonetheless, it was noted that none of the women invited declined to partake in the study. On the contrary, each woman said that she was eager to participate, and many expressed the opinion that such research was important, and that they wanted to be involved.

3.4.2.3 Demographics

This study was built on the experiences of ten low-income, rural women who had been diagnosed as depressed. Participants' basic demographic information was collected via the use of a demographic questionnaire (see Appendix D). All the participants and the people revealed in their narratives were given pseudonyms, in respect of the ethical mandates for privacy, anonymity and confidentiality.

Most of the participants were between the ages of twenty-seven and thirty-eight. At twenty-seven, Anna, Christine and Linkie were the youngest participants. Elizabeth, aged sixty-nine, was the eldest.

Elizabeth was the only white participant, and Melissa was the only black participant. Christine, Anna, Chenille, Evergreen, Linkie, Nina, Tracey and Twela were coloured.

Elizabeth, Twela, Evergreen and Linkie had reached matric in school; the others had not. Half of the participants (Nina, Evergreen, Linkie, Melissa and Elizabeth) were unemployed at the time of the interviews, while the other half (Twela, Anna, Christine, Tracey and Chenille) were involved in menial, low-paying, and mostly temporary or seasonal employment.

Most of the women lived in small, overcrowded homes. Anna, Christine and Tracey shared their homes with eight people each, while Twela shared her living space with nine other people. Only Elizabeth lived alone.

All the women in this study were mothers; each had between one and three children in her care. Chenille and Elizabeth had both lost a son to illness.

Elizabeth was single, having been a widow for thirty years. Tracey was not in a romantic relationship, though she was pregnant with her second child by the same man (who was romantically involved with another woman). Anna, Chenille, Christine and Twela had boyfriends, and Linkie had a girlfriend. Evergreen and Melissa were married, and Nina, at the time of the interview, had been separated from her husband (of ten years) for nine months.

All participants cited "Christian" as their religious affiliation, and only three (Anna, Nina and Linkie) were not actively involved in their local church. This basic demographic information has been summarised and presented in Table 2.

Table 2: Participants' demographic information

Pseudonym	Age	Ethnicity	Relationship status	Children (age in years)	Persons in house	Rooms in house	Highest school level	Employment status	Income p/m
Anna	27	Coloured	Boyfriend of 3 years	1 (9)	8	3 (Shares a room with 3 other people)	Gr. 11	Sales clerk	R2945
Chenille	47	Coloured	Boyfriend of 6 months	2 (27 & son, deceased 2005)	2	2 (RDP house. Shares a room with her daughter.)	Gr. 10	Cashier	R1200
Christine	27	Coloured	Boyfriend of 7 years	3 (11, 6, 9-months) and foster child/nephew (5)	8	2 (RDP house. Shares a room with 5 other people.)	Gr. 8	Farm-labourer	R1900
Elizabeth	69	White	Single (widower of 30 years)	3 (33, 36 & son, deceased 1978)	1	3	Matric	Unemployed	R2000
Twela	38	Coloured	Boyfriend of 2 years	1 (13)	10	4 (Shares a room with her son.)	Matric	Shop attendant	R2500
Nina	34	Coloured	Marital separation for past 9 months	3 (13, 10, 8)	5	3 (Sleeps on a couch in the living room/kitchen.)	Gr. 8	Unemployed	R0 – +/-R400
Evergreen	51	Coloured	Second husband of 8 years	2 (24, 30)	2	2 (RDP house. Shares a room with her husband.)	Matric	Unemployed	R1140 (Disability grant)
Linkie	27	Coloured	Girlfriend of 10 months	1 (3)	7	4 (Shares a room with 3 other people.)	Matric	Unemployed	R260 (Child support grant)
Tracey	32	Coloured	Single	1 (9), Tracey was 8 months pregnant at time of interview	8	3 (Shares a room with 4 other people.)	Gr.11	Farm labourer	R1200
Melissa	36	Black	Husband of 15 years	3 (15, 10, 6)	4	2 (Shares a room with 3 other people.)	Gr. 7	Unemployed	R800 (of which R400 given to her mother)

"Rooms in house" indicates the total number of rooms in the house (kitchen, living-room, bedrooms) but excludes the bathroom. All participants had either one bathroom or an out-house which functioned as such.

All participants had at least one electricity/power point in their home.

All participants cited "Christian" as their religious affiliation. All but three claimed that they were "actively involved" in their local church.

3.4.3 Measurement instrument

3.4.3.1.1 Semi-structured interviews

Consistent with the stated goals of this study (see section 3.3), I wanted to allow each woman the opportunity to tell her own story in her own words, and to use a methodological framework that facilitated her often muted expression of the unique experiences that she felt contributed to her diagnosis of depression. This required a flexible data collection instrument, such as a semi-structured interview (Smith & Osborn, 2008). According to Reinharz (1992, as cited in Fisher & Embree, 2000), the use of semi-structured interviews

> has become the principle means by which feminists have sought to achieve the active involvement of their respondents in the construction of data about their lives… Some feminists who engage in intensive interviewing label their method "phenomenological interviewing", an interviewee-guided investigation of a lived experience. (p. 21)

More specifically, the data used in this study was collected during the clinical assessment and subsequent semi-structured in-depth interviews with ten low-income women who had either a past or present diagnosis of depression. Given the purposes of this research project, the clinical assessments and subsequent semi-structured in-depth interviews focused specifically on the experience of depression. Clinical assessments also typically assume the form of semi-structured interviews, and are designed to collect the following information (Morrison, 2007):

- Presenting problems
- History of current illness
- Psychiatric history
- Violence (towards self or others)
- Medical history
- Substance use
- Family history of psychiatric illness
- Family history of substance use/abuse

- Developmental history
- Current functioning
- Mental Status Examination
- Diagnosis
- Psychotherapy and/or treatment plan.

Discussing the feminist phenomenological approach to research interviews, Fisher and Embree (2000) agree that open-ended questions maximise discovery and description, and facilitate the researcher's access to participants' ideas and descriptions. Appendix E gives an example of the qualitative interview schedule, which includes a number of questions pertaining to the women's experiences of depression. By asking participants questions such as "What effect has depression had on your life?" or "Do you think your medication is helping you?" critics might say that I was "forcing the data" by asking preconceived questions of it. Charmaz (1995) responds to this criticism, stating that such questions produce data by exploring aspects of experience that research participants might take for granted. The answers to such questions can contribute to a more sophisticated and comprehensive understanding of depression in women and are therefore regarded as important.

As feminist phenomenological studies view the research participants as the experiential experts on the subject concerned, it follows that participants should be allowed maximum opportunity to tell their own stories (Smith & Osborn, 2008). Thus, the semi-structured interview schedule was designed to function as a guide for the interviews, and was not intended for rigid and absolute adherence. In line with feminist phenomenological research, I wanted to "create a rapport of social interaction that transcended the boundaries between interviewer and interviewee, and which facilitated the interviewee's transformation from common-sense person to research participant" (Levesque-Lopman, 2000, as cited in Fisher & Embree, 2000, p. 110). Therefore, rather than presenting the interview questions in the exact order that they were written on the schedule, I tried to introduce them at points in the conversation where they seemed appropriate or relevant, and thereby allowed the participants to partake in guiding the interview. Similarly, in composing the semi-structured interview, I included only a few broad, open-ended questions pertaining to the various experiences of depression, so that my discussions with study participants could be guided by the schedule and not dictated by it (J.A. Smith, Flowers, & Larkin, 2009). I was consequently able to follow participants' areas of concern or focus, and to probe any interesting topics that arose during our discussions. As a result, participants sometimes led our interviews into novel areas, and overall, we probably achieved richer data than what might have been yielded from a different, more structured data collection technique (Smith & Osborn, 2008).

One of the stated goals of this project was to use "the research process to benefit the research participants" (McLeod, 2003, p. 72). In an attempt to achieve this goal, I designed the interview process to be a therapeutic and empowering experience. This was done by creating open-ended research questions, attending to each woman in a relaxed and empathic manner, and by encouraging each to take as much time as she needed to fully express herself. It was hoped that the women involved in this study would experience the research process as personally meaningful, and further, that having their opinions heard and validated might be experienced as empowering.

In summary, as a data collection tool, the semi-structured interview offered me an effective way of gaining an in-depth understanding of women's lived experiences. It may also have helped facilitate the empowerment goals that were central to this study's ambitions. As stated by Fisher and Embree (2000):

> Open-ended interviews are ideally suited to revealing the multi-layered texture of women's lives. When the interviews are integral to women's experiences of their everyday life, there is the possibility of their assuming the added significance of an instrument of empowerment through the recovery or (re)discovery of aspects of their experiences so often unreachable by traditional methodological frameworks not open to women's perspectives. (p. 127)

3.4.4 Procedures

All meetings between the participants and myself took place in my offices in various government clinics in the Western Cape. As described in section 1.2, owing to my position as a Community Service Clinical Psychologist in the area, many women who had been diagnosed with depression were referred to me on a weekly basis. Once ethical approval for the current study had been obtained (see Appendix A), all the women who were referred to me were screened for their eligibility and willingness to participate in the study. During this brief screening interview, potential participants were told about the purposes of the study (contained in the Participant Information and Consent Form, Appendix C). Prospective participants were told that should they want it, their clinical evaluation and treatment would proceed regardless of their eligibility or willingness to participate in the study, that is, that their treatment would not be compromised under any circumstances whatsoever.

At the close of the screening/information discussion, interested persons were given the Informed Consent Form and encouraged to use the time between the screening session and subsequent appointment to consider whether or not they truly wished to participate. It was hoped that the time between the first screening/information session and the second interview session would give them an opportunity to make their decisions thoughtfully and independently, and diminish any participants' tendencies to acquiesce superficially. Nevertheless, as has previously been noted, none of the women invited to partake in this study declined the invitation, and similarly, none elected to withdraw.

The research interview session consisted of two parts. First, standard questions relating both to clinical evaluation and socio-demographic variables were asked (see Appendix D). Following this, the bulk of the interview time was spent working through the material contained within, or inspired by, the semi-structured interview schedule (see Appendix E). Consistent with phenomenological research, I had to attempt to suspend or bracket my preconceptions before each interview, and further, to become immersed in listening and hearing (Fisher & Embree, 2000). Everything was important: the women's words, the organisation of their thoughts and ideas, their decisions about when they had said enough and when they had more to say, and their ways of making their meanings evident to me. Everything else was suspended – including my prior learning on the topic of depression and my preconceived notions of how the interview should proceed – all such things were temporarily suspended (or bracketed), while I was deeply involved in my attempts to enter and relate to each woman's subjective world.

The goal of the interviews was to provide each participant with an opportunity to reflect on her experiences as a woman who had been diagnosed with depression, and to uncover the meanings she attributed to her depression-linked experiences – what she thought and felt about them – as well as the interpretations and significance of these experiences embedded in her everyday life. Each interview was conducted in an open, relaxed and empathic manner so as to build rapport and encourage each participant to feel secure and respected. I believed that it was important to create an atmosphere in which each participant felt that she could tell me, from her own perspective, what I was interested in learning: her lived experiences and descriptions of emotional distress. This style of interviewing elicited lengthy narratives and detailed digressions. As the interview content was worked though at each participant's own pace, the number of interview sessions varied from person to person. In total, ten participants were interviewed – one participant twice, and two participants three times. Each interview was digitally recorded using a Dictaphone and lasted between 60 and 90 minutes.

3.4.5 Data management

As stated above, qualitative, semi-structured interviews were conducted, recorded, transcribed and analysed for the purposes of this research paper. Only my supervisor and I had access to the raw data, which was stored electronically and under password on our private computers.

Kvale (1996) writes: "Transcribing the interviews from an oral to a written mode structures the interview conversations in a form amenable for closer analysis. Structuring the interview into texts facilitates an overview and is in itself a beginning of analysis" (p. 168). I chose to transcribe the recorded data in full myself. This enabled me to consider it from a different, slightly removed perspective, while simultaneously enhancing my familiarity with the content, as each transcript required multiple re-readings to ensure accuracy. This effected a careful engagement with the raw data over a prolonged period of time.

I found transcribing the audio recordings to be a fascinating process. On the one hand, I was able to hear and recognise a good deal of information that I had missed during the actual interview sessions. On the other hand, I was bitterly disappointed at how much rich information gets lost without the important aspects of nonverbal communication, including bodily gesture, posture, eye-contact and voice intonation. Some interview sessions that had overwhelmed me with the amount of energy and feeling in the room, ended up looking dull and flat when transcribed. Others, which I experienced as lacklustre during the interview, revealed rich and interesting themes and insights when transcribed onto paper. In an attempt to provide the reader with at least some nonverbal information, I chose to use square brackets in the transcriptions to refer to important nonverbal behaviour, and parentheses to clarify the subject of speech.

3.4.6 Data analysis: Interpretative Phenomenological Analysis

Consistent with this study's feminist phenomenological orientation, the data analysis methodology chosen was Interpretative Phenomenological Analysis (IPA). IPA uses in-depth qualitative analyses in an attempt to understand what it is like to experience a particular event or situation, from the point of view of the experiencing person him or herself (K. Reid et al., 2005; Schweitzer et al., 2012; J.A. Smith et al., 2009; Smith & Osborn, 2008).

IPA was first used as a distinctive research method in psychology in the mid-1990s (Shinebourne, 2011). In a seminal paper, J.A. Smith (1996) argued for an approach to psychology that allowed researchers to capture the qualitative and experiential dimension of human experience, while still maintaining dialogue with mainstream psychology. Later, J.A. Smith and Osborn (2008) described IPA as an approach that operates within the intellectual currents of phenomenology in the context of psychology, as it is concerned with exploring lived experiences and the meanings which people attribute to those experiences.

3.4.6.1 Epistemological underpinnings of IPA

IPA's epistemological framework and research methodology draw from three main areas of philosophy of knowledge: phenomenology, hermeneutics and idiography (J.A. Smith et al., 2009). It is phenomenological in its attempt to access participant's personal experiences, but recognises that this inevitably becomes an interpretative (i.e. hermeneutical) endeavour. J.A. Smith et al. (2009) succinctly explain the interaction between the phenomenological and hermeneutical components of IPA: "Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenon would not be seen" (p. 37). Idiography, in turn, aims for an in-depth analysis of the unique and particular, which is impossible in general nomothetic research studies (Shinebourne, 2011).

Tomkins and Eatough (2010) stress the point that IPA's epistemology is founded on the hypothesis that experience can be accessed through interpretation. They suggest that interpretation simultaneously facilitates and complicates the process of gaining access to, and then understanding participants' subjective experiences, because:

> In IPA, the interpretative or sense-making process is seen as a "double hermeneutic," with the participant trying to make sense of his personal and social world, and the researcher trying to make sense of the participant trying to make sense of that world. (p. 255)

IPA is also influenced by the phenomenological and existential perspectives of Heidegger, Merleau-Ponty and Sartre. Thus, it considers the person as embodied and embedded in a specific social context that has been powerfully influenced by both history and culture (Shinebourne, 2011). As discussed in Chapter 2, the careful consideration of subject-in-context is central to feminist thought, too. This makes IPA particularly well suited to the current feminist phenomenological study.

3.4.6.2 The use of IPA in the current study

IPA aims to understand the phenomenon under investigation from the participants' unique frame of reference, that is, from their lived experience (K. Reid et al., 2005; Schweitzer et al., 2012). IPA is therefore used in this study to explore the lived experiences of depression, as recounted by depressed women themselves. The approach is phenomenological, in that it involves a detailed examination of the participants' subjective experiences and attempts to explore personal perceptions and accounts of an experience (such as feeling "depressed"), rather than attempting to produce an objective statement about the event or experience itself (Smith & Osborn, 2008).

Consistent with feminist perspectives, IPA researchers view their participants as experts of their own experiences, "who can offer researchers an understanding of their thoughts, commitments and feelings through telling their own stories, in their own words, and in as much detail as possible" (K. Reid et al., 2005, p. 20). However, the IPA researcher can also critically investigate participants' narratives, by asking questions such as: "Is something happening here that wasn't intended?" or "Might I be aware of something here that participants are not aware of?" (Smith & Osborn, 2008). Thus, interpretation can be descriptive and empathic, aiming to produce "rich experiential descriptions", but also investigative and critical "in ways which participants might be unwilling or unable to do themselves" (Shinebourne, 2011, p. 21).

IPA recognises the fact that research is a dynamic process, in which the researcher plays an active part in shaping the study outcomes (Smith & Osborn, 2008). "The inductive and iterative procedures of IPA are intended to help the researcher to develop an initial 'insider's perspective' on the topic" (K. Reid et al., 2005, p. 22). The researcher documents this insider's perspective in the form of an interpretative document that is illustrated with (and supported by) a number of verbatim examples from the participant interviews (Tomkins & Eatough, 2010). However, the insider's perspective is only one part of the analytical process, because the researcher can also provide an interpretation of what it might mean to the study participants, in their particular contexts, to have their particular concerns. This indicates that there is a balance of "emic" and "etic" positions in IPA (K. Reid et al., 2005). In the former (phenomenological, insider) position, the researcher listens to and prioritises participants' stories and experiences. In the latter (interpretative, outsider) position, the researcher tries to understand those stories, especially in light of the research question.

The current research study made use of the following step-by-step approach to data analysis in IPA studies, as delineated by J.A. Smith and Osborn (2008):

1. Looking for Themes in the First Case

The first transcript is read and re-read a number of times, so that the researcher can become as familiar with the text as possible. Interesting uses of language, thoughts and points of potential significance are noted in the left-hand margin. The transcript is then re-read again, and this time, the initial theme headings are noted in the right-hand margin. During this process, the original notes are refined into specific phrases that succinctly capture the essence of what was found in the transcript. Theme titles are often set at a "slightly higher level of abstraction and may invoke more psychological terminology" (J.A. Smith & Osborn, 2008, p. 68), but they must always clearly link back to what the participant actually said.

2. Connecting Themes

Having completed the process of reading, re-reading, and assigning notes and then themes to the first transcript, all the emergent themes are then listed. Next, one looks for connections between these themes. This stage "involves a more analytical or theoretical ordering", as one tries to understand the links between the various themes (J.A. Smith & Osborn, 2008, p. 70). Certain themes will cluster together and some "will emerge as superordinate concepts" (J.A. Smith & Osborn, 2008, p. 70). While organising and clustering the themes, the transcripts are checked to ensure that the connections correspond to the original raw data – the actual words of the participant. To aid this process, one should compile directories of the participants' phrases to be used as quotes that support the related themes.

The following is a list of themes that appeared frequently during my initial analysis of the data:

- Bodily pain
- Sleep disturbance and lethargy
- Anger
- Feeling alone
- Self-isolation/emotional withdrawal
- Anxiety/feeling afraid/panic attacks
- Sadness/tearfulness

- Personality incongruence “I’m not myself”
- Mood fluctuations
- Self-blame/guilt/shame
- Feeling inadequate
- Darkness
- Feeling hopeless/helpless/powerless
- Hiding feelings
- Being strong
- Being a good mother
- Substances
- Death or loss of loved ones
- Relationship problems
- Childhood trauma
- Lack of support
- Abuse by husband/partner
- Violence/threat to safety/feeling vulnerable
- Many responsibilities/concern for others
- Healing/supportive relationships
- Religion
- Treatment/medication/therapy.

3. Forming Superordinate Themes

The third stage in IPA analysis is to refine, organise and group the various themes under a number of superordinate theme headings. Each superordinate theme is given a name that attempts to reflect the themes clustered beneath it (J.A. Smith & Osborn, 2008).

4. Continuing the Analysis with Other Cases

J.A. Smith and Osborn (2008) write: “A single participant’s transcript can be written up as a case study in its own right or” (as was done in the present study) “the analysis can move on to incorporate interviews with a number of different individuals” (p. 73).

It is equally important to discern repeating patterns as it is to acknowledge new issues that emerge while working through the transcripts. In other words, it is important to accept that there will be convergences and divergences within the data. Having used the interpretative process to analyse each transcript, a final table of superordinate themes is produced. This requires the researcher to reduce and prioritise the data, which is often difficult (Smith & Osborn, 2008, p. 74). Themes should be chosen based on factors such as their prevalence within the data, the richness of specific disclosures, and how the theme helps illuminate other aspects of the account. In the current research project, I decided to organise my data under five superordinate theme headings, as shown in Table 3.

Table 3: IPA stage 3: Forming superordinate themes and corresponding theme clusters

Bodily experiences of depression	Sleep disturbance Tiredness Body pain
Emotional experiences of depression	Anger Loneliness Anxiety Sadness Guilt and shame Powerlessness: Helplessness & hopelessness Experience of the self: A lost self
Behavioural manifestations of depression	Withdrawal and hiding feelings Substance use Aggression directed at self Aggression directed at others
Subjective beliefs about the factors that cause or exacerbate depression	Loss or death of a loved one Childhood trauma Relationship problems Abuse by partner Multiple responsibilities Lack of support Consequences of poverty Fear: Violence in the community
Subjective beliefs about the factors that alleviate depression	Relationships Religion Treatment: Medication & psychotherapy

5. Writing Up

The last step in IPA is writing up the analysis. This entails explaining the final themes and understandings in the participants' transcripts. In IPA, "the division between analysis and writing up is, to a certain extent, a false one, in that the analysis will be expanded during the writing phase" (Smith & Osborn, 2008, p. 76). In this phase, the themes are clarified, nuanced and illustrated with verbatim excerpts from the raw data. Here it is important "to distinguish clearly between what the respondent said and the analyst's interpretation or account of it" (Smith & Osborn, 2008, p. 76). According to K. Reid et al. (2005), a good IPA analysis is: "interpretative (and thus subjective), so the results are not given the status of facts; transparent (grounded in example from the data) and plausible (to participants, co-analysts, supervisors, and general readers)" (p. 20).

Following the phenomenological directive to become immersed in listening and hearing (Fisher & Embree, 2000), this research required great attentiveness on my part during each in-depth interview, as well as a kind of trust that each woman would lead me in a fruitful direction. What possibly contributed most to this occurring was my use of the terms and meanings that the women themselves used to represent their thoughts and interests.

Understanding the content and complexity of what research participants say about the topic under investigation is central to IPA (Smith & Osborn, 2008). While the IPA researcher tries to capture and accurately represent the experiences and meanings of the study participants, those meanings are not always immediately evident – some only emerge after a process of interpretation and sustained engagement with each text (J.A. Smith et al., 2009). In other words (and as suggested by the name Interpretative Phenomenological Analysis), as researcher, I had to engage in an interpretative relationship with each participant's narrative. It is therefore to be remembered that qualitative analysis is fundamentally a personal endeavour. This is in accordance with (and indeed a part of) the developmental, creative nature of qualitative psychology.

While it is undeniable that IPA as an approach is particularly well suited to the aims, ambitions and theoretical orientation of the current study, it is not without its faults. Tomkins and Eatough (2010) outline one of the primary criticisms directed at IPA:

"Its analytical technique of disaggregation of data and its synthesis of disaggregated concepts into a thematic hierarchy ignores the chronology or sequencing of that data" (p. 255). They acknowledge that while this technique facilitates the researcher's intense interpretative engagement with the text, it does so at the cost of potentially losing "the richness of seeing how an individual's story naturally unfolds" (p. 255). It is true that accounts may develop as the relationship between participant and researcher evolves, and that participants may build towards a finale as they progressively think about what their experiences were like for them. "The possibility that some of this chronological, incremental sense-making might get lost in post-hoc analysis" is an undeniable weakness of IPA, and indeed of all other thematic induction techniques (Tomkins & Eatough, 2010, p. 255).

As will be seen in Chapter 4, I attempted to compensate for this potential weakness of IPA by presenting my data – specifically, the superordinate themes – in the same order that they were generally attended to by the study participants. For example, it was noticed that when first asked about symptoms of depression, each participant immediately replied with details of her difficulty sleeping, tiredness or other somatic complaints. Thus, the superordinate theme "Bodily experiences of depression" is presented first in the Results chapter.

3.4.7 Processes of validation

Yardley's (2000) guidelines for assessing validity and quality in qualitative research provide broad-ranging criteria that can be applied irrespective of the specific theoretical orientation of the qualitative study. She suggests four key dimensions by which qualitative studies can be assessed:

1. Sensitivity to context
2. Commitment and rigour
3. Transparency and coherence
4. Impact and importance.

Each of these dimensions was constantly kept in mind throughout the entire execution of this study.

According to Yardley (2000), there are multiple ways to establish sensitivity to context, including being considerate of the socio-cultural area of the study, to the participants involved, and also to the relevant theoretical literature. In IPA, sensitivity to context is required during all stages of the analytic process, particularly in dealing with the study participants and in attending closely and carefully to the process of data analysis. A good interpretative phenomenological analysis will demonstrate a sensitivity to the raw material and "will always have a considerable number of verbatim extracts from the participants' material to support the argument being made, thus giving participants a voice in the project and allowing the reader to check the interpretations being made" (J.A. Smith et al., 2009, pp. 180-181; Wertz, 2005).

Rigour in IPA refers to the "thoroughness of the study, for example in terms of the appropriateness of the sample to the question in hand, the quality of the interview and the completeness of the analysis" (J.A. Smith et al., 2009, p. 181). Commitment and rigour can be demonstrated via prolonged engagement with the research topic, complete immersion in the data, and being meticulous when engaging in data analysis (Shinebourne, 2011; Yardley, 2000).

Yardley's third criterion is transparency and coherence. Transparency speaks to the clarity of the description of the stages in the research process (Shinebourne, 2011). In IPA, this entails clearly explaining the processes involved in the construction of the interview schedule, participant selection, and the stages of data analysis, as has been done throughout this chapter. Meanwhile, coherence refers to the presentation of a sound analytic report, which includes an articulate presentation of the main ambiguities and contradictions found in the data (Shinebourne, 2011). Coherence can also "describe the 'fit' between the research question and the philosophical perspective adopted, and the method of investigation and analysis undertaken" (Yardley, 2000, p. 222).

Yardley contends that notwithstanding how well research is conducted in terms of the other validity criteria, impact and importance constitute "the decisive criterion by which any piece of research must be judged" (p. 223). This links to the opinions of J.A. Smith et al. (2009), who suggest that the validity of a qualitative research document "lies in whether it tells the reader something interesting, important or useful" (p. 183). Yardley is careful to point out, however, that usefulness can be evaluated in different ways, and that the overall worth of a piece of research should also be measured against the study's original objectives and intentions.

Overall, in this paper, I tried to produce valid and reliable data by carefully describing the research context and considering each of the study participants as an individual woman who had overcome and continued to face significant life challenges. One of my primary goals was to listen carefully and then give voice to these women's experiences and insights. The resulting analyses were built directly upon verbatim quotes, and were also revised regularly and checked during supervision to ensure that my analyses never strayed far from the raw data itself. It is sincerely hoped that this final research document will offer, in J.A. Smith et al.'s words, "something interesting, important or useful".

3.5 Ethical considerations

This study was approved by the Psychology Department at Stellenbosch University, the Stellenbosch University Research Ethics Committee and the Health Research Ethics Committee at Tygerberg Hospital (see Appendix A). All participants gave their written informed consent. Each participant was aware that if she decided not to take part in (or to withdraw from) the study at any stage, her routine care and treatment would not be affected.

Ethical guidelines for conducting research were developed to prohibit the mistreatment of those being researched (Morrell, Epstein, & Moletsane, 2012). Studies involving human subjects – in particular those from vulnerable population groups – have become increasingly regulated by protocols that aim to protect people's best interests. Thus, the instruction "do no harm" remains an important directive that guides all phases of the research process.

The primary ethical considerations in the current study concerned the fact that the research involved persons from a vulnerable population group (low-income women who had been diagnosed with depression). The ethical issues surrounding obtaining informed consent as well as using clinical material for academic purposes had to be carefully considered. Sound ethical practice additionally necessitated my acknowledgement of my own subjectivity as researcher and my continuous commitment to the ethical execution of this research project. Each of these points will be discussed below.

3.5.1 Working with vulnerable populations

The importance of conducting ethical research cannot be underestimated, especially when the research project concerns a vulnerable population group. The research participants involved in this study can be considered vulnerable on at least four different counts. Firstly, as predominantly coloured, low-income women, they comprised part of a "socially disadvantaged" (and therefore disempowered and vulnerable) population group (Nama & Swartz, 2002). Secondly, the participants were all women who came from a traditionally patriarchal society in which they had a long-standing history of being politically silenced. Thirdly, persons who are depressed are considered to be in sub-optimal mental (and oftentimes physical) health (Kupfer et al., 2012). Finally, it must be acknowledged that the power differential between researcher and participant leaves the latter inherently vulnerable. Overall then, the research participants' positions as low-income, female women suffering from depression rendered them a particularly vulnerable population group. As such, care had to be taken to ensure that the highest ethical guidelines were adhered to throughout the research process.

Depression is a psychologically painful experience. Discussing this topic can elicit uncomfortable feelings in some people. Before undertaking this research project, I had been comprehensively trained to deal with and contain any such emotional reactions in participants. There was also a firm referral chain for psychiatric emergencies (such as suicidal or homicidal impulses or ideation in participants) between the clinics where participants were to be interviewed and the district hospital. It was suggested that the potential benefits of conducting the research (including the positive therapeutic effects of the interviews, possible empowerment of the participants, and a more complex understanding of depression which could assist in the development of future assessment, treatment and preventative strategies) outweighed the potential risks.

As a feminist researcher, I aimed to conduct my work in responsible, accountable and non-exploitative ways. The influence of power relations – both within the research encounter and in the wider social context – were at all times considered. Although some power differentials were unavoidable, I tried to remain aware of "whose words were privileged" (Madriz, 2000, p. 842) in the research process, and I endeavoured to conduct the research in collaboration with the participants, not "on them or about them" (Greenwood & Levin, 1998, p. 3).

3.5.2 Using clinical material for academic purposes

The subject of writing about clinical patients has always been a contentious one, and therefore deserves careful deliberation. Today, patients' rights are accentuated more than ever before, and this is as it should be. Unfortunately, however, this tends to diminish psychologists' inclination to communicate clinical material (Kantrowitz, 2004).

Freud (1905) stated that analysts should publish what they learn from their patients in order to advance the field of psychoanalysis. In fact, he regarded psychoanalysis as equally "a theory of mind and a method of research as well as a clinical intervention" (p. 8). In line with such thinking, throughout my research process, I remained mindful of the fact that as a psychologist, I had a duty to "act in the service of the well-being of the participants", and as a researcher, I had a duty to "collect data and make a contribution to knowledge and understanding" (McLeod, 2003, p. 174).

Nonetheless, research that involves persons from vulnerable groups (low-income women) and attends to sensitive issues (experiences of depression, traumatic life events etc.) is likely to generate difficult choices. Therefore, such research is usually only conducted on carefully agreed conditions (most often, of anonymity) (Morrell et al., 2012). In the current study, participants were assured that their rights to confidentiality and anonymity would at all times be respected by the use of pseudonyms. I chose to alter only names of individuals and to omit precise geographic locations so as to represent as accurately as possible the lived contexts and dynamics of the participants' lives. I made sure to regularly check that each participant remained comfortable with her decision to partake in the study.

3.5.3 The issue of informed consent

One mechanism deployed towards ensuring ethical practice is "informed consent" (Morrell et al., 2012). The research subjects who chose to participate in the current study were required to sign a form indicating that they understood the scope and ambitions of the project, and that they had agreed to partake in it (see Appendix C).

Gaining participants' fully informed consent was particularly relevant to the current study's ethical procedures. This included potential participants being told and understanding that their right to treatment would in no way be compromised, irrespective of their decision to refrain from or partake in the research project. However, as pointed out by Kantrowitz (2004), two major problems exist with regard to informed consent. First, truly informed consent can't ever be obtained, because it is always given under the influence of the transference between participant and researcher. Second, participants' opinions and decisions about the academic use of their personal data might change over time.

However, "granting that consent can never be truly informed does not lead inevitably to the conclusion that patients will be adversely affected by giving permission" (Kantrowitz, 2004, p. 93). The very act of holding these potential issues and perspectives in mind can heighten a researcher's sensitivity towards her participants. Thus, I carefully explored each participant's thoughts and feelings about having her material published, and ensured that each woman understood and would feel comfortable to exercise her right to withdraw from the study at any stage. Irrespective of this, it was noted that each participant expressed a clear willingness (and even determination) to have her story heard and, moreover, shared in the form of research.

Consent, however, is only the beginning of carrying out ethical research (Morrell et al., 2012). There is a difference between "procedural ethics" (e.g. facilitating informed consent) and "ethics in practice" (Guillemin & Gillam, 2004). The former does not in itself provide all that is needed for the latter. Particularly when executing qualitative projects, there is a need to engage in reflexive research, so that the work may be carried out with unremitting respect and sensitivity.

Although no single procedure can absolutely guarantee ethical conduct, continual "reflexivity is more likely to ensure ethical research practice than pre-research ethical compliance" (Morrell et al., 2012, p. 616). That is, reflexivity (the researcher's awareness of the power, bias or influence she might exert in relation to her research participants) is at all times necessary. Researcher reflexivity has therefore become a term that is commonly associated with ethical practice in qualitative research, and as such, will be discussed below.

3.5.4 Researcher reflexivity

Reflexivity in qualitative research requires an "acknowledgement of the impossibility of remaining 'outside of' one's subject matter while conducting research" (Willig, 2001, p. 10). It is a prerequisite of good qualitative research and is thus required during all study stages, from formulating the research questions and selecting the research participants, through to conducting the interviews and writing up the final research document (Banister et al., 1994).

On this topic, Mauthner and Doucet (2003) similarly point out that research should not be considered an objective attempt to represent participant's voices, because the very process of data collection and analysis involves tremendous input from researchers, who must select, edit and categorise the information. In other words, what is said about research participants' stories will ultimately reflect the researcher's own opinions. Therefore, personal reflexivity should involve thinking about "how the researcher's own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research" (Willig, 2001, p. 10).

While much has been written on the subject of reflexivity as a significant element of qualitative research, it is not always clear how this should be accounted for in a research document. Mauthner and Doucet (2003) suggest that reflexivity should include disclosing the social position of the researcher, her theoretical perspective(s), emotional responses to participants, and the epistemological assumptions that inform her research, as well as detailed descriptions of the research methodology employed. It is also advised that researchers explore the personal relevance of their choice of topic, write in the first-person style, and disclose relevant background information about themselves. Similarly, the reflexive researcher should at all times remain conscious of the inherent power-relations that are at play in knowledge production – especially when research participants are drawn from vulnerable population groups. I have attempted to incorporate all of these elements throughout this dissertation.

My identity as a white, middle-class, English-speaking urban woman in my late twenties has informed this research study in many known and unknown ways. I will probably remain unaware of many of the finer nuances, but I attempt to continually reflect on my unique position in this project. I remain cognisant of the fact that my personal values, beliefs, life experiences and social identity shape the research I conduct and influence the interpretations I make when examining the narratives of my research participants, who are predominantly poor, coloured, Afrikaans- and English-speaking women with little formal schooling. As all the participants were female, our shared gender may have contributed to a perceived solidarity as women (Riessman, 1987). However, it is assumed that our class and racial differences might easily have influenced our differing experiences as women, partners, daughters and sisters. Some of my ability (or lack thereof) to hear and understand all of my participants' experiences and meanings may be attributed to such differences.

Appelt (2006) suggests that reflexivity also involves acknowledging the researcher's interest and investment in her study. It is therefore important to remember that this study was conducted as part of my doctoral dissertation through the Department of Psychology at Stellenbosch University. As such, various procedures and academic requirements informed the design, implementation, analysis and reporting of the results. My involvement in the study was also a product of my own experience of depression, in myself and in the women in my life. I am attracted to this research perspective as it is consistent with my political agenda and also my experiences of a largely patriarchal society. Additionally, like Shefer (in MacLeod, 2004), I "believe that it is important for those who have skills, knowledge and resources to carry out research where it is most needed" (p. 534). I felt personally invested in this research owing to a combination of the reasons given above, and also because I would like to make some small contribution towards social change.

3.6 Conclusion

This chapter attempted to show how the study's research methodology was positioned within the broader framework of feminist phenomenological, qualitative research. It was shown that the study's methods of data collection (semi-structured in-depth interviews) and analysis (IPA) were consistent with its stated goals and overall theoretical orientation. The chapter concluded with a discussion of the important ethical matters pertaining to the overall research project. Chapters 1, 2 and 3 have therefore detailed the study's background, rationale, theoretical underpinnings and methodology. In Chapter 4, the focus shifts to a presentation and discussion of the study findings.

CHAPTER 4: RESULTS AND DISCUSSION

4.1 Introduction

The primary goal of this study was to provide phenomenological descriptions of the lived experience of depression in low-income women. Specifically, it was hoped that this study could provide a broad overview of the participants' depression-related experiences and insights, while remaining cognisant of the contexts within which they became depressed. A second goal was to consider the study findings in light of both the extant feminist and epidemiological literature on the subject of depression in women. Therefore, the central research questions being asked were:

- How does one group of low-income South African women who have been diagnosed with depression subjectively experience, describe and make sense of their emotional distress?

- How might these descriptions be considered in the light of the existing epidemiological and feminist literature on the subject of depression in women?

Towards answering these questions, Interpretative Phenomenological Analysis was used to make sense of the raw data (the transcribed interviews that were conducted with each research participant). By starting with data from their lived experiences, my immediate focus was on how each woman understood and explained her situation. In line with feminist phenomenological research, my research strategy involved attending closely to the data and then building analyses directly upon my understandings of that data.

As explained in Chapter 3, this research forms part of a multi-site longitudinal study. Researchers Taylor (2011) and Lourens and Kruger (2013) recently conducted comparable qualitative interviews with analogous groups of women. While Lourens and Kruger, Taylor and I each gathered and analysed our data independently, our final research documents report remarkably similar findings. Specific areas of similarity or difference will be highlighted throughout this chapter.

In an attempt to forefront the human story and personal voice of each woman in the study, I have included a significant number of verbatim excerpts in the data analysis and discussion that follows. While citations were kept as concise as possible, it was at times necessary to show the context within which certain statements were made. Some citations are therefore lengthy. It must also be noted that the women's stories (all of which were transcribed verbatim) contained a significant number of grammatical errors. While some authors would indicate their awareness of these errors by including the notation [sic] after every mistake, I have chosen not to do so for two reasons. Firstly, while working from the feminist phenomenological perspective, I wished to interfere as little as possible with each woman's voice and story. Secondly, noting each linguistic and grammatical error would likely cause a staccato-like interference in the smooth running and reading of the text. However, where necessary in the transcriptions, I have used square brackets to refer to important nonverbal behaviour, and parentheses to clarify the subject of speech.

Phenomenological studies typically contain a large amount of complicated data (Lester, 1999). I have tried to present the findings in a way that is accessible and useful, yet still respectful of their necessary complexity. This chapter is therefore lengthy. It begins with a brief explanation of the presentation of results. The study participants will then be introduced, followed by a short discussion of their use of culturally specific terminology and metaphor. The remainder of the chapter will be dedicated to the documentation and discussion of the study findings.

4.1.1 Presentation of results

Finlay (2008) reminds us that regardless of the variant of phenomenological analysis employed, every way of presenting data ultimately both reveals and conceals. That is, "However rich and comprehensive, any one analysis is, inevitably, incomplete, partial, tentative, emergent, open and uncertain" (p. 6). With this in mind, the analysis that follows should by no means be read as definitive. It is merely my subjective understanding, organisation and presentation of the data that emerged during my engagement in this research project.

One of the guiding beliefs of this study is that a person's illness experience correlates with the psychological, moral and social explanatory models of his or her culture (Gwyn, 2002). The experience of depression thus entails all the patterns of social context, including past and present power issues and conflicts, one's relationships, occupations, social roles and status. The same objectively defined "illness" is therefore unlikely to be experienced in exactly the same way by different persons. I tried to remain mindful of this – the uniqueness of each individual participant's experience of depression – throughout each stage of my study, from data collection to analysis and write-up. However, it was impossible to ignore some of the striking similarities between the participants' descriptions. In writing and rewriting this chapter, I aimed to elucidate the most important findings concerning the participants' experiences of their lives and depression; to provide a context in which to understand these findings, and finally, to make comparisons with and contributions from the relevant literature. During this process, a rich and textured account of the experience of depression became evident. I began to group and organise the most common themes together under one of five superordinate theme headings, as follows:

1. Bodily experiences of depression
2. Emotional experiences of depression
3. Behavioural manifestations of depression
4. Subjective beliefs about the factors that cause or exacerbate depression
5. Subjective beliefs about the factors that alleviate depression

It is important to note that while these themes are presented categorically here, they should not be read as such. That is to say, while each theme will be considered separately in this chapter, one must remain cognisant of the fact that many of them are involved in mutual relationships of influence.

The structure of this chapter has been inspired by Giorgi's (2010) opinion that in phenomenological research, "careful observations and descriptions come first and the phenomenal givens obtained can then be the basis for a more thorough understanding that often follows their discoveries" (p. 151). Therefore a phenomenological description of each theme will be presented first, and then followed with a discussion of that theme in light of the relevant epidemiological and feminist literature. Where possible, a dictionary definition will precede the description and discussion of each theme, in order to facilitate clarity on the construct being discussed. The Dictionary of Psychology (Reber, 1985) will be used for this purpose. In line with this study's theoretical framework, it is acknowledged that no one perspective can provide the ultimate truth (or "definition") on any matter. Accordingly, the Dictionary of Psychology will be used for purposes of consistency rather than authority.

4.2 Participants

4.2.1 Anna (27)

Anna, a coloured, unmarried, single parent of one child (Donald, aged nine years), was first diagnosed with Major Depressive Disorder in September 2011, by the clinic doctor. She was prescribed 20mg of Fluoxetine daily.

When I first met Anna, I thought that her physical appearance made her look older than her twenty-seven years. I would have guessed that she was perhaps in her mid-thirties. Her tired eyes were sunken beneath dark circles, she was short and rotund, her jeans and tracksuit top were old and a little too big, and her hair was scraped back and tied at the nape of her neck.

Anna presented with fluctuating feelings of irritability and anger outbursts, low mood, insomnia, tearfulness, occasional suicidal ideation (without attempt), neck/shoulder pain and complaints of feeling "unwell". She would frequently make statements such as "everyone is letting me down", "I don't have enough support", and "I am angry and sad".

At the time of our interview, Anna was living in her parents' two-bedroomed house with seven other family members and her boyfriend of three years. Anna, her mother, sister and niece slept in one bedroom, while her father, son, boyfriend and nephew shared the second room. Anna worked as a sales clerk in a small shop and her parents were unemployed. She said that while her religious affiliation was Christian, she was not actively involved in any religious pursuits.

Anna told me that she had been born into an emotionally close, low-income family. She had three siblings. Their father abused alcohol throughout their childhood. Anna's family emphasised the importance of education and good behaviour. They were therefore very disappointed when Anna, aged seventeen and in Standard 9 (Grade 11), fell pregnant with her son and consequently discontinued her schooling. Falling pregnant at a young age and out of wedlock, as well as discontinuing her schooling, continued to be a source of much shame and regret for Anna. Her relationship with Donald's father, Ronaldo, ended when Donald was four years of age, owing to Ronaldo's infidelity. This too was a source of much pain and resentment for Anna.

During our interview, I often forgot how young Anna was. She spoke easily about the difficulties of being a single parent, her relationship problems, history of sporadic alcohol abuse, alimony disputes and other significant financial and social constraints. All this seemed to me to be an incredibly heavy load for a young woman in her mid-twenties to carry.

My feelings for Anna fluctuated during our time together. Mostly, I felt incredibly sad for her situation, which seemed both unfair and unchangeable. I was aware of our similar age, and could not help thinking about how easy and fortunate my life had been in comparison to hers. At times during our discussion I detected a certain fieriness within her. I sensed that she was short of temper, which, if I was not careful, I might easily trigger. She would shoot glaring looks or tap the desk forcefully with her index finger to emphasise points that she felt passionate about. Then she would suddenly break down and cry – sometimes in sadness and sometimes in what seemed like desperate frustration. In those moments, she looked like a little girl. I began to see that her irritation and anger would disappear and reappear as quickly as her sadness and hopelessness. Moving between these extreme feelings so many times over the course of our time together left me feeling tired, confused and frustrated.

4.2.2 Chenille (47)

Chenille, a forty-seven-year-old, unmarried, coloured, Christian woman, was first diagnosed with Major Depressive Disorder in September 2011 by the attending clinic doctor. At the time, she presented with suicidal ideation, low mood and insomnia. She was prescribed 20mg of Fluoxetine daily.

Chenille shared her one-roomed Rural Development Project (RDP) house with her only daughter, who was twenty-seven years of age. Her only son had died unexpectedly when he was aged thirteen. Chenille explained to me that all of her symptoms of depression were brought about by the death of her son, and that her grief had seldom remitted in the six years since his passing.

Chenille was born into a poor family as one of four children. She left school in Standard 8 (Grade 10). At the time of our interview, she was employed as a cashier in a grocery store. Chenille had never married, and spent most of her adult life as a single parent. However, she had spent the past six months in a romantic relationship with one of her male friends (who had also tragically lost a child).

When Chenille first came into my office, she was neatly dressed and appeared far older than her chronological age. She looked timid, sad and slightly anxious, yet clearly eager to tell me her story. I was overcome with sadness when she began to tell me about her experiences of depression. According to Chenille, her emotional distress was caused by the death of her only son, six years previously. Our discussion revolved around this loss, as it was undoubtedly her primary focus. The sense of tragedy associated with the untimely death of a child left me feeling utterly helpless. I thought that my responses and questions sounded shamefully inept – there was nothing I could say to take away any amount of the pain that Chenille had been through and continued to endure daily. At the end of our appointment (which was my last for the day), I offered to drive Chenille home, as it was an incredibly hot afternoon – temperatures were well above forty-five degrees Celsius. She accepted my offer and directed me to her home. As we drove for far more kilometres than I had expected, through the informal settlements and government RDP houses on the outskirts of the town, I became astounded by the distance Chenille had walked to get to the clinic on this blisteringly hot day. Seeing her tiny and impoverished house also affected me deeply. I imagined that Chenille had to contend with so many finance-related problems – none of which she mentioned during our time together. I wondered if the enormity of the loss of her son had left little room for her to feel the weight of any other burdens.

4.2.3 Christine (27)

Christine, a twenty-seven-year-old, coloured, Christian woman, had been diagnosed with depression in 2010 by the clinic doctor. She refused to take the antidepressant medication that had been prescribed for her, saying that she only needed medication that would help her manage the occasional pain in her leg and head. At the time of our meeting, she presented with a number of depressive symptoms: low mood, difficulty concentrating, tearfulness, somatic pain (sore neck, headaches, and pain in her right leg, which was significantly shorter than her left), and feelings of anger, frustration and anxiety (particularly regarding the safety of herself and her family). She reported that she had been experiencing these symptoms for the five years since her mother's death.

At the time of our interview, Christine had been in a relationship with her boyfriend for the past eleven years. Together they had three children (aged nine-months, six and eleven years respectively) as well as a nephew (aged five years), whom they considered to be their foster child. Christine shared her two-bedroomed RDP home with eight family members. Christine, her boyfriend and four children shared one bedroom.

Christine was born the middle child of three daughters, and believed that she had always been the "responsible one" in her family. She attended school until Standard 6 (Grade 8), at which stage she left in order to help with the domestic chores at home. From an early age, she cared for both of her siblings, her parents, and her extended family as well – initially emotionally, and in later years, both emotionally and as far as possible, financially. At the time of our interview, Christine was employed as a manual labourer at a local fruit farm. Her family was extremely poor. While some family members had low-paying work, most remained unemployed and many had problems with alcohol/substance abuse.

One week before our appointment, Christine's sister was murdered. She claimed that her usual symptoms of depression had not changed in any significant way since her sister's death. In fact, Christine felt almost indifferent about her sister's death, saying that she and her boyfriend were both "alcoholics" who were "always fighting". She did not get on with her sister very well, and was not overly surprised to hear that one of her drunken disputes had resulted in death. Despite the fact that Christine never felt emotionally close to her recently deceased sister, she believed that it was her duty to care for her sister's children, and it was thus her young nephew that she had recently taken in as her "foster child". Christine similarly assumed a maternal relationship with her own younger sister, who had been living with her since their mother's death in 2006.

Christine wore casual, clean, but noticeably old clothing. She had sad eyes and a beautiful smile. She was shy at first, but I warmed to her immediately. She had a gentle presence and showed a few signs of a delightful sense of humour. She seemed to have an astounding inner strength, personal resolve and love for others, despite all the responsibilities that she carried. Christine was fiercely independent and appeared to take in her stride all the curve-balls life had thrown at her – having to cope with considerable financial constraints, having many sick and dependent family members and young children to care for, as well as having family members with substance abuse problems to contend with. Christine's strength, fuelled by her obvious love for her family, seemed to wax and wane. In the troughs between her generous and energetic waves, she would talk of withdrawing into herself and of wanting to be "left alone in silence and stillness". Listening to Christine's story aroused in me a great deal of empathy, admiration and respect.

4.2.4 Elizabeth (69)

Elizabeth, a sixty-nine-year-old, white, devout Christian widow, was first diagnosed (by a medical doctor) with Major Depressive Disorder in 2001. She had remained on medication (most recently 20mg Fluoxetine daily) since that time.

Elizabeth and her husband had three children. Their first-born contracted meningitis and passed away at the age of eight. Her husband died three years later. At the time of the interview, Elizabeth was unemployed, and lived alone in a small one-bedroomed home.

Although all the other participants in this study were either coloured or black, I included Elizabeth because she fitted all the inclusion criteria, and race was not part of the exclusion criteria of the study (see section 3.4.2.1).

Elizabeth greeted me confidently and with a warm smile. She had short, white hair and wore a simple, old-fashioned dress and pair of shoes. She was not depressed at the time of our interview – she said that she had been stabilised on medication for quite some time – but she wanted to share her previous experiences of depression with me. I felt comfortable with Elizabeth and warmed to her immediately.

Elizabeth was the eldest of nine siblings. They were raised on their parents' smallholding in the rural Western Cape. Elizabeth said that although they were a poor family, she did not know there was any other way to live until she was a teenager, at which stage their poor financial status became more obvious to her. Elizabeth's mother played an important role in managing her large family. Her father suffered from depression and would often spend his days alone in a darkened room. Elizabeth's most frightening memory from her childhood was her father holding a gun and threatening to shoot her entire family. Elizabeth went to boarding school at that time and recalls wanting never to go home so that she could avoid her father and the feelings of fear and confusion which he aroused in her.

Over the course of our hour together, I began to feel tremendous sorrow for the many hardships that Elizabeth had had to endure during her lifetime, from living with a deeply troubled father, to the death of her eight-year-old child and soon thereafter, the death of her husband; to having to raise her remaining two children single-handedly, all the while fighting against the waves of depression that battered her for years. Elizabeth's ubiquitous sadness, connected to the death of her son, affected me greatly as I listened to her recount the story of his passing. Given the tragedy that had coloured her life, I was stuck by the optimistic message that she was determined to convey: that depression is not permanent and that "there is always hope".

4.2.5 Twela (38)

Twela, a thirty-eight-year-old, coloured, Christian woman and single mother of one child (Chandre, aged thirteen), was first diagnosed (by the attending clinic doctor) with Major Depressive Disorder in 2011. She did not want to take any medication, saying that it would not help her. At the time of our interview, Twela presented with frequent tearfulness, very low mood, reports of feeling "unwell" with a sore neck and headaches, as well as feelings of inadequacy and anger related to her interpersonal relationships and her perceived inability to fall pregnant.

Twela was born the middle child of three daughters. Her family was poor and became more so after her father's death, which occurred when Twela was thirteen years old. Her mother worked hard to keep herself and her three daughters together in their home. Twela left school in Standard 10 (Grade 12) and took up employment on a part-time basis in a local fish-and-chips shop – a position she maintained until the time of our interview.

Chandre's father had been killed in a motor vehicle accident in 2000 – a loss which continued to cause Twela tremendous sadness. Two years prior to our interview, Twela became involved in an unhappy relationship with John. She wanted to leave him, yet feared being alone.

Twela lived in her mother's house, together with nine other family members. Although minimal, her salary was higher than that of the other employed members of her family, and for that reason, she had always been expected to provide for their needs. As a single mother who earned a meager salary and was in tremendous financial debt, Twela deeply resented the fact that she was expected to provide for the other members of her family, particularly because she regarded them as ungrateful and also irresponsible with money. They often made purchases that she deemed "luxurious" or they would spend what little money they had on alcohol. This infuriated Twela, who felt powerless to effect any change in them.

When I first met Twela, she was dressed in old work clothes and looked very sad and withdrawn. She greeted me quietly and sat down in a disconsolate position. Within a few minutes of her telling me her story, she began to sob. I perceived her to be kind, intuitive, intelligent, loving and profoundly sad. While listening to her story, I began to feel angry that she was not in a more stimulating job and earning a better salary. I felt angry that her family and her boyfriend were abusing alcohol and taking advantage of her, that the father of her child had died, and that her health seemed to be failing, leaving her feeling sick and scared. I was particularly sad to discover that Twela blamed herself for her situation – claiming that she was "too moody", that she used too many "bad words" and that she was "too impatient". I cared for Twela a great deal. I found myself wishing for the circumstances in her life to improve, and also for her to become more compassionate with and tolerant of herself.

4.2.6 Nina (34)

Nina, a thirty-four-year-old, coloured, non-practising Christian woman and mother of three daughters (aged thirteen, ten and eight years respectively), was first diagnosed (by the district's psychiatric nurse) with major Depressive Disorder in 2005. She was prescribed Trepeline. However, she stated that she did not want to take any medication other than what was prescribed for her high blood pressure and Type II diabetes, because she did not believe that antidepressant medication could help her.

At the time of the interview, Nina had been separated for nine months from the emotionally and physically abusive man to whom she had been married for the previous ten years. Nina left school in Standard 6 (Grade 8). Although she was officially unemployed, she occasionally got paid to do hairdressing for the people in her neighbourhood. She shared her two-bedroomed house with her three daughters and a boarder. Nina slept on a couch in the communal section of their home.

Nina presented with low energy, insomnia, depressed mood, muscle aches, and irritability, anger and hatred, which was primarily directed at her husband. She also described moments of feeling emotionally detached from and uncompassionate towards her children. She felt "unwell", "dark" and "heavy" and observed that her low mood and feelings of anger had been a part of her life for many years, but that she could not let these feelings overwhelm her, because despite occasionally feeling uncompassionate towards her children, she maintained that she had to remain active in caring for them, as no one else was available to do so.

During our initial discussion, Nina described having a “negative life” which had started with her being abandoned on a railway by her biological mother. She was later found and taken to a convent, where she was cared for until she was three, at which stage she was formally adopted. Nina had no recollection of the years at the convent prior to her adoption. She described her adoptive parents as warm and loving. She was close to her father’s family but never felt loved or accepted by her mother’s relatives. Her father passed away in 1999 and her mother in 2001 – she experienced both deaths as overwhelming losses. She had had no contact with her extended family since that time. Despite her difficult start to life, Nina stated that her symptoms of depression had only developed during the past ten years of her abusive marriage.

I perceived Nina’s character to contain a curious mixture of “tough”, “sad” and “confident”. She was very overweight and wore casual clothes. Her bright pink lipstick provided a mocking contrast to her tired, sunken eyes. Nina’s conversation focused primarily on her relationship with her exceptionally controlling, emotionally and physically abusive husband. Her concern for the wellbeing of her three daughters was also evident. Nina felt overburdened by the obstacles and responsibilities in her life, and longed to finish her schooling via adult-education/distance learning so that she could study towards becoming a healthcare worker.

I was sad and felt an immense sense of injustice while listening to the conditions of Nina’s life – the same mixture of sadness and frustration at the injustice of it all that I was getting used to feeling during most of my research interviews. Nina longed to get out of the town where she lived and thereby escape her abusive husband, but could not afford to do so. She longed to become a healthcare worker, but did not have the basic educational qualifications to begin training as such. She longed to feel loved and cared for, but no one was there to look after her. She wanted to talk to someone about her troubles, but could not trust the people in her town. Nina’s stories left me feeling sad, tired, powerless and frustrated.

4.2.7 Evergreen (51)

Evergreen, a fifty-one-year-old, coloured, devoted Christian woman, was first diagnosed (by a medical doctor) with Major Depressive Disorder in 1992. However, she believed that she had suffered from recurrent episodes of depression since childhood.

At the time of our interview, Evergreen presented with symptoms of tearfulness, low mood, low energy, difficulty sleeping, chronic bodily pain and some suicidal ideation. She had been married to her second husband (aged seventy-eight) for the past eight years. They lived alone in a small RDP house. Evergreen had one daughter (aged thirty) and one son (aged twenty-four) from her previous marriage to an emotionally and physically abusive man. After she had completed her final year of schooling, Evergreen went on to become a nursing sister. However, she had been unemployed and on a disability grant (because of chronic back pain and arthritis) since 2004. Her elderly husband was also unemployed.

Evergreen's mother had three children, each from different fathers. Evergreen grew up alone with her mother, who was employed as a live-in domestic helper. She and her mother lived in a small room on the property of her mother's workplace. Evergreen's father was in prison during her childhood, and she described her mother as being frequently drunk and often emotionally and physically abusive towards her. Oftentimes while Evergreen's mother was at work, her mother's male friends would come to her room and sexually abuse her. When Evergreen eventually found the courage to tell her mother about these happenings, her mother refused to believe her, and instead hit and shouted at her. Evergreen also recounted her memories of how her mother, intoxicated with alcohol, would sometimes try to drown both herself and Evergreen. Evergreen believed this was because she looked like her father, and therefore reminded her mother of him, which caused her mother to hate her.

Evergreen worked hard at hiding her true feelings, and this was a significant theme during our discussion. She told me that she was "the great pretender" and that she had a "smiling depression" – that she relied heavily on her façade of joviality to conceal her inner sadness, shame and fear. I mused that even her choice of pseudonym fitted this picture: Ever-green, ever-happy. Discovering what lay hidden beneath that façade made me feel extremely sad and angry. Evergreen suffered a childhood riddled with sexual abuse, a neglectful and abusive, alcohol-dependent mother, and later a similarly abusive first husband. In her later years, she married a man far older than herself, and resigned herself to a life of caring for his needs. It seemed to me that no one had ever really cared for hers.

4.2.8 Linkie (27)

Linkie, a twenty-seven-year-old, coloured, single mother of one child (a son, aged three), was first diagnosed (by a medical doctor) with Major Depressive Disorder in 2000, following an attempted suicide. In the ten years since her first diagnosis, she suffered from recurring symptoms of depression and had attempted suicide via overdose on six recorded occasions. Our interview took place in a hospital, where she had been staying as an inpatient following her most recent suicide attempt, one week previously.

Linkie presented with feelings of sadness, anger, fatigue, hypersomnia, suicidal ideation and tearfulness. She ascribed her characteristically low mood and attempted suicides entirely to her childhood history of chronic emotional and sexual abuse.

At the time of our interview, Linkie and her son lived with her aunt, uncle and three cousins. She had completed her final year of school but had never been employed. She had been involved in a romantic relationship with her first girlfriend, Tina, for the past ten months.

I found it difficult to maintain a flowing conversation with Linkie – she gave very little detail in short, clipped answers. She did however disclose that she had grown up alone with her mother, who was alcohol-dependent and would allow men to fondle or have sex with her for money, which she then used to purchase alcohol. Linkie's vehement anger and despair that her mother would allow such things to happen to her seemed to invade her every thought. Our session was difficult for me. It was interspersed with long silences and I felt wary of Linkie; she seemed to be irritable and despondent. Perhaps she had become closed-off as a means of self-preservation during her traumatic childhood years.

4.2.9 Tracey (32)

Tracey, a thirty-two-year-old, coloured, Christian woman and single parent of one child (a daughter, aged nine), was first diagnosed (by a clinical psychologist) with Major Depressive Disorder in 2007, following an episode of self-harm (cutting and burning) and an attempted suicide.

When I first met Tracey, she was dressed in old, soiled clothing and was obviously pregnant. Tracey explained to me that her previous self-harm and attempted suicide had been in response to the discovery that her boyfriend (and the father of her child) was leaving her for another woman. She was currently eight months pregnant with her second child from the same man. Thus, although her romantic relationship with him had officially ended four years previously, their sexual relationship continued sporadically. Tracey remained profoundly distressed by this and desperately wanted him to be faithful only to her.

Tracey described having experiences of anger, body pain, depressed mood, disturbed sleep and experiences of "night-time panic attacks" – symptoms which she stated worsened on the days following her regular weekend use of alcohol, marijuana and crystal methamphetamine ("*Tik*").

Tracey and her three siblings were born into a poor family. Their father had a long history of alcohol and drug (Mandrax and marijuana) misuse, and was often physically abusive towards their mother. Owing to severe financial constraints, Tracey and her siblings were never able to move out of their family home. Thus she and her daughter lived at home with her parents, her two sisters, her brother and her sister's daughter. Tracey left school in Standard 9 (Grade 11) to take up employment as a seasonal worker on a local farm. As a seasonal worker, she remained unemployed for significant periods of time each year.

I perceived Tracey to be somewhat overbearing and I found it difficult to warm to her. She was forceful in her speech, gestures and behaviour. She would lean in uncomfortably close to my face, to emphasise certain words with an angry or vindictive tone of voice, which created a sense of discomfort and defensiveness in me. These feelings escalated when I realised that throughout her pregnancy, Tracey had been smoking, drinking alcohol and using *Tik*. In all, I found it to be a challenging interview session which aroused mixed emotions in me. In some ways I felt sad for the obvious pain and anguish that had riddled Tracey's life, and in others, I felt angry at her impetuous and deleterious behaviour. I felt completely inept – unable to improve the conditions of Tracey's life, and (specifically in my role as a researcher) unable to stop her from engaging in what I believed were harmful behaviours towards herself and her children.

4.2.10 Melissa (36)

Melissa, a thirty-six-year-old, black, Christian woman and mother of three daughters, was first diagnosed (by a medical doctor) with Major Depressive Disorder one month prior to our interview. However, she reported that she had felt depressed for the most part of her fifteen-year marriage, because of her husband's alcohol dependence and abusiveness. At the time of our interview Melissa described having feelings of low mood, fatigue, ill health, bodily pains, aggressiveness, irritability and some suicidal ideation.

Two of her daughters (aged six and ten) lived with her and her husband of fifteen years, in a one-bedroomed RDP house. She and her husband were both unemployed and relied on the AllPay grant (R800 per month) as their single source of income, half of which was sent to Melissa's mother in Cape Town, as payment for taking care of her eldest daughter (aged fifteen).

Melissa was born into a poor family, as the middle child of three siblings. She had vivid memories of her father regularly beating her mother, especially when he was drunk. Her father died when Melissa was sixteen years old.

Melissa left school in Standard 5 (Grade 7), and moved out of her mother's small home when she married her husband at twenty-one years of age. Her two siblings continued to live with her mother, along with their children. Melissa said that she wanted to leave her husband and return to her mother's home, but that she could not do so, because her mother's house was already overcrowded. Having promised herself that she would find a better husband for herself than her mother had managed to, Melissa was sad and disappointed that her own husband similarly abused alcohol and became verbally and physically violent towards her.

When I first met Melissa, she had dark circles around her eyes. She looked tired, angry and sad. She spoke at length about how her husband would become drunk and abusive multiple times per week, and how he would often hit her while she was holding her children. Melissa longed to escape her husband but felt that she had nowhere to go. Her sense of hopelessness and helplessness made me feel sad and equally powerless. I was particularly sad to hear that Melissa's greatest times of distress were when her children had to go hungry. I left the interview session feeling sad and dismayed that Melissa, such a sweet and gentle lady, was essentially trapped in such a difficult and hopeless situation.

4.3 Culturally specific terminology and use of metaphor

Culture influences the experience and expression of all mental illnesses (Yardley, 2000). Sensitive contextual awareness is therefore vital to effective cross-cultural psychiatric theory and practice. Consistent with this, Hornstein (2013), a feminist and psychological phenomenologist, writes that culturally specific terms need to be carefully acknowledged and investigated if we are earnest in our attempts to better understand a phenomenon from the perspective of the experiencing person.

To this end, one of the first observations I made when discussing the experience of depression with the women in this study, was that they seldom used the word "depression" of their own accord. Rather, they tended to describe their emotional experiences by using words such as "stress" or expressions such as "freaking out".

> Carla: Do you think that you're depressed at the moment?
>
> Linkie: I don't know.
>
> Carla: Have you heard the word "depression" before?
>
> Linkie: Yes.
>
> Carla: And how do you understand it? What do you think it means?
>
> Linkie: I don't know exactly what is depression. I heard the word "stress" but not "depression".
>
> Carla: OK. Do you think that you feel stressed?
>
> Linkie: Yes.

> Carla: What does it mean to you, to be "depressed"?
>
> Christine: Just thinking and stress about stuff, just thinking about my problems, and I seeing now "Oh, my relationship is not on a level now that it should be", and finances and start freaking "Oh, my kids is doing not well at school"…

> Twela: But I don't want Jet to be in debt, you know. That is freaking me out because, but [sighs], I must learn to not stressing about every little thing, and that, that's my problem: I'm stressing about every little thing…

While it appeared that these terms – stress, freaking and depression – could be used interchangeably in many of the women's descriptions of their emotional experiences, being "stressed", "stressing" or "freaking" seemed at times to connote a very subtle self-blaming – as though one should not allow oneself to behave badly by "stressing", or that one's tendency to "freak" was indicative of the fact that one had a problem.

In her study of low-income South African people living with HIV/AIDS, Andersen (2012) similarly noticed that many of her study participants used culturally specific terms, such as "darkness", to explain their experiences of depression. The word "dark" (and its derivatives) was also often used amongst this study's participants, as a metaphor for their experiences of depression.

> Elizabeth: …I'm talking to the Lord, "Why is this happening to me, all this darkness?"

> Nina: At this moment, is very dark for me. Maybe if I go out, out of this town, maybe it's going to be a little bit lighter. A new experiences and stuff. I must first, it's not so easy, also, just to go, because there's kids in school, you know, there must be a place to stay, I must get work, and you know, it's not easy, but I'm just trying. I'm going to the Welfare. I must stand up and do it!
>
> Twela: [Crying] …I just kept quiet about my, my darkness and whatever I feel inside me… That, that, that feeling what I had inside me, that, that, that bitterness and all that dark things that I had, ah, *hoe kan ek nou se* (how can I now say)? …And if I feel like cry, I just cry, and if I feel like shout, then I want to shout. But there was a time that everything was, *hoe kan ek se* (how can I say)? Just dark… That's why I'm sometimes lonely, and I feel like sometimes depressed, or something like that. That's why I'm in a dark corner, or in a dark room or my face tells them that they must leave me alone…
>
> Carla: What is it like for you to feel depressed? How would you describe it?
> Evergreen: [Crying] The worst, ever, a dark, a big dark hole I'm getting under and there's no light. And I feel that I live in a house and there's no windows and stuff, you know? It suffocates me. And it's a real, the word I find, it's rotten, it's a rotten feeling. It's so bad, Oh! I feel I can get out of myself and run away from myself. Because I don't want to feel this way.

J.P. Smith (1997) writes that some of the component features of depression, specifically pessimism and emptiness, are often grouped under the experiential theme labelled "darkness", and further, that this term is commonly used in many cultures internationally to describe the experience of depression. As has been shown above, darkness was certainly a frequently used metaphor for the experience of depression amongst the women in the current study.

Another phrase that was used extremely often by the participants when describing their experiences of depression was "I am not myself". Because of its prominence and the frequency with which it was used throughout the interviews, it will be considered separately and in depth in section 4.5.7 (Experience of the self: A lost self).

4.4 Bodily experiences of depression

It is significant that all the participants in this study experienced and expressed their depressive symptoms in bodily (i.e. somatic) terms. Even more noteworthy is the fact that each participant mentioned somatic experiences ahead of any other troubling symptom. When posing questions such as “Do you think that you are depressed?” or “What does it feel like to be depressed?” I was surprised to receive answers that focused so intently on bodily experiences – most often trouble sleeping, fatigue and bodily pain. These experiences caused the study participants immense physical and psychological discomfort. As such, each will be considered separately below.

4.4.1 Sleep disturbance

Sleep disturbance was immediately and repeatedly equated with depression by many of the women whom I interviewed. Moreover, it was usually the first experience they chose to speak about in our interviews. Some even regarded their inability to have restful sleep as their most significant symptom of depression.

> Carla: When was the first time that you started to feel depressed?
> Anna: Um, a long time ago, that I feel I’m not myself. I’m not sleeping, um, my, I feel like I’m getting upset for anything… So the doctor told me that he’s going to send me to you, because why, um, I don’t sleep so he’s feeling that I am depressed and getting worse, so I must see someone.
>
> Carla: …And you’re very sad that you can’t have a child for him.
> Twela: [Sighs] Yes and, [whispers] *ek weet nie* (I don’t know). *Ek kan nie, ek kan nie slaap nie* (I can’t, I can’t sleep).
> Carla: You can’t sleep?
> Twela: I can’t sleep any more.
> Tracey: Then I’m wake up and then I sit the whole night, waking.
> Carla: So you’re not sleeping properly?
> Tracey: No, I don’t sleeping.

Sleep disturbance or insomnia was undoubtedly the experience the women most often equated with their depression, and correspondingly seemed also to be the symptom most often attended to by their family members. As such, it was often given primary focus and was thought to justify the need for medication. Hence, many of the women mentioned "sleeping tablets" as something that helped them through their depression, or in response to being questioned about the medical treatments they had previously received for their depression.

> Anna: I was feeling well, because the sleeping pills did help, most of the time. But the meds is up, it's like going back – because I don't sleep.
>
> Carla: Has anything the doctors have done helped you?
> Chenille: Doctor Smit had speak with me, and, but not every night I drink, not every night those pills, Trepeline, when I cannot sleep any more. It's not every night that I drink them. Only when I need them.
>
> Elizabeth: Doctor asked me, he looked in my eyes and he said "what's wrong?" And I told him how I feel: I lie awake at night, I'm up at night and I want to go to the safe and shoot me. And he said "you're depressed" and I must go to (town name) hospital, and he said to me "do you know you had depression?" …He (the doctor) himself had depression and um, he explained it very, um, so that I could understand exactly what has happened to me. I slept bad, and more bad, and some nights I sleep nothing… *Ja*[2]*, ja*, and he put me on a sleeping pill, to sleep. So I can sleep and rest, and um, as I say, I thought, when I return, I feel better and better… The sleeping pills makes that I slept from twelve o'clock in the evening 'till six in the morning. So, in a way I was feeling better, because I could get rest during the night.
>
> Nina: She (the nurse) said, she didn't really say nothing. She just gave me pills to sleep and calm. Then, um, I didn't drink that pills. I was drinking it, but I stopped drinking it... And, even now, at night, I don't sleep…

According to the DSM-5, sleep disturbance (either sleeping more or less than usual) is a recognised symptom of depression (APA, 2013). Consequentially, it is a symptom

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[2] "*Ja*" ("yah") is the Afrikaans word for "yes" and is widely used in everyday South African English.

to which most medical personnel are alerted. Barrett (1996, as cited in Georgaca, 2013) offers a sound explanation for this:

> Once a diagnosis is given and a person's troubles are reformulated in psychiatric terms, professionals' interactions with clients actively encourage them to adopt this perspective when describing their experiences... Clients seem to learn, for example, through repeated interviews with mental health staff, to self-select and volunteer from the range of their experiences only those that are relevant to a psychiatric examination. (p. 57)

As my interviews with study participants took place in a clinical setting, it is likely that Barrett's explanation is applicable – namely, that the women first disclosed their sleep problems when being questioned about their mood because they had been previously primed on this topic, and/or because their sleep-related symptoms typically received the most attention during their previous interactions with the healthcare staff at their clinic. On another level, it may also symbolically refer to the inability to rest, to be peaceful or to relax. From this perspective, the women's heightened state of awakening corresponded both with their expressed sense of anxiety (see section 4.5.3) and with their experience of fatigue, which will be explored in the following section.

4.4.2 Tiredness

The women linked their inability to rest peacefully or sleep at night with their experience of fatigue and lethargy during the day. They spoke not only of a physical tiredness, but also of an emotional fatigue. In the excerpt below, Elizabeth describes feeling so tired during her worst experiences of depression (to which she referred as being "sick" with depression) that she was unable to attend to her prized garden or even engage in basic self-care and grooming.

> Elizabeth: And suddenly, when they left home, it's as if my body say "It's done. End!" I just collapsed. I, I start feeling tired, I lose weight and I didn't know what was going on… When I was sick, everyone could see in my garden, I didn't even bother. Everything was dying; it looked bad. And when I am feeling a bit better, I attend to my garden and I plant things and I water it

> and somebody stop in the street and look at me and said to me "you're getting better!" But, as I said, I just, you just, you're just so tired. So tired. I even don't get up in the morning. It feel like a big, big job to wash my hair, to put my hands on (my head). And I can understand how people neglect themselves, lay in the dark, don't bath, don't wash their hair, but you haven't got – you're so weak and tired – you can't describe it to someone else.

Like sleep disturbance (discussed above), fatigue is a recognised symptom of depression in the DSM-5 (APA, 2013). Perhaps the women emphasised their fatigue for the same reasons they emphasised their sleep disturbances – namely, that those are the symptoms that receive the attention of medical personnel (Georgaca, 2013). As discussed in the section on sadness (section 4.5.4), I began to notice that most of the women were more inclined to say "I am tired" than "I am sad".

> Tracey: I'm tired of fighting, with my own life. I'm really tired… I'm tired of fighting, about him and this bloody man. [Whispers] I'm tired… I'm fighting that for four years now. But it don't want to stop. I'm now full. I'm tired. I'm tired.

In the excerpt above, for example, it seemed to me that Tracey could have used the word "sad" in many of the instances where she used the word "tired". Even her interesting statement "I'm now full" seemed to suggest that she had become battle-weary and full of sadness. Similarly, both Twela and Evergreen used the word "tired" when they were obviously profoundly sad.

> Carla: So he doesn't really understand your sadness?
> Evergreen: [Crying] No. In my, um, lounge wall I have all the photos of the children, and I just sit there.
> Carla: [Whispers] You look very upset.
> Evergreen: [Whispers, crying] I'm tired. Oh.
>
> Carla: What are you feeling?
> Twela: Tired. I don't know how I feel, but, [crying] I am very scared.

Twela could not articulate why she was scared, and it seemed to me that she intended this explanation to function in the same way that "I am tired" did – as a blanket statement that was designed to halt any further investigation into her feelings. Once again I could not help but wonder if there existed a silent cultural norm that disallowed the articulation of sadness.

Ussher (2013) contends that women signal their emotional pain through culturally approved symptoms, which allow their distress to be considered "real". I too began to believe that "feeling tired" might function as one of those culturally sanctioned symptoms which allowed the women to explain their behaviour and speak about their distress indirectly. Speaking about having bodily pain (as seen in the following subsection) probably functioned in the same way. This of course is not to say that either their fatigue or pain was imaginary. (On the contrary, both were clearly experienced by the women in this study, particularly in conjunction with their experiences of depression.) It is merely to say that most of the women spoke about these aspects of their depression ahead of any other.

4.4.3 Body pain

The following excerpts show how many of the women interviewed chose to speak about their experiences of bodily pain when questioned about their experiences of depression.

> Christine: …Yes, because my mind at times, because when I'm thinking a lot, and then I get a headache. I can't open my eyes. I just sit and drink pills.
> Carla: What pills do you drink?
> Christine: Pain pills. I buy it at the chemist.
>
> Elizabeth: My, um, I was still working in the library that Friday. And I went to my doctor, he was in (town name), and I didn't realise it was depression. I thought, I look at people and I had no idea what's depression like, and I've never, I've never could imagine that your whole body is full of pain. You feel like it everywhere, like your –
> Carla: Physical pain?

> Elizabeth: *Ja, ja*, you've got pain everywhere…

> Elizabeth: …*Ja*, I, I know, I know that sort of pain: the loss of a child – that pain – you feel that pain from your head to your toes.

It was interesting to observe that having begun to talk about their emotional experiences, the women would often suddenly switch to a discussion of their physical maladies. At times this switch seemed to be made unconsciously. At other times, however, participants (Evergreen and Christine in particular) indicated a clear awareness of the fact that they disguised their emotional pain by focusing on their physical discomforts. Christine and Nina acknowledged the fact that they preferred to tell the hospital staff that they had physical pain rather than admitting that they felt sad.

> Carla: Can you tell the clinic sisters that you're sad?
> Christine: No. I just come with a headache problem.

> Carla: How would you describe the feeling of depression to somebody else?
> Nina: The day I get depressed, *né*[3], I just don't want to talk to no one. I don't think, I just smoke and I drink a lot of coffee, and if I don't have coffee, I drink tea. And that's all. I never – I go for, this heartache, *né*, but it's nothing and (doctor) Smit tell me that it's depression.

Similarly, Evergreen admitted that she tended to disguise her emotional pain as physical malady.

> Evergreen: *Ja*. So at times I cry and then he sees and "What's wrong with you?", "No, it's my knee. My knee pains" – and it's not my knee, you know?
> Carla: You just pretend it's something physical?
> Evergreen: *Ja*.

---

[3] The word "*né*" is commonly used in everyday spoken Afrikaans, usually to mean "yes?" or "do you follow/understand/agree?"

The women's tendencies to report physical pain (headaches, heartaches, aching bones and bodies) rather than emotional pain became increasingly apparent to me during the interview sessions. For instance, towards the end of a particularly emotional discussion with Christine, I asked her to describe how she was feeling, as I thought that she was looking incredibly sad. Yet she maintained that it was the pain in her leg that was most troubling to her.

> Carla: How are you feeling now?
> Christine: I'm feeling alright, but my leg starts to pain now.

The DSM-IV-TR stated that in general medical settings, people with depression "have more pain and physical illness and decreased physical, social and role functioning" than non-depressed people (APA, 2000, p. 371). It further assumed that some pain was associated only with psychological factors, some with medical disease, and some with both. The more recent DSM-5 takes a slightly different approach, saying that it is impossible to make such distinctions, and that psychological factors influence all forms of pain (APA, 2013). It thus appears that the DSM remains consistently aware that bodily pain is not an uncommon or disconnected feature of depression. However, not much more than this is stated, and bodily pain is certainly *not* listed as one of the nine possible DSM-5 criteria for a diagnosis of depression.

Pertinent to the South African context, researchers have recognised that different population groups experience emotional distress in different ways. This point is particularly relevant when considering South Africa's undemocratic social history and multicultural composition. In a literature review on the presentations of depression, Tomlinson et al. (2007) commented that a substantial body of research suggests that depression may manifest in somatic form in certain African populations. Confirming this hypothesis, Ngcobo and Pillay (2008) reviewed the mental health records of women who presented with depression at a government hospital in KwaZulu Natal, and found that 75.9% of the participants cited pain as their most troubling symptom. Similar results were found by Lochner (1999). These authors explained that in the context of depression, bodily pain can be considered a physical expression of emotional pain. In this way, the pain may symbolically represent a person's emotional status. Of course, having bodily pain might also legitimise a person's help-seeking behaviour in a context where many needs compete for limited resources.

Thus, pain may symbolically represent one's emotional status, and physical expression can sometimes be used instead of verbal expression of emotion (Jenkins, 2001; Liebert, 2010; Lochner, 1999). Methods of help-seeking that rely on the body have been recognised in other studies too (Cosgrove, 2000; Cosgrove, 2005; Lochner, 1999; Nettleton, 2006). It therefore seems important that researchers and clinicians begin to attend more closely to physical modes of emotional expression, as so doing has the potential to improve treatment and general client-patient collaboration (Nettleton, 2006).

4.5 Emotional experiences of depression

A number of recurring themes were revealed in participants' explanations and descriptions of what it "feels like" to be depressed. Most prevalent were the emotional experiences of anger, loneliness, anxiety, sadness, guilt and shame, powerlessness, and a changed sense of self. The women described these feelings as forming the component parts of their overall emotional experience of depression. As such, each will be outlined and discussed below.

4.5.1 Anger

The Dictionary of Psychology (Reber, 1985) defines "anger" as:

> A fairly strong emotional reaction which accompanies a variety of situations such as being physically restrained, being interfered with, having one's possessions removed, being attacked or threatened, etc. …As with many emotions, anger is extremely difficult to define objectively. The problem is that it is a rather fuzzy concept and hedges into other emotional reactions of similar kind such as animus, rage, hostility, hatred, etc. (p. 35)

Almost all of the participants in this study clearly described experiencing strong emotions of hostility and anger, and further, considered these to be component parts of their depression. When asked “What does it feel like to be depressed?” many of the women responded with statements such as “When I’m sad, I get angry” and “I’m just angry”, as seen below.

> Christine: My down days is when I’m angry.
>
> Twela: It’s, I’m just sitting there and, and, I don’t want to, to, to stand up, to do things in the house. If I want to lay down, I just want to lay. I don’t want to stay up and, and do things… And I just… just... *aggressiewe* (aggressive)… Yes. If I told you to do the thing and you don’t do that, or you make too long, and I’m just angry and I shout at you, and, and, and… I just get angry for every little thing… That’s it, *né*! You know… when I’m sad, I get angry.
>
> Anna: I’m out of order… I keep it in, in, in. I don’t talk, I’m just angry. For a week, for two weeks, I’m not talking to him, I’m just angry… So, um… when I’m arguing with him I’m getting angry. So I want to fight with him – fight with him – and cry [sighs]. I am feeling that… very hatred for them.

Through disclosures such as “My down days is when I’m angry” (Christine) and “When I’m sad, I get angry” (Twela), it became apparent that for these women, their anger was just as much a feature of their depression as was their sadness.

Many psychologists have suggested that women tend to passively suppress and turn their anger inwards towards themselves, where it manifests as depression (McWilliams, 1994; J. Newman, Gray, & Fuqua, 1999). This was certainly *not* seen to be the case for the participants in the current study. Rather, their anger was actively manifested outwardly, in the form of aggressive feelings and behaviours that were directed both at others and at themselves. This will be discussed further in sections 4.6.3 and 4.6.4, under the heading “Behavioural manifestations of depression”.

Anger was also a significant finding in Lochner’s (1999) study of a low-income South African community. Specifically, Lochner observed that her participants frequently reported that they would engage in screaming, swearing and physical violence to communicate their needs and sadness. Taylor (2011) uncovered similar findings in her intersubjective psychoanalytic case study of depression in one low-income South African woman. Disclosures not only of persistent frustration, but also of anger and absolute rage were noted throughout Taylor's paper. Similar findings again emerged in Lourens and Kruger's (2013) qualitative study, which clearly noted anger as a component of the overall experience of depression amongst low-income women.

Recent international research has suggested that there are clear gender differences in the pathologisation of emotions – specifically anger. Men's sadness and anger is often thought to be an understandable consequence of situational factors (e.g. "having a bad day"), while women's sadness or anger is more often thought to be evidence of pathology or of her "being emotional" (Barrett and Bliss-Moreau, 2009, as cited in Ussher, 2013). Perhaps it was for these reasons that the female participants in the current study were distressed by and ashamed of their "bad" angry feelings, as indicated below in the excerpt by Twela.

> Twela: I don't want to be that person, that "bad" person, like swearing and whatever. And I don't want to be impatient. It isn't right to swear to express your feeling, to be impatient to express your feeling, it isn't right. So I don't want to be that person. I want to be, ah, calm, still and, I want to be that person. Yes, and I don't want that angry. It's, it's frightening. I don't want that angry. And, and, and it isn't good because, ah, we can do anything wrong, you can for instance, can make somebody hurt or you can hurt yourself. I don't want that kind of angry… I want to talk with a kind voice but I don't want to shout back and ignore them or whatever, I don't want to do that…

It is possible that women like Twela are ashamed of their angry feelings because the topic of female anger is largely obscured (if not silenced) in many contexts. Feminist psychologists such as Jack (1991) suggest that the culture in which most women are raised encourages the denial of the many forms of aggression that intimate relationships with others can evoke and entail. Jack also highlights the fact that discussions on femininity tend to omit the subject of anger, specifically how women can express anger towards their family, their friends and themselves. These authors contend that the social constructions of a "good" woman indicate that women should not experience, much less express, anger (Jack, 1991; Lafrance & McKenzie-Mohr,

2013) and observe that this is largely implicated in the frequent occurrence of female depression.

Other feminist authors offer additional explanations for the occurrence of anger and depression in women. For instance, the onset of depression has been linked to the experience of sexual abuse and other traumatic life events, which are more common among low-income than high-income women (Belle & Doucet, 2003; Roseman, Antoniou & Jose, 1996; Ussher, 2013). As written by Lerner (2004), "our anger may be a message that we are being hurt, that our rights are being violated, that our needs or wants are not being adequately met, or simply that something is not right" (p. 1). Perhaps then, when we remember that the women who partook in this study had frequently been abused, mistreated, disrespected, overburdened and neglected during the course of their lifetime (see section 4.7), their anger becomes more understandable.

Thus, anger emerged as a prominent feature of depression amongst the women who partook in the current study, and also in a number of other similar South African studies (Kruger et al., in press; Lochner, 1999; Lourens & Kruger, 2013; Taylor, 2011). Despite these findings, as well as those of other researchers and clinicians who acknowledge "a considerable relationship between anger and depression" (J. Newman, Fuqua, Gray, & Simpson, 2006, p. 160), anger is not a recognised symptom of depression in mainstream diagnostic manuals (Sadock & Sadock, 2007). In the DSM-IV-TR (APA, 2000) it was said that depression may manifest as "irritability" in young children or adolescents, but this possibility was not extended to adult populations. The more recent DSM-5 went a few steps further by stating that anger may be a "diagnostic feature" of depression, and acknowledged that "many individuals report or exhibit increased irritability (e.g. persistent anger, a tendency to respond to events with angry outbursts or blaming others, an exaggerated sense of frustration over minor matters)" (APA, 2013, p. 163). Despite this acknowledgement and the multitude of studies that recognise the frequent co-occurrence of anger and depression, it is still not regarded as a possible diagnostic criterion for depression. It is also noteworthy that while the DSM-5 discusses anger as a possible *feature* (not *criteria*) of depression, it does so with reference to "personality disturbances" and "cognitive styles" that may account for anger outbursts and/or depression. No mention is made of justifiable anger or the various social contexts or interpersonal conditions that may logically cause one to feel angry. Unsurprisingly, it is this individualistic and person-blaming stance of the DSM that is widely criticised (Lafrance & McKenzie-Mohr, 2013; Marecek & Gavey, 2013; Swartz, 2013).

4.5.2 Loneliness

The Dictionary of Psychology (Reber, 1985) does not provide a definition for the world "loneliness". The word represents a theme heading in this study because it was used repeatedly by the participants to indicate their feelings of being desolate and without companionship.

Given that all the women who participated in this study lived in small, close-knit communities, and that most of them lived in over-crowded houses (i.e. that they all were frequently in the presence of other people), I was struck by how "lonely" each of them appeared and claimed to be.

> Elizabeth: It was now, the thoughts, the thought of loneliness. Very often because my, my, I feel lonely now, I feel lonely now. Feel lonely. What's the, um, what's the use of going on?
>
> Twela: I just feel, ah, sad, sometimes I feel lonely and then sometimes I just feel a bit darkness and then I just start crying or I just, angry… But, but, but the other emotions, ah, the other emotions, like ah, sadness and loneliness, I just feel like that every time.
> Carla: Sadness and loneliness?
> Twela: Loneliness. That's why I, I stay in my room watching TV or sleep when I want to sleep… That's why I'm sometimes lonely, and I feel like sometimes depressed, or something like that.

Most of the women's experiences of loneliness seemed to stem from an absence of close emotional attachments and support. The fact that these women correlated their feelings of depression with their feelings of loneliness (despite the fact that their living and working conditions necessitated that they were almost constantly in the presence of others) coincides with Stoppard's (1999) conceptualisation of depression as a disease in which women feel as though they cannot form meaningful connections with other people. Probably related to this, feeling misunderstood was commonly reported by the women in this study, and no doubt served to exacerbate their general sense of loneliness.

> Anna: [Crying] Yes. Even though they don't understand what I'm going through now…
>
> Nina: I can't explain it. It's so hard to explain because, there are so many things that going through, that I go through, I don't know… I don't know if people understand me and if they'll ever understand me, because, I'm just, I'm just a lot, and there's a lot of things to talk about, for days and days…
>
> Twela: *Ja*. Sometimes it feels, sometimes I feel that I give all that I have inside me for him, but I didn't get back... He, he, doesn't understand what I want for, for, for, for, all, for, for, for us all, and he can't understand me…

Further, it seemed that the participants' experiences of feeling alone were linked to a number of different emotions (e.g. sadness), beliefs (e.g. "I must not burden others with my sadness") and behaviours (e.g. hiding feelings). Hiding feelings in particular was frequently mentioned by study participants, and is therefore discussed separately in section 4.6.1.

Overall, loneliness constituted a significant theme amongst the women who participated in this study, as well as in the similar studies by Taylor (2011) and Kruger and Lourens (2013). Loneliness was also one of the most prominent findings in Herbst's (2006) research regarding HIV-infected low-income coloured mothers living in the Western Cape region of South Africa. Collectively, these qualitative studies give credence to the importance of the experience of loneliness as a significant feature of (and possible precursor to) depression in low-income women.

While a number of international papers (DeBerard & Kleinknecht, 1995; Lewis, 1996; Waite, Hawkley, & Thisted, 2006; S. Weiss, 1973) have explored the links between loneliness and depression, relatively little South African literature has done so. One recent South African study (Doman & Le Roux, 2010) conducted a literature review on the causes of loneliness and the factors that contribute to it. The authors asserted that loneliness could contribute not only to depression, but also to suicide, alcoholism and psychosomatic illnesses. These observations are in agreement with DeBerard and Kleinknecht's (1995) findings that both the intensity and, more specifically, the duration of loneliness are predictive of symptoms such as anger, anxiety, somatic complaints and depression. Doman and Le Roux (2010) point out that loneliness can cause depression, but depression can also cause loneliness, so the relationship between the two should be considered bidirectional. Either way, the fact remains that in this study (and indeed in a number of recently conducted qualitative studies of depression in low-income South African women), feeling alone appears to be a significant component of the overall experience of depression.

4.5.3 Anxiety

The Dictionary of Psychology (Reber, 1985) defines "anxiety" as "A vague, unpleasant emotional state with qualities of apprehension, dread, distress and uneasiness" (p. 43).

While reading through the raw data, I assigned the note "anxiety" to all symptoms of general worrying, fear and apprehension that emerged during the research interviews. It was noticed that many anxiety-related experiences were described in physical terms, such as dizziness, insomnia, nausea or "panic attacks". Elizabeth, for instance, felt that her experiences of depression went hand-in-hand with her experiences of having panic attacks. In an effort to communicate what those experiences were like for her, she wrote a poem for her family and brought it to her interview so that she could also share it with me.

> Elizabeth: But it was three very bad years with a lot of panic attack… *Ja*, after my depression I start writing poems for my family, and, OK, Panic Attack:
> Would the hell be more bad?
> What I'm going to do with all the frights?
> I rattle, I shake. I sweat.

> I'm talking to the Lord: "Why is this happening to me, all this darkness?"
> My left arm and jaw became lame
> I feel so tired
> Am I going to have a heart attack?
> Am I going to get bad?
> …Oh yes, a lot of that… it was during my depression. That was, terrible. Oh, it's terrible! I even haven't got the right words to describe it to someone. Only someone who has experienced it can exactly understand what you're talking about. I sometimes said to my children "I feel I've lost control over my own life". *Yoh*! (expression of exclamation) it was very bad…

The anxiety Elizabeth felt over losing control not only of her body, but also of her entire life, was something that she found impossible to describe: "I even haven't got the right words to describe it to someone."

Other participants evidenced their anxiety through disclosures of rumination or being distracted by troubling thoughts:

> Twela: [Sobbing] And it's my fault for eleven years I was alone, anything that gets wrong, I get a fright. Some nights I just sleep, *né*, and I dreamt about who, my son dying and that kind of thing. It scares me…

> Christine: I think a lot about what is going to happen and stuff… This is why I am afraid now. I don't know what, I cannot concentrate on work because my child is sick… But, I just pray "Dear God must help me." Also if she is sick. He must help me, every day help me. On Friday night, I cannot sleep… I was the whole weekend I was thinking about the child… worrying… Because my uncle is there, sick: TB. Yesterday he is going, just laying there, and I'm just taking his food and saying "come, walk a little bit" and he said "OK" and he stand up and walk and say "don't worry about me, I'm fine." And I say "No, you are not fine"… and he tell me "You are always stressed about our sickness!" And I said "Yes, I'm worried about you."

As seen above, words such as “afraid”, “worry” and “stress” repeatedly featured in Christine’s accounts and indicated that a pervasive sense of anxiety permeated her daily life. In this particular excerpt, Christine was focusing on illness in her family – her own child’s sickness as well as her uncle’s tuberculosis. As she did not have the financial means to provide proper healthcare for her family, perhaps she felt that her only options were to “worry” and to “pray”.

Anxiety was similarly a common feature in Evergreen’s descriptions of her daily experiences. She described entertaining an intrusive sense of dread that “something was going to happen”, and later suggested that perhaps this was caused by the fact that “so many bad things” had happened to her during her lifetime, that she had become accustomed to “waiting for the next bad thing”.

> Evergreen: ...Because if I get anxious, I talk a lot… I’m scared, most anxious, scared, you know? Everything, even um, I just say everything must, there was something going to happen. You know, because I always had to be on the lookout, and be on my guard and, something to, something’s going to happen…

As appeared to be the case for Evergreen, exposure to physical and sexual abuse is commonly associated with the onset of anxiety and depression (Martinez, Israelski, Walker, & Koopman, 2002). It is therefore not surprising that anxiety emerged as a prominent feature in this study, as all of the participants lived in communities where crime and interpersonal violence were relatively common occurrences, and many of the participants had childhood and/or recent histories of physical and/or sexual abuse. Supporting these findings, Faure and Loxton (2003), Theron (2005), Taylor (2011), and Kruger and Lourens (2013) all found that most South African women who were diagnosed with depression were also found to have anxiety disorders. These findings are not unique to this study or to the South African context in general. Many international authors have commented on the frequent co-occurrence of symptoms of anxiety and depression (Barlow, 1991; T. Brown, DiNardo, Lehman, & Campbell, 2001; Rivas-Vasquez, 2001; Watson, 2005; Mineka, Watson, & Clark, 1998).

It was therefore a surprising omission (and one which was often criticised) that the DSM-IV-TR did not formally recognise anxiety as a common feature of depression (APA, 2000). The recent DSM-5, however, has responded to these criticisms and recognised the substantial body of research that indicates the importance of anxiety as relevant to the treatment, decision-making and prognosis attached to a diagnosis of depression. The new specifier "with anxious distress" has been added to the DSM-5 to allow clinicians to rate the severity of anxiety in patients who have been diagnosed with depression (APA, 2013). Similarly, the International Classification of Diseases (ICD) contains a diagnosis of Mixed Anxiety and Depression (WHO, 1992). Most authors agree that because symptoms of depression and anxiety tend to exacerbate each other, and as both can influence all other health-related behaviours (such as substance use, sexual risk taking, medication compliance etc.), both should be closely attended to not only during assessment and diagnosis, but during treatment implementation too.

4.5.4 Sadness

The Dictionary of Psychology (Reber, 1985) does not provide a definition for "sadness". The word is used here to indicate a lack of happiness, and is presented as a theme because references to the emotional experience of sadness were made consistently throughout the interview sessions.

However, it must be noted that while sadness was absolutely implicit in each participant's disposition and story, it was seldom explicitly mentioned. Indeed, in some participants' descriptions, it was not articulated at all, and was only inferred via other disclosures, a general tearfulness or a melancholic disposition. Participants spoke easily about their trouble sleeping, bodily pain, anger and stress – I noticed that they were far more likely to say "I feel angry" or "I feel tired" than "I feel sad". In contrast, "feeling sad", if brought up at all, was usually only mentioned briefly.

> Twela: I just feel, ah, sad, sometimes I feel lonely and then sometimes I just feel a bit darkness and then I just start crying or I just, angry… But, but, but the other emotions, ah, the other emotions, like ah, sadness and loneliness, I just feel like that every time.

Like Twela, Melissa too used the word "sad", but specifically in reference to her felt responsibilities towards her children. Although she did eventually articulate the fact that she felt sad, it should be noted that Melissa's expression of "worry" preceded her expression of sadness.

> Melissa: And I worry about the children, also.
> Carla: Do you feel responsible for them?
> Melissa: *Ja*. Because they're alone there, and he drink also.
> Carla: Does he hurt them, as well?
> Melissa: Shouts them and they, he don't hit them, but he just shouts them, and shouting and screaming.
> Carla: How does it make you feel when he's shouting at them?
> Melissa: Oh, very sad. That's why I take them and we go off, for long walks, out back.

Rather than "sad", Anna and Linkie used the words "upset", "devastated" and "too hurt" to describe their feelings.

> Carla: When was the first time that you started to feel depressed?
> Anna: Um, a long time ago, that I feel I'm not myself. I'm not sleeping, um, my, I feel like I'm getting upset for anything
> Anna: I was so devastated because, you can't, love is not something you can buy.

> Carla: Linkie, can you describe for me what you're feeling right now?
> Linkie: [Whispers, crying] Too hurt.

It is possible that sadness was seldom explicitly expressed by the participants in this study because many of them felt that it was disallowed. Indeed, the following excerpts from Nina, Christina and Evergreen all suggest that they believed that they should not show their sadness. Most of them appeared to believe this because of previous reactions from loved ones – during their times of expressed sadness, they had been told that they were "mad" or that they "mustn't feel like that".

> Nina: …I cry these days. “You are mad! Why you crying? You are my wife and I’m in a relationship with you”…
>
> Christine: Mmm, they say my face is very sad. When I sit like this, somebody says “No! Don’t sit like this!” Even my uncle, he told me, “No don’t sit there, you are thinking a lot”, OK and then he start to make a joke.
>
> Evergreen: …Or that I’m missing my parents or so, I say for him “I feel – ” he say “No, you mustn’t feel like that. Because if you cry, you tell the Lord that he made a mistake, by taking away your parents and taking away all your loved ones.”
> Carla: He tells you, you shouldn’t be crying?
> Evergreen: *Ja*. So at times I cry and then he sees and “What’s wrong with you?”, “No, it’s my knee. My knee pains”, and it’s not my knee, you know?
> Carla: You just pretend it’s something physical?
> Evergreen: *Ja*.

Sadness therefore appeared to be disallowed in the communities where these women lived. Even sitting in a disconsolate posture or “looking sad” was forbidden (“No! Don’t sit like this!”, “No, you mustn’t feel like that”). Sadness, it seemed, was such a taboo that it could barely even be named. Rather than acknowledging that Christine looked sad, her uncle told her that she was thinking too much, and implied that she should stop.

Thus “sadness”, while absolutely implicit in each participant’s disposition and story, was seldom explicitly mentioned. This is interesting because sadness is traditionally recognised as the ultimate and defining feature of depression (APA, 2013). Yet in this study, avoidance and denial of sadness seemed to be the socially prescribed protocol. This might have been due to a specific cultural, or perhaps even religious discourse (“No, you mustn’t feel like that. Because if you cry, you tell the Lord that he made a mistake”). Having been repeatedly told that they should not feel or display their sadness, it is possible that these women began to feel ashamed of their emotions. Indeed, shame was detected throughout the interviews, and as such, will be discussed further in the following section.

4.5.5 Guilt and shame

The Dictionary of Psychology (Reber, 1985) defines "guilt" as:

> An emotional state produced by the knowledge that one has violated moral standards. Most authorities recognize an emotional state as guilt only when the individual has internalized the moral standards of the society; thus it is distinguished from simple fear of punishment from external sources – guilt is, in a sense, a self-administered punishment. Distinguish from shame, where knowledge of the transgression is part of the concept. (p. 313)

"Shame" is defined in the same dictionary as "An emotional state produced by the awareness that one has acted dishonourably or ridiculously. The term is usually reserved for situations in which one's actions are publically known or exposed to real or potential ridicule" (p. 695). Perhaps a clearer way of understanding the distinction between these two emotions is that "guilt" can be thought of as about doing, while "shame" is about being.

Many of the women in this study expressed a sense of self-recrimination, shame or guilt regarding their emotions, thoughts and behaviours. Correspondingly, most believed that they would feel better if only they "behaved better" (i.e. were more patient, had better qualifications, could earn more money etc.). Anna, Nina and Tracey in particular felt ashamed of their diagnosis of depression. They viewed it as their personal behavioural and emotional "problem", and as proof of their inadequacy, general weakness or "badness".

> Nina: …I'm that "nothing" again. And it's not like I wants to be something, but, it's just… You see, all my life I'm depressed. Because, I was the one that since the day I was born, I'm a problem for everyone…
>
> Anna: I'm out of order… I have a problem...
> Carla: You say your "problem" – what do you think that problem is?
> Anna: Depression.
> Carla: Depression?

> Anna: That I must work on my health and my relationship with my child. This is why I can't cope like this. I must behave…
> Tracey: Now I wonder what is this woman thinks now about me [laughs].
> Carla: You're wondering what I'm thinking about you –
> Tracey: Mmm. This woman with this mad, sad story [laughs].
> Carla: You feel like you have a mad, sad story?
> Tracey: Mmm. I'm sick...

Anna and Tracey in particular felt ashamed of their diagnosis of depression, which they viewed as proof that they were "mad" and "a problem"; they saw themselves as "bad". In the following excerpt, Anna continues to talk about herself as "misbehaving" and being "unwise". She felt particularly guilty for falling pregnant out of wedlock and while still in school, believing that this "let herself and her parents down".

> Anna: Yes, like I don't behave myself. I just want to fight… I hate it, because I know, I must go on, those things through, I didn't, if I didn't have getting pregnant, and if I was being more wiser –
> Carla: You feel like you should have been wiser?
> Anna: Mmm [starts to cry]… I'm feeling, I'm feeling, I'm letting myself down, and my parents.

Similarly, the following statements by Evergreen and Twela revealed their belief that if they behaved better (did not "feel vulnerable" or were "more patient", respectively) other people would treat them better. Such beliefs highlighted their tendencies to feel responsible for (and guilty about) not only their own, but also for other people's behaviour. That is to say, these women appeared to believe that anyone else's badness was a function of their own inadequacy or badness.

> Evergreen: [Crying] I feel vulnerable, I feel vulnerable, and I remember that if I feel vulnerable, then people take advantage of me. So I should try to not to feel that way.

> Twela: I want to be that (patient) person, and then they treat me right… *Want ek is baie ongeduldig* (Because I am very impatient)… *Ja*, but sometimes I'm very impatient, and that's my problem.

> Twela: [Crying] *Ek kan dit nie meer nie* (I can't do it anymore). And sometimes, I, if I talk about it, I feel it's my fault.
> Carla: What is your fault? What are you blaming yourself for?
> Twela: [Crying] For everything what goes, what goes wrong in my life. I feel it's my fault… [Sobbing] …And now I can't get pregnant and that's freaking me out… He can just leave me, because I'm moody or because I can't give him any children – that kind of thing. I am just scared… It, it makes me feel, ah, ah, ah, I feel I'm not worthy. *So, so voel ek* (that's how I feel).
> Carla: You're not worthy of him?
> Twela: Of him, or other men.
> Carla: Do you think that if you were worthy of him, he would behave better?
> Twela: I think so.

Twela felt ashamed of herself for being unable to fall pregnant, and believed that this and all the other hardships in her life were somehow indicative of her unworthiness as a woman ("I feel I'm not worthy"). During our discussion, it emerged that Twela had also been feeling deeply guilty for being impatient with her son moments before he was involved in a minor motor vehicle accident. She nervously told me the story, in hurried and anxious speech, before finally breaking down into remorseful sobs.

> Twela: [Starts to sob] I was, I feeling that, that, that it's my fault that he get hurt, because I was the whole day impatient, but at that moment I told him to buy the, the, the food and I told him "you must hurry!"
> Carla: You feel that it's your fault that he got hit by the car?
> Twela: [Sobbing] Yes, that's my fault, and I told him that, that, I feel it's my fault.

Feelings of guilt and shame, particularly in connection with who they were (shame) and what they could or could not do (guilt) as parents, were common amongst participants. Christine, for instance, felt responsible for her daughter's possible contraction of tuberculosis, because she left her daughter with her family while she was at work.

> Christine: Yes. The sister talked to me, said she could help. I think it's my problem, because I let a lot of people in the house. And she is just now nine months, and how can she get so fast TB at such an early age?
> Carla: You're afraid it's your fault?
> Christine: Mmm, because I had, I leave my children with my great grandmother when I'm at work…

Christine also admitted to feeling guilty about not knowing more about her mother's illness, despite the fact that she was clearly a concerned and compassionate daughter.

> Christine: I didn't know my mom has cancer. She was going for operations and stuff, but I didn't ask my mom "What is the operations about?" because it's her privacy, I respect her privacy. But that day, that time in the hospital, I heard that my mom has cancer, I said "No!" I wish I had asked her. I was not responsible. I blame myself for that time.
> Carla: You blame yourself?
> Christine: Why did my mom not tell me about her illness, and how at the last moment I must hear that she has cancer?
> Carla: Why did you blame yourself for that?
> Christine: Because I didn't ask her "how" every time when she was sick, I didn't ask her. I just ask her "how you feeling?" "Fine", but I didn't ask her "Mommy, what's going on?"

Disclosures of shame similarly emerged when Christine and Tracey spoke about their physical appearances, and explicitly linked this to their feelings of depression. Christine had been born with a pronounced leg length discrepancy, and although this condition was clearly no fault of her own, she nonetheless felt deeply ashamed of it – of the person she physically was. Tracey, in turn, explained that at the height of her depression, she felt incredibly "ugly" and unattractive, and therefore unworthy of love or attention.

> Christine: …And he said "no, don't be ashamed, because there's a lot of people that walk like you; it's not your problem. If your mom was doing the right thing, you would be right today." But my mom was scared. My mom was afraid and she was scared at that time… Doctor Len told me "no, we can make you shoes, if you don't want to go in an operation, you can go for the shoes and stuff, and, and go for the shoes and stuff". But I'm not wearing them because I'm ashamed.

> Tracey: Yes, at that, that stage I don't. I not feel pretty. And I can't bear it. I look at a mirror, and I told myself, I'm going "You're ugly, ugly, ugly – that's why he don't want you any more! You're ugly, you're ugly!"

In contrast, Evergreen's feelings of guilt and shame (about being "dirty" and "sinful") seemed to stem directly from her childhood experiences of sexual abuse, and later from her own appraisal of her marital divorce.

> Evergreen: …I had just this, this, feeling that I'm dirty, dirty, dirty, feelings, you know? …But at night when I lie in bed or, you know, when I'm just, at this point in my life, I just live for, ah, church services, um, to have the Holy Communion, to get Holy Communion to give myself faith, you know. Just to hear the words "Your sins are forgiven".
> Carla: Do you feel that you have sinned?
> Evergreen: Yes, yes. And even being divorced and to marry again, then you are an adulteress. According to the Bible, if you divorce and then you remarry…

Evergreen's faith in the panacea of religion is evidenced in her statement "your sins are forgiven". However, what she defined as her "sins" – being abused as a child, and later leaving her abusive husband – seemed to me to be entirely mislabeled. Indeed, while many of the women in this study cited multiple reasons and explanations for their feelings of guilt and shame, they seemed oblivious to the fact that most of these conditions were beyond their control. In line with these findings, McWilliams (1994) explains that feelings of shame are usual in people who suffer from symptoms of depression:

> People with depressive psychologies believe that at the bottom they are bad. They lament their greed, their selfishness, their competition, their vanity, their pride, their anger, their envy, their lust. They consider all these normal aspects of experience to be perverse and dangerous. (p. 237)

An alternative explanation is offered by Jack (1991) who, using women's subjective accounts of depression, suggests that women experience themselves negatively through their relationships, where they are judged by others and judge themselves according to internalised, male-based values. Regardless of the finer-grained explanations offered by the different theoretical perspectives, the experience of excessive guilt has been recognised as a common feature of depression, according to both feminist and mainstream researchers alike. Thus, “excessive or inappropriate guilt” is considered by the DSM to be one of the diagnostic criteria for a Major Depressive Episode (APA, 2000, p. 356).

4.5.6 Powerlessness: Helplessness and hopelessness

The Dictionary of Psychology (Reber, 1985) defines “powerless” as “A psychological state in which one feels deprived of power, control or influence over events. The state may relate to feelings vis-à-vis social and political events or to feelings with respect to one’s own personal psychological needs.” (p. 562)

Feelings of being helpless and hopeless (of being stuck in low-paying jobs, in debt, in the memories of being raped, in unfavourable family dynamics, and in abusive relationships) and therefore of being powerless to effect change, pervaded almost all of the women’s stories, and no doubt exacerbated their every experience of depression. Echoes of this theme are therefore found throughout the various subsections of this paper, and are not limited to the following examples.

> Anna: [Crying] …Feeling that I’ve failed him, and myself, and now I must depend on other people. I’m feeling very hopeless, and helpless.

> Christine: …I was moving out and I was the only one working in the house. And I give up hope. "Why am I the only one working in the house?" and all that stuff.

> Tracey: It's very hard. Sometimes I deal with it. And then just since the other day I can't. I cry the whole day for Dawie. Crying and crying and crying – and nothing helps... nothing can stop this feeling.

As seen in the excerpts above, the specific words "hopeless" and "helpless" were used time and again. Anna felt "very hopeless and helpless", Christine "gave up hope" and Tracey believed that "nothing helps" her to feel better. Relatedly, each woman felt powerless to effect any change that could result in a genuine, qualitative improvement in her life. Twela, for instance, felt powerless over her body, and this caused her tremendous distress. She sobbed while explaining her belief to me that she was unable to fall pregnant because there was something "wrong" with her body (despite the fact that this had not been confirmed by a medical professional).

> Twela: I want to fall pregnant but I can't. [Sobbing] I, I feel there is something wrong, but sometimes I drink a little bit of water or I eat like a slice of bread or something like that, then I feel I had a lot of food… I can't sit or lie... [Crying] I feel, I don't feel well.

Similarly, Elizabeth conveyed her sense of apathy ("I didn't even bother") that transpired when she was "sick" with depression. Although in the following excerpt she was speaking specifically about her once-prized garden that she neglected during her worst times of depression, her statement "everything was dying" could just as easily be applied to the losses in her life – specifically, the loss of her eight-year-old child, and three years thereafter, the death of her husband (discussed in section 4.7.1). Such momentous losses might logically have caused her to feel utterly hopeless and helpless.

> Elizabeth: When I was sick, everyone could see in my garden, I didn't even bother. Everything was dying; it looked bad.

These findings mirror those of Rapmund (1999), Rapmund and Moore (2000), and Taylor (2011), who conducted similar in-depth qualitative interviews with a small number of South African women who had been diagnosed with depression. The women in each of these studies seemed to believe that they were in hopeless situations, which left them feeling "stuck" in their depression. This coincides with Seligman's (1975) learned helplessness theory, which explains how women who lack control over their lives can develop feelings of helplessness, which consequently results in depression.

Feelings of being helpless, hopeless or powerless to effect change are not considered by the DSM to form part of the overall experience of depression. Feminists argue that this is unsurprising, given that epidemiological literature tends to disregard the political and other contextual challenges that lead to psychological distress (Evans et al., 2005; Marecek & Gavey, 2013; Ussher, 2010). The theme of power is central to feminist theory, where a variety of terms are used to refer to the power relations that are operative in society, including "oppression", "patriarchy", "subjection" and "domination".

Simone de Beauvoir's The Second Sex (1974) is considered one of the first feminist phenomenological analyses of patriarchy and women's powerlessness. De Beauvoir discusses the historic, social and economic conditions which impact upon women's lives. In her book, The Second Sex, de Beauvoir writes: "[woman] is defined and differentiated with reference to man and not he with reference to her; she is the incidental, the inessential as opposed to the essential" (p. xxii). This is the crux of de Beauvoir's understanding of male domination and correspondingly, female powerlessness, which, in turn, contributes to the higher rates of emotional distress in women than men.

As the theme of powerlessness is so fundamental to feminist theory, I tried to remain alert to its many presentations, both subtle and blatant, during my discussions with the women in this study. I began to believe that their experiences of powerlessness were directly linked to their feelings of depression. Melissa's sense of powerlessness, for example, was omnipresent during our discussion. She wanted to leave her abusive husband but felt unable to do so due to her extremely limited financial resources (often she had no money whatsoever), and also because of her feelings of obligation towards her children.

> Carla: What is it like being married to him?
>
> Melissa: Everything was nice, but now, mm-mm [shakes her head to indicate "no"]. I can't take him any more. But I live in (town name) and I've got no one to go to.
>
> Carla: There's nobody for you to go to?
>
> Melissa: No one. Then I must just stay there because where must I go with children?
>
> Carla: You feel that you can't leave him because you don't know where to go. So you're stuck with him at home, even though you want to divorce him.
>
> Melissa: [Whisper] Yes… [Sighs] He was fighting again, and he was beating me. [Long pause.] I, I just want another house, I just want to move out, get a divorce, the kids want to go to school, that's all they want.

Melissa explained her feelings of depression and powerlessness via reference to her abusive relationship with her husband, her care-taking responsibilities towards her children, and her social position of poverty. According to the literature, this is not unusual. Many international feminist studies have noticed that feelings of depression are often described with reference to social context, specifically in terms of relationship to others (Lewis, 1996). Belle and Doucet highlight the fact that powerlessness is particularly common amongst low-income women, and cite a study participant who succinctly defined poverty as "having no options" (Wasylishyn & Johnson, 1998, p. 978, as cited in Belle & Doucet, 2003). Focusing on poverty and discrimination as causes for depression amongst American women, Belle and Doucet emphasise the reality that economic power engenders political power, and point out that the absence of both in low-income women undoubtedly contributes to their experiences of depression. In the current study, poverty was irrefutably connected to the women's powerlessness. In a remote and rural town, and without the means to leave their abusive husbands, how could Melissa and Nina be expected to do so? Therefore, helpless, they remained trapped in the context that caused their greatest distress.

4.5.7 Experience of the self: A lost self

The Dictionary of Psychology (Reber, 1985) defines "self" as:

> One of the more dominant aspects of human experience is the compelling sense of one's unique existence, what philosophers have traditionally called the issue of personal identity or of the self… The following are what appear to be the six primary intentions of the users of the term self: 1. Self as an inner agent or force with controlling and directing functions over motives, fears, needs, etc. …2. Self as an inner witness to events. Here, self is viewed as a component of the psyche which serves an introspective function… these two meanings might best be spoken of as the me and the I, the me being the self known… and the I being the knowing self... 3. Self as the totality of personal experience and expression, self as living being… 4. Self as synthesis, self as an organized, personalised whole… 5. Self as consciousness, awareness, personal conception; self as identity… 6. Self as abstract goal or end point on some personalistic dimension. (pp. 675-676)

A particularly interesting and unanticipated finding in the current study concerned the women's experiences of their own "selves". Specifically, the women interviewed associated their depression with a sense of personality or character change. Many made statements such as "I am not myself" and commented on a displeasing distinction between their past and current experiences and opinions of their characters. All of them believed that their depression had a negative effect on their personality or sense of self.

> Carla: When was the first time that you started to feel depressed?
> Anna: Um, a long time ago, that I feel I'm not myself. I'm not sleeping, um, my, I feel like I'm getting upset for anything… Like when I'm not sleeping, I'm not myself, I'm feeling, I don't want to be around people, I don't want to talk…

> Elizabeth: And that’s when I became lonely and um, I begin to sleep bad, I lose a lot of weight and um, as I told you, I went to the doctor “I’m not feeling myself”…
>
> Tracey: …I want more people to understand what is depression all about, because at that stage you aren’t yourself.

Thus, the women in this study frequently experienced a change in their sense of self, which they attributed to their depression. This change was not only perceptible to them, but also to their families and loved ones.

> Carla: What did they notice in you that made them say you must get help?
> Anna: My behaviour, my, I’m not myself any more…
>
> Carla: What do you hope for yourself in the future?
> Linkie: To get a better life.
> Carla: *Ja*? What would your better life look like?
> Linkie: Like the person I was before.
> Carla: Can you describe that person for me?
> Linkie: I was laughing at people, making jokes, doing something with my friends, I was playing um, cricket, something like that.
> Carla: You don’t do those things anymore?
> Linkie: No.

Nina, Tracey and Twela spoke of a change in themselves that made them become “hard”, “nasty” and “impatient” – personality characteristics that they disparaged and were ashamed of.

> Nina: …I was actually sad now, I feel my eyes is red, and, for a long time, I get hard. I start to get hard. Sometimes I don’t even feel if my child fall, like, the first one, I’m running “get up”, and, or I run to her or whatever, but, the baby is falling “*agh*, get up, man!” and Oh!
> Carla: You feel like you’ve become “hard”?
> Nina: Yes.

> Carla: What has caused that?
> Nina: All the negative stuff in my mind. There is so few positive things. I can't even remember when my life was for one day positive. It's negative. Everyone is negative.

> Tracey: …I get, ah, I'm nasty with anybody, with my child, with my parents in the house, with my sisters. I'm just not the same person from that day, any more. Everything is changed at that time, in my whole life, everything. I, it was, it was very, it was very, it was very horrible. It is, it is, I don't want any body else to go through that thing that I was going through. It's not nice. Because you are in a state to do anything that's nasty and, [sighs] I don't want to remember it any more…

Twela was particularly disappointed in the changes that she had noted in her personality during her depression. In her descriptions, she sounded angry with and disappointed in her (depressed) self.

> Twela: [Sobbing]…I know I'm not that person; I'm not a person who just cry and moody and whatever, I wasn't that person. I was someone who listen to others and I was someone who likes to smile, and I'm another person now, [sobbing] I'm just moody and just, just angry and just, *ek weet nie* (I don't know)! …I'm stressing about every little thing and, and, and, I'm not that kind of person, just stressing, I know, I had sometimes, ah, get angry or so, but now, I just get angry for every little thing.

Twela noticed many differences between her depressed self and her non-depressed self: "I wasn't that person". She described how she used to "listen to others" and "smile" before she became depressed, at which stage she changed into someone who was "moody", "stressed", "angry" and tearful.

Investigating the social status of low-income women, Leenerts (1999) similarly noted the phenomenon of a "loss of self" amongst her study participants and suggested that some women might experience this when situated in a context of disadvantageous social circumstances and multiple daily stressors, as was the case for each of my study participants.

Focusing her research on mothers, Lewis (1996) found that women lose their personal freedom and identity when they adopt the social identity of "wife" and "mother", and sacrifice themselves to meet the needs of their families. This particular angle was not explored in depth in the current study, but it is entirely possible that the participants' declared loss of self was linked to the multiple roles they had to fulfil in their daily lives (see section 4.7.5, on Multiple responsibilities). It must be noted that while a "loss" or at least a "changed sense" of self was commonly reported in this study, and indeed has been considered by a number of feminist and critical writers (Jack, 1991; Lewis, 1996), the phenomenon is disregarded in mainstream diagnostic manuals (with the exception of "dissociation" proper). As these manuals inform clinical assessment and treatment, it is a fundamental omission, and as such, deserves careful attention in future research. Phrases such as "I am not myself" may be important and culturally specific ways of communicating emotional distress. They should therefore be carefully listened for and attended to, particularly by South African healthcare practitioners and researchers.

4.6 Behavioural manifestations of depression

In the present study, the emotional experiences of depression manifested in a variety of ways that impacted upon the women's daily lives. These manifestations can be understood as flowing directly from the subjective emotional experience of depression. The behavioural manifestations of depression were therefore the overt signs – both cognitive and operational/behavioural – that the women in this study associated with their experiences of depression. Most prominent among these were withdrawal, substance use, violence and aggression.

4.6.1 Withdrawal and "hiding feelings"

The Dictionary of Psychology (Reber, 1985) defines "withdrawal" as:

> 1. A pattern of behavior characterized by the person removing him or herself from normal day-to-day functioning – with all of its attendant frustrations, tensions, and disappointments. Here the sense is of a neurotic removal of self from normal social discourse, accompanied by uncooperativeness, irresponsibility, and often a reliance on drugs and alcohol to facilitate the social remoteness. 2. A conscious removing of oneself from particular situations. Here the connotation is very different from 1; in this sense the withdrawal is a calculated decision not to be involved for strategic, philosophical, political or other reasons. (p. 831)

As discussed in section 4.5, above, the women in this study described their feelings of loneliness, anxiety, sadness, guilt and shame as some of the component parts of their overall emotional experience of depression. Such feelings, they said, caused them to withdraw into themselves and avoid social interaction with others. In particular, the women spoke about wanting to "hide their feelings" from others. Thus, some of the subjective emotional experience of depression (feelings of anxiety, sadness, guilt and shame) seemed to be made manifest in the general behaviour of social and emotional withdrawal.

> Anna: No, I don't sleep well. And I don't want people around me…

Wanting to be "left alone" and "not wanting people around" them when they felt depressed was commonly reported by study participants. I quickly learned that at their times of deepest depression, the women in this study tended to keep themselves both physically and emotionally isolated from others. There seemed to be a number of implied reasons for this. Christine, for instance, did not want people near her when she was feeling sad ("I don't want people near me when I'm down"), and in particular, she did not want anyone to help her. She valued her own independence and did not want to be a burden on anyone ("I don't want it (help) from any people, just want to help myself"). Melissa too explained her tendency to "keep things to herself" as resulting from her wish to not burden anyone.

> Christine: I don't want it (help) from any people, just want to help myself. But [sighs], sometimes people, my mother in-law, wants to help me, and I tell her

> "no, don't worry"… and I say "no, leave me alone" then I walk away or something. I don't want people near me when I'm down.

> Carla: Is there anybody in your life that understands how you're feeling?
> Melissa: Only my mother knows. Even knows that he abuses me. But I don't tell her anything… I just keep it to myself.
> Carla: Why do you keep it to yourself?
> Melissa: Don't problems. I don't problems… I must carry my own burdens… I like to keep things to myself.

I asked Melissa about her relationship with her eldest daughter, and specifically whether they spoke about Melissa's husband's alcoholism and abusiveness. Melissa said that she did not talk to her daughter about these things, just as she did not speak to her own mother, and thus clearly illustrated the intergenerational silencing and hiding of feelings that was active in her family.

> Carla: Do you speak to her about her father?
> Melissa: She sees everything.
> Carla: Does she speak about it?
> Melissa: [Shakes her head to indicate "no"]
> Carla: It's something that you both know about but don't talk about?
> Melissa: Mmm, just walk away…

Many of the women hid their true feelings not only from their acquaintances, but also from their partners and closest family members. In these ways, it is possible that they contributed to their own sense of emotional isolation and loneliness.

> Anna: Out of order. Like, when I'm feeling like something… I don't feel it's nice or good, or anything in that way. So, I keep it in, in, in. I don't talk, I'm just angry...

Another frequently cited reason for their emotional withdrawal and hiding of feelings was lack of trust. Most of the women in this study felt that they could not discuss their feelings with friends or family, firstly because there seemed to be an unspoken social norm that disallowed the expression of sadness (as discussed in section 4.5, above), and secondly because they doubted whether anyone would treat the information with sensitivity, confidentiality and respect. Many of the women felt deeply ashamed of their "negative" feelings (e.g. of sadness, anxiety and anger) and feared that others might find out about those feelings. Specifically, the women feared being gossiped about, and they therefore chose to keep their experiences of "bad feelings" hidden.

> Evergreen: And the people around here, you know, they like to talk about other people. Like to make your business their business. I think that's also a burden.
> Christine: …But I'm not talking to other people. Because peoples, you know how people is. When I'm telling them something, the story they make, all talk to other people, then all, everyone is knowing about my problems. I don't want people knowing… Mmm, I don't want other people knowing my problem.
>
> Twela: …But otherwise I don't want other people in my business. I don't want other people to know what I feel inside.

In the following excerpt, Evergreen explains that she makes excuses to hide her feelings of sadness from her husband. She became very upset, and when I commented on this, she (perhaps out of habit) suddenly hid her thoughts and feelings from me too, by claiming that she was "tired".

> Evergreen: *Toe sien ek vir hom, hy weet nie* (Then I saw him, he doesn't know), I must, I must, *die senuwee lyer né, oe senuwee lyer* (the sufferer from nerves, oh, the sufferer from nerves. – A similar colloquial English statement would be: "I am a nervous wreck"). Or that I'm missing my parents or so, I say for him "I feel-" he say "No, you mustn't feel like that. Because if you cry, you tell the Lord that he made a mistake, by taking away your parents and taking away all your loved ones."
> Carla: He tells you, you shouldn't be crying?
> Evergreen: *Ja*. So at times I cry and then he sees and "What's wrong with you?", "No, it's my knee. My knee pains" – and it's not my knee, you know?

> Carla: You just pretend it's something physical?
>
> Evergreen: *Ja*.
>
> Carla: So he doesn't really understand your sadness?
>
> Evergreen: [Crying] No. In my, um, lounge wall I have all the photos of the children, and I just sit there.
>
> Carla: [Whispers] You look very upset –
>
> Evergreen: [Whispers, crying] I'm tired. Oh… I can't, I've just got to, like Freddie Mercury says, "I'm the great pretender", you know? [Sighs.]

Evergreen thus introduced me to the version of herself that was "the great pretender". She felt that she could not trust people (including her husband) with her true feelings, and she therefore behaved differently in order to hide those feelings. Within her community, Evergreen, "the great pretender", was perceived as jovial, resilient, and perhaps even as someone to be admired. Almost identical findings emerged in Taylor's (2011) in-depth case study of one low-income South African woman (Vané) who had been diagnosed with depression. Like Evergreen, Vané too described herself as "a great pretender" (Taylor, 2011, p. 33). According to Miller (2007), when interacting with the members of their communities, many women (like Evergreen and Vané) project a smiling and contented image (i.e. the feminine ideal), and in so doing, construct a "false self". Evergreen admitted that the image of herself that she projected served to "cover up" the sadness and fragility that she truly felt. She feared that she would be taken advantage of if she showed her vulnerability.

> Evergreen: I just, no, I say I've got a smiling depression and then laugh…
>
> Carla: What does that mean to you?
>
> Evergreen: It means that I laugh just to, that people don't see the hurt. It just covers it up.
>
> Carla: Why don't you want people to see the hurt?
>
> Evergreen: [Crying] I feel vulnerable. I feel vulnerable, and I remember that if I feel vulnerable, then people take advantage of me. So I should try to not to feel that way.

It is not difficult to understand how the emotional experiences of shame, fear and vulnerability might cause one to "hide one's feelings", as is often the case in instances of sexual or physical abuse, as illustrated by Evergreen, below.

> Evergreen: [Crying] *Ja*. One time I asked the one girlie "Does your daddy also touch you there?" She looked at me so funny, but luckily she forgot about it.
> Carla: Why do you say that, "luckily"?
> Evergreen: Because I was scared she was going to tell her parents or somebody else.

According to both mainstream and feminist literature, these were not unusual findings. The inclination towards social withdrawal has long been recognised as a typical symptom of depression (Sadock & Sadock, 2007). Similarly, in feminist literature, the emotional experience of loneliness has often been associated with shame, anxiety, depression and withdrawal from society (Stoppard, 1999; S. Weiss, 1973).

Lewis (1996) suggests that depression is usually kept hidden and not discussed because it is extremely difficult to explain to other people, and is also often perceived as unacceptable by others. People typically find depression incomprehensible, particularly if they can identify no cause for it, in which case they may think it irrational. The concealment or hiding of feelings can also be considered a coping strategy, particularly when one fears being stigmatised or rejected on the grounds of being depressed (O'Leary & Helgeson, 1997; Rokach & Brock, 1998). Unfortunately, this interpersonal estrangement usually sets up a cycle that perpetuates the experience of loneliness, and often results in the worsening of psychological and behavioural problems and conditions such as anxiety and depression (Rokach & Brock, 1998).

Finally, it is worth drawing attention to the fact that while the women said they hid their true feelings from their families and loved ones, they generally presented them quite openly to me.

> Nina: …I won't go in there and talk with anyone like I talk with you, and, um, you know what, why I'm also like that, I don't want them knowing my life…

This is interesting because it is often suggested in the literature that sameness is necessary for disclosure (Riessman, 1987), but this was not found to be true for the current study. I was distinctly different from my study participants, by virtue of my race, education levels and socio-economic status. According to Riessman's paper, "When Gender is Not Enough", these differences should have caused the women with whom I spoke to be distrustful of me. However, most of the women explained that it was relatively easy to trust me *because of* my differences from them, which caused them to believe that I had neither opportunity nor reason to discuss their private thoughts and feelings with others who lived in their community. While none of the participants openly reflected on my "whiteness", given South Africa's social history, it is also possible that my skin colour might have been associated with professionalism and expertise, which may have engendered a certain amount of trust and respect (Appelt, 2006). Alternatively, perhaps they believed that in certain caregiving contexts, such as in the clinic with me, a psychologist, they were allowed to be sad, and could therefore disclose the feelings of fragility and vulnerability that they usually kept hidden (Miller, 2007).

4.6.2 Substance use

While it was not a particularly prevalent topic, some of the participants in this study indicated that their experiences of depression contributed to their use of various substances – usually alcohol or cigarettes, and in some instances methamphetamine ("*Tik*") and/or marijuana ("*dagga*"). Although it emerged as a relatively uncommon theme, it is included here as I consider it to be an important contextual factor in the overall understanding of these women's daily lives. Various excerpts throughout this chapter indicate that issues around the drug and alcohol using/abusing habits of their loved ones constituted a major problem for the women in this study. Thus, while not every woman in this study used or abused these substances, each was profoundly affected by the substance using habits of the other people in their lives.

The four women in this study (Linkie, Nina, Anna and Tracey) who used substances explained that they did so for various reasons, most usually to alleviate boredom, to relax or as part of engaging in social activities, or in response to feeling angry and frustrated, as shown below.

Linkie said that she used *Tik* and *dagga* to alleviate her boredom ("It's very boring. That's why I'm smoking"). It appeared that her substance use might also have functioned to quash her intrusive memories of her childhood abuse ("I'm thinking the whole time that (sexual abuse) what happened to me and, um, bad things (drugs) I'm doing").

> Linkie: I'm thinking the whole time that what happened to me and, um, bad things I'm doing; isn't right.
> Carla: You're doing bad things?
> Linkie: Yes. Drugs. *Tik*, also smoking *dagga*…I can't sleep if I smoke *Tik* and, um, am I going to feel something just with *Tik*, but *dagga*, *dagga*, *dagga* is alright, but not *Tik*.
> Carla: What made you start with *dagga* and *Tik*?
> Linkie: [Sighs] …I'm not working, and, I'm alone at home, sometimes, at my girlfriend's house, and, it's very boring. That's why I'm smoking.

Nina explained that she used alcohol in order to "relax", as a social activity when in the company of other people, and also in response to feeling mistreated by her husband.

> Nina: He doesn't want me to go out. And it's not like I am someone for men, or something. OK, me and him is, nine months, um, I let him go nine months ago, and still at this time, I don't have any men. And he talk with a lot of women. I don't know. He is nasty with me, Oh! Like he go to the Welfare, Monday, *ja*, OK I start to drink, but it's not like I'm drunk like in drunk. It's just like, I just want to be with other people and I just want to relax and if I feel now I start to get drunk, then I go home…

Somewhat similarly, Anna said that she would use alcohol when she felt misunderstood and angry. Likewise, Tracey said that her methamphetamine ("*Tik*") use made her feel calm, and also that it allowed her to consume more alcohol before feeling drunk. For both Anna and Tracey, then, their emotional experiences of anger seemed implicated in their substance-using behaviours.

> Carla: People tell you that you’re wrong; they can’t understand your feelings?
> Anna: None of them do. They say “that’s not right; you’re seeing things different” and so I argue with them and I’m getting very angry, like I will go and feel like I want to drink now…
>
> Tracey: …Then my friends um, told me “you must, um, calm down and, be calm, don’t always shout and *skel* (“scold”) and get that outbursts and things like that”. Then, they um, come and introduce, ah, *Tik* to me. Yes and then I start to use it, because, I found out that it’s making me calm. But in the mean time, it do a lot of harm. As it make me feel calm for that hour or two… I like to use it when we going to, um, we going to have a party tonight and there’s a lot of booze there, and then um, when you use the *Tik* and you’re going to use a lot of booze, it, it tooks a long time before you get drunk.
> Carla: OK, so you can drink more without getting drunk?
> Tracey: You can drink more without getting drunk, yes.

Epidemiological and mainstream research concludes that substance dependence can contribute to the onset or exacerbation of depression (APA, 2000; Patel, Kirkwood, Pednekar, Weiss, & Mabey, 2006; Sadock & Sadock, 2007). Beake and Goosen (1996) write that alcohol abuse in South Africa is especially problematic in low-income communities where women have many caregiving responsibilities and are frequently exposed to violence and low rates of employment. They suggest that women turn to substances as a temporary escape from (or way of coping with) their stressful living conditions. Here “coping” refers to “the marshaling of efforts to ameliorate the effects of potentially stressful events” (O'Leary & Helgeson, 1997, p. 30).

Some authors have divided the ways individuals cope into two categories – problem-focused coping and emotion-focused coping. Problem-focused coping aims to change the stressful situation (e.g. by seeking medical attention or engaging in stress-relieving activities) while emotion-focused coping aims to change the stress reaction (e.g. by avoidance, distraction or escapism via substance abuse) (O'Leary & Helgeson, 1997). It was clear from the descriptions of the participants in the present study that they employed emotion-focused coping strategies more frequently than problem-focused coping strategies. Their choice of coping strategy was probably influenced by their socio-economic status, their experiences of loneliness and by their lack of support. Collectively, these experiences usually left the women feeling powerless (see section 4.5.6), and it is probably for this reason that some turned to substance use. In her study of the coping mechanisms of one group of low-income coloured women in the Western Cape, Spies (2001) found that the women's poverty and their disempowered status influenced the coping strategies available to them, and forced them to rely more on emotion-focused strategies, such as escapism via substance use. Spies's findings therefore correspond with the findings of the present study, in which the participants spoke about using mechanisms such as avoidance, religion (discussed in section 4.8.2) and striving towards self-sufficiency, in their efforts to cope with the psychological and emotional experiences of depression.

4.6.3 Aggression directed at self

The Dictionary of Psychology (Reber, 1985) defines "aggression" as:

> An extremely general term used for a wide variety of acts that involve, attack, hostility, etc. Typically, it is used for such acts which can be assumed to be motivated by any of the following: (a) fear or frustration; (b) a desire to produce fear or flight in others; or (c) a tendency to push forward one's own ideas or interests. While this will do as a loose but acceptable definition, it barely touches on the nuances of usage in the psychological literature… Those who tie together the notions of aggression and frustration define it as any response to a frustrating situation. (p. 18)

Suicidal behaviour and other intentionally self-harming behaviours are considered forms of aggression that are directed towards the self (Hillbrand, 2001). In the present paper, these are regarded as the behavioural manifestations of anger, which the women in this study identified as one of the emotional experiences associated with their depression (see section 4.5.1).

It must first be noted that in general, the study participants did not spontaneously raise the subject of suicidal thoughts or actions. I chose to temporarily forsake the phenomenological investigation directive of "bracketing" my prior conceptions, and deliberately raised the subject of suicide because it is commonly considered to be one of the most important features of a depressed mood (APA, 2013; Sadock & Sadock, 2007; World Federation for Mental Health, 2011). Nonetheless, when first asked about suicidal ideation or intent, many of the women fervently denied entertaining any such thoughts, and usually explained their stance by referring both to their religious beliefs and to their responsibilities towards their children.

> Evergreen: And I'm very spiritual also, and I say "help me" because if you believe in the Lord, you're going to go to hell if you take your own life. And nothing is so difficult in life that you must do that…
>
> Carla: Have you ever thought about killing yourself?
> Christine: Not even once… And not in this year. Because a lot of people is doing it. I'm just living for my kids.
>
> Carla: When you saw the doctor, you said that you sometimes think of hurting yourself when you are very sad?
> Chenille: Yes… That was one year, the next year, and my birthday, and, the, two years I feel awful. I will drink some pills. And they come to me, I have a child that needs me so I didn't do it… And my boyfriend, he give me the power, and I mustn't do that because he had also a son who passed away in April at the sports field, when he was playing cricket. So he speak to me, I mustn't do that because he is there for me and I must think about my child.

Hoping that I might ease the anxiety that was clearly aroused by broaching such a socially taboo topic, I made sure to maintain an open, warm and non-judgemental attitude while talking with each participant. Gradually, and only when very gently questioned further, some of the women began to discuss what they considered to be their deeply personal – and oftentimes shameful – experiences of entertaining suicidal ideas. For instance, as our conversation deepened, Evergreen began to disclose the fact that she had indeed contemplated suicide on at least two different occasions during her lifetime. Evergreen's description of the most recent occasion implied her desire to escape the burdens and responsibilities of her daily life, which she experienced as “coming down on her like a ton of bricks”. She added that during her fleeting wish to end her life, her caretaking responsibilities towards her husband entered her consciousness, and thereby halted her suicidal impulses.

> Evergreen: …So, and when was it, last week, hey, it was just all this financial stuff, just came down on me like a ton of bricks. And I was walking on the road, the 364. And you know, a big, big truck came out from the beach side, with that ah, silver thing in front, shiny, glimmering in the sunlight. All of a sudden this thought came to me, “you can just run in front! It will be over just like that!” [snaps her fingers]. [Sighs] You know, it felt like a big hand pushed me, *né*, on my back. But I stood, I stood my ground. My knees, if I, I couldn’t believe it, this urge. Some time ago I had this thoughts and stuff, but the minute I thought about Evan, “who’s going to take care of him now?” And then this truck just went past…

Given her religious beliefs, Evergreen probably experienced a great deal of shame around this topic. In the following excerpt, she talked about the first time she considered killing herself. Such contemplations caused her to feel “weak” and as though she had “failed” in respect to both her religious commitments and her maternal obligations towards her son.

> Evergreen: The earth can just open, and I just wanted to die. In the first case, I took his gun, it was in the room, and I locked the door. And I feel [whispers] “Oh my word” my head, it was like my head was empty. There was nothing in there, you know. *Jissis*! (expression of exclamation) I never want to feel like that. [Crying] The other day it was nearly like that type of feeling, but it, *ja*. But I could hear him screaming outside the door “Evergreen, open the door!” And, ah, I sit, with the gun, and the minute I open the door, he, he bashed it with his knee, there was a hole in it, I looked at him. He took the gun away from me. [Crying] I was in the room there, I just sobbed. My son also came in, I didn’t like, you know, he grew up in that. And I cried. I felt so weak and, a failure, you know?

Evergreen may have evaluated herself as “weak and a failure” for allowing herself to consider committing suicide, or alternatively, because she failed to carry out her suicidal intention. Her feelings of failure and self-recrimination no doubt worsened her overall experience of depression. Other study participants gave different explanations for their self-directed aggression. Tracey, for instance, described how her impulses to engage in self-harm (“cutting”) and suicide arose from the frustration, desperation and powerlessness that she felt upon discovering that her boyfriend had been unfaithful to her.

> Tracey: The first time when I find that my boyfriend is dating another girlfriend, after my back, so, then it feels like I can’t handle this thing that’s now busy happening with me from inside. This feeling, I can’t handle it. That was the first time I get this depressed feeling… Crying and bursting out and want to cut myself, and, want to ending my life. At that stage, I don’t understand it’s depression, until I came to see a doctor, here…

For Linkie, it was her deep desire to escape the memories of her tortured past that caused her to want to end her life.

> Linkie: [Starting to cry]… I don’t know. I was drinking pills.
> Carla: Why did you drink the pills?
> Linkie: [Whispers] I wanted to die.
> Carla: Can you tell me what made you feel so bad, that you wanted to kill yourself?
> Linkie: I was thinking of the bad things that have happened to me… [Whispers, crying] I don’t want to live any more…

Melissa, in turn, described how she would sometimes “snap” and suddenly be consumed with the thought of ending her own life, so as to escape the current conditions of her abusive marriage. Yet again, like Chenille and Evergreen, Melissa added that it was her concern for her children that always halted her contemplations about ending her own life.

> Melissa: It's not fun. I leave him alone and he start with me. All about my stuff, and, but for me it's fine. Just sometimes I just snap. I can't take it anymore… That's why I drink the pills. I think about a lot of stuff. Why? What's going to happen with the children? Stuff like that. Because he don't care. But I'm used to it!

For Elizabeth, it was her emotional experience of loneliness (rather than anger) that she believed manifested in her suicidal ideation and intent.

> Elizabeth: It was now, the thoughts, the thought of loneliness. Very often because my, my, I feel lonely now, I feel lonely now. Feel lonely. What's the, um, what's the use of going on? I, I, I had suicide. Thoughts… I had to talk to myself, at the time the safe was in the house with my husband's guns and the revolver. And [sighs] I just want to and opened it and take the revolver and shoot me in the back yard.

For each of these women, then, it appeared to be the idea of "escaping" – whether from past memories or current circumstances – that caused them to consider the idea of suicide. However, probably due to their subscription to cultural norms regarding religion and mothering, they felt deeply guilty about such thoughts, and therefore tended not to speak about them. This finding has potentially important consequences for healthcare workers in similar communities in South Africa, as it suggests that without vigilant and sensitive delivery, traditional suicide-screening interviews may not be useful. This subject is therefore worthy of careful further attention and qualitative research.

4.6.4 Aggression directed at others

As stated above, and probably due to the prevailing social and religious norms, the women who partook in this study did not easily discuss or admit to having any self-directed feelings of aggression. In somewhat surprising contrast, they easily admitted to entertaining strong feelings of aggression towards other people. Thus, the anger that was spoken about as one of the emotional experiences of depression (section

4.5.1) was felt to be made manifest in the form of aggressive fantasies and behaviours that the women directed at the other people in their lives.

Vivid accounts of aggressive fantasies, verbal and physical abuse, as well as other self-destructive behaviours, were not uncommon:

> Anna: So, um… when I'm arguing with him I'm getting angry. So I want to fight with him – fight with him – and cry [sighs]. I am feeling that… very hatred for them.
>
> Nina: Even, even, I should yell out. I just feel like, if I had the power, to hurt him so much that he will never bother me – I just want to hurt him so much that he never wakes up again... It's like I want to, I just want to kill him…
>
> Linkie: So every time I'm thinking about that, I want to kill him.
>
> Tracey: I think I want that um, laser eyes, and then I want to look at that girlfriend and I want to burn *gatjies* (little holes) into her face… I think sometimes I wish [whispers] she can die.
>
> Twela: And if I feel like cry, I just cry, and if I feel like shout, then I want to shout. I swear. I just had a swearing life, it's like normal, I swear for everything. When I'm angry I'm swearing. Like for me it's normal. And, and, and, many people say to me "why are you swearing so much?" I said it just, it comes out naturally, it's like eating bread.
>
> Twela: … And I just… just... *aggressiewe* (aggressive)… Yes. If I told you to do the thing and you don't do that, or you make too long, and I'm just angry and I shout at you, and, and, and… I just get angry for every little thing…
>
> Evergreen: And I remember I went into the kitchen, I wanted to reach for the knife, I stood there, I just breathe, *né*… I wanted to kill Tonie.

> Tracey: Because I was very angry, with myself. I want to end my life. I want to cut myself. I get, ah, I'm nasty with anybody, with my child, with my parents in the house, with my sisters. I'm just not the same person from that day, any more... Because you are in a state to do anything that's nasty and, [sighs] I don't want to remember it any more.

In the following excerpt, we see Nina's belief that her anger had caused her to become "hard" and at times unfeeling towards her children. Similar findings are discussed in the study by Cooper et al. (1999), who concluded that South African mothers with depression were significantly less sensitive than non-depressed mothers in their interactions with their babies.

> Nina: I was actually sad now, I feel my eyes are red, and, for a long time, I got hard. I started to get hard. Sometimes I don't even feel if my child fall, like, the first one, I'm running "get up and" or I run to her or whatever, but, the baby is falling "*agh*, get up, man!" and oh!

Other researchers have found similar findings amongst populations of low-income South African women who have been diagnosed with depression (for example, see Kruger et al., in press; Lochner, 1999; Lourens & Kruger, 2013; Taylor, 2011). A more comprehensive investigation of aggression as a theme in the current study is to be found in section 4.5.1.

4.7 Subjective beliefs about the factors that cause or exacerbate depression

During the interviews, each woman identified a number of specific factors or incidents that she believed caused or worsened her experiences of depression. I noticed a large degree of commonality amongst the women's opinions in this regard. The reasons most often given for causing/exacerbating depression were: the loss or death of a loved one; having experienced childhood trauma; having relationship problems and/or being in an abusive relationship; having to manage multiple responsibilities without support; living with severe financial constraints; and feeling emotionally and/or physically vulnerable in one's daily environment. Each of these themes will thus be considered in turn.

4.7.1 Loss/death of a loved one

When asked what might have caused their feelings of depression, many of the participants described their experiences of loss. In some cases, their sense of loss had been due to relationships ending, while others resulted from the death of a loved one. The women explained how each loss had caused them to feel varying levels of sadness, anger and distress.

> Christine: …For the whole year when my mom was dying, I was very sad in myself…
>
> Twela: In February, this year, February, *né*? I just had a miscarriage… Yes, in February, the 10th of February I just lost my baby. It was five weeks. Five weeks, *ja*. And nobody talks about it [starts to cry]. Nobody talks to me.
>
> Twela: [Crying] For everything what goes, what goes wrong in my life. I feel it's my fault. And before, before I was in a relationship with John, my, my, my, my child's father is dead, about ten years ago… He just was in an accident and a month after the accident he died. He dies because his, his injuries was too bad. But, *ja*, his injuries were too bad… [Starts to sob.]
>
> Evergreen: [Crying] He (Evergreen's father) also died in 1999, April.
> Carla: Was he a good person in your life?
> Evergreen: [Crying] Yes. And he actually asked for my forgiveness, for not being there for me. He said all he gave me was my name… [Sighs] And my sister died in 2004. We were three children, my brother, the eldest, and my sister and me... And you know what, for two years I didn't see her, I wrote her a letter, I told her "if Evan die, I'm going to come stay there by you" and then [starts to sob] she passed on in 2004. I didn't see her for two years… [Sobbing]... And when I got to the funeral, they was about, they was about to

> close the coffin, before I could see her. I saw her… [sobbing] Oh! I'm glad you came today…

Thus Christine, Twela and Evergeen each described being deeply affected by the death of their parents, family members or partners. Chenille and Elizabeth had both experienced the death of their children as an overwhelming, life-changing loss, and understood it to be the primary cause of their depression, as shown below.

> Carla: Can you tell me about the first time that you felt depressed?
> Chenille: My child has died. That child of mine, in May 2006 and from this time, I cannot forget. Every year when I'm, when it's my birthday; May is my birthday month and he is on my birthday. It was his funeral on my birthday. And every year I feel the same, I feel the same… [sobbing]…

Elizabeth spoke about the death of her son, and three years later, that of her husband. Although her son had died over thirty years before our interview, Elizabeth still felt the grief of his loss almost constantly. A large portion of the interview transcript is included here, to help convey the profound impact that losing her child had on Elizabeth's life-long experiences of depression.

> Carla: What do you think made you depressed?
> Elizabeth: I think I didn't have an easy life. I lost my eldest son, of eight years, do you know what it is? The germ attacks the brain – in Afrikaans, it's "*breinvliesontsteking*" (meningitis)… I lost my eldest son… He was eight years old and my daughter was a baby of five months. And after I lost my son, my husband, he withdrawing totally. He wasn't interested in the farm, he wasn't interested in the children, and it wasn't long before they diagnosed kidney cancer. And he had the sickness of three years before he died…
> Carla: Do you mind talking about what it was like to lose your child?
> Elizabeth: [Sighs] I think that's the most painful experience everyone, every, you could have in your life. It's the hardest part. You thought when he was born you the first mommy who could bring this child into the world, you know, so special. And he was such a loveable child. Everyone loved him. He was, he was special, very, very special. And I don't know why, but suddenly

> one day – he was always the bad luck one… And he got sick [sighs], he had a cough and I gave him medicine for a cold and he told me “my head is aching, mommy” and the whole Saturday afternoon he slept, and I thought “that’s not like my, my, like he is. He’s too busy, and [sighs] doing things and on his bicycle!” And, and that night, I awoke and I hear he is in the, in the, by the toilet, and I hear he is throwing-up, and he come to me at my husband’s room, and he stand before the bed and he said to us “Can I sleep tonight with you?” and he laid between us. OK, so we all get back to sleep. And the Sunday morning, I stand up and I went to the kitchen to make coffee for my husband, and I go back and I said to him “would you also like to have coffee like daddy?” and he don’t answer me. And I feel him, and he don’t answer. And I said to my husband “Something big is wrong. He is very sick.” He had fallen into a coma, between us. [Sighs]… he was taken up in (name) hospital… but he never ever give any sign of life again. One night when we was visiting, I take his hand [gesticulates a small hand movement], but the doctor told us that it’s only, uh, the reflex. [Sighs] And they called me and my husband and they said to us, they said, they told us “Please, you can’t go on like this, please went home to your farm and try to rest, and return Monday morning”. Then we will decide if we would – um, *asemhalings* (ventilator) – the machine? ...Turn it off. We had to decide on Monday morning. The machine, to turn it off. And that Friday night, it was about twelve o’clock, somebody knock on my door… And then I heard our preacher’s voice… and then he say, to me and my husband, “I’ve got very bad news. He passed away, about ten o’clock.” [Crying] And, I still remember every, I will always, in my mind, my husband went to bed. Oh [sighs, crying]. He was heartbroken. The whole bed was shaking. I cannot [pauses, crying] – The next morning we had, I had to go to tell my son, the middle child, that he’s gone… [Sighs] *Ja*, I, I know, I know that sort of pain, the loss of a child, that pain you feel that pain from your head to your toes… and, and [crying], his, his mates was carrying his coffin, his small classmates, and, the whole, I was never be, you can’t be the same. Never, ever in your life. You can’t be…

Grief has been defined by Mullan, Pearlin and Skarr (2000) as “the complicated set of emotional and cognitive responses that accompany loss” (p. 149). They state that grief can manifest itself in many ways, ranging from an emotionally crippling state to a low-grade dysphoria or sadness in people who nonetheless continue to function in their normal social roles, as Chenille and Elizabeth were seen to do. It will be shown later (in section 4.7.6 on Lack of support) that Elizabeth described her husband as “so heart-broken” in the years after their son’s death, that he could not emotionally or physically support her. For both Elizabeth and Chenille, it seemed as though experiencing their grief as emotionally *crippling* was not an option, because they both *had to* continue to function – to earn money to feed their remaining children, for example. This echoed the presentation of depression in general amongst the women I interviewed. They did not have the opportunity to sit in an inert or “crippled” state (of either grief or depression), because their daily lives were so impoverished and precarious that they simply *had to* attend to the necessities that ensured their survival. I could not help but wonder if these women would regard staying away from work because of grief or depression (as is usual in more affluent communities) as a luxury that was beyond their reach.

Elizabeth Kübler-Ross (Kübler-Ross & Kessler, 2005) suggested that there are different stages of grief, namely: shock, denial, anger, bargaining, depression and acceptance. She believed that the first four stages functioned primarily as various types of coping mechanism, which later gave way to the experiences of depression and acceptance. In her later work, Kübler-Ross wrote that rather than being linear and sequential, these stages are often revisited time and again for indefinite periods. Depression, according to Kübler-Ross, may be seen as a “normal” response to a significant loss, even for a prolonged period of time.

Taking a strictly clinical approach that stands in contrast to Kübler-Ross’s views, the DSM-IV advised clinicians to refrain from diagnosing major depression in individuals within the first two months following the death of a loved one, in what has been referred to as the “bereavement exclusion” (APA, 2000). This exclusion has however been removed from the DSM-5 for a number of reasons. Firstly, it was deemed inappropriate to imply that bereavement only lasts for two months when health workers and grief counsellors (such as Kübler-Ross) recognise that the duration is more commonly one to two years (or longer). Secondly, research shows that individuals are more susceptible to bereavement-related major depression if they have a past personal or family history of major depression. Thirdly, the symptoms associated with bereavement-related depression have been found to respond to the same medical and psychosocial treatments as non-bereavement-related depression. Finally, the authors of the DSM-5 claim that omitting the bereavement exclusion from the manual helps to prevent major depression from being ignored and increases the possibility of appropriate treatment for distressed individuals (APA, 2013).

Irrespective of the DSM's arguably bureaucratic rules pertaining to grief and the diagnosis of depression, the findings of the current study clearly show that many of the women interviewed attributed their feelings of depression to the loss of loved ones, irrespective of how long ago that loss had occurred. Their profound sense of sadness was not resolved within a certain time frame. On the contrary, these women – particularly Elizabeth and Chenille, the mothers who had lost children – spoke of "living with" (rather than "getting over") the omnipresent sadness that surrounded their losses.

4.7.2 Childhood trauma

The Dictionary of Psychology (Reber, 1985) defines the word "trauma" as "From the Greek for *wound*, a term used freely either for physical injury caused by some direct external force or for psychological injury caused by some extreme emotional assault" (p. 789).

As shown in the following excerpts, five of the ten participants in this study had histories that included significant childhood traumas. These women carried the weight of their traumatic histories with them throughout their lives. In the passage below, Elizabeth recalls some of the terrifying experiences she suffered from her own father's emotional instability.

> Elizabeth: Oh, I was at that time I was in a boarding house in (town name). And at weekends I was so scared. He (Elizabeth's father) one day took the gun, he want to shoot us all. And I didn't at that time, I was twelve years old, I didn't realise what was wrong. I think "Why? He told us he love us, why do he want to shoot us?"… It was a terrible experience. I even sometimes think

> about it, I better want to stay in the boarding house then to go home. *Ja*. It was very bad. And there was a lot of children, there's nine children, I'm the eldest, and my youngest brother, he's eighteen years younger than me, he got depression, and went through heavy panic attacks and fake heart attacks and I've got a lot of sympathy with him.

Similarly, the following excerpts from Evergreen and Linkie highlight the multiple and entwined forms of trauma and abuse that children can be subjected to. Both women had alcoholic, violent and neglectful mothers who did not protect them from the appalling sexual abuse that they suffered at the hands of others.

> Carla: Can we talk about the first time that you started to feel depressed? When was that?
>
> Evergreen: Yes, that was, the time that I was raped, *ja*. Because I've suffered numerous sexual molestation since I was a little girl. And um, you know, I don't know, I'm, I'm a very friendly person. I grew up without my daddy, and my mommy – he was in prison, *né* – and my mommy worked in service in Durbanville. We stayed in a backroom there… She worked for white people there, as a servant. A sleep-in… I lived there. And at night when she would go from seven o'clock to ten o'clock, she would attend to Mrs. B. You know, wash her and dress her and all that. And I would stay in the room and my mother's friend would sometimes come, you know, and he would like touch me and all that, you know. And, ah, thereby I told mommy and she said "No, *jy hou net vir jou ougat!*" (This is an Afrikaans idiom that is commonly used to imply that someone is being precocious. A comparative English idiom would be "you are too big for your boots". However, in Afrikaans, when this idiom is used in the context of a conversation that is sexual in nature – as is the case when Evergreen tells her mother that she is being sexually abused – it implies blame and that the child was both sexually promiscuous and precocious.) In Afrikaans she say "*jy hou vir jou 'n ougat*!" and she would hit me.
>
> Carla: She didn't believe you?
>
> Evergreen: No, she didn't. And after all those times, I thought "maybe it must be like this." You see, and, the older people used to come to me, because I'm

> so friendly and trusting and all that, and OK, that person did it, maybe it must be like that… [Crying]… And as I said, there was no other girls. My mommy was drinking a lot…

Having explained that her alcohol-dependent mother would physically abuse her, and further, refused to believe or protect her from being sexually abused by others, Evergreen then told me that her mother had also on occasion tried to drown her. These early childhood experiences caused Evergreen to "fight every day" to resist being engulfed by sadness, so that she could continue with her daily responsibilities.

> Evergreen: [Crying]... I must um, *ja*, the abuse. The one from my mother's side, *né*, when she divorced my father, she would come and hit me for no reason because I – after all the years I found out that I look like him. And whenever there's a Christmas or a Good Friday or a holiday day, we went to the beach or so, and she would come and, [sighs] she would want to come and go and drown us.
> Carla: The two of you? Yourself and your mother?
> Evergreen: *Ja*, and she want to drown us, and I had to run away and hide myself… A thing that I can get all these bad thoughts out of a person's head, you know? You must, you know, it's, I just, they know me, I'm reach every day, every day, every day it's really a fight, I tell you, just to be on top of it all the time… [Crying]... My mommy always told me "You're good for nothing." Because she used to scold me, you know. "You're just like your dad, you're good for nothing. Just go!"

Linkie similarly recalled her traumatic childhood of being prostituted by her alcohol-dependent and abusive mother. As was the case for Evergreen, Linkie's childhood memories continued to mar her adult years, and frequently pushed her towards suicidal thoughts and even attempts.

> Carla: Can you tell me what made you feel so bad, that you wanted to kill yourself?
> Linkie: I was thinking of the bad things that have happened to me.
> Carla: Mmm? What were those things?

> Linkie: It was a long time ago… [Crying] My mother sent me to a man. He put his penis in me. I was in grade, in grade nine… Because she was a drinker. She don't have money to buy herself… [Crying] And every time the man give the money to me, I had to return it to my mom. That's why, I think the first time, um [sighs] I think of that… [Crying] For me is it very hard, because, how can a mother do something like that to a child? [Crying] …She can, she can go, she can go to this man. Why me? I was just a little girl.
> Carla: She let him abuse you.
> [Long pause while Linkie cries.]
> Linkie: [Crying] Every time, if there's nobody around me, I'm crying. I'm thinking about that, these things.
> Carla: Thinking about it all the time –
> Linkie: All the time.
> Carla: Did you ever get the opportunity to ask your mother?
> Linkie: No… Because I was afraid of her.
> Carla: You were afraid?
> Linkie: She hurt me every time.
> Carla: How did she hurt you?
> Linkie: By the *plak* (plank).

Thus, both Evergreen and Linkie's childhood experiences of being abused by others as well as their own mothers caused them a profound and life-long sadness. Unfortunately, their experiences, however traumatic and distressing, are not unusual. Rape and sexual abuse is rife in South Africa, but particularly prevalent and unreported in low-income black and coloured populations (Jewkes, Levin, Mabananga, & Bradshaw, 2002; Jewkes, Penn-Kekana, Levin, Ratsaka, & Schreiber, 2001a; Kaminer & Eagle, 2010; Williams, Williams, Stein, Seedat, Jackson, & Moomal, 2007). It has been thoroughly documented that in South Africa, nearly three-quarters of pregnant teenagers and nearly two-thirds of teenage girls who have never been pregnant report experiences of coerced sex (Jewkes, Vundule, Maforah, & Jordaan, 2001b). Many researchers – both mainstream and critical or feminist alike – have concluded that child abuse and neglect are associated with an increased risk of depression in adulthood (Bifulco, Brown, & Adler, 1991; Chase, 1998; Jumper, 1995; McWilliams, 1994; Widom, DuMont, & Czaja, 2007). These findings remain true for both clinical populations (G. Brown & Anderson, 1991; McCauley, et al., 1997) and community surveys (Kendler et al., 2000; Kessler, Crum, Warner, & Nelson, 1997; E. Weiss, Longhurst, & Mazure, 1999), and certainly stand in agreement with the subjective experiences and beliefs of the women in the current study, too. Time and again throughout our discussions, both Linkie and Evergreen would convey to me their fervent belief that their current experiences of depression and suicidal impulses were due largely (if not entirely) to their childhood experiences of abuse, and specifically to the fact that their mothers not only failed to protect them, but worse, often facilitated their abuse. They implied that the trauma was even more unbearable because the perpetrator was the provider.

4.7.3 Relationship problems

While there might at times be significant overlap between the themes Lack of support (section 4.7.6), Abuse by partner (section 4.7.4) and the current theme, Relationship problems, the latter will focus specifically on the difficulties the participants experienced with their primary partners, and how they believed these difficulties caused (or impacted negatively upon) their experiences of depression.

> Carla: What does it mean to you, to be depressed?
>
> Christine: Just thinking and stress about stuff, just thinking about my problems, and I seeing now "Oh, my relationship is not on a level now that it should be", and finances and start freaking "Oh, my kids is doing not well at school".

Although Christine generally reported having a good relationship with her boyfriend of seven years, the above excerpt suggests that she remained critically aware of the quality (which she termed the "level") of her relationship with him, and further, that she believed that her experiences of depression were partially dependent on the quality of their relationship.

Unlike Christine, Twela explained that she was generally unhappy and dissatisfied with her relationship with John, and consequently experienced significant amounts of distress in this regard.

> Twela: [Crying] My relationship with, with, with John isn't *lekker* (good/nice). There's something wrong… and, when I talk about it, *né*, he just shuts me out. He just say I'm paranoid… But I don't feel that. My thing, when something is bothering me, *né*, I want to, I talk about it… and then when he gets angry, I feel that he just get lost me or that he just want to end the relationship. Then, then I keep, then I keep quiet… And I don't want to leave, he's not that bad, but I think "let's talk about those things that's bothering you", but he don't want to... He isn't the right person for me. I just feel it. I just know it.

The following excerpt illustrates how desperately Twela wanted a partner who would act as a confidant, companion and support for her – someone who would return the emotional investments and sacrifices which she made for him.

> Twela: *Ja*, and, [sighs] I don't know. And the other hand, it's, it's when he get in that mood that he don't want to talk about it, and it feels for me, I'm the one who is wrong, and then, that, I'm decided at when it at that point that I must leave him. [Crying] I must just stop the whole thing and he can solve his problems at his own. And I have my problem and I just to be alone sort it alone. [Sobbing] I just want someone to help me solve problems, financial problems or whatever problems, I want to, someone to help me, someone to help me, someone beside me… sometimes it feels, sometimes I feel that I give all that I have inside me for him, but I didn't get back…

Such findings are not unfamiliar. It has been established that particularly in South Africa, low-income couples tend to experience more relationship problems and distress than higher income couples (Jewkes et al., 2001a). Lesch and Engelbrecht (2011) investigated the relationship satisfaction in a sample of 93 heterosexual committed couples in a low-income South African community. They found that the women in their study, who (like those in the current study) were generally disadvantaged with regard to education levels, income and employment, reported lower relationship satisfaction than their male counterparts. Lesch and Engelbrecht also found that among the stressors that low-income couples typically have to contend with, issues around fidelity, trust and commitment are often prevalent. This was found to be the case in the current study too. Twela, Anna, Tracey and Melissa's partners had all been unfaithful to them. The infidelity caused each of these women to feel long-lasting anger and anguish, which they found incredibly difficult to resolve, and indeed, believed contributed towards their experience of depression.

> Twela: [Crying]… For being unfaithful, I forgive him for that. But he don't want to talk about it, and that, ah, frighten me… That's why my, my, my, my, my relationship with my (boy) friend, I can't, I can't even trust him and, and that's what frightens me. Because he didn't speak so badly, but feels for me, he do a lot of things that I don't like…

> Anna: …My child's father, he was having an affair with his colleague… So, maybe it (the depression) is that.

> Tracey: …Me and my boyfriend, and um, I feel that he was, um, treat me wrong. Because he must have the decency to come and tell me that "Tracey, this is ending now. I don't want to go with the relationship because I got another girlfriend" and all that stuff…

> Melissa: My husband was fighting, fighting, fighting a long time ago. So I go back to Cape Town, my mother's house. So he goes on with the other girls and I forgive him again and we start it again. Off again. Start again. Like that.

During our many discussions, I began to realise that the women in this study typically assumed a great deal of responsibility for the quality of their relationships with their partners, regardless of their partner's behaviours or contributions to those relationships. Unfortunately, this often resulted in the women blaming themselves for situations in which their partners seemed to me to be at least equally, but often more, blameworthy than the women. For instance, Twela believed that her "moodiness" negatively affected her relationship with John (rather than considering the alternative possibility that her poor relationship with John might be causing her "moodiness").

> Twela: [Sobbing]… Sometimes I'm just moody. And that effects my, my, my, my relationships. He don't understand what's wrong with me, and I can't tell

> him every time the same thing. Sometimes he won't listen to me… I don't know [sighs]… I want to talk about it. I like to talk about my problems but he don't want to talk about his problems. So there's a communication, a, there's a communication problem between us…

Relationship problems, particularly the lack of satisfying communication and relationship infidelity, undoubtedly negatively affected the women in this study, and added significantly to their experiences of depression. In line with this study's findings, G. Brown and Harris (1978, as cited in Rehman, Gollan & Mortimer, 2008) found that the lack of a confiding relationship could instigate the development of depression in women. Other epidemiological researchers have consistently found that people who report unhappy marriages also report more depressive symptoms (Beam et al., 2011; Rehman et al., 2008). This correlation can be interpreted as indicating either that depressive symptoms cause poor marital quality, or vice versa. While the current study was not designed to comment on the causal direction of these variables, it can definitively conclude that, according to the women interviewed, their experiences of depression were positively correlated with their appraisals of the quality of their intimate partner relationships.

While some authors have commented that unmarried women may be vulnerable to depression because of the social stigma that is associated with being single in a society which values marriage (Bhagwanjee et al., 1998), others regard marriage as a risk factor for the development of depression in women because of the gender-specific demands it can stimulate (Ngcobo & Pillay, 2008). Specifically, depression has been associated with women's burdensome roles as mothers and housewives (G. Brown & Harris, 1989). Agreeing with this suggestion, Shek (1995, as cited in Lesch & Engelbrecht, 2011) argues that the roles of married women are more stressful and disadvantaged, but less gratifying, than the roles of married men. Furthermore, and particularly applicable to the current study, it has been found that in economically disadvantaged communities in the Western Cape, traditional gender roles are dominant (Shefer et al., 2008, as cited in Lesch & Engelbrecht, 2011), and often leave women feeling overburdened and under-appreciated (as discussed further in section 4.7.5). Investigations into the marital context of depression have therefore concluded that depression has interpersonal causes and is interpersonally mediated (Rehman et al., 2008). Similarly, there is a large body of feminist (and other) literature that states that the quality of intimate relationships is a crucial factor in personal wellbeing, and that poor relationship quality can contribute to the development of depressive symptoms (Beach, Sandeen, & O'Leary, 1990; Du Rocher Schudlich, Papp, & Cummings, 2011; Jack, 1991; Lesch & Engelbrecht, 2011; Lewis, 1996; Repetti & Crosby, 1984; Vanfossen, 1981; Whisman, 2001).

4.7.4 Abuse by partner

The Dictionary of Psychology (Reber, 1985) does not provide a definition for the word "abuse". I have chosen to use the term here to connote interpersonal mistreatment that is severe enough to cause emotional and psychological repercussions in the victim of the abuse.

When asked about the factors that they believed contributed towards their experiences of depression, Evergreen, Nina and Melissa immediately described their personal experiences of being emotionally and physically abused by their intimate partners.

> Evergreen: Yes, my first husband. He was not, he was in the police, you know… the house was never a home, actually, and um… He was very, what can you say, emotional abusive, you know?

> Nina: …Um, *ek het* (I have) many problems with my husband, um, he's from West Africa and I'm stayed married with him. We have two children, and, you see, I'm not a doctor or something, ah, but I feel he's really sick, because he wants to control me, he wants to control my mind. And I was here already by sister De Lange, and I was talk to her because at that stage I just need to go out, work and be with other people. Sometimes he's beating me and I don't even know why, where I fill in, and saying things that hurt. The most of the time he say things that hurt…

Nina believed that part of her husband's abusive behaviour was driven by his need for absolute power and control. He insisted that she resign from her job, as he did not want her to have her own money. He also did not approve of her leaving the house without him. It was Nina's opinion that her husband wanted her to be afraid of him.

> Carla: He didn't want you to work while you were married?
>
> Nina: *Ja*, but he didn't buy for me even shoes, he didn't buy for me nothing. I start to get All Pay for the children, and then he also want that money. He was beating me so bad, *né* … Beating me, so bad that I didn't come out of the house for days… I know that I can't forget about it. The first time I go out, the first three months I didn't go out… Like, he wants to, that time he was the husband at my house, he want me scared of him… with me it was mostly um, mind-controlling… *Ja*. Abuse. And, me, I think that the beat, I prefer to be beaten, than saying things that you remember, because I have this top, um, I know, I remember what he said that day when I have this top, you know, that day when I had that *tekkie* (shoes) on, you know, I remember what he say that day I had the *tekkies*.
>
> Carla: So many things remind you –
>
> Nina: *Ja*… Then, the black-eye go away, you know? The scratch go away. And you forget about the scratch. Maybe next week another one, you know? But the things stay stuck here (points to her chest).

Nina used these vivid descriptions to explain to me that for her, being physically abused was less painful than being emotionally abused. "I prefer to be beaten than saying things that you remember… The black-eye go away… the scratch go away… But the things he says stay stuck here". It seemed important to Nina that I understood just how damaging emotional abuse was; that it should in no way be considered less serious than physical abuse, or rather, that it could be considered more so.

Once again, these findings are not unusual. Several epidemiological studies report that South Africa has high levels of gender-based violence (Ackerman & De Klerk, 2002; Coombe, 2002; Jewkes et al., 2001b), and further, that among low-income adults, intimate partner violence is associated with depression in women (Bean & Moller, 2002; WHO, 2006; Wong, Huang, DiGangi, Thompson, & Smith, 2008). Particularly in poor communities, violence reverberates through networks of support and becomes folded into the everyday in many different ways (Moultrie & Kleintjes, 2006).

Women not only bear its brunt, but in addition are often responsible for the reparation of social relations (Lesch, 2000). McDonnell and Gielen (2003) state that a partner's substance abuse is often implicated in the increased occurrence of intimate partner violence, as was apparently the case for Melissa. According to her, the abuse she suffered at the hands of her alcohol-dependent husband was so severe that she was desperate to escape by leaving him. However, because she felt that she had no viable alternative options for herself and her children, and because he always apologised, she always ended up returning to him.

> Melissa: It's my husband. Abuse. Drink. Don't get money. All that stuff [sighs]. Worry about the children… My husband was fighting, fighting, fighting a long time ago. So I go back to Cape Town, my mother's house. So he goes on with the other girls and I forgive him again and we start it again. Off again. Start again. Like that.
> Carla: You've left him many times.
> Melissa: Every time "I'm sorry, I'm sorry, I'm sorry, I'm sorry!" And now, it's worse. He's fighting every day, he's drinking every day. I told him, I can't take it anymore… Swear, hit… *Ja*, it's what he does. Even my baby's on my lap, he will still do it then. He don't care. Fight!
> Carla: He will beat you while you are holding your child?
> Melissa: Yes.
> Carla: What does that feel like for you?
> Melissa: *Ek kan nie* (I can't) explain that feeling.
> Carla: Can you try?
> Melissa: [Shakes her head in silence.]

In her sentence "and I forgive him again and we start it again. Off again. Start again." Melissa alludes to both the cyclical nature of intimate partner violence that has been observed by epidemiological studies (WHO 2006) and to her sense of powerlessness and hopelessness, as observed by feminist studies (Stoppard & McMullen, 2003). In Moultrie and Kleintje's (2006) brief literature review on gender violence in South Africa, it is suggested that domestic violence in particular is related to the social status of women in society. (However, it can be argued that low-income women simply do not have the mechanisms to hide evidence of their abuse as effectively as more affluent women might.) Lesch (2000) reported that the South African women she interviewed were often victimised, hurt and harassed by the men in their communities. Lesch noted that these women were typically perceived as powerless and usually also perceived themselves to be powerless in relation to men. Unfortunately this is to be expected, given that as a social group, women have a long history of social oppression and relative weakness as compared to men (Jewkes et al., 2002; Kruger, 2005; Kruger & Van der Spuy, 2007; Lesch & Kruger, 2004). These social conditions tend to maintain themselves and thus perpetuate the cycle of female powerlessness and women's vulnerability to abuse. For a further discussion of powerlessness as it pertains to the current study, see section 4.5.6.

The varied and far-reaching consequences of violence should never be underestimated. It is not difficult to understand that these experiences will have deleterious effects on any person's mental health. It has been formally recognised that violence against women is a significant social problem in South Africa (Ackermann & De Klerk, 2002; Kruger & Van der Spuy, 2007; Lesch, 2000; McDonnell & Gielen, 2003), and it will continue to be so until it is tackled and addressed at every level in every society.

4.7.5 Multiple responsibilities

Most of the women who participated in this study assumed an inordinate number of roles and responsibilities in their everyday lives. It was not unusual for all the duties related to parenting, cooking, cleaning, caring (for children, partners and extended family members), as well as income-generation and household financial management, to fall entirely upon one woman.

> Elizabeth: You must be strong. It's just work, work, work, work. And without, I didn't have help in my house. Weekends it's the ironing, it's the washing, it's work, it's work, and keep up to date with the children.
>
> Evergreen: Now I'm helping this funeral service people just to collect the people's money, and I've got a lot of writing to do, and I feel Oh! My ironing is getting, you know, ah, and the housework and even Evan is getting, not neglected, but I do all this stuff, I just need to, my time management I need to

> be enough… Yes, people's money also works also on my nerves, it's a big responsibility, you know…

Each of these excerpts implies a sense of being overwhelmed by a multitude of duties and responsibilities, which collectively, left little time for the women to take care of their own needs. For further example, in the excerpt below Twela explains that she has so many responsibilities to others that she seldom has time to attend to her own personal needs and problems.

> Twela: At home is it, I am the only one at home who pays… Automatically the others, if there's something, if there's something that's broken in the house, nobody wants to do a thing, do a thing about it. They just want for me to, to, to, take initiative to do the things… And sometimes my, my own, my own problems, must I, put my own personal life I must put away, so that I can take on others' problems.
> Carla: And there are a lot of people in your house that you are looking after.
> Twela: Yes, a lot of people. [Crying] And, and not financially but we all in the same house, but nobody wants to do a thing if a thing is broken. Or nobody wants to do a thing if they, if the, if the bills come. Nobody wants to pay for it. But they want me to pay for that. And I think it is wrong. And I just want to leave the house, but I can't. My mom stays in the house and I don't want to leave her alone with, with my sisters.
> Carla: It sounds like you take a lot of responsibility for your mother –
> Twela: And for the house.
> Carla: – and for the whole house.
> Twela: And my, and my (boy) friend don't want that. I don't want that either, but what can I do? I just can't turn my back on the house. Because [crying] my child, I must think of my child, I must think about my mom. So I can't turn my back, but they don't understand… I'm very unhappy, I'm just unhappy and [sobbing] my, my son, *gesond* (health), *ja*, my child's health, and my financial – it's all too much for me, at that moment.

Twela was obviously extremely distressed by the number of responsibilities she had to attend to. Not only did she have to cope as a single parent, but she felt responsible for her mother too ("I must think of my child, I must think about my mom"). Further still, she carried the bulk of the financial responsibility for the nine people with whom she lived, despite the fact that her salary was minimal, and that she was in considerable financial debt. She longed to relinquish some of these responsibilities, but felt trapped and unable to do so ("I just can't turn my back on the house").

It appeared, then, that the women in this study felt responsible not only for their own wellbeing, but for that of their children, partners and extended family members too. There was seldom any recognition of alternative options – they believed (perhaps correctly) that if they did not assume the role of primary caretaker, no one else would.

Other similar South African studies have shown that, particularly in low-income communities, "women, more than men, are still primarily responsible for childcare" (Lesch & Engelbrecht, 2011, p. 68). An alternative way of thinking about this phenomenon is provided by McWilliams (1994), who posits that persons with depression often feel guilty and inherently "bad" (correspondingly, "guilt and shame" are discussed as themes in section 4.5.5), which in turn motivates them to engage in altruistic activities. She writes:

> Depressive people often handle their unconscious dynamics by helping others, by philanthropic activity, or by contributions to social progress that have the effect of counteracting their guilt. It is one of the great ironies of life that it is the most realistically benevolent people who seem most vulnerable to feelings of moral inferiority. (p. 238)

One might thus argue, as suggested by McWilliams, that people who are prone to depression voluntarily take on multiple responsibilities. Alternatively, one could argue that being given multiple responsibilities can cause symptoms of depression. Either way, in this study, the two were undeniably correlated. Some of the women claimed to have got their sense of responsibility from their own mothers, either via imitating the roles their mothers played ("I must look after my mother because she looked after me"), or via an actual directive ("My mother told me I must take care of them"), as shown in the following disclosures by Christine.

> Christine: …I was moving out and I was the only one working in the house. And I give up hope. “Why am I the only one working in the house?” and all that stuff. And it was my responsibility to take care of all of them because my mother told me “you must take care of them, even your older sister, because she cannot look after herself, you are the one with the energy and the rights for the family.”
>
> Christine: …The whole time I was going early in the morning to work, after I come back I was seeing to her. Four o’clock in the morning I must get up, quarter-past five I must go do all that stuff. But, I don’t blame myself for that, because I must look after my mother because she looked after me. And that time I was, my older sister was at home but she did not look after my mother, because she was drinking… I did everything for my mom by myself, nobody was helping me.

I began to recognise the sentiment expressed in the excerpt above (“nobody was helping me”) as a common theme throughout the interviews with each participant. As such, it will be considered separately in the following subsection.

4.7.6 Lack of support

Adding to the difficulty of managing so many responsibilities, most of the women felt that they were largely unsupported (both emotionally and practically) in their endeavours.

> Christine: …I was the only one working in the house. And I give up hope. “Why am I the only one working in the house?” and all that stuff. And it was my responsibility to take care of all of them…
>
> Elizabeth: He (my husband) was sick. He was sick. I never had, ah, let us put it this way: He couldn’t support me. He was – Oh [sighs], so heart-broken.

Despite the fact that she was similarly grief-stricken by the loss of their son, Elizabeth had to cope on her own, both with her grief and with managing the responsibilities of the family, because her husband was too “heart-broken” to help her.

The themes of Loneliness (section 4.5.2), Multiple responsibilities (section 4.7.5) and Lack of support appear to be intrinsically linked. In discussing their experiences and understandings of depression, most of the women in this study described feeling alone, and therefore unsupported in their attempts to cope with the demands of their daily lives. Twela felt particularly overwhelmed and under-supported. During my discussion with her, she began to sob inconsolably, saying that all she needed in order to feel better was someone who could provide her with emotional and practical support.

> Carla: What do you think you need, to make you feel better?
> Twela: [Sobbing] I need someone, to understand what, what I'm talking about. And I need someone to, to, to, to be with me. And I need someone, [sobbing] if I can't, if I can't do the things, then he shall do the thing for me. I need someone to trust… [Sobbing]… I just want someone to help me solve problems, financial problems or whatever problems, I want to, someone to help me, someone to help me, someone beside me. You know, someone who, someone who understands me. Because, we are, we, we, are used to be as one. Why must, why, I just, this is why must I get this feeling that, that I stand alone? …He must give me more support… He relies on me for everything, and I don't want that… I can't rely on him, really.

Instead of being attended to, supported and nurtured as they longed to be, these women received little to no support from others. (However, as discussed in section 4.6.1, it was seen that on the rare occasions in which the women were offered help, they usually denied it.) Motz (2001, as cited in Kruger et al., in press) writes that anger can be experienced when one is not cared for, helped or supported the way one wants to be, and that this is particularly pronounced in the context of continuous neglect and denial of needs. This appears to fit the findings of the current study, in which the women (who existed in impoverished conditions) clearly articulated not only feeling unsupported, but also deeply angry.

These findings also coincide with a number of feminist and epidemiological studies that claim that women frequently report feeling unsupported. Pillay and Kriel (2006) concluded that almost 90% of the 422 South African women who utilised district-level psychology services in their study described feeling unsupported by their partners, and similar findings were reported in the study by Lesch and Engelbrecht (2011). These and many other authors have therefore identified the lack of a supportive partner as an important vulnerability factor for depression in women (Belle, 1990; G. Brown & Harris, 1989; Davilia, Bradbury, Cohan, & Tochluk, 1997; Schrimshaw, 2003).

Belle (1982) coined the term "the stress of caring" to highlight and give credence to the significant demands that are placed on women in society, who are automatically assumed to take responsibility for the wellbeing of their family members. It has been found that this is particularly true of low-income South African populations, in which the women are expected to carry many of the responsibilities of family life without support (Lesch & Engelbrecht, 2011). Belle (1990) reminds us that although support from friends and family is associated with a reduced risk of depression among low-income women, those same social networks can also serve as conduits of stress. Specifically, she points out that it is not unusual for women whose relatives and friends experience stressful life events to find these events to be personally, vicariously stressful. It would seem then, that in some impoverished contexts, being either with or without supportive networks can be experienced as equally stressful.

Overall, in this study it remained clear that each of the women held multiple roles and responsibilities, and most lacked the support and care from significant others that they urgently needed. They believed that this contributed to a significant number of their daily stressors, and consequently, depression. Both epidemiological and feminist literature confirm that the demands placed on women in society render them vulnerable to the symptoms of both physical and psychological ill health (Belle, 1990; Belle and Doucet, 2003; G. Brown & Harris, 1989; Davilia et al., 1997; Lewis, 1996; Schrimshaw, 2003). Throughout the study, I remained convinced that these women were in desperate need of more care and support than they were currently receiving.

4.7.7 Consequences of poverty

The Dictionary of Psychology (Reber, 1985) defines "poverty" as "a relatively low standard of living in terms of goods and materials. 'Relative' here is characterised in terms of the general standard of living in the society, its distribution of wealth, one's social status and one's personal expectations" (p. 562).

Poverty is considered one of the most reliable predictors of depression in women (Belle and Doucet,2003), yet this was not a straightforward conclusion in the current study. The women whom I interviewed did not seem to be distressed about being poor *per se*. What they claimed distressed them most were the factors that were indirectly related to their economic position. They spoke mostly about the distress they felt at not being able to provide for their children.

> Nina: …I do hair, um, during the week and weekend, and that help me at night, if I get a R40 today, for the day, I can buy a bread and something for the bread, and you know if the change is there I can give them (Nina's children) each a R2 or something…

> Anna: …He (Anna's son) must go to (town name) for sport, um athletics, in his group he was the best at the beginning of the year [sighs] and they're going to take him now, with other children to (town name) for the weekend, and I don't have money to let him go. [Starts to cry] It's very hard for me. And the tenth of October is his crown birthday, and I can't give him a party. My sister was talking to me and she said but "*ons kannie* (inaudible) *ons moet vir hom 'n party reel* (we can't (inaudible), we must give him a party) first week in November". So she will help me. I was just feeling that, that day is his birthday… [Crying] But I can do nothing. What can I do? Because it is very hard for me… Because, I don't want to ask someone money. I will be without money and going on like nothing is happening, or I am trying.

Like Anna, Melissa had to rely on others for financial assistance. She spoke about asking her mother and neighbours for bread or money when she could not afford to feed her children.

> Carla: You said that you get the All Pay grant for your children, but that half of that goes to your mother?

> Melissa: Mmm, for the oldest one, who's staying there. And the other I keep for these two here.
> Carla: So what you have left for your children here, is how much per month?
> Melissa: R400.
> Carla: R400. It must be quite difficult –
> Melissa: Oh! It's difficult. [Whispers] Very difficult… There's many times we go sleeping just like that. I just ask someone for bread for the two, I don't worry about me, while they eat.

It thus appeared that for Anna and Melissa, their poverty only became important when it affected their ability to take care of their children. Chenille, on the other hand, did not mention anything at all that was related to her poor financial position. Instead she attributed her depression entirely to the loss of her son. As explained in the beginning of this chapter, I was shocked to see Chenille's impoverished RDP house, and wondered if the grief over the death of her son eclipsed all possible financial concerns.

In the transcript that follows, Christine explains that because she didn't earn an income for the two days she missed work in each of the previous two weeks (due to her sister's murder and funeral), the full amount of her reduced weekly income went straight into her bank loan repayment, leaving her with no money available for the week.

> Christine: And I must work, because I don't have an income. That's why my boyfriend helps, but not much.
> Carla: Money has been a problem for you?
> Christine: Yes, a lot of problems. This week I don't have even, I work but I don't have money because the bank took all my money, and that was the main problem.
> Carla: What happened there?
> Christine: Um, they took um, two week's money.
> Carla: Why did they do that?
> Christine: Because the week before, I just work for three days. And then I get not the full amount, and this week they take it all, because I didn't get the full

> amount of pay. And when I come there Friday, they say I can do nothing because the, the office is closed. So that's the thing...

In this way, Christine appeared to lack control over her own financial position. The same could be said for Nina, though for slightly different reasons. Nina explained how her husband controlled her financially, taking what little money she had and/or becoming physically violent with her if she tried to maintain her own finances.

> Nina: *Ja*, but he didn't buy for me even shoes, he didn't buy for me nothing. I start to get All Pay (social grant) for the children, and then he also want that money. He was beating me so bad, *né*, that I didn't come out of the house for days. My mother and my father leave me money… and he didn't know about that money because, just some income I mustn't tell him about. And, I don't know how he found out, but I can't lie to someone and I just said "*Ja*, I have the money." "Borrow me that money!" But I say "No". Then he started hitting me again.

The women's poverty was clearly illustrated by their living arrangements. Most of the women shared a bedroom with between three and five other people. Nina did not have a bedroom – she slept on a chair in the communal lounge/kitchen area of her small house. Without explicitly linking their living arrangements to their financial status, Anna, Melissa, Tracey and Twela all spoke about the discomfort they felt in having to share a small living space with several other people.

> Anna: It's not nice. You don't have your privacy. I'm not at work alone. I'm not at home alone. I just want to be alone, but sometimes it feels like I'm just going to sleep now, but I'm not sleeping. But it don't help. Because people are around me. It's making me frustrated.

> Tracey: I don't want to stay there because um, we are too many in the house, and it's too small…

Unlike the other participants, Twela eventually verbalised the stress she felt because of the extent of her financial debt and her boyfriend's lack of practical support in this regard.

> Twela: I just use my card for all the things I want to have, but, my, my whole, ah credit is, is, is, is, it's all used… and that's why, that's why the whole matter is bothering me… And I can't cope weekly with all of that, all of that bills… Even when I'm, when I'm in need, when I'm in need, ah, financial, *né*, and I, and I ask him for money or what, and he can't give it to me. And I know, and I know he can't give it to me because he, he, he had no money, and then I ask him ah, "go ask by your friends, someone who you really trust" and he can't. But when he is in a financial trouble, *né*, he ask me for money, and I didn't have money, *né*, then I asked my friends for money…

Twela thought it unfair that she would ask her friends for money when her boyfriend was "in financial trouble", but that he would not afford her the same favour. Again, it did not seem to be the fact that she was without money that troubled Twela the most, but rather that her boyfriend was not helping her to get money.

Five of the ten participants in this study were unemployed. Linkie, Nina and Melissa in particular longed for stable employment, as they believed that it would solve many of their problems and thereby alleviate their depression.

> Carla: Can you think of anything that might help you feel better?
> Nina: A permanent job, *ja*, and to be busy… I try, doctor, but like I said, if I had a job, a permanent job, and I know that, um, I know I can move to be with other people, a new environment, you know? That is what I'm trying to do. I will change the view of life now. At this moment, it's very dark for me. Maybe if I go out, out of this town, maybe it's going to be a little bit lighter. A new experiences and stuff. I must first, it's not so easy, also, just to go, because there's kids in school, you know, there must be a place to stay, I must get work, and you know, it's not easy, but I'm just trying…

> Melissa: …But I live in (town name) and I've got no one to go to… Then I must just stay there because where must I go with children?
> Carla: You feel that you can't leave him because you don't know where to go. So you're stuck with him at home, even though you want to divorce him.
> Melissa: [Whispers] Yes… [Sighs] He was fighting again, and he was beating me. I, I just want another house, I just want to move out, get a divorce, the kids want to go to school, that's all they want.

Similar to Twela, for both Nina and Melissa, it was not the lack of money that they focused on, but rather what having money would enable them to do – namely, move away from their abusive husbands and settle with their children in a new location.

As has been shown, for the most part in this study, economic disadvantage was only implied through the brief mention of overcrowded living conditions, the urgent necessity for employment, the lack of food or unpaid bills and debt. Explicit statements such as "I am sad because I am poor" were not made. Rather, "being poor" seemed to surface as a problem only when it affected the women's ability to care for their family members – particularly their children – or when it highlighted displeasing interpersonal behavioural tendencies (for instance, Twela's boyfriend's reluctance to borrow money from his friends when she needed it). Poor people's explanations thus indicate that "poverty" is a multidimensional social phenomenon (Patel & Kleinman, 2003).

South African and international studies alike have consistently found that depression is more prevalent among poorer than richer persons (Bhagwanjee et al., 1998; Belle & Doucet, 2003; Elliot & Masters, 2009; Levy & O'Hara, 2010; Moultrie & Kleintjies, 2006; Nadeem, Lange, & Miranda, 2009; Pillay & Sargent, 1999; Theron, 2005). For this reason, poverty is considered to be an important antecedent to depression. Correspondingly and more specifically, going hungry (as both Melissa and Nina often did) because one cannot afford food is a recognised predictor of major depression among low-income women (Siefert, Heflin, Corcoran, & Williams, 2001, as cited in Belle & Doucet, 2003).

Kehler (2001) points out that poor rural women’s restricted access to resources is compounded with unequal rights in family structures (clearly evident in Nina’s case), which renders them poorer not only in society as a whole, but also in their own families, and thereby explains why their “level and kind of poverty is experienced differently and more intensely than that of men” (p. 46). Similarly, Belle and Doucet (2003) explain the dynamic nature of discrimination and how its effects perpetuate and accentuate existing social inequalities:

> Discrimination can lead to lowered economic and social status and losses (of jobs, promotions, housing, etc.) which are particularly frustrating and anger-producing. Such experiences of loss and lack of control can lead to diminished self-esteem and feelings of helplessness, inducing depression. Women experience discrimination based on many characteristics, including sexual orientation, disability, and age… race, and socioeconomic status… these forms of discrimination are most central to the maintenance of women's poverty and economic inequality. (p. 106)

Having reviewed the research on the links between poverty and mental health from a number of different countries, Patel and Kleinman (2003) conclude that the relationship between poverty and mental disorders exists irrespective of a society’s level of development. However, and in line with the findings of the current study, these authors stress the point that it is not low-income *per se*, but its consequences that have a deleterious impact on mental health. Specifically, poverty and mental health are related by way of malnutrition, overcrowding, poor ventilation, low education, hopelessness, low access to healthcare, hunger and material stressors such as debt, as well as the insecurity and humiliation of living in noisy, polluted, unsafe and impoverished living conditions.

While a significant volume of research has focused on the deleterious effect of poverty on mood states, the women interviewed in this study did not pay much attention to the effect their financial position had upon their depression. Nonetheless, it is widely accepted that poverty, both directly and indirectly, does negatively affect mental health, and the women interviewed in this study were certainly aware of the indirect links that added to their daily stresses and concerns. It appeared that gender plus poverty interacted to leave the women in this study doubly disadvantaged and at increased risk of the numerous symptoms of depression. The economically impoverished conditions of their lives could not be ignored, even though they did little to emphasise this. Their poverty undoubtedly rendered these women vulnerable to depression (and probably a myriad of other health problems). There is therefore an obvious need to champion fairer divisions of social resources and power – without which, physical and psychological ill health will undoubtedly remain a significant problem amongst low-income women. In this light, poverty alleviation and the promotion of gender equality and fairer income distribution may be the most powerful interventions to promote mental health, especially among poor women.

4.7.8 Fear: Violence in the community

The Dictionary of Psychology (Reber, 1985) defines "fear" as "an emotional state in the presence or anticipation of dangerous or noxious stimulus. Fear is usually characterised by an internal, subjective experience of extreme agitation, a desire to flee or to attack and by a variety of sympathetic reactions" (p. 271).

Feeling vulnerable is arguably a logical and understandable consequence of living in an environment where interpersonal violence, rape, robbery and murder are commonplace. The women interviewed in this study displayed a clear awareness of the fear they felt about living in a context in which their personal safety and the safety of their loved ones was seldom guaranteed. To this end, many of the women spoke about "being afraid".

> Chenille: …When he come from the school dance he was murdered. He was on call that time. My child was younger than him. I was very afraid of whoever and the school and the kids dying. That afternoon after he died, the day my child goes, I said my friend mustn't go in the night, only the afternoon because I was afraid my niece child would be hurt.

> Evergreen: …Or when something, when something happen, like when they stab my son last year, they stab him eight times, and I'm so far from him, and,

> you know? Eventually when I got there, he was in hospital. They had to cut a piece of his lung away.

> Christine: …But on Tuesday morning one of my colleagues comes, that work with me, she said to me "you know Christine?" I ask "what?" "Last night and this morning, past three, they were stabbing two, ah, black men, that died."… Because she said come from where my street starts, where (town name) is, in that road, maybe four or five people are dying there. Now I am afraid for my kids and all that stuff. But I don't want to be over-protective of them.
> Carla: You don't feel safe?
> Christine: Mmm, I don't feel safe. At home. At work. Nowhere. I don't feel safe.

Thus, accounts of violent interpersonal attacks permeated the women's accounts of their everyday lives. Further, the women often knew the perpetrators of these crimes. This no doubt had the effect of heightening their sense of vulnerability – of bringing it "closer to home".

> Christine: …Because my child don't have time to spend with her father, and he's twenty-five years in jail, and now I think maybe, it's my problem, but, it's ok… Also for murder.
> Carla: Who did he murder?
> Christine: His brother in-law.

In the excerpt below, Evergreen recounts her rape by her nephew, Eric. She explains that her husband, Tonie (nicknamed "Lovie") was out working while she was at home, lying on her bed. Eric let himself into her house and proceeded to overpower and rape her. Evergreen clearly describes her feelings of powerlessness and vulnerability – she tried, but failed to "fight him off".

> Evergreen: …And then, one day his nephew came back in the house, I was just lying and Tonie was working, and he came in, Eric, I could recognise his voice, when he opened the door I could see he was drunk. And he came in "Ah Lovie", his nickname was Lovie, and I see he told me "OK, *ek is nou hier*

> (I'm here now) I'm here and you're here" you know. And I looked at him, he say "Lovie is a very lucky man" and "he doesn't deserve you" and you know, this and that, and the next minute he went and he locked the door. You know, even I was stood there [whispers, crying] "Oh no, not again, not again, please!" And then he, I tried to fight him off me but he strengthens out me onto the carpet. Oh man, Oh! I said "No, I can't do this anymore."

Evergreen believed that her experience of being raped, and by extension, of being helpless and vulnerable even inside her own home (just as she was as a child), contributed significantly to her feelings of depression. Similarly, Linkie explicitly linked her feelings of fear and vulnerability to her experiences of depression. In fact, she had often believed that her own death was preferable to the constant terror of living in the same community as one of the men who used to sexually abuse her when she was a child.

> Carla: Why don't you want to live anymore?
> [Long pause.]
> Linkie: Because, that man was doing it to me, he terrorise me.
> Carla: You still know him?
> Linkie: Yes.
> Carla: Is he in town?
> Linkie: Yes.
> Carla: What is he saying to you?
> Linkie: Every time I saw him, if I walk, um, and then he show me his penis or make a something like that [gesticulates with her hand].

Many of the women in this study therefore attributed at least some of their experiences of depression to the constant fear they felt as a consequence of living in a context that roused near-daily reminders of their own vulnerability and fragility. Sadly, such experiences are not limited to the women in the current study, but are in fact a "normal" feature of low-income community life in South Africa, where the rates of violence against women, female children, and babies are amongst the highest in the world (Lesch & Engelbrecht, 2011; South African Institute of Race Relations, 2004). Poor women in particular experience more discrimination and more frequent, more dangerous and more uncontrollable life events than do members of the general population (Belle, 1990; Kruger et al., in press). Feminist authors such as Belle and Kruger et al. remind us that when violent community contexts are properly considered, rather than being thought of as a psychological affliction that is located within the individual, "depression" increasingly sounds like a logical and entirely human consequence of living in or being subject to grossly disadvantageous conditions.

4.8 Subjective beliefs about the factors that alleviate depression

Each woman in this study was able to identify a number of factors or experiences which she believed improved her emotional and psychological wellbeing. Most of these were simply the opposite counterparts of the factors that they had identified as causing their depression. For example, feeling safe, supported, cared for and understood were all frequently cited as factors that served to increase their sense of wellbeing. In particular though, three themes emerged as important to the women when discussing their sources of resiliency against depression: good interpersonal relationships, religion, and treatment in the form of psychotherapy and medication. Each of these themes will be discussed separately in the following subsections.

4.8.1 Relationships

This theme is closely related to the previous themes entitled Relationship problems and Lack of support (sections 4.7.3 and 4.7.6). The women whom I interviewed repeatedly emphasised the impact that depression had on their relationships with the significant people in their lives, and vice versa. It was clear that they regarded the quality of their interpersonal relationships as a central component of their psychological wellbeing, or conversely, their ill-health. Consequently, the women who felt that they were supported by their partners or loved ones were notably more resilient and hopeful than those who did not.

Of all the participants in the study, only Chenille, Christine and Evergreen felt that their partners supported them adequately. This, they said, helped them to positively manage their symptoms of depression.

> Chenille: …And my boyfriend, he give me the power, and I mustn't do that (commit suicide) because he had also a son who passed away in April at the sports field, when he was playing cricket. So he speak to me, I mustn't do that because he is there for me and I must think about my child.
>
> Carla: Does it help to have a boyfriend who's been through a similar experience?
>
> Chenillle: Mmm, *ja*.
>
> Carla: He is some support for you –
>
> Chenille: Mmm, he is very strong.
>
> Carla: Do you feel strong?
>
> Chenille: [Crying] Not so, very. But I think I can, with his help, I shall come over this, I think so.

Similarly, Christine explained that when she felt depressed, her boyfriend would help her by distracting her and by encouraging her to talk about her feelings.

> Carla: And when you are like that (depressed), how does it affect your relationships?
>
> Christine: It affects it a lot. I know when my boyfriend because he understands me by now.
>
> Carla: He understands you. And how does he respond to you when you're like that?
>
> Christine: Just making jokes and playing with me, he says "No, don't be like that, there's a lot of people who are like that, talk to me about it. Don't worry about stuff!" and he's talking to me and I say "OK" …It helps me a lot, because he always sees what I cannot see… Later he will come back "Are you feeling alright now?" "Yes, I am alright" "No, you are not alright. Come, let's walk to the shop or down the road. There's somebody that we can find" And we go to his sister or we go to my people, my uncle, and then I just sit there for fifteen minutes and say "OK, let's walk"… He really understands me…

The fact that her boyfriend knew how to help and support her (by gently "distracting her", by "playing with her" and by asking her to "talk about it") indicated to Christine that he "understood" her. Specifically, he understood what she needed during her times of sadness, even when she would not admit to feeling sad ("Are you feeling alright now?" "Yes, I am alright" "No, you are not alright…"). This of course stands in marked contrast to the many women in this study who equated their experiences of depression with feeling lonely and misunderstood (section 4.5.2). In the transcript above, Christine mentions that her boyfriend plays with her, and that this is something that she enjoys and finds helpful. Evergreen too described a similar experience with her partner.

> Evergreen: …And we, we definitely have laughs, honestly.
> Carla: It sounds like you've got a good relationship with him?
> Evergreen: We really connect emotionally, and he do whatever I want him to do. You know, sometimes it's serious stuff or, and sometimes silly stuff you know, and I said I was always, I don't to lose, even though my childhood was so bad, I don't want to lose that feeling like a child, the child I feel is inner, I want to keep that, otherwise they must go bury me!

It can thus be said that for both Evergreen and Christine, being part of a relationship in which they could play and do "silly stuff" was ultimately important towards their feelings of resiliency and health. In more general terms, and according to all of the women in this study, being in a supportive relationship was seen to be a significant mitigating factor in the battle against depression.

Other people's responses to the women in general, and to their moods or depression in particular, were similarly experienced as being fundamentally important. Participants clearly recounted the comfort they gained from a supportive friend, partner or health professional, particularly in the context of their depression. In this way, feeling supported seemed to act as a kind of antidote to some of the subjective experiences of depression, specifically feeling alone, isolated or misunderstood (as discussed in sections 4.5.2 and 4.6.1).

> Christine: Um, I talk a lot about to my sister-in-law because we are open to each other. Then, that woman at work. Just those two ladies, we are also very close.
> Carla: Does it help you to talk to them?

> Christine: Yes, a lot, because then I feel good to go the day on.

> Elizabeth: *Ja*, we (the psychosocial rehabilitation group) come together. We all had the same, had plus-minus the same experience. We, how should I say it in English? We understood each one's problems…
> Carla: It helps to be with people who have had the same experiences.
> Elizabeth: *Ja, ja, ja*. Very much!

> Elizabeth: I think, um, after a few months, I realised, that, the Lord in his mercy, is so big, and so good, and the prayers of lots of friends, it feels as if you, you feel hands beneath you, carrying you through the day [cups her hands in mid-air, to gesticulate being carried].
> Carla: Your friends and their support carried you.
> Elizabeth: Yes, and the prayers of so many people.

In research that compares sources of social support, it has been found that support specifically from a romantic partner or spouse is consistently positively associated with psychosocial adjustment (Lesch & Engelbrecht, 2011; Schrimshaw, 2003). Unfortunately, the majority of women in the present study did not receive care and support from their partners, and this undoubtedly added to their emotional distress and loneliness. However, forming relational bonds and receiving emotional support from friends, family or members of the community is also known to have a generally positive effect on psychological wellbeing (Belle, 1982; Lesch & Engelbrecht, 2011), and was frequently mentioned by this study's participants as being tremendously important and helpful towards improving their mood states.

The importance of social support has also been highlighted in other international phenomenological studies of depression (Farmer, 2002, as cited in McCann, Lubman, & Clark, 2012). Ironically, many of the women who were adamant that they should keep their feelings of depression hidden and private would nonetheless admit that talking about their feelings improved their mood dramatically. On the one hand, they would say "I don't want anyone knowing my problem" and on the other, they acknowledged their loneliness and would admit that "talking makes me feel better".

This is discussed further in section 4.8.3, in which the women's appraisals of psychotherapy are explored.

4.8.2 Religion

The Dictionary of Psychology (Reber, 1985) defines "religion" as:

> A system of beliefs with either an insitutionalised or a traditionally defined pattern of ceremony. Religion is regarded by many as a cultural universal which emerges invariably as an outcome of the need to understand the human condition. Most, although not all, religions share certain characteristics, notably the concept of a (or several) supreme being(s), the promise of a pathway to an ideal existence and an afterlife. (pp. 636-637)

Religion emerged as a significant theme in almost every discussion held with the participants in this study. Each woman cited Christianity as her religious affiliation, and most repeatedly affirmed their faith in God, particularly in matters relating to their depression and the tribulations of their daily lives. Most often, the women spoke of God "protecting" and "providing for" them.

> Chenille: Um, you must be strong, you must pray every day, forgive, be strong, because God helps us through all this.

> Elizabeth: …We needed income and we moved to the town and I pray for a job. And the librarian job was given to me by the Lord… Yeah! And, and "I'm fine. I'm not sick. I'm strong. The Lord will protect me"…Trust in the Lord and he provides.

> Christine: …But, I just pray "Dear God must help me." Also if she is sick. He must help me, every day help me...

> Carla: When are you the most sad?
> Melissa: When the babies is hungry. That time.

> Carla: That's the most difficult part for you. What do you think to yourself when your babies are hungry?
> Melissa: [Sighs] I think many things. So I told them "The Lord will provide" that "Everything is fine."

Repeating phrases such as "the Lord will provide" and "the Lord will protect me" appeared to have a self-soothing function for the participants. They recounted how they would repeat these phrases during their worst times of depression, fear or anxiety, and that doing so helped to alleviate those unwelcome feelings. It was also noticed that some of the participants believed that improving their religious commitments and practices could solve their general life problems. Linkie, for instance, believed that "going to church" and "getting someone to pray for her" would "make things better", and Tracey believed that "praying very hard" for herself would help her to stop using alcohol and "*Tik*".

> Linkie: If I'm coming out of this, I will make things better for me, for me, and for myself and for Tina.
> Carla: How do you think you can do that?
> Linkie: I'm going to church, I'm going to get someone to pray for me. And, I'm not going to live there anymore.

> Tracey: No, it's not something I want to carry on (using *Tik*). I try very hard to ending it. I'm, we got a um, we have prayer sessions Mondays, Wednesdays and Friday nights, me and my sisters, and other young women also in (town name), and we pray a lot about um, *Tik* and alcohol and the young people today. And me, I'm praying very hard for myself.

Other psychological researchers have similarly found high rates of subscription to Christianity in low-income South African communities (Lesch & Engelbrecht, 2011; Lourens & Kruger, 2013; Ngcobo & Pillay, 2008; Taylor, 2011). I found the participants' persistent focus on religion and God (who they believed was caring for them) to be particularly interesting, especially given the impoverished and ostensibly "uncared for" conditions of their daily lives. I therefore briefly considered the possible explanations for the devout subscription to religion that was seen in this and other South African studies.

O'Leary and Helgeson (1997) suggested that turning to prayer in times of distress could be considered an emotion-focused coping strategy. From a more psychoanalytic perspective, it was pointed out that the usual beliefs about God's characteristics (e.g. loving, protective, responsive) match the essential features of a secure attachment figure (Carone & Barone, 2001; Kirkpatrick, 1994). From this perspective, each woman's representation of God could be understood as a perpetuation of her childhood attachment experiences or as a reparation for those attachments that had been unfulfilling (Sorenson, 1997). As many of the women felt unsupported or even entirely abandoned by their loved ones, perhaps the most important function served by their religious commitment was that it allowed them to feel supported and cared for by a compassionate God, who they believed could never abandon or disappoint them. In addition, because secure attachments are related to reduced levels of anxiety, having a caring, responsive God as a substitute attachment figure might improve one's overall wellbeing (Sable, 1989). This certainly seemed to be the case for the women in the current study, most of whom declared that their religious faith provided them with immense relief from the undesirable symptoms of depression.

However, if we accept the spiritual attachment figure premise, the question remains: how do persons (such as many of the participants in this study) who have negative schemas of themselves/others and a related history of insecure attachments, end up believing that God loves and cares for them? Kirkpatrick (1998) answers that according to many religions, God's love is universal and unconditional. That is, a person's religious beliefs about God can override their past negative attachment experiences. Therefore, believing in God's universal and unconditional love and engaging in religious prayer or ritual can provide a sense of hope and peace when one's social world does not.

Religion thus offers a way to cope with life's adversities (Carone & Barone, 2001), such as loneliness (Rokach & Brock, 1998) and the loss of loved ones (Thompson & Vardaman, 1997). This certainly seemed to be true for many of the women in the present study, particularly Evergreen, as seen in the excerpt below.

> Evergreen: …And I'm very spiritual also, and I say "help me" because if you believe in the Lord, you're going to go to hell if you take your own life. And nothing is so difficult in life that you must do that. And um, I'm just holding onto the hope, that I share that, that the cross that I bear for a crown one day. You know, sometimes, at first it sounds to me just like words. OK, it's nice, you can share this, change, *né*, you can change your cross for a crown, glory. Now that I'm living it, it seems to be getting more real to me. Every time I feel that helps me to overcome the feelings… And only, um, as I said, I could just pray and, you know, for this religion, my Christianity and Jesus, it's not abstract, you must really believe. That's what faith is, it's believing in something you can't see. You know, it's so hard when something so bad happen in your life, you still hold on to that faith, you still believe… I had just this, this, feeling that I'm dirty, dirty, dirty, feelings, you know… But at night when I lie in bed or, you know, when I'm just, at this point in my life, I just live for, ah, church services, um, to have the Holy Communion, to get Holy Communion to give myself faith, you know. Just to hear the words "Your sins are forgiven"… Sometimes I pray and then I just sit… [Sighs] Just whatever way, I feel it's getting worse. You know, um, the thoughts, about it. But I feel like I manage. I manage as long as I can go to the service then I keep, keep Jesus in my heart, and that's the only thing I can hold onto now…

This account from Evergreen caused me to conclude that more important than understanding the reasons *why* religion bolstered the wellbeing of the study participants, was the fact that it simply *did*. The frequent mentioning of God and prayer in the women's narratives highlighted the fact that religion played a significant role in their lives. In the context of daily deprivation, fear, loneliness and abuse, they affirmed that their religion had an ameliorating effect on their depression, and it provided them with a sense of purpose, tranquility and hope. The findings of this study gave me reason to agree with Ngcobo and Pillay's statement (2008): "understanding the significance of depression in African women requires the recognition of the fundamental importance of religion" (p. 134).

4.8.3 Treatment: Medication and psychotherapy

The Dictionary of Psychology (Reber, 1985) defines "treatment" as:

> 1. Generally, and loosely, the subjecting of some person or something to some action, substance or other influence. 2. Any specific procedure designed to cure or to lessen the severity of a disease or other abnormal condition. The meaning is also rather general and is used to cover medical, pharmacological, surgical, or psychotherapeutic procedures. (p. 790)

The term "depression" inevitably carries clinical connotations, and as such, depression is usually seen as a problem that can be effectively treated by doctors through medicine (Lewis, 1996). In addition, when medical personnel are overburdened by vast numbers of patients, as is the case in low-income communities in South Africa, doctors usually prescribe the treatment that is most easily available, affordable and fastest at reducing manifest symptoms, rather than attempting to resolve underlying problems (Lewis, 1996). Thus it is not surprising that all the participants in the current study had at some stage been offered or prescribed antidepressant medication. However, only some of them accepted or continued to use such medication. Elizabeth in particular believed that medication played a central role in her management and overcoming of depression, so much so that she persisted in trying six different types of antidepressant medications, despite the fact that some had induced horrible side effects in her.

> Elizabeth: It was a very bad experience (Elizabeth's reaction to the third medicine that was prescribed for her symptoms of depression). And um, when I awoke I was so confused, I don't know where I was, what's my name, I don't know which year it is, I was totally confused. And, um, I went to my doctor… I had a lot of tests and they can't find anything. And then he put me on the fourth type of medicine. I thought I was coping better, but, I don't feel like I feel today. The next, um, I was told that affecting the liver and they put me on Trepeline, and there's a bit better, and finally I was put on Fluoxetine, which did a lot for me, and I am coping very well on Fluoxetine.

Like Elizabeth, Anna believed that medication played a vital role in her experience of wellbeing. She found "sleeping pills" to be particularly helpful in this regard, and she did not believe that she would function well without them.

> Carla: I would also like to ask you about the first time the doctor diagnosed you with depression. What treatments did he offer you or give you, to help?
> Anna: Um, sleeping pills and antidepressants and to come to you.
> Carla: And how did you feel about that treatment plan?
> Anna: I was feeling well, because the sleeping pills did help, most of the time. But the meds is up, it's like going back… because I don't sleep. In the morning I am feeling that I am still tired. So, my whole body feels like it didn't get the rest. [Sighs]… Um, but all of the pills is up now.

Important to both Anna and Elizabeth was their lived experience that ''medication works.'' Other participants were less convinced of the efficacy of medication. For some, the chance to openly discuss their thoughts and experiences was the only remedy in which they had faith; they said that they wanted to talk about their feelings, "not swallow pills".

> Carla: Have you ever been given pills to help make you feel better?
> Christine: No.
> Carla: Do you think you need anything like that?
> Christine: No, just talking.

> Carla: What do you think you need to help you to feel better?
> Twela: Someone who listen, man, I, um, medicines or what didn't help for something inside you. It's, it's, it's that you, you must use yourself, yourself must ah, learn to, to, to go with that inside you, or to cope with that inside you.

In their recent epidemiological review, Kupfer et al. (2012) conclude that while no fully satisfactory treatments for depression are available, pharmacotherapy and psychotherapy are both reasonably effective, either singly or in combination. Similarly, and as indicated above, the women who participated in the current study believed that as a treatment, medication and/or having a space in which they could talk openly and be "listened to" was ultimately helpful towards alleviating their feelings of depression. In particular, and echoing the sentiments expressed in section 4.8.1 on Relationships, many of the women expressed their conviction that having a good relationship with a health professional (most often a doctor, clinic nurse or psychologist) was an effective treatment against depression.

> Carla: What about it (the treatment) do you think helped you?
> Tracey: Just to talk about um, what was happening in my relationship, what was what and what I'm going to do about it now, and how I'm going to do it, and, things like that… After I talk I feel good.

These findings stand in contrast to the opinions of Pillay and Kriel (2006), who believe that as a treatment in South Africa, the utility of traditional psychotherapy is limited. Rather, they attest that women who enter district-level mental health services need emergency intervention, medication and practical information. Yet even the simple experience of being interviewed for this research project (specifically, being asked to discuss their experiences of depression with me) was perceived by the majority of the women involved to be beneficial and therapeutic in its own right. This indicates the potential usefulness and value of psychotherapy as a treatment for depression in low-income women.

> Carla: How are you feeling now?
> Chenille: Better. I feeling also better when I talk about it. *Nou voel ek beter* (Now I feel better).
>
> Elizabeth: You know, I don't, how shall I put it? I don't want to talk to my children as I've talked to you. But it was good for me to talk to you!
>
> Carla: Nina, how are you feeling now?
> Nina: You know what? I'm feel actually better, *né*!
> Carla: What do you think has made you feel better now?
> Nina: A talk. I won't go in there and talk with anyone like I talk with you…

As shown above, most of the women experienced the interview as beneficial, which was one of the stated ambitions of this project. When I asked them how they were feeling at the end of our discussion, Chenille and Nina both replied that they "felt better". When I then asked what might have caused this, Nina replied "A talk. I won't go in there and talk with anyone like I talk with you" (where "in there" referred to the rest of the clinic where we met). Similarly, towards the end of my time with Elizabeth, who was forty-two years my senior, she looked at me and said "I don't want to talk to my children as I've talked to you. But it was good for me to talk to you!" Each of these women believed that talking about their feelings helped them to feel better; that talking was "good" for them. Yet this was also something that they felt they could not do with anyone, anywhere, because of the fear of gossip, burdening others, or being considered inferior (as detailed in section 4.6.1).

Similar to Nina, Chenille and Elizabeth, during our final meeting together, Twela (whom I had met for a total of three interview sessions) reflected on our discussions and identified a number of changes that she believed had taken place in herself by virtue of our time together, and commented that "it was nice to talk to somebody who listens."

> Carla: And you know, Twela, that this is our last session together. How are you feeling about that?
> Twela: I'm feeling, I can't say I'm feeling alright, but I'm a little bit more open, and I feel a little bit calmer. And I feel that I can cope…
> Carla: What have our discussions been like for you?
> Twela: The sessions, that sessions they give me, how can I say, ah, a more, ah, a more open and I'm more open… And I feel that, that this session, *né*, give me more, ah, feeling of control in my own, ah, my own decisions or my, my, my, my own needs inside me.
> Carla: You've become more aware of yourself?
> Twela: *Ja*! And, and, and I know, and I know myself and I know how to handle ah, my, my situation… It was nice to talk to somebody who listens; don't want to talk out and, it was really nice! …*Ja, want vanoggend, die eerste ding ek kan, ek kan* (Yes, because this morning I can, I can), I can't wait to be

> here, and I'm, that's why ah, I just, ah, *amper het ek nou gevra, sien jy, vir die sessies* (I almost asked, you see, for the sessions).
> Carla: Mmm, you look forward to coming in?
> Twela: Really I do! And, and, and that's why I just, ah, doing the washing and talk my, my, my niece that take care of my washing so that I can quickly go here!

As detailed in Chapter 1, the assumption that depression is an illness situated within individuals is implicit in mainstream literature (Stoppard, 2000; Stoppard & McMullen, 2003). Unsurprisingly then, the relatively small portion of South African literature on treatment for depression focuses predominantly on treatments that alter women's biochemistry, behaviour, or cognitive patterns (Hugo et al., 2003), while generally disregarding wider social influences on health or indeed women's own opinions on this subject. To this end, Lewis (1996) draws our attention to the important issue of the appropriateness of treatment, and explains that while most healthcare systems encompass a variety of disciplines, they tend to offer treatment on the basis of problems defined according to traditional medical values. The question of who defines depression, when depression becomes a problem, what the problem is and for whom it is a problem, may be answered in suggesting that in practice, depression is medically defined through the availability of medical treatment and through the structure of medical service providers in gatekeeping those treatments. Lewis laments that such a medically based approach usually fails to ask what the distressed person herself believes is the problem, and/or what help she wants, and thereby misses the important issue of the appropriateness of treatment.

A relatively recent and undoubtedly important advance in the medical field has been the acknowledgement of patients' opinions regarding the quality of treatment they receive (Fernandez-Ballesteros, 2003). Mindful of this, my ambition in the current study was to discover the actual experiences and expressed needs of women who had been diagnosed with depression. Having presented my findings, it must be acknowledged that one of the "treatments" (and perhaps preventions) for depression that the women believed to be the most effective, is simply the provision of an opportunity to feel safe enough to talk openly and further, to be heard. These are the fundamental elements of psychotherapy.

Given the widespread agreement that depression in women constitutes a significant social problem, South Africa's dire lack of psychological treatment resources is remarkable (Joska & Flisher, 2005), as is the fact that only a minimal amount of research has been conducted on the treatment and prevention of depression in this country (Dukas, 2009; Tomlinson et al., 2007). This means that mental health interventions in South Africa are based on those that are researched and utilised in other countries (Jacob, et al., 2007). This is probably inappropriate, given South Africa's vastly different social, political and economic environment and given the fact that depression manifests differently in different contexts.

In summary, this study's participants emphasised that they found tremendous relief from their symptoms of depression when they felt cared for, listened to and understood by a healthcare professional. In addition, some found medication (especially to alleviate sleep disturbance) to be particularly useful. In terms of treatment, it is highly likely that the combination of pharmacotherapy and basic psychotherapy can go a long way towards alleviating some of the neurovegetative symptoms (e.g. insomnia) and emotional experiences (e.g. feeling alone and uncared for) of depression that were commonly reported by the women who participated in this study.

4.9 Conclusion

In this chapter, IPA was used in an attempt to describe and make sense of the raw data that was collected for the current study on the subjective experiences of depression in low-income South African women. A number of related themes were presented and discussed in light of the existing and relevant epidemiological and feminist literature. Although this was done categorically for ease of presentation, the deeply complex and intertwined nature of each of these themes remains recognised and appreciated. Likewise, it has been acknowledged that each theme warrants a far greater depth of discussion than was possible here. In sacrificing depth of analysis, the current chapter was able to achieve its aim of presenting a broad overview and phenomenological description of the subjectively lived experience of depression in one group of low-income South African women. A comprehensive summary of the collected findings will be documented in the following and final chapter of this research project.

CHAPTER 5: SUMMARY OF FINDINGS, STUDY LIMITATIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter presents a summary of the main aims, methods and findings of the research project. A critical review of the work is then offered, followed by recommendations for future research. Finally, some personal reflections on my experience of conducting this research are shared.

A review of the past decade of research on the subject of depression in South African women found it problematic that the voices and stories of low-income women were seldom heard or studied. Inspired by this and the recent feminist critiques of the concept of depression, this feminist phenomenological study aimed to bring traditionally overlooked perspectives to the fore, by providing rich descriptions of the subjectively lived experience of depression, as recounted by low-income women who had been diagnosed as depressed. The study was built on the assumption that the current conceptualisations of the medical diagnosis “depression” may not fully capture low-income women’s experiences of distress, and further, that such partial or misguided conceptualisations may serve to pathologise women while simultaneously obscuring the possible impact of socio-economic and political contexts on their mental health.

One of the primary goals of the study was therefore to investigate the under-researched topic of low-income women’s subjective experiences of depression. This goal was operationalised by conducting semi-structured in-depth interviews with ten low-income women who had been diagnosed as “depressed”. Feminist phenomenological perspectives and methods of doing research were employed, as these perspectives give credence to women’s experiences and understandings of their own lives, within their specific social and political contexts (Røseth, Binder & Malt, 2011; Schlimme, 2013). In line with feminist ideologies, it was assumed that the women’s subjective experiences, descriptions and understandings of depression would have been shaped by their own personal histories and by the complex interplay of race, class and gender in South African society (Lorber, 1997; Gwyn, 2002). Theoretically, this study was informed by feminist phenomenology. The two broad research questions posed at the outset of the study were:

- How does one group of low-income South African women, who have been diagnosed with depression, subjectively experience, describe and make sense of their emotional distress?

- How might these descriptions be considered in the light of the existing epidemiological and feminist literature on the subject of depression in women?

The resulting narratives did not present a simple, single vision or version of depression. Rather, they revealed a complex and deeply layered picture that highlighted the diverse ways in which women can experience and make sense of their depression. While I was trying to capture and do justice to the women's descriptions and understandings in order to learn more about their mental and social worlds, those understandings were not always blatant. Some were acquired only after multiple close readings of the transcripts. This was facilitated by the use of Interpretative Phenomenological Analysis.

Each interview transcript was coded inductively. This means that the themes emerged from the raw data rather than some prior theory (MacKay & Rutherford, 2012). This approach was used to understand the women's stories by attending closely to their own words. A myriad of interconnected thoughts, feelings and behaviours were revealed in the data and were understood as affecting each other in ways that either exacerbated or alleviated the overall experience of depression. Therefore, unlike many quantitative and mainstream accounts, this qualitative study did not intend to provide a simplistic and concise answer to the question "what is depression?" Rather, it exists to highlight the complexity of women's lived experiences and to stimulate new perspectives on women's mental health.

5.2 Descriptive summary of findings

Although each woman was interviewed privately and in isolation, the collected narratives were not only largely in agreement with one another, but were at times even remarkably similar. The participants' narration of their experiences of depression encompassed details such as the time and environment in which they became depressed, the key protagonists and antagonists, as well as the impact that depression had had on their lives.

I made sense of the raw data during the analysis by organising the most prominent and commonly recurring themes under five superordinate theme headings, as shown in Table 4 and discussed in the following subsections of this chapter.

Table 4: Superordinate themes and corresponding theme clusters

Bodily experiences of depression	Sleep disturbance Tiredness Body pain
Emotional experiences of depression	Anger Loneliness Anxiety Sadness Guilt and shame Powerlessness: Helplessness & hopelessness Experience of the self: A lost self
Behavioural manifestations of depression	Withdrawal and hiding feelings Substance use Aggression directed at self Aggression directed at others
Subjective beliefs about the factors that cause or exacerbate depression	Loss or death of a loved one Childhood trauma Relationship problems Abuse by partner Multiple responsibilities Lack of support Consequences of poverty Fear: Violence in the community
Subjective beliefs about the factors that alleviate depression	Relationships Religion Treatment: Medication & psychotherapy

5.2.1 Summary: Emotional and bodily experiences of depression

The women's construction of depression was firstly that of an experience that was dark and elusive, that caused both physical and psychological pain, disrupted sleep and lethargy (Elizabeth: I know that sort of pain; the loss of a child – that pain – you feel that pain from your head to your toes). Having fully explained the somatic symptoms of the experience, the women proceeded to explain their depression in terms of anger, distress, sadness, anxiety, loneliness and emotional isolation. For many, it was an experience equated with feelings of despair, guilt, shame, powerlessness, vulnerability, and personality or character incongruence (Anna: I'm not myself anymore). It encompassed debilitating feelings of hopelessness, of being uncared for, unsupported and overburdened by responsibilities (Twela: I don't want that either, but what can I do? I just can't turn my back on the house. Because my child, I must think of my child, I must think about my mom).

Many of these feelings seemed to be inextricably linked in ways that exacerbated and perpetuated the overall experience of depression. For instance, all the participants were aware of the social stigma attached to "being sad" and relatedly, of the social ideals of femininity that were active in their communities. This was evidenced by their feelings of guilt, shame, self-blame, anxiety and their resolve to deny or hide their "bad, dark feelings" of depression from others (Twela: I just kept quiet about my, my darkness and whatever I feel inside me). Unfortunately however, the concealment of emotions usually generates higher levels of psychological distress, anxiety and depression (Simoni & Ng, 2000), and this appeared to be true for the women in the current study too. In hiding their feelings, they began to feel even more alone, ashamed, sad and overwhelmed (Nina: It's so hard to explain because, there are so many things that I go through, I don't know… I don't know if people understand me and if they'll ever understand me, because, I'm just, I'm just a lot, and there's a lot of things to talk about, for days and days). These feelings no doubt exacerbated their sense of sadness, hopelessness, darkness and despair, and thus contributed to the continuation of the depressive experience. Therefore, rather than considering these experiences as isolated symptoms of a disorder, it is undoubtedly more useful to consider them as intricately linked to one another in the complex formation of the overall web (or construction) of depression.

The fact that the participants in this study experienced anger and aggression in addition to their other symptoms of depression deserves special attention. Their anger was not internalised or "silenced" as many authors suggest (Jack, 1991; Lerner, 2004), but rather, was often verbally and behaviourally expressed outwards (towards both the self and others). Further, it was noted that the women did not consider their anger to be an ego-syntonic emotion, and the experience thereof consequently caused them to feel even more distressed (Twela: So I don't want to be that person. I want to be, ah, calm… Yes, and I don't want that angry. It's, it's frightening. I don't want that angry). Such findings stand in contrast to the existing diagnostic systems and mainstream accounts of depression. While the DSM-5 mentions that anger may be a "feature" of depression, it does not consider it seriously enough to be a criterion. Yet the current study's findings on depression and anger have emerged in a number of other South African studies on similar populations of low-income women too (Kruger et al., in press; Lochner, 1999; Lourens & Kruger, 2013; Taylor, 2011). Interestingly, in its sparse recognition of anger as a possible feature (not criteria) of depression, the DSM-5 focuses more on "personality disturbance" and "cognitive styles" that may give rise to anger outbursts. It gives no consideration to the possible interpersonal or social conditions that may justifiably result in anger. Kruger et al. thus emphasise the urgent need for researchers to attend to these issues, and simultaneously warn that if women's anger and violence are reported without due consideration for the adverse conditions within which they live, individual women will continue to be pathologised.

5.2.2 Summary: Behavioural manifestations of depression

The women in this study stated that their depression manifested itself in various ways. Their emotional experiences of guilt and shame, as well as their belief that they should not show or burden others with their sadness or admit that they needed support, were manifested in their tendencies to hide their feelings of sadness from others (Twela: I don't want other people to know what I feel inside / Melissa: I must carry my own burdens). Ironically, while many of the women defended their need to conceal their feelings via social isolation and emotional withdrawal, they all claimed to have a strong yearning for emotional closeness and support from loved ones, and admitted that they benefited from sharing their feelings with others (Tracey: After I talk I feel good).

The women's emotional experiences of anger were manifested in their display of aggression, which was directed both towards themselves and towards others. Specifically, the participants claimed that when they felt depressed, they would become angry and impatient (Twela: when I'm sad, I get angry), and further, that they would outwardly express this anger by swearing, shouting or engaging in physically aggressive acts. When questioned about suicide, which can be regarded as an act of aggression that is directed towards the self (Hillbrand, 2001), most of the participants immediately denied entertaining any such thoughts or impulses, explaining that this would be wrong on two counts. Firstly, they regarded suicide as a religious sin (Evergreen: if you believe in the Lord, you're going to go to hell if you take your own life), and secondly, they believed that it would be wrong to abandon their child and family caretaking responsibilities in that way (Christine: I'm just living for my kids). However, upon further careful questioning, many of the women eventually admitted to experiencing suicidal ideation and even attempts. For each of them, this was inspired by a desire to escape either the conditions of their daily lives (Evergeen: It will be over, just like that!), or the memories of their tortured pasts (Linkie: I was thinking of the bad things that have happened to me…I don't want to live any more).

Four of the participants said that their feelings of depression became manifest though their substance-using behaviours (usually cigarettes and alcohol, and in the case of two participants, marijuana or methamphetamine). These women said that they used those substances to alleviate boredom, to relax, as part of engaging in social activities, or in response to feeling angry, frustrated or mistreated.

Overall, despite certain commonalities between the participants in this study, it should be recognised that depression can manifest differently in different women, and that personal pain can be acted out or hidden in a variety of ways, some of which might not typically resemble "depression" as we currently know it. For instance, during their times of greatest depression, the women in this study explained that they became anxious and angry with those who they felt did not understand or support them adequately. In a medical model framework, the complexity of these women's emotional experiences and reactions might have resulted in the diagnosis of a personality disorder. Yet such a diagnosis would undoubtedly obscure the fact that symptoms are always an articulation of distress, and further, that distress is intricately linked to historic, social and relational contexts.

5.2.3 Summary: Subjective understandings of the causes of depression

This and other South African studies that have assessed women's opinions on the causes of their depression, all report remarkably similar findings: women tend to attribute their depression to social causes (such as abuse and deprivation) and interpersonal factors, specifically, how others could hurt or humiliate them (Lourens & Kruger, 2013; C. Newman, 2005; Polders, Nel, Kruger, & Wells, 2008; Rapmund, 1999; Rapmund & Moore, 2000; Taylor, 2011; Westwood, 2006). When asked what might have caused their feelings of depression, the women in this study typically gave reasons that focused on: the loss of an important relationship (whether by death or abandonment); a history of childhood trauma (physical or sexual abuse as a child and/or negative relationships with parents); intimate partner relationship problems or abuse; having multiple responsibilities; feeling either emotionally or practically unsupported; and feeling constantly afraid by virtue of living in dangerous and violent communities.

It was the theme of relationship problems, however, that emerged as the primary focus area across the collected narratives. In both this study and in the related studies by Lourens and Kruger (2013) and Taylor (2011), women's references to their relationships (with their friends, family members, husbands, partners and/or children's fathers) were prominent. Feeling supported and part of a good relationship was the most frequently offered explanation for their resiliency and recovery, and conversely, the loss of a relationship or the absence of a satisfying relationship was the most frequently cited reason for feeling depressed. Clearly, then, relationships played a central role in the measure of quality in these women's lives. In other words, it was in the context of relationships where the women's depression came to the fore. Participants believed that their experiences of depression had a negative impact on their interpersonal relationships, which in turn further contributed to their feelings of depression. However, they also indicated that this was a bidirectional cause-and-effect sequence, as problematic relationships with significant people in their lives were seen to function as both causes and consequences of depression. Conversely, each participant indicated that her health and resiliency was bolstered by virtue of caring and satisfying interpersonal experiences.

While problematic relationships with their own parents or family members often featured in the women's narratives, it was their difficult, frustrating or abusive relationships with their intimate partners or the fathers of their children that appeared to affect them the most. The women explained that these problematic relationships contributed to their experiences of depression by making them feel unsupported, misunderstood and emotionally isolated – feelings which, in turn, gave rise to their experiences of loneliness, anger, stress and anxiety – that is, to many of the component parts of their overall experience of depression. Such observations give credence to the relationally informed models of depression and also point to the fact that while depression might be conceptualised as an experience that is isolated, personal and private, it is nonetheless interpreted with reference to interpersonal experiences and social context.

Poverty is believed to be one of the most reliable predictors of depression in women (Belle and Doucet, 2003). It was therefore expected at the outset of this study that participants would attribute their depression primarily to their poor socio-economic status. This, as has been shown, was *not* found to be the case. While issues related to poverty or economic disadvantage were occasionally mentioned or implied, "being poor" was never explicitly cited as a reason or explanation for feeling depressed. Rather, what the women claimed distressed them most in this regard, were the factors that were indirectly related to their economic position. For instance, Melissa, Anna and Nina described not being able to provide for their children as particularly depressing (Carla: When are you the most sad? Melissa: When the babies is hungry. That time).

5.2.4 Summary: Subjective beliefs about the factors that alleviate depression

Participants were easily able to identify a number of conditions which they said helped them to feel better or more resilient in the face of depression. In particular, being able to share one's feelings in the context of a supportive relationship, involving oneself in religious activities, and having access to healthcare services, were all identified as being especially valuable.

Maintaining their religious beliefs was particularly important to many of the women who partook in this study. Reciting prayers or other religious statements seemed to provide them with ways of remaining calm and hopeful in the context of daily trials and hardships. (Elizabeth: The Lord will protect me… Trust in the Lord and he provides. / Evergeen: I had just this, this, feeling that I'm dirty, dirty, dirty… I just live for, ah, church services, um, to have the Holy Communion, to get Holy Communion to give myself faith, you know. Just to hear the words "Your sins are forgiven.")

Anna and Elizabeth expressed their belief that medical treatments for the symptoms of depression were both necessary and useful (especially with regard to alleviating insomnia, which most of the women identified as a particularly troubling symptom). However, the majority believed that interventions that focused exclusively on medication had only limited usefulness. They affirmed that the protective and healing effect of feeling cared for in an empathic relationship should not be underestimated. Specifically, they claimed that engaging in an open, non-judgemental dialogue – the simple practice of having a respectful, considerate interpersonal relational encounter with another – provided them with tremendous relief from many of their depression-linked experiences, including loneliness, despair, sadness and anxiety. (Carla: What do you think you need to help you to feel better? Twela: Someone who listen, man, I, um, medicines or what didn't help for something inside you.) Indeed, most of the women experienced their participation in the research interviews for this study as therapeutic in its own right. They commented that the process made them feel listened to, respected and therefore cared for. (Carla: Nina, how are you feeling now? Nina: You know what? I'm feel actually better, *né*! Carla: What do you think has made you feel better now? Nina: A talk. I won't go in there and talk with anyone like I talk with you.)

5.2.5 Summation of findings

This study's detailed explorations of women's subjective experiences of depression allowed a more complex picture to emerge than that which is currently offered by mainstream models and diagnostic systems alike. The women interviewed attempted to explain why they had become depressed in terms of their complex relationships and life events – they did not confine their explanations to assumptions of individual pathology, chemical imbalances, hormonal fluctuations or poverty.

Elizabeth explained depression as a process of adaptation and personal change, as part of her experiences of loss and the demanding responsibilities of being a single parent. Evergreen and Linkie explained their experiences in terms of childhood sexual abuse and neglect. Melissa, Twela, Christine and Nina felt crippled by multiple responsibilities, problems and troublesome relationships. Overall, it was demonstrated that social factors cannot be considered as distinct from their meaning to the person, and that meaning is constructed through social experiences. Therefore, the findings of this study suggest that it is not only the social environment that is important in explaining depression, but a person's subjective experience of that social environment too. As written by Jack (1991):

> In order to understand how a woman's external and internal worlds affect and depress her, we must learn about how she sees and interprets them. What affects her is not some clearly perceptible, objective actuality, but experience as she perceives it. To learn of it there is no better source - indeed no other source - than the woman herself. (p. 23)

Studies that focus on social influences to the neglect of biological factors (and vice versa) are equally limited in their explanatory ability, because they cannot explain why some women recover from depression despite unchanged conditions. That is, the explanatory power of those models of depression are inadequate, primarily because they do not recognise the importance of subjective interpersonal and intrapersonal experiences, and thus do not provide sufficient depth of understanding of the phenomenon under investigation. It is therefore believed that in order to gain a better understanding of depression in women as a social phenomenon, we must first explore their subjective experiences so that we may begin to comprehend the interaction between their inner (individual) and outer (social) worlds. As stated by Grace (2010): *"*The 'causes' of that vast array of possible affects symptomatic of 'depression' can only be 'known' (never fully, the truth is only half-said) by the experiencing subject [herself]" (p. 276).

The participants in this study appeared to share the belief that a good woman or mother was one who was the primary caregiver in the family; was physically and emotionally strong; was able to uphold multiple responsibilities while remaining eternally healthy, productive, calm and patient (never angry); was self-sacrificing and self-sufficient, and thus never required help or assistance from others. According to Jack (1991), these feminine ideals reflect wider social values and gender constructions which women cannot actually meet, but against which they are judged and judge themselves as failing. The findings of this study therefore highlight the truth in the feminist dictum that the personal is political (Hanish, 1970). With this understanding in mind, we may begin to comprehend at least some of the reasons for the highly gendered nature of depression. For instance, in this study, the women's distress was clearly linked to and maintained by a particular socio-political context which included multiple social ideals and expectations (e.g. "mothers are always caring" and "women should hide their sadness"). The stress generated by trying to live up to these unachievable ideals added significantly to the participants' experiences of depression, specifically by increasing their sense of guilt, shame, despair, emotional isolation and frustration. It is also of utmost importance to remember that these women lived not only in contexts of poverty and patriarchy, but also in the context of post-apartheid South Africa, where many women of colour are still socially disadvantaged.

The health status of women depends on the complex interrelationship between multiple social contexts, personal history, environment, behavioural risk and low income, and not by each factor alone (Lachman, 1991). When we consider the personal histories and social contexts of the women in this study, the fact that they suffer from emotional ill-health (labeled here as "depression") is not surprising. However, when we consider each of these same factors, we also begin to realise that the current, clinical conceptualisation of the term "depression" is vastly insufficient and barely aides our understanding of any individual who may receive the diagnosis.

Overall, the narratives contained in this paper offer the possibility of filling a gap in our understanding of low-income, rural South African women's experiences of depression. They are rich in the nuances, silences, contradictions and ambiguities that cannot be well captured by procedure-bound styles of interviewing. They show the continuity of struggle across generations of women's lives and demonstrate not only the ongoing challenges facing low-income women, but also their remarkable resilience and determination. Ultimately, this study's guiding assumption – that there is more to the concept of depression than mainstream literature suggests – was found to be correct. A number of other significant findings are briefly summarised below.

1) Somatic complaints (particularly trouble sleeping and bodily pain) were expressed ahead of emotional disclosures (even when directly questioned about emotional status).
2) In general, the women's affective vocabulary was limited. Rather than speaking about being "sad", they tended to say they were "tired", "stressed", "angry", "upset" or "not myself".
3) Most of the symptoms of depression that were identified by the women are consistent with ICD and DSM-5 criteria, although some presentations were perhaps culture-specific (e.g. strong focus on somatic complaints) and some symptoms (most notably anger) are not recognised by diagnostic systems as being indicative of depression in adults.
4) Participants were clearly aware of depression-linked changes in themselves/their personalities ("I'm not myself"), and this was often accompanied by distress, self-blame and guilt ("It is my problem").
5) Depression was predominantly understood and experienced in relational terms. Problematic relationships with significant people in the participants' lives were perceived to function as both causes and consequences of depression.

It should be noted that remarkably similar findings emerged in the related (but independently conducted) studies by Taylor (2011) and more recently, Lourens and Kruger (2013) and Kruger et al. (in press). The low-income women who partook in each of these South African studies had to cope with: childhoods marked by violence, disruption and abuse; partial schooling; absent parents; multiple pregnancies and deaths; overcrowded housing; sexual violence; substance abuse; having to make a living to support themselves and their families, and trying to care (often single-handedly) for their children and other family members. In this light, it was not at all surprising that these women felt depressed. However, to describe them as such was to capture only one fragment of their very complicated experiences of themselves. In fact, such a diagnosis might actually serve to obscure the intricacy of their emotional experiences as well as their ability to cope.

In other words, this study has shown that depression is a complex phenomenon which cannot be adequately captured by simplistic diagnostic categories. It has shown that depression might better be considered a personal and interpersonal experience which individuals try to make sense of in the context of their own lives. The study participants most often described their depression in terms of bodily pain, difficulty sleeping, changed patterns of behaviour, changed relationships with others and also a changed sense of self. Overall, a depressed woman was portrayed as someone who felt rejected, disconnected, alone, angry, vulnerable, afraid, tired, fragile, frustrated, abandoned and uncared for; as someone who was overburdened by multiple and opposing responsibilities, who desperately wanted and needed support, but believed that she should not ask for it.

It was evident that the emotional experiences of depression and their corresponding physical and behavioural manifestations had a deleterious effect on the women's daily lives. While all of the participants had at some stage experienced an overwhelming desire to simply "give up" or disengage from their daily lives and responsibilities, none of them truly considered this to be a tenable option. So committed were they to their roles and responsibilities, that they simply persisted in trying to meet those daily demands and ideals, even when doing so was to their own detriment. This picture of depression – of continuing to function and engage with daily life, often in a way that is energised by anger – contrasts with the traditional portrayal of depression as being an inert state of disengagement and apathy. Again it becomes apparent that depression in some low-income South African women might not always resemble traditional, mainstream depictions of the condition. Again it is argued that it may be more useful to understand depression as a dynamic and variable experience, rather than as a static state, and as an ongoing element of the more complex experiences of a capricious self in a particular sociopolitical context.

5.3 Limitations of the study

A number of limitations can be identified in this study, including issues around subjectivity, sample composition, language, feminist theory and depth of analysis – each of which will be discussed below. Despite these limitations, constant reflection and regular discussions were employed to maximise reliability and minimise misrepresentation. As a result, this study has achieved its initial ambition of providing a broad description of ten low-income women's subjective experiences of depression.

5.3.1 Researcher subjectivity

Research into the experience of illnesses such as depression traditionally involved passive patients and directive researchers who would control the conversation. More recently, there has been an increased focus on the ethical necessity of fostering a dialogical relationship between researchers and participants, and this has given rise to different qualitative approaches. Authors such as Carson (2002) state that discussions between researchers and participants "must strive to be radically egalitarian" (p. 175). Jones (2010) agrees that researcher-participant conversations should aim to be as non-hierarchical as possible, but points out that even in Carson's work, the researcher's subjectivity and role are nonetheless still privileged. That is, that even when researchers actively involve participants, the relationship remains non-egalitarian, even if not obviously so. While participant and researcher may feel like conversational partners whose words are equally valued, it is still the researcher who tends to decide what will be researched and how – the researcher asks the questions and the researcher chooses which segments to include in the article. Further, the participant's social status may play an invisible yet mediating role in the interaction (Benatar, 2002). These points are of great concern in qualitative health research, where despite the best intentions of researchers who aim to give voice to participants, those participants can all too easily become study subjects, or even objects (Jones, 2010) in the shadow of the researcher's subjectivity.

As the author of the present study, I was involved in every phase of the research, from the initial planning and interview construction, to data collection, analysis and write-up. Such close involvement assisted me in gaining insight and a thorough understanding of the data, which in turn allowed me to carefully describe and interpret the experiences of the study participants, as I understood them. However, being from a different cultural and socioeconomic group, I remained an outside observer throughout the process. It is therefore possible that an entirely different analysis and conclusion could have been drawn, had the study been conducted by an inside researcher, or indeed by another outside researcher with different subjectivities to my own.

While it is recognised that my own subjectivity as researcher undoubtedly affected every stage of the research process, it is a limitation of this study that its scope did not allow for a more detailed investigation of exactly how my subjectivity influenced this project.

5.3.2 Homogeneous sample

In line with the sample size guidelines for researchers who intend to use Interpretative Phenomenological Analysis, the current study consisted of a very small number of low-income women, all of whom were living in the same subdistrict of the Western Cape Province of South Africa. That is, the sample was relatively homogeneous. This was deemed acceptable, based on the argument that the study was sacrificing breadth for depth of data. However, a less advantageous consequence of this decision was that other groups of South African women who might be able to offer vastly different and valuable perspectives were not represented in this study. Therefore, future research should be extended to include other groups of women within the broader South African context. Specifically, similar research should involve non-English-speaking women, women from different regions, and women from different socioeconomic, racial and cultural groups.

5.3.3 Language

Due to the fact that I have only a limited proficiency in speaking Afrikaans (the primary language spoken in the area in which my study was conducted), I selected only participants who were comfortable with conversing in English. Despite this, I was aware that speaking English would provide at least some challenge to those who otherwise conversed in Afrikaans. I remained mindful of the fact that speaking in one's "second language" might become increasingly difficult when discussing the deeply personal and emotional topics that my interview questions invoked. As a proud South African, I was also embarrassed by my inability to speak one of the country's extremely common official languages, and perhaps even more so by the fact that my limited ability highlighted previous social divides between the English- and Afrikaans-speaking people of South Africa. For all of these reasons, I encouraged each participant to speak Afrikaans whenever it became too difficult for her to describe her thoughts of feelings in English. This was frequently done, as seen in the transcripts, where all Afrikaans-English translations are clearly indicated. Fortunately, I am able to understand slightly more Afrikaans than I can speak, and given the contexts of our discussions and my determination to remain empathically attuned to each participant, I was usually able to follow each story without difficulty. At times, however, I had to ask for clarification, and I believe that this deepened our connections and helped to produce richer data.

Nonetheless, while the qualitative data that emerged from the participants' narratives provided detailed descriptions of their lived experiences of depression, it is likely that an even fuller account could have resulted, had they been speaking their primary language. Similarly, the raw data could give rise to deeper analyses if more interpretative analytical methods, such as discourse analysis, were employed. Should similar future research be undertaken with the intention of applying discourse analysis to the data, it is recommended that the interviews be conducted in the participants' first language.

5.3.4 Limitations of feminist theory

Although feminist studies have highlighted the flaws in mainstream research and contributed to a more comprehensive understanding of depression in women, they are not without their shortcomings. For instance, while prioritising the sociopolitical context is important, feminist writers tend to make this emphasis at the expense of women's agency. That is, where the medical model tends to construct women as passive victims of biochemistry, feminist theory tends to construct women as passive victims of society (Mauthner, 1998) and thereby fails to recognise the diversity among women's experiences. Such perspectives are therefore unhelpful when we consider why some women emerge from depression despite unchanged social and political conditions.

The present study, informed by feminist phenomenological theory, attempted to avoid such limitations by offering that no single perspective (feminist, medical, social or other) could ever provide both the breadth and depth of insight that is necessary for a thorough understanding of a phenomenon as complex as depression. Thus, as per the discussion (in section 5.4.1) below, it is suggested that we begin to conceptualise a new, broader, more inclusive model of depression – one that is built on the offerings of both expert opinion and subjective, experiential knowledge of the subject.

5.3.5 Depth of analysis

In line with the original intention of phenomenological investigations, the primary goal of this project was to provide a phenomenological *description* of the subjective, lived experiences of depression in one group of low-income South African women (i.e. not an *explanation* or thorough *analysis* thereof). It was argued that this would be both a necessary and logical place to start if we truly wish to achieve better understandings and new conceptualisations of the phenomenon. However, having this intention meant that, for the purposes of this thesis, I often had to forsake exploring all the findings as deeply as I would have liked. Many of the findings were interesting enough to have warranted being the focus of a dissertation in their own right. Some that undoubtedly deserve further analysis and discussion include:

- The physical modes of emotional expression. That is, bodily pain or disturbance as symptoms of emotional distress;
- The experience of anger as a component of the emotional experience of depression;

- Religious or cultural norms which appeared to prohibit the expression of sadness;
- Culturally specific terminology and phrases (including statements such as "I am not myself") that may alert healthcare providers to the presence of severe emotional distress;
- The presence, function and effect of guilt and shame in low-income women;
- Religious or culutral norms which might inspire the reflexive tendency to fervently deny the presence of suicidal ideation or intent (and thus query the usefulness of traditional suicidal screening interviews in South African community contexts).

5.4 Recommendations

The knowledge that was gained through this research project can only be considered useful if it is able to inform future research, policy and mental health practices. To this end, a number of recommendations pertaining to future theory, research and intervention will be made in the following subsections.

5.4.1 Working towards new understandings of depression

It has been argued throughout this thesis that mainstream biological and psychosocial models tend to position depression as a naturally occurring pathology in women, usually brought about by their biology, cognitions or defective ways of coping. Feminist writers such as Ussher (2010) protest that this medicalises women's misery and obscures the contextual (social, political, environmental and economic) aspects of their experience. The findings of this study support Ussher's argument, and indicate that there is more to the concept of depression than mainstream literature suggests. Therefore, while there may be some advantages to the use of the term "depression" (e.g. in helping to communicate the extent of a woman's distress and/or to validate her emotional experiences), this study stands in general agreement with the feminist writers who state that the term desperately needs to be "conceptualised outside of a medical model that positions it as pathology within the woman" (Ussher, 2012 p. 24) and that there is an "urgent call to destabilise and dethrone the medical model from its master status so that there is room for more varied and emancipatory constructions of human suffering" (Lafrance & McKenzie-Mohr, 2013, p. 136).

However, as has been pointed out by MacKay and Rutherford (2012), while feminist perspectives are useful in conceptualising and politicising women's mental health, they "may not capture the painful material reality of living with depression" (p. 181). Here "material" includes both the physical world (and body) and the social structures (institutions and general environments) which function as sites for the production of experience and understanding (Lafrance & McKenzie-Mohr, 2013). Towards addressing this problem, Ussher (2010) suggests that researchers employ a critical realist epistemological position to conceptualise depression. She writes: "a critical-realist epistemology allows us to acknowledge the material-discursive-intrapsychic concomitants of experiences constructed as depression, without privileging one level of analysis above the other" (Ussher, 2010, p. 9). Therefore, those who take a critical-realist epistemological standpoint acknowledge the contributions of many different types of research study, without having to accept or resolve competing theoretical or disciplinary commitments (Lafrance & McKenzie-Mohr, 2013). In fact, critical-realists specifically value a diversity of perspectives. They claim that different perspectives can contribute towards different understandings of the multifaceted problem that is depression, and collectively can promote the emergence of deeper, more comprehensive conceptualisations of the phenomenon (Ussher, 2010).

The current thesis therefore endorses the need for new understandings of emotional distress – understandings which respect the knowledge gained from biological, social, relational and psychological models of depression. Moreover, it recommends that multifactorial, contextual and subjective influences should be better integrated into the existing understandings of depression in women (Kruger et al., in press; Mauthner, 1998; Ussher, 2010). This can be achieved by firstly moving the concept of depression beyond its current clinical and individual focus to include what women actually experience as depression. The subjective understandings of depression, as recounted by women who have personally experienced the phenomenon, connote a richness and complexity of knowledge that stands in contrast to the clinical picture of depression that is usually presented by "expert" healthcare professionals and diagnostic manuals alike. An integrative framework that combines subjective interpersonal and intrapersonal contributions will undoubtedly have greater explanatory power than any perspective considered alone.

5.4.2 Future research on depression in women

Most of the published research articles on the subject of depression in South African women are epidemiological in nature and reiterate the need for more epidemiological studies (Dukas, 2009). However, responding to the problem of depression in women by simply doing more research is inadequate – that these papers call for more of the same is highly questionable and unlikely to further our knowledge. Ultimately what is needed is a deeper understanding of depression – without which it is unlikely that solutions will be discovered, and women's concerns and mental health will continue to be marginalised.

The findings discussed in this study indicate that a wide range of interpersonal, social, political, emotional, physical and practical issues affect the quality of life and determine the health and wellbeing of low-income women. The participants' narratives highlighted how gendered power relations affected their experiences of exploitation and interpersonal abuse within their families and communities. It is undeniably important that we continue to acknowledge and challenge the social context with regard to gendered and economic power relations. In fact, it is recommended that such social inequalities be foremost in mind when planning research or developing healthcare and psychosocial support services for low-income women. Similarly, it is of utmost importance that researchers make use of theoretical perspectives and research methodologies that are sensitive to the multilayered, complex psychological experiences of depression in low-income women. Therefore, in addition to the recommendations made in section 5.3.5 above:

- Future research should respect the legitimacy of women's own accounts of their experiences as a source of information, and thus prevent hegemonic practice from assuming "expert" knowledge on the subject.
- More research conducted from social constructionist, phenomenological and feminist perspectives is needed on the topic of depression in women, so that we can increase our understanding of women's unique illness experiences in the

context of their social and cultural positioning, with the ultimate goal of utilising this knowledge so that new solutions can be found to the myriad of problems that affect women's quality of life.

- Future research should be extended to include other groups of women within the broader South African context. Specifically, similar research should involve non-English-speaking South African women, women from different regions, as well as women from different socioeconomic, racial and cultural groups within South Africa.
- As depression manifests differently across cultures, future research should attend to the issues of validity and reliability of measurement instruments. More phenomenological studies of women's experiences will also be helpful in verifying whether instruments are in fact measuring the correct constructs.
- More research is needed on the treatment/prevention of depression; on the impact of social/political conditions; and on the effectiveness of existing treatment interventions.
- Researcher transparency and reflexivity should become a non-negotiable standard so as to facilitate researchers' more responsible and critical engagement with their own power and subjective perceptions inherent to their research, and thus construction of knowledge.

5.4.3 Interventions

It has been demonstrated in this study that new understandings of women's mental health issues in general, and the concept of "depression" in particular, are sorely needed. The study has also shown how pervasive and chronic poverty, abuse and neglect affect generations of women and children. "Such situations are destructive to women's mental health, and must be challenged at a societal level, since social change can only be achieved when women are able to question the societal structures that sustain oppression" (Pillay & Kriel, 2006, p. 591). Researchers, healthcare professionals and policy-informers must therefore become committed to highlighting the "links between the social conditions of people's lives and their suffering: When there is oppression, there is pain" (Lafrance & McKenzie-Mohr, 2013, p. 136). However, highlighting the circumstances of people's lives is only the first step. Rather than simply helping people to adjust to the conditions that cause their distress, the necessary second step should be towards transforming those conditions (Hare-Mustin and Marecek, 1997). That is, social and political interventions are needed so that women no longer have to live in contexts of poverty, inequality, violence and abuse (Ussher, 2010). To this end, more education and employment opportunities as well as poverty alleviation programmes that aim to empower women economically are absolutely essential.

Women in general, and poor women in particular, have for too long been silenced in society. They are given too many burdens to carry and receive too little support and recognition for doing so. Mental health and social workers in low-income communities typically focus on empowering women to improve their poor socio-economic status in order to alleviate their symptoms of depression, and this, as previously stated, is both necessary and good. However, if (as suggested by the current study) women's primary concerns are not economic, but rather concern their problematic interpersonal relationships, then the current primary treatment and prevention strategies may be misdirected. While it is entirely likely that the factors associated with poor socio-economic conditions contribute to the experience of depression, it is important that mental health workers and policy developers also pay attention to the issues that depressed women themselves are most concerned about. Inviting someone to tell her story respectfully conveys the message "you have something to tell that is important for both of us" (Hedelin & Jonsson, 2003, p.321; Allan & Dixon, 2009). *Truly* empowering women to improve the quality of their lives may begin with listening to what they themselves believe to be the causes of and likely solutions to their problems with depression. As advised by Leibrich (1998):

> Then listen to the people you want to help. Learn to be still and listen. Put aside the rush to find answers and listen. Listen for the voice in the wind. Do not force solutions. Let them emerge. Let the problems speak. (p. 277)

The women who participated in this study, for instance, felt certain that being provided with both therapy and medication (primarily to alleviate symptoms such as insomnia) were ultimately beneficial treatments for depression. Having a space in which they felt secure enough to share their feelings was regarded as especially helpful. Given the strong emphasis on sleep disturbance and bodily pain that was recognised in this study, it is also recommended that healthcare workers in South Africa should carefully assess patients who present with somatic complaints for other symptoms of depression.

In clinical practice, we also need to begin to use descriptions rather than one word. Talking about feeling “tired, angry, sad, anxious, alone” and so forth, instead of “depressed” would not only decrease stigmatisation and improve understandings of people’s experiences, but it would also facilitate better communications and perceptions when working in multi-lingual and heterogeneous socioeconomic contexts, such as South Africa. In addition, given that some low-income women experience significant amounts of guilt or shame, healthcare professionals are advised to strive towards creating a warm, accepting, confidential and respectful therapeutic atmosphere. Overall, this thesis stands in agreement with the many writers who insist that if treatment is to be effective, it should be concerned also with prevention; with the context of the illness as well as intervention; and with care as well as cure.

5.5 Conclusion

In order to plan appropriate mental health interventions and contribute to policy development for low-income women in South Africa, psychological research on women’s lived experiences is urgently needed. This study represents a first step towards meeting this need.

The findings of this study stand to support the many authors who claim that the medical diagnosis of depression serves to obscure the more complex nuances of women’s psychological distress (Lafrance & McKenzie-Mohr, 2013; Mauthner, 1998; Stoppard, 2010; Ussher, 2010). One cannot help but wonder with other feminist psychologists about the functions of diagnosis, or why certain “symptoms” of depression are recognised in diagnostic systems while others remain obscured. These political questions have been asked by feminist researchers and need to be answered.

5.6 From the researcher

Living and working in rural and disadvantaged communities has undoubtedly affected me as a person, as a woman, and as a psychologist – it is difficult to explain exactly how or why in this limited space.

I was immediately drawn in by each woman's emotional distress. I felt compelled to help in any way I could, and it was hard for me to simply listen to each participant's story and to ask mostly open, non-directive questions. Often, so doing left me feeling as if I had been withholding or ineffectual. I believed that each woman desperately needed to be heard and attended to. Perhaps that is why I became so determined to produce a competent research document. I wanted to facilitate the clear expression of these women's stories through my thesis. That is to say, that I felt a considerable degree of responsibility to each of the participants, to do justice to their narratives. Following Oakley's (1981) sentiments, I wanted to do research *for* rather than *on* women.

Having said that, the research account presented here is neither definitive nor comprehensive. There are too many issues contained in the raw data to do justice to all. Therefore I chose to present only that which I believed to be salient to the psychology of depression in low-income women. Towards this end, I tried to develop a way of writing up the data in such a way that guides the reader through the analysis, while still paying tribute to its complexity.

One challenge that I grappled with throughout this project concerned the tension between my provision and exploration of theory (that is, the knowledge of expert researchers or theorists) and the participant's own knowledge. I have personally been trained to respect "expert" voices in academia, and I thus often judged the content of this project as insufficient. Yet at the same time, it was exactly the hegemony of traditional academia that I wanted this dissertation to stand in contrast to. While I specifically did not want to write a document in which the occasional participant excerpt became overshadowed by multiple expert hypotheses, I could not ignore my own critical gaze that has been shaped by my formal schooling. I was also aware of the academic requirements of the doctoral degree that I am working towards, and believed that I could not provide a purely phenomenological description (as I had wanted to) without engaging in some exploration of theory. Thus, this project became (and indeed remained) an inherently contradictory and difficult task for me.

Another, though entirely different challenge, was the sense of powerlessness, despair and guilt that arose in me while sitting with the women who participated in this study. Those same feelings often resurfaced during the many months of my engagement with their interview transcripts. Nonetheless, I remained grateful for the frequent reminders of the privileges that I so often take for granted. My life has been immeasurably easier simply by virtue of my being born into an affluent, white and educated family.

This project – from data collection, through analysis and write-up – has at times caused me to feel absolutely helpless and hopeless. But the opposite has also been true, as it has caused me to feel capable and hopeful. Completing this project has taught me that engaging in qualitative research can be emotional, stressful and personally meaningful for both researcher and participants alike, and moreover, that these characteristics are what make the work worthwhile.

I hope that those who read this document are able to learn something about the lives of low-income women, and further, become inspired to pass that learning on. For myself, I hope that my personal and professional determination to shed light on these issues will remain as strong and resilient as some of the women this study afforded me the chance to meet.

REFERENCES

Accortt, E.E., Freeman, M.P., & Allen, J.B. (2008). Women and major depressive disorder: Clinical perspectives on causal pathways. *Journal of Women's Health, 17*(10), 1583-1590.

Ackermann, L., & De Klerk, G. (2002). Social factors that make South African women vulnerable to HIV infection. *Healthcare for Women International, 23*(2), 163-172.

Ahmed, R., & Pillay, A. (2004). Reviewing clinical psychology training in the post-apartheid period: Have we made any progress? *South African Journal of Psychology, 34*(4), 630-656.

Allan, J., & Dixon, A. (2009). Older women's experiences of depression: A hermeneutic phenomenological study. *Journal of Psychiatric and Mental Health Nursing*, *16*(10), 865-873.

American Psychiatric Association (APA). (2000). *Diagnostic and statistical manual of mental disorders: DSM-IV-TR*. Washington, DC: American Psychiatric Association.

American Psychiatric Association (APA). (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, DC: American Psychiatric Association. Retrieved July 2, 2013, from http://www.dsm5.org

Andersen, L. (2012). Lessons learned from Ziphamandlas: A study aimed at adapting a cognitive-behavioural based intervention for adherence and depression in HIV to the South African context. Public Lecture. May 4, 2012, Cape Town: Red Cross Child Guidance Clinic.

Appelt, I. (2006). Narratives of hope: Trauma and resilience in a low-income South African community. Unpublished doctoral dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Appignanesi, L. (2010). *Mad, bad and sad: A history of women and the mind doctors from 1800 to the present*. Britain: Virago press.

Banister, P., Burman, E., Parker, I., Taylor, M., & Tindall, C. (1994). *Qualitative methods in psychology: A research guide*. Buckingham: Open University Press.

Bardwick, J. (1971). *Psychology of women*. New York: Harper & Row Publishers.

Barlow, D. (1991). The nature of anxiety: Anxiety, depression, and emotional disorders. In R. M. Barlow, *Chronic anxiety: Generalized anxiety disorder and mixed anxiety-depression* (pp. 1-28). New York: Guilford Press.

Beach, S., Sandeen, E., & O'Leary, K. (1990). *Depression in marriage: A model for etiology and treatment*. New York: Guilford Press.

Beake, L., & Goosen, M. (1996). Healthy living. In M. Goosen, B. Klugman, M. Goosen & B. Klugman (Eds.), *The South African women's health book* (pp. 127-171). Cape Town: Oxford University Press.

Beam, C., Horn, E., Hunt, S., Emery, R., Turkheimer, E., & Martin, N. (2011). Revisiting the effect of marital support on depressive symptoms in mothers and fathers: A genetically informed study. *Journal of Family Psychology, 25*(3), 336-344.

Bean, J., & Moller, A. (2002). Posttraumatic stress and depressive symptomatology in a sample of battered women from South Africa. *Psychological Reports, 90*(3), 750-752.

Beauvoir, S. de. (1974). *The second sex*. New York: Vintage Books.

Belle, D. (1982). The stress of caring: Women as providers of social support. In L.

Goldberger & S. Breznitz (Eds.), *Handbook of stress: Theoretical and clinical aspects* (pp. 496-505). New York: Free Press.

Belle, D. (1990). Poverty and women's mental health. *American Psychological Association, 45*(3), 385-389.

Belle, D., & Doucet, J. (2003). Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly, 27*(2), 101-113.

Benatar, S. (2002). Reflections and recommendations on research ethics in developing countries. *Social Science & Medicine, 54*(7), 1131-1141.

Bhagwanjee, A., Parekh, A., Paruk, Z., Petersen, I., & Subedar, H. (1998). Prevalence of minor psychiatric disorders in an adult African rural community in South Africa. *Psychological Medicine, 28*(5), 1137-1147.

Bifulco, A., Brown, G., & Adler, Z. (1991). Early sexual abuse and clinical depression in adult life. *British Journal of Psychiatry, 159*(1), 115-122.

Brown, G., & Anderson, B. (1991). Psychiatric morbidity in adult inpatients with childhood histories of sexual and physical abuse. *American Journal of Psychiatry, 148*(1), 55-61.

Brown, G., & Harris, T. (1989). *Social origins of depression. A study of psychiatric disorder in women*. London: Routledge.

Brown, L.S. (1994). *Subversive dialogues: Theory in feminist therapy*. New York: Basic Books.

Brown, T., DiNardo, P., Lehman, C., & Campbell, L. (2001). Reliability of DSM-IV anxiety and mood disorders: Implications for the classification of emotional disorders. *Journal of Abnormal Psychology, 110*(1) 49-58.

Burdette, A., Hill, T., & Hale, L. (2011). Household disrepair and the mental health of low-income urban women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 88*(1), 142-153.

Campbell, R., & Wasco, S. M. (2000). Feminist approaches to social science: Epistemological and methodological tenets. *American Journal of Community Psychology, 28*(6), 773-291.

Carone, D., & Barone, D. (2001). A social cognitive perspective on religious beliefs: Their functions and impact on coping and psychotherapy. *Clinical Psychology Review, 21*(7), 989-1003.

Carson, R. (2002). The hyphenated space: Liminality in the doctor-patient relationship. In R. Charon & M. Montello, *Stories matter: The role of narrative in medical ethics* (pp. 171-182). New York: Routledge.

Cederberg Municipality Draft. (2012). *Integrated development plan*. Retrieved June 25, 2013, from http://www.cederbergmunicipality.co.za/Documents/2012041642009_item_Cederberg%20Draft%20IDP%20V4.pdf

Charmaz, K. (1995). Between positivism and postmodernism: Implications for methods. In N. Denzin, *Studies in symbolic interaction* (pp. 43-72). Greenwhich, CT: JAI.

Chase, A. (1998). *The development of pathogenic beliefs that result in chronic depressive disorders: A control mastery formulation.* Integrative paper submitted as partial requirement for advancement to candidacy. Retrieved April 25, 2013, from http://sfprg.org/control_mastery/docs/Chase1998.pdf.

Cohan, N., & Atwood, J. (1994). Women and AIDS: The social construction of gender and disease. *Family Systems Medicine, 12*(1), 5-20.

Coombe, C. (2002). HIV/AIDS and trauma among learners: Sexual violence and deprivation in South Africa. In J. Maree & L. Ebersohn, *Lifeskills within the caring professions: A career counselling perspective for the bio-technical age* (pp. 235-249). Cape Town: Heinemann.

Cooper, P., Landman, M., Tomlinson, M., Molteno, C., Swarts, L., & Murray, L. (2002). Impact of a mother-infant intervention in an indigent peri-urban South African context. *British Journal of Psychiatry, 180*(1), 76-81.

Cooper, P., Tomlinson, M., Swartz, L., Molteno, C., Stein, A., et al. (2009). Improving quality of mother-infant relationship and infant attachment in a socioeconomically deprived community in South Africa: Randomised controlled trial. *British Medical Journal, 338*(1), 997-997.

Cooper, P., Tomlinson, M., Swartz, L., Woolgar, M., Murray, L., & Molteno, C. (1999). Postpartum depression and the mother-infant relationship in a South African peri-urban settlement. *British Journal of Psychiatry, 175*(6), 554-558.

Cosgrove, L. (2000). Crying out loud: Understanding women's emotional distress as both lived experience and social construction. *Feminism & Psychology, 10*(2), 247-267.

Cosgrove, L. (2003). Feminism, postmodernism, and psychological research. *Hypatia, 18*(3), 85-112.

Cosgrove, L. (2005). When labels mask oppression: Implications for teaching psychiatric taxonomy to mental health counselors. *Journal of Mental Health Counseling, 27*(4), 283-296.

Crawford, M. (2006). *Transformations: Women, gender & psychology*. New York: McGraw-Hill.

Davilia, J., Bradbury, T., Cohan, C., & Tochluk, S. (1997). Marital functioning and depressive symptoms: Evidence for a stress generation model. *Journal of Personality and Social Psychology, 73*(4), 849-861.

DeBerard, M., & Kleinknecht, R. (1995). Loneliness, duration of loneliness, and reported stress symptomatology. *Psychological Reports, 76*(3), 1363-1369.

Denzin, N.K. (2009). *Qualitative inquiry under fire: Toward a new paradigm dialogue.* Walnut Creek, CA: Left Coast Press.

Denzin, N.K., & Lincoln, Y.S. (Eds.) (1994). *Handbook of qualitative research*. London: Sage.

de Villiers, S. (2011). Mothering as a three-generational process: The psychological experiences of low-income mothers sharing child-care with their mothers. Unpublished doctoral dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Doman, L., & Le Roux, A. (2010). The causes of loneliness and the factors that contribute towards it - a literature review. *Tydskrif vir Geesteswentenskappe, 50*(2), 216-228.

Dukas, C. (2009). Misunderstanding depression in South African women: A feminist social constructionist analysis of the literature. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Du Rocher Schudlich, T., Papp, L., & Cummings, E. (2011). Relations between spouses' depressive symptoms and marital conflict: A longitudinal investigation of the role of conflict resolution styles. *Journal of Family psychology, 25*(4), 531-540.

Elliot, L., & Masters, H. (2009). Mental health inequalities and mental health nursing. *Journal of Psychiatric and Mental Health Nursing, 16*(8), 762-771.

Evans, K.M., Kincade, E.A., Marbley, A.F., & Seem, S.R. (2005). Feminism and feminist therapy: Lessons from the past and hopes for the future. *Journal of Counseling & Development, 83*(3), 269-277.

Faure, S., & Loxton, H. (2003). Anxiety, depression and self-efficacy levels of women undergoing first trimester abortion. *South African Journal of Psychology, 33*(1), 28-38.

Fee, D. (2000). *Pathology and the postmodern*. London: Sage.

Fernandez-Ballesteros, R. (2003). *Encyclopedia of psychological assessment.* London: SAGE Publications.

Field, W., & Kruger, C. (2008). The effect of an art psychotherapy intervention on levels of depression and health locus of control orientations experienced by black women living with HIV. *South African Journal of Psychology, 38*(3), 467-478.

Finchilescu, G. (1995). Setting the frame: Gender and psychology. *South African Journal of Psychology, 25*(3), 133-139.

Finlay, L. (2008). *Introducing phenomenological research*. Retrieved September 4, 2013, from http://www.lindafinlay.co.uk/publications.htm

Fisher, L. (2010). Feminist phenomenological voices. *Continental Philosophy Review, 43*(1), 83-95.

Fisher, L., & Embree, L. (Eds.). (2000). *Feminist phenomenology*. The Netherlands: Kluwer Academic Publishers.

Flax, J. (1993). *Mothers and daughters revisited*. London: Routledge.

Foster, D. (2008). Liberation psychology. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman & I. Parker, *Critical psychology* (pp. 559-602). Lansdowne: UCT Press.

Freud, S. (1905). Fragments of an analysis of a case of hysteria. *Standard Edition, 7*, 7-122.

Garko, M.G. (1999). Existential phenomenology and feminist research. The exploration and exposition of women's lived experiences. *Psychology of Women Quarterly, 23*(1), 167-175.

Georgaca, E. (2013). Social constructionist contributions to critiques of psychiatric diagnosis and classification. *Feminism & Psychology, 23*(1), 56-62.

Gergen, M. (2008). Qualitative methods in feminist psychology. In C. Willig & W. Stainton-Rogers (Eds.), *The Sage handbook of qualitative research* (pp. 280-295). London: SAGE Publishers.

Gilbert, J. (2006). Cultural imperialism revisited: Counselling and globalization. In P. Gobodo-Madikizela, A. Collins & G. Eagle, *Critical psychology in Africa* (pp. 10-28). London: Lawrence and Wishart.

Giorgi, A. (2010). Phenomenological psychology: A brief history and its challenges. *Journal of Phenomenological Psychology, 41*(2), 145-179.

Giorgi, A. (2012). The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology, 43*(1), 3-12.

Golding, P., & Murdoch, G. (1992). Culture, communication and political economy. In J. Curran & M. Gurevitch, *Mass media and society* (pp. 178-237). London: Edward Arnold.

Grace, V. (2010). The desiring, gendered speaking being: Going a bit further with Ussher on women and depression. *Feminism & Psychology, 20*(2), 272-277.

Green, M., Freedman, D., & Gordis, L. (2000). *Reference manual on scientific evidence* (2nd ed.). Retrieved July 30, 2009, from Washington, DC: Federal Judical Centre: www.fjc.gov/public/pdf.nsf/lookup/sciman06.pdf/$file/sciman06.pdf

Greenspan, M. (1993). *A new approach to women and therapy*. Blue Ridge Summit: TAB Books.

Greenwood, D.J., & Levin, M. (1998). *Social research for social change*. Thousand Oaks, California: Sage.

Guilfoyle, M. (2013). Client subversions of DSM knowledge. *Feminism & Psychology, 23*(1), 86-92.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and "ethically important moments" in research. *Qualitative Inquiry, 10*(2), 261-280.

Gwyn, R. (2002). *Communicating health and illness*. Gateshead: Athenaeum Press.

Hamad, R., Fernald, L., Karlan, D., & Zinman, J. (2008). Social and economic correlates of depressive symptoms and perceived stress in South African adults. *Journal of Epidemiology & Community Health, 62*(6), 538-544.

Hanish, C. (1970). The personal is political. *Notes from the Second Year: Women's liberation; major writings of the radical feminists.* New York: NYRF.

Hare-Mustin, R., & Marecek, J. (1990). Gender and the meaning of difference: Postmodernism and psychology. In R. Hare-Mustin & Marecek, J. (Eds.), *Making a difference: Psychology and the construction of gender* (pp. 22-64). New Haven and London: Yale University Press.

Havenaar, J., Geerlings, M., Vivian, L., Collinson, M., & Robertson, B. (2008). Common mental health problems in historically disadvantaged urban and rural communities in South Africa: Prevalence and risk factors. *Social Psychiatry Epidemiology, 43*(3), 209-215.

Hedelin, B., & Jonsson, I. (2003). Mutuality as background music in women's lived experience of mental health and depression. *Journal of Psychiatric and Mental Health Nursing 10*, 317-322.

Herbst, E. (2006). The illness experience of HIV-infected low-income Coloured mothers in the Winelands Region: Theoretical and practical implications. Unpublished doctoral dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Hillbrand, M. (2001). Homicide–suicide and other forms of co-occurring aggression against self and against others. *Professional Psychology: Research and Practice, 32*(6), 626-635.

Hollway, W., & Jefferson, T. (2000). *Doing qualitative research differently: Free association, narrative and the interview method*. Thousand Oaks, CA: Sage.

Hornstein, G. A. (2013). Whose account matters? A challenge to feminist psychologists. *Feminism & Psychology, 23*(1), 29-40.

Hugo, C., Boshoff, D., Traut, A., Zungu-Dirwayi, N., & Stein, D. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social Psychiatry & Psychiatric Epidemiology, 38*(12), 715-719.

Husserl, E. (1962). *Ideas. General introduction to pure phenomenology* (Book 1, Trans. W. R. B. Gibson). New York: Collier Books. (Original work published in 1913).

Husserl, E. (1970). *The crisis of European sciences and transcendental phenomenology*. Evanston, Ill.: Northwestern University Press. (Original work published 1936).

Inhorn, M., & Whittle, K. (2001). Feminism meets the "new" epidemiologies: Toward an appraisal of antifeminist biases in epidemiological research on women's health. *Social Science & Medicine, 53*(5), 553-567.

Jack, D. (1991). *Silencing the self: Women and depression*. Cambridge, MA: Harvard University Press.

Jacob, K., Sharan, P., Mirza, I., Garrido-Cumbrera, M., Seedat, S., Mari, J., et al. (2007). Global mental health 4. *Lancet, 370*(9592), 1061-1077.

Jenkins, A. (2001). *Invitations to responsibility: Therapeutic engagement of men who are violent and abusive*. Adelaide: Dulwich Centre Publications.

Jewkes, R., Levin, J., Mabananga, M., & Bradshaw, D. (2002). Rape of girls in South Africa. *Lancet, 359*(9303), 319-320.

Jewkes, R., Penn-Kekana, L., Levin, J., Ratsaka, M., & Schreiber, M. (2001a). Prevalence of emotional, physical and sexual abuse of women in three South African provinces. *South African Medical Journal, 91*(5), 421-428.

Jewkes, R., Vundule, C., Maforah, F., & Jordaan, E. (2001b). Relationship dynamics and adolescent pregnancy in South Africa. *Social Science & Medicine, 52*(5), 733-744.

Johansson, E., Bengs, C., Danielsson, U., Lehti, A., & Hammarstrom, A. (2009). Gaps between patients, media, and academic medicine in discourses on gender and depression: A metasynthesis. *Qualitative Health Research, 19*(5), 633-644.

Jones, A. (2010). From principles to reflective practice or narrative ethics? Commentary on Carson. In R. Carson & C. Burns, *Philosophy of medicine and bioethics: A twenty year retrospective and critical appraisal* (pp. 193-195). Dordrecht, Netherlands: Kluwer Academic Publishers.

Joska, J., & Flisher, A. (2005). Letters (to the editor). An innovative inpatient psychotherapy unit in South Africa. *Psychiatric Service, 56*(10), 1316-1317.

Jumper, S. (1995). A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect, 19*(6), 715-728.

Kagee, A. (2008). Symptoms of depression and anxiety among a sample of South African patients living with chronic illness. *Journal of Health Psychology, 131*(5), 547-555.

Kaminer, D., & Eagle, G. (2010). *Traumatic stress in South Africa*. Johannesburg: Wits University Press.

Kantrowitz, J. (2004). Writing about patients: I. Ways of protecting confidentiality and analysts' conflicts over choice of method. *Journal of the American Psychoanalytic Association, 52*(1), 69-99.

Kazdin, A.E., & Rabbitt, S.M. (2013). Novel models for delivering mental health services and reducing the burdens of mental illness. *Clinical Psychological Science, 1*(2), 170-191.

Kehler, J. (2001). Women and poverty: The South African experience. *Journal of International Women's Studies, 3*(1), 41-53.

Kendler, H.H. (2005). Psychology and phenomenology: A clarification. *American Psychologist, 60*(4), 318-324.

Kendler, K., Bulik, C., Silberg, J., Hettema, J., Myers, J., & Prescott, C. (2000). Childhood sexual abuse and adult psychiatric and substance use disorders in women: An epidemiological and cotwin control analysis. *Archive of General Psychiatry, 57*(10), 953-959.

Kessler, R. (2003). Epidemiology of women and depression. *Journal of Affective Disorders, 74*(1), 5-13.

Kessler, R., Crum, R., Warner, L., & Nelson, C. (1997). Lifetime co-occurrence of DSM-III-R alcohol abuse and dependence with other psychiatric disorders in The National Comorbidity Survey. *Archive of General Psychiatry, 54*(4), 313-321.

Kirkpatrick, L. (1994). The role of attachment in religious belief and behaviour. In D.

Perlman & K. Bartholemew, *Advances in personal relationships* (vol. 5., pp. 239-265). London: Jessica Kingsley.

Kirkpatrick, L. (1998). God as a substitute attachment figure: A longitudinal study of adult attachment style and religious change in college students. *Personality and Social Psychology Bulletin, 24*(9), 961-973.

Kohen, D. (2000). *Women and mental health*. London: Routledge.

Kruger, L. (2005). Childbirth and the breakdown of narrative: Implications for mental health care. *Psychodynamic Psychotherapy in South Africa, 13*(2), 1-23.

Kruger, L., & Van der Spuy, T. (2007). Obscuring the pregnant body: A feminist psychodynamic perspective on undisclosed pregnancy. *South African Journal of Psychology, 37*(1), 1-24.

Kruger, L., van der Straaten, K., Taylor, L., Dukas, C., & Lourens, M. (In Press). The melancholy of murderous mothers: Reflections on the violence of the institution of motherhood. *Feminism & Psychology.*

Kübler-Ross, E., & Kessler, D. (2005). *On grief and grieving. Finding the meaning of grief through the five stages of loss*. London: Simon & Schuster.

Kupfer, D., Frank, E., & Phillips, M. (2012). Major depressive disorder: New clinical, neurobiological, and treatment perspectives. *Lancet, 379*(9820), 1045-1055.

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing.* Thousand Oaks, California: Sage Publications.

Lachman, S. (1991). *The emergent reality of heterosexual HIV/AIDS: A primer for medical practitioners and healthcare workers*. South Africa: Lennon Limited.

LaFrance, M.N. (2009). *Women and depression: Recovery and resistance*. London: Routledge.

Lafrance, M.N., & McKenzie-Mohr, S. (2013). The DSM and its lure of legitimacy. *Feminism & Psychology, 23*(1), 119-140.

Lafrance, M.N., & Stoppard, J. M. (2006). Constructing a non-depressed self: Women's accounts of recovery from depression. *Feminism & Psychology, 16*(3), 307-325.

Langellier, K.M. (1994). Appreciating phenomenology and feminism: Researching quiltmaking and communication. *Human Studies, 17*(1), 65-80.

Leenerts, M. (1999). The disconnected self: Consequences of abuse in a cohort of low-income white women living with HIV/AIDS. *Healthcare for Women International, 20*(4), 381-401.

Leibrich, J. (1997). The doors of perception. *Australian and New Zealand Journal of Psychiatry 31*, 389-407.

Lerner, H. (2004). *The dance of anger.* London: Element.

Lesch, E. (2000). Female adolescent sexuality in a Coloured community. Unpublished doctoral dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Lesch, E., & Engelbrecht, S. (2011). Relationship satisfaction and gender differences in a South African farmworker community. *South African Review of Sociology,42*(1), 58-77.

Lesch, E., & Kruger, L. (2004). Limited sexual agency in young women's first experiences of sexual intercourse. *South African Journal of Psychology, 34*(3), 464-486.

Lester, S. (1999). *An introduction to phenomenological research*. Retrieved September 4, 2013, from http://www.sld.demon.co.uk/resmethy.pdf

Levy, L., & O'Hara, M. (2010). Psychotherapy interventions for depressed, low-income women: A review of the literature. *Clinical Psychology Review, 30*(8), 934-950.

Lewis, S. (1996). *The social construction of depression: Experience, discourse and subjectivity* (vol. 2). Departments of Psychology and Psychiatry. England: University of Sheffield.

Liebert, R. (2010). Feminist psychology, hormones and the raging politics of medicalization. *Feminism & Psychology, 20*(2), 278-282.

Lochner, C. (1999). Women on farms: Discourses of distress. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Lorber, J. (1997). *Gender and the social construction of illness*. Thousand Oaks, London and New Delhi: SAGE Publications.

Lourens, M., & Kruger, L. (2013). Die subjektiewe ervaring van depressive onder Suid-Afrikaanse vroue in 'n lae-inkomste gemeenskap. *Social Work/Maatskaplike Werk, 49*(2), 248-270.

Lupton, D. (1995). *Medicine as culture: Illness, disease and the body in Western societies.* Thousand Oaks, London and New Delhi: SAGE Publications.

MacKay, J.M., & Rutherford, A. (2012). Feminist women's accounts of depression. *Journal of Women and Social Work, 27*(2), 180-189.

McLeod, J. (2003). *Doing counselling research* (2nd Edition). London: Sage.

MacLeod, C. (2004). Writing into action: The critical research endeavour. In D.
Hook, P. Kiguwa & I. Parker, *Critical psychology in South Africa* (pp. 523-539). Lansdowne: UCT Press.

Madriz, E. (2000). Focus groups in feminist research. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research: Second Edition* (pp. 835-850). London: Sage.

Manikkam, L., & Burns, J.K. (2012). Antenatal depression and its risk factors: An urban prevalence study in KwaZuluNatal. *South African medical Journal, 102*(12), 940-944.

Marecek, J. (2003). Dancing through minefields: Toward a qualitative stance in psychology. In P.M. Camic, J.E. Rhodes & L. Yardley (Eds.), *Qualitative research in psychology: Expanding perspectives in methodology and design* (49-70). Washington, DC: American Psychological Association.

Marecek, J. & Gavey, N. (2013). DSM-5 and beyond: A critical feminist engagement with psychodiagnosis. *Feminism & Psychology, 23*(1), 3-9.

Marshall, M. (1996). Sampling for qualitative research. *Family Practice, 13*(6), 522-525.

Martinez, A., Israelski, M., Walker, C., & Koopman, C. (2002). Posttraumatic stress disorder in women attending human immunodeficiency virus outpatient clinics. *AIDS Patient Care and STD's, 16*(6), 283-291.

Mauthner, N. (1998). 'It's a woman's cry for help': A relational perspective on postnatal depression. *Feminism & Psychology, 8*(3), 325-355.

Mauthner, N., & Doucet, A. (2003). Reflexive accounts and accounts of reflexivity in qualitative data analysis. *Sociology, 37*(3), 413-431.

Mazure, C., Keita, G., & Blehar, M. (2002). *Summit on women and depression: Proceedings and recommendations*. Washington, DC: American Psychological Association.

McCann, T.V., Lubman, D. I., & Clark, E. (2012). Views of young people with depression about family and significant other support: Interpretative phenomenological analysis study. *International Journal of Mental Health Nursing, 21*(5), 453-461.

McCauley, J., Kern, D., Kolodner, K., Dill, L., Schroeder, A., DeChant, H., et al. (1997). Clinical characteristics of women with a history of childhood abuse: Unhealed wounds. *JAMA, 277*(17), 1362-1368.

McDonnell, K., & Gielen, A. (2003). Does HIV-status make a difference in the experience of lifetime abuse? Descriptions of lifetime abuse and its context among low-income urban women. *Journal of Urban Health: Bulletin of the New York Academy of Medicine, 80*(3), 494-509.

McMullen, L., & Stoppard, J. (2006). Women and depression: A case study of the influence of feminism in Canadian Psychology. *Feminism & Psychology, 16*(3), 273-288.

McWilliams, N. (1994). *Psychoanalytic diagnosis*. New York: The Guilford Press.

Miller, A. (2007). *The drama of the gifted child*. New York: Basic Books.

Merleau-Ponty, M. (1962). *Phenomenology of perception* (C. Smith, Trans.). London: Routledge & Kegan Paul. (Original work published 1945).

Mineka, S., Watson, D., & Clark, L. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Psychology, 49*(1), 377-412.

Mkhize, N. (2008). Psychology: An African perspective. In. D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman & I. Parker, *Critical psychology* (pp. 24-52). Lansdowne: UCT Press.

Morrell, R., Epstein, D., & Moletsane, R. (2012). Doubts, dilemmas and decisions: Towards ethical research on gender and schooling in South Africa. *Qualitative Research, 12*(6), 613-629.

Morrison, J. (2007). *The first interview* (3rd ed.). New York: Guilford Press.

Moultrie, A., & Kleintjies, S. (2006). Women's mental health in South Africa. *South African Health Review, 21*(1), 347-366.

Mullan, J., Pearlin, L., & Skarr, M. (2000). The bereavement process: Loss, grief, recovery. In A. C. Lemelle, Harrington & A. LeBlanc, *Readings in the sociology of AIDS* (p. 149). Englewood Cliffs, NJ: Prentice-Hall.

Nadeem, E., Lange, J., & Miranda, J. (2009). Perceived need for care among low-income immigrant and U.S.-born black and Latina women with depression. *Journal of Women's Health, 18*(3), 369-375.

Naidoo, P., & Mwaba, K. (2010). Helplessness, depression, and social support among people being treated for Tuberculosis in South Africa. *Social Behavior & Personality: An International Journal, 38*(10), 1323-1333.

Nama, N., & Swartz, L. (2002). Ethical and social dilemmas in community-based controlled trials in situations of poverty: A view from a South African project. *Journal of Community & Applied Social Psychology, 12*(4), 286-297.

Nel, A., & Kagee, A. (2013). The relationship between depression, anxiety and medication adherence among patients receiving antiretroviral treatment in South Africa. *AIDS Care, 25*(8), 948-955.

Nettleton, S. (2006). 'I just want permission to be ill': Towards a sociology of medically unexplained symptoms. *Social Science & Medicine, 62*(5), 1167-1178.

Newman, C. (2005). Stories of sadness: The experience of depression amongst urban black women in Hillbrow, South Africa. Unpublished M.A. dissertation, Department of Psychology. Johannesburg: University of Witwatersrand.

Newman, J., Fuqua, D., Gray, E., & Simpson, D. (2006). Gender differences in the relationship of anger and depression in a clinical sample. *Journal of Counselling & Development, 84*(2), 157-162.

Newman, J., Gray, E., & Fuqua, D. (1999). Sex differences in the relationship of anger and depression: An empirical study. *Journal of Counseling & Development, 77*(2), 198-203.

Ngcobo, M., & Pillay, B. (2008). Depression in African women presenting for psychological services at a general hospital. *African Journal of Psychiatry, 11*(2), 133-137.

Noble, R. (2005). Depression in women. *Metabolism Clinical and Experimental, 54*(1), 49-52.

O'Leary, A., & Helgeson, V. (1997). Psychosocial factors and women's health: Integrating mind, heart, and body. In S. Gallant, G. Keita & R. Royak-Schaler (Eds.), *Healthcare for women: Psychological, social, and behavioural influences* (pp. 25-40). Washington, DC: American Psychological Association.

Oakley, A. (1981). Interviewing women: A contradiction in terms. In H. Roberts (Ed.), *Doing feminist research*. London: Routledge and Keegan Paul.

Olley, B. (2006). Psychological distress in the first year after diagnosis of HIV Infection among women in South Africa. *African Journal of AIDS Research, 5*(3), 207-215.

Pappin, M., Wouters, E., Booysen, F.L.R. (2012). Anxiety and depression amongst patients enrolled in a public sector antiretroviral treatment programme in South Africa: A cross-sectional study. *BioMed Central Public Health, 12*(1), 244-252.

Patel, V., & Kleinman, A. (2003). Poverty and common mental disorders in developing countries. *Bulletin of the World Mental Health Organization, 81*(8), 609-615.

Patel, V., Kirkwood, B., Pednekar, S., Weiss, H., & Mabey, D. (2006). Risk factors for common mental disorders in women: Population-based longitudinal study. *The British Journal of Psychiatry, 189*(6), 547-555.

Peltzer, K., & Phaswana-Mafuya, N. (2013). Depression and associated factors in older adults in South Africa. *Global Health Action, 6*(1), 1-9.

Peltzer, K., & Shikwane, M.E. (2011). Prevalence of postnatal depression and associated factors among HIV-positive women in primary care in Nkangala district, South Africa. *Southern African Journal of HIV Medicine, 12*(4), 24-28.

Pillay, A., & Kriel, A. (2006). Mental health problems in women attending district-level services in South Africa. *Social Science & Medicine, 63*(3), 587-592.

Pillay, A., & Sargent, C. (1999). Relationship of age and education with anxiety, depression, and hopelessness in a South African community sample. *Perceptual and Motor Skills, 89*(3), 881-884.

Polders, L., Nel, J., Kruger, P., & Wells, H. (2008). Factors affecting vulnerability to depression among gay men and lesbian women in Gauteng, South Africa. *South African Journal of Psychology, 38*(4), 673-687.

Powell, P.A., Overton, P.G., & Simpson, J. (2013). The revolting self: An interpretative phenomenological analysis of the experience of self-disgust in females with depressive symptoms. *Journal of Clinical Psychology*, 1-17.

Ramchandani, P., Richter, L., Stein, A., & Norris, S. (2009). Predictors of postnatal depression in an urban South African cohort. *Journal of Affective Disorders, 113*(3), 279-284.

Rapmund, V. (1999). A story around the roll of relationships in the world of a "depressed" woman and the healing process. *Contemporary Family Therapy: An International Journal, 21*(2), 239.

Rapmund, V., & Moore, C. (2000). Women's stories of depression: A constructivist approach. *South African Journal of Psychology, 30*(2), 20-30.

Reber, A.S. (1985). *Dictionary of psychology*. London: Penguin Books.

Rehman, U., Gollan, J., & Mortimer, A. (2008). The marital context of depression: Research, limitations, and new directions. *Clinical Psychology Review, 28*(2), 179-198.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18*(1), 20-23.

Reid, P. (1993). Poor women in psychological research: Shut up and shut out. *Psychology of Women Quarterly, 17*(2), 133-150.

Repetti, R., & Crosby, F. (1984). Women and depression: Exploring the adult role explanation. *Journal of Social and Clinical Psychology, 2*(1), 57-70.

Rhodes, J., & Smith, J. (2010). "The top of my head came off": A phenomenological interpretative analysis of the experience of depression. *Counselling Psychology Quarterly, 23*(4), 399-409.

Richardson, D. (1992). *Women, motherhood and childrearing*. London: Macmillan.

Riessman, C.K. (1987). When gender is not enough: Women interviewing women. *Gender and Society, 1*(2), 172-207.

Rivas-Vasquez, R. (2001). Antidepressants as first-line agents in the current pharmacotherapy of anxiety disorders. *Professional Psychology: Research and Practice, 32*(1), 101-104.

Rochat, T.J., Richter, L., Doll, H., Buthelezi, N., Tomkins, A., & Stein, A. (2006). Depression among pregnant rural South African women undergoing HIV testing. *The Journal of the American Medical Association, 295*(12), 1376-1378.

Rochat, T.J., Tomlinson, M., Bärnighausen, T., Newell, M-L., & Stein, A. (2011). The prevalence and clinical presentation of antenatal depression in rural South Africa. *Journal of Affective Disorders, 135*(1), 362-373.

Rokach, A., & Brock, H. (1998). Coping with loneliness. *The Journal of Psychology, 132*(1), 107-127.

Rose, N. (1988). Calculable minds and manageable individuals. *History of the Human Sciences, 1*(2), 179-199.

Roseman, I.J., Antoniou, A.A., & Jose, P.E. (1996). Appraisal determinants of emotions: Constructing a more accurate and comprehensive theory. *Cognition and Emotion, 10*(3), 241-277.

Røseth, I., Binder, P-E., & Malt, U.F. (2011). Two ways of living through postpartum depression. *Journal of Phenomenological Psychology, 42*(2), 174-194.

Russell, D. (1996). Between a rock and a hard place: The politics of White feminists conducting research on Black women in South Africa. *Feminism & Psychology, 6*(2), 176-189.

Sable, P. (1989). Attachment, anxiety, and loss of a husband. *American Journal of Orthopsychiatry, 59*(4), 550-556.

Sadock, B., & Sadock, V. (2007). *Kaplan and Sadock's synopsis of psychiatry: Behavioural sciences/clinical psychiatry* (10th ed.). Philadelphia: Wolters Kluwer/Lippincott, Williams & Wilkins.

Schlimme, J.E. (2013). Depressive habituality and altered valuings. The phenomenology of depressed mental life. *Journal of Phenomenological Psychology, 44*(1), 92-118.

Schrimshaw, E. (2003). Relationship-specific unsupportive social interactions and depressive symptoms among women living with HIV/AIDS: Direct and moderating effect. *Journal of Behavioural Medicine, 26*(4), 270-313.

Schweitzer, R., Griffiths, M., Yates, P. (2012). Parental experience of childhood cancer using interpretative phenomenological analysis. *Psychology and Health, 27*(6), 704-720.

Seekings, J. (2007). *Poverty and inequality after apartheid*. CSSR, UCT. Retrieved June 13, 2013, from http://www.sarpn.org.za/documents/d0003024/index.php

Seligman, M. (1975). *Helplessness: On depression, development and death*. San Francisco: Freeman and Co.

Shefer, T. (2008). Psychology and the regulation of gender. In D. Hook, N. Mkhize, P. Kiguwa, A. Collins, E. Burman & I. Parker, *Critical psychology* (pp. 187-202). Lansdowne: UCT Press.

Shinebourne, P. (2011). The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis, 22*(1), 16-31.

Simoni, J., & Ng, M. (2000). Trauma, coping and depression among women with HIV/AIDS in New York City. *AIDS Care, 12*(5), 567-581.

Smith, J.P (1997). Depression: Darker than darkness. *American Scholar, 66*(4), 495-497.

Smith, J.A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.

Smith, J.A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. *Psychology & Health, 11*(2), 261-271.

Smith, J.A., & Osborn, M. (2008). Interpretative phenomenological analysis. In Jonathan A. Smith (ed.), *Qualitative psychology: A practical guide to research methods.* London: Sage.

Smith, J.A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis. Theory, method and research.* London: Sage.

Sorenson, R. (1997). Doctoral students' integration of psychology and Christianity: Perspectives via attachment theory and multidimensional scaling. *Journal for the Scientific Study of Religion, 36*(4), 530-548.

South African Institute of Race Relations. (2004). *South Africa Survey 2003/2004*. Johannesburg: South African Institute of Race Relations.

Spies, D. (2001). The coping mechanisms of low-income women: A grounded theory analysis of subjective descriptions of coping. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Stacey, M. (1999). Gender differences in mood and anxiety disorders: Patterns of diagnosis amongst patients admitted to Western Cape psychiatric hospitals. Unpublished M.A. dissertation, Department of Psychology. Cape Town: University of the Western Cape.

Statistics South Africa (2013). *Quarterly labour force survey: Quarter 1, 2013*. Retrieved July 9, 2013, from http://www.statssa.gov.za/publications/P0211/P02111stQuarter2013.pdf

Stein, D., Seedat, S., Herman, A., Moomal, H., Heeringa, S., Kessler, R., et al. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *British Journal* *of Psychiatry,192*(2), 112-117.

Stoppard, J.M. (1999). Why new perspectives are needed for understanding depression in women. *Canadian Psychology, 40*(2), 80-90.

Stoppard, J.M. (2000). *Understanding depression: Feminist social constructionist approaches.* New York: Routledge.

Stoppard, J.M. (2010). Moving towards an understanding of women's depression. *Feminism & Psychology, 20*(2), 267-271.

Stoppard, J.M., & McMullen, L. M. (Eds.). (2003). *Situating sadness: Women and depression in social context*. New York: New York University Press.

Storkey, K. (2006). The prevalence of depressive symptoms in the prepartum and postpartum period: A study of low-income women in the Western Cape, South Africa. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Swartz, S. (2013). Feminism and psychiatric diagnosis: Reflections of a feminist practitioner. *Feminism & Psychology, 23*(1), 41-48.

Taylor, L. (2011). “Mad, bad and sad” – but still coping: An intersubjective psychoanalytic case study of depression in one low-income South African woman. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Terre Blanch, M., & Durrheim, K. (1999). *Research in practice: Applied methods for the social sciences.* Cape Town: UCT Press.

Theron, L. (2005). An investigation of depression and anxiety amongst women in the Swartland Region of South Africa. Unpublished M.A. dissertation, Department of Psychology. Pretoria: University of South Africa.

Thompson, M., & Vardaman, P. (1997). The role of religion in coping with the loss of a family member to homicide. *Journal for the Scientific Study of Religion, 36*(1), 44-51.

Tomkins, L., & Eatough, V. (2010). Reflecting on the use of IPA with focus groups: Pitfalls and potentials. *Qualitative Research in Psychology, 7*(3), 244-262.

Tomlinson, M., Grimsrud, A., Stein, D., Williams, D., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *South African Medical Journal, 99*(5), 368-373.

Tomlinson, M., Swartz, L., Cooper, P., & Molteno, C. (2004). Social factors and postpartum depression in Khayelitsha, Cape Town. *South African Journal of Psychology, 34*(3), 409-420.

Tomlinson, M., Swartz, L., Kruger, L., & Gureje, O. (2007). Manifestations of affective disturbance in sub-Saharan Africa: Key themes. *Journal of Affective Disorders, 102*(1-3), 191-198.

UNIFEM. (2010). *Women, poverty and economics*. Retrieved June 13, 2013, from http://www.unifem.org/gender_issues/women_poverty_economics/

United Nations Human Development Report. (2006). Retrieved June 13, 2013, from http://www.hdr.undp.org/en/reports/global/hdr2006

Ussher, J.M. (2010). Are we medicalising women's misery? A critical review of women's higher rates of reported depression. *Feminism & Psychology, 20*(1), 9-35.

Ussher, J.M. (2013). Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology, 23*(1), 63-69.

Vanfossen, B. (1981). Sex differences in the mental health effects of spouse support and equality. *Journal of Health and Social Behaviour, 22*(1), 130-143.

Waite, L., Hawkley, L., & Thisted, R. (2006). Loneliness as a specific risk factor for depressive symptoms: Cross-sectional and longitudinal analyses. *Psychology and Aging, 21*(1), 140-151.

Watson, D. (2005). Rethinking the mood and anxiety disorders: A quantitative hierarchical model for DSM-V. *Journal of Abnormal Psychology, 114*(4), 522-536.

Weiss, E., Longhurst, J., & Mazure, C. (1999). Childhood sexual abuse as a risk factor for depression in women: Psychosocial and neurobiological correlates. *American Journal of Psychiatry, 156*(6), 816-828.

Weiss, S. (1973). *Loneliness: The experience of emotional and social isolation.* Cambridge: The MIT Press.

Wertz, F.J. (2005). Phenomenological research methods for counseling psychology, *Journal of Counseling Psychology, 52*(2), 167-177.

Westwood, B. (2006). Comparing prevalence rates of depressive symptoms in postpartum and nonpostpartum samples in a low-income community. Unpublished M.A. dissertation, Department of Psychology. Stellenbosch: University of Stellenbosch.

Whisman, M. (2001). The association between depression and marital dissatisfaction. In S. Beach, *Marital and family processes in depression: A scientific foundation for clinical practice* (pp. 3-24). Washington, DC: American Psychological Association.

White, K. (2002). *Sociology of health and illness*. London: SAGE Publications.

Widom, C., DuMont, K., & Czaja, S. (2007). A prospective investigation of Major Depressive Disorder and comorbidity in abused and neglected children grown up. *Archives of General Psychiatry, 64*(1), 49-56.

Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Buckingham: Open University Press.

Willig, C. (2008). *Introducing qualitative research in psychology: Adventures in theory and method* (2nd ed.). Maidenhead: McGraw-Hill Open University Press.

Wong, F., Huang, Z., DiGangi, J., Thompson, E., & Smith, B. (2008). Gender differences in intimate partner violence on substance abuse, sexual risks, and depression among a sample of South Africans in Cape Town, South Africa. *AIDS Education & Prevention, 20*(1), 56-64.

World Federation for Mental Health. (2011). *The great push: Investing in mental health*. Retrieved August 23, 2013, from http://www.wfmh.com/2011DOCS/2011%20WORLD%20MENTAL%20HEALTH%20DAY%20document.pdf

World Health Organization (WHO). (1992). *ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines*. Geneva, Switzerland: WHO.

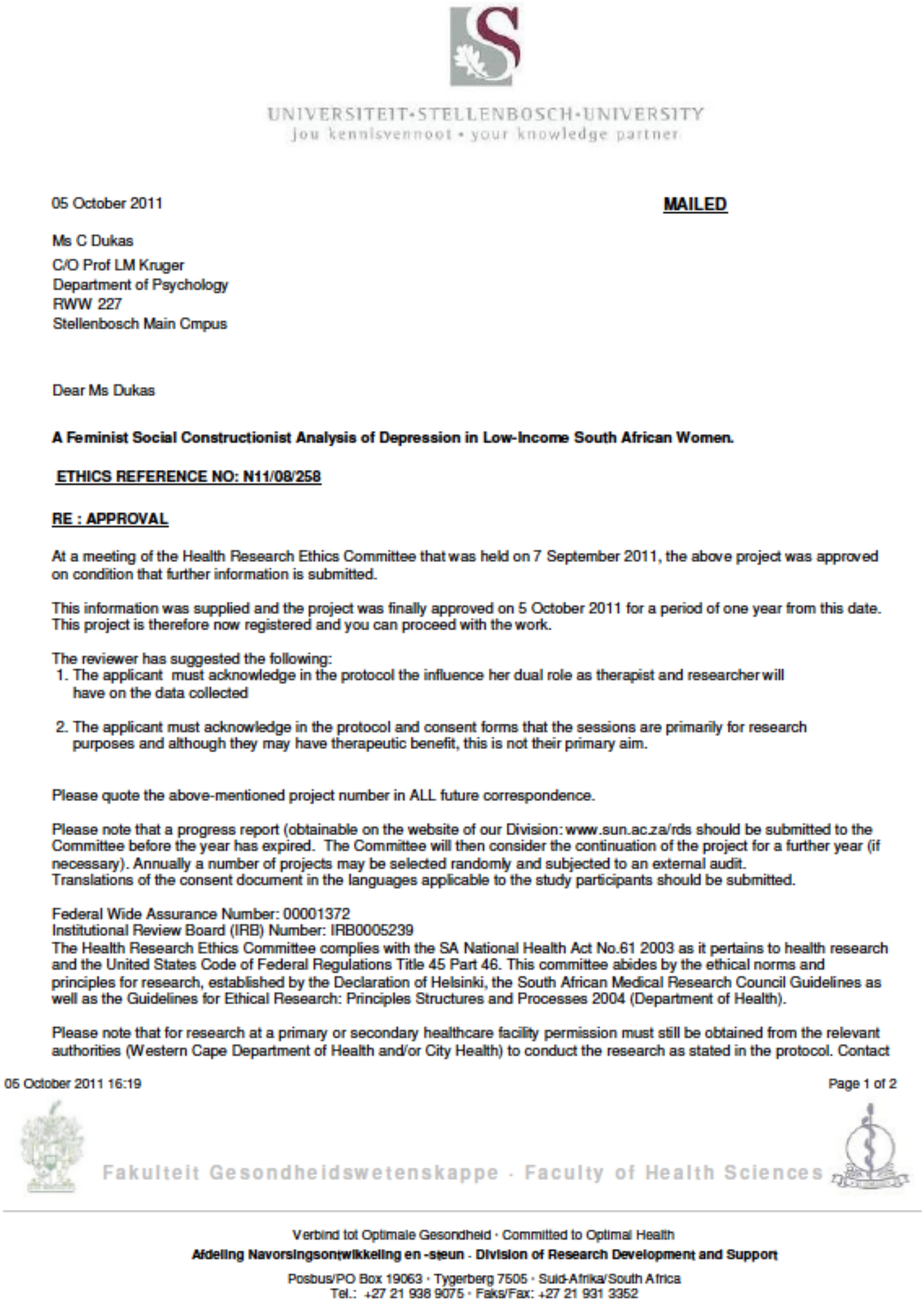
World Health Organization (WHO). (2006). *Women's mental health: A public health concern*. Regional health forum. Geneva, Switzerland: WHO.

World Health Organization (WHO). (2008). *Task shifting: Global recommendations and guidelines*. Geneva, Switzerland: WHO.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15*(2), 215-228.

APPENDICES

Appendix A: Ethical Clearance



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05 October 2011 **MAILED**

Ms C Dukas
C/O Prof LM Kruger
Department of Psychology
RWW 227
Stellenbosch Main Cmpus

Dear Ms Dukas

A Feminist Social Constructionist Analysis of Depression in Low-Income South African Women.

ETHICS REFERENCE NO: N11/08/258

RE : APPROVAL

At a meeting of the Health Research Ethics Committee that was held on 7 September 2011, the above project was approved on condition that further information is submitted.

This information was supplied and the project was finally approved on 5 October 2011 for a period of one year from this date. This project is therefore now registered and you can proceed with the work.

The reviewer has suggested the following:

1. The applicant must acknowledge in the protocol the influence her dual role as therapist and researcher will have on the data collected
2. The applicant must acknowledge in the protocol and consent forms that the sessions are primarily for research purposes and although they may have therapeutic benefit, this is not their primary aim.

Please quote the above-mentioned project number in ALL future correspondence.

Please note that a progress report (obtainable on the website of our Division: www.sun.ac.za/rds should be submitted to the Committee before the year has expired. The Committee will then consider the continuation of the project for a further year (if necessary). Annually a number of projects may be selected randomly and subjected to an external audit.
Translations of the consent document in the languages applicable to the study participants should be submitted.

Federal Wide Assurance Number: 00001372
Institutional Review Board (IRB) Number: IRB0005239
The Health Research Ethics Committee complies with the SA National Health Act No.61 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 Part 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes 2004 (Department of Health).

Please note that for research at a primary or secondary healthcare facility permission must still be obtained from the relevant authorities (Western Cape Department of Health and/or City Health) to conduct the research as stated in the protocol. Contact

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Fakulteit Gesondheidswetenskappe · Faculty of Health Sciences

Verbind tot Optimale Gesondheid · Committed to Optimal Health
Afdeling Navorsingsontwikkeling en -steun - Division of Research Development and Support

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persons are Ms Claudette Abrahams at Western Cape Department of Health (healthres@pgwc.gov.za Tel: +27 21 483 9907) and Dr Hélène Visser at City Health (Helene.Visser@capetown.gov.za Tel: +27 21 400 3981). Research that will be conducted at any tertiary academic institution requires approval from the relevant hospital manager. Ethics approval is required BEFORE approval can be obtained from these health authorities.

Approval Date: 5 October 2011 Expiry Date: 5 October 2012

Yours faithfully

MS CARLI SAGER
RESEARCH DEVELOPMENT AND SUPPORT
Tel: +27 21 938 9140 / E-mail: carlis@sun.ac.za
Fax: +27 21 931 3352

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Appendix B: Letter to Head Nurse/Doctor

Dear Clinic Sister/Doctor,

Research study: Women and depression

I hereby ask you and the staff of [redacted], [redacted], [redacted] and [redacted] Clinics to cooperate with me on a study concerned with low-income women and depression.

The purpose of this study is to develop an in-depth understanding of low-income South African women's subjective experiences of depression. By making the research participants 'experts' of their own experiences, this study aims to explore how women experience being depressed and how they make sense of their depression. It is hoped that such an investigation will not only serve to illuminate dominant themes in women's experiences of depression, but will also serve to reveal underlying gender discourses that inform women's experiences of themselves and their moods. Such a study can facilitate a better conceptualisation and more effective treatment of depression in the South African context.

Your participation in this study is entirely voluntary. Should you decide to partake, your participation will entail referring depressed women, who are interested in participating in the study, to me.

When referring women to the study, it is important that you clearly communicate the following:
That it is entirely her decision whether or not to partake in the study
That is, that each woman's participation is voluntary; there is no obligation to partake & no financial reward for participation
Her participation will require her to discuss her experiences of depression privately with me
Services will not be compromised for those who do not wish to partake
Participants may withdraw (without penalty) from the study at any stage whatsoever

Following your referrals to me, I will arrange to meet with each woman in order to give her more information about the study and to get her informed consent.
As depression is a sensitive topic, it is anticipated that some participants may need further referrals, help and support. I will ensure that I am available for further consultation with each participant as is customary in usual therapy. If I assess a participant's Mental Status to constitute a 'medical emergency' (i.e. that she is suicidal or homicidal), I shall follow the standard procedures for emergency hospital admission. A firm referral system is in place for this.

If you and your staff are willing to participate in the study, I would be most appreciative if you would confirm your decision in writing.

I look forward to hearing from you.

Kind regards,

Ms. Carla Dukas

Prof. Lou-Marie Kruger (Supervisor)

Appendix C: Participant Information and Consent

Title of the research project: A Feminist Social Constructionist Analysis of Depression in Low-Income South African Women*

Principal investigator: Carla Dukas

Contact number: 072 329 5850

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask Carla Dukas any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is entirely voluntary and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Health Research Ethics Committee (HREC) at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

10 participants will be recruited for this study, which will take place in Carla Dukas' offices in the [redacted], [redacted], [redacted] and [redacted] Clinics.

What is this study all about?
The study aims to record the thoughts and feelings of women like you, who have been diagnosed with depression.

The study will consist of normal interview/discussions between you and me. We will focus specifically on your experience of depression. Our discussions will be recorded on a digital voice-recorder. I will then listen to and transcribe (write down in words what was said during) the sessions. Finally, I will compare all of the discussions I have had with each participant. I will look for contrasting and recurring themes in how women with depression understand and make sense of their experiences. I will document my findings in the form of academic research.
At all times the identity of each participant will be kept anonymous, as I will use pseudo names. You may choose a fake or false name by which you will be known in my research.

Medication will not be used or prescribed as part of this study, but participants may be referred for medication to an outside person.

Women who are eligible to take part in this study must:
Be at least age 20
Be able to understand and speak English fluently
Have a diagnosis of depression
Have low/no-income
Be willing to participate in this study by agreeing to have their interview sessions recorded and used for academic purposes

What will your responsibilities be?

It is your responsibility to answer the questions about your depression with honesty and as much detail as possible.
However, you are also free to *not* answer any question that makes you feel uncomfortable.
Although I will do my best to ensure you understand the details or questions contained in this study, it is also your responsibility to ask for clarification if you do not understand something.
You may ask me to stop recording our discussion at any time.

Will you be paid to take part in this study and are there any costs involved?
You will not be paid to take part in the study.
If you do take part in the study, there will be no costs involved for you, other than the cost of getting to and from the clinic for our interview session(s).

Many women feel better once they have spoken about their difficult feelings of depression.
By allowing me to publish the information from our discussion about your experiences of depression, other people might gain a better understanding of what it is like for women in your position to be depressed. This may lead to better diagnosis, treatment and prevention of depression in women in the future.

Talking about your experiences of depression might be emotionally difficult for you, as depression is a painful experience. You might start to cry or feel vulnerable when talking about your feelings. If you feel that you need extra emotional support after our discussion hour, I will schedule a follow-up session or refer you for extra care.

If you do not agree to take part, what alternatives do you have?
You can choose not to enter therapy with me.
You can choose to enter therapy with me, and our sessions *will not be recorded* or used for research.

Who will have access to your medical records?
The information collected during our discussions will be treated as confidential and protected under password on my private computer.
When I publish the results of this study, all names will be changed so that your identity will remain anonymous (your real name will not be used).
My supervisor and all interested parties will be able to read the finished article/thesis.

It is very important that you understand that you have the right to decide whether or not you will participate in this study. You do not have to have your discussion with me (Carla Dukas) recorded if you do not want to. You may change your mind and cancel the recording of the session at any time, with no repercussions.
Whether you participate in this study or not will not affect any of your future treatment or access to services.
You can contact the Health Research Ethics Committee at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed here. You may also call the study Supervisor, Prof. Kruger at 021 808 3460.

Declaration by participant

By signing below, I ……………………………………..………. agree to take part in a research study entitled A Feminist Social Constructionist Analysis of Depression in Low-Income South African Women.*

I declare that:

I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.

I have had a chance to ask questions and all my questions have been adequately answered.

I understand that taking part in this study is voluntary and I have not been pressurised to take part.

I may choose to leave the study at any time and will not be penalised or prejudiced in any way.

I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....……………………. on (*date*) …………....………. 2011.

Signature of participant   Signature of witness

Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

I explained the information in this document to …………………………………………………..

I encouraged him/her to ask questions and took adequate time to answer them.

I am satisfied that he/she adequately understands all aspects of the research, as discussed above

Signed at (*place*) ....……………………. on (*date*) …………....………. 2011.

Signature of investigator   Signature of witness

*Study name changed during write-up

Appendix D: Demographic Questionnaire

Respondent number:__________Codename:____
Language:_________________________Age:____

Household:
Composition of household:
____
____
____

Relationship status: (In relationship? Married? Live together? How long?):
____
____

Children (gender and age):
____
____

Work (type / fulltime / part-time / unemployed):
Self:____
Partner (man/boyfriend):____
Parents:____

Income:
Self:_______________________Partner:_______________________Parents:_________________

Literacy:
Comfortable read and write: _________________________School to standard:______________

Religion:
Religious affiliation: _____________________________Actively involved:____________________

Accommodation: (type) _____________________
Years in that accommodation____________________
No. of rooms in house: ________________________________No. of bedrooms:______________
With whom do you sleep in a bedroom?____
Is there a bathroom in the house? ____________Is there electricity in the house?__________

Appendix E: Qualitative Interview Schedule

Questions to be incorporated into clinical assessment and psychotherapy

The interview schedule indicates the topics to be covered and the general style of interviewing. Following guidelines for open-ended interviews (Willig, 2008), clinicians should ask as few questions as possible, but attempt to cover the topics indicated below. Order of questions may differ and all questions may not have to be asked.

Current symptoms and signs

Hello x. We discussed why I'm talking to you today. The sister/doctor said that you struggle/have struggled with depression…

- I will begin by asking you how you are doing today? *(Reflect back answers in empathetic way, ask for more details, but do not ask any leading questions.)*
- Would you say that you are currently depressed?
- (*if no)*
  - How do you normally feel when you are depressed?
  - When last were you depressed?
  - When you were depressed, how did you describe your depression to other people?
- *(if yes)*
  - How long have you been depressed for?
  - Are you having any treatment for your depression? Do you think that it is helping you?
  - How do you describe the depression to other people?

- Are you on any medication for your depression? Do you think that it is helping you?

First diagnosis

I want you to think back to the first time you were diagnosed with depression – or perhaps this is your first time – I want to talk about your *first* diagnosis….

- Who first diagnosed you?
- When was this?

  What did this diagnosis mean to you? How did you understand the fact that you were diagnosed with depression? How do you understand the word "depression"?
- How did you feel about this diagnosis?
- What treatment plan was prescribed for you?

  How did you feel about that treatment plan? Did it help you? Would you have preferred a different type of help/support? *(if "yes", what?)*

Prior to diagnosis

I'd like you to think back to the very first time you felt that way (the way you just described) – *before* the Doctor/sister told you that they think you are depressed *(We are interested in before the actual diagnosis to try and get to a lay understanding of depression-like symptoms.)*

- Can you remember when it was and exactly how you felt? In your body? In your head? In your heart? How did you feel about the experiences you were having?
- Before you went to speak to the Doctor/sister/clinic, what did you think was happening to you? How did you describe it to other people? What did the people around you say about it? Are there specific words that you used to describe your feelings and experiences?
- What did you do about it before you went to the clinic/sister/hospital/doctor? Who did you go to for help and support? Did that help?

Reasons for depression: participant

You have felt like this before (*try to use participant's own words)*. I want us to go back to every time you have had these feelings, and talk about what you think was going on in your life at the time that could have caused you to feel that way. What do you attribute the feelings to / what do you think caused the feelings? *(Try to get participant's own theory about* ***each episode*** *– it may only be one episode. No leading questions, but as many prompts as possible: tell me more? Can you say more? Can you expand on that?)*

Reasons for depression: community

Who were the most important people to you in your life during these times? What did they think? Why did they think this happened to you / why did they think you felt like this? What did they think caused it? *(Try to get lists of important people and their theories about the participant's depression. Again no leading questions)*

Impact on life

What impact do you think depression has had on your life? - On your work? - On your relationships? - On how you think of yourself?

Treatment

As *you* have personally suffered from depression, one could say that you are an expert on it… which is why I want to ask you…

- What do you think helped you?
- What didn't help at all or only helped a little bit?
- What help would you have preferred?
- If you had to give people advice regarding what helps, or what type of help they should get, what would you say?

Closure

Thank you very much for taking the time to talk to me about your experiences of depression – I know that it can be a difficult thing to talk about. How do you feel now?