How do Black South African Youth Understand and Cope with Depression?

by

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Dedication

I dedicate this research study affectionately to the following:

My mother: Lenah Ntjeka Kgatla

My grandmother: Sophia Kgatla

LOB'J (Siblings): Bethuel, Chalton-Junior and Omphile Kgatla

Acknowledgements

At the beginning of this journey, there were times I felt discouraged; however I am thankful to the handful of people who were in my corner. This journey was rough but the people surrounding me made things a lot easier.

Firstly my Lord and saviour – I am truly grateful for your mighty hand. Your love and grace is truly sufficient for me. Thank you for being the light in my journey.

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Abstract

Depression is conceptualised differently across cultural groups and contexts. How people understand depression influences the treatment sought and the response to it. This study explored the understandings and perceptions of black South African youth who experience depression. Eight participants were interviewed; some were diagnosed by a psychologist with depression while others were not officially diagnosed. Semi-structured interviews were conducted in an environment conducive and convenient for participants; therefore the interviews took place in different places. The findings of the study showed that some black South African youth conceptualised depression differently. Firstly, through received discourses from their social background; they saw depression as a stigmatised experience described as witchcraft, alcoholism and madness. Secondly, in response to the stigmatisation, they also developed their own discourses; they described depression as a weight, a case of sadness, and the brain taking over. In addition, participants used a portfolio of coping mechanisms to deal with or manage depression; on the whole, they moved away from the typical coping strategies such as therapy or medication. Rather, participants highlighted how young people understand depression to create more meaningful interventions. The use of internet and social media was a key part of their coping methods for depression. Therefore it is apparent from the study that, based on the given findings, more knowledge and attention should be focused on how the internet and social media play a huge role in lives of people experiencing depression.

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Chapter 1. Introduction to the study

1.1. Introduction

This study presents findings about the experiences of black South African youth experiencing depression. The study highlights the way in which black South African youth understand and cope with depression. In addition, the study describes what has influenced the participants' understanding of depression and how they cope with it.

In this chapter I discuss the problem statement and objectives of the study and my reasons for undertaking this type of study. This is followed by a brief discussion on the choice to study black South Africans and the meaning of "black". Lastly, I will provide an overview of the dissertation.

1.2. Problem statement

A large body of research shows that depression is common among young people, with symptoms such as depressed mood, loss of interest or pleasure, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration (World Health Organization 2012). However, there is a growing literature that questions the privileging of a biomedical understanding of depression and argues that this undermines other ways of dealing with depression (Deacon 2013). In keeping with this literature, this study will investigate how black South African youth understand and cope with depression.

Much of the existing research into depression follows a medical model in the sense that it emphasises diagnosis and treatment based on identification of symptoms (Deacon 2013). However, recent literature extensively criticises the appropriateness of this medical model. For instance, in Starkowitz's (2013) study in KwaZulu Natal, participants indicated that what might be called depression from a biomedical approach can be recognised as a sign of spiritual calling. Similarly, the Zulu Shaman, Vusamazulu Credo Mutwa (Mutwa 2003: 22) recognises that what may appear as "madness" or a nervous breakdown might actually be a calling to be a traditional healer. This kind of critique has led to a growing literature that understands depression not in medical terms, but rather as "idioms of distress" whereby a more grounded approach that attempts to understand people's own sense of their distress is validated (Sabri 2018). Furthermore, the different ways in which

depression is viewed can influence the experiences of depression and how an individual deals with it.

In addition there has been a growing call to understand depression within its broader context such as taking into account how socioeconomic factors also have an impact on a person's understanding of depression and their strategies for coping with it (Martin and Kagee 2011). The lack of economic resources can act as a barrier in finding assistance, irrespective of how people experiencing depression conceptualise the feelings of depression. For example, being unable to access health care services due to lack of economic resources such as transportation or service costs can hinder access to assistance. According to Patel et al. (2011), people from low and middle-income countries are more likely to opt to seek help from informal social networks such as relatives or trusted members of the community than those from higher income groups who seeks professional services. Informal social networks often bear the burden of caring for those with depression. Martin and Kagee (2011) state that one of the most significant structural barriers is 'waiting time at clinic was too long' whilst others include unaffordable transport costs. Thus, inequality is a factor to individuals accessing assistance, and influences the type of coping mechanisms one can use. While South Africa is a multicultural society, it has one of the highest inequality rates in the world, with a very high Gini coefficient of 0.63 in 2015 (Creamer 2018). Black African people are victims of multiple forms of structural inequality that shape their experiences of depression (Harmse 2013; Keeton 2014). This indicates that depression can be viewed and understood in various ways beyond the biomedical perception, and this study seeks to investigate the different ways that people conceptualise depression.

1.3. Objectives of the study

This qualitative study seeks to find an answer to the overarching question:

How do black South African youth understand and cope with depression?

The main objectives of the study include the following:

1. To add to the existing literature that seeks to understand the coping mechanisms of young black South Africans experiencing depression.

2. To contribute to creating interventions for young people that draw on coping mechanisms that are relevant to the worldviews of young black South Africans.

The main objective of the study is to investigate young black South Africans' understanding of depression and identify their coping mechanisms. Furthermore, I aimed to identify what influences their decisions for using certain coping mechanisms. To achieve this, the focus of the study was on the personal experiences of participants with depression, either diagnosed by a psychologist or not.

It was important to study depression as it is highly prevalent, and some authors argue that it is heavily stigmatised and historically neglected, especially among black people (WHO 2012). Thus, this study is necessary to create more meaningful interventions in South Africa.

I employed semi-structured in-depth interviews in this study because they are particularly good at identifying culturally and contextually defined perceptions, beliefs and norms and their influence on participant's help-seeking. In addition, it takes into consideration the different factors potentially influencing the type of treatment participants seek to cope with depression, such as culture and tradition, and also the idioms of distress used to explain depression.

1.4. Choice of the black South African population

During the Apartheid era in South Africa, the population was classified under four categories namely; white, black, coloured and Indian (Jano and Naidoo 2002; Mare 2001). At the beginning of democracy in 1994, new policies were put in place to address past racial discrimination, promote equality and uplift historically disadvantaged people in South Africa. Examples include policies such as the Employment Equity Act, 55 of 1998 and the Broad Based Black Economic Empowerment Act, 53 of 2003, which drew on apartheid classifications in order to effect change (Lewis 2001). In this study, all participants were black African in terms of the apartheid classification. Therefore, when using the historic racial classifications, the definition of black cannot be used or adopted universally. For the purposes of this study, only those who would have been called black Africans in the South African discourse were included.

In this study I focused on black South Africans as they engaged multiple health providers (Atindanbila and Abasimi 2011), and yet their voices seldom feature in research on mental

health which focuses on diagnosis and treatment by an outside expert. In addition, there are not many studies in South Africa concentrated on black youth; a number of studies are focused on the older generation or adolescents with depression and other studies focus on depression as a consequence of having a chronic disease such as cancer and heart diseases. The experiences of people who do not completely ascribe to the biomedical approach have been neglected and thus a biomedical intervention becomes normalised and valued over other kinds of interventions. Thus the blanket approach might not allow me to capture the reality of the minority and will forfeit the purpose of the study and create a split focus. Moving from a broader perception to narrow the angle is a more logical approach to fully understand the differences and specific needs before generalising.

1.5. Organisation of the study

Chapter 1: focuses on the study rationale, problem statement and the objectives of the study.

Chapter 2: provides the reader with a detailed review of literature, which highlights findings from studies that explore coping mechanisms of people with depression. A concerted attempt has been made to capture studies that pertain to minority populations. The study looked at how people from different backgrounds conceptualise depression. Additionally, the chapter discusses the theoretical framework guiding the study. The theory used to guide the study is Goffman's (1959) dramaturgy, which indicates a way that people with depression might choose to cope with depression.

Chapter 3: addresses the research design and methodology used in the study. It elaborates on the choice of the qualitative approach as a tool for both data collection and the process of data analysis.

Chapter 4: results and findings answers the specific objectives of the study. It draws on data from people who are currently experiencing depression. The data will be drawn from life experiences of the participants and how they perceive depression in their own understanding, thus capturing the true reality. In addition, it discusses the participant's understanding of depression and what has influenced that understanding. This chapter will look into two discourses; firstly the discourses received from their social background and the development of their own discourses.

Chapter 5: this chapter presents coping mechanisms of black South African youth with depression, and the elements that have the potential to influence the help-seeking or treatment process. In this chapter I look at the use of the internet, online support and the cleaning house as ways to cope with depression.

Chapter 6: the study concludes by identifying limitations of this study and recommended directions for future research.

1.6. Conclusion

This chapter has provided an outline for the study by highlighting the problem statement which indicates the research gap that the study will address. The gap focused on how depression is conceptualised differently, and not only understood through the biomedical way. In addition the chapter provided the statement of intent that provided reasons for undertaking the study and further explained the reasons for the choice of people being studied in this study

The following chapter provides a detailed background for the study on how people understand and cope with depression, and factors that influence their understanding and subsequently affect their choice of coping strategies. In addition, this chapter also looks at the literature around depression, not only in South Africa but globally and the theoretical framework that guide the study.

Chapter 2. Literature review

2.1. Introduction

Depression is a broad and complex subject, and this chapter aims to look into depression in detail to better understand the phenomenon. Specifically, I will be defining depression, giving an overview of depression, and discussing depression in pre- and post-apartheid in South Africa, I will consider culture, stigma around depression, social factors influencing coping strategies of people with depression and the theoretical framework.

Subsequent chapters will discuss the research design and methodology, including sample selection, data collection, analysis and analysis procedures; the narrative research; the key research findings, results and conclusions.

2.2. Overview of depression research

Most of the research that has been done on depression has sought to answer the question: why do people become depressed? Typically, the conclusion has pointed to a history of separations, rejections and insecure attachments (Hammen 2009; Weissman, Markowitz and Klerman 2000). There are other reasons which account for depression. These include personal or family history of depressive mental illness, prior suicide attempts, substance use, lack of social support and stressful life events (Schlebusch 2005). These can lead to a person experiencing an episode of depression.

Another area of research has focussed on categorising what depression is and typically episodes of depression have been defined as ‘sadness, indifference, apathy or irritability’ (World Health Organization 2018). A depressive episode has a number of effects such as changes in sleep patterns, appetite and weight; motor agitation or retardation; fatigue; and impaired concentration and decision-making. It also includes feelings of shame or guilt and thoughts of death or dying (World Federation of Mental Health 2012; WHO 2018). A small number of patients are likely to experience psychotic symptoms. Eight out of ten people who have experienced an initial major depressive episode are likely to experience at least one more episode in their lifetime (Fava, Ruini and Sonino 2003; American Psychiatric Association 1994).

Literature has indicated that people experiencing depression are less likely to seek help themselves because they may not be aware that they have depression. In addition, people

who do not realise that they are depressed may find it difficult or impossible to take treatment instructed by a mainstream mental health[1] practitioner (WHO cited in Cesar and Chavoushi 2013). The quality of care sought by patients and care received from others is highly affected by the concurrence of depression (Cesar and Chavoushi 2013).

Many researchers have been concerned with identifying different kinds of depression. Symptoms present in a depressive episode include depressed mood, loss of interest and enjoyment and increased fatigability. A depressive episode can be categorised into mild, moderate or severe, depending on the number and severity of symptoms occurring (Cesar and Chavoushi 2013; WHO 2012). A person with a mild depressive episode faces difficulty in continuing to execute daily ordinary tasks and social activities. However, it does not hinder a person from continuing daily living activities. The severe depressive episode is the total opposite, where an individual is less likely to continue with social, work or domestic activities, except to a very limited extent (World Federation of Mental Health cited in Cesar and Chavoushi 2013; WHO 2012).

Another kind of depression that has been documented is recurrent depressive mental illness. Those episodes occur without experiencing independent episodes of mood elevation or increased energy (mania) previously (Cesar and Chavoushi 2013). However sometimes immediately after a depressive episode, brief episodes of mild mood elevation and over-activity (hypomania) occur. These episodes are sometimes caused by people using anti-depressants (Cesar and Chavoushi 2013). A person can experience the first episode between the early years of their lives and their later years, and it may last from few weeks to numerous months. The inception of the episode can either be acute or insidious (Cesar and Chavoushi 2013). A person suffering from recurrent depressive mental illness is still likely to experience an episode of mania.

Much work has been in the medical model but lately there has been a focus on context and meaning of depression, and this study concentrates on the latter. The following section will provide context to depression in South Africa.

[1] For the purpose of the study, the term mainstream mental health will be used which entails using the Western knowledge, insights and ideologies in order to understand and treat mental illness.

2.3. Depression in South Africa: pre and post 1994

Preoccupations with mental health are deeply embedded in the colonial history of South Africa. As early as the eighteenth century, mainstream mental health services began in South Africa. For example, in 1711 there was a small hospital in Cape Town catering specifically for mentally ill people. The prison colony on Robben Island was converted into a hospital for mentally ill people and other people with chronic diseases in 1846 and by 1912, there were 500 mentally ill people at Robben Island Infirmary (Sey 2010). It was around this period that other hospitals were built in order to isolate mentally ill people from the community (Sey 2010). These hospitals served discriminatory functions, including inhibiting their patients from passing on their unwanted traits through procreation (Horwitz 2009; Sey 2010).

These mental health institutions operated like prisons, overflowing with patients, many of whom were underprivileged and deemed "deviant". Therapeutic treatment was barely offered (Horwitz 2009; Sey 2010). However white patients were treated better than black patients. By 1910 there were eight institutions that accommodated roughly 1 692 white patients and 1 932 black, coloured and Indian patients (Horwitz 2009). This links with scientific racism which is 'the act of justifying inequalities between natural groups of people by recourse to science' (Marks cited in Meloni 2017: 1).

White people have been given privilege in mental health facilities historically. Facilities started housing poor white people whom the government deemed as unstable and those the state wanted to prevent from procreating to isolate them from the community. They were also accommodating soldiers returning from World War 1 who were suffering from different psychiatric problems (Horwitz 2009). On Robben Island, people who were seen as degenerate were abused and locked up in appalling conditions, often in the name of helping them. Those who were deemed less dangerous and curable were moved from the Island to the mainland and by 1890 only those who were considered "mentally deranged" were moved to the Island (Horwitz 2009; Sey 2010). This was largely due to the expense of keeping them on the Island.

In a recent study of race in diagnosis and treatment, Szabo et al. (2000: 500) found that racial discrimination was a 'frequent area of observed abuse and '78% of the respondents acknowledged that racial discrimination existed in psychiatry' (Szabo et al. 2000). This is similar to medical services generally in South Africa, where better services are rendered in

white communities while black people use lower level services offered by the government (Kohn et al. 2004).

2.3.1. Mental health during apartheid

During the apartheid era, South Africa was filled with repression, human rights abuses, violence, alcohol-related issues, malnutrition and poverty; thus the society was psychologically challenged. Black people were stripped of their dignity by the government and made to feel insignificant (Horwitz 2009). Black people suffering from psychological distress faced double stigma, based on their race and on discriminatory access to mental health services (Horwitz 2009). Overall, the psychological distress of black people was not a priority, which also affected the treatment they got for their distress.

Under apartheid, black people with psychological distress were held in private institutions against their will and they were used to make profit for white-owned companies (World Health Organization 1977). These companies had an agreement with the government to provide “custodial care” for people with psychological distress and, as profit; the company received a government subsidy (WHO 1977). The companies often misused the government subsidy and exploited the labour of black people who came for occupational and other forms of therapy (WHO 1977). During apartheid in South Africa, there were no black psychiatrists and the life of black people with psychological distress was in the hands of part-time physicians who did not speak or understand the language of the clients. The majority of white people considered psychologically distressed received care from government services; however black people were forcefully transferred to the profit-making white-owned companies called “human warehouses” (WHO 1977).

These “human warehouses” were in appalling conditions and the care provided was humiliating to the “inmates” and extremely poor. The standards were not just poor in comparison to those received by white people, but also in relation to the basic human needs and rights (WHO 1977). These institutions were used to oppress and racially discriminate against black people (WHO 1977).

In addition, apartheid mental health facilities denied black people their services because the biomedical concepts were believed to be in conflict with the culture of black people who needed treatment (Horwitz 2009). For instance, during apartheid black people’s way of healing was communication with ancestors and was of importance to them but was not understood by white people. White establishments defamed black people’s cultural

heritage as ‘ignorance, traditional taboos and superstition’ (WHO 1977). A government publication arrogantly stated that ‘Gradually the Bantu have been weaned away from their centuries-old superstitions and belief in witch-doctors; and it can be stated that in South Africa today the battle is all but won’ (WHO 1977: 7).

In addition, diagnostic criteria were also used as a way of controlling and silencing activists and placing patients in facilities controlled by the government (Horwitz 2009). Black people were arrested on Saturday nights because they ‘stirred up trouble, brandished a knife, insulted the Government, or appeared drunk’ and the WHO noted that ‘when one policeman and one doctor, after a hasty examination, decide that a particular black person seems imbalanced, this is sufficient evidence to send him away to a camp’ (WHO 1977: 17). There was a rule where black people were considered “mentally retarded” after an “observation” and were transferred to privately white-owned institutions for occupational therapy (WHO 1977). The occupational therapy included black people doing ‘farm work, renovating the buildings, mat-weaving, production of rubber knee-guards for miners and wire coat hangers’ (WHO 1977: 19).

The political structure that was built in South Africa in the apartheid era was condemned by the rest of the world because of its inhumane treatment of black people. The constitutional framework was framed around skin colour and ethnicity which determined where a person could live, visit, get educated and also who to fall in love with. Some people rationalised this structure as “the diversity of people” in South Africa, others rationalised it as “maintenance of privilege and power” and other people rationalised it as “maintenance of oppression” to people (Greenberg 1980).

Usually psychology and politics are seen as separate areas of inquiry in human affairs and it is uncommon to recognise psychology based in society. For instance Schweiz (1979) argued that, scientifically, psychology does not concern itself with politics. Psychologists rarely argue that ‘psychology and its applied derivatives are inevitably influenced by the ideological and political contexts in which they are embedded’ (Danziger 1979; Beit-Hallami 1974; Moll 1983; Ingleby 1981).

The concept of ideology indicates how apartheid ideology had an impact on work in the mental health profession in South Africa. Dawes (1985: 56) argued that the apartheid government ‘exhibit[ed] powerful support (through silence) for practices which [were] destructive to the mental health of the South African community’. Ideology is perceived and understood differently, and Carlton (1977: 23) defined ideology as ‘a pattern of beliefs

and concepts (both factual and normative) which purport to explain complex social phenomena with a view to directing and simplifying socio-political choices'. Therefore, ideology dictates what is deemed as normal and natural. The important point derived from above is that, through socialisation, both citizens and scientists unconsciously accept false elements of what is a considered natural. As Dawes (1985) has argued, science is imbued with values, beliefs and investments (Dawes 1985).

When people are unaware of the influence of ideology in their work, they tend to fervently believe that they are dealing with the truth. Therefore when people are unaware, they can unintentionally play a role that supports a particular socio-political order and fail to question what is natural about a social or psychological phenomenon (Ingleby 1974). This is demonstrated by Gabel (1975) where, for instance, Israelis as a "racial group" have high rates of coronary disease and of schizophrenia and therefore these can be considered as natural biological laws about Israeli Jews. Thus, false consciousness is evident when these observances are explained as a genetic biological characteristic alone. This is because social context is not taken into account.

Similarly black people with psychological distress were placed in inadequate facilities for treatment due to unfounded ideologies such as the belief that black people could not get depressed or that they should be cured by sedatives (Horwitz 2009). Black people tended to be diagnosed with more severe mental illness such as schizophrenia, paranoia and epileptic psychosis whereas white people experienced what were deemed as less severe diseases such as manic-depressive psychosis, neurosis and defective mental development (Horwitz 2009). Therefore, these observations are not founded because social context was not taken into consideration. Much progress was made after the apartheid era regarding the mental health problems of people including those of black people.

2.3.2. Depression in post-apartheid

Since the end of apartheid in 1991 and the new democratic government elected in 1994, South African psychiatry has been in transition. The discriminatory practices during apartheid towards black people with psychological distress were revealed and there were allegations regarding both social and political abuse of black people (Kohn et al. 2004). As a consequence, the American Psychiatry Association (APA) condemned how black people were treated and "cared for" in private institutions - the "human warehouses" (Kohn et al. 2004). Therefore the American Association for the Advancement of Science (AAAS),

Physicians for Human Rights and other organisations based in the United States of America were requested to examine the human rights violations that took place in the health sector during apartheid. The objective of the request was for these organisations to make recommendations in order to build human rights within the health sector (Chapman et al. 1998 cited in Kohn et al. 2004).

Post-apartheid measures were put in place to rectify the injustices that took place in mental health facilities during apartheid. The South African Mental Health Act of 2002 emphasised the human rights of people with mental illness, at a national level, such as access to care (Lund et al. 2007). Steps have been taken to diminish racial inequalities regarding mental health, including a major consultative process at provincial and national mental health summits between February and April 2012. In addition, a more significant step occurred in July 2013 when the Mental Health Policy Framework (MHPF) was adopted by the National Health Council for South Africa and the Strategic Plan 2013-2020 (Stein 2014). The policy included eight key objectives: '(a) district-based mental health services and primary healthcare re-engineering; (b) building institutional capacity; (c) surveillance, research and innovation; (d) building infrastructure and capacity of facilities; (e) mental health technology equipment and medicines; (f) inter-sectoral collaboration; (g) human resources for mental health; (h) advocacy, mental health promotion and prevention of mental illness' (Janse van Rensburg 2013 cited in Stein 2014: 115). These initiatives are important as they bridge a gap of racial inequalities in public health and reflect changing attitudes towards mental health. From the aforementioned, it is evident that the medical model is institutionalised through policy and that is deemed as damaging and unhelpful (Beresford, Nettle and Perring 2010).

These eight objectives go along with key activities to ensure that results are achieved most effectively. Following the MHPF, the Society of Psychiatrists of South Africa (SASOP) issued position statements and reflected on the eight objectives (Janse van Rensburg 2013; Janse van Rensburg 2012). They further addressed the potential strengths and weaknesses of the objectives. For instance, SASOP approved of community-based services regarding the district-based mainstream mental health services; however it indicates they should not discard the mental health experts. Furthermore secondary and tertiary levels of services should be taken into consideration and are in need of flexible co-operation and effective communications with these levels of services (Stein 2014).

It is important to acknowledge mental health at a local level because there are still mental health plans that need to be developed and implemented, which will lead to equality in

financing mental health (Tomlinson and Lund 2012). Unlike in developed countries where there is growing research on this particular issue, developing countries have comparatively little work on the issue (Lund et al. cited in Stein 2014). Additionally, research on MHPF activities is needed. For instance it is understandable that the policy endorses the national education programme on depression; however there should be research done on how and whether it will impact on depression (Stein 2009). Educating communities on depression is important because it will broaden people's perceptions about depression so that they are not only influenced by factors such as culture alone.

2.4. Young people and depression

A lot of literature indicates that young people may express depression differently from adults. Depression in young people is often unrecognised and dismissed as "growing pains" amongst young people (Sabaté 2004). The diagnosis of depression among young adults may be missed because often they present with oppositional or antisocial behaviour and use of substances (Paruk and Karim 2016). Young people who are depressed normally have issues at home and usually parents suffer from depression too (Mitchell et al. 1989). Existing literature explains how young people experiencing depression are at a risk of suicide, increased risk-taking behaviour - for instance substance abuse – and early onset sexual experimentation, teenage pregnancy, adult depression, conduct mental illness, and delinquency (Birmaher et al. 1996).

There has been significant progress in understanding mood mental illness (Remick 2002); however, there is still a lack of understanding regarding treatment for young people with depression. The underdiagnoses and misdiagnosis, under-treatment and mistreatment and lack of follow-up and management of depression has been high generally, but more so among the youth (Sebaté 2004). In order for prevention of depression to be effective, young people should be the target and focus. There is a limited research that is conducted in South Africa on young people with depression (Calitz et al. 2007). Therefore, there is a need for research on young people experiencing depression in South Africa because, as young people engage with global youth culture and different experiences, their understanding will change.

2.5. Culture and depression

Culture is considered a dynamic and a process, that evolves and changes over time, which can be defined as ‘ideas, customs and social behaviour of a particular group of people or society’ (Shafi and Shafi 2014: 392). Issues such as gender, age, race, religion, country of residence, country of origin and education can influence culture. The integration of several cultures, focusing on cultural beliefs and ideologies being accepted into other cultures, has been greatly influenced by globalisation (Shafi and Shafi 2014). Therefore culture is a great part of people’s lives which consequently affects how they view and understand different things including depression.

Our experiences are not only influenced by our own culture, but multiple facets of a multicultural society. Therefore different cultures have an impact on how people understand health threats or illnesses. The common Sense Model (CSM) argues that individuals use common sense beliefs to construct lay theories, called representations, of health threats or illnesses (Adair-Stantiall 2010). These representations are based on ideas, attitudes, and beliefs formed by experience, cultural traditions, formal education, and stories from family and friends (Diefenbach and Leventhal 1996 cited in Mengesha and Ward 2012). Therefore, how they cope with health threats and illnesses is guided by those representations or beliefs.

The CSM model is evident in how people choose to cope with depression, which differs as people are from different cultures and have various beliefs. According to a study conducted by Sulaiman, Bhugra and Da Silva (2001), who looked into views of men and women in Dubai who hold different views regarding the significance of crying when depressed, the older generation abided by the quote, ‘we are Arabs, we never cry, we endure, but these new generations, they are so soft and weak, they cry for any reason’ (Sulaiman et al. 2001). Thus they regarded crying when depressed as a shame due to a belief that one’s inner feelings should be kept to oneself, and if it becomes unbearable, the correct way is to cry alone. However, the young generation followed the quote that reads, ‘a woman who cries feels better’. This indicates acculturation where people from the same culture might be influenced by other cultures and integrates it with their own culture to better their coping mechanisms, thus evolving culture (Coertze 1968 cited in Fisha 2001). Other coping mechanisms included speaking to relatives, ‘asking God for help, reading a religious scripture, praying or asking a religious leader for guidance’, rather than visiting a psychologist (Sulaiman et al. cited in Shafi and Shafi 2014: 393).

As culture influences the perceptions of individuals with regard to depression, it consequently impacts the support or help which people with depression tend to seek. Participants from Sehoana's (2015) study, conducted in the Limpopo province, tended to view depression from a spiritual perspective, thus leading them to seek help from spiritual and traditional healers as it believed that depression is born from the spirit (Sorsdahl cited in Sehoana 2015). The beliefs, customs, thought patterns and symbolism of culture influences the individual's experience of himself, his behaviour and his interaction with others because a person is a carrier of culture (Schlebusch, Wessels and Rzadkowolsky cited in Fisha 2001). Therefore, people give different meaning to distress, depending on culture and context.

Idioms of distress are meanings people give to their distress that shape the expression of it and the solutions sought. For instance, Shafi and Shafi (2014) indicated that some participants would describe their depression via metaphors and proverbs such as "a dark life" and physical symptoms, which are a genuine and morally accepted reason to visit a doctor (Desai and Chaturvedi 2017). Idioms of distress are successful in expressing symptoms of distress and providing appropriate coping strategies (Desai and Chaturvedi 2017). For instance, Bhugra and Mastrogianni (cited in Shafi and Shafi 2014: 391) studied Punjabi women of two generations and discovered the younger generation recognised the term depression while the older generation used different terms such as "weight on my mind" or "pressure on the mind". This is an example of generational differences in conceptualising depression.

Acculturation can be described as a process where cultural patterns evolve and change due to systematic and continuous influence by other culture(s) (Coertze cited in Fisha 2001). Therefore, one culture adopts products, thought patterns and ways of life of another culture through this process, which will ultimately result in them being of great similarity. This suggests that that the manner in which depression is interpreted, experienced and expressed could also change, based on the direction of how it occurs according to the dominant cultural norms, which the individual adheres to (Fisha 2001).

Different cultures conceptualise what western mainstream mental health would call depression in various ways which consequently impacts the coping mechanisms. An example would be how religiosity and spirituality are essential aspects of African American culture, identity and coping. The internalised sense of connectedness to religious values that many African Americans were raised with provides a sense of purpose, power and self-identity (Mengesha and Ward 2012). Thus, prayer and religion has been identified as

African American's primary coping mechanisms in dealing with problems such as, cancer, recovery from substance abuse, pregnancy or infant loss, agoraphobia, bipolar mental illness and depression (Mengesha and Ward 2012).

Therefore, people use idioms of distress to present depression in ways acceptable to them and their culture in order to cope with it. For example, some people commonly present somatic symptoms, which is often a feature of depression. For some cultures, this might be deemed as a valid reason to visit the doctor, which has fewer stigmas (Kirmayer et al. cited in Shafi and Shafi 2014). In addition, Kleniman et al. (cited in Shafi and Shafi 2014) presented a study that stipulates that in the mid-1980s; only 1% of people in a week were diagnosed with depression at the psychiatric out patient's clinic in Hunan, China. Nonetheless, 30% were diagnosed with "neurasthenic" complaints, which some people understand to mean "neurological weakness" and do not experience as stigmatising. However, Kleniman et al. (cited in Shafi and Shafi 2014) came to realise that the people were more accepting of this diagnosis than the psychologists.

The effects of acculturation do not affect all members of society in the same way, as levels of acculturation generally differ (Fisha 2001). Similarly, one culture does not completely influence and take over all spheres of another culture; instead cultures incorporate aspects of other cultures. Usually, the old culture retains its old elements, which differ 'across different spheres of life, community to community, from one geographical area to another and from individual to individual' (Fisha 2001). It also depends on the specific situation an individual is in at a particular time. For instance, in one context, they might present traditional psychological processes; however in another context they might use mechanisms influenced by another culture (Coertze cited in Fisha 2001). A study by Atindanbila and Abasimi (2011), which focused on coping mechanisms of Ghanaian youth with depression, indicated that students use a variety of coping mechanisms from various cultures. These coping mechanisms included cognitive methods, social and spiritual methods and physical coping methods such as exercising and relaxing after work (Kyriacou 1987). This was all used alongside the medical approach (Atindanbila and Abasimi 2011). A study by Ngcobo and Pillay (2008) in South Africa indicates that more than 40% of people used both traditional and western forms of treatment in combination to cope with depression. In fact, those people consulted traditional healers before seeing a primary health care practitioner (Ngcobo and Pillay 2008: 135). This indicates forms of acculturation as participants from the study incorporated both their culture and Western cultures to cope with depression.

Cultural beliefs influence ways of dealing with depression in various ways. Topper et al. (2015) conducted a study in the Eastern Cape, South Africa, which identified barriers to accessing Western mainstream mental health services. These included long waiting times at the clinic (structural barriers), dissatisfaction with the negative attitude of the staff, and receiving help from another source. All these barriers happen in most low- and middle-income countries where community resources assist people with depression (Patel et al. 2011).

Notably, participants in Topper et al.'s (2015) study, as well as many others, were concerned about other people knowing about their illness and thus did not trust the health care practitioners to uphold client confidentiality (psychosocial barriers). Participants in Topper et al.'s (2015: 377) study mentioned the following as their key problems with health care practitioners; "shame," "stigma," and 'lack of trust of health care professionals concerning client confidentiality'.

2.6. Stigma and depression

Stigma has, to an extent, an influence when people avoid going to mental health institutions and seek help from traditional healers and religious leaders first. This is to avoid 'fear of embarrassment or shaming their family' (Sulaiman cited in Shafi and Shafi 2014). Stigma creates labels such as shame and social disgrace, where the behaviour of a person is an embarrassment to family and friends. This can ultimately lead to people concealing their true emotions out of fear of being disowned or brushed aside (Shafi and Shafi 2014). Thus help or treatment is sought only when one finds himself in a desperate situation or when depression has affected several areas of their lives, such as employment or relationships. Stigma aggravates a condition that is already affecting individuals and their family members negatively (Shafi and Shafi 2014). Stigma makes a condition such as depression, which is already hard to deal with, even harder because it hinders people from seeking help because of the fear of being disowned by their families, or brushed aside. Therefore, stigma leads people to conceal their true feelings in an attempt to save themselves from shame or embarrassment (Shafi and Shafi 2014), which is very common among teenagers.

During the teen years, stigmatising attitudes towards individuals with depression are very common, which can consequently lead to negative emotions, stereotyping and discriminatory behaviours (Medina and Overton 2008). Therefore, individuals with

depression might internalise the stigma and feel a sense of hopelessness and a decreased self-esteem (Jorm and Reavley 2011). Thus, when it is used in reference to depression, it consists of feelings, attitudes and behaviours (Penn and Martin cited in Medina and Overton 2008). There are theories in place on how stigma can be deconstructed and defined (Medina and Overton 2008) and the following sections will discuss those theories.

2.6.1. Theories of stigma

Social norms are considered to be what is right or wrong in the eyes of a society (Medina and Overton 2008). Therefore, societies or large groups within societies use social norms as a factor in determining if people are “normal”. Spoiled collective identity is a term used to stigmatise people based on their character and identity. Scientific racism can be regarded as a typical modern way of thinking (Meloni 2017). The behaviours of people with depression are judged while failing to comprehend that the behaviours do not define their entire being (Medina and Overton 2008). Depression was historically considered by some people as a character or moral flaw. Thus, with a spoiled collective identity, those stigmatised are not regarded as normal but as ‘a tainted being that is discounted’ (Medina and Overton 2008). According to Crawford and Brown (2002) stigma is born from what society regards as an ideal identity and anything that falls short of the ideal identity is not “normal”.

The second theory of stigma is structural stigma, which is similar to spoiled collective identity as a person is judged based on the societal norms. This theory searches deeper than the surface of stigma, it looks at stigma as a process through culture and how it functions as a whole (Medina and Overton 2008). The theory looks into stigma in detail in order to uncover the meaning behind stigmatisation. Structural theory provides an illustration of the physical barriers societies build for people with depression. This theory shows how people with depression falls short of opportunities than people who are considered “normal” (Medina and Overton 2008). People with depression may find it hard to find empathy and support, participatory citizenship and happiness. Therefore, a person experiencing depression gets different aspects from the society that impacts on their lives could be in a negative or positive way.

In addition to stigma from others, people with depression also suffer self-stigma, whereby they engage in introspection and judge themselves. The judgment maybe the results of negative commentaries from the community’s social norms; however the judgement is

placed by the individual on themselves (Medina and Overton 2008). The judgement lowers the self-esteem of an individual, leaving them feeling inadequate because they fail to reach expectations set for them by the community (Blankertz 2001). Those stigmatised might sometimes internalise the negative comments that dehumanise them when they feel like they are failing to meet the set expectations leading to self-hate, feelings of inferiority and shame (Lenhardt 2004). Self-stigma is a private shame that affects an individual's self-esteem negatively, leading one to doubt their capabilities to lead a normal life (Corrigan 2002). This can also impact on how they choose to cope with distress and they might use the dramaturgy to hide their true feelings and act in ways desired by society.

2.6.2. Dramaturgy

Dramaturgy provides an outlook on how people cope with depression in a way acceptable to society. It is a process people engage in when they feel depressed as a way to cope with or manage their depressive feelings. This theoretical framework assumes that people with depression use the metaphor of a theatre when depressed to cope with it; on one stage they hide their true feelings to portray a false persona, and on another they are able to be true to their feelings and be who they are (Knudson, Svanoe and Tappe 2008)

This theory postulates that human actions depend on time, place and audience. Individuals, in their daily lives, present themselves to each other on the basis of cultural values, norms and expectations through the "front stage" and "back stage" (Goffman 1959; Knudson et al. 2008). Thus, on the "front stage", people portray themselves in ways that are of approval to the audience. However, in the "back stage", individuals are who they really are - their true being - and can express themselves in an earnest way without being worried about how people perceive them. Therefore, there is a possibility that those with depression cope by making use of these two distinct stages. In the "front stage", they act in ways that show they are content; they have it all together. However, on the "back stage" they show their true emotions and feelings of hopelessness and insecurity (Goffman 1959; Knudson et al. 2008). Thus, those with depression may feel that their "front stage" will be more acceptable to those around them, while the "back stage" will reveal that they have difficulty coping with internal and external pressures. Consequently, they continue presenting a "front stage" as a coping mechanism in order to live up to the expectations of society and the values, norms and expectations of their particular culture (Knudson et al. 2008).

Nonetheless, since culture is not static, but evolves as different cultures influence one another, an individual might acquire a coping mechanism influenced by another culture which aligns with their personal view on how to cope with depression. This will ultimately influence their “front stage” and “back stage”, where they might use a coping mechanism accepted in a “front stage” by another culture but not theirs. For instance, participants in a study by Sulaiman et al. (2001) expressed difference in how they cope with depression, with the older generation avoiding crying in public but the younger generation feeling that crying is a good coping mechanism. Furthermore, they can use a coping mechanism accepted by their culture in the “front stage”, but use other ways to cope with depression in the “back stage” that is influenced by other cultures. This will allow people to use different methods to cope with depression.

2.6.2.1. Impression management

Central to Goffman’s theory of “front stage” and “back stage” is the idea of impression management, whereby people present themselves in the best way possible in order to gain acceptance from their audience (Goffman 1959). When the individual leaves the “front stage”, they no longer require impression management as they enter into the “back stage” because they are away from the audience they are trying to please. This then allows them to transform into who they really are. When in back stage the impressions are hindered: ‘it is here that the capacity of a performance to express something beyond itself may be painstakingly fabricated; it is here that illusions and impressions are openly constructed’ (Goffman 1959: 112).

The “front stage” is regarded as what is visible to the audience and the “back stage” consists of all things that are not visually accessible to the audience. The “back stage” is where actors are able to act in ways that are deemed as subversive in their front stage performances (Goffman 1959; Wood 2004; Kivisto and Pittman 2013). For instance, when attending a dramatic presentation, there are certain things that are not visible to the audience that make the front stage performances believable, such as ‘not seeing the grips working on scenery, lighting, and other physical aspects of the set, actors rehearsing lines and gestures and directors guiding how the actors perform’ (Wood 2004: 121; Kivisto and Pittman 2013). Similarly to the theatre, everyday life is seen both on the “front stage” and “back stage”.

The “front stage” and “back stage” of theatre have to be integrated in order to genuinely appreciate how social interaction works as drama. The “back stage” enables people to

engage with their true emotions, a safe space where they can vent their feelings without interfering with their performances on the “front stage” (Goffman 1959; Wood 2004; Kivisto and Pittman 2013). The knowledge that the “back stage” exists as a safe place where people can be at ease, blow off some steam and relax, sometimes can help in tolerating stressful events that occur on “front stage” (Wood 2004). It is important to point out that there is limited literature on case studies about depressed people using the “front stage” and “back stage” as ways to manage or cope with depression. The use of “front stage” and “back stage” can be also caused by social factors such as religion or family which influence how people understand and view depression.

2.7. Social factors influencing coping mechanisms

A variety of social and relational interactions or events can lead a person to experience depression. This section will discuss factors such as religion and family that have an influence on someone experiencing depression.

2.7.1. Religion and depression

There has been a growing body of literature on depression and religion and the latter offers the comfort of the belief in a higher power as well as community networks and relationships (Koeing 2002). In contrast, spirituality is defined as ‘the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community’ (Koeing 2002).

There is a relation between religious beliefs and activities, with higher well-being and satisfactory health associated with being religious (Wittink et al. 2009). Religious individuals use religious beliefs, such as praying and trusting God, as coping mechanisms when faced with stress (Wittink et al. 2009). Existing literature indicates a positive association from religious coping activities aforementioned which lead to life satisfaction, stress-related growth, well-being and better physical health. The notion that religious coping activities may be effective in improving and individual’s adaption to stress is supported by research. Some research argues that the relation between religious coping activities and well-being and psychological distress are less intensified by cultural and ethnic factors (Wittink et al. 2009). People using religious activities and beliefs to cope

alleviate their levels of stress. People engage in a variety of religious activities to cope or deal with depression.

2.7.1.1. Religious activities used for dealing with depression

Researchers have conducted studies to reveal the typical activities people use to cope with depression. For example, Wittink et al. (2009) conducted a cross-sectional study of forty-seven older African American patients recruited from primary care practices in Baltimore. Participants in the study presented a faith-based explanatory model of depression (Wittink et al. 2009). In order for healing to occur, participants argued that faith and spiritual or religious activities are effective in working together with medical treatments as it is believed that depression is due to “loss of faith” (Wittink et al. 2009).

Participants discussed the importance and value of faith and spiritual activities in coping with depression, and further explained how spiritual coping methods could directly relieve depression and how conventional medical treatments can be enhanced by spiritual coping (Wittink et al. 2009). Participants in Wittink et al.’s (2009) study value their spiritual coping methods and would prefer them being incorporated with depression treatments as they believe that they are truly helpful, referencing from their own experiences. A large scale quantitative study of a random sample of 1 600 adults from Sri Lanka discovered that about 1% reported visiting a religious leader for emotional or stress-related matters. Other ways identified to relieve stress were astrologers (5.5%), wearing religious stones and bracelets (10%), and making use of herbal or traditional medicine (15%) (Beiser et al. cited in Pandalangat 2011). Making use of religious leaders and engaging in religious rituals has proven to exert positive effects on those using them to cope with depression.

Other religious activities believed to assist in coping with depression include prayer, where participants view prayer as an ‘active strategy of seeking guidance and of helping oneself’ (Pandalangat 2011). Respondents postulated that prayer is important in helping oneself and can be done independently or collectively with others, and corresponds well with other forms of help-seeking (Wittink et al. 2009; Jones and Ford 2008; Nadeem, Lange, and Miranda 2008). Another valued religious activity to cope with depressive symptoms is speaking to a pastor or religious leader. Wittink et al. (2009) argue that their participants stated that a pastor is a member of their community and can be trusted, is caring and ensures confidentiality. A minister was viewed as providing a link between the people and the spiritual or religious realm. Thus, one participant expressed that even though doctors and ministers might be able to help with depression, only ministers have “God in them”:

‘First you got to have some part of Jesus in you. You can be a doctor but the doctor does not have the sympathy and that feeling that they need to give you. They have to have some of God in them. You can go to your minister and you can go to the hospital but I prefer the minister’ (Wittink et al. 2009). They recurrently spoke of church as a place to go to when in crisis, for strength, comfort and support. Therefore, going to church was perceived as a way to regain lost faith and to bolster one’s strength (Wittink et al. 2009).

South Africans are generally religious. Pillay, Ramlall and Burns’ (2016) research in KwaZulu-Natal found that participants, when feeling hopeless, usually turn to spirituality or the higher power in order to cope. Believing in the higher power can be regarded as assisting people to define their life purpose. Quality of life is associated with a belief in a higher force (Pillay et al. 2016). Pillay et al.’s (2016) study indicates that higher quality of life is linked to higher levels of spirituality and low depressive symptoms. Generally, when an individual has a high level of spirituality, it leads to a higher sense of well-being (Baker 2003) and that results in a better quality of life (Pillay et al. 2016). A traditional healer interviewed by Starkowitz (2013) stated that healers cannot cure depression, but what helps is prayer to God and ancestors. However, prayer was not the only tool traditional healers’ use for depression, because some traditional healers believe in medicinal substances such as the use of herbs for treatment.

It is clear that although religion is central, it is also integrated with other systems such as quality of life and traditional healing. Another social factor that has an immense effect on the understanding and coping mechanisms of depression is a person’s family, as their views are important to an individual.

2.7.2. Family and depression

The definitions of sanity and madness are influenced by the behaviour of families, and more so their ideas and assumptions about appropriate behaviour regarding depression are influential. Family ideologies are important in how people understand depression (Jones 2002). According to Stevenson and Davis (cited in Davis and Stevenson 2006), youth usually adjust to their family socialisation and internalise the socialisation which ultimately influences how they deal with their emotions. Stanhope (2002) contends cultural factors, such as interdependence, an externalised locus of control and family involvement, are responsible for better prognosis of individuals with psychiatric disabilities in developing countries. However, a qualitative study of an Asian Indian population in the United States, which collected data by interviewing service providers in a psychiatric facility and reviewing

medical records (Conrad and Pacquiao 2005), yielded contradictory findings. The study stipulated that family involvement was both a strength and obstacle to help-seeking and service utilisation among young people. Much literature has focussed on whether family involvement in young people's depression is a source of support for help seeking or not. Whilst the results are contradictory, it is clear that family is understood, in the literature on depression, as having a key role in the responses that are used. Social ties are important for a person who experiences depression as they have an influence on people's psychological well-being.

2.7.3. Social ties

Dating back to Durkheim, sociology has established a link between social isolation and reduced psychological well-being (Kawachi and Berkman 2001). Therefore, 'smaller social networks, fewer close relationships, and lower perceived adequacy of social support', are all related to depressive symptoms (Kawachi and Berkman 2001). Researchers are in agreement that social ties have a constructive influence on mental health and psychological wellbeing (Kawachi and Berkman 2001).

Cohen and Wills (1985) have brought forward two models to explain the mechanisms whereby social relationships influence health outcomes; the main effect model and the stress-buffering model. The stress-buffering model stipulates that social ties are only linked to the well-being of a person who is under stress, whereas the main effects model states that whether an individual is under stress or not, social relationships have a productive effect (Kawachi and Berkman 2001). Therefore, the two models give an explanation for certain aspects' influence on psychological health while stress-buffering mechanisms operate on the functional aspects, such as perceived support. For example, 'the perceived availability of functional support is thought to buffer the effects of stress by enhancing an individual's coping abilities' (Kawachi and Berkman 2001). In contrast, 'the degree of integration in a social network is postulated to have a direct effect on well-being regardless of the presence of stressful circumstances' (Berkman and Glass 2000).

Social influence is a way in which the members of a certain social network are guided through norms about health-relevant behaviours such as physical activity or cigarette smoking (Berkman and Glass 2000). However, it is vital to note that certain social networks might practice norms that are destructive, such as encouraging smoking and inactive behaviour. A social network that is integrated might produce positive psychological states, including a sense of belonging, purpose, security and recognition of self-worth

(Cohen, Underwood and Gottlieb 2000). Thus, these positive psychological states might trigger increased motivation for self-care, which in turn benefit mental health (Kawachi and Berkman 2001).

Lastly, being active in a broader social structure, by participating in community organisations, involvement in social networks, and immersion in intimate relationships, leads to acquiring variety forms of support which will be beneficial by protecting one against distress (Lin, Ye and Ensel 1999). Those resources include access to health-relevant information or receipt of informal health care that could assist in hindering a minor illness from progressing to a more serious psychiatric mental illness (Cohen et al. 2000). Social support in the stress-buffering model is theorised to prevent or moderate responses to health that are deemed stressful and harmful. Support may occur at varying points between stressful events and eventual depression. Therefore, perceived availability of social support when faced with a stressful challenge might assist in assessing the situation more positively, thus preventing negative emotional and behavioural responses (Thoits 1986). In addition, perceived or received support 'may either reduce the negative emotional reaction to a stressful event or reduce the physiologic or behavioural responses to stress' (Kawachi and Berkman 2001).

The concept of social ties emphasises social network and social support. Therefore, an individual's social network has an influence on how they perceive things, including depression. Thus the support acquired from social networks can be beneficial to a person experiencing depression (Cohen et al. 2000). Being engaged in one's social networks is one way of helping to deal with negative emotions. Being involved in community activities and being socially active helps an individual to have a positive perception on life when faced with challenges. Social networks help in coping better with distress because of the influence they have on acceptable ways of doing things. Social networks offer a sense of belonging and security which is beneficial to someone who is distressed, because a positive psychological state leads to them being able to care for themselves (Cohen et al. 2000).

2.8. Conclusion

This chapter reviewed different ways that research has tackled the question of depression. There has been a particular focus on categorising and defining depression; however my primary concern has been with understanding the history of depression in South Africa,

and more than this, also people's subjective experience of it and their chosen coping mechanisms, with an emphasis on integration of different responses. The following are ways of thinking about it. Some believe that spiritual and physical factors cause depression. How some people react and respond to depression is highly influenced by cultural values and beliefs. People experiencing depression tend to also seek help outside medical health facilities such as churches or traditional healers, and engage in rituals that help in resolving their depression. The primary concerns in the literature have been with defining and classifying depression; however there has been other literature that has looked far more at a cultural understanding of depression and it is in this literature that I have located in my study. The next chapter will look at methods used to gather data.

Chapter 3. A description of the research process

3.1. Introduction

This chapter examines the research methodology adopted in this dissertation. It provides information regarding methods I used to undertake this research as well as the justification for using a specific method, including justification for using interviews, as well as sampling and ethical considerations. The chapter further describes the different stages of the research, which includes the selection of participants, the data collection process and the process of data analysis. In addition, the chapter will discuss my role as the researcher in qualitative research in relation to reflexivity and my own personal experiences and ideas about the researched phenomenon. The chapter concludes with a discussion of trustworthiness by making use of phenomenography to ensure that credibility, dependability, confirmability, transferability and authenticity were upheld.

The interaction between the participants and I consisted of a semi-structured interview dialogue in which participants shared their experiences of depression and the coping mechanisms they used or use. The qualitative epistemology was based on an interpretive method. From an interpretivist perspective, we can only seek to understand real-world phenomena by studying them in detail within the context in which they occur (Alvermann and Mallozzi 2010).

3.2. Research methodology

According to Denzin and Lincoln (2005), the nature of the research question and the subject investigated determines a research methodology. Therefore the research format used should be regarded as a tool to answer the research question. This research aimed to explore and understand the meanings constructed by the participants. In addition, the study aimed to derive meaning about the phenomenon and a particular way of looking at the phenomenon by investigating the experiences of people with depression. This study was guided by the following research questions:

- What is your understanding of depression?
- What has shaped this understanding?
- How has your social background shaped your understanding of depression?

- What do you do when depressed?

I collected data using semi-structured interviews. The next paragraphs outline a detailed justification for using specific approaches and methods.

3.3. Justification for using qualitative research

A qualitative research approach was chosen as the methodology because this approach emphasises understanding and interpretation of meaning. Qualitative research is described as a multidimensional research method, which involves an interpretative, naturalistic approach to a subject matter (Denzin and Lincoln 2005; Kielmann, Cataldo and Seeley 2012; Brikci and Green 2007). Due to qualitative research being multidimensional, it allows researchers to develop a holistic picture of the phenomena. Denzin and Lincoln (2005) provide two key principles that underlie qualitative research: firstly, that it is holistic and aims to understand a whole phenomenon, and secondly that it looks at the bigger picture and attempts to understand the subject of investigation intensely. This holistic approach is about a focus on context and meaning, which is the primary concern of my study. Qualitative research focuses on interconnected relationships within a system and focuses on understanding the whole system. For instance, my study focused on interlinked experiences of people with depression, which helps make sense of the whole system - namely, black South African youths' understanding of depression and how they cope with depression. In the study, I focused on the experiences of participants without making predictions, rather allowing participants to share their own stories.

Data analysis in qualitative research is time consuming and requires the data analysis to be an on-going process. As the researcher I become the research instrument and this allows me to discuss my own biases and ideological preferences. The design of qualitative research includes informed consent decisions and pays attention to ethical considerations (Denzin and Lincoln 2005).

The objective in qualitative research is exploratory and descriptive (Ferreira et al. 1998). The descriptive nature of qualitative research enables me to provide a description of the participant's experiences, which will in turn either sustain or confront the study's basic theoretical assumptions (Meyer 2001). Furthermore, the descriptive nature of qualitative research allows readers to understand the meaning attached to the experience, the distinct nature of the problem and the impact of the problem (Meyer 2001).

Qualitative research was considered best suited for this research as the purpose of the study was to explore the subjective experiences and perceptions of black South African youth with depression. The objective of the study was to explore a particular meaning without presenting the findings as the ultimate truth, but as a way in which some South African youth understand and cope with depression. During the interview process, even though the foundation of choosing participants was that they all experience depression, it was their individual descriptions of what depression is that differentiated their perceptions. There were different ways in which participants understood depression. In order to ensure the findings accurately reflect the way participants construct meaning, much time had to be spend on analysing the data.

I already mentioned that the main data collection method for this study was interviews. A semi-structured interview approach facilitated a clear understanding of the problem from the participant's perspective in the study. I will now discuss the reasons for using interviews in more detail.

3.3.1. Justification for using interviews

A valuable tool for collecting data in qualitative research is making use of interviews (Potter 1996). The one-on-one interview enabled an interaction with participants and allowed me to observe non-verbal cues during the interview. For instance, during the course of the interviews, some participants, when referring to stereotypical statements regarding depression made by other people, would "purse" their lips to the side and raise their eyebrows for emphasis and as a sign to indicate that I relate to what they are saying, because usually it was followed by "right".

I employed a fairly open framework for the in-depth, semi-structured interview method, which is more focused on allowing a two-way communication. The in-depth, semi-structured interview method also allowed probing, giving explanations and leaving out unnecessary questions. During interviews, because it is semi-structured, it does not restrict the direction of the interview; therefore, there were times when participants answered questions I had not asked yet. So participants also controlled the direction of the interview. In addition, I used the in-depth interviews to explore in detail the responses of the participants about how they understand and cope with depression. For instance, during the process of interviewing, there were times when I had to redirect my questions because of the participant's responses, in order to explore their response in detail. I had to probe

due to some findings that were surprising; therefore probing was used to source more information.

I made use of interviews as a method of data collection to achieve an insightful understanding of participants' constructions through a dialogue, and also through their chosen language when constructing the different discourses. The reporting and analysis of data is the participants' reflective perceptions.

I was a peer to participants and there are both pros and cons to being the same age as participants. The advantage was I was able to build trust with participants. This in turn made it easier for participants to share their experiences without fear of being judged. However the disadvantage was reading from their body language; some participants seemed embarrassed sharing some of their experiences with someone around their age. They would refrain from giving too much detail, avoid eye contact and look down. However, in the selective information participants gave, they ensured it was in line with the purpose of the study and limited it to their experience with depression.

3.3.2. Sampling

In this study I used purposive and snowball sampling. Using purposive selection, I interviewed eight participants who fitted the specific criteria that were required by the study (Berg 2009), which were black South African youth between the ages of 18 and 25, who self-identify as experiencing depression. In addition, snowball sampling was used to recruit other black South African youth living with depression, to whom I was referred by participants (Berg 2009; Bless, Higson-Smith and Sithole 2013; Neuman 2011).

I initially approached potential participants known to me. This was done by actively selecting participants who met the criteria to participate in the study (Marshall 1996), for instance black South Africans experiencing depression. In order to expand the sample, I asked identified participants to refer me to other young people experiencing depression who were known to them who might be willing to give an input in line with the research topic. This is known as snowball sampling (Berg 2009). I then approached potential participants and those who fit the criteria and were willing to participate in the study were interviewed.

In trying to find participants, posters were displayed at Psychological Services and Career Development (PsyCad), for people who might be willing to participate to contact me. PsyCad provides services such as counselling, career guidance and assessment to the

students and staff of the University of Johannesburg. This process delayed the research because I had to go through different channels to put up posters. Firstly, I had to consult with the team leader at PsyCad to explain the purpose of displaying the posters. When they agreed to display posters, the Student Representative Council (SRC) had to be contacted to get a stamp on the posters before displaying them. Before stamping posters, the SRC required a letter or email from one of my research supervisors confirming that I was indeed a masters' student and stating the title of the study. The supervisor sent an email and proof of registration to the SRC. Upon returning to the SRC offices at Auckland Park Campus, I could not find the person who was assisting me. Fortunately after three days he was found. He stamped the posters which enabled me to put them up at PsyCad.

Another hurdle was that someone contacted me as a result of the posters, who was enthusiastic and excited about participating in the study and scheduled a meeting. However, the potential participant was actually Zimbabwean and so the interview had to be cancelled as the participant did not meet the criteria of this research. It delayed the progress because on that day another interview was scheduled with someone else and I had to find a different a time slot to fit in the potential participant, and then another participant was needed to replace the Zimbabwean potential participant. It also made me question using nationality as a basis for sampling, because I sat down with the potential participant explaining the criteria of the study to him to show that he cannot participate, but then we still sat and spoke about depression and his experiences. Due to curiosity I spoke to him off the record - just a friendly conversation - and realised that his experiences are somewhat similar to those of the South African participants I interviewed. I realised in that moment that maybe it was a weakness of my study to have nationality as a basis for sampling.

The number of participants interviewed in this study was pre-determined due to the sensitivity of the topic, which meant that acquiring participants would not be easy. This proved to be correct as it was difficult finding participants when data collection began.

In total, eight interviews were conducted, and by the fourth interview, themes were already emerging. With the additional interviews conducted similar themes emerged, along with new ones. The last interviews confirmed the information gained in previous interviews which demonstrated that the information gathered answered the research question.

To ensure participants were respected and well represented, ethics were taken into consideration, and the next section will give a detailed discussion.

3.3.3. Ethical considerations

It is important to ensure participants are respected and are not harmed in conducting research (Silverman 2009). To ensure that ethical requirements are met when conducting research, the Faculty of Humanities at the University of Johannesburg has a Research Ethics Committee to protect the participants. Before conducting research, this research was approved by the Faculty Ethics Committee (See appendix D). In addition to signing the informed consent document, participants also verbally consented to taking part and being interviewed and recorded before the actual interview took place (Leedy 2000; Neuman 2000). The consent form that was used as a guideline for the research consent process is attached as Appendix B.

Before conducting research interviews, the purpose of the study was explained to the participants and they were informed that the study is voluntarily, so anytime they became uncomfortable and wished to withdraw, they could do so without any repercussions. Furthermore, permission to record was obtained from participants before the interview, both written and verbal consent, and none of the participants had issues with me recording the interviews. Before continuing with the interview, I went through the consent form with them and asked for their consent to continue with the interview before starting. Additionally, participants were informed that pseudonyms would be used and not their real names in the final report in order to uphold confidentiality of participants. Participants were further assured that their information would remain confidential and would only be accessible to the researcher and supervisors. The supervisors and participants had no contact nor were they known to each other.

Additionally, a debriefing session with participants is needed after sensitive interviews to ‘help the participant back to a normal state of arousal from the intensity of the interview’ (Sammut, Abela, and Vetere 2012: 107). It was my responsibility as a researcher to provide contact details of sources of support for additional support for participants (Dempsey et al. 2016). Both I and participants had a debriefing session after the interviews to discuss the interview process and the impact of the interview. The debriefing was concentrated on finding out how participants felt after the interview, how participants were emotionally affected, and answering any questions participants might have had. This was a way to ensure that the participants were not left emotionally harmed or traumatised from the interview. Some participants expressed being excited to have participated as they

were interested in sharing their experiences. Although they were offered psychological counselling, none of the participants requested psychological help after the interviews.

After the interviews some participants seemed to be feeling good, and they confirmed that they were. Even during the interviews, some participants appeared to be free in sharing their experiences and true emotions in a safe and conducive environment without the fear of being judged. This was beneficial to the study as it helped for some to open up and go into detail about their experiences with depression. Other participants expressed their appreciation of me doing this kind of study, as they believe it will help others learn more about depression.

The participants' appreciation was in line with my political commitment to representing young people in ways that are not pathologised, as that shapes what I choose to share about them. This is a group of people who are not typically represented well in the literature. These are young, black and fairly poor people who are usually seen as a problem in society; with this study I have a different representation, to present them in a respectful and decent light.

The following section will discuss the process that took place when collecting data.

3.4. Data collection process

Context is important when analysing data from qualitative research (Denzin and Lincoln 2005). The participants were given the liberty to choose where the interview would take place during the data collection phase of the research process. Therefore I interviewed each participant in the venue of their choice, at a time convenient for them. Participants were either interviewed at a restaurant of their choice or at the University of Johannesburg, Auckland Park campus in the library.

The interviews were conducted by me and were all conducted in English, and participants were asked consent to conduct the interview in English. Although there are some participants that used few words in their home language - either Setswana or IsiZulu - I was able to transcribe the interviews without having to translate first because the interviews were conducted mainly in English. However, phrases and words which participants expressed in their home language were translated during the transcription. I saw the need to translate interview material into English so that the data can be of convenience to those who do not speak Setswana or IsiZulu.

It is important to have awareness as it allows you to absorb reality and be accommodating. Self-awareness entails being aware of current realities and surroundings, and having the ability to identify with one's perceptions, feelings and nuances of behaviour. The self has the ability to recognise and acknowledge its experiences (Kondrat 1999). Therefore, I was aware of my experiences and the potential impact on the study. Given that I myself experience depression, it was easier to identify with the responses of the participants. One dilemma I had was that, I was sometimes tempted to explore more on participant's responses that were not related to the study, as well as deciding in the moment whether some things were relevant to the study or not. There were times I wanted to passionately and loudly agree and confirm something said by participants that I could relate to, or to express my frustration about some stereotypical statements they experienced from other people, but I restricted myself. I refrained to some extent from imposing my own views on the participants. My participants' and my social location, such as race and social status, shaped the research process positively (Edwards 1990; Orbele 2002). Due to a similar social background of both mine and the participants', developing a relationship with participants became easier, which in turn created a safe and conducive environment for participants to freely construct the meaning of their experiences without the fear of being judged. Even after the interview, there are some participants I still engage with because of shared experiences.

My own experiences of depression positioned me at the same level as participants. Although participants were not all aware that I also experience depression, some participants asked after the interviews about my interest in the research topic. Therefore I explained how the research was prompt by my own challenges experiencing depression and how those challenges shaped my construction of depression, whilst avoiding providing redundant information. It was evident that the transparency excited some participants even more about the research and reassured them that they made the right choice in participating. In three instances participants expressed how it was good that someone who experiences depression is the one doing the study; that way their experiences would be captured in the best way possible.

In order to capture participants' experiences, the interviews were semi-structured, having seven pre-formulated questions (See Appendix C) which each opened a window to probing and explaining some concepts, while leaving out redundant questions. Therefore the interview was partly guided by the conversation between the researcher and the

participant. I personally interviewed every participant and all interviews were recorded on my smartphone.

The participants were co-constructors of knowledge in the study and thus told their own stories. As this was a semi-structured interview, it allowed me to probe, which then allowed me to gain more data (Adams 2015). Probing indicated that I was listening and interested in what had been said without seeming astonished or shocked. This was also a way to reassure participants that I was listening to what they said and not just nodding along when they talked (Adams 2015). However, there were times when participants assumed I could relate to what they meant when talking about certain things. They would say things like, 'Well you know how black people are,' and 'you know what I mean'.

Even though the nature of the interviews was conversational, the nature of the topic was sensitive, so it was difficult for some participants to be fully open and transparent about experiencing depression. I was aware that some participants were selective in what they shared because when I probed, some participants avoided answering certain questions. However I deliberately allowed participants to provide information only voluntarily, given the sensitivity of the research, because participants will give information that they think is specifically related to the study.

The interview style was based on the qualitative research interview method described by Neuman (2000), in which questions were made to specifically fit the participant's situation. Much attention was focused on the participant's responses and encouraged elaboration. For instance, some participants made use of social media as their coping mechanism, which was unexpected; therefore that led to a change in my questions to get further details on that. The interview was more like a friendly conversation, thus allowing jokes, side stories and diversions, which were recorded. Both myself and participants together controlled the pace and direction of the interview. Adjustment to the norms and language usage of the participants was necessary. Adjustment had to be made throughout the data collection process.

Due to adjusting in order to accommodate participants, the interviews were conducted over a period of three months because there were cancellations and rescheduling of meetings. One interview was conducted during the December holidays after the proposal was approved by the Faculty Ethics Committee, and the other interviews were conducted in February the following year. Another participant who agreed to participate during

December ended up withdrawing from the study due to relapsing and being admitted to the hospital.

The average length of the interviews was about thirty minutes. Due to my essential role in the research and positionality in the research, the following discussion in the next session will focus on reflexivity - my role as a researcher in qualitative research.

3.5. Reflexivity in qualitative research

As a researcher I am aware that I am an instrument of data collection, and data interpretation therefore plays an important role in a qualitative research (Creswell 1994). Subjective individuals take up research and therefore their subjectivity should be acknowledged (Parker 1994). In addition, it becomes easier as a researcher to account for my reasons for taking an interest in investigating this particular phenomenon if I acknowledge my subjectivity. My life experiences, outlook on life and observations are more likely to affect the process of data collection, data analysis and interpretation.

I am a South African young adult who has been experiencing depression for more than ten years. I have not been diagnosed officially but have been to therapy and the psychologist hinted that I show signs of depression. I have used therapy occasionally as a coping mechanism without taking any medication. I believe that depression can be both genetic and caused by social issues. My own understanding of depression is that it can be from chemical imbalances exacerbated by social events that occurred in my life. To cope with depression I do exercise, journaling, spending time alone and talking to people who are in the same position as me. I am currently part of a WhatsApp group named ‘Taking a Deep Rest’; which was an outcome of the research because it was set up by one of my participants in the study; Bonolo, after an interview with her. It is a group where people with similar experiences share their stories support each other and do daily tasks to help manage depression. I am also part of a “depression team” on Facebook which is where I met Bonolo. Therefore my experiences are in line with those of participants.

Due to this background, I was able to easily identify with and understand the different constructions that participants present. Women basing research they conduct on their own experiences are able to have a clear understanding of the dynamics of the said investigation (Matsumoto 1996). Although I could identify with the participants, I refrained from imposing my insights on the participants during the interview by also not mentioning my own experiences with depression. I refrained from being vocal about my own

experiences with depression in order to allow participants to go into detail when telling their stories and not assume I understand what they mean and give incomplete statements just because I also experience depression.

Through reflexivity I have been able to reach a deeper understanding of the meaning of the phenomenon researched (Burns 2006). This suggests that as a researcher I was able to understand and identify with what the participants said due to my own experiences during the research process. There were times during the interview process where I genuinely related with what the participant had said and it is something that intrigues me, and I wanted to share my thoughts and opinions but refrained from it due to my position as the researcher. The focus remained on understanding the phenomenon from the perception of participants (Babbie and Mouton 2001). Therefore, much attention was focused on what was said and on keeping an open mind for understanding without imposing my own understanding on the subject matter. Additionally, during the data analysis, focus was on the descriptions, perceptions and insights of participants.

3.6. Data analysis

Data analysis is defined as a process in which a phenomenon is broken down into various components to be easily and better understood (Mouton and Marais 1991). Data analysis was done using case studies and thematic analysis. Thematic analysis assists in organising and summarising findings from a large diverse body of research (Mays, Popay and Pope 2007). Firstly, data was transcribed by me. Secondly, I examined transcripts closely, then coded and grouped into conceptual themes. Thirdly, clusters of themes were grouped together chronologically. Lastly, an intense analysis and theoretical arranging of themes occurred (Smith and Osborn 2008).

Additionally, case studies were used to interpret the experiences of each participant. By using case studies, I was able to closely examine the data within a specific context (Zainal 2007). The core nature of case studies is to explore, and a case study as a research method focuses on a limited number of events and their relationships to investigate modern real-life phenomenon by using a detailed contextual analysis (Zainal 2007; Rowley 2002). Case studies are a great way of looking at the world around us (Rowley 2002).

According to Yin (1984), a case study can be considered when the study answers questions of “how” and “why” and when the behaviour of participants cannot be manipulated. Additionally, a case study is relevant when contextual conditions are covered

because of their relevance to the phenomenon under study. Using case studies for this research was deemed appropriate because the project focused on investigating the perceptions and insights of participants, focusing on real-life experiences of people with depression and answering the question of “how” participants understand and cope with depression.

The discussion below will consider the authenticity of the study.

3.7. Trustworthiness

To ensure trustworthiness in this study, Lincoln and Guba’s (1985; 1986) criteria were used: credibility, dependability, confirmability and authenticity.

Phenomenography research is defined as an approach used to describe how a group of people understand a phenomenon in different ways (Marton 1981). A sample in a phenomenographic study must be suitable and relevant to the study (Collier-Reed, Ingerman and Berglund 2009); thus to ensure participants were relevant to the study, I used clear characteristics (black South African youth between the ages of 18 and 25 who believe they experience depression) for individuals participating in the study. To further ensure credibility, participants were from various backgrounds, which made their experiences different and unique from one another.

To ensure dependability, there were seven pre-structured main questions asked in interviews, which allowed probing to illuminate and highlight different and unique experiences of participants regarding the phenomenon in question (Marton and Booth 1997). Although interviews were semi-structured, participants were able to tell their own unique stories, which allowed participant’s experiences to be authentic.

To further ensure authenticity I personally conducted the interviews and transcribed the recorded interviews. The processes of analysis were described in order to establish an audit trail. In addition, to ensure and strengthen confirmability of the findings, quotations were used in the findings discussion in chapter 4 and 5.

3.8. Conclusion

This chapter explored the methods used for collecting and analysing data. Furthermore, it illustrated how the participants were selected and the approach used to analyse the texts. I noted that a qualitative method was employed as it was deemed as best fitted for this

study, which seeks to understand and interpret experiences of black South African youth with depression. Qualitative research enabled me to study the phenomenon in question holistically in its natural state, because it is multidimensional.

To gather data for the study, semi-structured interviews were used; this allowed participants to be co-constructors of the knowledge produced in the study. Participants were able to control to a certain extent how they told their stories within the perimeters set by me. The study focused on specific types of people, and therefore made use of purposeful and snowballing sampling to identify participants. Before commencing with the study, certain ethical requirements were taken into consideration, such as having the proposal approved by the ethics committee at UJ, having participants sign a consent form and give a verbal consent before starting with interviews, and lastly briefing participants about the purpose of the study.

This chapter also included a description of data collection. Interviews were conducted at the location of the participant's choice and at times that suited both participants and I. Interviews were conducted in English, and participants consented to conducting interviews in English. Given that I was aware of my own positionality, I avoided the expert role and imposition of my own insights to allow participants to tell their own stories.

Following on from this was a section on reflexivity which highlighted my positionality. It is important, in a qualitative study, for me to be aware of my subjectivity in order to account for the reasons for investigating the said phenomenon (Parker 1994). I am also a black South African youth experiencing depression, and therefore had to be aware of my positionality and the potential influence it had on the research. Therefore, I refrained from imposing my subjectivity on the data analysis and the interpretation of data.

The data was analysed by using thematic analysis. The collected data was read and re-read to get a better and more thorough understanding of the experiences of participants. Common themes were identified regarding the coping mechanisms of participants.

Trustworthiness was ensured by making use of Lincoln and Guba's (1985; 1986) criteria, which were credibility, dependability, confirmability and authenticity. Different approaches were used to achieve the above criteria. The study focused on different participants from different backgrounds which made their experiences peculiar and different from one another. All interviews were conducted in a similar manner by me. Additionally, I followed the Lincoln and Guba's (1985; 1986) criterion to ensure trustworthiness by extensively reading and being knowledgeable on the investigated topic.

Chapter 4. Experiences of black South African youth with depression

4.1. Introduction

This chapter will discuss the data analysis by making use of interviews and describe how the data was gathered and transcribed into written text. In order to respect the diversity of the participants' idioms of distress, I have chosen to first present a brief description of each participant and how they thought about depression before drawing out themes that were common.

Each participant's interview was analysed individually. Common themes constructed by participants were found; that focus on how they understand depression. The presentation of the study is led by how the participants describe the phenomenon. Following this is an analytical discussion of how participants understand and view depression.

4.2. Presentation of findings

The following briefly introduces the participants and gives an overview of their idioms of distress. Furthermore, I will discuss how their social background influences how they perceive depression.

4.2.1. Karabo "Depression is self-perpetuating"

Karabo is twenty-two years old and has been diagnosed with depression by a psychologist. He is interested in raising awareness about depression in order to show people; through him, that one can live a "normal, fruitful life" after being diagnosed with depression.

Depression for him personally meant feeling sad without understanding the reason behind his sadness. He used to find himself in a cycle of sadness because he is suffering from depressive thoughts. For Karabo, depression is "self-perpetuating" because it forced him to focus on himself excessively. He often found himself focusing on himself a lot after being diagnosed. Central to his narrative was this sense of enlightenment he got from engaging with the medical model.

> Until I actually went through it right and… what I noticed or what I realised basically is that like… it's a chemical imbalance in your brain…ahm there's certain ah neurotransmitters in your brain; serotonin, oxytocin… what? Dopamine, serotonin and something else… ah and if you don't have sufficient amount of…each or different levels of each that can… ah wanna make you feel depressed or… you know.

Karabo states that before being diagnosed he did not know what depression was; it was only after experiencing depression that he learned more about it. From the interview, it was evident that he is well-informed on medical approaches to depression and has integrated these into his understanding of depression. He speaks passionately about bringing awareness to other people and educating them more on depression. During the interview, he did not hold back but expressed himself, his thoughts and perceptions. He even went on to express how appreciative he was of this particular study because of his passion for awareness around depression. He has a positive outlook about his experiences with depression and it showed during the interview. He was talkative, eloquent, and communicative.

4.2.2. Masego "…it literally weighs you down"

Masego is a twenty-two year old, third-year student at the University of Johannesburg. She has had depression for two years and was diagnosed with it by a psychologist in her second year of university. For her, depression negatively affects her mentally, physically and emotionally. This consequently has an impact on her ability to do things she normally does and those that she really wants to do. Being depressed leads to her lacking motivation to achieve certain things like finishing her degree or simple tasks like being around with her friends.

> Everything that… you normally do… just doesn't interest you anymore, ahm… I know I was… I, I… cause even the people I was close to, I didn't want to… hang around them, I didn't want to speak to them, I literally wanted to be alone… ahm I felt no motivation to… finish this degree, to go to school, to go to classes even, I was like, 'I don't need this', I don't want to do this. And deep down you want to, it's not like you don't want to, but it's just… it's almost as someone is dragging you down or something is pulling you, like there's a weight on your shoulders and you just don't know what it is or don't know how to make it stop and it's a continuous thing. It's not… a one day thing, like 'ah today I just

> don't feel like going to school', it's today, tomorrow… the next day you know… and then maybe one day I will be fine *nyana* (for a bit), then it goes on and on.

She takes a more metaphorical approach than the previous participant, describing it not in medical terms but as a weight on her shoulders. She told me how people around her, such as her friends, had experienced depression and therefore she was aware of its existence and took it seriously. Nonetheless, she could not fully empathise with them because of her lack of knowledge on the subject. Thus, it took a long time for her to learn about depression and understand it.

During the interview, Masego stated that she eventually learned about depression after she was diagnosed. She was open about her experiences with depression, and welcoming. Masego seemed comfortable during the interviews, was very talkative and answered questions before they were asked. She offered to participate in the study after knowing the topic of my research and her willingness showed during the interview. She was at ease which I could tell from her body language: playing around with the chair, hand gesturing, side jokes and posture.

4.2.3. Anele "… a feeling of disconnection with people"

Anele is a nineteen year old student at the University of Johannesburg studying biochemistry and zoology. She is from the Eastern Cape, Umtata, and enjoys writing poetry and singing. Anele believes she experiences depression but has not been diagnosed by a psychologist. She views depression as mainly a feeling of disconnection from people, being down and unable to get out of bed. Her experience with depression impacted a great deal on her life in general and was apparent during the interview.

> Mm… ah… it's… a feeling of disconnection with people… yeah that's how I feel mainly. And you know the… the… being down most of the time… and not being able to get out of bed… yeah and it's… it's sickness not a choice, people… think that it's a choice… it's not a choice, you don't choose to be depressed. It's not like you can just wake up and… wear it out.

In the process of conducting the interviews, Anele was guarded and limited her responses. She seemed uncomfortable talking about her experiences with depression. It was surprising because she offered willingly to take part in the study but was not very communicative. It seemed as if there was a barrier between us. She was "crouching" in her chair and barely made eye contact.

4.2.4. Thando "… one of those things that you stuck with"

Thando is nineteen years old, originally from Limpopo but currently residing in Gauteng. She told me that she has experienced depression since she was sixteen. When she is depressed, she stated that she becomes filled with anger and resentment. This is due to her feeling unwanted and alone even if there are people around her. She wants to feel wanted and for those around her to show her care and give her attention because she can only handle depression but not get rid of it completely.

> My personal understanding of depression is… it's a… it's a condition… that… doesn't go away… you know, you can't treat it but it's one of those things that you stuck with for a very long time. The treatment of it isn't like making it go away, it's more like being able to handle it… being able to… live and cope with it.

She perceives depression as a condition that is not treatable and one that you have to live with forever. In the course of the interview, Thando showed her willingness in participating in the study; she was open and vocal about her experiences even though they still deeply affected her. She was emotional when talking about her experiences. However that did not hinder her from sharing her story. Even though she was very communicative and vocal, she also seemed a bit guarded, and that was evident in her body language and posture: she avoided eye contact, looked down and crossed her legs as she rocked back and forth while talking.

4.2.5. Masedi "depression is like the weather"

Masedi is a twenty-five year old from Pretoria, Silverton. She works as a ghost-writer in the media industry. She was diagnosed with depression in October 2018. She described depression as being like Cape Town's or Europe's weather where one minute it is hot, the next thing it is cold and raining. She contends that, with depression, you become numb to everything and no longer have interest in things that you used to love.

> …well for me depression is like a feeling… no no no, actually let me just say depression is like the weather. Mm one minute is hot, Cape Town weather or Europe weather, let me use that. One minute it's hot, the next is ahh mmm cold, the next is raining… so yeah you don't wanna do anything, you become very

> numb to everything. Things that you used to love or interest you they no longer interest you anymore.

Before being diagnosed, Masedi used to write a lot but eventually realised that she could not concentrate anymore. She did not want to engage in activities she used to love because she finds herself with racing thoughts in her mind. She tends to feel numb and avoid doing anything.

She was calm and nonchalant during the interview but she was also friendly and open about her experience with depression. During the interview she remarked on how calm she was for the past few months, as she is usually anxious. She seemed comfortable but also distanced. She was very assertive, and confident but not in a threatening manner.

4.2.6. Dineo "… you can manage it… you can live with it"

Dineo is a twenty-one year old currently residing in Johannesburg, but originally from the North West Province. She was diagnosed with depression eight years ago; however she did not know what depression was then. She got to learn more about depression after being diagnosed. She claims that even though it is not curable, one can live with it.

> Well, according to my understanding, I'd say depression is… more of… ah… how do I put it? ... Psychological mental illness… it's…you can manage it… it's not like, you can't… you can live with it and it's very… I can't say… it's… you can't cure it, even though you think that because there are times where I think, 'yeah am done with depression', then boom, it comes back. So it's not something that… it… that goes away…

Even though she feels depression is not curable, there are times she feels that she has conquered it. However, because it is not curable, it comes back out of the blue. For Dineo there are different levels of depression that she finds herself in and it is not just a single phase. She argues there are different stages of depression that she has experienced. There are stages were she feels numb and wants to be left alone, keep to herself and not do anything. At other stages she feels emotional and wants to cry. She described how she goes to the extent of cutting her wrist. At other times she has suicidal thoughts. Therefore, she goes through different experiences of depression which evoke different emotions and actions.

During the interview, she was emotional and seemed sad about her experiences with depression. She was very calm; she spoke softly and in a lower voice. She often spoke indirectly and not explicitly; she would find “nice” words to describe something. She kept trying to find ways to say things in a polite manner. For instance, according to her psychologist, her mother was emotionally abusive towards her and when she stated that, she paused to found a polite way of saying it, such as ‘my mom… is not a very nice person’. She indicated during the interview that she is still battling with her experiences.

4.2.7. Rendani “…depression is a very complex thing”

Rendani is a twenty-one year old second year student doing Psychology at the University of Johannesburg. She has been living with depression for seven years now. She indicated that she experienced depression at the early age of ten years old and at the time she did not know what depression was. She is interested in resolving issues regarding depression across all races and gender.

> I had to be… diagnosed for me to believe that depression is real because in the longest time ever…all I had, all I did was to… overdose and I thought it’s a good thing to do because I didn’t have an insight on depression.

For her, depression is no longer being interested in things you used to love to do and not doing them the way you used to. She stated that when depressed, you get tired all the time and have headaches. Additionally, she said that you constantly have severe thoughts, including suicide, harming yourself or thinking badly about others to make yourself feel better. As a depressed person, she feels, you harbour resentment but misplace the anger by directing it at everyone. Her understanding came after being diagnosed. She told me how she had to be diagnosed with depression for her to believe in its existence. She was always aware of her experiences with depression but could not identify them as depression, which prompted her to constantly question what was going on with her, why it had to be her going through difficulties, and whether it would ever end.

She seemed to still be going through hardships and difficulties because she believes being depressed has changed her into a different person. She has embraced that different version of herself. For example she decided to stop dating because she believes her personality places strain on her relationship, and, because she is still struggling with depression, she cannot fully commit herself to a relationship. She was very honest and open about the kind of person she is during the interview. Rendani was communicative but

indicated that she does not like public spaces and because the interview was in a public place, she stated that she was not comfortable and could easily get irritable. Therefore, to an extent she was guarded; her eyes were fixed forward and she avoided eye contact.

4.2.8. Bonolo “depression for me is a state of mind”

Bonolo is a twenty-four year old. She told me that she was suffering from major depression, Post-Traumatic Stress Disorder (PTSD) and anxiety, according to a psychologist. The first definition of depression she got was that chemicals in her brain are imbalanced and she needs medication; however different things can impact those chemicals to cause them to be imbalanced. She stated that she allows her mind to be medicated in order to regenerate.

> Ok, well… depression for me is a state of mind. So how you acquire depression is through various lifestyle traumas or situations that put you in that state of mind. But when I say… personally when I say, [I] am depressed it doesn’t mean that am sick or anything. For me, it just means am in a state where my mind needs a deep rest. Like, it needs to recover, essentially for me cause my depression came later… cause of like trauma, I realised that there were chemical imbalances in my brain that made me feel like… it’s all medical for me… like it made me feel worse than I was supposed to feel and it is your body’s way of needing rest, that deep rest that your mind needs is the reason why you feel this way. Or at least why I feel this way. Taking my meds and seeing professions and getting help is my way of allowing my brain and my mind to rest and recover from those traumas even if they do take a long time because the process, is a long process. Like with therapy and all those things. So for me is just a state of rest that you allowing yourself self-care, you’re allowing yourself to put yourself first and you allowing yourself to get better because you undergone or gone through some trauma or something…

For her depression comes and goes, so there are times when she is really happy and times when she is down. However there is a consistent feeling of numbness, emptiness, fear, dread and overthinking that does not go away no matter her mood. Therefore, she said, her mind takes time to focus on itself because the brain is meant to do multiple functions; therefore focusing on itself to take a deep rest is something outside the brain’s “normal” function.

Bonolo has embraced her experiences with depression. She was very eager to participate in the study because she also likes to educate people about depression by sharing her experiences. She was very communicative and passionate when she spoke about her experience and her knowledge of depression.

4.2.9. Coming to terms with experiencing depression

One of the things that struck me in the descriptions above is that participants conceptualised depression in many different ways. In addition some struggled to come to terms with explaining their experience as depression. Several participants refused the notion that they are depressed, and struggled with accepting the diagnosis they had been given. Even after being told that they are depressed and formulating an understanding of what depression means, they still refused to accept that they are depressed because they did not believe that they fit the description of people who experience depression, for instance being weak, not intelligent and sad. In one instance, Masego expressed struggling with the term depression before she could accept that she is depressed.

> Ahm… I think once I've passed through the denial phase, I mean I think… I was always someone who was very… strong-willed and my character was like that. So for me… I was almost in denial because am like, 'Hai this is a sign of weakness was not for me [both chuckle]… am strong so, it can't be me …am okay, am just having a bad day'. Ahm so I'd always push away any form of negative emotion. Ahm before the whole depression, I think it was probably another problem 'cause everything would just build up and build up over years, cause I was like, 'nah am a happy person, am fine' …'leave me alone, depression' whatever… you know and I think overtime… once I passed the denial phase and I was honest with myself … am like, 'okay, look am stuck, am in a mess, what is wrong' (Masego, Interview 5 February 2019).

Being in denial was caused by the character she built for herself; thus she saw depression as a sign of weakness and because of the image she built for herself, she did not believe she could have depression. She saw herself as strong-willed and a tough person who does not give in to negative emotions.

> Any negative emotion when, like, when I was unhappy or when am sad, am like, 'these are negative emotions, I don't wanna associate with this', so am not sad, am not unhappy, so obviously I wasn't gonna accept am depressed as well

> because even I was angry I'd get upset at myself for getting angry because I was under the impression that…strong people that have their life together, only have positive emotions (Masego, Interview 5 February 2019).

After her denial phase, she introspected and was able to be honest with herself and realise that she was not okay; she was stuck and did not understand what was going on. She described how she had to remember how she got into the depressive state she was in and decided to go see a psychologist where she was diagnosed with depression.

Dramaturgy by Goffman (1959) is evident, as Masego was in the front stage not acknowledging her depressive thoughts in front of people. Even when her scholarship funders advised her to take a break from her studies, she refused and claimed that she is doing fine. She used the front stage as a way to convey that there was nothing wrong with her while hiding what she was really feeling.

Similarly, Karabo refused to believe that he is experiencing depression because of labels he put on himself. Before experiencing depression, Karabo was an entrepreneur and had two start-up businesses, both incubated. One of the businesses had funding and the other had a patent. He was in a great long-term relationship with his girlfriend and was excelling academically. He was a head academic advisor at his residence. He held himself in high regard because of these things and defined himself in accordance to them.

> … so…I was an entrepreneur right…ah I had two start-ups…ah both incubated, one had funding, one had ah… patent…ah I had really ah… what I thought was a really great relationship at the time with my long-term girlfriend… were dating for like two and a half years. Ah… I was really good academically… but I was ah… the head academic… the head residence academic advisor at my res… ah so things like that, right. So, I held myself to those things and those around me, knew me as that person… you get me. So that… when those labels…like… kind of went off the table and I broke up with my girlfriend, when I started failed and I later on resigned ah… from the other start-up, when my academics went south because of everything happening… all those labels were gone…socially it's like, 'whoa who am I' (Karabo, Interview 11 February 2019).

When he lost his girlfriend and those labels started to fade and he started failing at school and later resigned from both his businesses, he then began to question his identity, because the labels he had put on himself were no longer there. Anele also went through a similar thing to Karabo, because of the labels she placed on herself; it was difficult for her

to deal with depression. She fell pregnant and started failing at school and because she was a “straight-A” student and smart, she struggled to cope with failing for the first time in her life. She was upset with herself for getting pregnant because she believed that, because she is smart, she should not have put herself in that situation. Therefore, she avoided people because the image she built of herself; a straight-A student, who always had things together, was fading in her eyes.

> Yeah, being in that situation and being alone, I was… alone in that situation because … ah… am this smart student so, am supposed to know that… it… how can I get into that situation, as smart as I am, how can I fail? Failing for the first time in your life, getting straight A’s for your entire life and then… failing… for the first time, it was… so I couldn’t talk to anyone cause… I always have my… stuff together… ‘So how did I get here?’ (Anele, Interview 13 February 2019).

When she was depressed, she went through the experience alone at first because of the image she had built of herself. Anele described how she likes being alone with her thoughts and tries not to engage with people because of the “shame” she believes she has brought upon herself. When in the back stage (Goffman 1959), she is able to be true to herself about her depressive thoughts. When alone she is able to engage with her depressive thoughts and acknowledge their existence and that she has depression. When in front stage, she refuses to accept that she might be depressed, and maintains that by avoiding talking about her feelings. Even though her peers were aware that she was not okay, she refused to see a psychologist. She stated that she “ran away” from seeing a psychologist after her friends suggested it.

This section indicates how these participants found it difficult to accept that they might be depressed because they integrate depression with who they think they are. However, eventually they had a moment of “coming out” whereby they, in a moment of “awakening” or “enlightenment”, move from denial to acceptance that they are experiencing depression, finally being true to themselves about their depressive feelings.

Participants explained that their difficulty accepting depression as an explanation for their emotions was also caused by being ashamed of admitting to having depression, due to their sense of who they were. Additionally, the difficulty was caused by the societal expectation that people should always be happy, and participants describe a clear front and back stage in line with the theory of dramaturgy. This was also caused by stigma

because they did not believe that people with such positive labels could be depressed. Therefore, participants used various metaphors, some received and others of their own, to make sense of depression and how they chose to cope with it.

One of the key reasons that participants gave for their negative association with the term depression was because of popular understandings of depression that they had grown up with. In the next section I will describe these popular understandings and then go on to look at how participants critiqued them and created new meanings of depression. The following discussion is on two different discourses in which participants conceptualise depression.

4.2.10. Received discourses

Participants made sense of depression by basing their perception on how people they interacted with over their lives perceived depression. Therefore, these are discourses received from their social background, which have influenced some participants in their understanding of depression. People who form part of some participants' social background understood and perceived depressive symptoms from observing people experiencing depression. They claimed that growing up, depression was conflated with being a drunkard, a [drug] addict or a crazy person. This is similar to the findings of Ben-Tovim (1987); Moroka (1998); Seloilwe and Thupayagale-Tshweneagae (2007) whose participants argued that symptoms that may be understood as depression were believed to be caused by paranormal things such as 'punishment for sins, witchcraft and evil intentions by the punishment from Gods and ancestors, sorcerers, rituals and charms, possession of bad spirits' (Moroka 1998: 9). Still other participants from Modie-Moroka's (2016) study thought the cause of depression included using marijuana or alcohol, genetic causes and as a complication of physical illness (the illness has gone to the head) (Modie-Moroka 2016). In one instance, because Thando was aware that her community viewed people with depression as "crazy", she then hid her experience with depression out of fear of being called crazy. Even though she believes people have "evolved" and now understand what it is, she did not let go of previous stereotypes of depression when she encountered it herself.

> It's been coming out that depression is an actual thing; it's not that… like that time when your parents didn't know what it was… you know. So when… when I first encountered it, people had… an idea of what was going on and they knew that… being… called crazy isn't the way to go about it, you know. I think for me,

> at that time, it was me judging myself… and being like, "if I do this, they gonna think am crazy" (Thando, Interview 18 February 2019).

Therefore, the community's idiom of distress has affected Thando's reaction to her experience with depression initially; however, people around her grew to accept her illness. In another instance, how people around Rendani and her family and friends viewed depressed people influenced her perception of people with depression and psychiatric clinics.

> So… when… the minute I got into a psychiatric clinic, I was like, "what… what am I doing here?", because people who are here… are people… well I myself thought people… who only go to psychiatric clinics are crazy [Both chuckle], that's what I thought (Rendani, Interview 8 February 2019).

Apart from people thinking that those with depression are crazy, others claimed that people around them believe they are bewitched and this explains their behaviour. Pretorius (1986) and Savov (1997) stated that, in South Africa, depression is commonly believed to be caused by witchcraft, ancestral wrath and failure to honour cultural practices.

> So, if you have issues, it's because you are bewitched. That's it, you don't have depression… I mean what is depression in the black community? (Rendani, Interview 8 February 2019).

> So my society… or my community made me look… at… those people who go there as people who… are actually weak… or people who don't want to admit that they are bewitched (Rendani, Interview 8 February 2019).

> You know how black people are… to them it's either… you're alcoholic; you're bewitched (Anele, Interview 13 February 2019).

Therefore, depression is conceptualised in racialized ways which ultimately influence how those with depression react to their experiences with depression. However, with Anele the received discourses from her social background led to her self-judging, and, unlike Thando, she still does not talk about her emotions. Some of the received discourses included the following:

> You know how black people are… to them it's either… you're alcoholic, you're bewitched [Both chuckle]… you know, all that… or… *ufunde kakhulu* (too

> educated) (Researcher: Yeah)… yeah. So, I'd like to think black people don't really… understand (Researcher: Yeah)… it's like you a spoilt child or something (Anele, Interview 13 February 2019).

Additionally, for some people being "too educated" can lead to depression, as Anele expressed. This resonated with her because she is a straight-A student, so people told her she is depressed because *ufunde kakhulu* (too educated). This education is racialized as we see in her expression 'You know how black people are,' thus associating depression with increasing education and associated whiteness. The influence of how participants understood depression goes beyond the physical community to include the virtual one; this includes movies or series people are exposed to. In one instance, Thando expressed how movies also had an impact on how she perceives people with depression or people who visit psychologists. Using past experiences, such as an old movie she watched growing up that portrayed people going to see a psychologist as crazy, led to her believing if she became vocal about her depression, others would perceive her as crazy:

> It was just something from the inside plus it was my first encounter with it and when we were growing up seeing… watching movies and everything, people would always be like… 'The psychiatrist thinks am crazy'… you know. So it was stuff from there that I was like, 'oh my gosh now I gotta go through the same thing'… and… people will think am crazy… you know. It was me… acting from past knowledge or… stuff that I've seen before, actually understanding what the entire thing was about (Thando, Interview 18 February 2019).

My participants have access to popular culture and internet that provide other possible meanings (positive and negative) to those they grew up with. Thando used popular culture to make sense of depression and what it means. By doing so, she judged herself even though she claimed that she has not experienced judgement from those around her. Despite her self-judging, it still did not prevent her from talking about her emotions.

Participants had different and common metaphors and idioms of distress to express their emotions and feelings in relation to how depression affects them. Participants defined depression in various ways, which ultimately affected how they chose to "manage" or "cope" with depression. However, it also allowed them to find their own discourses in an attempt to understand depression and not base their knowledge about depression only on the received discourses. Neither the biomedical nor the received idioms of distress had

positive meaning for my participants; however many of them did find new positive ways of making sense of their distress, which will be discussed in the next section.

4.2.11. Owning depression discourses

Although all participants were aware of the term depression, they nevertheless conceptualised depression in their own ways, according to how they feel when depressed and the meaning they attribute to those feelings. Participants defined depression using their own discourses in the form of metaphors and idioms of distress different to the received discourses to make sense depression. According to Refaie (2014: 150) 'metaphor is a fundamental property of all human thought, which allows us to understand abstract areas of our lives in terms of more concrete and embodied experiences'. Metaphors are figures of speech where a word or a phrase is used to define something in a different way from its normal definition, making an implicit comparison (Soukhanov 1992). Idioms of distress are ways to experience and express distress that is socio-culturally accepted (Nichter 2010). In different contexts, different things are seen as normal, such as depressive symptoms, and one of the problems is this universalises what is normal; however participants have shown how they distance themselves from what is deemed as normal with regards to depression and rely on their own experiences to make sense of things. They rely on personal and cultural meaning, and the values of society have an impact on the idioms of distress (Desai and Chaturvedi 2017).

4.2.11.1. Depression as a weight

Participants used different metaphors and idioms of distress to describe their experience with depression. Those that are unique to them individually and their experiences were influenced by their own personal perception of depression. Some participants used metaphors such as depression weighing you down, mentally, physically and emotionally. The following is one example of such a metaphor:

> It literally weighs you down on you, mentally, physically, emotionally… (Masego, Interview 5 February 2019).

> … it's almost as someone is dragging you down or something is pulling you, like there is a weight on your shoulders, and you just don't know what it is or don't know how to make it stop and it's a continuous thing (Masego, Interview 5 February 2019).

Describing the feelings of depression as sinking and falling usually reflect both embodied experience and dominant cultural values. Being “down” is not only connected to illness and death but with low status, moral deficiency and lack of individual agency and power (McMullen 2008). Masego expressed how she was doing well academically and even got a scholarship, but as time went by her marks started dropping, but she was supported by people from her scholarship. They suggested she take a semester off and rest but she refused and continued, and wrote a few sick tests because she was barely coping. This led to her realising that she was not okay and that challenged the person she thought she was. She saw depression as a sign of weakness and because of the image she had built for herself as successful and competent, she did not believe she could have depression. She saw herself as a strong-willed and tough person who did not associate with negative emotions. Due to this image, she believed herself to be a happy person, and thus she only associated with positive emotions. Therefore for her, being “down” meant weakness, which correlates to how depressed people, as mentioned above, view being “down” or lacking the strength to rise above the weight.

Other participants expressed how depression affects them not only mentally but physically. As you feel depressed, simultaneously you feel drained physically and lack motivation to do anything. This leads to some of them choosing to be by themselves and always alone because of the lack of energy even to engage with friends or family.

4.2.11.2. “My case of sadness”

As mentioned above, metaphors and idioms of distress are ways in which people make meaning of their experiences. In one instance, Thando described her depressive feelings as a different kind of sadness. She indicated that her sadness was different from that of her peers, which alarmed her friends and teachers that there was something more serious than just “sadness”.

> Yeah, definitely… when… I was in high school… I was with… friends who were in a similar situation… they weren’t depressed or anything I mean… they also went through times of sadness… and I think it was them that I could tell that there… there’s a huge difference between their type of sadness and my type of sadness at the time. So, they were the ones who actually… at the time I thought it was okay…I thought, ‘no I was… am just upset… like everybody else’… but my friends were actually the ones who would go speak to the teachers and let them know that, ‘listen… something isn’t right’… and it was actually my

> teachers who then came to me and sat me down and were like… 'You know these are the types of stuff that you do… when… when stuff like this is going on because you're... I don't know; let's say 'your case of sadness' (Thando, Interview 18 February 2019).

Her depressive feelings denoted a different kind of "sadness" that was unfamiliar, which led to people around her to try and understand her kind of "sadness" through the use of that metaphor. Sadness can be caused by various phenomena, such as disappointment, rejection, separation even if it is temporary, or the loss of a loved one (Bondolfi, Mazzola and Arciero 2015). Thando experienced adversity through bereavement. In this case, Thando lost her boyfriend to a car accident which led to her kind of "sadness". For her friends and teachers to view it as a different type of sadness was due to her reaction to her hardship that was foreign to them, because it was a different kind of "sadness" to the one they usually deem as normal after going through adversity.

4.2.11.3. Brain taking over

Bonolo had a particularly unique idiom of distress. She uses the phrase "state of mind" to make meaning of her depression. She describes how usually the brain is selfless and takes care of everything around it, but with depression it takes time out of its normal schedule to focus on itself and that interrupts its routine. The brain usually sends out instructions to do tasks, but when depressed there is a breakdown of communication and instructions are not sent from the brain because it is focused on healing itself. She argues that depression is caused by traumas that affected your brain and now you take an initiative to focus on it to make it better, in order for your brain to go back to being selfless, because depression leads you to being selfish.

> The brain is like a selfless person that is constantly taking care of everything around it and then when you only focused on your brain and only trying to make your chemicals balance then it's kind of like… oh my gosh what am I doing… how am I supposed to do this. So that's why your medication and your treatment always feel worse before they feel better because you need an adjustment period for your rest. That's how I consider depression, my understanding is you've encountered a trauma or you've encountered something in your life that has now made you… made your brain sick… made your mind sick. And you need to take initiative… you need to take steps and measures to actually go give your mind the rest that it needs, the medication

> that it needs, so that you can now allow yourself to be self-less for other people. Being depressed essentially makes you very selfish because if you don't take care of yourself you end up killing yourself or worse you end up killing people around you and harming those around you because you can no longer function (Bonolo, Interview 10 December 2018).

She personifies her brain as an autonomous reflexive being that can take decisions and get sick, independently of the rest of her. When she feels depressed, she believes she is in a state where her mind needs deep rest. For Bonolo, self-care is very important because it allows you to take better care of yourself and put yourself first. Bonolo stated that you self-care because of the trauma that has made you unhappy and continues to constantly make you unhappy and affects the way you live your life.

4.3. Conclusion

This chapter has introduced the participants and described their idioms of distress. Many used the biomedical model but some also resisted it and popularised it in their own way. For instance, participants understood depression away from the biomedical model and conceptualised it as a weight, a case of sadness and a brain taking over. Participants tried to distance themselves from the received discourses such as perceiving depression as a result of witchcraft, alcoholism and madness. Even though their surroundings produce certain perceptions about depression, participants emphasised relying on themselves to be more knowledgeable about depression, allowing them to form their opinions outside their social background. The conceptualisation of depression has eventually affected how they choose to currently manage depression. These are, in a sense, young people going through transition, living across multiple meaning systems and integrating them.

In the next chapter, the themes relating to coping strategies are interrogated, interpreted and discussed. In addition, I link the identified themes to the to the literature reviewed and the theoretical framework by showing how some participants deal with their depression by dissolving the distinction between back and front stage.

Chapter 5. How black South African youth cope with depression

5.1. Introduction

In the previous chapter I discussed how participants understand depression. This chapter will consider the coping mechanisms that participants used in light of their understandings of depression.

5.2. Hybridisation of coping mechanisms

Participants used multiple coping mechanisms when dealing with depression. They used a number of methods before settling on those that best suited their personal needs. The key point is how they integrated different world views in order to manage depression. While in the process of finding the best coping mechanisms, participants also found other coping strategies that were not beneficial to them. Therefore, according to some participants, some coping mechanisms failed to help them cope with depression. The following is an example of that.

5.2.1. Therapy and medication

As part of integrating different methods, finding those that best suited participants and leaving those which were believed to be unhelpful for them was part of the process of finding methods best suited for coping with depression. Most participants had at some time tried therapy and medication. However, although there were those that found therapy and medication helpful, findings in this study indicate that most of the participants do not believe that therapy works for them. A common theme among participants was scepticism about therapy and medication because they were afraid they would be dependent on both of them if they used them to cope with depression. There are those who left therapy altogether to focus on other ways to cope with depression. They decided to cope with depression by finding ways better suited for them because they did want to depend on someone else (in this case, the psychologist) but want to rely on themselves. This is a statement from one of the participants:

> Researcher: Okay, so when you feel depressed or you feel like you becoming depressed, what do you do, apart from going to see a therapist?
>
> Masego: Oh yah… yah I actually haven't… like right now, I've learned to self-help myself, like I don't really go anymore. Ahm 'cause I felt it was important for me to find a sustainable way that… I don't… really become dependent… on them or her (Masego, Interview 5 February 2019).

Participants wanted to find different ways to cope with depression and not depend on therapy because they do not want to end up being dependent on the psychologist. Similarly with medication, findings show that most participants either refused to take medication or do not use medication anymore. Again this was due to fear of depending on it in the long run because of experiences of other people around them who take medication. The following is one example:

> I refused to go on anti-depressants, ahh because …mainly because I felt like eventually I will get dependent on them [Both chuckle]. I've seen cases where people actually get dependent on them, so I don't wanna be part of that statics, yeah (Masedi, Interview 2 February 2019).

The study indicates that participants prefer being left to their own devices to deal with depression, rather than being dependent on either therapy or medication. They prefer self-care over everything, and to take control of their mental health. However one participant refused to go on medication for a different reason:

> Yeah, I just went to therapy, yeah I wouldn't take anything… ah no. Also I was donating blood, like I was a regular blood donor and stuff, ahm… so I didn't want anything to interfere with that. Ahm… I wanted to continue donating and I had low iron at some point, so am like, 'okay, what if I take these, what if they have side effects'… ahm what if I become dependent on them, ahm so I was completely against… taking them… ahm I, I wanted to rather find… alternative coping mechanisms (Masego, Interview 5 February 2019).

In addition to being afraid of being dependent on medication, Masego was also afraid of being unable to donate blood due to medication. Therefore, the solution was to find other ways to cope with depression that would not jeopardise her donating blood.

For other participants, they used therapy and medication after failing to cope with depression on their own. They therefore began making use of therapy and medication to

help manage and cope with depression. However, when therapy and medication did not work for them they opted for independent coping methods. Participants finding other ways to cope with depression are similar to the participants in Sulaiman et al.'s (2001) study, who preferred to use a range of methods such as praying, talking to a relative or reading a religious scripture rather than going to a psychologist. These were Arab men and women who thought there are better ways to cope with depression owing to lack of faith in psychologists. Similarly to participants in the study, participants reckoned it was better to find their own methods, due to being sceptical about therapy and medication.

5.2.2. Self-help

Given the scepticism about mainstream psychological interventions described above, some participants looked for other sources to cope with depression. In other words, the consequence of this model or understanding of main stream psychology led to self-help. What is interesting about all these different themes is that most people focused on quite individual strategies for coping, which were not about reaching out but self-care.

In the study there were participants who talked about what might be seen as negative coping strategies such as self-harming, use of drugs and alcohol. The study will focus on two key strategies that participants used: relying on social media and 'cleaning house'. However, first I will briefly discuss the aforementioned coping strategies deemed as negative.

5.2.2.1. Unhealthy coping strategies

Participants engaged in various methods before settling on those deemed beneficial to them. People's understanding of their illness or symptoms is associated with the way they choose to manage their illness and their coping mechanisms (Kasi et al. 2012). The findings indicate that those who did not understand that they were depressed or "extremely sad", those who felt hopeless trying to manage their depression and those who expressed that they were in denial about having depression, engaged in unhealthy coping strategies. However, some are aware that their coping mechanisms provided an instant relief although the mechanisms are unhealthy and eventually led to negative consequences. For instance to try and numb the pain of depression, some participants resorted to overdosing on pills, substance abuse and "partying". These are ways they used to try and forget about their problems, which, however, provided only temporary relief. Self-harm is another way of coping with depression that one participant described using. When in an emotional

state, Dineo for instance turns to self-harm practices such as cutting her wrist as deep as desired to ease her depression. In another instance, Masedi uses alcohol when she feels depressed to try and ease and forget her problems. She expressed that going to therapy is a decision one needs to take for healing and she has not taken that decision. Therefore, she prefers to cope with her depression her own way, and drinking alcohol is part of that even though she is aware that it is not a healthy way of coping, it works for her for now.

Some of the ways participants use to cope with depression relate to the theory of dramaturgy (Goffman 1959) for instance, making use of alcohol and partying can be regarded as a front stage. Participants engage in these methods to try and block out or escape from their depressive thoughts or to present themselves as happy and outgoing, when in fact they feel completely otherwise. They do so by acting in ways that seem "normal" to others while trying to hide how they truly feel. Here is an extract of one typical example:

> Yeah, it would either be alcohol… or… tablets you they make you fall asleep. I know that… allergex… if you take certain amount of allergex… you will fall asleep. So it used to be like alcohol… constant partying… my friends and I would always be out… not because it is fun… or anything but because you constantly want to get away from home… or getting away from… your thoughts, and being away from all that. Being around people really… does… take it away but the point… at that point it wasn't healthy. 'Cause I mean… you… you are getting away from your thoughts, at the same time… you creating bigger problems for yourself (Thando, Interview 18 February 2019).

Alcohol or partying makes them happy for that moment, thus they act in a way different to how they feel. For instance Thando partied to try and forget about her depressive feelings, but as soon as she was alone, she would stop suppressing those feelings. She would go out clubbing with friends a lot and drink alcohol excessively. Additionally, those that used pills or cutting themselves might be using that as a back stage because they usually do that when alone (Goffman 1959). They get to engage with their true feelings and act in ways to try and cope with their feelings but they do that away from people. When they are alone, they are true to their feelings and emotions, as Rendani mentioned that she waits until she goes to sleep to "overdose[2] of pills" so her family might think she is sleeping.

[2] In this case she uses overdosing to cope with depression. She struggled to sleep due to her depressive thoughts, and therefore she overdoses so she can fall asleep; this was not an attempt to commit suicide.

Therefore, they avoid company when they start to feel depressed and go to the back stage to express how they truly feel; in this case their bedroom is the back stage (Goffman 1959).

According to Orzechowska et al. (2013), some people with depression use ineffective and avoidance methods to cope with stress instead of healthy mechanisms. These authors argue that depressed people are more focused on relieving emotions; therefore they find quick ways as an attempt to cope with depression, such as alcohol, overdosing on pills and cutting themselves. However, Rendani created a personality that helps her cope when depressed. This personality shields her from feeling certain emotions and avoiding certain situations. She uses this personality as a mask and is a different person when she has this personality on.

> Because when you depressed and it eats you up for the longest time…you end up building… like… you… I don't know if it's you building a personality… that saves you from being too depressed. So it's… to me it's like I created this personality. I wouldn't say it's an angry person…but a person who is so mad at a lot of things… and I just decided… am gonna have this personality that… looks and really feels like they don't care. But when I know *gore* (that) another part of me… cares, but when I play this personality… I can't say I have two personalities… I don't have borderline personality mental illness. But… I created… a person that I can cope and some… a person that can take whatever that comes her way. And also I'll be this vulnerable person but when I have that person full on and is in control, it's like I don't care. If am telling you, 'you did this' … you don't decide if you did not… because yes you did it and it affected me, you can't say no, it didn't affect me, you are not me (Rendani, Interview 8 February 2019).

This relates to Goffman's theory of dramaturgy, where people often have two stages in their lives, the back stage where they are their real self and the front stage where they portray a totally different person (Ritzer 2008). Therefore, the participants often portray a different personality to who they are in order to protect themselves. When in an emotional state, to avoid being deeply affected, they put on this mask of personality and that helps them become stronger, firm and sometimes fuming with anger and resentment. This mask can be regarded as a front stage (Goffman 1959) because Rendani uses it to avoid being affected negatively by emotions; to suppress her true emotions, she puts on a mask to

portray different emotions that makes her feel stronger and firm as opposed to feeling emotions of sadness or pain. She uses this strong character to avoid being vulnerable.

Others prefer to be alone and even though it is not as intense, participants still perceived that as unhealthy. Some participants tried to escape their depressive thoughts; therefore some prefer being by themselves or sleeping to quieten down their thoughts. In an attempt to escape from depressive thoughts, one participant, Karabo, uses the term “manic defence” to describe how he coped with depression. According to Karabo (2019) manic defence ‘…is that like you fill your time with activities, right… so as to stop negative thoughts, beliefs from entering your consciousness…’ He filled his time with exercising and going to the gym a lot; it benefited him in the long run because he was into the habit of exercising and being healthy. Nonetheless, Karabo was unable to forget about his problems and this had severe consequences, because the main reason for him to be manic was to run away from his thoughts.

However, for Thando, being alone is not viewed as negative or unhealthy when compared to how she used to cope with depression. Before she used to party and drink; however now she prefers being alone as a better way to cope.

> So most of the time, I just detach from people and sleep. I’ve… I’ve definitely come to a point where I don’t use alcohol or substances to… to help myself… I don’t… I don’t want to do that anymore, I don’t do it anymore. So the best thing now for me is to just stay away… from human contact… just for that little, until I can understand what’s going on. I would… I would turn to books; I would turn to something but at that moment… (Thando, Interview 18 February 2019).

When in a depressive state, Thando prefers being by herself and going through her emotions away from people. Therefore, she uses the back stage to engage with her depressive thoughts and prefers to do it away from people, thus people do not get to see her being depressed but only experience her when she is not depressed (Goffman 1959). Therefore, even though being alone to others is deemed as unhealthy, for Thando it is a better way for her to handle her depressive thoughts. Therefore, what works for others, do not necessarily work for all as evident from how Thando chose to cope with her depression as opposed to others who regard it as unhealthy.

5.2.2.2. “Cleaning house”

For a better quality of life, participants expressed doing what one participant named “cleaning house” to cope with depression. This involves a variety of methods employed as a way to manage depression in a healthy way. “Cleaning house” is a method used to work on and focus on themselves to get better. It is also used to deal with participants’ emotions and their inner person as they do for their physical body. It is basically about changing their environment and taking charge of it; getting rid of wrong people or old habits. This is a distinctive example of “cleaning house”:

> Well for me first thing is also like you cut ties from those toxic things that like …put you in that state of mind. For example for me, like I can’t go to certain hospitals because it triggers me, like I can’t, I can’t see certain people because during that time those people would make me feel worse. So I’d just cut ties completely with them ahm I call it cleaning house. Like I clean, I clean my house essentially I get rid of people who make me upset, people who don’t know how to be sensitive or who… just don’t know better, ahm I get rid of them. I bring closer the people who bring me peace. Peace is really important… mmm for me, for my character, for example I have a very high stressed job, very demanding occupation, very demanding family. So for me I need to be able to find like a safe space, like a happy space. Where my phone doesn’t exist, my friends don’t exist, my partner wouldn’t exist, like no one exists but me and my happiness and my joy. Some place where your thoughts, your bad thoughts are not welcome. And that came to me via allowing myself to actually rest, like take time away, I would take a holiday, a walk, read a book, ahm those things, peaceful things that make you feel good (Bonolo, Interview 10 December 2018).

“Cleaning house”, for this participant, involves getting rid of negative things that do not help in coping with depression and rather focusing on the self. This includes not talking to certain people, avoiding going to certain places and avoiding negative comments people make about depression. It is mainly about focusing on the individual and what is best for them and doing simple things such as using a different perfume to feel empowered. “Cleaning house” is used to let go of the negative things that worsen an individual’s depressive state and invite positive energies to help better cope with and manage depression. Another example of how a “Cleaning house” is conducted:

> I surrounded myself… and this was over a process of like… kind of introspecting and seeing like… I didn't do this, but I like… I think subconsciously I did this… I had in my mind like columns… for people that made me feel like great, people who made me feel neutral and people that made me feel bad. And I'd focus my time… I'd invest my time and spending time with those that made me feel great only right. Then later on I went on to delete numbers of people that made me feel neutral or bad and I literally had just… handful of people that were in my corner and so yeah. So another is like spending time with like genuine people that make you feel awesome (Karabo, Interview 11 February 2019).

Using "cleaning house" to manage depression allows participants to be free around people who actually support them; as it helps them manage their external environment. Therefore, they are able to be open and free about their depression in the front without pretending to be fine, to act in ways acceptable to others. "Cleaning house" allows people to be who they are in both the front stage and back stage. Therefore this is very beneficial to them as they are surrounded by positive energy and do not need to work on impressing anyone, because they are surrounded by people who support them. "Cleaning house" is a place where participants can engage with their true feelings when alone and when they are with people who are supportive of them. Therefore, they are open about experiencing depression both in the front and the back stage which enable them to focus on themselves to get better.

5.2.2.1.1. "I will defeat depression by exercising and being creative"

The ultimate objective of "cleaning house", as much as it is focused on being in control of the external environment, is focused on the individual. Therefore, it helps to ensure that an individual is healthy mentally and physically. According to Calfas and Taylor (1994), people tend to show lower levels of depression, anger, stress and other negative emotions when they exercise two to three times weekly compared to those who do not exercise. Young people with high levels of physical activity tend to be more mentally resilient (Gerber et al. 2012; Helgadóttir 2016).

One of the coping mechanisms for some participants is to change their level of physical activity, which has proven to be beneficial for them. Three participants stated that going to the gym, walking and generally exercising has been helpful in coping with depression, even though for others it was a way of keeping busy to block out any negative thoughts

and an attempt to escape their depression. One typical example of the latter is Karabo, who initially used exercise as a way to run away from the idea that he has depression. He used the gym to try and block out his depressive thoughts and believed that he could manage or get rid of depression by simply exercising.

> So now the problem with that is that… the problem with that is that… there's a term called manic defence right … what manic defence basically is, is that like you fill your time with activities right… so as to stop negative thoughts, beliefs from entering your consciousness, right, but there comes a point where… no matter what you put on schedule, those thoughts and everything come back and when they come back they come with vengeance (Karabo, Interview 11 February 2019).

Therefore, Karabo came up with the idea to exercise on his own after finding out that he has depression from a psychologist, to try and forget about his problems, but eventually realised his problems could not be escaped. He then ended up using exercising as a way to manage his depression. He therefore integrates the idioms of a biomedical model to shape his coping behaviour. For other participants, they exercise because it helps them in relaxing them and releasing tension and similarly becomes a way to manage their depression. In addition to exercising, others expressed that being creative has also helped participants in coping with their depression. Going forward, they incorporated the physical activities with other coping mechanisms.

> Another one is like pursuing a creative task… I know it's weird, right, but because I study economics, so it's very like linear and strategic and analytic. Pursuing something creative ah… I don't know like, it just… it just makes you feel great ah so I took up photography, I took up writing (Karabo, Interview 11 February 2019).

Blomdahl et al.'s (2016) study about expert opinions on art therapy for patients with depression has indicated the therapeutic value of combining communication both verbally and through art-making when experiencing stressful life events.

> Ahm am a creative person as well, so… that's something that while I was going through the… peak of my depression, I just didn't write anymore, I didn't draw, I didn't paint… I didn't do anything. So now I can do that more… and that's actually… I don't know, I'd say improved my work… yeah I just take it to art really (Masego, Interview 5 February 2019).

Masego now uses art to help cope with her depressive thoughts; however it was not always the case. When she was heavily depressed, it hindered her from being creative but eventually she used art as a way of dealing with her emotions. Additionally, because art stimulates one's thoughts, feelings and experiences in a positive way, it has also improved her work because she now engages with her emotions.

5.2.2.1.2. "Ensuring my chakra is intact"

Participants claimed that the ability to engage with one's inner thoughts and emotions is important as it helps with spirituality and ultimately in coping with depression. Spirituality was a common theme, and most people used it interchangeably with religion and religious activities such as going to church and praying. This can be regarded as part of "cleaning house" because it focuses on the individual and ensuring that an individual feels good spiritually, which ultimately affects them positively mentally. Some participants started to use spirituality as a way to cope with depression. This includes going to church, praying and listening to gospel music. The positive association between religion and strong mental health has been documented in research that shows the role religious beliefs play by providing comfort, particularly in times of distress (Moreira-Almeida, Neto, and Koenig 2006). Therefore they use spirituality as religion; for instance, one of the participants stated:

> Ahm… I am… I am a very spiritual person as well…ahm this whole experience has made my relationship with God much stronger … so that is also, always a thing I turn to. I mean we can say a lot about the church and stuff but then I feel like… that's just how they've interpreted spirituality but I can still have… spirituality the way I choose to practice it and that's something I can do on my own because… you can't go to church and now… put your beliefs or your way of doing things on them… so it's great, so it's something I can do on my own (Masego, Interview 5 February 2019).

Therefore, for Masego, being spiritual means having a relationship with God, going to church and focusing on her own beliefs. When depressed, she turns to God and chooses how to practice spirituality in order to better cope with depression. Therefore, participants find different ways that best suit them to cope with depression.

> … I was looking for different ways to cope with things and ah… with all the things that I have tried… focusing on my spirituality helped… listening to gospel music and praying always… always really helped (Dineo, 12 February 2019).

Similarly, Dineo uses spirituality as a coping mechanism and links it to religion; therefore she employs religious activities such as prayer to help cope with depression. According to Bartkowski, Acevedo and Loggerenberg (2017), religion is not constituted by beliefs alone but religious beliefs are 'given efficacy through congregationally based networks that collectively reinforce values and serve as critical conduits of social support'. Religious networks refined by attending worship services, prayer groups and scripture study fellowships can also form part of coping mechanisms (Krause et al. 2001).

In addition to participants using religious activities to cope with depression, including attending church services and allowing other people to pray for them, gospel music also plays a role in their betterment when feeling depressed. Those coping mechanisms, among other aspects of religious life, may involve guidance, tenor and substance of prayer (Bartkowski et al. 2017).

This is in keeping with much literature which looks at the positive role that prayer and meditation can have as it helps people with being calm and mindful, which elevates their positive emotions, and that ultimately helps with dealing with depression (West 2016). Meditation in the West is a wide-ranging set of practices considered as a balancing approach to health, and can include yoga, which is the most popular, with a lot of alternatives such as Tai Chi and Qigong (Clarke et al. 2015). Existing literature shows that all these spiritual practices and rituals can be beneficial to a person experiencing depression. A substantial amount of research on meditation indicates it as a practice used in the United States and broadly in the West (Stratton 2015). Similarly, in this study participants make use of meditation to cope with depression.

The above indicates the use of acculturation by integrating methods from various cultures in order to better cope with depression (Fisha 2001). Participants merely borrow from other cultures and integrate techniques in order to have a portfolio of coping mechanisms. They do not rely only on their own culture and beliefs but source some aspects of beliefs and traditions from other cultures to cope with depression.

However there was another example where a participant uses spirituality as a metaphor to explain their experience with depression in a different way opposed to how others described and coped with depression. In this case, for a better understanding, Masedi uses spirituality to make meaning of the experience that she is going through. For her, spirituality relates to who she is and does not necessarily focus on religion. Although she engages in religious activities such as prayer to ensure that her spirituality is intact, religion

merely feeds that spirituality, which in essence is who she is. Therefore, for her spirituality is separate from religion.

> Am a very spiritual religious person, so if you not in touch with that… ahm [Researcher: your spiritual being?] yeah your spiritual being at that moment… then I feel like things just mix up (Masedi, Interview 2 February 2019).

She believes that depression has to do more with the spiritual being of an individual. Her spiritual being was interrupted when she was in an abusive relationship and that contributed to her having depression. Masedi believes a lot in her spiritual being; therefore being in a good place is when her spiritual being is calm and high. So her depression started when she was involved in an abusive relationship which evoked negative emotions that let her spiritual being break from being at ease and crashed her spirit to a low point. In addition she lost her grandmother which added to her being depressed. Therefore, for her to cope with depression, she has to ensure that her spirit is in the right space.

> So I know they do… ironically this year am very calm, surprisingly, am not a calm person, am always agitated, anxious and I need to get things done now, and and and…but this year am very calm, laid back and I think that just because of… a higher being or my spiritual side is…is you know… my chakra is intact (Masedi, Interview 2 February 2019).

> My inner being is very peaceful…so I think that's why. 'Cause other people have been praying and I've started praying again this year, so I think that's a good thing (Masedi, Interview 2 February 2019).

Masedi views and understands depression through the spiritual eye. Therefore, for her, being depressed is associated with your spirit being low and needing to be revived, through prayer for instance, to better cope with depression. Spirituality has an impact on the quality of life of an individual (Baker 2003). Quality of life is very broad and it is a measure of an individual's overall well-being and their perception of their position in life, which includes the aspects of physical and mental health, relationships and environment (Baker 2003). Therefore, Masedi uses spirituality to measure her level of mental health well-being, to ensure the quality of her life.

5.2.2.3. Using social media and the internet to manage depression

Participants talked about social media as having an impact on their ability to cope with depression. The forms that this took were often surprising. Below is a case study of Bonolo that shows social media as a space for support and empowerment. For instance, Bonolo started a YouTube channel for her family. On her channel she would talk about her true emotions in order to help her family understand what she is going through. Therefore, she uses this platform to engage with her true depressive feelings and emotions; this includes her breaking down, crying and sharing her happy and sad moments. The YouTube channel is like a diary that she shares publicly.

> I mostly YouTube to vent (Bonolo, Interview 9 December 2018).

> What happened was; my family didn't know how to be there for me, so I made the channel to explain it and they watch. Living with it has been so much better now (Bonolo, Interview 9 December 2018).

Being open on YouTube has helped her by allowing her to vent and equally by educating her family about her depression, and it has worked out for her. For instance in one of her YouTube videos titled "Anxiety and self-harm", she talks about having a tendency to harm herself by cutting her body with a razor as a way to make her feel better about her depressive thoughts and feelings. However she talks about how she is resisting self-harm because she understands that it is wrong. She then goes on to discourage the urge to self-harm and to motivate other people to try and do better when feeling the urge to self-harm. Bonolo was open and vocal about her depressive thoughts, emotions and feelings to the public, as the YouTube channel is accessible to everyone. In addition to the YouTube channel, she also found a coping mechanism in Facebook, by being a part of a "depression team" group. A "depression team" is a group on Facebook, where anyone, globally, who believes they have depression can join, share their emotions and feelings every day, and get support from fellow members.

Bonolo then realised from her friends that there are other people who are not as privileged as her and who do not have access to a phone or internet. She then decided to also use her channel to help those that at least have access to the internet at schools. As a way to help others, she posts videos about depression and how she copes with depression, as a way to show people that it is alright to experience depression. She uses her platform to encourage and motivate people who might be experiencing depression. Additionally, after

the interview, Bonolo created a WhatsApp group and acts as a counsellor to people who experience depression from different places and backgrounds. Therefore, for Bonolo, social media and having access to the internet had been a great help to her and she experienced it in a positive way. Social media functions like a virtual support group for her.

However, the experience with social media was different for another participant. Karabo's first experience with depression was a negative one. Social media perpetuated his depressive thoughts and led to him becoming even more depressed.

> I think also exacerbating is the fact that is the fact you go on social media… right and those who … you kind of like measured up to ah… you see their life, you see your life, then you like, 'whoa what the hell happened' you know. So, I believe that like… society's like… is mostly average right… so… the population is normally distributed right and most people fall in the average…so now with social media what you get… what you get exposed to is the extreme tails of the normal distribution… you see really low, lows you see really high, highs… and that's what you… kind of like ah… compare your life to… which is unrealistic… comparison. Ah it's only natural for humans to compare… we are geared that way. So having had those labels… I don't know… those labels off the table and now comparing myself to like… to things that I knew were actually not reality but at the that time is the only thing you see and you see a lot of it… that contributed a lot… (Karabo, Interview 11 February 2019).

Social media played a role in him questioning who he is after losing the things that he felt defined him. According to Karabo, with social media one gets exposed to only the "extreme tails" of reality, which is either living a perfect life or doing really badly. Therefore, if you compare yourself to the extreme positive and fail to measure up then you feel you belong in the extreme negative. So he feels people tend to compare themselves to those "extreme tails" which, according to Karabo, are unrealistic because there is no knowing what is happening in-between those "extreme tails". So Karabo also compared himself according to the standards of those "extreme tails" and defined himself according to them.

After "losing his identity" (see chapter 4), social media led to him being even more depressed because he could no longer maintain the standard on social media that he previously displayed - the perfect life he was living, having a great relationship, doing great at school and having two successful businesses. Karabo believes that people on social media do not show the struggles and hardships they go through, including him. This has

also affected his identity because Karabo associated himself with certain labels that defined who he is, such as being successful; but when he felt the success was disappearing, he could not be himself and that affected him because he then did not know who he is anymore. So on social media people are acting in ways acceptable in the social media world and do not really show the whole truth. This experience is in stark contrast to that of Bonolo, where she used social platforms as a way to express and to be true to her emotions.

Eventually, Karabo did something similar to Bonolo and turned his negative experience with social media into a positive one. Karabo created a blog to share experiences about his life to educate people and give people experiencing depression hope, which also helps him in return to cope with depression.

> …quite recently I've… gotten into mental health and am kind of raising awareness about it by blogging. Typically what I blog about is the experiences that I've been through and how I am trying to…trying to sort of like recover from things that I won't entirely forget… you know. Kind of like ah… raising awareness through that medium. Ahm and yeah man… like just living my life and trying to show that… trying to show people through me that you can be diagnosed with certain things but still live a fruitful life and then ah… just be normal like everyone… (Karabo, Interview 11 February 2019).

This is similar to what Bonolo is doing, trying to use social media to be true to who they are and to be vocal and open about their depressive thoughts, feelings and emotions. Revathy, Aram and Sharmila (2018) did a study on how social media is used to overcome stress, and it indicated that people paid attention to videos that provided information on stress and depression. Revathy et al. (2018) state that, 'In YouTube videos, 45% of video format[s] were actuality like giving tips or remedies about stress and depression issues, 35% of video formats were in demonstration [format] such as yoga and physical exercises, 15% were in testimonial format such as explaining their personal experience, and the remaining 5% were animation videos to attract users' attention' (Revathy et al. 2018: 54). Videos are more popular because they are more authentic, because 'they presented instances from real life and helped reinforce social norms' (Revathy et al. 2018). The videos are regarded as more authentic because people can relate more to what is shown and present examples from reality.

In this study, participants therefore felt that it could be a positive or a negative, and some turned it into a positive by using social media to empower other people - to use social media as a platform to raise awareness about depression to alert people that one can live a fruitful life even if one is diagnosed with depression. Karabo does state how social media can be harmful to an individual and also feeds their depression negatively; however in the two instances discussed above, the study indicates how social media has helpful spaces where people can actually find help. Literature has focused a lot on the negative links between social media and depression, where social media affect young people negatively (Ahmad, Hussain and Munir 2018) but it is clear from this study that social media is complex and can be a place where people find both help and harm. The study indicates how social media is very broad and when unpacked it can be seen how social media also has a positive impact on people with depression (Ahmad et al. 2018).

The study further shows how, returning to Goffman's characterisation, social media is neither the front stage nor back stage but a blur of both stages. For instance, the WhatsApp group that Bonolo has created is very intimate, careful and gentle; that is part of social media but quite different from other social media such as the YouTube channel or the Facebook "depression team" which are not intimate but are more educational and act as a support system on a broader scale. Thus WhatsApp can be viewed as the back stage where people are able to be who they truly are but on Facebook where the audience is bigger, people engage more with the front stage and use impression management.

Goffman's dramaturgy theory has been recently applied by many scholars to online media contexts in order to try and understand how impression management is employed on online platforms and how the online platforms allow the "presentation of self" (Boyd 2004; Boyd 2006; Boyd 2007; Lewis, Kaufman, and Christakis 2008; Mendelson and Papacharissi 2010; Tufekci 2008b). Researchers made use of Goffman's approach to try and show that back stage is possible on Facebook (Lewis et al. 2008; Tufekci 2008a). However other research studies discarded the above claim and argued that on these platforms, people are just putting on performances and probably 'even more public and intensified compared to front stages as within Goffman's traditional model' (Aspling, 2011: 6).

Therefore, the study shows how relationships are formed nowadays and that social media is a huge part of it, and can be both harmful and helpful (Ahmad et al. 2018). Young people are greatly influenced by social media and the influence grows gradually. Young people make use of social media which plays an important role in their lives (Pierce 2009).

Social media is popular worldwide and it is used for a variety of things which includes seeking information, entertainment, interacting people and escape (McQuail 1994). Social media has become the easiest and fastest-interacting tool and a platform where people from different backgrounds can interact. That enables people to exchange insights and opinions and communicate with each other irrespective of the geographical area (Rebecca 2011). What this study shows is that there is no single answer; young people are engaging on social media in complex and often contradictory ways.

5.2.2.3.1. Social media is an alternative to mainstream mental health services

This study indicates that some participants are not getting their psychoeducation via mental health systems but use the internet and social media platforms to get information in order to self-help. According to Colom and Lam (2005: 359) psychoeducation 'focuses on the early identification of prodromal signs and possible predisposing and precipitating causes of these mental illnesses'. It is about people understanding their condition, which will then assist them in seeking the appropriate coping strategies for the condition. Furthermore, Colom and Lam (2005) argue that psychoeducation helps people to explore their health beliefs and illness awareness and to be able to understand the complexity of the relationship between symptoms, personality, interpersonal factors and environment.

The participants in this study noted how social media and the internet had an impact on their understanding of and coping with depression. Social media platforms such as Facebook have influenced the way people communicate, interact and socialise with each other worldwide (Kietzmann et al. 2011; Xiang and Gretzel 2010). The following is a typical example of that:

> I got to go to school, so private schools, I had access to the internet, I had access to a phone, computers you know. So I realise the only reason am still alive today is that I had the opportunity to actually research my symptoms and, you know, I had the chance to get on the phone and contact a shrink, you know (Bonolo, Interview 10 December 2018).

Having access to the internet has helped Bonolo in coping with depression. It allowed her to research her symptoms and allowed her to learn more about depression. In addition, it has helped her meet different people with depression and thus be exposed to different ways depression is perceived. This ultimately helped her in forming her own views on depression. Her experience with social media and the internet has alerted her to the gap between people who are privileged to have access to those platforms and those that are

not privileged to have those in their homes. Social media here was used as a positive tool to attempt to assist other people who might be going through depression.

Therefore, the study has indicated that some people are getting their information and assistance about depression on social media. Thus, social media is a sort of psychoeducation because people are using it to provide and get information from it. A typical example of social media as psychoeducation is the following:

> Then I had the chance to go on Google and see oh my gosh these are my… these are my symptoms. Ahm these extreme ones require a doctor, these not so extreme ones requires a walk, ahm they require meds… they require… you know. I could actually research and help myself (Bonolo, Interview 10 December 2018).

My participants see social media information as an alternative to mainstream mental health services. They hardly go to mainstream mental health practitioners for information but source their information from social media platforms such as Facebook and YouTube. Consequently, people often turn to social platforms to access information about healthcare (Revathy et al. 2018).

5.3. Conclusion

The treatment for depression is sought from making use of a portfolio of methods fitting to each individual according to their preferences. Participants integrate different methods and do not just focus on a single method. Even though the mainstream mental health services were used at some point, eventually participants opted to find their own ways that suited their individual needs to manage depression. Overwhelmingly, psychological and psychiatric services were viewed in a negative light. Participants found themselves using the option of self-help in order to cope with depression and that led to major coping strategies, namely “cleaning house” and social media. The different ways people conceptualise depression indicates the need for further research that will alert people to different ways of managing depression and allow them to view it through multiple lenses.

Chapter 6. Conclusion

6.1. Introduction

This study revealed that young people's idioms for depression centre on their own discourses and that social media provides a hitherto underexplored means for young people to explore self-help coping mechanisms. In this chapter, I reflect on the findings of the study by returning to the original research questions and will provide concluding remarks, most importantly highlighting that black South African youth seek coping mechanisms outside conventional therapy such as social media and the 'cleaning house'. In addition, I include my reflections on the study, the limitations of the study and recommendations for future research. Lastly, the chapter will provide concluding remarks.

6.2. Answering the research questions

This research aimed to understand how black South African youth experiencing depression understand it. In addition, the researched aimed to investigate these young people's idioms of distress and how they cope with depression. The questions that were asked in this research are:

- What is your understanding of depression?
- What has shaped this understanding?
- How has your social background shaped your understanding of depression?
- What do you do when depressed?

With regards to the first question, the study found that participants had different views on depression. Some participants had two perceptions; one before being diagnosed and a different one after being diagnosed or experiencing depression. Before being diagnosed with depression, different participants had various understanding of depression which were based on received discourses from their social background, including depression being a disconnection from people, a complex and untreatable condition. However, there were those who did not understand what depression was until they experienced it themselves. After experiencing depression, participants integrated the biomedical perspective to try and understand depression, reworked it and gave it their own definition and drew on different things to understand depression. Participants had two discourses; one which

they received from other people in relation to how they understood depression, which mostly happened before being diagnosed or experiencing depression. The other discourse, which they developed themselves, is how they individually understand depression.

In relation to the second question, participants' understanding of depression was shaped by various things - for instance, how they define themselves has impacted on how they view depression and has consequently affected how they react to being depressed. Past knowledge from watching movies has affected the knowledge that some participants had of depression. This had let to them being in denial for a period of time before actually seeking help. Labels participants put on themselves to define who they are included being a strong-willed person, being a straight-A student and a successful young entrepreneur. Those labels had either hindered them from believing that they could be depressed or, when those labels were no longer available, they experienced depression because they lost a sense of who they are.

In relation to the third question, half of the participants believed their social background did not influence their understanding of depression. Slightly less than half of the participants argued that their social background influenced how they viewed depression and only one contends that his social background slightly influenced his understanding. The former were aware of the negative views of depression in their social background, but constructed their own understanding without allowing the influence from their surroundings to impact on their understanding (surroundings being their family, friends and community, but the schools they enrolled in exposed them to different perceptions of depression and they formed their understandings from that). The latter were influenced negatively by their social background but their perceptions changed when they experienced depression themselves.

Regarding the last question, participants used a variety of coping mechanisms to cope with depression. Due to participants going through two stages - experiences before being diagnosed and after being diagnosed or experiencing depression - they had different coping methods for each stage. Before being diagnosed or being aware that they had depression, some participants would engage in unhealthy coping mechanisms to manage their "distresses". Even after being diagnosed, others fell into the denial phase and that impacted on how they dealt with depression and therefore employed unhealthy coping mechanisms. After a deep introspection and being honest with themselves, some participants used social media to cope with depression in addition participants employed

physical and emotional coping mechanisms. They use different methods separately as needed. There were coping strategies that were believed to be unhelpful to some participants, such as therapy and medication. This consequently led to self-help which includes two key coping methods, ‘cleaning house’ and social media.

Participants mostly believed that their depression is not curable but can be managed. Therefore, they know that a person can live a fruitful and healthy life even after being diagnosed with or experience depression, if proper healthy coping methods are employed. However for others depression changed their outlook on life negatively and they have accepted the outlook as a way to cope with depression. For instance, in Rendani’s case, she created a personality - a “bad” person - and that is because depression affected her negatively. She believes the personality is helpful in coping with depression; therefore she has accepted that and owns that.

6.3. Reflections on the study

Qualitative research acknowledges that it is impossible for research to be objective because the researcher holds his or her own subjective experiences, values and beliefs. Furthermore, the questions from the research process were encouraged by my hope to answer them (Denzin and Lincoln 2005). As a result, my personal experiences with depression initiated the study, with the objective of investigating how other black South African youth understand and cope with depression.

My perception on depression as a young black South African varied before experiencing depression and after. Before acknowledging that I might be experiencing depression, the knowledge of it did not exist to me. Therefore, empathising with people experiencing depression tended to be a little difficult and it was hard to understand the experiences they go through. I had to go through depression to fully understand what it means to be depressed. My social background does not recognise depression and views it negatively, which forced me, after realising that I might suffer from depression, to focus on my own opinion by researching and enquiring about depression because of too much exposure to the negative opinions about depression.

It was therefore easy to understand and relate to the participants construction of depression and methods employed to cope with depression during the interviews. Omitting my experience of depression as a researcher might have been beneficial for both myself and the participants, as it might have required participants to explain their experiences in

detail to someone deemed an outsider. However, omitting my experience might have limited the extent to which I as a researcher probed or interrogated some of the responses of participants because I could relate to their experiences. My experiences also allowed the opportunity to probe on things foreign to my own experiences to gain better understanding.

As a researcher I am aware that I am an instrument of data collection and analysis according to qualitative researchers (Gibbs 2002). I am also an important tool in the construction of meaning. Nonetheless, it is of great importance for me to remain open to the notion that people might have different perceptions and differences in how they construct the same phenomenon (Denzin and Lincoln 2000). Therefore, room for different perceptions on depression were kept despite my own understanding and experience of depression.

As a researcher, I was able to draw from my own experiences during the data analysis process, despite being true to what was said by participants. Therefore, it was easy to analyse the findings of the study. Nonetheless, the ability to deeply understand the constructions of participants might have influenced the presenting of findings.

6.4. Limitations of the study

This study explored the perceptions and experiences of black South African youth on how they understand and cope with depression. There is limited literature on the experiences of black South African youth who experience depression. This resulted in difficulty comparing findings of the study to previously researched work. Previous studies are important in identifying whether there has been a shift in the conceptualisation of depression and to also compare and confirm some findings from the study. Therefore, this might have had an impact on the legitimacy of participants' responses. However, studies on other South Africans from a different age group, and studies on depression associated with chronic illness and any study on depression helped with the literature of the study.

Due to the sensitivity of the research, finding participants proved to be difficult. There were people who were keen to participate but had to withdraw from participating because they had relapsed and been admitted to the hospital. Others agreed to participate but were reluctant to meet and rescheduled more than twice, and I then deliberately cancelled the meeting because I was aware that the potential participants were uncomfortable. For others, they honestly and openly expressed that they could not participate due to the

sensitivity of the topic. Therefore, having to find other participants to replace those that withdrew delayed the process and it proved to be difficult to secure interviews with participants for such sensitive research.

The methodology used in the study might be criticised because only a few people were interviewed. Therefore the findings of the study cannot be generalised to all other black South Africans experiencing depression. However, the study did not intend to generalise findings from chosen participants but to investigate their understandings of and coping mechanisms for depression. Thus, qualitative research was deemed as appropriate for the study.

Another criticism could be that the study focused only on a particular age group and certain race group. Allowing the study to encompass other age groups and race groups experiencing depression could have uncovered more varied constructions to investigate. This would have allowed me to make comparisons between the different age and race groups about the researched phenomenon. Nonetheless, my study can be seen as a first step to research more about black young South Africans since they are under researched.

6.5. Recommendations for future research

Based on the limited research done on how black South African youth understand and cope with depression, it is recommended that further research be on a similar topic outside the South African context. This study is focused only on two aspects of the topic; how they understand and cope with depression. Further research can focus on other topics such as challenges black youth experiencing depression face in the workplace and in intimate relationships. This study did not focus on the specific type of depression to contrast different challenges faced by different people with different types of depression therefore further research can focus on that.

Due to the sensitivity of the topic, future research could consider using a different method for research. Quantitative research can be used, where participants can go at their own pace and alone, therefore not opening up to a stranger. Furthermore, the study could make use of a combination of quantitative and qualitative method for researchers to be able to draw on different data and to make comparisons.

Future research can broaden the study by focusing on other age groups and races about their experiences with depression within the South African context. This will allow

researchers to be able to compare and contrast experiences of people from different backgrounds. In addition, further research can also focus on experiences of people with depression from disadvantaged backgrounds.

This study highlighted people making use of unhealthy ways of coping with depression due to lack of information or knowledge about depression or being in denial. Therefore, further research can try to focus on the effects of lacking information and knowledge about depression and the unhealthy ways people cope with depression which leads to detrimental consequences. Future interventions for young people can capitalise on their use of social media. Also mainstream mental health services can be revisited to ensure that they integrate the idioms of distress that are meaningful to young people in their interventions.

6.6. Concluding remarks

This study did not find that the social background of young black South Africans influenced how they understand depression. Although they are knowledgeable about the stereotypical and negative comments about depression from their social background, they formed their own perceptions about depression. Participants formed their own opinion by doing research on their own about depression or experiencing the health care system. However others gained enlightenment about depression after experiencing depression themselves and distanced themselves from the perceptions in their social backgrounds.

Based on their personal experiences, participants understand and view depression from a social perspective. Through their experiences they learned their depression was caused by social events that occurred in their life. However, they did not write off the biomedical route of understanding depression. They acknowledged that depression could be caused by genetics, but according to their experiences it relates more to social factors. Therefore, this influenced how they chose to cope with depression and they avoided medication to find other ways that suited them personally. This relates to the notion of the privileging of a biomedical understanding of depression and the undermining of other ways of dealing with depression.

Furthermore, the study found that participants use a combination of methods to cope with depression. They use them separately as needed but rely on different methods as opposed to one. Most of them do not use therapy anymore because they want to rely on themselves to manage their depression and avoid being dependant on psychologists,

similarly to using medication, where participants avoid taking medication because they do not want to depend on medication to cope with depression.

References

Adair-Stantiall, A. 2010. 'Illness Representations, Coping and Psychosocial Outcome in Chronic Pain'. PhD thesis, University of Southampton.

Adams, W. 2015. 'Conducting Semi-Structured Interviews'. In Newcomer, KE, Hatry, HP and Wholey, JS. (editors). *Handbook of Practical Program Evaluation*. San Francisco: Jossey-Bass.

Ahmad, N, Hussain, S and Munir, N. 2018. 'Social Networking and Depression among University Students'. *Pakistan Journal of Medical Research,* 57(2): 77-82.

Alvermann, DE and Mallozzi, CA. 2010. 'Interpretive Research'. In McGill-Franzen, A and Allington, RL. (editors). *Handbook of Reading Disability Research*. New York: Routledge.

American Psychiatric Association. 1994. *Diagnostic and Statistical Manual of Mental Illness (DSM-IV).* Washington, D.C.: American Psychiatric Association.

Aspling, F. 2011. 'The Private and the Public in Online Presentations of the Self'. MA dissertation, Stockholms University.

Atindanbila, S and Abasimi, E. 2011. 'Depression and Coping Strategies among Students in the University of Ghana'. *Journal of Medicine and Medical Sciences*, 2(12): 1257-1266.

Babbie, J and Mouton, CJ. 2001. *Introduction to Qualitative Research Methods.* Pretoria: Human Science Research Council.

Baker, DC. 2003. 'Studies of the Inner Life: The Impact of Spirituality on Quality of Life'. *Quality of Life Research*, 2(0): 51-57.

Bartkowski, JP, Acevedo, GA and Loggerenberg, H. 2017. 'Prayer, Meditation, and Anxiety: Durkheim Revisited'. *Religions,* 8: 1-14.

Beit-Hallami, B. 1974. 'Salvation and its Vicissitudes: Clinical Psychology and Political Values'. *American Psychologist*, 29: 124-129.

Ben-Tovim, D. 1987. *Developmental Psychiatry: Mental Health and Primary Health Care in Botswana*. London: Tavistock.

Beresford, P, Nettle, M and Perring, R. 2010. *Towards a Social Model of Madness and Distress?*: *Exploring what Service Users Say*. London: The Joseph Rowntree Foundation.

Berg, BL. 2009. *Qualitative Research Methods for the Social Sciences*, seventh edition. Boston: Allyn and Bacon.

Berkman, LF and Glass T. 2000. 'Social Integration, Social Networks, Social Support, and Health'. In Berkman, LF and Kawachi, I. (editors). *Social Epidemiology*. New York: Oxford University Press.

Birmaher, B, Ryan, ND, Williamson, DE, Brent, DA and Kaufman, J. 1996. 'Childhood and Adolescent Depression: A Review of the Past 10 years'. *Journal of the American Academy of Child and Adolescent Psychiatry,* 35:1427-1583.

Blankertz, L. 2001. 'Cognitive Components of Self-Esteem for Individuals with Severe Mental Illness'. *American Journal of Orthopsychiatry,* 71: 99-106.

Bless, C, Higson-Smith, C and Sithole, SL. 2013. *Fundamentals of Social Research Methods: An African Perspective,* fifth edition. Cape Town: Juta.

Blomdahl, C, Gunnarsson, BA, Gurega, S, Rusner, M, Wijk, H and Bjrklund, A. 2016. 'Art Therapy for Patients with Depression: Expert Opinions on its Main Aspects for Clinical Practice'. *Journal of Mental Health,* Early online: 1-9.

Bondolfi, G, Mazzola, V and Arciero, G. 2015. 'In Between Ordinary Sadness and Clinical Depression'. *Emotion Review*, 7(3): 1-7.

Boyd, D. 2004. 'Friendster and Publicly Articulated Social Networking'. *Conference on Human Factors and Computing Systems (CHI 2004)*. Vienna: ACM, 24-29.

Boyd, D. 2006. 'Friends, Friendster and MySpace top 8: Writing Community into being on Social Network Sites.' Accessed 30th August 2019, http://firstmonday.org/issues/issue11_12/boyd/index.html

Boyd, D. 2007. 'Why Youth (Heart) Social Network Sites: The Role of Networked Publics in Teenage Social Life'. In Buckingham, D. (editor). *MacArthur Foundation Series on Digital Learning – Youth, Identity, and Digital Media Volume.* Cambridge, MA: Massachusetts Institute of Technology Press.

Brikci, N and Green, J. 2007. 'A Guide to Using Qualitative Research Methodology'. *Research Unit, London School of Hygiene and Tropical Medicine.* Bloomsbury: London School of Hygiene and Tropical Medicine.

Burns, ML. 2006. ‘Bodies that Speak: Examining the Dialogues in Research Interactions’. *Qualitative Research in Psychology*, 3(1): 3-18.

Calfas, K and Taylor, W. 1994. ‘Effects of Physical Activity on Psychological Variables in Adolescents’. *Pediatric Exercise Science,* 6: 406-423.

Calitz, FJW, Veitch, M, Verkhovsky, A, Nieuwoudt, D, Myburg, J and Joubert, G. 2007. ‘The General Profile of Children and Adolescents with Major Depression Referred to the Free State Psychiatric Complex’. *The South African Journal of Physiotherapy,* 13(4): 132-136.

Carlton, E. 1977. *Ideology and Social Order*. London: Routledge and Kegan Paul.

Cesar, J and Chavoushi, F. 2013. ‘Priority Medicines for Europe and the World: A Public Health Approach to Innovation’. *Update on 2004 Background Paper, BP 6.15 Depression.* Geneva: World Health Organisation.

Clarke, TC, Black, LI, Stussman, BJ, Barnes, PM and Nahin, RL. 2015. *Trends in the Use of Complementary Health Approaches among Adults: United States, 2002–2012*. Hyattsville: National Center for Health Statistics.

Cohen, S and Wills, TA. 1985. ‘Stress, Social Support, and the Buffering Hypothesis.’ *Psychol Bull,* 98: 310-357.

Cohen, S, Underwood, LG and Gottlieb BH. 2000. *Social Support Measurement and Intervention. A Guide for Health and Social Scientists.* New York: Oxford University Press.

Collier-Reed, BI, Ingerman, Å and Berglund, A. 2009. ‘Reflections on Trustworthiness in Phenomenographic Research: Recognising Purpose, Context and Change in the Process of Research’. *Education as Change,* 13(2): 339-355.

Colom, F and Lam, D. 2005. ‘Psychoeducation: Improving Outcomes in Bipolar Mental Illness’. *European Psychiatry*, 20(5-6): 359-364.

Conrad, MM and Pacquiao, DF. 2005. ‘Manifestation, Attribution, and Coping with Depression among Asian Indians from the Perspectives of Health Care Practitioners’. *Journal of Transcultural Nursing*, 16(1): 32-40.

Corrigan, PW. 2002. ‘Empowerment and Serious Mental Illness: Treatment Partnerships and Community Opportunities’. *Psychiatric Quarterly,* 7: 217-228.

Crawford, P and Brown, B. 2002. 'Like a Friend Going Round: Reducing the Stigma Attached to Mental Health in Rural Communities'. *Health and Social Care in the Community,* 10: 229–238.

Creamer, T. 2018. 'Extreme Inequality in South Africa is Constraining Growth and Investment.' Accessed 07 October 2018, http://www.engineeringnews.co.za/article/extreme-inequality-is-constraining-south-african-investment-and-growth-2018-04-10

Creswell, JW. 1994. *Research design: qualitative and quantitative approaches.* London: Sage.

Danziger, K. 1979. 'The Social Origins of Modern Psychology'. In Buss, AR (editor). *Psychology in Social context*. New York: Wiley.

Davis, GY and Stevenson, HC. 2006. 'Racial Socialization Experiences and Symptoms of Depression among Black Youth'. *Journal of Child and Family Studies*, 15 (3): 303-317.

Dawes, A. 1985. 'Politics and Mental Health: The Position of Clinical Psychology in South Africa'. *South African Journal of Psychology*, 15: 55-61.

Deacon, BJ. 2013. 'The Biomedical Model of Mental Disorder: A Critical Analysis of its Validity, Utility, and Effects on Psychotherapy Research'. *Clinical Psychology Review*, 33: 846-861.

Dempsey, L, Dowling, M, Larkin, P and Murphy, K. 2016. 'Sensitive Interviewing in Qualitative Research: Sensitive Interviewing'. *Research in Nursing and Health*, 39: 480-490.

Denzin, NK and Lincoln, YS (editors). 2005. *Handbook of qualitative research* (third edition). London: Sage.

Desai, G and Chaturvedi, SK. 2017. 'Idioms of Distress'. *Journal of Neurosciences in Rural Practice*, 8(Suppl 1): S94–S97.

Edwards, R. 1990. 'Connecting method and epistemology: a white woman interviewing black women'. *Women's Studies International Forum,* 13(5): 477-490.

Fava, GA, Ruini, C and Sonino, N. 2003. 'Treatment of recurrent depression: a sequential psychotherapeutic and psychopharmacological approach'. *CNS Drugs*, 17(15): 1109-1117.

Ferreira, M, Mouton, J, Puth, G, Schurink, E and Schurink, W. 1998. *Introduction to Qualitative Research Methods*. Pretoria: Human Science Research Council.

Fisha, S. 2001. 'Depression among African Patients: Three Diagnostic Approaches'. PhD thesis, University of Pretoria.

Gabel, J. 1975. False Consciousness: An Essay on Reification. Oxford: Blackwell.

Gerber, M, Kalak, N, Lemola, S, Clough, PJ, Puhse, U, Elliot, C, Holsboer Trachsler, E and Brand, S. 2012. 'Adolescents' Exercise and Physical Activity are Associated with Mental Toughness'. *Mental Health and Physical Activity,* 5: 35-42.

Gibbs, G. 2002. *Qualitative Data Analysis: Explorations with NVivo*. Buckingham: Sage.

Goffman, E. 1959. *The Presentation of Self in Everyday Life*. New York: Random House, Inc.

Greenberg, SB. 1980. *Race and State in Capitalist Development*. New Haven: Yale University Press.

Hammen, C. 2009. 'Adolescent depression'. *Current Directions in Psychological Science,* 18(4): 200-204.

Harmse, L. 2013. 'South Africa's Gini Coefficient: Causes, Consequences and Possible Responses'. MA dissertation, University of Pretoria.

Helgadóttir, B. 2016. 'Exercise as Treatment for Depression'. PhD thesis, Karolinska Institutet.

Horwitz, S. 2009. *Health and Health Care under Apartheid.* Johannesburg: Adler Museum of Medicine.

Ingleby, D. 1974. 'The Psychology of Child Psychology'. In Richards, MPM (Editor). *The Integration of a Child into a Social World*. London: Cambridge University Press.

Ingleby, D. 1981. *Critical Psychiatry*. Harmondsworth: Penguin.

Jano, R and Naidoo, AV. 2002. 'Role salience of dual-career woman managers'. *South African Journal of Industrial Psychology*, 28(3): 69-74.

Janse van Rensburg, AB. 2013. 'Contributions from the South African Society of Psychiatrists (SASOP) to the National Mental Health Action Plan.' *South African Journal of Psychiatry,* 19: 205-212.

Janse van Rensburg, BJ. 2012. 'The South African Society of Psychiatrists (SASOP) and SASOP State Employed Special Interest Group (SESIG) Position Statements on Psychiatric Care in the Public Sector'. *South African Journal of Psychiatry,* 18(3): 133-148.

Jones, D. 2002*. Myths, Madness and the Family: The Impact of Mental Illness on Families*. New York, NY: Palgrave Macmillan.

Jones, LV. and Ford, B. 2008. 'Depression in African American women'. *Affiliate: Journal of Women and Social Work,* 23(2): 134-143.

Jorm, AF and Reavley, NJ. 2011. 'Young People's Stigmatizing Attitudes towards People with Mental Disorders: Findings from an Australian National Survey'. *Australian and New Zealand Journal of Psychiatry*, 45: 1033–1039.

Kasi, PM, Naqvi, HA, Afghan, AK, Khawar, T, Khan, FH, Khan, UZ, Khuwaja, UB, Kiani, J and Khan, HM. 2012. 'Coping Styles in Patients with Anxiety and Depression'. *International Scholarly Research Network,* 10: 1-7.

Kawachi, I and Berkman, LF. 2001. 'Social Ties and Mental Health'. *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 78(3): 458-467.

Keeton, G. 2014. 'Inequality in South Africa'. *The Journal of the Helen Suzman Foundation*, 74: 26-31.

Kielmann, K, Cataldo, F and Seeley, J. 2012*. Introduction to Qualitative Research Methodology: A Training Manual, Produced with the Support of the Department for International Development (DfID), UK, under the Evidence for Action Research Programme Consortium on HIV Treatment and Care (2006-2011)*. Accessed 10 March 2018, http://www.dfid.gov.uk/R4D/Output/188391/Default.aspx

Kietzmann, JH, Hermkens, K, McCarthy, IP and Silvestre, BS. 2011. 'Social Media? Get serious! Understanding the Functional Building Blocks of Social Media'. *Business Horizons,* 54(3): 241-251.

Koenig, HG. 2002. *Spirituality in Patient Care: Why, How, When and What*. Philadelphia: Templeton Foundation Press.

Kohn, R, Szabo, CP, Gordon, A and Allwood, CW. 2004. 'Race and Psychiatric Services in Post-Apartheid South Africa: A Preliminary Study of Psychiatrists' Perceptions'. *International Journal of Social Psychiatry*, 50(1): 18-24.

Kondrat, ME. 1999. 'Who is the "Self" in Self-Aware: Professional Self-Awareness from a Critical Theory Perspective'. *Social Service Review*, 73(4): 451-477.

Krause, N, Ellison, CG, Shaw, BA, Marcum, JP and Boardman, JD. 2001. 'Church-based Social Support and Religious Coping'. *Journal for the Scientific Study of Religion,* 40: 637-56.

Kyriacou, C. 1987. 'Coping Actions and Occupational Stress among School Teachers'*. Educational Research and Reviews,* 24: 57-61.

Leedy, PD. 2000. *Practical research: planning and design*. New York: MacMillan.

Lenhardt, RA. 2004. 'Understanding the Mark: Race, Stigma, and Equality in Context'. *New York University Law Review,* 79: 803–931.

Lewis, K, Kaufman, J and Christakis, N. 2008. 'The Taste for Privacy: An Analysis of College Student Privacy Settings in an Online Social Network'. *Journal of Computer-Mediated Communication*, 14: 79-100.

Lewis, M. 2001. *Social Cognition and the Acquisition of the Self*. New York: Plenum Press.

Lin, N, Ye, X and Ensel, WM. 1999. 'Social Support and Depressed Mood: A Structural Analysis.' *Journal of Health and Social Behavior,* 40: 344-359.

Lincoln, YS and Guba, EG. 1985. *Naturalistic inquiry.* Beverly Hills: Sage Publications.

Lincoln, YS and Guba, EG. 1986. 'But is it Rigorous? Trustworthiness and Authenticity in Naturalistic Evaluation'. *New Directions for Program Evaluation,* 1986(30): 73-84.

Lund, C, Stein, DJ, Flisher, AJ and Mehtar, S. 2007. 'Challenges Faced by South African Health Services in Implementing the Mental Health Care Act.' *The South African Medical Journal*, 97(5): 352-353.

Mare, G. 2001. 'Race Counts in Contemporary South Africa: An Illusion of Ordinariness'. *Transformation*, 47: 75-93.

Marshall, C. 1996. *Designing Qualitative Research*. London: Sage.

Martin, L and Kagee, A. 2011. 'Lifetime and HIV-related PTSD among Persons Recently Diagnosed with HIV'. *AIDS and Behavior*, 15(1): 125-131.

Marton, F and Booth, S. 1997. *Learning and Awareness.* Mawah, New Jersey: Lawrence Erlbaum Associates.

Marton, F. 1981. 'Phenomenography Describing Conceptions of the World Around Us'. *Instructional Science*, 10: 177-200.

Matsumoto, V. 1996. 'Reflections of oral history in Japanese American community'. In Dianie, L (editor). *Feminist Dilemmas in Fieldwork*. Colorado: Westview Press.

Mays, N, Popay, J and Pope, C. 2007. *Synthesising Qualitative and Quantitative Health Evidence: A Guide to Methods*. England: Open University Press.

McMullen, LM. 2008. *Fact Sheets as Gendered Narratives of Depression. Depression and Narrative: Telling the Dark.* Albany: Albany State University.

McQuail, D. 1994. *Mass Communication*. Hoboken, NJ: John Wiley and Sons, Inc.

Medina, SL and Overton, SL. 2008. 'The Stigma of Mental Illness'. *Journal of Counseling and Development,* 86: 143- 151.

Meloni, M. 2017. 'Scientific Racism'. In Turner, BS. (editor). *The Wiley Blackwell Encyclopedia of Social Theory.* New Jersey: John Wiley and Sons, Ltd.

Mendelson, A and Papacharissi, Z. 2010. 'Look at us: Collective Narcissism in College Student Facebook Photo Galleries'. In Papacharissi, Z. (editor). *The Networked Self: Identity, Community and Culture on Social Network Sites*. London: Routledge.

Mengesha, M and Ward, EC. 2012. 'Psychotherapy with African American Women with Depression: Is it okay to Talk about their Religious/Spiritual Beliefs?' *Religions*, 3: 19-36.

Meyer, M. 2001. *Methods of Critical Discourse Analysis*. London: Sage.

Mitchell, J, McCauley, E, Burke, P, Calderon, R and Schloredt, K. 1989. 'Psychopathology in Parents of Depressed Children and Adolescents'. *Journal of the American Academy of Child and Adolescent Psychiatry,* 28:352-357.

Modie-Moroka, T. 2016. 'A Historical Evolution of Mental Health Services in Botswana: Past and Present'. In Sossou, M and Modie,T. (editors). *Mental Health Conditions and*

Services in Selected African Countries: Implications for Social Work and Human Services Professions. New York: Nova Science Publishers.

Moll, I. 1983. 'Editorial Comment'. *Psychology in Society*, (0): 1-20.

Moreira-Almeida, A, Neto, FL and Koenig HG. 2006. 'Religiousness and Mental Health: A Review'. *Revista brasileira de psiquiatria,* 28: 242-250.

Moroka, T. 1998. 'Community (Mental Health) Care a Justification for Social Work Involvement in Botswana'. *Maatskaplike Werk/Social Work,* 34(4): 344-360.

Mouton, CJ and Marais, HC. 1991. *Basic concepts in the methodology of the social sciences.* Pretoria: Human Science Research Council.

Mutwa, VC. 2003. *Zulu Shaman: Dreams, Prophecies and Mysteries*. Vermont: Destiny Books.

Nadeem, E, Lange, JM, and Miranda, J. 2008. 'Mental Health Care Preferences among Low-Income and Minority Women'. *Archives of Women's Mental Health,* 11(2): 93-102.

Neuman, WL. 2000. *Social Research Methods: Qualitative and Quantitative Approaches* (fourth edition). Boston: Allyn and Bacon.

Neuman, WL. 2011. *Social Research Methods, Qualitative and Quantitative Approaches*. Boston: Allyn and Bacon.

Ngcobo, M and Pillay, BJ. 2008. 'Depression in African Women Presenting for Psychological Services at a General Hospital'. *African Journal of Psychiatry*, 11(1): 33-137.

Nichter, M. 1982. 'Idioms of Distress: Alternatives in the Expression of Psychosocial Distress: A Case Study from South India'. *Culture Medicine and Psychiatry*, 0: 380-408.

Orbele, S. 2002. 'Motivational and Volitional Processes in Action Initiation: A Field Study of Implementation Intentions'. *Journal of Applied Social Psychology,* 30(4): 780-797.

Orzechowska, A, Zajączkowska, M, Talarowska, M and Gałecki, P. 2013. 'Depression and Ways of Coping with Stress: A Preliminary Study'. *Medical Science Monitor*, 19: 1050-1056.

Pandalangat, N. 2011. 'Cultural Influences on Help-Seeking, Treatment and Support for Mental Health Problems - A Comparative Study using a Gender Perspective'. Phd thesis, University of Toronto.

Parker, I. 1994. 'The Information Society: A Retrospective View'. *Canadian Journal of Communication*, 19(3): 235-239.

Paruk, E and Karim, S. 2016. 'Update on Adolescent Mental Health'. *South African Medical Journal*, 106(6): 548-550.

Patel, V, Chowdhary, N, Rahman, A and Verdeli, H. 2011. 'Improving Access to Psychological Treatments: Lessons from Developing Countries'. *Behaviour Research and Therapy*, 49: 523-528.

Pierce, T. 2009. 'Social Anxiety and Technology: Face-to-face Communication versus Technological Communication among Teens'. *Computers in Human Behavior*, 25(6): 1367-1372.

Pillay, N, Ramlall, S and Burns, JK. 2016. 'Spirituality, Depression and Quality of Life in Medical Students in Kwazulu-Natal'. *The South African Journal of Psychiatry*, 22(1): 1-6.

Potter, J. 1996. 'Discourse Analysis and Constructionist Approaches'. In Richardson, JE. (editor). *Handbook of Qualitative Research Method for Psychology and the Social Sciences.* London: Routledge.

Pretorius, BT. 1986. 'Cross-cultural Application of The Centre for Epidemiological Studies Depression Scale: A study of Black South African Students'. *Psychological Reports*, 69: 1179-1185.

Rebecca, S. 2011. 'The Impact of New Social Media on Intercultural Adaptation. Senior Honors Projects.' Accessed on 30th August 2019, http://digitalcommons.uri.edu/cgi/ viewcontent.cgi?article=1230&context=srhonorsprog

Refaie, EE. 2014. 'Looking on the Dark and Bright Side: Creative Metaphors of Depression in Two Graphic Memoirs'. *Auto Biography Studies,* 29(1): 149-174.

Remick, RA. 2002. 'Diagnosis and Management of Depression in Primary Care: A Clinical Update and Review'. *Canadian Medical Association Journal*, 167:1253-1260.

Revathy, I, Aram, A and Sharmila, VS. 2018. 'Social Media as a Means to Overcome Stress and Depression among Women'. *Journal of Media and Communication Studies,* 10(6): 46-64.

Ritzer, G. 2008. *Sociological Theory*. New York: McGraw-Hill Higher Education.

Rowley, J. 2002. 'Using Case Studies in Research'. *Management Research News,* 25(1): 16- 27.

Sabaté, E. 2004. 'Depression in Young People and the Elderly'. *Priority Medicines for Europe and the World "A Public Health Approach to Innovation" Background Paper.* Geneva: World Health Organisation.

Sabri, T. 2018. 'The Dividual Self: Ethno-Psychology, Idioms of Distress and Explanatory Models of Mental Illness in Karachi, Pakistan'. MA dissertation, University of Washington.

Sammut, SC, Abela, A and Vetere, A. 2012. 'Ethical Dilemmas of a Clinician or Researcher Interviewing Women Who have Grown Up in a Family where there was Domestic Violence'. *International Journal of Qualitative Methods*, 11(2): 102-112.

Savov, R. 1997. 'Transcultural Aspects of Psychiatry in the Republic of South Africa'. *Psychosomatic Medicine*, 5: 25-29.

Schlebusch, L. 2005. 'Depression and Suicidal Behaviour'. *South African Family Practice*, 47(5):61-63.

Schweiz, JJ. 1979. 'Politics and Psychology'. *Bulletin of the British Psychological Society*, 32: 177-178.

Sehoana, MJ. 2015. 'Exploring the Perceptions of Mental Illness among Pedi Psychologists in the Limpopo Province'. MA dissertation, University of the Witwatersrand.

Seloilwe, ES and Thupayagale-Tshweneagae, G. 2007. 'Community Mental Health Care in Botswana: Approaches and Opportunities'. *International Nursing Review,* 54: 173-178.

Sey, J. 2010. 'The Black Asylum'. In Allen, L and Mbembe, A. (editors). *The Johannesburg Salon: Volume Three.* Johannesburg: Johannesburg Workshop in Theory and Criticism.

Shafi, A and Shafi, R. 2014. 'Cultural Influences on the Presentation of Depression'. *Open Journal of Psychiatry*, 4: 390-395.

Silverman, D. 2009. *Doing Qualitative Research*. London: Sage.

Smith, JA and Osborn, M. 2008. 'Interpretive Phenomenological Analysis'. In Smith, JA. (editor). *Qualitative Psychology: A Practical Guide to Research Methods*. London: Sage.

Soukhanov, A (editor). 1992. *The American Heritage Dictionary* (third edition). Boston: Houghton Mifflin Company.

Stanhope, V. 2002. 'Culture, Control and Family Involvement: A Comparison of Psychosocial Rehabilitation in India and the US'. *Psychiatry Rehab Journal*, 25(3): 273-280.

Starkowitz, M. 2013. 'African Traditional Healers' Understanding of Depression as a Mental Illness: Implications for Social Work Practice'. MA mini-dissertation, University of Pretoria.

Stein, DJ. 2009. 'Is there a 'Mosquito Net' for Anxiety and Mood Mental Illness?' *Current Psychiatry Reports*, 11(4): 264-265.

Stein, DJ. 2014. 'A New Mental Health Policy for South Africa'. *The South African Medical Journal,* 104(2): 115-116.

Stratton, SP. 2015. 'Mindfulness and Contemplation: Secular and Religious Traditions in Western Context'. *Counseling and Values*, 60: 100-18.

Sulaiman, SOY, Bhugra, D and Da Silva, P. 2001. 'Perceptions of Depression in a Community Sample in Dubai'. *Transcultural Psychiatry*, 38: 201-218.

Szabo, P, Kohn, R, Gordon, A, Levav, I and Hart, GAD. 2000. 'Ethics in the Practice of Psychiatry in South Africa'. *South African Medical Journal*, 90: 498-503.

Thoits, PA. 'Social Support as Coping Assistance'. *The Journal of Consulting and Clinical Psychology,* 54: 416-423.

Tomlinson, M and Lund C. 2012. 'Why does Mental Health not get the Attention it Deserves? An Application of the Shiffman and Smith Framework'. *Journal of the Public Library of Science,* 99(2): 1001-1178.

Topper,K, Van Rooyen, K, Grobler, C, Van Rooyen, D and Andersson, LMC. 2015. 'Posttraumatic Stress Mental illness and Barriers to Care in Eastern Cape Province, South Africa'. *Journal of Traumatic Stress*, 28: 375-379.

Tufekci, Z. 2008a. 'Can You See Me Now? Audience and Disclosure Regulation in Online Social Network Sites'. *Bulletin of Science, Technology and Society*, 28(1): 20-36.

Tufekci, Z. 2008b. 'Grooming, Gossip, Facebook and MySpace'. *Information, Communication and Society*, 11: 544-564.

Weissman, MM, Markowitz, JC and Klerman, GL. 2000. *Comprehensive Guide to Interpersonal Psychotherapy*. New York: Basic Books.

West, MA. 2016. *The Psychology of Meditation: Research and Practice*. New York: Oxford University Press.

Wittink, MN, Joo, JH, Lewis, LM and Barg, FK. 2009. 'Losing Faith and Using Faith: Older African Americans Discuss Spirituality, Religious Activities, and Depression'. *Society of General Internal Medicine,* 24(3): 402-407.

Wood, JT. 2004. *Communication Theories in Action: An Introduction* (third edition). Belmont, CA: Wadsworth.

World Federation of Mental Health. 2012. *Depression: A Global Public Health Concern.* Accessed 13 April 2019, http://www.wfmh.org/2012DOCS/WMHDay%202012%20SMALL%20FILE%20FINAL

World Health Organization. 2018. *Depression Fact Sheet*. Accessed 13 April 2019, http://www.who.int/mediacentre/factsheets/fs369/en/index.html

World Health Organization. 2012. *Depression, A Hidden Burden: Let's Recognize and Deal with it.* Geneva: World Health Organization.

World Health Organization. 1977. *Apartheid and Mental Health Care: A Preliminary Review by WHO Secretariat of the Available Information on Mental Health Services in the Republic of South Africa, Prepared for the United Nations Special Committee against Apartheid.* Geneva: World Health Organization.

Xiang, Z and Gretzel, U. 2010. 'Role of Social Media in Online Travel Information Search'. *Tourism Management,* 31(2): 179-188.

Yin, RK. 1984. *Case Study Research: Design and Methods*. Beverly Hills, California: Sage Publications.

Zainal, Z. 2007. ‘Case Study as a Research Method’. *Jurnal Kemanusiaan*, 9: 1- 6.

Appendixes

Appendix A: Information sheet

Dear prospective participant

My name is Brightness Kgatla and I am master's student at the University of Johannesburg. I am conducting research as part of the fulfilment of my masters' degree in the Department of Sociology, University of Johannesburg.

I would like to ask your permission to participate in an interview that will be held at a convenient venue. The topic of my master's dissertation is: **How do Black South African youth understand and cope with depression?** This research seeks to examine how you cope with depression in your day to day life in a black community.

Your participation in this study is entirely voluntary. You can choose not to be involved. Your real name, identity and affiliation will not be revealed in the dissertation or transcripts. Furthermore, I will make use of pseudonyms to protect your identity. If you agree to participate in this study I would like to request that you please sign the consent form in the space allocated below. Once we start with the interview you are under no obligation to continue with the interview and you can terminate the session at any time. There are no rewards for participation.

If you agree, the interview will be recorded using a digital recording device. The duration of the recorded interview will be approximately 90 minutes. Only I, as the researcher and my supervisors, Mr Muhammed Suleman and Professor Ingrid Palmary from the Department of Sociology, will have access to the transcripts. The transcripts will be stored on an encrypted storage device for 10 years for legal and ethical purposes.

Dissemination of research results: The results will be used to complete a master's degree. Furthermore, the results of this particular study will be disseminated at relevant meetings/conferences such as the annual South African Sociological Association (SASA). The research results could also be published in relevant academic journals.

If you have any questions about any aspect of this research (now, or in the course of this study, or later) please do not hesitate to contact me or my supervisors on the following number, 082 364 7470 and email brightnesslesedi77@gmail.com.

The following are my supervisor's contacts: Mr Muhammed Suleman

muhammeds@uj.ac.za
083 313 8167
Prof Ingrid Palmary
ipalmary@uj.ac.za
0115592975

We will be glad to answer all questions.

Thank you

Brightness Kgatla (Ms.)

Appendix B: Informed consent form

Title of Research

How do Black South African youth understand and cope with depression?

I……..... ***(Full names of the participants)*** hereby agree to participate in the study. I understand that withdrawal from the interview can be done at any time without any repercussions or penalties. I understand that all collected information will be kept safe and pseudonyms will be used for protection of sensitive information.

Name of the participant……..Date……

Signature of participant……..Date……

Recording of Interview

I …….. ***(Full names of the participant)*** hereby agree to participate in the study. Importantly, I understand that I will be interviewed and the interview will be fully recorded as part of an audit trail.

Name of the participant …… Date…….

Signature of participant……..Date…….

Appendix C: Interview guide

Title of Research

How do Black South African youth understand and cope with depression?

1. Tell me about yourself
2. What is your own personal understanding of depression?
3. What has shaped your understanding of depression?
4. How has your social background shaped your understanding of depression?
5. What do you do when you feel yourself becoming depressed?
6. Is there someone you talk to when you feel depressed?
7. How did you know you were depressed?

Appendix D: Ethical Clearance

UNIVERSITY OF JOHANNESBURG

FACULTY OF HUMANTIES

RESEARCH ETHICS COMMITTEE

13 November 2018

ETHICAL CLEARANCE NUMBER	**REC-02-00180-2018**
REVIEW OUTCOME	**Approved with Recommendations**
APPLICANT	Kgatla, BL
TITLE OF RESEARCH PROJECT	How Do Black African Youth Understand and Cope with Depression?
DEPARTMENT	Sociology
SUPERVISOR/S	Mr M Suleman Prof I Palmary

Dear Kgatla,

The Faculty of Humanities Research Ethics Committee has scrutinised your research proposal and confirm that it complies with the approved ethical standards of the Faculty of Humanities; University of Johannesburg. We have made some recommendations, set out below, for consideration in consultation with your supervisors.

This is an excellent proposal, highly relevant and well presented; a few recommendations below will improve its ethical considerations.

Recommendations

- There is a possibility that the people participating in this research study may assume that they will get better treatment for their depression. The information sheet should emphasise that this is not the case and the research study is conducted for research purposes only—it does not ensure better or safer treatment.
- The research participants belong to a sensitive population (with a possibly elevated risk for suicide or relapse), this should be
- The physical environment or clinical setting where study procedures will be taking place need to be specified.
- The student states on p.6 "Participants will be referred to PsyCad or another service provider (such as Islamic care line, life line etc.) if distressed by the interview". However, it is not outlined how this will be done.

- Identified Potential harm from participation will be resolved through referral to mental health organisations - Risk monitoring and safety planning have to be considered in this research.
- .

Yours sincerely,

Prof Grace Khunou
Chair: Faculty of Humanities REC
Tel: 011 559 3346
Email: gracek@uj.ac.za