



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

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Abstract

In this feminist phenomenological study rich descriptions of the subjectively lived experience of depression, as recounted by ten low-income rural women themselves, were provided. Analysis of the data obtained through semi-structured interviews, highlighted that the depressed women in this community often articulated their psychological distress as bodily symptoms. Emotions of anger, anxiety and hopelessness were also more commonly experienced and expressed than sadness. The implication is that depression in some low-income South African women might not always resemble traditional, mainstream depictions of the condition, and further, that a diagnosis of depression may serve to obscure women's feelings of anger and anxiety that are intrinsically linked to their disadvantageous social and living conditions.

Keywords

Depression, Low-income women, Interpretative phenomenological analysis

Introduction

Major depressive disorder is the single most commonly occurring mood disorder in the world [1,2]. It exacts considerable personal and social costs [3,4] and has become one of the largest social and health problems of our time [5]. The burden of depressive disorders (years of good health lost because of disability) has been ranked third in the list of mental and physical diseases [6], and it has been projected that by 2030, depression will be the number one cause of disability, ahead of HIV/AIDS, traffic accidents, cardiovascular and chronic pulmonary diseases [7].

The fact that there is a twofold greater prevalence of depressive illnesses in women than in men is similarly one of the most widely documented findings in psychiatric epidemiology [8-14]. This gender difference is typical of South African populations too [11,15-18].

Further, women in low-income communities are more likely to develop depression than women in middle- and high-income communities [19-22]. Poverty is thought to contribute to depression via its association with low self-esteem and agency, an increased number of stressful life events and chronic social adversity [11,23]. In addition, psychological literature suggests that factors such as gender, race, class and motherhood may also increase the risk of depression [16,18,22-30]. In the South African context this means that low-

income, coloured¹, black and Indian mothers are particularly at risk for developing depression [29].

Despite the fact that low-income South African women are deemed to be severely at risk for developing mental disorders such as depression, they, like low-income women elsewhere, have been largely "shut up and shut out" [31] of mainstream psychological research [12,17,32,33]. In particular, qualitative studies in which the subjective experiences of low-income women themselves are foregrounded, are scarce [26,34]. In this feminist phenomenological study, the aim was to obtain descriptions of the subjectively lived experience of depression, as recounted by low-income rural women themselves.

Method

Feminist phenomenology

Feminism and phenomenology have divergent social and theoretical roots. However, they are compatible and are thought to complement each other in important ways [35,36]. Concerned with elucidating the purely subjective aspects of conscious experience, the phenomenological researcher endeavours to provide a rich and nuanced description of a particular lived experience [37-40]. In its broadest sense, feminism can be considered an intellectual and political movement that is committed to challenging the socially and politically entrenched positions of gender inequality which disempower and subordinate women via traditional practices and attitudes [41,42]. While the feminist perspective acknowledges power differentials and pays close attention to culture, context and language, the phenomenological perspective is focused on individuals' unique lived experiences. Because feminist phenomenology concerns itself with starting from women's lived experiences while offering contextually sensitive analyses, it is deemed by some to be particularly appropriate for the study of psychological disorders such as depression [40].

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

Table 1: Participants' demographic information.

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

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

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

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

Participant selection

Phenomenological studies usually employ purposive and convenience sampling techniques in order to recruit a closely defined group for whom the research questions will be significant [43]. For the purposes of this research, female patients at a health clinic in a rural area in the Western Cape of South Africa, who were over the age of twenty and met the diagnostic criteria for major depression [44], and were of low socio-economic status (as defined by the Living Standards Measure [45], were invited to participate in the study. The first ten women who fulfilled these criteria became participants in the study after giving informed consent. Potential participants were assured that they could withdraw from or refuse to participate in the study without jeopardizing their routine care and treatment at the clinic. There were no refusals to participate and no one withdrew from the study (Table 1).

Most of the participants were between the ages of twenty-seven and thirty-eight, with the exception of Elizabeth, who was sixty-nine. One participant was white, one was black, and the other eight were coloured. Educational levels ranged from the completion of junior school to achieving a high school diploma. Four of the women had completed high school. Half of the participants were unemployed at the time of the interviews, while the other half were involved in low-paying and mostly temporary or seasonal employment. Participants lived in small and simple dwellings. Most of them, like many low-income South Africans, were sharing their homes with as many as ten other people, often including members of their extended families and/or friends. All the women were mothers; each had between one and three children in her care. Two of the women had lost a son to illness. All participants cited "Christian" as their religious affiliation, and only three were not actively involved in their local church.

Interviews

The first author of this paper conducted individual, semi-structured, in-depth interviews with each participant. Each interview lasted between 60 and 180 minutes. The interview schedule was developed with open-ended questions that allowed participants to flexibly explore their past and present experiences of depression [46]. All interviews were audio recorded and transcribed verbatim.

Ethical considerations

This study was approved by the Psychology Department at Stellenbosch University, the Stellenbosch University Research Ethics Committee, and the Health Research Ethics Committee at Tygerberg Hospital. All participants gave their informed consent both verbally and in writing. All location names, participants and persons revealed in their narratives were given pseudonyms, in respect of the ethical mandates for privacy, anonymity and confidentiality.

Data analysis

Data were analysed using Interpretative Phenomenological Analysis (IPA) as described by Smith and Osborn (2008) [47] and Smith et al. (2009) [46]. Each transcript was read and reread for familiarization before initial annotations were made. Emerging themes were then grouped into superordinate themes and corresponding theme clusters before writing up the findings. IPA is consistent with the feminist phenomenological underpinnings of this study as it considers people as embodied and embedded in specific social contexts that have been powerfully influenced by both history and culture [48].

Results and Discussion

Five superordinate theme headings emerged from the data: 1) Bodily experiences of depression; 2) Emotional experiences of

depression; 3) Complex processes of coping with depression; 4) Subjective beliefs about the factors that cause or exacerbate depression, and; 5) Subjective beliefs about the factors that alleviate depression. A number of theme clusters nestled under each superordinate theme and are discussed in the following summary and discussion of findings. While in our analysis the emphasis was on how ten individual women experienced depression, in this paper we focus on the how the experiences of participants were convergent. Where appropriate, we have commented on divergences of experiences.

Superordinate theme 1: Bodily experiences of depression

One of the most prominent findings in the study was that all the participants experienced and expressed their depressive symptoms in bodily (i.e. somatic) terms. When asked questions such as “Do you think that you are depressed?” or “What does it feel like to be depressed?” participants typically first spoke about bodily experiences that caused them immense physical and psychological discomfort. Those experiences included disturbed sleeping patterns, fatigue and bodily pain. Sleep disturbance was immediately and repeatedly equated with depression. Moreover, it was usually the *first* experience participants chose to speak about.

Interviewer: When was the first time that you started to feel depressed?

Anna: Um, a long time ago, that I feel I'm not myself. I'm not sleeping, um, my, I feel like I'm getting upset for anything... So the doctor told me that he's going to send me to you, because why, um, I don't sleep so he's feeling that I am depressed and getting worse, so I must see someone.

The women spoke not only of a physical tiredness, but also of an emotional fatigue. Interestingly, most of the women were more inclined to say “I am tired” rather than or before saying “I am sad”.

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

Ironically and poignantly, Tracey describes her utter sense of depletion, as a subjective sense of being “full”. Like Tracey, Evergreen also does not use the word “sad” or “upset”, even when the interviewer uses those words.

Interviewer: So he doesn't really understand your sadness?

Evergreen: [Crying] No. In my, um, lounge wall I have all the photos of the children, and I just sit there.

Interviewer: [Whispers] You look very upset.

Evergreen: [Whispers, crying] I'm tired. Oh.

The fact that sadness was not directly spoken about is interesting. We wondered whether there was a silent cultural norm that disallowed the articulation of sadness. This hypothesis has been explored by Swartz et al. [49] (1998) and Ussher (2013) [50], who contend that in certain contexts women signal their emotional pain through culturally approved symptoms, which allow their distress to be considered “real”. In our study, “feeling tired” appeared to function in this way.

Depression was also associated with a “body full of pain... everywhere”:

Elizabeth: My, um, I was still working in the library that Friday. And I went to my doctor, he was in X-town and I didn't realize it was depression. I thought, I look at people and I had no idea what's depression like, and I've never, I've never could imagine that your whole body is full of pain. You feel like it everywhere, like your -

Interviewer: Physical pain?

Elizabeth: *Ja*², *ja*, you've got pain everywhere...

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

It was interesting to observe that having begun talking about their emotional experiences, the women would often suddenly switch to a discussion of their physical maladies.

Interviewer: Can you tell the clinic sisters that you're sad?

Christine: No. I just come with a headache problem.

Some participants explained that they preferred to report a physical problem rather than an emotional one:

Evergreen: *Ja*. So at times I cry and then he sees and “What's wrong with you?”, “No, it's my knee. My knee pains” - and it's not my knee, you know?

Interviewer: You just pretend it's something physical?

Evergreen: *Ja*.

Pertinent to the South African context, researchers have recognized that different population groups experience emotional distress in different ways [12,17,18,49]. These authors explain that in the context of depression, bodily pain can be considered a physical expression of emotional pain. Thus, pain may symbolically represent one's emotional status, and emotional distress and depression can be experienced and expressed as physical pain [51-53]. Of course, having bodily pain might also legitimize a person's help-seeking behaviour in a context where many needs compete for limited resources. Also, given the fact that we found that many participants seemed to be ashamed about their emotional distress (see below), it may also be that an inability for, or social suppression of verbal emotional reaction has a direct effect on the production of physical symptoms [54,55].

Superordinate theme 2: Emotional experiences of depression

Participants, having explained the physical manifestations of depression, would eventually speak about the emotional experience of depression. Here, anger was usually prioritized:

Christine: My down days is when I'm angry.

Twela: When I'm sad, I get angry.

Anger emerged as a prominent feature of depression amongst the women who participated in the current study, a finding that was also prominent in other studies conducted by our research group [26,56,57]. While the DSM-5 [44] discusses anger as a possible feature (not criteria) of depression, it does so with reference to “personality disturbances” and “cognitive styles” that may account for anger outbursts and/or depression. No mention is made of justifiable anger at the various social contexts and interpersonal conditions that may logically cause one to feel angry. Unsurprisingly, it is this individualistic and person-blaming stance of the DSM that is widely criticized by feminist scholars [58-60].

Other emotions associated with depression in our study were loneliness and anxiety:

Elizabeth: It was now, the thoughts, the thought of loneliness. Very often because my, my, I feel lonely now, I feel lonely now. Feel lonely.

Evergreen: ...Because if I get anxious, I talk a lot... I'm scared, most anxious, scared, you know? ... You know, because I always had to be on the lookout, and be on my guard and, something to, something's going to happen...

Once again these findings are not unique, as both loneliness and anxiety as features of depression have been recognized in other South African studies [56,57,61-63].

Feelings of guilt and shame were also expressed by participants. Guilt, listed as a symptom of major depression in DSM-5, can be defined as a feeling of responsibility or remorse for something, real or imagined, that one has felt or done. Although Twela does not use the word guilt, in the quote below, she expresses that she feels bad about something she is doing and feeling.

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

Shame can be defined in many ways [64], but generally refers to unbearable psychological pain [65] related to perceptions of the self as being flawed, inadequate and bad [9]. Nina's sense that she is "that nothing" and "a problem for everyone" is an example of how shame emerged as an important emotion associated with the experience of depression, even if the word was not used by participants themselves:

Nina: ...I'm that "nothing" again. And it's not like I want to be something, but, it's just... You see, all my life I'm depressed. Because, I was the one that since the day I was born, I'm a problem for everyone...

The shame articulated often was associated with a changed sense of self, a gap between the ideal self and the actual self:

Tracey: ...I want more people to understand what is depression all about, because at that stage you aren't yourself.

Anna: I'm not myself anymore.

Shame and a "loss" or at least a "changed sense" of self was commonly reported in this study, as in other similar studies conducted by our research team. While these forms of emotional distress have been considered by a number of feminist and critical writers [66,67], the phenomena of shame and a loss of sense of self seem to be disregarded in mainstream diagnostic manuals (with the exception of "dissociation" proper). We have argued elsewhere that this experience of shame may be linked in pivotal ways not only to feelings of anger and/or anomie, but also to acting out behaviours ranging from verbal and physical aggression to passive withdrawal. As such, these feelings should be listened for and attended to, particularly in contexts where women are unable to live up to their and others' expectations of motherhood and womanhood.

In some cases, these complex feelings of despondency can be experienced as feelings of hopelessness, as articulated here by Elizabeth:

Elizabeth: What's the, um, what's the use of going on?

However, also apparent were the complex coping mechanisms employed by the women, ranging from acting out behaviours to covering up behaviours. These will be reported on in the next section.

Superordinate theme 3: The complexity of coping with depression

Participants reported that they coped with their feelings of distress in various ways. From the above it is apparent that they do not feel comfortable with reporting emotions such as sadness, anger and anxiety. Seemingly ashamed of such emotions they tend to be more likely to report physical problems. Also, coping mechanisms that were prominent, often served to obscure the negative emotions.

Some of the participants said that their feelings of depression became manifest through their substance-using behaviours (usually cigarettes and alcohol). These women said that they used substances to alleviate boredom, to relax, to escape traumatic memories, or in response to feeling angry, frustrated or mistreated.

Their emotional experiences of self-recrimination, low self-esteem, as well as their belief that they should not show or burden others with their sadness or admit that they needed support, were manifested in the women's tendencies to socially withdraw and hide their feelings of sadness from others:

Twela: I just kept quiet about my, my darkness and whatever I feel inside me.

Evergreen: I just, no, I say I've got a smiling depression and then laugh...

Interviewer: What does that mean to you?

Evergreen: It means that I laugh just to, that people don't see the hurt. It just covers it up.

All the participants appeared to be aware of the social stigma attached to being emotionally distressed and therefore tended to keep "quiet about my, my darkness" or developed what Evergreen calls "a smiling depression" so "that people don't see the hurt". It was clear that they were ashamed of the emotions associated with depression, thus the paradoxical notion of a smiling depression. However, in hiding their feelings, they began to feel even more distressed, alone and overwhelmed, and thus perpetuated the depressive experience.

The women's emotional experiences of anger (reported above) were manifested in displays of aggression, swearing and shouting:

Nina: Even, even, I should yell out. I just feel like, if I had the power, to hurt him so much that he will never bother me - I just want to hurt him so much that he never wakes up again... It's like I want to, I just want to kill him³...

Twela: ... And I just... just... *aggressive we* (aggressive)... Yes. If I told you to do the thing and you don't do that, or you make too long, and I'm just angry and I shout at you, and, and, and... I just get angry for every little thing...

Anger and aggressive behavior as a prominent manifestation of depression in South African women has been recognized and discussed by other authors [26]. The women, however, did not consider their anger to be an ego-syntonic emotion, and the experience thereof consequently caused them to feel even more distressed:

Twela: So I don't want to be that person. I want to be, ah, calm... Yes, and I don't want that angry. It's, it's frightening. I don't want that angry.

When questioned about suicide, which can be regarded as an act of aggression that is directed towards the self [68], most of the participants immediately denied entertaining any such thoughts or impulses, explaining that this would be wrong on two counts. Firstly, they regarded suicide as a religious sin:

Evergreen: if you believe in the Lord, you're going to go to hell if you take your own life.

Secondly, they believed that it would be wrong to abandon their child and family caretaking responsibilities in that way. However, upon further careful questioning, many of the women eventually admitted to experiencing suicidal ideation and even attempts.

Evergreen: ...And I was walking on the road, the 364. And you know, a big, big truck came out from the beach side, with that ah, silver thing in front, shiny, glimmering in the sunlight. All of a sudden this thought came to me, "you can just run in front! It will be over just like that!" [snaps her fingers]. [Sighs] ...I, I couldn't believe it, this urge. Some time ago I had this thoughts and stuff, but the minute I thought about Evan, "who's going to take care of him now?" And then this truck just went past...

For each participant, it appeared to be the idea of "escaping" - whether from past memories or current circumstances - that caused them to consider the idea of suicide. However, probably due to their subscription to cultural norms regarding religion and mothering, they felt deeply shameful about such thoughts, and therefore tended not to speak about them.

Superordinate theme 4: Subjective beliefs about the factors that cause or exacerbate depression

This and other South African studies that have assessed women's constructions of the causes of their depression all report remarkably similar findings: women tend to attribute their depression to social causes (such as abuse and deprivation) and interpersonal factors,

³ The researcher in this study (a clinical psychologist) thoroughly risk-assessed all mentions of suicidal or homicidal tendencies during the participant interviews. As the interviews took place at a primary health care clinic, participants who required prolonged assessment or hospital admission could be appropriately attended to. None of the study participants required hospital admission.

specifically, how others could hurt or humiliate them [33,34,56,57,69]. When asked what might have caused their feelings of depression, the women in this study typically gave reasons that focused on: the loss of an important relationship (whether by death or abandonment); a history of childhood trauma (physical or sexual abuse and/or negative relationships with parents); intimate partner relationship problems/abuse; having multiple responsibilities; feeling either emotionally or practically unsupported; and feeling constantly afraid by virtue of living in dangerous and violent communities.

While issues related to poverty or economic disadvantage were occasionally mentioned or implied, having limited financial resources was never explicitly cited as a reason or explanation for feeling depressed. Rather, what the women felt distressed them most in this regard, were the factors that were indirectly related to their economic position. For instance, many of the women described not being able to provide for their children as particularly depressing [70]:

Interviewer: When are you the most sad?

Melissa: When the babies is hungry. That time.

However, it was the loss of a relationship or the absence of a satisfying relationship that was the most frequently cited reason for feeling depressed. In other words, it was in the context of relationships that the women's depression came to the fore.

Interviewer: What does it mean to you, to be depressed?

Christine: Just thinking and stress about stuff, just thinking about my problems, and I seeing now "Oh, my relationship is not on a level now that it should be"...

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

Superordinate theme 5: Subjective beliefs about the factors that alleviate depression.

Participants identified a number of conditions that helped them to feel better or more resilient in the face of depression. Most of these were simply the opposite counterparts of the factors that they had identified as causing their depression. In particular, feeling cared for and able to share one's feelings in the context of a supportive relationship, involving oneself in religious activities, and having access to healthcare services, were all identified as being particularly valuable.

Christine: Just making jokes and playing with me, he says "No, don't be like

that, there's a lot of people who are like that, talk to me about it. Don't worry

about stuff!" and he's talking to me and I say "OK" ...It helps me a lot... because he always sees what I cannot see... Later he will come back "Are you

feeling alright now?" "Yes, I am alright"...He really understands me.

Elizabeth: Ja, we [the psychosocial rehabilitation group at the clinic] come together. We all had the same, had plus-minus the same experience... We understood each one's problems...

Interviewer: It helps to be with people who have had the same experiences.

Elizabeth: Ja, ja, ja. Very much!

Maintaining their religious beliefs was especially important

to many of the participants. Engaging in prayer or religious ritual seemed to provide them with ways of remaining calm and hopeful in the context of daily trials and hardships. Similar findings have been reported in other studies on depressive symptoms [71-73].

Elizabeth: The Lord will protect me... Trust in the Lord and he provides.

Evergeen: I had just this, this, feeling that I'm dirty, dirty, dirty... I just live for, ah, church services, um, to have the Holy Communion, to get Holy Communion to give myself faith, you know. Just to hear the words "Your sins are forgiven."

Two participants expressed their belief that medical treatments for the symptoms of depression were both necessary and useful (especially with regard to alleviating insomnia, which most of the women identified as a particularly troubling symptom):

Elizabeth: They put me on Trepeline, and there's a bit better, and finally I was put on Fluoxetine, which did a lot for me, and I am coping very well on Fluoxetine.

Anna: I was feeling well, because the sleeping pills did help, most of the time.

But the meds is up, it's like going back... because I don't sleep.

However, the majority believed that interventions that focused exclusively on medication had only limited usefulness. They affirmed that the protective and healing effect of feeling cared for in an empathic relationship should not be underestimated. Specifically, they felt that having a respectful, considerate relational encounter with another provided them with tremendous relief from many of their depression-linked experiences, including loneliness, despair, sadness and anxiety.

Interviewer: Have you ever been given pills to help make you feel better?

Christine: No.

Interviewer: Do you think you need anything like that?

Christine: No, just talking.

Interviewer: What do you think you need to help you to feel better?

Twela: Someone who listen, man, I, um, medicines or what didn't help for something inside you.

Conclusion

In order to plan better mental health interventions and contribute to policy development for low-income women in South Africa, psychological research on women's lived experiences is urgently needed. In this feminist phenomenological study our aim was to bring traditionally overlooked perspectives to the fore, by providing rich descriptions of the subjectively lived experience of depression, as recounted by low-income women who had been diagnosed as depressed. The findings revealed that the current dominant conceptualization of depression may be culturally inappropriate and insufficient, as it does not account for the multifaceted nuances of women's psychological distress or attend to the social/political contexts within which women become depressed.

In this phenomenological study concerned with a group of low income women's subjective experiences of depression a more complex picture (than that which is typically offered by mainstream models and diagnostic systems alike) of "depressed" women's psychological distress emerged. While there were of course differences between participants, our most striking finding was the complexities of the clinical picture that emerged for all the women, a clinical picture that seemed to be obscured by existing descriptions of major depression. Prominent for the participants in their experience of depression were sleeping difficulties, exhaustion and bodily pain. More difficult for participants to talk about was their feelings of

sadness, anxiety, loneliness and anger. They seemed to be ashamed of their emotional distress and experienced it as a changed sense of self resulting in changed relationships. They coped with these complex feelings by not directly recognizing the emotional distress: they used substances, denied their depression by pretending to be happy and by acting out in aggressive ways. The depressed woman in this study felt rejected, disconnected, alone, angry, vulnerable, afraid, tired, fragile, frustrated, abandoned and uncared for. Participants clearly felt overburdened by multiple and opposing responsibilities, understood that their emotional distress was caused by feelings of isolation and loneliness, but despite desperately wanting and needing support, they seemed to be too ashamed to directly ask for it.

It was evident that the emotional experiences of depression and their corresponding physical and behavioural manifestations had a deleterious effect on the women's daily lives. While all of the participants had at some stage experienced an overwhelming desire to simply "give up" or disengage from their lives and responsibilities, none of them truly considered this to be a tenable option. So committed were they to their roles and responsibilities, that they simply persisted in trying to meet them, even when doing so was to their own detriment. This picture of depression - of continuing to function and engage with daily life, often in a way that is energized by anger - contrasts with the traditional portrayal of depression as being simply an inert state of disengagement and apathy [26]. It quickly became apparent that depression in some low-income South African women might not always resemble traditional, mainstream depictions of the condition.

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

The women interviewed attempted to explain why they had become depressed in terms of their complex relationships and life events. When asked about the causes of depression, participants clearly constructed depression as a psychosocial, or more specifically, a relational phenomenon. Research on women and depression supports the notion of the cause and experience of depression being situated within the relational domain. For instance "(i)mpaired bonding and loneliness" were found as strong predictors or causes for postpartum depression in women [74]. Further important risk factors related to depression in women were found to be "inadequate social support, high relational conflict, sense of belonging, and loneliness" [75]. Relational well-being was also found to be a buffer against depressive symptoms in women [76].

Throughout the course of their lives, the women in this study had to cope with: childhoods marked by violence, disruption and abuse; partial schooling; absent parents; multiple pregnancies and deaths; overcrowded housing; sexual violence; substance abuse; having to make a living to support themselves and their families; and trying to care (often single-handedly) for their children and other family members. However, to describe them simply as "depressed" would be to capture only one fragment of their very complicated experiences. In fact, such a diagnosis might actually serve to obscure the intricacy of their emotional experiences as well as their ability to cope [58,77].

Clinical implications

The findings discussed in this study indicate that a wide range of interpersonal, social, political, emotional, physical and practical issues affect the quality of life and determine the health and wellbeing

of low-income women. The participants' narratives highlighted how pervasive and chronic poverty, abuse and neglect affect generations of women and children: "Such situations are destructive to women's mental health, and must be challenged at a societal level, since social change can only be achieved when women are able to question the societal structures that sustain oppression" [27]. Researchers, healthcare professionals and policy-informers must therefore become committed to highlighting the "links between the social conditions of people's lives and their suffering: When there is oppression, there is pain" [58]. However, highlighting the circumstances of people's lives is only the first step. Rather than simply helping people to adjust to the conditions that cause their distress, the necessary second step should be towards transforming those conditions [77].

The women in this study clearly communicated their conviction that being provided with both therapy and medication (primarily to alleviate their symptoms of insomnia and bodily pain) were ultimately beneficial treatments for depression. Given the strong emphasis on sleep disturbance and bodily pain as features of depression found in this study, it is also recommended that healthcare workers carefully assess patients who present with somatic complaints for other symptoms of depression [53].

Given the high incidence of depression in women and the pervasive loneliness that depressed women feel, it may also be worthwhile to consider the benefits of support group therapy, particularly in low-income South African communities where there are not enough mental health-care practitioners to support the number of people needing assistance. Overall, it is our belief that if treatment is to be effective, it should be concerned also with prevention; with the context of the illness as well as intervention; and with care as well as cure.

Limitations of the current study

The study is limited in several ways. Firstly, the first author of the present study was involved in every phase of the research. Such close involvement assisted us in gaining insight and a thorough understanding of the data. While it is recognized that her subjectivity as researcher undoubtedly affected every stage of the research process, the scope of the current paper did not allow for a more detailed investigation of exactly how her subjectivity influenced the research. Secondly, the current study consisted of a very small number of low-income women. This was deemed acceptable, based on the argument that the study was sacrificing breadth for depth of data. It is possible that other groups of South African women might offer vastly different and valuable perspectives. We are not claiming that this is a representative sample and that results can be generalized to all South African women. Also, while in our analysis the emphasis was on how ten individual women experienced depression, in this paper we focus more on how the experiences of participant were convergent. Where appropriate, we have commented on divergences of experiences, but it is clear that case studies of the individual participants may yield even richer results. Thirdly, as English was not the primary language of the women who participated in this study, it is likely that the richness of the data has been compromised.

In conclusion, depression, as experienced by the women in this and other South African studies [17,26,34], emerged as something far more complex than a discrete diagnosis as purported by the biomedical model of depression. Rather, it was shown to be a convoluted and pervasive state that infiltrated and changed every aspect of a woman's body, personality, relationships and indeed, life-world. Thus we suggest that it may be more useful to understand depression as a dynamic and variable experience, rather than as a static state, and as an ongoing element of the more complex experiences of a capricious self in a particular sociopolitical context. It seems that no single perspective (feminist, medical, social or other) can provide both the breadth and depth of insight that is necessary for a thorough understanding of a phenomenon as complex as women's psychological distress. We suggest that it is important to think about women's emotional distress in new, broader and more inclusive ways - not necessarily captured by a diagnosis of depression.

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References

- Mazure C, Keita G, Blehar M (2002) Summit on women and depression: Proceedings and recommendations. American Psychological Association, Washington, DC.
- Schlimme J (2013) Depressive habituality and altered valuing. The phenomenology of depressed mental life. *Journal of Phenomenological Psychology* 44: 92-118.
- Hugo C, Boshoff D, Traut A, Zungu-Dirwayi N, Stein D (2003) Community attitudes toward and knowledge of mental illness in South Africa. *Soc Psychiatry & Psychiatr Epidemiol* 38: 715-719.
- Kupfer DJ, Frank E, Phillips ML (2012) Major depressive disorder: new clinical, neurobiological, and treatment perspectives. *Lancet* 379: 1045-1055.
- (2006) Women's mental health: A public health concern. Regional health forum. World Health Organization (WHO), Geneva, Switzerland.
- (2011) The great push: Investing in mental health. World Federation for Mental Health.
- (2008) Task shifting: Global recommendations and guidelines. World Health Organization (WHO), Geneva, Switzerland.
- Kessler RC (2003) Epidemiology of women and depression. *J Affect Disord* 74: 5-13.
- Kohen D (2010) Women and mental health. Routledge, London.
- McMullen L, Stoppard J (2006) Women and depression: A case study of the influence of feminism in Canadian Psychology. *Feminism & Psychology* 16: 273-288.
- Moultrie A, Kleintjies S (2006) Women's mental health in South Africa. *South African Health Review* 21: 347-366.
- Ngcobo M, Pillay BJ (2008) Depression in African women presenting for psychological services at a general hospital. *Afr J Psychiatry (Johannesbg)* 11: 133-137.
- Nolen-Hoeksema S, Keita GP (2003) Women and depression: An introduction. *Psychology of Women Quarterly* 27: 89-90.
- Rocha N, Schuch F, De Almeida F (2014) Gender differences in perception of quality of life in adults with and without chronic health conditions: The role of depressive symptoms. *Journal of Health Psychology* 19: 721-729.
- Olley BO (2006) Psychological distress in the first year after diagnosis of HIV infection among women in South Africa. *Afr J AIDS Res* 5: 207-215.
- Stein DJ, Seedat S, Herman A, Moomal H, Heeringa SG, et al. (2008) Lifetime prevalence of psychiatric disorders in South Africa. *Br J Psychiatry* 192: 112-117.
- Tomlinson M, Swartz L, Kruger LM, Gureje O (2007) Manifestations of affective disturbance in sub-Saharan Africa: key themes. *J Affect Disord* 102: 191-198.
- Tomlinson M, Grimsrud A, Stein D, Williams D, Myer L (2009) The epidemiology of major depression in South Africa: Results from the South African stress and health study. *S Afr Med J* 99: 368-373.
- Burdette AM, Hill TD, Hale L (2011) Household disrepair and the mental health of low-income urban women. *J Urban Health* 88: 142-153.
- Elliott L, Masters H (2009) Mental health inequalities and mental health nursing. *J Psychiatr Ment Health Nurs* 16: 762-771.
- Havenaar J, Geerlings M, Vivian L, Collinson M, Robertson B (2008) Common mental health problems in historically disadvantaged urban and rural communities in South Africa: Prevalence and risk factors. *Soc Psychiatry Psychiatr Epidemiol* 43: 209-215.
- Levy LB, O'Hara MW (2010) Psychotherapeutic interventions for depressed, low-income women: a review of the literature. *Clin Psychol Rev* 30: 934-950.
- Belle D, Doucet J (2003) Poverty, inequality, and discrimination as sources of depression among U.S. women. *Psychology of Women Quarterly* 27: 101-113.
- Kagee A (2008) Symptoms of depression and anxiety among a sample of South African patients living with a chronic illness. *J Health Psychol* 13: 547-555.
- Kehler J (2001) Women and poverty: The South African experience. *Journal of International Women's Studies* 3: 41-53.
- Kruger L, Van der Straaten K, Taylor L, Dukas C, Lourens M (2014) The melancholy of murderous mothers: Reflections on the violence of the institution of motherhood. *Feminism and Psychology* 24: 461-478.
- Pillay AL, Kriel AJ (2006) Mental health problems in women attending district-level services in South Africa. *Soc Sci Med* 63: 587-592.
- Ramchandani PG, Richter LM, Stein A, Norris SA (2009) Predictors of postnatal depression in an urban South African cohort. *J Affect Disord* 113: 279-284.
- Jeremy Seekings (2007) Poverty and inequality after apartheid. Centre for Social Science Research (CSSR), University of Cape Town, South Africa.
- Tomlinson M, Swartz L, Cooper P, Molteno C (2004) Social factors and postpartum depression in Khayelitsha, Cape Town. *South African Journal of Psychology* 34: 409-420.
- Reid P (2011) Revisiting "Poor women: Shut up and shut out". *Psychology of Women Quarterly* 35: 189-192.
- Dukas C (2009) Misunderstanding depression in South African women: A feminist social constructionist analysis of the literature. Unpublished (MA) dissertation, Stellenbosch University.
- Newman C (2005) Stories of sadness: The experience of depression amongst urban black women in Hillbrow, South Africa. Unpublished (MA) dissertation, University of Witwatersrand.
- Rapmund V, Moore C (2000) Women's stories of depression: A constructivist approach. *South African Journal of Psychology* 30: 20-30.
- Fisher L (2010) Feminist phenomenological voices. *Continental Philosophy Review* 43: 83-95.
- Fisher L, Embree L (2000) Feminist phenomenology. Kluwer Academic Publishers, The Netherlands.
- Finlay L (2008) Introducing phenomenological research.
- Giorgi A (2012) The descriptive phenomenological psychological method. *Journal of Phenomenological Psychology* 43: 3-12.
- Kendler HH (2005) Psychology and phenomenology: a clarification. *Am Psychol* 60: 318-324.
- Røseth I, Binder P, Malt U (2011) Two ways of living through postpartum depression. *Journal of Phenomenological Psychology* 42: 174-194.
- Russell D (1996) Between a rock and a hard place: The politics of White feminists conducting research on Black women in South Africa. *Feminism & Psychology* 6: 176-189.
- Shefer T (2008) Psychology and the regulation of gender. In: D Hook, N Mkhize, P Kiguwa, A Collins, E Burman, I Parker, Critical psychology. UCT Press, Lansdowne, 187-202.
- Carolan M (2014) Diabetes nurse educators' experiences of providing care for women, with gestational diabetes mellitus, from disadvantaged backgrounds. *J Clin Nurs* 23: 1374-1384.
- (2013) Diagnostic and statistical manual of mental disorders. (5th edn), American Psychiatric Association, Washington, DC.
- Golding P, Murdoch G (1992) Culture, communication and political economy. In Curran J and Gurevitch M, Mass Media and Society, Edward Arnold, London, 178-237.
- Smith J, Flowers P, Larkin M (2009) Interpretative phenomenological analysis. Theory, method and research, Sage, London.
- Smith J, Osborn M (2008) Interpretative phenomenological analysis. In: J. Smith, Qualitative psychology. A practical guide to research methods, Sage, London.
- Shinebourne P (2011) The theoretical underpinnings of interpretative phenomenological analysis (IPA). *Existential Analysis* 22: 16-31.
- Swartz L (1998) Culture and mental health: A Southern African view. Oxford University Press, Cape Town, South Africa.
- Ussher J (2013) Diagnosing difficult women and pathologising femininity: Gender bias in psychiatric nosology. *Feminism & Psychology* 23: 63-69.
- Jenkins A (1990) Invitations to responsibility: Therapeutic engagement of men who are violent and abusive. Dulwich Centre Publications, Adelaide.
- Liebert R (2010) Feminist psychology, hormones and the raging politics of medicalization. *Feminism & Psychology* 20: 278-282.
- Rytwinski N, Avena J, Echeverri-Cohen A, Zoellner L, Feeny N (2014) The relationships between posttraumatic stress disorder severity, depression severity and physical health. *Journal of Health Psychology* 19: 509-520.
- Kirmayer LJ (1984) Culture, affect and somatization. *Transcultural Psychiatric Research Review* 21: 159-188.

55. Lochner L (1999) Women of farms: Discourses of distress. Unpublished Masters thesis, Stellenbosch University.
56. Lourens M, Kruger L (2013) Die subjektiewe ervaring van depressie onder Suid-Afrikaanse vroue in 'n lae-inkomste gemeenskap. *Social Work/ Maatskaplike Werk* 49: 248-270.
57. Taylor L (2011) "Mad, bad and sad" - but still coping: An inter subjective psychoanalytic case study of depression in one low-income South African woman. Unpublished (MA) dissertation. Stellenbosch University.
58. Lafrance M, McKenzie-Mohr S (2013) The DSM and its lure of legitimacy. *Feminism & Psychology* 23: 119-140.
59. Marecek J, Gavey N (2013) DSM-5 and beyond: A critical feminist engagement with psychodiagnosis. *Feminism & Psychology* 23: 3-9.
60. Swartz S (2013) Feminism and psychiatric diagnosis: Reflections of a feminist practitioner. *Feminism & Psychology* 23: 41-48.
61. Faure S, Loxton H (2003) Anxiety, depression and self-efficacy levels of women undergoing first trimester abortion. *South African Journal of Psychology* 33: 28-38.
62. Herbst E (2006) The illness experience of HIV-infected low-income Coloured mothers in the Winelands Region: Theoretical and practical implications. Unpublished(PhD) dissertation, Stellenbosch University.
63. Theron L (2005) An investigation of depression and anxiety amongst women in the Swartland Region of South Africa. Unpublished (M.A.) dissertation, University of South Africa.
64. Kruger L (2012) 'Vrot kolletjies': shame, silence and enactment in psychotherapy with impoverished clients. *Psycho-analytic Psychotherapy in South Africa* 20: 1.
65. Pattison S (2003) *Shame: Theory, therapy, theology*. Cambridge University Press, Cambridge.
66. Jack D (1991) *Silencing the self: Women and depression*. Harvard University Press, Cambridge, MA.
67. Lewis S (1996) The social construction of depression: Experience, discourse and subjectivity. Departments of Psychology and Psychiatry, University of Sheffield, England.
68. Hillbrand M (2001) Homicide-suicide and other forms of co-occurring aggression against self and against others. *Professional Psychology: Research and Practice* 32: 626-635.
69. Polders L, Nel J, Kruger P, Wells H (2008) Factors affecting vulnerability to depression among gay men and lesbian women in Gauteng, South Africa. *South African Journal of Psychology* 38: 673-687.
70. Kruger LM, Lourens M2 (2016) Motherhood and the "Madness of Hunger": "...Want Almal Vra vir My vir 'n Stukkie Brood" ("...Because Everyone Asks Me for a Little Piece of Bread"). *Cult Med Psychiatry* 40: 124-143.
71. Archibald P, Dobson S, Daniels K, Bronner Y (2013) Explaining African-Americans' depressive symptoms: A stress-distress and coping perspective. *J Health Psychol* 18: 321-331.
72. Bekke-Hansen S, Pedersen C, Thygesen K, Christensen S, Waelde L, et al. (2014) The role of religious faith, spirituality and existential considerations among heart patients in a secular society: Relation to depressive symptoms 6 months post-acute coronary syndrome. *Journal of Health Psychology* 19: 740-753.
73. Bennett KS, Shepherd JM (2013) Depression in Australian women: the varied roles of spirituality and social support. *J Health Psychol* 18: 429-438.
74. Kruse JA, Williams RA, Seng JS (2014) Considering a Relational Model for Depression in Women with Postpartum Depression. *Int J Childbirth* 4: 151-168.
75. Kruse J (2012) Considering a relational model for depression in women. University of Michigan. (D Thesis), Ann Arbor.
76. Lund T, Chan P, Liang B (2014) Depression and relational health in Asian American and European American college women. *Psychology in the Schools* 51: 493-505.
77. Ussher J (2010) Are we medicalizing women's misery? A critical review of women's higher rates of reported depression. *Feminism & Psychology* 20: 9-35.