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Contextualized understanding of depression: A vignette study among the !Xun and Khwe of South Africa

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Abstract

Colonial misconceptions about the absence of depression and the lack of a psychologization of distress among Africans have long been refuted. However, cultural variation in depression in terms of symptomatic expression, conceptualization, explanatory models, and social responses is widely acknowledged. Insight into the cultural variation of depression is useful for providing appropriate care; however, few studies have explored cultural understandings of depression in African settings. In a depression vignette study of two displaced and marginalized San communities in South Africa, we conducted 20 semistructured interviews to explore causal interpretations and strategies for coping. Causal interpretations consisted of several dimensions, including life struggles and physical, psychological, and spiritual interpretations. Respondents primarily focused on life struggles in terms of socioeconomic and interpersonal problems. They described coping strategies as primarily addressing negative emotional and psychological affect through social support for relief, comfort, distraction, or advice on coping with the situation and emotions. In addition, religious coping and professional support from a social worker, psychologist, support group, or medications were mentioned. Findings illustrate that depression should be understood beyond individual suffering and be situated in its immediate social environment and larger sociopolitical setting. Interventions for depression therefore may benefit from a multilevel approach that addresses socioeconomic conditions, strengthens local resources, and fosters collaboration among locally appropriate informal and formal support structures.

Keywords

depression, indigenous people, San, South Africa, vignette study

Introduction

In the colonial era, depression and other mental health problems were perceived to be absent or rare among Africans (Gureje, 2007; Prince, 1967). This reasoning was in line with colonial ideas about Africans as ''primitives,'' depression as an elite condition (Njenga, 2002; Prince, 1967), and Africans as protected by traditional social and cultural values (Njenga, 2002). When mental health professionals did acknowledge mental health problems among Africans, their understanding was typically characterized by highly cultural and discriminatory attitudes. Such views were expressed, for example, by describing specific conditions as an ''African illness'' for which Western approaches were considered useless, or explaining mental health problems in terms of an ''African personality,'' such as an inability to express emotions (Swartz, 1986, 1987). These findings and interpretations had a profound impact on how colonial states related to native populations and those affected by mental health problems. Njenga (2002, p. 356) mentions that colonial governments used the aforementioned interpretation to

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‘‘‘prove’ that Africans agitating for independence were psychopathic.’’ Similarly, Swartz (1996) describes how cultural relativism was used to legitimize unequal access to Western treatment based on a belief that indigenous healing was the Africans’ ‘‘natural’’ choice in South Africa. However, Swartz (1986, 1987) also notes that there were critical voices that considered exotic interpretations of mental health problems among Africans as discriminatory and have advocated for a universalistic understanding of mental health problems. Currently, cultural relativism remains a sensitive topic in some African settings, such as South Africa. This sensitivity is reflected in the critical statement by Tomlinson, Swartz, Kruger, and Gureje (2007) that studies often focus on how depression differs in African cultures.

Current research on mental health in African countries often takes a universalistic stance. Epidemiological studies provide evidence for the existence of depression and other Western diagnostic categories for mental disorders (e.g., Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009; Tomlinson et al., 2007). In addition, formal health care systems commonly take a biomedical, or Western, approach to diagnosis and treatment. However, other studies that take a cultural relativistic stance and argue that Western diagnostic criteria are adopted without critical reflection on construct validity (Kleinman, 1977; Parry, 1996; Sweetland, Belkin, & Verdeli, 2014), describe this process as a category fallacy. Critiques of the universalistic approach also include concerns about replacing local idioms and understandings with Western diagnostic categories (Abramowitz, 2010; Summerfield, 2012)—a process which Summerfield (2012) has described as reminiscent of imperialism. Critics thus point out that, in this process, local idioms are disentangled from sociocultural contexts and are transformed into individualistic and often medical conditions (Abramowitz, 2010; Summerfield, 2012).

Research conducted in various world regions has identified cultural variations in depressive conditions in terms of symptomatic expression, conceptualization, explanatory models, and social responses (Bhugra & Mastrogianni, 2004; Kirmayer, 2001). For example, in some settings, conditions resembling depression may be better described as ‘‘soul loss’’ rather than ‘‘sinking mood’’ (de Jong, 2004). Several approaches such as the notions of explanatory models (Kleinman, Eisenberg, & Good, 1978; Weiss, 1997), idioms of distress (de Jong & Reis, 2013; Nichter, 1981, 2010), and semantic network analysis (Good, 1977) have contributed to a cultural understanding of mental health problems. The few studies on cultural understanding of depressive conditions in South Africa (Davies, Schneider, Nyatsanza, & Lund, 2016; Kathree, Selohilwe, & Petersen, 2014) indicate that meanings are situated in local contexts in which financial insecurity, dysfunctional (family) relationships, violence, and lack of social support are central. In addition, local idioms of distress such as ‘‘thinking too much’’ were identified (Davies et al., 2016). Insights into cultural understanding of mental health problems have proven useful for facilitating intercultural clinical encounters, for example, for treatment negotiation or compliance, therapeutic alliance, recognition of signals of distress, and identification of cultural resources that could complement psychiatric treatment (Bhui & Bhugra, 2002; Hinton & Lewis-Fernández, 2010; Kirmayer, 2001; Kleinman et al., 1978). Cultural understanding of depressive conditions and in particular the identification of local resources could be useful for developing locally appropriate care and bridging the treatment gap in low-resource settings. However, the paucity of studies on this topic in African settings obstructs the development of locally appropriate care.

This paper reports on a vignette study of depression among the San people living in South Africa and seeks to contribute to a cultural understanding of depression. The San are a group of indigenous people from southern Africa who have experienced social, cultural, economic, and political oppression; land dispossession; and displacement (Gordon & Sholto-Douglas, 2000; Robins, Madzudzo, & Brenzinger, 2001; Suzman, 2001). These disruptive histories and poor socioeconomic conditions cannot be seen as separate from mental health outcomes (Cohen, 1999; Desjarlais, Eisenberg, Good, & Kleinman, 1995; Miller & Rasco, 2004; Miller & Rasmussen, 2010; Patel & Kleinman, 2003; Porter & Haslam, 2005; Steel et al., 2009). Despite NGOs’ and scholars’ interest in San communities, mental health has received little to no attention. Consequently, we do not have information on the San’s understanding of mental health problems and their social response. The study reported here is part of a doctoral research project on mental health perceptions and care among the !Xun and Khwe San communities in South Africa.

Context of the study

The !Xun and Khwe are two San communities of approximately 4,500 and 1,700 people, respectively (South African San Institute, 2010). They are linguistically distinct and predominantly speak their own San languages, !Xun and Khwe. Afrikaans is used as lingua franca and English is spoken by only a few, generally in the younger generation. The communities share a history of war and displacement, and currently reside together in the Platfontein township on the outskirts of the Northern Cape capital, Kimberley.

The !Xun and Khwe are originally from southern Angola and northeast Namibia and were brought

together in the Angolan War of Independence (1961–1974) and the South African Border War (1966–1989; den Hertog, 2013). In the Angolan War of Independence, the!Xun and Khwe fought alongside the Portuguese against various liberation fractions. After Angola's independence in 1975, many!Xun and Khwe fled the country. They did so in fear of retribution by former enemies. This was not an unfounded concern considering the local population's wish for revenge on the San and reports of a large number of San having been killed during and near the end of the war (Battistoni & Taylor, 2009; Brinkman, 2005; Robbins, 2007; South African San Institute, n.d.). The !Xun and Khwe seeking refuge in northeast Namibia (Caprivi area) were incorporated in the South African Defence Force (SADF; Sharp & Douglas, 1996). Khwe originally residing in the Caprivi area also joined ''Bushman battalions.'' The San soldiers lived with their families on a military base and depended on the SADF for housing, employment, schooling, general services, and everyday activities (Gordon & Sholto-Douglas, 2000). After Namibia's independence in 1990, many!Xun and Khwe opted to follow the SADF to South Africa in fear of retribution and maltreatment by the South West Africa People's Organization (SWAPO) government and because of their loyalty towards the SADF (South African San Institute, n.d.). In South Africa, they soon outlived their military purpose and faced an uncertain future. The Bushman battalions were disbanded, many people lost their employment in the defence force, and permanent housing plans were suspended (Robbins, n.d.). The !Xun and Khwe resided in a tented camp on a military base in the Northern Cape for nearly 13 years before being forced to relocate to Platfontein after a local community successfully filed a land claim for the military base (South African San Institute, n.d.).

A history of marginalization and displacement left the!Xun and Khwe facing a myriad of problems while trying to build a life in South Africa. Although life improved in terms of housing, proximity to a large city, and access to health care,!Xun and Khwe people continue to feel marginalized and neglected by the local government (Tempelhoff, 2014). The poor quality and limited number of houses, and poor provision of services are pressing issues voiced by the San communities. Poverty is another pressing issue, as 97% of the!Xun and Khwe live on less than US$1.00 per day, and unemployment is at 95% (Dalton-Greyling & Greyling, 2007; South African San Institute, 2010). Consequently, most families live on social grants or the income generated by one family member. Social conflicts and alcohol abuse have been reported among the!Xun and Khwe (Robins et al., 2001) and continue to the present day. Although statistics are not available, HIV/AIDS and tuberculosis are considered to be major health issues by community leaders, NGOs, and staff of the health care clinic situated in the centre of Platfontein (Govender, Miti, Dicks, & Ewing, 2013; Letsoalo, 2010). In addition to biomedical health care, the!Xun and Khwe use traditional healing to address health issues (De Jager, Prinsloo, & Joubert, 2010; Letsoalo, 2010).

Method

This study is part of a research project on mental health perceptions and care among the!Xun and Khwe, which took place in three consecutive fieldwork visits of approximately three months each, between 2012 and 2014. The aim of the study described here was to explore local San perceptions of depression, defined as ''the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function'' (American Psychiatric Association, 2013). A qualitative approach was adopted in the form of a vignette study with semistructured interviews. In addition, ethnographic data were used to situate research findings in the local sociocultural context.

Sample

Data were collected from March to June 2013 by the first and second authors. The !Xun and Khwe were both part of this study. Various sampling procedures were used to recruit respondents in a broad age range (above 18 years) and an equal distribution of gender and San groups (!Xun and Khwe). First, since the study was exploratory, convenience sampling was used whereby social contacts developed throughout our fieldwork resulted in initial recruitment. Second, snowball sampling was used to facilitate access to additional participants. Finally, research facilitators (community members who assisted us during various research projects) helped us with purposively recruiting respondents who were underrepresented, specifically older respondents. Recruitment took place during the predetermined length of 2.5 months of fieldwork. In total, 24 interviews were conducted, of which, four were excluded because communication difficulties resulted in unintelligible and superficial data. Data analysis revealed data saturation in the main themes and underlying patterns. Throughout our fieldwork period, we were assisted by several Khwe community members, although similar assistance was not available in the!Xun community. In order to compensate for this situation among the!Xun, we increased our time in the community to recruit respondents. Nonetheless, our sampling was skewed towards Khwe respondents.

Descriptions of respondents

Of the 20 respondents, 14 were Khwe and six were!Xun (12 males and eight females). The age distribution was concentrated in age groups 18–25 years (eight respondents) and 26–35 years (six respondents). The age of the other six respondents ranged from 44 to 77 years. The majority of respondents had an education level between Grades 8 and 12 (secondary school), one had received additional training in tourism, five had attended primary school (Grades 0–7), and two had no formal education. Half of the respondents were employed, which was more than expected from employment statistics. Nearly all respondents were Christian, most were members of the Dutch Reformed Church, and a few were members of the Zionist Church. One person described his religion in terms of Khwe culture.

Procedure

A depression vignette was used to provide focus during semistructured exploratory interviews (Rubin & Rubin, 2005). Vignettes are short stories that describe particular situations or behaviours and are used to elicit rich but focused responses to gain insight into beliefs and attitudes (Schoenberg & Ravdal, 2000). Some advantages of the vignette technique are that it enables respondents to describe a situation or behaviour in their own terms, allows space for respondents to contextualize their response, and offers a safe distance for respondents to discuss sensitive topics (Barter & Renold, 2000; Schoenberg & Ravdal, 2000). Therefore, the vignette technique is useful for eliciting emic perceptions on mental health problems, particularly because it allows respondents to make sense of behaviour or psychological conditions within their own cultural frames and thereby prevent a category fallacy. In this study, we used a depression vignette derived from a study by Patel (1998, pp. 25–26):

> For a few months, a 40-year-old woman has been looking very sad, miserable and unable to look after her home and children, slow in speech and movements. She says that life is not worth living. Nothing seems capable of cheering her up. She does not eat or sleep well and lies on a bed for days without doing anything. Once she even tried to take her own life.

This depression vignette was chosen because it proved to work well to elicit emic perceptions on depression in Zimbabwe and most closely resembles our study population compared to other depression vignette studies. Half of the interviews were conducted in English, four in Afrikaans, two in a combination of Afrikaans and English, and four in Khwe with the assistance of an interpreter. Interpreters were community members who were conversant in Afrikaans and English. They were familiar with the research aim and procedures, and a debriefing was used to identify difficulties in translation and facilitate learning for future translations (Borchgrevink, 2003). The first author, who fully comprehends Afrikaans and is able to speak it at a basic level, conducted the Afrikaans interviews. A bilingual Afrikaans–English speaker translated the English interview guide and vignette into Afrikaans. The interpreter verbally translated the vignette when the interview was conducted in Khwe.

Interviews were initiated with general questions about participants' characteristics such as age, education, religion, and living situation. The participant was additionally asked to share general reflections on life in Platfontein as a way to make the person feel more at ease and gain insight into their current outlook on life. This was followed by a few open questions about their perceptions of nonphysical aspects of health, and health in relation to the mind. These questions were included to supplement data of an earlier research phase. The vignette was then presented in writing and/or read out by the interviewer or interpreter. Questions in relation to the vignette were partly derived from key characteristics of explanatory models (Kleinman et al., 1978) and included the following topics: whether the situation of the woman in the vignette is problematic, and if yes, what is considered to be most problematic; if the problem has a name; familiarity with the problem; consequences; course; causal explanations; coping and help-seeking strategies. Specific probes into causes and coping strategies were used after respondents' spontaneous responses were exhausted. A list of potential causes, partly derived from Patel (1998), was used for additional probing and included: ancestral spirits, witchcraft, bad airs, alcohol, drugs, heredity, thinking too much, and life history. Responses in relation to these probes were separated from spontaneous responses in analysis and appeared less valuable, as responses remained superficial and some of the probes (bad airs, heredity, life history) did not appear to make sense to respondents. For coping and help-seeking strategies, additional probing was done to elicit perceptions on the appropriateness of seeking help from a traditional healer, health care clinic and the role of medication, or social worker to resolve the woman's situation.

Ethnographic data on living circumstances, everyday activities, and community issues were obtained through informal conversations and observations (Angrosino, 2007) during consecutive fieldwork visits by the first author. Field notes and daily reflections, written down as extended field notes, were used to record the ethnographic data.

Analysis

Interviews were audio-recorded and transcribed verbatim. Transcripts and ethnographic data in the form of field notes and daily reflections were read several times to become familiar with the data. Qualitative data analysis software (Atlas.ti Version 7) was used to order data. The interview topic list served as initial descriptive coding, and during analysis additional codes were created inductively (Miles & Huberman, 1994). Reviewing codes and data segments led to the identification of overarching themes and patterns within themes. Causal interpretations and coping strategies revealed the most detailed insights into the understanding of depression as described in the vignette, and are the primary focus here.

Ethical considerations

Before the start of an interview, the research purpose and aim, interview process, and the rights concerning participation were verbally discussed with respondents and presented in writing. Specific attention was given to the voluntary basis of participation, confidentiality in terms of data handling (preventing access by third parties), and protecting respondents' identities by preventing traceability in publications. Respondents signed the informed consent form when they chose to participate. Interviews took place at a location chosen by respondents. Ethical clearance was obtained from the Humanities & Social Sciences Research Ethics Committee of the University of KwaZulu-Natal (Ref. No. HSS/0054/013D).

Findings

The findings are described in terms of general reflections, causal interpretations, and coping and help-seeking strategies. English and Afrikaans quotes were not corrected on grammar in order to maintain local validity.

General reflections

All respondents considered the woman's situation to be problematic and many focused on suicidal thoughts as the most important problem. In an attempt to name the woman's condition, respondents provided a variety of names that reflected their general understanding of the problem. Respondents often conceptualized the problem in psychological and emotional terms, such as "thinking problems," "thinking too much," "thinking about many things," "sickness in thoughts," "bad thoughts," "stress," "pain in the heart," "sadness," and "loneliness." Additionally, physical conceptualizations were mentioned, such as "low in energy," "old age," and "sickness." One person interpreted the problem in spiritual terms: "bad spirit."

Causal interpretations

Respondents' causal interpretations often took the form of contextualized stories by drawing on personal or social network experiences, salient issues in the community, and spiritual beliefs. Our analysis revealed four dimensions through which respondents constructed their causal explanations: life struggles, as well as physical, cognitive, or spiritual dimensions. It should be noted that respondents often formulated causal explanations by drawing on more than one of these dimensions. This enabled respondents to construct a coherent story or leave options open for multiple theories of causation.

Life struggles included socioeconomic and interpersonal problems and were discussed in terms of stressors that could explain the woman's negative emotional affect. Socioeconomic stressors were related to poverty, lack of employment opportunities, and alcohol abuse. Interpersonal problems included violence, loneliness, lack of support, relationship issues, and losing loved ones. These stressors were often described as an interconnected whole. For example, one respondent shared a personal experience about alcohol abuse, poverty, and child neglect.

> Maybe, like in our family, when my father was not drinking . . . on that day it was right. My mother was not drinking, that was right . . . They support us with maybe clothes or shoes, like those things. But when my father started to drink alcohol . . . then you can also see, life is getting changed. There is a lack of money, we don't have too much money, because my father also used to spend all money on drank [alcohol]. After my mother saw "no, my father is drinking too much," then she also started drinking . . . they are supposed to see [look after] their house but they started to drink both of them. Now we are suffering. We must starting to cook for ourselves. . . . And you can also see that is a problem. . . . In the morning if you wake up your parents are gone. They're going to the shebeen [informal bar] they are drinking there. They didn't even realize "we left our children." They come [back] in the night! So it means I'm the old one there; I have small sisters and a small brother. So I have to do, I must starting to try looking for food. (Male, Khwe, 32 years, interview conducted in English)

Another respondent related the situation of the woman to alcohol abuse, poverty, disruptive social relations, and violence.

> I think there are a few elders in our community who used to have a problem like this . . . So they are stressing ''why are my children doing this?'' And sometimes children they used to hit or fight with their elders, especially [with] the women. A child sometimes comes to ask for money to drink and the mother said she doesn't have the money and then the problems start and they fight. Maybe that is the stress of this woman. (Male, Khwe, 24 years, interview conducted in English)

These quotations reflect common pressures in Platfontein related to poverty and substance abuse, and the disruptive outcomes for social relations and individual (psychological) well-being. Pressure on social relations resonates with the respondents' interpretations that explained the woman's situation in terms of a lack of support and loneliness. Respondents said that the woman was probably without support while facing challenges due to old age, physical illness, or effects of poverty. Additionally, loneliness was considered to reflect an emotional state of sadness due to not feeling loved or cared for. A respondent described how past struggles in parent–child relations may have resulted in the woman facing life issues without support and how this affects her emotional well-being.

> Sy weet nie wat om te doen, now sy se okay, ek is nou alleen met hierdie probleme, my ma, my pa, my familie, hulle kyk nie saam met my die probleme . . . so daai probleem ook. . . hy eet ook die mense se lewe, jy voel baie sleg. Want die mense is daar, maar . . . hulle worry jou nie, se nee, ons het jou gekere, maar jy't nie geluister nie . . . dis jou probleem dan, dan . . . dan eet hy baie. She doesn't know what to do, now she says okay, now I'm alone with this problem, my mom, my dad, my family, they are not looking after me with this problem. So that problem . . . it also eats a person's life up, you feel very bad. Because the people [family] are there, but they are not concerned about you, [they] say no, we tried to stop you, but you didn't listen . . . it's your problem this one, then, then, [that problem] eats you a lot. (Male, Khwe, 50 years, interview conducted in Afrikaans)

The idea that a problem can ''eat a person's life up'' illustrates the psychological and physical strain that a person may experience.

Physical causal interpretations included old age and physical illness. ''I see she is sick because her movement and speech are slow and from there I can see that she is sick'' (male, Khwe, 60 years, interview conducted in Khwe with interpreter). As this quote illustrates, physical interpretations were often linked to specific symptoms described in the vignette, especially the following symptoms: ''slow in speech and movement,'' ''not eat or sleep well,'' and ''lies on a bed for days.''

Physical illness was in turn linked to negative emotional affect (e.g., sadness), for example, through experiencing a lack of support and social isolation.

> Like maybe [for example], if I have TB, I'm coughing too much. My friends say ''no man, you're coughing too much, we don't like you.'' Yeah it is also a problem. According maybe, you have to try to help me. You must tell me ''go to the clinic, you are coughing too much.'' But you . . . chase me away. Cause I am coughing, you chase me away. Now I am thinking also ''no.. .'' because I am the sick person I am . . . because my friends say ''you are going to make us sick, we don't like you now.'' This is also a problem. (Male, Khwe, 32 years, interview conducted in English)

Many respondents included cognitive dimensions in their causal explanations that involved ruminating or worrying about a particular situation. In their explanations, respondents used words such as ''stress,'' ''thinking too much,'' and ''thinking about many things.'' In addition, although most respondents did not mention the following spontaneously, when probed, they did believe that ''thinking too much'' was a likely cause for the woman's condition. The cognitive dimension served as a bridge to connect life struggles (and in some cases, physical ailment) to negative emotional affect.

> There are a lot of people out there struggling in their life... it is like this. Some of their family don't even care about them and they have stress about these problems and it keeps them thinking about this and it hurts them inside. So they want to end their life because they don't feel worth it, they feel like useless. (Male,!Xun, 20 years, interview conducted in English)

A few respondents used spiritual interpretations by drawing on Christian beliefs to explain the woman's situation.

> Respondent: It is just the bad spirit. The bad spirits are visiting the woman maybe . . . that is why you are feeling the darkness, you are not feeling well.
> Interviewer: And why does the bad spirit come to you? Is there a reason for that?
> Respondent: It is the work of evil; Satan is doing that. That's why it comes to you.... Satan is like that . . . the competition between Satan and God. Satan is trying to kill people [so] that he can get more people at his side. (Male, Khwe, 77 years, interview conducted in Khwe with interpreter)

Spiritual explanations other than Christian beliefs were not spontaneously mentioned as causal explanations. However, after probing, some respondents explained that ancestors and witchcraft could cause someone to have suicidal thoughts, feel sad, and be physically sick. These respondents also suggested that traditional healers had to deal with such problems.

Coping and help-seeking strategies

All respondents believed that the woman should reach out to friends, family, and other social resources to resolve the situation.

> Sy moet vriende maak, en sy moet . . . sit, en praat sy met haar vriende. ''Hoe sal ek die probleme oplos?'' Dat sy vriende vir haar idee gee. Se vir haar ''my vriend, gaan straight na die plek toe, en gaan soek wat jy soek . . . en hoor, wat sal die mense se, of hulle sal jou help.'' Sy moet straight gaan na haar vriende. As sy vriende het, alles gaan verby.
> She must make friends, and she must . . . sit and she must speak with her friends. ''How am I going to solve these problems?'' So that her friends can give her an idea. Say to her ''my friend, go straight to this place, and look for what you need . . . and listen, what will the people say, or how they will help you.'' She must go straight to her friends. If she has friends, everything is going to go away. (Female, Khwe, 28 years, interview conducted in Afrikaans)

In this example, friends are considered to be valuable for solving underlying problems. However, in most cases, coping and help-seeking strategies were aimed at addressing negative emotional affect and rumination about life struggles. Respondents mentioned various resources to cope with distress states. Immediate social relations, such as friends and family, were often considered as a first choice. Other sources of support included church functionaries, church groups, and professional support such as psychologists, therapists, support groups, social workers, and the health care clinic.

> Maybe you go there [the social worker] and she will look for a place where those women can be in counselling. Speak with her and maybe if there is a support group that can also come and visit her . . . that will help her. (Female, Khwe, 27 years, interview conducted in English)

Strategies included sharing problems and feelings, distraction, religious practices, and medication.

> It was very bad for me, but I ran to the pastor and I told all my problems to him. He prayed for me and I cried while he was praying for me. I left everything there where I was crying and where the pastor prayed for me. I went back home, from there to home, and I felt relieved and I was fine, yeah. (Female, Khwe, 45 years, interview conducted in Khwe with interpreter)

This example illustrates that the pastor may function as a person of trust and provide emotional support through religious practices. Sharing problems and feelings provided the respondent with a sense of relief. Sharing feelings was in addition considered to be important for receiving support in the form of comfort and advice on how to cope with emotions. The importance of this strategy was emphasized by respondents' beliefs that if a person bottles up his or her feelings, it may aggravate the situation and ultimately cause a person to have suicidal thoughts.

> As 'n mens het nie pyn in jou binnekant nie, dan jy kan nie jou self moord. Maar as jy iewers, het jy 'n pyn in binnekant . . . As ek nie my pyn met hom deel nie . . . dan gaan, dit kan ook met my gebeur. Want as ek het 'n pyn in, dan ek moet hom deel, ek sê, ''Broer hoor hierso, ek het dit en dit en. . .hierdie pyn, hoe sal ek oplossing kry?'' Dan miskien hy het die manier om 'n raad na my te gee, hoe ek moet die pyn wegloop, die gevoel so wegloop . . . Ja, maar as 'n mens so iets geheim hou, ja jy sal . . . selfmoord.
> If you don't have the pain inside yourself, then you won't kill yourself. But if you have a pain somewhere inside . . . if I don't share my pain with him, then it's going to, it can also happen with me [that I kill myself]. Because if I have a pain inside, then I must share it, I say, ''Brother, listen to this thing/listen here, I have this and this . . . this pain, how will I find a solution?'' Then maybe he has the way to give me advice, how I will make this pain go away, the feeling go away. Yes, but if you keep something like this secret, then yes you will . . . kill yourself. (Male, Khwe, 50 years, interview conducted in Afrikaans)

Distraction was a strategy described as diverting attention away from negative thoughts and preventing rumination about life struggles. Strategies involved reaching out to friends and family for company, and various activities such as exercising or reading the Bible.

> When I go to the [soccer] field to exercise with some teams. That can help me yeah... when I am sitting and thinking about a lot of stuff and now the training time is at four so I have to prepare myself to go to the field, get some training you know. So it did help me a lot, yeah. (Male,!Xun, 27 years, interview conducted in English)

> But if you are alone then you can think more of . . . then you can get more feelings. You see, if you sit alone and you think, you think more problems... or what you are going through, yes. But if someone is there with you or friends or maybe the children is in the house and they playing or they speaking with you, and you are speaking to each other then it is better. (Female,!Xun, 24 years, interview conducted in English)

Religious practices were also mentioned as a way of coping with negative emotional affect and life problems. "When you feel sad, or you are stressing or you feel miserable, just sit on your knee. Ask the God to give you power. Yeah. . . sometimes when I do that it helps me" (male,!Xun, 27 years, interview conducted in English). Respondents described effects in terms of regaining hope for the future, receiving the power or strength to continue in life, and having faith in God to resolve the situation. In addition to prayer, respondents mentioned strategies that involved visiting church and reading the Bible.

Some respondents believed that medication could be a solution to manage emotions or symptoms associated with distress, such as high blood pressure or difficulty eating and sleeping.

> I think there is a role for medication because maybe she is in stress . . . or maybe she had a high blood. Stress can go to high blood and... it can't take anymore. She can go to the clinic or the hospital for the medication. (Female, Khwe, 27 years, interview conducted in English)

The health care clinic was also considered useful for referrals to professional psychological support. Other respondents mainly associated the health care clinic and medication with physical illnesses.

In addition to these coping strategies for dealing with negative emotional affect and rumination, a few respondents described strategies aimed at addressing the problems underlying the woman's situation, for example, a lack of food, relationship problems, or physical ailment. The following quote illustrates the perceived need to search for and address the root of the problem.

> So it is better to find out what is the problem. She don't want to sleep or eat and she has to look for a solution. Because when I am sick, that is the way, I don't want to do anything, I am sleeping during the day, don't want to do anything. So maybe I am stressing or I am sick. So let me go to the hospital if I am sick. If I am stressing, this is the cause that is stressing me, so let me just look for the solution for this. (Male, Khwe, 24 years, interview conducted in English)

Respondents considered poverty and unemployment as the main challenges facing people living in Platfontein. Solutions for problems arising out of this situation were mentioned in the form of material or instrumental support such as providing food or applying for social benefits. In addition, the problem of unemployment was also perceived to have consequences for psychological well-being. For example, one respondent explained how employment would be beneficial since it would activate a person and give meaning to his or her life.

> I'll make an example of myself: I don't have a job, the whole day there is nothing to do. So you will be feeling lazy and there will be a problem. . . . The lady, if she would have a job she will be like . . . she has to prepare for the job, . . . she is like fresh and she wants more of these challenges in her life. She is clean and she will do things, she will eat and live healthy. (Female, Khwe, 28 years, interview conducted in Khwe with interpreter)

Discussion

Respondents' contextualized causal interpretations positioned depression as a condition related to the life stressors present in Platfontein. This is similar to the findings of other studies in African settings in which respondents have described psychosocial, social, or socioeconomic causes or stressors in relation to mental health problems (Abas & Broadhead, 1997; Aidoo & Harpham, 2001; Burgess & Campbell, 2014; Davies et al., 2016; Kathree et al., 2014; Okello & Ekblad, 2006; Patel, Gwanzura, Simunyu, Lloyd, & Mann, 1995; Ventevogel, Jordans, Reis, & de Jong, 2013). Of specific interest here is the contextualization that took place by drawing on personal experiences, experiences from their immediate surroundings and salient community issues. With this focus, the causal interpretations became a mirror of the sociocultural context (Cabassa, Lester, & Zayas, 2007; Karasz, 2005). In addition, contextualization provided a holistic view of the interrelations among socioeconomic conditions (e.g., poverty, unemployment, and alcohol abuse), interpersonal problems (e.g., violence, abuse, and neglect), and experiences of negative psychological and emotional affect. These findings draw our attention to the contextual circumstances of depression and the need to address underlying stressors as well as distress states.

Respondents primarily interpreted the depression vignette as a cognitive (e.g., "thinking too much") or emotional (e.g., "sadness," "suicidal thoughts," "loneliness") condition. Findings indicate that the cognitive dimension, especially ruminating about current problems, is a conceptually important dimension for understanding depression. Other studies in African settings have identified similar aspects of excessive thinking, worrying, and rumination in relation to depressive

conditions (e.g., Abas & Broadhead, 1997; Davies et al., 2016; Okello & Ekblad, 2006; Patel et al., 1995; Ventevogel et al., 2013). Rumination was considered to aggravate the emotional condition and, therefore, was a key element addressed in coping strategies. A follow-up study (den Hertog, de Jong, van der Ham, Hinton, & Reis, 2015) confirmed the key role of rumination in the process of stress and psychological distress by exploring the Khwe idiom of distress "thinking a lot." The respondents' primary attention to address distress states further emphasizes the importance of emotional and cognitive dimensions in their understanding of depression. Tomlinson et al. (2007) have noted that, at times, studies seem to focus on how depression is experienced and understood distinctly in African cultures. This perpetuates exotization and makes it necessary to reiterate and refute colonial misconceptions. This study's findings contribute to refuting colonial misconceptions about the lack of a psychologization of distress among African or other non-Western cultures (Bhugra & Mastrogianni, 2004; Kirmayer, 2001). At the same time, we should not fall into the trap of considering depression as it is classified in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or in the International Classification of Diseases (ICD) to be a universal experience. Qualitative studies on the perceptions and experience of depressive conditions reveal cultural variations (Bhugra & Mastrogianni, 2004; Kirmayer, 2001). In African settings, Mosotho, Louw, Calitz, and Esterhuyse (2008) have emphasized somatic, delusion, and hallucination experiences; Abas and Broadhead (1997) have reported a more frequent use of psychological and behavioural idioms over somatic idioms; Davies et al. (2016) have identified behavioural (social isolation and not caring), emotional (sadness and crying), and cognitive (rumination) as most common symptoms; and Okello and Ekblad (2006) have reported on an emphasis on cognitive rather than emotional aspects. Understanding such variation is essential for providing appropriate care (Bhui & Bhugra, 2002; Hinton & Lewis-Fernández, 2010; Kirmayer, 2001; Kleinman et al., 1978) and brings the focus back to the locality of experiences and expressions of distress. Steps are undertaken to account for sociocultural differences in clinical settings, such as the Cultural Formulation Interview in the DSM-V (American Psychiatric Association, 2013).

The respondents' views on coping strategies highlight the importance of social support for addressing distress states, which reflects the findings of other studies in African settings (Abas & Broadhead, 1997; Burgess & Campbell, 2014; Petersen, Hancock, Bhana, & Govender, 2013; Ventevogel et al., 2013). The beneficial effects of social support for individuals in distress are well known and described as stress-buffering mechanism (Kawachi & Berkman, 2001; Thoits, 2011). Yet, social support in many studies on treatment gaps or pathways to care for common mental health problems is not included as a source of care (e.g., Burns & Tomita, 2014; Kohn, Saxena, Levav, & Saraceno, 2004; Sorsdahl et al., 2009). Our findings lend support to a growing body of studies suggesting that social support may have therapeutic value. Respondents in our sample described it as a source of relief, comfort, and advice on coping with the situation, emotions, and distraction. However, it should be noted that in our study population, social support may not always be readily available due to pressures on social relations arising from poverty, unemployment, and substance abuse. This is illustrated by the respondents' interpretations of lack of care and support and by the identification of interpersonal problems as source of distress. Social ties may in this respect paradoxically have a negative effect on mental health (Kawachi & Berkman, 2001). Interventions aimed at strengthening social support through support groups and group therapies are described to be successful in terms of reducing depressive symptoms and dysfunction, and improving resilience and coping (Bolton et al., 2003; Chibanda et al., 2014; Petersen, Baillie, & Bhana, 2012; Petersen, Bhana, & Baillie, 2012; Petersen, Hanass Hancock, Bhana, & Govender, 2014). However, studies also indicate limitations of social support interventions, as peer support may encourage acceptance of difficult living circumstances and not empower individuals to challenge sociocultural and political inequalities that underpin distress states (Burgess & Campbell, 2014; Petersen, Baillie & Bhana, 2012). Studies in postconflict settings and displaced communities, where the social environment is severely disrupted, underline the importance of addressing social circumstances through psychosocial interventions aimed at increasing community care as part of mental health care (de Jong et al., 2001; Jordans et al., 2010; Miller & Rasco, 2004; Tol et al., 2011). Such interventions revitalize community support structures, strengthen individual resilience, and address local stressors that increase the risk of developing mental health problems. These interventions may also be of great value for the!Xun and Khwe considering the disruptive social circumstances.

Our findings further indicate that the San consider professional support in the form of counselling as appropriate. The way in which the San described professional support was similar to informal support, which probably contributed to the perceived appropriateness. Considering the San's preference for informal forms of support, the use of community caregivers to provide effective therapies to manage depression may further enhance the local appropriateness of

professional support (Petersen et al., 2013). In low-resource settings it is often suggested to bridge treatment gaps by fostering collaboration between informal and formal support structures (de Jong, 2014; Sorsdahl et al., 2009). In addition to focussing on collaboration among traditional healers, faith healers, and formal mental health services, we propose formal mental health services link with community social structures. In Platfontein, church groups may be key resources for addressing depression.

Strengths and limitations

The community sample and qualitative approach allowed us to gain insights into local understandings of depression and identify available and appropriate forms of informal and professional support. However, there were also limitations to be considered. Our sample contained relatively more respondents from a younger generation (less than 35 years) and from the Khwe community. This may have resulted in an underrepresentation of certain views. In addition, the skewed sample and small sample size prevented us from giving indications of potential differences in perceptions between the!Xun and Khwe, or in relation to age groups and gender.

The depression vignette method used in this study elicited stories that contextualized depression and therefore provided insights into the sociocultural context and stressors. Whereas the vignette method has been praised for its distancing ability, thus facilitating discussions about sensitive topics (Schoenberg & Ravdal, 2000), we found that the vignette also worked well to elicit personal stories (Hughes, 1998). The personalized accounts provided deeper insights into the understanding and experience of depression. However, there were also limitations related to the use of a vignette method. The vignette was based on a Western experience and expression of depression as described in the DSM and ICD. Depressive conditions are generally thought to be universal, but with cultural variation in conceptualization, experience, and (clinical) expression (Kirmayer, 2001). Therefore, the vignette may include symptoms that were not salient in our study context or may have excluded important local symptoms or idioms of distress. Another limitation was that certain characteristics described in the vignette might have influenced responses. For example, one respondent explained that the woman's age, 42 years, made him consider that she might be suffering from physical complaints due to old age. In addition, the vignette did not describe a life partner, and this may have led respondents to interpret that the woman was alone and therefore they described the situation in terms of loneliness and social neglect. Last, the fact that the vignette described a woman might have resulted in the elicitation of specific stressors such as domestic violence. A vignette with other characteristics might have resulted in alternative responses and might have highlighted other social issues as stressors.

Notwithstanding these limitations, the findings of this study reveal that depression is primarily understood in terms of psychological and emotional states embedded in socioeconomic and interpersonal struggles, which first and foremost require social support. We are confident that these main findings are unlikely to change with a more balanced sample or a vignette with alternative characteristics.

Conclusion

The findings of this study indicate that the!Xun and Khwe understand depression in terms of emotional and psychological functioning, and situate the condition primarily in life problems. Contextualized stories revealed the social realities brought about by their marginalized and displaced position. The results highlighted the continuous pressures on social relations, which emerged as stressors, while simultaneously describing social relations as source of support and essential for coping strategies. These findings direct our attention to the multilevel dynamics of depression—individual suffering should be understood in its immediate social environment and larger sociopolitical setting. Taken together, these insights suggest that interventions for mental health care may benefit from a multilevel approach by addressing socioeconomic conditions, strengthening local resources, and fostering collaboration among locally appropriate informal and formal support structures.

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