

EXPLORING EXPERIENCES OF ADOLESCENTS LIVING WITH A DEPRESSED  
PARENT

By

MAFOLE GLODEAN MAKUWA

submitted in accordance with the requirements

for the degree of

MASTERS OF ARTS IN CLINICAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: DR B C VON KROSIGK

April 2014

Student Number: **4715-351-2**

Declaration

I, hereby declare that:

“Exploring experiences of adolescents living with a depressed parent” is my own work, and that all the sources that I have used or quoted have been indicated and acknowledged by means of complete references, and that this study has not been submitted for any other degree at any other university.

.....

SIGNATURE

(MS MAFOLE MAKUWA)

.....

DATE

## ACKNOWLEDGEMENTS

My grateful thanks to:

My supervisor, *Dr Beate von Krosigk*, for her encouragement and patient guidance throughout the whole process of writing the dissertation. Your ability to remain positive when times were tough motivated me to pull through when I felt like giving up. It has been a privilege to work with someone as knowledgeable and experienced as you. Thanks for believing in me.

*The participant*, my sister, *Inga Missy*, thank you for your honesty and willingness to participate in the study and your openness in sharing a part of your experiences with me.

*My family*, without whom I would have never arrived at this point. My father, *Thokwane Joseph*, your ever-present support and unwavering belief in my abilities gave me the determination to carry on when times were tough. My sister, *Inga Missy*, thank you for your emotional support over the years. Your encouragement kept me going. Thank you for your continued support and patience.

*My dearest friend*, *Dr Thapelo Phahladira*, you showered me with words of encouragement when I most needed them and grounded me when I wanted to escape. Thank you for being there in good and bad times.

*My class colleagues*, thanks for the amazing two years of hard work and extensive learning. Your support and loyalty I will forever cherish.

Aboveall, all this hard work was made possible not only by my efforts and perseverance, but through Jehovah God. I owe my gratitude to Him for granting me the strength, wisdom and opportunity to undertake and complete this study. "Trust in Jehovah with all your heart and do not lean upon your own understanding, in all your ways take notice of Him and He will make your paths straight." Proverbs 3: 5 & 6

## SUMMARY

In this qualitative study the researcher explores the experiences faced by adolescents living with a clinically depressed parent, and the emotional, social and intellectual challenges they go through, with the aim to identify and explore the emotional impact of parental depression on adolescents. The approach employed in this study is based on an ethnographic stance. A qualitative methodological design was followed allowing for personal experiences and meaning attributions to come to the fore. The participants were selected because they were accessible and met the criteria of living with a depressed mother. The study's results were presented in the form of descriptive text with particular reference to the thematic analysis process. An analysis of the participants' global themes revealed that by experiencing and sharing their mother's pain the experience had a negative emotional, social and behavioural impact on them and affected their interactional relationships with their parent.

Key terms: adolescents, adolescence, depression, experience(s), depression in parent, impact, family context, relations, ethnography, qualitative research.

# TABLE OF CONTENT

	Page number
ACKNOWLEDGEMENTS	ii
SUMMARY	iii
<b>CHAPTER 1: OVERVIEW OF THE STUDY</b>	1
1.1 Introduction	1
1.2 Statement of the Problem	2
1.3 Aims and Objectives of the Study	3
1.4 Purpose of the Study	4
1.5 Research Question	5
1.6 Rationale of the Study	6
1.7 Dissertation Outline	7
<b>CHAPTER 2: DEFINING DEPRESSION</b>	9
2.1 Introduction	9
2.2 Epidemiology of Depression	10
2.2.1 Prevalence	10
2.2.2 Gender	11
2.2.3 Age	12
2.3 Definition of Depression	13
2.4 Etiology of Depressive Disorders	14
2.4.1 Socio-Cultural Perspective	15
2.4.2 Psychological Perspective	16
2.5 Clinical Criteria and Diagnosis	18
2.6 Depression as a Relational Phenomenon	26
2.7 Depression in Parents	29

2.8 The Impact of Depression on Family Relationships	30
2.9 The Impact of Parental Depression on Adolescents	32
2.9.1 Psychosocial Impact on Adolescents	34
2.9.2 Emotional Impact	36
2.9.3 Cognitive Impact	39
2.10 Conclusion	40
<b>CHAPTER 3: EXISTING THEORIES ON THE STAGE OF ADOLESCENCE</b>	42
3.1 Introduction	42
3.2 Adolescence	43
3.2.1 Erikson's Theory	43
3.2.2 Dreyfus' Theory	48
3.2.3 Rogers' Theory	49
3.2.4 Frydenberg's Theory	49
3.3 Definitions	50
3.3.1 Defining Development	50
3.3.2 Defining Identity	51
3.4 Family Relationships during Adolescence	51
3.5 Parent- Adolescent Relationships	53
3.6 Conclusion	55
<b>CHAPTER 4: RESEARCH DESIGN AND METHOD</b>	56
4.1 Introduction	56
4.2 Research Design	56
4.2.1 Qualitative Research Design	57
4.2.2 Ethnography	58

4.2.3 The Research Design applied in this Study	60
4.3 Aims of the Study	61
4.4 Method	61
4.4.1 Selection of Research Participants	61
4.4.2 Data Collection	62
4.4.3 Procedure	63
4.4.4 Data Analysis	64
4.4.5 Ethical Considerations	67
4.5 Conclusion	69
<b>CHAPTER 5: PRESENTATION OF THE FINDINGS</b>	<b>70</b>
5.1 Introduction	70
5.2 Presentation of the Themes that were Identified	70
5.3 Findings from the Researcher	71
5.3.1 Lack of Knowledge	71
5.3.2 Anger	72
5.3.3 Guilt	72
5.3.4 Communication Barrier and Difficulty	73
5.3.5 Worry	74
5.3.6 Care and Support	74
5.3.7 Empathy	75
5.3.8 Helplessness	76
5.3.9 Encouragement	76
5.3.10 Understanding the Impact of Depression	77
5.4 Findings from the Sister	77
5.4.1 Lack of Knowledge	77
5.4.2 Anger	78

5.4.3 Guilt	78
5.4.4 Communication Barrier and Difficulty	79
5.4.5 Worry	79
5.4.6 Care and Support	80
5.4.7 Empathy	81
5.4.8 Helplessness	82
5.4.9 Encouragement	82
5.4.10 Understanding the Impact of Depression	83
<b>CHAPTER 6: DISCUSSION OF THE FINDINGS</b>	<b>84</b>
6.1 Introduction	84
6.2 Lack of knowledge	84
6.3 Anger	85
6.4 Guilt	87
6.5 Communication Barrier and Difficulty	88
6.6 Worry	89
6.7 Care and Support	90
6.8 Empathy	91
6.9 Helplessness	92
6.10 Encouragement	93
6.11 Understanding the Impact of Depression	94
6.12 Integration of the Adolescents' Discussions	95
6.13 Conclusion	98
<b>CHAPTER 7: CONCLUSION</b>	<b>100</b>
7.1 Introduction	100
7.2 Presentation of the three research aims and outcomes	100

7.2.1 The Emotional and Social Experiences of Adolescents	
Living with a Depressed Mother	100
7.2.2 The Impact the Parent's Depression had on the Adolescents and the Challenges they faced	101
7.2.3 Exploring and Examining the Adolescents' Personal Understanding of Depression	102
7.3 Results	103
7.4 Recommendations	105
7.5 Suggestions for Further Research	106
7.6 Limitations of the study	106
7.7 Strengths of the study	107
7.8 Conclusion	108
<b>REFERENCES</b>	<b>110</b>

## CHAPTER 1

### OVERVIEW OF THE STUDY

#### 1.1 Introduction

Depression is one of the most prevalent clinical mood disorders in the world (Nozek, 2008). According to Stahl (2008), there is much more depression around than we realize, that is endemic to different cultures in the world. Twice as many women as men across all racial groups are likely to suffer from depression (Corey, 2005; Nosek, 2008; Talseth, Lindseth, Jacobsson & Norberg, 2001). Estimates vary, probably between one fourth and one third of women experience a clinically significant Major Depressive Episode at some point during their lives (Greene & Kropf, 2009). Depression is highly likely to recur with one's risk for a second episode being about 50% and for the third episode as high as 80% (Levinson, 2002; Whitney, Kuznir & Dixie, 2002). Given the rate in depression among young adult women, it should be no surprise that depression rates are especially high among women of childbearing ages (Kessler, 2003). Thus, children are very likely to be exposed to depression from their mothers very early in life, and moreover, to experience repeated exposures throughout their childhood and adolescent years.

Depression as a health problem and its impact reaches beyond the individual to touch family members. It affects functioning emotionally, behaviourally, interactionally and socially.

Of great concern are the interpersonal effects that the depressive disorder creates – loss of energy, less enjoyment of pleasurable activities, less ability to solve

problems, irritability, a negative outlook and reduced capacity to work (Macfarlane, 2003), as by the time a depressed individual seeks medical advice about the disorder, the family will likely be affected. The interactions between a depressed individual and a family member are often punctuated by emotional distance, negative thinking, and irritability (Monroe & Reid, 2009). This implies that the depressed individual will seek confirmation of worthiness and lovability from others. In response, family members, who grow tired of the mood variability, often distance themselves from the depressed person. The distance can increase a sense of isolation and confirm the depressed person's negative point of view (Whiffen, 2005), which produces distress and impairment in social and interpersonal functioning (Stahl, 2008).

## **1.2 Statement of the Problem**

The study is motivated by my experiences of living with a clinically depressed mother, the impact that the experience had on me, and the emotional and social challenges I went through. The aim is to explore experiences faced by adolescents living with a clinically depressed parent, and the emotional, social and intellectual challenges they go through. Limited attention has been given to this population of depressed women and the impact they have on their families. Hammen and Brennan, (2003) provide a useful framework for examining reasons for concerns about children living with a depressed parent. They theorise that depression in parents was found to correlate with adjustment of difficulties in children and the experience has a negative impact on them and it further affects their interactional relationship with the parent.

The questions asked of adolescents living with a depressed parent relate to the emotional wellbeing of family members, the relational functions of the family, support provided for members of the family, the impact of the dysfunctionality of family members on the depressed parent, and roles that are to be assumed to keep the family at homeostasis (Nosek, 2008), since it becomes challenging to try to keep up the relations among family members in an attempt to accommodate the depressed parent and not to exclude him/her in family affairs. This tends to pose a difficult task in the lives of family members, as it becomes difficult to include the depressed parent in the family's daily activities, as he/she is not interested most of the times. Mostly it becomes a challenge for the family because they have no idea of how to handle the depressed parent.

This study aims to explore the experiences and challenges the adolescents faced living with their depressed parent.

### **1.3 Aims and Objectives of the Study**

This in-depth study consists of thick descriptions of the experiences of two adolescents living with a clinically depressed parent. Such a family is easily overwhelmed by responsibilities and feelings of helplessness when the depressed parent has become dependent on the family for support and developed an inability to engage in family activities due to a lack of will and motivation (Nosek, 2008).

Denzin (1997) describes this term as follows: "A 'thick description' does more than record what a person is doing. It goes beyond mere fact and surface appearances. It represents detail, context, emotion, and the web of social relationships that join

persons to one another. A thick description evokes emotionality and self-feelings. It inserts history into experience. It establishes the significance of an experience, or the sequence of events, for the person or persons in question. In a thick description, the voices, feelings, actions and meanings of interacting individuals are heard.” (cited in Mouton, 2001, p.188)

The aim of the research is thus to

- explore the emotional and social experiences of adolescents living with a depressed parent.
- explore the impact the parent’s depression has on the adolescent and the challenges they face.
- explore and examine their personal in-depth understanding of depression.

This research study further aims to achieve the following:

- contribute to the *debate* of experiences of adolescents living with a depressed parent.
- contribute to generating further research, since there is a scarcity of such research

#### **1.4 Purpose of the Study**

The overall purpose of the study is to explore and describe the experiences of adolescents living with a depressed parent. The experiences of these adolescents are also aimed at identifying the defects and impairments they cause on interpersonal and social functioning within the family context. Additionally, this study will open a platform for the adolescents’ experiences to be heard by the public, in

order to provide readers with an understanding of the challenges the adolescents faced.

### **1.5 Research Question**

The overarching question in this study is: What were the adolescents' experiences of living with a depressed parent?

This question will explore the following aspects:

1. What experiences did adolescents have living with their depressed parent?
2. How did depression as a relational phenomenon impact on family relationships?
3. How did living with a depressed parent affect and impact on the adolescents in the family context?

A qualitative ethnographic approach will be adopted in this study. Qualitative research entails the collection, analysis, and interpretation of comprehensive narrative data in order to gain insight into a particular phenomenon of interest. The phenomenon is studied as it occurs within its natural context (Ellis & Bochner, 2000). Various data gathering methods will be employed, including: data from journals, diaries, semi-structured interviews, daily process notes and informal discussions. The purpose of the semi-structured interviews is to understand the world from the participant's perspective, and to enable the participants to play a more active role in shaping the direction of the research. The conversation at hand is engaged in in-depth (Sugarman, 2001). What is involved is not simply an interviewing technique or procedure, but a relationship of some intimacy, intensity, and duration. Journals,

diaries, process notes and informal discussions will deliver samples of documented data. Each meeting with the participant will be documented in order to produce a sample of written data. The textual data will undergo a process of thematic content analysis, as adapted from the work of Anderson (2007), Kelly (2006a), TerreBlanche, Durrheim and Kelly (2006) and Kelly (2006b). This will entail identifying, reporting and analysing patterns or themes within the data.

## **1.6 Rationale of the Study**

In this study it will be argued that the experiences of the adolescents living with a depressed parent cannot be viewed from the parent's point of view. We would like to explore the unique experiences and understandings of the adolescents within a family context. The case to be made is that, in order to obtain a comprehensive understanding of the experiences of the adolescents within a specific context, a comprehensive understanding of the attitudes and meanings attached to caring for the depressed parent needs to be attained from a different point of view. This understanding cannot be based solely on the parent's experience, but needs to be rooted in the social circumstances and lived experiences that form part of who the adolescents are and, subsequently, how they experience their living with a depressed parent.

The study will be of benefit to the readers for understanding the experiences of adolescent children living with a depressed parent, the impact it has on the significant others, and the challenges and difficulties their families are faced with (Horowitz & Strack, 2011). I, the researcher will be in a prime position to explore the experiences of adolescents living with a depressed parent, because of the similar

experiences I share with them, and being able to identify with their situation and their view on depression.

The study will give voice to the silent ones, whose narratives have not been told. The study will also open an arena for individuals to let their experiences be heard, in particular adolescent children, who experienced life with a depressed parent and never told their stories nor narrated their stories to the public (Hammen, 1997). The researcher deliberately selected a small sample, which fits the research aim.

Most research has been written about depression, depression and support, depression in women, depression and family, yet very little has been written about the impact it had on family members. Research is thus needed to understand the inner world of the families who live with and care for a depressed parent (Talseth, Lindseth, Jacobsson & Norberg, 2001).

## **1.7 Dissertation Outline**

Chapter 1 provided an outline of the study by analysing the problem, which leads to the investigation and orientates the reader in terms of the research approach employed in this study.

Chapter 2 provides a background and literary investigation of the key theoretical elements, which relate to adolescents and the experiences of living with a depressed parent in general.

Chapter 3 outlines and describes the existing theories on the stage of adolescence. Theories about adolescence are discussed in this chapter as a way to understand

the adolescent's development. Various definitions of the terms adolescence from different theorists are described.

Chapter 4 outlines the methodology that was employed to explore the experiences of adolescents living with a depressed parent. An argument is made for the appropriateness of a qualitative research design for this particular study and the various methodologies employed are discussed in detail.

Chapter 5 presents the findings of this study, and provides a discussion on each of the themes that have been identified.

Chapter 6 provides a brief discussion of the results, and ends with a conclusion. The main themes and proactive interactions and management of dealings with a depressed parent are highlighted and recommendations for future research are made. Finally limitations and strengths of the study are discussed and the researcher's reflections provide the closing comments.

## CHAPTER 2

### DEFINING DEPRESSION

#### 2.1 Introduction

This chapter offers a brief overview and clinical presentation of Major Depressive Disorder (MDD).

According to Burns and Grove (2001, p.23) a literature review “encapsulates the researcher’s work on the topic in an effort to discuss the literature in a coherent and systematic manner” and also identifies shortcomings and provides guidance for future research.

The first part of this chapter provides a definition and a brief overview of the epidemiology of depression, which is followed by an exploration of the etiology of depression from the socio-cultural and psychological perspectives respectively. Thereafter, a brief overview of depression as a relational phenomenon and depression in parents is provided. The impact of depression on family relationships is also highlighted, followed by the impact of parental depression on adolescents. The remainder of this chapter offers a brief overview of depression from the adolescents’ perspective.

## **2.2 Epidemiology of Depression**

### **2.2.1 Prevalence**

Kessler (2003), Wilhelm, Parker and Hadzi-Pavlovic (1997), Lewis-Hall, Williams and Panetta (2002), Greene and Kropf (2009); and Stahl (2008) studied the high prevalence of depression among parents, mostly women. According to Stahl (2008), Wilhelm et al. (1997) and Kessler's (2003) review stimulated the interest in the predominance of depression in parents in relation to the effect it has on their children. According to the above authors, the female:male sex ratio of the prevalence of depression is cited as 2:1. Furthermore there is a general consensus about the gender ratio of depression that more research should be done on determining the impact of this phenomenon on family members, particularly children.

The pattern for depression for women differs from that of men. Kaplan and Sadock (2003) cite the mean age of depression in both men and women as 40 years. The WHO (2001) expressed concern that the highest prevalence of depression among women occurs during the mid-adult years, as it is when women are most productive in terms of child rearing and employment. According to Kaplan and Sadock (2003), the lifetime prevalence of depression is 15% overall and possibly as high as 25% among women. However, Kessler (2003) cites Blazer, Kessler, McGonagle and Swart's (1994) postulation of a total population prevalence of between 6 and 17%. Wilhelm et al. (1997) estimates the prevalence at 33% in women and 25% in men.

In the analysis of the role of depression in the development of gender differences, Costello (2009) found that the prevalence of major depression was almost twice as high in women as in men. The higher prevalence of depression in women is found throughout the world, in developed and developing countries (Boland & Keller, 2009;

WHO, 2001). However, further research is required in order to identify and explore the emotional, cognitive and behavioural impact of parental depression on adolescents.

### **2.2.2 Gender**

The most important aspect of depression among women is recorded and the rate of this illness in the female population is higher compared to men across ages as well as cultures (Whitney et al., 2002). These authors are also of the opinion that several interlinking factors possibly play equally important roles to bring about this significant situation in sex ratios.

Gregory (1999) lists several possible factors to consider for explaining the higher rates of depression among women, including

- a difference in the recall of previous depressive episodes by men and women
- genetic factors
- hormonal differences
- differences in social and economic factors for both men and women
- expansion of women's societal roles

Gregory (1999) maintains that these differences in biological, sociological, and genetic aspects may influence the higher occurrence of depression in women therefore different diagnostic criteria need to be considered in order to address and acknowledge the differences in illness courses and symptomatology.

Angst and Dobler-Mikola cited in Whitney et al. (2002) stated that women generally report more symptoms than men do and these reported symptoms are more severe for women. Additionally Ingram and Segal (2011) report that three explanations

could possibly be the major contributors to the highest rates of depression among women: women's willingness to seek help, biological differences between the sexes, and certain psychological factors.

### **2.2.3 Age**

Kaplan and Sadock (2003) cite the mean age of depression in both men and women as 40 years, but emphasise that onset can occur at any age. Hammen (2003), however, expressed particular concern about reports of increasing rates of depression in teenaged women with the increased possibility of recurrence in their adult years. According to Levinson (2002), the gender differences in depression start in adolescence and reach their peak in midlife, with the highest level at childbearing age.

## **2.3 Definition of Depression**

The term Depression is used in everyday language to describe a range of experiences from a slightly noticeable temporary mood decrease to a profound impaired even life-threatening disorder (Gregory, 1999). It is a universal, timeless, and ageless human affliction (Bockian, 2006). Depression refers to a constellation of experiences including not only mood, but also physical, mental, and behavioural experiences that defines more prolonged, impairing, and severe conditions that may be clinically diagnosable as a syndrome of depression (Stahl, 2008).

Depressed people may differ from one another by the number, unique patterns, and severity of the symptoms. The four general domains are *affect, cognition, behaviour and physical functioning*.

In order to enhance understanding of the symptoms of depression, these are classified:

**Affective symptoms.** Depression is one of several disorders generically called affective disorders, referring to a manifestation of abnormal affect, or mood, as a defining feature. Thus, depressed mood, sadness, feeling low, down in the dumps, or empty is typical (Hammen, 1997). However, sometimes the most apparent mood is irritability (especially in depressed children). Nothing seems enjoyable – not even experiences that previously elicited positive feelings, including work and recreation, social interactions, and sexual activity. Pastimes are no longer enjoyable; even pleasurable relationships with one's family and friends may no longer hold appeal or even be negative.

**Cognitive symptoms.** Schwartz and Petersen (2006); Fendrich, Warner, and Weissman (1990); and Eberhart and Hammen, (2009) have called depression a disorder of thinking, as much as it is a disorder of mood. Depressed people typically have negative thoughts about themselves, their world, and the future. They experience themselves as incompetent, worthless, ineffective and are relentlessly critical of their own acts and characteristics, and often feel guilty as they dwell on their perceived shortcomings (Costello, 2009). Cognitions reflecting hopelessness about one's ability to control desired outcomes may be common, and despair may also give rise to thoughts of wanting to die or take one's own life. In addition, depression is marked by difficulties in mental processes involving concentration, decision-making, and memory (Hammen, 1997).

**Behavioural symptoms.** Because of their apathy and diminished motivation of depression, it is common for individuals to withdraw from social activities or reduce

their typical behaviours (Boland & Keller, 2009). Actual changes in movements are observed, somewhat taking the form of being either slowed down or agitated and restless. Their speech is marked by pauses, fewer words, a monotone voice, and less eye contact (Cloitre, Katz, & Van Praag, 1993; Eberhart & Hammen, 2009).

**Physical symptoms.** In addition to motor behaviour changes that are apparent in some depressed people, changes in appetite, sleep, and energy are also common (Bockian, 2006). Reduced energy is a very frequent complaint. Sleep changes are one of the hallmarks of depression, and can take several forms: difficulty falling asleep, staying asleep, and too much sleep. Depressed people complain of listlessness, feeling heavy and leaden, and lack the physical stamina to undertake or complete tasks (Hammen, 1997).

Moderate and severe depression obviously interferes with a person's ability to work, perform chores, and relate to family and friends. At depression's worst, the afflicted person may spend endless hours in bed or staring into space, or aimlessly pacing and brooding – often finding it difficult to perform minimal tasks such as bathing or getting dressed. The negativism, hopelessness, and lack of motivation are often a source of wonder or even of frustration and impatience to others, and it is therefore not difficult to foretell the development of interpersonal conflicts added on to apparent problems in typical roles (Hammen, 1997).

## **2.4 Etiology of Depressive Disorders**

The etiology of depressive disorders, with specific reference to Depression is discussed from the socio-cultural and psychological perspectives respectively. This offers a more comprehensive view of multiple variables, which contribute to

depression, and it assists in a better understanding of particularly the psychosocial effects that depressed parents have on their surroundings.

#### **2.4.1. Socio-Cultural Perspective**

According to this perspective, there seems to be a gender imbalance among people who experience depression. According to Monroe and Reid (2009), almost 70% of individuals with Major Depressive Disorder are women. Social responsibilities and roles, familial and occupational responsibilities and depression are strongly related. Lovejoy, Graczyk, O'Hare and Neuman (2000) notes that these social role conflicts and low familial support are particularly able to generate if not contribute to depression.

Further, in the study of Joiner, Katz, and Lew (1999) it was found that 21% of women who experience occupational difficulties and familial conflict reported severe depression at a rate three times higher than that for women who had family support.

The development of mood disorders is strongly influenced by perceptions of uncontrollability. The cultural way in which sex roles are assigned to men and women may contribute to this perception. Both genders are encouraged to socially part-take in different roles. Men are encouraged to be active, independent, masterful and assertive whereas women are encouraged of to be passive, sensitive to other people, and to rely on others. Culturally, induced dependence and positivity may predispose women to Mood Disorders by increasing their sense of helplessness and eroding a sense of mastery over their lives (Ehrenberg, 2010; Sadock & Sadock, 2003). According to Hoffman, Crnic, and Baker (2006), cultural constructions prepare women to abandon their own perspectives and values and adopt the prevailing male-

oriented value. This forms their experience of creating relationships and female knowledge systems.

According to Schwartz and Petersen (2006), any social construction, which devalues women, tends to socialise women to gender normative behaviours, which include silencing oneself in so many contexts. This gender imbalance, as it applies to the experience of depression, appears to be constant around the world. Women are socialised to define themselves via their interpersonal roles and relationships.

Another social influence in the onset of depression is social support. It appears that when people perceive that they have social support, they are less likely to develop symptoms of depression and visa versa (Bockian, 2006; Sadock & Sadock, 2003).

#### **2.4.2 Psychological Perspective**

According to this perspective, stressful and traumatic life events may contribute to the etiology of Depressive Disorders.

Sadock and Sadock, (2003) describe that a possible genetic and psychological vulnerability makes people susceptible to a disorder when the right kind of stressor appears to activate it. This would offer an explanation for why depression is not an outcome for everyone who experiences a stressful life event (Barlow & Durand, 1999; Sadock & Sadock, 2003).

It follows that the context of an event as well as the meaning it holds for the individual should be considered before defining it as a significant stressful event (Bockian, 2006). A marked relationship has been found between depression and events, which were experienced as traumatic (Brown, Harris, & Hepworth, 1994).

When the person with a genetic/psychological vulnerability experiences an event as significantly stressful, the person often experiences feelings of loss of control. It takes the form of an attribution, which is made by a person that he/she has no control over the stress in his or her life. This trend is referred to as the learned helplessness theory of depression (Abramson, Seligman & Teasdale, 1978; Sadock & Sadock, 2003). Abramson, Metalisky, and Alloy (1989) revised the model of learned helplessness to highlight the development of a sense of hopelessness as a crucial component of depression.

From the above it follows that when an individual with the self-perception of having little or no control over his/ her life events (as influenced by the socio-cultural context) received a Major Depressive Disorder (MDD) diagnosis; her sense of loss of control is likely to be compounded. In line with this, Lovejoy et al. (2000); Loh and Vostanis, (2004); and Hoffman, Crnic and Baker (2006) found that depression is related to disrupted and dysfunctional emotions and behaviour.

The person internally experiences the depressive attributional style, which means the person attributes negative events to personal failings (Whiffen, 2005). It is also experienced as stable, in that the attribution of personal responsibility for negative events remains even once the negative event has passed. The style is also experienced as global, where the attributions extend across a wide variety of issues (Sadock & Sadock, 2003). According to Gotlib, Kurtzman, and Blehar (1997), the cognition of depressed persons is consistently more negative than that of non-depressed persons. People are more likely to recall negative events when they are depressed than when they are not depressed, or when they are non-depressed people (Gotlib et al., 1997).

According to Beckian (2006), depression may result from a tendency to interpret everyday events in a negative way and this is described as cognitive errors in terms of how information is processed. Arbitrary inference manifests as an emphasis of the negative aspects rather than the positive aspects of events (Loh & Vostanis, 2004). Overgeneralization manifests as a negative generalization based on a single critical experience (Hoffman, Crnic, & Baker, 2006).

## **2.5 Clinical Criteria and Diagnosis**

The experience of depression is psychiatrically classified as a Mood Disorder. Mood Disorders have a disturbance in mood as the predominant feature/symptom. These disorders are generally defined according to criteria listed by the American Psychiatric Association (APA) in the Diagnostic and Statistical Manual of Mental Disorders, DSM–5 (APA, 2013).

According to the DSM–5 (APA, 2013), Mood Episodes (Major Depressive Episode, Mixed Episode, and Hypomania Episode) serve as the building blocks for diagnosing Mood Disorder (Major Depressive Disorder, Dysthymic Disorder, Depressive Disorder Not Otherwise Specified, Bipolar I Disorder, Bipolar II Disorder, Cyclothymic Disorder, Bipolar Not Otherwise Specified, Mood Disorder Due to a General Medical Condition, Substance-Induced Mood Disorder, Mood Disorder Not Otherwise Specified). The criteria sets for most of the Mood Disorders require the presence or absence of a specific Mood Disorder.

Since this study focuses on the general experience of Major Depressive Disorder, only the Major Depressive Disorder (MDD) and Major Depressive Disorder Recurrent will be fully outlined.

Depression can be defined and identified by a variety of means, of which the most commonly used is the American Medical Association's Diagnostic and Statistical Manual of Mental Disorders (currently DSM-5) and the World Organization's International Classification of Diseases (currently ICD-10) (Dowrick, 2004).

### **Symptoms of Major Depressive Disorder**

- *A depressed mood for most of the day*

The individual experiences a pervasive low mood for most of the day. The depressed mood differs from normal feelings of sadness as it is persistent and cannot be shaken off (Palazidou & Tiffin, 2000). This low mood can be observed as the individual appears miserable, brows are furrowed, the corners of his or her mouth are down turned, they have slumped postures and their contact is poor (Ingram et al., 2011).

- *A decrease in finding pleasure or interest in normal activities*

In psychiatric terms, this condition is described as anhedonia (Kaplan & Sadock, 2003). An individual suffering from depression typically does not find pleasure in previous enjoyed activities and tends to withdraw from social contact with others (Palazidou & Tiffin, 2000). According to Ingram et al. (2011), the individual is unable to experience normal emotions like joy, pleasure or grief.

- *Appetite and accompanying weight changes that can either mean an increase or a decrease*

Individuals with depression typically experience a loss of appetite with consequent weight loss. However, the tendency among the individuals to “eat for comfort” and thus gain weight has also been recorded (Palazidou & Tiffin, 2000). Atypical weight gain due to increased appetite can also occur in individuals with depression (APA, 2000).

- *Sleep disturbances, either insomnia or hypersomnia for most of the time*

These sleep disturbances that occur among depression sufferers affect their functioning during the day. Some sufferers wake up during the night and are unable to go back to sleep while others have difficulty falling asleep or wake up a few hours before their normal waking hours (Palazidou & Tiffin, 2000).

Hypersomnia is another atypical symptom of depression. This includes an extended night-time sleep period or daytime sleeping which results in more than 10 hours’ sleep over a 24hour period (APA, 2000).

- *Agitation or retardation of psychomotor functions*

Agitation is a dominant symptom especially in older persons. Psychomotor retardation occurs when sufferers have physically and mentally slowed down, causing indecisiveness about even simple or minor matters (Palazidou & Tiffin, 2000).

- *Lower energy levels and feelings of fatigue*

Individuals with depression experience a severe lack of energy and always feel tired, affecting their day-to-day activities negatively. They also tend to neglect their physical appearance (Palazidou & Tiffin, 2000).

- *Decreased concentration or indecisiveness*

Affected individuals suffer from a lack of ability to concentrate adequately and become forgetful, as their short-term memory is impaired (Palazidou & Tiffin, 2000).

- *Recurrent thoughts about death and dying, suicidal ideation with or without plan to commit or attempt to commit suicide*

Depressed individuals experience pervasive negative thoughts leading to feelings of no hope for the future. Not all depressed individuals or individuals with suicidal ideation do attempt or commit suicide.

**Diagnostic criteria for Major Depressive Disorder, Single Episode according to the DSM–5 (APA, 2013, p. 160)**

“ Major Depressive Disorder

- A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

**Note:** Do not include symptoms that are not clearly attributable to

another medical condition.

1. Depressed mood most of the day, nearly everyday, as indicated by their subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
2. Markedly diminished interest or pleasure in all, or most of all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
3. Significant weight loss when dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. (Note: In children, consider failure to make expected weight gain.)
4. Insomnia or hypersomnia nearly every day.
5. Psychomotor agitation or retardation nearly (observable by others not merely subjective feelings of restlessness or being slowed down).
6. Fatigue or loss of energy nearly everyday.
7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly everyday (not merely self-reproach or guilt about being sick).
8. Diminished ability to think or concentrate, or indecisiveness, nearly everyday (either by subjective account or as observed by others.)
9. Recurrent thought of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific

plan for committing suicide.

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attribute to the physiological effects of a substance or to another medical condition.

**Note:** criteria A-C represent a major depressive episode.

**Note:** Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia schizopreniform disorder delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a maniac episode or a hypomanic episode.

**Note:** this exclusion does not apply if all of the maniac-like or

hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

If the full criteria are currently met for Major Depressive Disorder, the current clinical status and/or feature should be specified: Mild, Moderate, Severe Without Psychotic Features or Severe With Psychotic Features; moreover it should be specified whether they are mood-congruent or mood-incongruent (APA, 2013).

- Mild

The symptoms result only in minor occupational, social activities and in relationship with others, impairment in functioning and the symptoms are in excess to make a diagnosis.

- Moderate

The symptoms present with functional impairment between mild and severe.

- Severe

Several symptoms present to make a diagnosis, and symptoms markedly interfere with occupational functioning, or with usual social activities or/and relationships with others.

Severity of depression often presents with Psychotic Features. Additionally, if psychotic features are present, the diagnosis should specify whether they are mood-congruent or mood-incongruent.

- Mood- congruent psychotic features

Are delusions or hallucinations whose content is fitting and harmonizing entirely with the typical depressive themes of personal inadequacy and guilt.

- Mood- incongruent psychotic features

Delusions and hallucinations content do not involve and are not directly related to typical depressive themes of personal inadequacy.

According to DSM–5 (APA, 2013), if the full criteria are not met for MDD, it must be specified whether the features of Depressive Disorder are In Partial Remission or In Full Remission

- In Partial Remission

During the past two months, symptoms of MDD are present but the full criteria are not met, or there is a period without any significant symptoms of MDD.

- In Full Remission

No significant symptoms of the disturbance are present during the past two months, which can be regarded as recovery.

Furthermore, if the full criteria are not met for MDD, it should be indicated and specified whether the Depressive Disorder is Chronic, with Catatonic features, with Melancholic features, with Atypical features or/and with Postpartum Onset (DSM–5, APA, 2013). ”

**Diagnostic criteria for Major Depressive Disorder, Recurrent according to the DSM–5 (APA, 2013, p. 162)**

“For an episode to be considered recurrent, there must be an interval of at least 2 consecutive months between separate episodes in which criteria are not met for a major depressive episode.

- A. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- B. The episode is not attribute to the physiological effects of a substance or to another medical condition.

**Note:** criteria A-C represent a major depressive episode.

- C. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia schizopreniform disorder delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.
- D. There has never been a maniac episode or a hypomanic episode.

**Note:** this exclusion does not apply if all of the maniac-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition (APA, 2013).”

## **2.6 Depression as a Relational Phenomenon**

Like a pebble that creates ripples when dropped into water, depression creates ripples in the interaction with the systems.

Depression of mild intensity is a common human emotion and it is relational, it usually is a consequence of recent stress (Hammen, 2003). Most people therefore have some basic understanding of and know something about depression but are able to function. This disorder may fulfil an adaptive function in the sense that it helps people to move on, to move from where they were stuck to a newer perspective with diverse possibilities (Rapmund, 1996).

The impact of depression as a health problem reaches beyond the individual to touch family members. It affects functioning in a variety of ways. Papp (2000) considered depression as a complex health problem that needs to be understood in the context of a person's relationship, culture, life events, his or her biology, and emotions and patterns of thinking.

It is easy to assume that the link between depression and stress moves in one direction, stress befalls people and that leads them to suffer depression (Eberhart & Hammen, 2009). However, depressed individuals can also generate stress, more problematically, depression may generate stressful life events that in turn lead to continued depression.

Of great concern are the interpersonal effects that the depressive disorder creates – loss of energy, less enjoyment of pleasurable activities, less ability to solve problems, irritability, a negative outlook and reduced capacity to work (MacFarlane, 2003), as it produces distress and impairment in social and interpersonal functioning (Stahl, 2008).

Horowitz and Strack (2011) argue that “a depressed individual often uses his or her symptoms to communicate and to seek repeated feedback in his/her testing of the nature of his/her acceptance and the security of her/his relationship” (p. 304). These

statements suggest that a major factor prompting negative mood induction in, and rejection from others is this annoying interpersonal style of excessively seeking assurance. The tendencies of depressed individuals to seek assurance from others, is driven by their increased experience of negative life events and low self-esteem (Joiner et al., 1999).

By the time a depressed individual seeks medical advice about the disorder, the family will likely be affected. The interactions between a depressed individual and a family member are often punctuated by emotional distance, negative thinking, and irritability (Monroe & Reid, 2009). This implies that the depressed individual will seek confirmation of worthiness and lovability from others. In response, family members, who grow tired of the mood variability, often distance themselves from the depressed person. The distance can increase a sense of isolation and confirm the depressed person's negative point of view (Whiffen, 2005). Over time, a reciprocal interaction pattern can develop in which the symptomatic behaviour fosters relationship distress and the relationship distress intensifies the symptomatic behaviour.

Horowitz and Strack (2011) theorise that depressive behaviour engages other people and places a burden on them. Others are assumed to offer sympathy and support but eventually tire of depressive displays, becoming angry and unhappy; and culminating in what is often referred to as non-genuine reassurance. The depressed person is aware of this lack of authenticity. In order to relate Horowitz and Strack (2011) noted that "he/she is aware by now that this response from others is not genuine and that they have become critical and rejecting" (p. 432). The rejection from the interpersonal environment is assumed to maintain the state of depression and accordingly "the symptoms have a mutually maintaining relationship with the response of the social environment" (Horowitz & Strack, 2011, p. 433).

## 2.7 Depression in Parents

Parental depression has been shown to have an impact on children. Depression in parents was found to correlate with adjustment difficulties in their children. According to Ehrenberg (2010), in families with a depressed father, the expression of positive outlooks was suppressed. This implies that this suppression was correlated with negative child outcomes and had a constraining effect on marital interactions. Whereas in families with depressed mothers, the interaction between the mother and child showed more negativity. Consequently, this indicates that other effects include insecure attachment, difficulties with developing social skills, and academic challenges (Burke, 2003; Whiffen, 2005). The family relationships are negatively affected by depression of a parent and tense interactions in the family were contributing to depression (Lovejoy et al., 2000).

Depression in parents is a significant risk factor for children, increasing a child's odds of developing both internalizing (e.g., depression, anxiety) and externalizing (e.g., behaviour) problems. In addition, parental depression negatively impacts parenting, family functioning and family relationships (Goodman & Godlib, 2002). Within the context of adolescents living with a depressed parent, Cumming, Davies, and Campbell (2000) suggest that one mechanism by which depression in parents may impact on an adolescent's functioning is via its harmful effects on parenting and the family environment.

Parenting changes are also significantly related to changes in depressive and anxiety symptoms in adolescents (Lovejoy et al., 2000). This suggests that remission of a parent's depressive symptom may have potentially far-reaching implications for the families and children in particular. It is likely that changing parenting behaviours

is harder for a mother who is depressed than for a mother who has recovered from depression (Loh & Vostanis, 2004).

Adolescents of a depressed parent have an increased risk for developing emotional and behavioural problems, including affective disorders (Boland & Keller, 2009). A depressed parent is also more likely to interact with her adolescent using an intrusive or insensitive style and to respond less contingently to her adolescent's emotional responses. Thus, the adolescent may experience a depressed mother's behaviours as stressful because they are more negative and less predictable (Ashmab, Dawson, Panagiotides, Yamada, & Wilkinson, 2002).

## **2.8 The Impact of Depression on Family Relationships**

Family discord, defined as marital discord, low family intimacy, and parental impairments, were found to be significant mediators for adolescents between histories of parental depression symptoms and both conduct problems and depressive symptoms of adolescents (Davies & Windle, 1997). However, Davies and Dumenci (1999) found that although marital stress mediated the association between maternal depressive symptoms and externalizing symptoms in adolescents, parental depressive symptoms mediated the effects of marital distress on adolescents' supporting a pathway from marital distress through parental depression to adolescents' depression. In line with the above, parents' use of observable conflict strategies involving depressive behaviours such as physical distress, withdrawal, sadness, and fear were found to mediate the association between depressive symptoms in parents and their adolescent's internalizing symptoms whereas

destructive and constructive marital conflict strategies did not serve as mediators (Du Rocher-Schudlich & Cummings, 2003).

Brown and colleagues found that negative self-evaluation, which they believe is associated with negative life events experiences and results from the presence of demoralizing chronic stressors, further increase the likelihood of depression associated with major life events (Brown, Bifulco, Harris, & Bridge, 1986). Among the many variables included in research, life stress appeared to be a predictor of the onset or recurrence of major and minor depression: twice as many individuals experiencing high levels of stress became depressed as opposed to those who experienced low levels of stress (Lewison, Hoberman, & Rosenbaum, 1988).

Barnett and Gotlib (1988) reviewed research on interpersonal functioning of depressed persons and concluded that dependency and introversion, low social integration, and marital distress are found to be common in depressed persons. Such interpersonal deficiencies may in part be consequences of depression, but they also may characterize qualities of the individual that disrupt relationships with others. Thus, symptoms, attributes, and behaviours of the depressed or depression-vulnerable individuals might actually contribute to the occurrence of the negative interpersonal stressor that in turn intensifies depression.

Fendrich, Warner, and Weissman (1990) found that certain family stressors, such as marital difficulties, are predictive of adolescent's diagnoses of mood disorders. However, despite the relatively little direct exploration of stress factors in families of parents with affective disorders, several studies have explored the effects of parental

symptoms as a stressor having an impact on adolescents or the joint effects of parental stressors and parental symptoms (Hoffman, Crnic & Baker, 2006).

Billing and Moos (1983) demonstrated that the adolescents of parents treated for depression were likely to experience adjustment problems and that if the depressed parent also faced high levels of stressful life events, the rate of child disorders was higher. Adolescents' stressors were associated with parents' symptoms (Horowitz & Strack, 2011).

## **2.9 The impact of Parental Depression on Adolescents**

Adolescents of the depressed parent are more likely to have experienced a mildly stressful event and to have experienced mild health problems (Ashmab et al., 2002). According to Swartz and Shorter (2007), adolescents of chronically depressed mothers were also more likely to endorse symptoms of Major Depression themselves. This implies that adolescents with elevated internalizing symptoms, which refer to children who are more anxious and withdrawn, may have a lower threshold for experiencing a novel or strange situation as threatening (Stahl, 2008; Swartz & Shorter, 2007). Furthermore, these adolescents may lack the resources with which to cope with stressful situations (Swartz & Shorter, 2007). Thus, the effect of early exposure to parental depression in this study may be related to the amount of exposure in a given period rather than the timing of exposure.

According to Hoffman, Crnic and Baker (2006) depression arising at any time is associated with a range of difficulties in interpersonal communication. Adolescents from these high-risk populations are likely to evidence clear disturbance during

interactions with their depressed mothers, typically showing avoidance and distress (Murray, Sinclair, Cooper, Ducournau & Turner, 1999). In the early depressive months, depression has been found to be associated with intensive and negative parental interactions with the child (Bockian, 2006).

Loh and Vostanis (2004) found that child gender and family social environment have most pervasive effects on adjustment: girls were judged more adaptable, outgoing, and pro-social than boys, relating more favourably in terms of their interpersonal relationships, their persistence, and their ability to ignore distractions. Boys of a depressed parent showed raised rates of behaviour disturbance, hyperactive behaviour, and high rates of distractibility (Goodman & Godlib, 2002). On the other hand, girls of a depressed parent were seen as least active and distractible and to have lowest rates of behaviour disturbance (Ashmab et al., 2002).

Within the context of adolescents living with a depressed parent, the adolescents' behaviour was strongly related to the quality of the mother's depression (Goodman & Godlib, 2002). Communication is regarded as important to tighten the relationship (Levinson, 2002). Having taken the mother's affect and behaviour into account, the adolescents' behaviour was found to be significantly associated with parental depression (Costello, 2009).

Although the various studies outlined above provide evidence of enduring difficulties in emotional and behavioural adjustment at home and at school in the children of depressed mothers, further research is required in order to identify and explore the impact of parental depression on adolescents.

### **2.9.1 Psychosocial impact on Adolescents**

Most forms of psychological disorder affect individuals' interpersonal lives, impairing their social functioning by altering interpersonal behaviours and the quality of relating to others. Depression is no exception, because the symptoms of depression interfere with normal relationships (Horowitz & Strack, 2011).

The child reciprocates the parent's negative behaviour. The child's maladjustment might have been caused by the mother's behaviour or it might be a continuation of pre-existing child problems that elicit a negative response from the mothers. There is a more complex reciprocal process, in which both the mother and the child contribute to each other's current difficulties and to the children's future difficulties (Swartz & Shorter, 2007). In order to relate, a negative and passive parenting style may be one source that contributes to the adjustment problems in adolescents of depressed parents, therefore, it is necessary to put into cognisance that this negative and passive parenting style has been identified as a risk factor for several other forms of maladjustment and especially for dysphoric affect and behaviour in adolescents (Patterson, 1982). The negative and passive parenting style elicits clinical depression in adolescents only in combination with a parental style that is behaviourally and affectively nonresponsive and that is characterized by high rates of dysphoric affect (Stahl, 2008).

According to Burke (2003), socially skilled adolescents are also likely to confirm their depressed parent's feeling of ineptitude and rejection by eliciting the negative responses that are common in depressed parents. Studies by Hammen (1991) and Monroe and Reid (2009) that linked temperament and resilience in adolescents have further suggested ways in which adolescent characteristics may elicit or maintain

particular parental behaviours. Schwartz and Petersen (2006) found that temperamentally easy going adolescents are more resistant to their depressed parent's behaviour than are more irritable adolescents. Resistance to the parent's negative behaviour may impede the development of the reciprocal pattern of negativity often seen in the interactions of depressed mothers and their children.

Adolescents are adversely affected by their depressed parent's affect, cognitions, and behaviour, and as a result they are exposed to high-risk environmental factors that hamper with their functioning (Whiffen, 2005). Depression in a parent interferes with the effectiveness of parenting on adolescents, and it clouds the adolescent's positive affect in their interactions with their depressed parent and alters their cognitions to perceive their interactions as non-effective (Costello, 2006).

According to Kobak and Sceery (1988), depressed parents often wish to be good parents, and are troubled by their difficulties. When observed in interactions with their youngsters, depressed mothers are frequently more passive, uninvolved, and unresponsive than non-depressed mothers (Kobak & Sceery, 1988). Studies of family relationships by Joiner, Katz, and Lew (1999) and Greenberg and Watson (2005) have indicated significant impairment of the parental role when a person is depressed. Therefore, according to the abovementioned studies, the effects on the adolescents of having a depressed mother uniformly indicate that the adolescents are at risk for developing depression, or other disorders, themselves (Downey & Coyne, 1990; Hammen, 1991). Much of the negative effect appears to be attributable to the parent's difficulties in sustaining warm, responsive, supportive relations with their adolescents (Whiffen, 2005).

As discussed in 2.7, depression in parents, the family context is also important in depression, in relation to the impact of a parent's depression on other family members. A depressed parent commonly has difficulty in his/her parenting roles, and such dysfunctions may contribute to high rates of depression and other disorders in the adolescents. Marital relationships also suffer as a result of the depression of one of the partners (Bockian, 2006). This implies that the depressed parent experiences relating to family members are highly stressful and this stress may contribute to further depression (Eberhart & Hammen, 2009).

Not only do some forms of depression appear to result from inadequate emotional connectedness with parents, but also depression appears to create interpersonal disruptions in families (Costello, 2009). Depression may induce negative reactions in others and thus promote disturbed interactions. Such stressful relationships may in turn contribute to further depression (Whitney et al., 2002).

Severe and repeated depression would likely cause the most negative consequences for adolescents; it is likely that even relatively mild but persisting or recurring symptoms may exert long-lasting effects (Stahl, 2008). Even mild depression may result in disruptions of adolescents' development of normal skills, by putting the adolescent at a disadvantage in dealing with challenges and mastery of new tasks (Beardslee, Bemporad, Keller, & Klerman, 1993; Lovejoy et al., 2000).

### **2.9.2 Emotional impact**

Adolescents living with a depressive parent acquire negative self-concepts, and negative relationships with the parent (Ingram, Atchley, & Segal, 2011). Such patterns reinforce speculation that family factors that contribute to the adolescent's

risk are not unique to a parent with affective disorders, but occur also under the conditions of ongoing stress and demoralization, such as illness and major stressors (Loh & Vostanis, 2004). This indicates that these stressors make it difficult for the depressed parent to sustain positive, involved interaction with his/her adolescent, and the adolescent's own problems may further contribute to a cycle of maladaptive interactions (Ehrenberg, 2010).

Within attachment theory, emotional security is seen as originating from a history of positive experiences between parent and child (Bowlby, 1969). In Bowlby's (1969) words 'confidence in the availability of attachment figures, or lack of it, is built up slowly during the years of immaturity – infancy, childhood and adolescence – and that whatever expectations are developed during those years tend to persist relatively unchanged throughout the rest of life' (p. 202). Furthermore, such expectations 'are tolerably accurate reflections of the experiences those individuals have had' (Bowlby, 1969, p. 202).

In line with the above, the adolescent's broader sense of emotional security is also influenced by their history of experiences. Parental warmth and emotional involvement foster a sense of security and confidence in adolescents, while parenting marked by withdrawal and a lack of availability threatens adolescents' security (Hammen, 1999). Patterns of emotional security, in turn, may guide and organize adolescents' functioning (Ingram, Atchley, & Segal, 2011).

Emotionally secure parent-child attachments foster children's 'felt-security' when faced with stress and the regulation of emotional distress (Bowlby, 1973; Cassidy, 1993). This impact of security attachments extends beyond the proximal context of the parent-child relationship and promotes children's adaptive functioning in other

social contexts (Bretherton, Ridgeway, & Cassidy, 1990). As a result, adolescents' experiences for guidance are dependent on the parents, who are open to their own experience (Papp, 2000). Although they feel helpless, they feel confident that their own experience provides a sufficient and satisfactory basis for deciding how to respond to a particular situation (Palazidou & Tiffin, 2000).

Emotional security is seen as having implications for children's regulation of their own emotions. Adolescents engage in a relatively sophisticated analysis of the meaning of parental emotional behaviour, and, in particular, evaluate it in terms of its emotional security implications for them (Loh & Vostanis, 2004). Children react to unresolved conflicts with emotional negativity, but they respond to the same conflicts with non-negative or even positive emotion if they are resolved (Burke, 2003). Therefore, a component of or the functioning of emotional security is the regulation of children's emotionality, including their (1) subjective feeling states, (2) overt behavioural expressions of emotion, and (3) physiological functioning (Campos, Campos & Barrett, 1989).

Serving a motivational function, emotional security guides children to cope with significant family events by motivating them to regulate or attempt to regulate their parents' behaviour (Bretherton, Fritz, Zahn-Waxler, & Ridgeway, 1986). According to Hoffman, Crnic, and Baker (2006), emotional security consists of adolescents' appraisal and internal representations of family relationships (Bowlby, 1969). Different family relationships may result in quite different internal working representations from the perspective of the child.

Adolescents respond to parental passiveness with social withdrawal and disengagement (Cohn & Tronick, 1989).

Maternal warmth and responsiveness is associated with positive child development outcomes, including sociability, self-regulation, pro-social behaviour, and high self-esteem. According to Cumming and Davies (1995), relations between a lack of parental emotional responsivity and a variety of negative child development outcomes, including social withdrawal, aggression, and attention-deficit-hyperactivity disorder, provides an opportunity for poor interactions and detachment between the parent and the child (Cumming & Davies, 1995).

Within the context of adolescents living with a depressed parent, emotional maltreatment, in the form of passivity and withdrawal is linked with extreme disturbances in attachment (Carlson, Cicchetti, Barnett, & Braunwald, 1989). Thus, securely attached adolescents exhibit less anxiety and distress than insecurely attached adolescents, functioning more optimally in a variety of domains. In line with the above, insecurely attached adolescents are at risk for a variety of maladaptive outcomes, including depression, anxiety, social withdrawal, as well as hostility, impulsivity, and aggression (Erickson, Sroufe & Egeland, 1985; Frydenberg, 1997; Hammen, 2003).

### **2.9.3 Cognitive impact**

Impaired cognitive functioning may render the child vulnerable, particularly in the context of adjustment to family context and school, because some aspects of cognitive impairment, such as poor concentration, may be an important element in certain forms of behaviour disturbance (Horowitz & Strack, 2011). Alternatively, faced with the demands of the school curriculum, children with poor cognitive functioning may develop low self-esteem that, in turn, may lead to behaviour difficulties (Murray et al., 1999). Attachment insecurity has been reported to be a risk

factor for a range of later difficulties in emotional and social adjustment, including mother-child interactions, and behaviour disturbances (Swartz & Shorter, 2007).

According to Hammen (2003), significant relationships between adolescents' perceptions of overall positivity of the mother's behaviour toward them and their self-view is motivated by adolescents' needs to accommodate the depressed parent, which at a later stage will impact negatively on the adolescents' life. Thus, the adolescents' perceptions of the quality of interaction and the actually observed quality of interaction in terms of maternal passivity were associated with having negative cognitions about the self (Murray et al., 1999).

The area of focus concerned is the context of adolescents' experiences of living with a depressed parent. The adolescents' self-views are greatly shaped by the kinds of actual experiences to which they are exposed with the likelihood that highly stressful circumstances and unrewarding environments have a negative influence on the adolescent's views of the worth and competence of the self (Greene & Kropf, 2009).

The depressed mother might exhibit self-deprecating cognitions or views of the world that the adolescent observes, and the adolescent may apply those cognitions to himself or herself. However, Jaenicke, Hammen, Zupan, Hiroto, Gordon, Adrian and Burge, (1987) reviewed the observational data for the mother-child interactions to see if mothers and children showed similar tendencies to make self-blaming remarks, but the correlation between the two was non-significant.

## **2.10 Conclusion**

Depression is one of the most severe life changing illnesses that exist. It leads to multiple changes, changes in behaviour, affect, cognitive and physical abilities even changes in family relations and interactions. These changes often lead to dysfunctionalities within the family context and create emotional and behavioural impairments within interpersonal relationships.

This chapter explored the literature on depression, and the epidemiology of depression was described. Definitions of depression were explained from different theoretical perspectives, and diagnostic criteria according to the DSM-5 were provided. Depression as a relational phenomenon was also described. Additionally, depression in parents, the impact of depression in family relationships, and the impact of parental depression on adolescents were described.

Although children at risk with parental psychopathology have been researched, experiences of adolescents living with depressed parents provides an opportunity to further explore the effects of stressful conditions on adolescents and the emotional impact they have on the adolescent.

Since this research study explores the experiences of adolescents living with a depressed parent, a short exploration of what we understand by adolescence follows now in Chapter Three.

## **CHAPTER 3**

### **EXISTING THEORIES ON THE STAGE OF ADOLESCENCE**

#### **3.1. Introduction**

The definitions of depression, and the etiology of depressive disorders, were highlighted in Chapter Two. Depression as a relational phenomenon, the impact of depression on family relationships and the impact of parental depression on adolescents were described.

Chapter Three describes the existing theories on the stage of adolescence. In line with the above, theories about adolescence are discussed in this chapter as a way to understand the adolescent's development. Although the literature does not describe the experiences of adolescents living with a depressed parent in this context, it provides information that has been used to explain the developmental stage of adolescence and its challenges.

This chapter begins with various definitions of the terms adolescence from different theorists, such as Erikson, Dreyfus, Rogers and Frydenberg. An overview is given of the stage of adolescence, and the effect it can have on the development of the adolescent's identity. The family relationships during adolescence and the parent-adolescent relationship are also presented.

## 3.2 Adolescence

### 3.2.1 Erikson's Theory

Erikson (1968) proposed that development takes place in eight life stages, starting with infancy at birth and ending with old age and death. He viewed each stage of development as a plateau for developing self to gain and restore a sense of mastery (Parrish, 2010).

Eight stages of Development according to Erikson (1968):

Stage	Basic Conflict	Important Events	Outcome
<b>Infancy (birth to 18 months)</b>	Trust vs. Mistrust	Feeding	Children develop a sense of trust when caregivers provide reliability, care, and affection. A lack of this will lead to mistrust.
<b>Early Childhood (2 to 3 years)</b>	Autonomy vs. Shame and Doubt	Toilet Training	Children need to develop a sense of personal control over physical skills and a sense of

			<p>independence.</p> <p>Success leads to feelings of autonomy, failure results in feelings of shame and doubt.</p>
<p><b>Preschool (3 to 5 years)</b></p>	<p>Initiative vs. Guilt</p>	<p>Exploration</p>	<p>Children need to begin asserting control and power over the environment.</p> <p>Success in this stage leads to a sense of purpose.</p> <p>Children who try to exert too much power experience disapproval, resulting in a sense of guilt.</p>
			<p>Children need to cope with new</p>

<p><b>School Age (6 to 11 years)</b></p>	<p>Industry vs. School Inferiority</p>	<p>School</p>	<p>social and academic demands. Success leads to a sense of competence, while failure results in feelings of inferiority.</p>
<p><b>Adolescence (12 to 21 years)</b></p>	<p>Identity vs. Role Confusion</p>	<p>Social Relationships</p>	<p><b>Teenagers need to develop a sense of self and personal identity. Success leads to an ability to stay true to yourself, while failure leads to role confusion and a weak sense of self.</b></p>
<p><b>Young Adulthood (19 to 40 years)</b></p>	<p>Intimacy vs. Relationships Isolation</p>	<p>Relationships</p>	<p>Young adults need to form intimate, loving relationships with other people. Success leads to</p>

			strong relationships, while failure results in loneliness and isolation.
<b>Middle Adulthood (40 to 65 years)</b>	Generativity Stagnation	vs. Work and Parenthood	Adults need to create or nurture things that will outlast them, often by having children or creating a positive change that benefits other people. Success leads to feelings of usefulness and accomplishment, while failure results in shallow involvement in the world.
			Older adults need to look back on life

<b>Maturity (65 to death)</b>	Ego Integrity vs. Despair	Reflection on Life	and feel a sense of fulfilment. Success at this stage leads to feelings of wisdom, while failure results in regret, bitterness, and anger.
-------------------------------	---------------------------	--------------------	--

Erikson (1968) further proposed that the stage of adolescence consists of identity versus role confusion, which is the fifth psychosocial developmental stage, occurring from ages twelve through twenty-one years. According to Erikson (1968), identity depends on social support that permits the child to formulate successive and tentative identifications.

Erikson's (1968) basic premise entailed a bio-psychosocial view of a lifelong development. He emphasized the dynamic relationship between individuals and their social environment. Erikson (1968) goes on to place more emphasis on social influences on adolescents and the manner in which they react and are affected by these influences.

It is important to note that during adolescence the individual struggles with issues of "how to be oneself" and "how to share oneself with others" (Erikson, 1959, p. 179). Additionally, it becomes further challenging to go through the adolescent phase experiencing familial social malfunctions.

From Erikson's (1968) perspective, adolescents are influenced positively or negatively by social forces they are highly aware of (Erikson, 1968). His primary concern was with a theoretical framework that addressed the capacity of the self to act on the environment, and be influenced by it. A focus on the interaction between the striving self and mastery of the environment is key to Erikson's formulation of personality (Horowitz & Strack, 2011).

### **3.2.2 Dreyfus' Theory**

Dreyfus (1976) defines adolescence as a period of "storm and stress for the individual..... Adolescence is a time of general instability" (p.20). Even though adolescence is primarily biologically determined, Dreyfus believes that the environment has a reasonable effect upon psychological development (Dreyfus, 1976).

According to Dreyfus (1976), the direct relationship between the involvements of both parents with the adolescent allows the adolescent to discover a sense of personal autonomy; however, minimal involvement of both parents can create anxiety and less autonomy. Too much or little involvement can inhibit the adolescent's achievement of independence (Dreyfus, 1976). This implies that if the parents remain superficially involved in their adolescent's life, the security that the adolescent needs for healthy development is undermined.

### **3.2.3 Rogers' Theory**

Rogers (1976) refers to adolescence as “a stage in the lifespan from puberty until maturity and includes all the physical, psychological and social traits characteristic of persons during this time” (Rogers, 1976, p.69).

According to Rogers (1976), development mostly depends upon **what is done to us**, and also depends primarily upon **what we do**. And while adolescence is a stage at which we are neither a child nor an adult, life is definitely getting more complex as we attempt to find our own **identity**, struggle with social interactions, and grapple with moral issues.

### **3.2.4 Frydenberg's Theory**

Adolescence is “that period between childhood and adulthood when the individual is confronted by a series of developmental hurdles and challenges” (Frydenberg, 1997, p.35).

According to Frydenberg's theory (1997) adolescence can be viewed as a time when coping is very important, when many new experiences and responsibilities are thrust upon individuals. The challenges and experiences adolescents are faced with around their environment, they are able to deal and cope with those challenges and experiences effectively. However, relationship patterns change and become more accommodating to the adolescent.

From Frydenberg's (1997) perspective, parental involvement in the management of adolescents provides opportunities for social interaction. This implies that

involvement in relationships is the basis on which independence is established, and is not perceived to contradict or interfere with the development of independence.

During this period, which Erikson called Identity versus Role Confusion, the child has to integrate all the tasks from the previous four stages into a coherent identity, and prepares to face the world as an independent adult (Maguire, 2002). During this phase, the adolescent must also connect the roles and skills he or she learned with what he or she wants to be as an adult. Integrating these skills and desires with practical realities takes place through the availability of parental involvement and the adolescent's maturity (Greene, 1999; Frydenberg, 1997; Parrish, 2010).

These theorists go on to state that adolescence is a time when an individual is required to fulfil social roles with peers and family, but being overburdened with these roles and responsibilities can become complex and affect and further disrupt the adolescent's cognitive, behavioural and emotional functioning (Dreyfus, 1976; Erikson, 1968; Frydenberg, 1997; Rogers 1976)

### **3.3 Definitions**

#### **3.3.1 Defining Development**

Development is better thought of as a process than as a state. Kreglinger (1986) defines development as a movement in the direction of perfection, although he acknowledges that what we mean by perfection is neither transparent nor easy to articulate. Accounts of personal growth include descriptions of self-actualization (Maslow, 1970), the healthy personality (Jourard, 1974), and the mature personality (Allport, 1964).

For the fully functioning person (Kirschenbaum & Henderson, 1989; Rogers, 1961), development is denoted by the process of moving in the direction of becoming more fully functioning. It is a process with “an increasing openness to experience, increasingly existential living and an increasing trust in one’s own identity” (Maguire, 2002, p.89).

### **3.3.2 Defining Identity**

Dreyfus (1976) equated identity with the self, he described it as “the person’s total subjective environment”. It includes amongst other things a system of ideas, attitudes, values and commitments. Identity is “the centre of experience and significance” (Dreyfus, 1976, p.7). It constitutes a person’s inner world as distinguished from the other world consisting of other people and things (Cruze, 1953; Greene & Kropf, 2009; Sprinthall & Collins, 1995)

## **3.4 Family Relationships During Adolescence**

At the foundation of understanding the link between family relationships and adolescence, Frydenberg (1997) postulates that adolescence is a period of growth and development, and the family is the context in which an adolescent spends much of his or her time to learn, and the parents’ involvement provides opportunity for social interactions (Parrish, 2010), and the study conducted by Greene and Kropf (2009) found evidence that the extent of the impactful life experiences of an adolescent is dependent on the stressful situation the adolescent finds himself or herself in. This theoretical link led to the line of reasoning that if minimal availability or unavailability of parental support is present, poor maladaptive interactions in the

family context will yield dysfunctionality in relationships and therefore, disrupts the adolescent's cognitive and emotional development (Lerner & Spanier, 1980; Skoe & von der Lippe, 1998).

Among environmental influences on mental development, family factors are paramount in an adolescent's life. Adolescents are fully aware that family experiences affect their emotional and mental development (Greene & Kropf, 2009).

As discussed in 3.2, Adolescence, adolescence is marked by the transition of moving from the culture of childhood to the culture of adulthood. This links with the fact that the extent to which the transition is experienced as stressful, is generally dependent on the impact and interplay between the adolescent and the situational determinants (Horowitz & Strack, 2011). The transition elicits the pressures of behaving like an adult and in some circumstances accepting the responsibilities of adulthood are being placed on adolescents.

In addition, Frydenberg (1997) found that there are situations in the family context that can deprive an adolescent's developmental autonomy. He identified the situations as:

*Minimal emotional and social support* – No or little support from family members and no interest in sharing the problem with others and enlisting their support in its management.

*Focusing on solving the problem* – The adolescents' needs in cognitive, socio-emotional, representational and biological domains are neglected to a certain point in order to accommodate the parent, which at a later stage will impact negatively on the adolescents' life.

*Worry* – The adolescent becoming hopeless and helpless, rendering himself or herself socially and cognitively ineffective, self-evaluating himself or herself negatively, having a negative interpretation of his or her experiences, and a negative view of the future.

*Social action* – the adolescent's experiences of emotionally supporting and caring for a chronically ill parent deprives the adolescent to grow according to his or her milestones but allows him or her to mature before her chronological milestones have been reached. It is about letting others know what is of concern, and the challenges the adolescent's family is going through.

*Helplessness* – the adolescent assumes the parental role within the family context, leading him or her to be vulnerable and to withdraw socially. The impact of the situation is that the adolescent's anger and passive rejection of the parent can be attributed to detachment and poor communication between the parent and the adolescent in the context of parent-adolescent relationships (Frydenberg, 1997).

Adolescence might be viewed as a challenging stage of development, however, Greene and Kropf, (2009) argue that positive involvement with family and positive experiences within the family during adolescence provide a foundation for a healthy and generative adult life.

### **3.5 Parent – Adolescent Relationships**

According to Horowitz and Strack (2011), parent-adolescent relationships are recognized as *bidirectional*: both parent and adolescent affect and are affected by

each other. Sprinthall and Collins (1995) also stated that interaction with parents is based more on conversation and joint decision making than the ability of parents to regulate the children's behaviour unilaterally.

From the adolescent's perspective, parent- adolescent relationships face a challenge: how to adapt to the changing abilities, experiences and demands of social change while maintaining a relationship quality that provides a secure base for accomplishing the developmental tasks of adolescence. Parents also change over the years, and these changes and stresses they experience often affect their responses to changes in their adolescent children (Adams, Montemayor & Gullotta, 1996; Scott & Scott, 1998). This implies that the changes strain the daily interactions of parents and adolescents and make it more difficult for each other to understand and respond sensitively to the other's behaviour. Therefore, adolescents are affected by the problems they encounter in their dysfunctional family context and it then follows that individual development occurs in the context of social change.

It is important to note that parents supervise and guide these interactions from time to time. Involvement in relationships is the basis on which independence is established, and is not perceived to contradict or interfere with the development of independence, but provides evidence that supports the connection between the reality that interaction between the adolescent and his or her context involves reciprocal influence, as the adolescent continues to impact the setting in which he or she finds himself or herself.

### **3.6 Conclusion**

Theories of the developmental stage of adolescence were provided, and family relationships and parent- adolescent relationships during adolescence were discussed.

From the above-mentioned theorists' perspectives, adolescence is a stage that proves to be challenging, as the basic conflict is identity versus role confusion. In order to relate the experiences of adolescents living with a depressed parent, it is necessary to understand the developmental stage of adolescence, as well as the importance of interaction between the adolescent and his or her family context, which involves reciprocal influences as they impact on each other.

The next chapter describes the research design and methods that were used to explore the above.

## **CHAPTER 4**

### **RESEARCH DESIGN AND METHOD**

#### **4.1 Introduction**

This chapter describes the research design and method employed to explore the experiences of adolescents living with a depressed parent. The research design refers to “the detailed methods and structures utilized to implement the study” and the research method entails “the whole strategy for the study from beginning to end” (Burns & Grove, 2003, p. 223).

The research design and the aim of the study will now be described, which is followed by a description of the method, the process of data collection, the data analysis and the ethical considerations.

#### **4.2 Research Design**

Coolican (cited in Soni, 2006) refers to a research design as a plan or strategy used to conduct scientific inquiry. According to Babbie (2007, p. 179), the primary aim of a research design “.....is to assist in and guide the way in which researchers conduct and proceed with investigations. This enables researchers to determine the answers to research questions”.

Neuman (2001) indicated that research could be divided into either qualitative or quantitative research styles. For this research study the qualitative approach was deemed most appropriate as will be described next.

#### **4.2.1 Qualitative Research Design**

In contrast to quantitative research in which control and prediction of variables takes precedence by means of measurement and quantification, a qualitative research design places the spotlight on the meaning and significance of themes that are based on first-hand experiences and participation. According to Creswell (2008) “the researcher builds a complex, holistic picture, analyses words, reports detailed interviews of informants, and conducts the study in a natural setting” (p. 15).

Moreover, qualitative research involves the studied use and collection of a variety of empirical material, personal experience, life story interview, observational, historical, interactional and visual texts – that describe routine and problematic moments and meaning in individuals’ lives (Denzin & Lincoln, 2000). The goal of qualitative research is to discover patterns, which emerge after close observation, careful documentation and thoughtful analysis of the research topic.

The key difference between quantitative and qualitative inquiries is that quantitative researchers work with a few variables or influences and many cases, whereas qualitative researchers rely on few cases and many interacting variables or influences (Cresswell, 2008).

This study clearly does not fit into the paradigm of quantitative inquiry, since the present study, grapples with the experiences of adolescents dealing with their mother’s depression. The approach employed in this study is based on an

autoethnographic stance. The researcher is not only an observer, but also a participant in the context that is being studied (Van Maanen, as cited in Genzuk, 1999). The researcher is part of the context and shares in her experiences of living with a depressed parent. The researcher sets out to explore the experiences of adolescents living with a depressed mother with the aim to identify and explore the emotional impact of parental depression on adolescents.

#### **4.2.2 Ethnography**

Ethnography is defined as a study of an intact cultural or social group based mainly on observations over a prolonged period of time in which the researcher is a participant. The researcher observes and listens to all participants with the intent of generating a holistic view of the experiences shared (Creswell, 1998; Hammersley & Atkinson, 1995; Thomas, 1993). Because of its flexible nature, ethnography is not restricted to any particular set of research rules, principles, or presuppositions. Ethnography may use any of the rules and guidelines belonging to both the quantitative and qualitative research paradigms.

Ethnography refers to the study of people in their natural context or setting. Observing and interacting with people in their natural setting and everyday context, rather than under traditional research experimental conditions created by the researchers, affords more spontaneity and less guardedness on the part of all the persons involved. The researcher becomes a natural and accepted participant of all interactions of which she is a part, and of which she is a witness. Ethnography thus refers to the understanding of a group of people interacting in a specific place, according to their everyday way of life (Ellis & Bochner, 2000; Hammersley, 1998; Neuman, 2001).

According to Hammersley (1998), the ethnographic approach refers to the following features I have employed as research strategies, method, data collection, and data analysis (p. 148):

- I have studied my family's behaviour in everyday contexts, (natural everyday group sharing activities) rather than under experimental conditions created by the researcher.
- I have gathered the data from a range of sources such as diaries, journals, process notes, but participation/observation and/or relatively informal conversations are usually my sources of data collection.
- My approach to data collection is 'unstructured' in the sense that it does not adhere to a detailed plan set at the beginning; nor are the categories used for interpreting what people say and do pre-given or fixed. This does not mean that the research is unsystematic; simply that initially the data are collected in as raw a form, and as wide a front, as feasible.
- My focus is a single setting such as my home and a single group, which is my family on a relatively small scale.
- The analysis of the data involves interpretation of the meanings and functions of the human actions and mainly takes the form of verbal descriptions and explanations, while quantification and statistical analysis do not play a role in this research study.

In line with Hammersley (1998) the above mentioned features and characteristics of ethnography, that I have used to explore adolescents living with a depressed parent, can be described as “..... a *picture of the way of life of some identifiable group of people*” (Wolcott, 1988, p. 188).

### 4.2.3 The Research Design applied in this study

A qualitative research design with an ethnographic/autoethnographic approach is used in this study. This type of design/approach uses a process of observing and listening to personal experiences. It involves carefully documenting the stories, analysing the words and sentences, and discovering patterns, carefully documenting them and analysing them (Neuman, 2001).

I chose a qualitative research design with an ethnographic/autoethnographic approach in order to present a detailed view of the topic, and to capture the inner world of the adolescents living with a depressed parent. As (Seale, 1999, p. 105) puts it:

*“ I use qualitative research to make sense of feelings, experiences and social situations and to share it with the reader”* (Seale, 1999, p. 105). A qualitative approach is therefore suited to the present exploration because it deals with details of daily living. Furthermore, a qualitative approach lends itself to uncovering the breadths and depths of experiences as captured within ethnographic stories (Richards, 2003).

Ethnography allows the researcher an easy access to primary data sources of the participants. It is also an excellent vehicle through which researchers come to understand themselves and others (Hammersley, 1990).

### **4.3 Aims of the Study**

This research study aims to achieve the following:

- Explore the experiences of adolescents living with a depressed parent, since there is a scarcity of such research.
- Contribute scientific knowledge to the *debate* of experiences of adolescents living with a depressed parent.
- Highlight intersections and correlations between the participants and their experiences.
- Contribute to generating further research.

### **4.4 Method**

#### **4.4.1 Selection of Research Participants**

The participants for this study consist of two adolescent girls between the ages of 12 and 18 years, who lived with their mother who was clinically diagnosed with Major Depressive Disorder for a period of five years until she committed suicide. My sister, Inga, and I are the participants, who are qualified to contribute to the research as “expert witnesses” due to having experienced a clinically depressed mother over a long time during our adolescence (Pearson, 1970, p. 137).

Babbie (2007, p. 176) refers to the selection of participants as “the process of selecting observations for a study”. The chosen participants are most appropriate for this research study because it enabled the researcher to fulfil the scope of the study by focusing on a whole family in various contexts (Burns & Grove, 2001).

The participants were selected because they were accessible and met the criteria of living with a depressed mother. Due to being sisters, they shared similar experiences.

#### **4.4.2 Data Collection**

In all types of qualitative research, Creswell (1998) suggests that the main methods for data collection consist of *participation observation*, *documentation*, and *interviewing*.

*Participation observation* refers to the researcher becoming a participant in the culture setting and thus observes by watching and listening to all overt and covert interactions with and between participants.

*Documentation* refers to all written material in the form of journals and diaries, process notes and informal discussions.

*Interviewing* refers to all formal interviews and informal conversations with participants.

- **Diaries and Journals.** Information was documented in, and obtained from personal diaries and journals (1996-2000).
- **Process notes** were made throughout the research pertaining to the information obtained.
- **Informal discussions** were shared with Inga.

Semi-structured interviews were employed for this study, where the goal is to understand the world from the participant's perspective, and to enable the participant to play a more active role in shaping the direction of the research. The conversation at hand is engaged in in-depth (Sugarman, 2001). What is involved is not simply an

interviewing technique or procedure, but a relationship of some intimacy, intensity, and duration.

Semi-structured interviews helped the researcher to resonate with the participant's perspective, and to unfold the meaning of her own experience. Semi-structured interviews are the active participation of the participant and the importance of giving the participant voice (Lindlof & Taylor, 2002).

The semi-structured interview was employed because it allows collecting large amounts of data quickly (Marshall & Rossman, 1989). It also permits immediate follow-up questions and clarifications (Kvale, 1996).

#### **4.4.3 Procedure**

Permission was obtained from my sister to use her narrative of her experience living with a depressed mother to conduct this research. The participant was informed that the study is being conducted to find out the impact of her mother's depression on her and her sister, and to explore their emotional and social experiences of living with a depressed mother during the adolescent years.

Ellis and Bochner (2000) illustrate the art of ethnographic writing in such a way that it captures core aspects of a narrative style, by imparting knowledge and expressing ideas, feelings, and beliefs in a creative and captivating way. Therefore, understanding and managing this process is a crucial part of my research method. The process is managed with sensitivity and discretion; it is a valuable learning experience for the participant as well as the researcher. Although therapy was not a primary aim, the interviews may have had therapeutic effects (Levinson, Darrow, Klein, Levinson & McKee, 1978).

#### 4.4.4 Data Analysis

Qualitative data analysis is often characterised by its lack of distinct rules. Henn, Weistein and Foard (2009) describe this lack of rules or rigidity as liberating, as there are no right or wrong approaches. However, general processes do exist which are valuable in guiding the researcher in the process of analysis. Data analysis within an ethnographic approach entails the description of the culture sharing group, as well as the themes that are presented in the group (Maritz & Visagie, 2011).

Henn et al. (2009) refer to data analysis as transforming fieldwork into deskwork, which is often a formidable task in ethnography. For the present study however, the data analysis has been continuous and a continuing process. As indicated in section 4.4.2, Data Collection, daily activities have been recorded in a variety of ways and forms. The following three quotations are practical guidelines, which I was able to identify with in my ongoing process of data analysis.

(a) Data analysis takes place “...*after recording, gathering, sorting, deciphering analyzing and synthesizing, dissecting and articulating*” (Denzin & Lincoln, 2000, p.231) all available information.

(b) The analysis of the data obtained from the culture-sharing group involves the process of “...*reviewing all the data and segmenting them into small sets of common themes, well supported in evidence in the data*” (Creswell, 2008, p. 245).

(c) The analysis of the data obtained in the intersections of the culture-sharing group, involves “...*the interpretation of the meanings and functions of human actions and mainly takes the form of developing a story from which descriptions and explanations are extracted*” (Papaikonomou & Nieuwoudt, 2004, p. 285).

Therefore, the method of data analysis should be carefully considered as it aims to transform the gathered information so as to answer the research question. The method of data analysis should therefore be coherent to the purpose of the research and the overall paradigm.

Thematic analysis is a descriptive presentation and interpretation of data, which involves the identification of themes from the text, which are not imposed by the researcher. This means that the researcher employs an exploratory stance in his/her approach to the data analysis. Anderson (2007) describes themes as expressions of the communality of voices across different research participants. These themes are then reflected upon by relating them to the contexts and experiences in order to root out the meaning of the descriptive presentation.

In the present study, the fieldwork procedure (gathering information through informal discussions) of ethnography/autoethnography for data gathering was employed in preparation for data analysis. The data was gathered by studying the behaviours of the culture-sharing group, mainly through observation, interacting and through interviews. Themes were drawn from the data as they emerged, and the process of data analysis followed by employing an adaptation of Anderson (2007), Kelly (2006a), TerreBlanche, Durrheim and Kelly (2006) and Kelly (2006b), which involves the following steps:

### **Step 1: Familiarisation and Immersion**

The process of familiarisation and immersion involves the researcher reading and re-reading the textual data gathered in order to get a feel for the overall meaning, and the different types of meaning, in the text. In order for familiarisation and immersion

to be effective, the researcher should confront the material with a more holistic view in order to allow him/herself to perceive the themes within the overall context.

### **Step 2: Thematising**

The process of thematising involves identifying the commonalities that underlie the textual data. This is a thorough process of going through the data and while doing so, highlighting and unpacking the different themes that emerge. Throughout this process, the researcher makes notes to unpack the themes, and creates sub-categories and clusters of information that emerge. All information that adds to or describes these clusters of meaning is noted.

### **Step 3: Coding**

The coding process requires the researcher to group together similar instances under the same theme. In this process the researcher marks different sections of the data as belonging to a specific theme identified in step 2. The processes of thematising and coding tend to blend together in practice and therefore do not necessarily comprise two different activities. Step 2 and 3 are repeated until the researcher is confident that the themes or categories reflect the interview transcript as a whole.

### **Step 4: Elaboration**

During this elaboration phase of data analysis, identified themes are explored more closely in an attempt to capture the finer meanings of that, which was missed in the original coding process. Through elaboration, it will be determined whether the coding system needs to be reviewed and the researcher may find him/herself moving

between coding and elaboration until he/she feels that he/she can give a good account of what the data results are.

### **Step 5: Interpretation and Checking**

This phase of the data analysis process involves the researcher reporting on, or putting together an account of the phenomenon that was explored. The report is usually comprised of a presentation of the themes and sub-themes that were discovered. The research study is considered “complete” once a point of saturation has been achieved. Saturation is described as the point where the researcher is confident that he/she has fully described, and has a satisfactory sense of, the phenomenon or experience that he/she has set out to explore.

According to Neuman (2004), the above-mentioned process is an appropriate process for gathering and coding qualitative information. As a result, thematic content analysis was chosen in this explorative study to transform the raw data into themes.

#### **4.4.5 Ethical Considerations**

Research in psychology usually involves human subjects, therefore, special precaution should be taken to ensure that the study adheres to sound ethical principles at all times. Furthermore, it is the personal responsibility of the individual researcher to act ethically when conducting the research (Neuman, 2001). This study obliges the researcher morally and professionally to always be aware of ethical loopholes when involved in the project, thus the researcher took the following considerations into account while conducting the study.

- **Scientific misconduct-** The researcher ensured that scientific misconduct did not occur by preventing plagiarism. She conducted her own study by generating new data. Accurate techniques were used when other researchers' work was cited.
- **Informed consent-** To obtain informed consent, the researcher explained the nature and purpose of the study to the participants. Participants were informed that their participation is voluntary, and as a result, they would not be rewarded financially or otherwise for participating in the study (Babbie, 2001).
- **Debriefing-** The researcher made the participants aware of their part in taking part in this study. The researcher and the participant discussed their experiences of the research in order to monitor any unforeseen negative effects or misconceptions. When the data were collected the researcher provided the participant with necessary information to complete her understanding of the nature of the study.
- **Withdrawal from the investigation-** The researcher made it clear to the participant regarding her rights to withdraw from the research at any time and to require that her own data be destroyed without the possibility of retribution and victimization.
- **Protection of the participant-** The best interest of the participant remains paramount.
- **The researcher has a primary responsibility-** To protect the participant from physical harm and mental harm during this study. The researcher took into consideration factors, such as pre-existing medical conditions, that might put the participant at risk, and was advised of any special action they should take to avoid risk (Sugarman, 2001).

## **4.5 Conclusion**

In this chapter an overview was given of the research design and the method employed to conduct this research study. The research design, the style of the design and the aim of the study were described. Additionally, the method of the study, the process of data collection, the procedure and the data analysis were described. Thematic analysis was utilised for data analysis to provide a clear picture of the overall process. Moreover, ethical considerations were explained to offer a clear understanding of adherence to ethical principles when conducting the research.

In the next chapter the findings will be presented.

## CHAPTER 5

### PRESENTATION OF THE FINDINGS

#### 5.1 Introduction

The data collection process was aimed at exploring the experiences of two adolescents living with a depressed parent over a period of 5 years (May 1996 – October 2000). This section of the study termed 'raw data' was done by an exploration of existing journals, diaries, daily process notes and unstructured interviews. The raw data collected from the two adolescents were retrieved from the journals, diaries and unstructured interviews, which were subsequently analysed and categorised into themes.

This chapter will provide an outline of the basic themes that emerged after analysing the data that were gathered from the participants.

The themes were sorted accordingly by grouping together similar instances and experiences that the adolescents shared, and thereafter the identified themes are explored more closely in an attempt to capture meaning of each adolescent's experiences.

#### 5.2 Presentation of the Themes that were Identified:

The data that were analysed were categorized into the following themes:

- Lack of knowledge
- Anger

- Guilt
- Communication Barrier and Difficulty
- Worry
- Care and Support
- Empathy
- Helplessness
- Encouragement
- Understanding the impact of Depression

These themes that were identified for each participant will now be presented.

### **5.3 Findings from the researcher**

#### **5.3.1 Lack of knowledge**

I described my personal experiences of living with a depressed mother as difficult and confusing. Little was known about my mother's illness.

"I knew my mother was not alright, maybe she had minor stress which increased with time. She was often down most of the time, skipped work, and never felt like doing anything. I did not take it really hard because I knew she was going to get better. Little did I know that those issues she complained about affected my mother to a point of being told that she is stressed and that she needed medication."

"I did not have insight at that age of what was really going on with my mother. All I knew is that she was not the person I knew, and she was forever sad and hurt. Her interest in activities deteriorated. She gradually isolated herself and spent most of the time by herself."

### **5.3.2 Anger**

This theme describes the way a lack of knowledge of my mother's illness made me feel. The theme of anger comes to the fore. My mother's dependent behaviour, lack of motivation, despair and isolation often made me annoyed and frustrated, which led to anger.

"I often got annoyed by my mother's behaviour and often yelled at her out of frustration. I got angry because of her behaviour."

"The impact of her behaviour made me angry at times and made me react negatively towards her."

"I got angry and irritated by her dependency style."

### **5.3.3 Guilt**

In an attempt to try to understand depression, knowledge about the illness was acquired. As knowledge was acquired, shifts and a different way of thinking took place (Eberhart & Hammen, 2009).

"Upon knowing that it was the illness that drove her to behave the way she behaved, I felt guilty about the way I treated her."

"I got to understand that it was not out of her own will to feel down in the dumps. It was her illness that made her to be the way she was."

I wanted her to know that I was sorry about how I treated her and made her feel, she was sick after all."

### 5.3.4 Communication Barrier and Difficulty

Communication became difficult between my mother and me. She could not verbalise her wishes, wants and needs. Most of the time my mother was non-communicative which proved to be difficult to for me to assist her with her needs, and as a result it became difficult for me to know and understand what was going on with her at that particular moment. It became even more frustrating for me to try to act as if I knew what my mother was going through and act as if I met my mother's needs.

"I hardly knew how to communicate with her. The conversations that we used to have had vanished. Spending time together with her seemed to be things in the past. We really missed her."

"I took her to go out for walks, to visit her friends, her sisters and her mother, which proved to be challenging for her. Most of the times she was not up for it, but when she felt like going for walks she did."

"because my mother communicated with us minimally, I had to take care of the household. She was in her bedroom most of the times; she found it difficult to communicate with us. She often said she does not know what to talk about....."

We developed a strategy to engage her in communication; we requested assistance from her mother and sisters to ask her to visit them. She then asked us to accompany her to her mother's house or her sister's house..... The outings were what we knew my mother needed and we knew it would enhance the lost communication between us. "

### **5.3.5 Worry**

A strong theme of worry emerged from the gathered data. At times I experienced a sense of uselessness, which led me to worry.

“I often worried about my mother’s wellbeing, I even stopped visiting friends and family members to monitor her. The worry was embedded in me as it came involuntary.”

“Every time she complained about her work place, I became worried because I knew she would relapse.”

“She was totally down in the dumps, and it worried us a lot. Worry became second nature to me. If I didn’t see her around me I would be worried and would start looking for her.”

### **5.3.6 Care and Support**

An interesting theme that emerged from the data was that of care and supporting the mother. This theme was implicit in the way the adolescents spoke and described their roles in the home environment.

“She reported that she was feeling down almost every day and locked herself in her bedroom. She spent the whole day in her room, particularly in bed. When I went inside her bedroom it was dark and stuffy; I opened the bedroom windows to let the fresh breeze in. I would force her to get out of bed because I thought her behaviour was making her feel down even more. She usually refused at first, and then later after some convincing she got out of bed. She spent most of the day in pajamas. The challenging part about these daily experiences was we (my sister and I) had to monitor her in getting her out of bed. She did not eat most of the time, we would beg

her to eat and at times we would leave her. Sometimes she would not bathe, and we forced her to bathe, which was a challenge thinking that she was adult and did not need to be reminded to bath. She reported that bathing consumed lots of energy for her. We ran a bath for her and made sure that she bathed. Looking after her and taking care of her was challenging, because she would be cooperative at times and at some other instances she would not even bother to be cooperative. Sometimes we got deprived of being with friends and playing with them because we had to be indoors with my mother.”

“When she cried, it was normal for me to give starch-water (sugar-water) and a hug. When she was down it was only natural to be with her, spend time with her, keep her company in an attempt to make her feel better.”

“I thought it was expected for a child to be emotionally supportive of her mother.”

As an adolescent I automatically assumed the role of supporting and caring for my mother.

### **5.3.7 Empathy**

I tried to understand what my mother was going through by asking her questions in an attempt to show that I was concerned about her wellbeing and her feelings.

“she often told me that if it was possible she would have a fresh brain just to erase what was happening in her head, to mute and completely shut all the voices in her head. I often wondered how “those voices” sounded like. I inquired about the voices in an attempt to understand what she was going through.”

“I tried to put myself in her shoes, and tried to understand and feel how she felt but I could not feel exactly what she felt. I resonated with her pain and despair.”

### **5.3.8 Helplessness**

The general idea of this theme is the feeling of helplessness I experienced as demonstrated in the following extracts of the data:

“My mother has lost motivation to be active in daily activities and she felt hopeless towards life. She cried most of the time. She spent the whole day in her room, not out of bed. My mother spent other days without bathing (how do you tell a young child what is going on). She has lost interest in activities, she no longer enjoyed to visit family members, and in actual fact she stopped visiting them. I sat there and watched her cry I did not know what to say and comfort her. She would cry out of the blue without any apparent reason and she would cry helplessly. My sister and I would sit with her with helplessness without any idea of knowing what we were doing.”

“Even when I understood what depression was, what saddened me the most is I was unable to help her, and I did not know how to help her. I was helpless, and my dad and I shared similar sentiments.”

### **5.3.9 Encouragement**

“I tried to make her happy and cheer her up most of the time, and tried to understand her unhappiness but I usually saw sadness in her eyes. Although she tried so hard to hide the emotions and look happy around us, I could read and sense her pain. As much as it was sad to see her lose her cheeriness, the smile and motherly-child spark, I came up with activities to encourage her to take part. We played games that cheered her up.”

### **5.3.10 Understanding the Impact of Depression**

An interesting theme that emerged from the data was that of getting to understand depression and its impact on the adolescents. This theme was implicit in the way I spoke of and described my mother. In most cases, I would describe how I felt. It became evident that I was negatively impacted by my mother's experience of the illness, but at some point I neglected my socio-emotional and representational domains to accommodate my mother, which at a later stage impacted negatively on my life.

"My mother's illness made us miss a lot of social activities with friends and family, which became a disadvantage on our side. Although we got to understand the nature of her illness and her behaviour, we had lost lots of time being adolescents. Instead we had to learn responsibility at a young age."

## **5.4. Findings from the Sister**

### **5.4.1 Lack of knowledge**

My adolescent sister described her personal experience of living with a depressed mother as confusing and stressful. She indicated that little was known about her mother's illness. The adolescent explains as follows:

"I did not have insight at that age of what was really going on with my mother. All I knew is that she was not the person I knew, and she was forever sad and hurt. Her interest in activities deteriorated. She gradually isolated herself and spent most of the time by herself."

“I didn’t understand what she was going through. I knew she was not the same person she was not bubbly anymore. She was sick.”

#### **5.4.2 Anger**

The adolescent indicated that due to her mother’s dependent behaviour, lack of motivation, despair and isolation she became annoyed and frustrated which lead to.....

“I knew she was a different individual, sometimes I will get frustrated and angry because she needed attention in a child-like manner.”

“I was unconsciously compelled to help my mother and the family, and sometimes even helping at my own expense or personal cost, it made me feel overly angry.”

“There were times I got angry with my mother, thinking that her negative thinking is a manoeuvre of attention seeking.”

#### **5.4.3 Guilt**

Emotional distance, negative thinking and irritability often punctuated the interaction between the adolescent and her mother. The distance increased a sense of isolation and fostered relationship distress.

“Upon knowing that it was the illness that drove her to behave the way she behaved, I felt guilty about the way I treated her.”

“I got to understand that it was not out of her own will to feel down in the dumps. It was her illness that made her to be the way she was.”

I wanted her to know that I was sorry about how I treated her and made her feel, she was sick after all.”

#### **5.4.4 Communication Barrier and Difficulty**

“most of the times she locked herself in her room, and spent the whole day without contact with us..... Communicating with her was a mission.”

“Physical activities with her promoted communication, which made her feel alive and worthy. Although we worked hard to get her to engage in communication with us, it was often a challenge but we managed to make her interact with us.”

“We really missed her.”

“I took her to go out for walks, to visit her friends, her sisters and her mother, which proved to be challenging for her. Most of the times she was not up for it, but when she felt like going for walks she did.”

“because my mother communicated with us minimally, I had to take care of the household. She was in her bedroom most of the times, she found it difficult to communicate with us. She often said she does not know what to talk about.....

We developed a strategy to engage her in communication, we requested assistance from her mother and sisters to ask her to visit them. She then asked us to accompany her to her mother’s house or her sister’s house..... The outings were what we knew my mother needed and we knew it would enhance the lost communication between us. ”

#### **5.4.5 Worry**

My adolescent sister had serious concerns about how my mother’s illness affected her social life.

“I often worried about my mother’s wellbeing, I even stopped visiting friends and family members to monitor her. The worry was embedded in me as it came involuntary.”

“Every time she complained about her work place, I became worried because I knew she would relapse.”

“I would find her in her robe, hurting and looking lifeless, worry always crawled in when she was in that state. What worried us the most was the fact that she had the potential to harm herself, which was a constant worry.”

“She was totally down in the dumps, and it worried us a lot. Worry became second nature to me. If I didn’t see her around me I would be worried and would start looking for her.”

#### **5.4.6 Care and Support**

An interesting theme that emerged from the data was that of care and supporting the mother.

“My adolescent sister reported that our mother was feeling down almost every day and locked herself in her bedroom. She spent the whole day in her room, particularly in bed. When I went inside her bedroom it was dark and stuffy; I opened the bedroom windows to let the fresh breeze in. I would force her to get out of bed because I thought her behaviour was making her feel down even worse. She usually refused at first, then later after some convincing she got out of bed. She spent most of the day in pajamas. The challenging part about these daily experiences was we (my sister and I) had to monitor her in getting her out of bed. She did not eat most of the time, we would beg her to eat and at times we would leave her. Sometimes she

would not bathe, and we forced her to bathe, which was a challenge thinking that she was adult and did not need to be reminded to bath. She reported that bathing consumed lots of energy for her. We ran a baths for her and made sure that she bathed. Looking after her and taking care of her was challenging, because she would be cooperative at times and at some other instances she would not even bother to be cooperative. Sometimes we got deprived of being with friends and playing with them because we had to be indoors with my mother.”

“When she cried, it was normal for me to give starch-water (sugar-water) and a hug. When she was down it was only natural to be with her, spend time with her, keep her company in an attempt to make her feel better.”

“I thought it was expected for a child to be emotionally supportive of her mother.”

The adolescents automatically assumed the role of supporting and caring for the mother.

#### **5.4.7 Empathy**

My adolescent sister always asked my mother and probed about her wellbeing. She spent time with her trying to understand what she was going through.

“my mother would want me to feel what she was feeling by telling me what was going on in her head and what she was thinking about. She often wished she could have a new good functioning brain and get rid of the one she had. She always talked about “the voices” in her head and how disturbing they were, I wondered how those voices sounded like. Seeing the sadness on her face, I constantly prayed that the voices would leave her alone and maybe she would get better.”

“it was always difficult to put myself in my mother’s shoes, because I could not understand how terrible she felt and I could not feel exactly what she felt.”

#### **5.4.8 Helplessness**

The general idea of this theme is the feeling of helplessness that my adolescent sister had experienced as demonstrated in the following extracts of the data:

“She always said ‘people will think I’m mad’, that is how she viewed her illness and I did not know how to respond to her thinking.”

“It was painful and heart tearing to see my mother cry, I think we had the same impact on her when she saw how we (my sister and I) shared her pain and how we empathized, thus, it is the reason she tried to contain her emotions most of the time. She cried most of the time, and that made us feel helpless.”

“Her inability to be emotionally present, to be hopeless and helpless immobilized her, and it made us helpless as well because we felt that there was nothing we can do to help her. We felt helpless.”

“What saddened me the most was seeing the pain in her eyes which longed for help as if she was thrown in a dungeon in seeking to be rescued. I hugged her a lot and told her that she was going to be fine and she must not think that she was worthless. I wished we could just give her what she wished for.”

#### **5.4.9 Encouragement**

“I initiated walks or jogs, which took the whole energy out of her. Some days she refused and others she participated, and other days she will be encouraged. We

also played crossword puzzles to keep her thoughts busy, massage her, plaited her hair and even visit my grandmother (my mother's mother)."

#### **5.4.10 Understanding the Impact of Depression**

An interesting theme that emerged from the data was that of getting to understand depression and its impact on the adolescents. My adolescent sister would describe how she felt. It became evident that my sister was negatively impacted by her mother's experience of the illness, because at some point she neglected her socio-emotional and representational domains to accommodate her mother, which at a later stage impacted negatively on her life.

"My mother's illness made me miss a lot of social activities with friends and family, which became a disadvantage on our side. Although we got to understand the nature of her illness and her behaviour, I lost lots of time being an adolescent and enjoying myself. Instead we had to learn responsibility at a young age. My mother's depression was bad, because we could not enjoy her as a parent "

The findings will be now be discussed in chapter 6

## CHAPTER 6

### DISCUSSION OF THE FINDINGS

#### 6.1 Introduction

This chapter aims at discussing the findings of the experiences of my sister and my experiences of living with our depressed mother. The findings consist of themes that emerged after analysing the data that were gathered from my and my sister's journals, diaries, interviews and process notes.

The identified themes will now be discussed.

#### 6.2 Lack of knowledge

##### **My experiences:**

The lack of knowledge theme represented my state of mind at the time as having no insight about our mother's illness. Although I knew that our mother was sick, I could not understand what might have been the problem and what was going on with her. If someone appears to be familiar and predictable, and yet behaves unexpectedly, unfamiliar and unpredictable the disturbance is not just surprising but profoundly disturbing according Lovallo (2005), which is exactly the way I felt about our mother. Thus lack of knowledge provided me with feelings of frustration and confusion, which led to anger.

### **Inga's experiences:**

Inga's experiences with having a lack of knowledge made her feel different to the way I felt. She stated that she knew our mother was not the same person she was before and as a result she did not understand what was going on with her. Lack of understanding, knowledge and insight can be detrimental to the parent-child relationship (Elliot, 2009). A healthy relationship between children and parents produce satisfactory interactions and communication, whereas disturbed communication and interactions create emotional distance between the child and the parent, leaving the child to figure out life by him/herself (Lovallo, 2005). A lack of knowledge for Inga meant that she developed feelings of frustration and confusion which had a negative impact on her interactions with our mother.

### **6.3 Anger**

#### **My experiences:**

According to Marcus (2007) adolescents tend to be emotionally volatile as they experience more extremes of mood and are inclined to have mood swings more often than adults. In my case as an adolescent at the time of my mother's illness, I got irritated and annoyed by petty little things. Our mother's behaviour and actions would frustrate, irritate and confuse me, which according to Elliot (2009) occurs because of the internal complexities of the adolescent stage, since anger is primarily an intrapersonal and interpersonal process.

Furthermore, Elliot (2009) denoted that adolescence is a period in which there is a substantial increase in the experience of negative emotions, and some actions and

emotions are often more extreme, more intense and more unpredictable and are elicited with less provocation (Elliot, 2009). In my case being an adolescent at the time of my mother's illness, my anger displays were not only produced by change in our mother's behaviour, emotions and actions but also by internal processes that were taking place within me. Although I knew that my mother was ill, her change in behaviour and actions coupled with my lack of knowledge about her illness, made my interactions with our mother disturbed because of the aggressive nature of our interaction, which according to Marcus (2007) created emotional distance, and self-reliant behaviour in me.

### **Inga's experiences:**

More recently, Welty (2011) interpreted anger as a phenomenon in which aggressive behaviour is mixed with unpleasant feelings of hostility. Inga's anger was induced by the way our mother sought attention and the manner in which she expected us to constantly be there for her.

The role of the parents in adolescents' emotional development is to assist and hone the adolescent to learn effective emotional regulation strategies, which help the adolescent to cope and deal with life's difficulties effectively (Timothy, Cavell, Kenya, & Malcolm, 2007). In our case, we could not regulate our emotions effectively to deal with our family context because our mother was not emotionally available to provide us with the guidance instead she was reliant on us for emotional support. As a result, my sister and I became self-reliant when caring for our ill mother. Reliance is the extent to which others look to an individual when they are in need (Nay, 2010).

## **6.4 Guilt**

### **My experiences:**

According to Nay (2010), the occurrence of guilt deals with the existence of anger and the existence of anger always leads to some form of guilt, and that is what my sister and I experienced when we were caring for our depressed mother.

Upon understanding what my mother's illness was all about through reading about the illness, and what the illness was doing to her emotionally, cognitively and psychologically I felt guilty of the way I treated her. According to Elliot (2009) and Nay (2010) being informed is essential to understand the circumstances of the situation in order to fully understand the whole situation.

Through the poor interactions with our mother, guilt made me channel my responsibility towards caring for her. As a result, I acquired knowledge about my mother's illness, which helped both our mother and I to understand depression and how to relate effectively in interaction with her as a depressed person (Ingram, Atchley, & Segal, 2011).

### **Inga's experiences:**

As knowledge was acquired about our mother's illness, shifts and different ways of thinking took place (Eberhart & Hammen, 2009). The interaction between our mother and us was often punctuated by emotional distance, negative thinking and irritability which was replaced by patience and understanding for our mother's state of being.

The essence of guilt supports the notion that Horowitz and Strack (2011) described, that a family has a strong sense of togetherness, which allows the family members to have a different outlook on pressing matters beyond previous experiences (Horowitz

& Strack, 2011), which implies that our familial maladaptive interpersonal relationships were managed through understanding the nature of our mother's illness.

## **6.5 Communication Barriers and Difficulty**

### **My experiences:**

Communication barriers between our depressed mother and me made it difficult for me to communicate with our mother. My mother cried in an attempt to express how she felt and to communicate how she felt. In order to avoid becoming overly overwhelmed by emotions when communicating with me she isolated herself by remaining away from me. According to Dryden (2011) my mother's interactional style created a barrier to communicate which made it difficult to reach her through communication. Despite the communication barrier, as time went by I got used to her minimal way of communicating and relating. I adapted to her way of communicating and relating to us, and found ways to adjust to and deal with the situation as Lovullo (2005) suggests.

### **Inga's experiences:**

My sister reported that communication between them was difficult as well, since our mother engaged minimally with her. Inga demonstrated an intense need to be useful and to impact our mother's life positively by encouraging her to participate in physical activities but our mother's attitude at the time made it difficult to engage with her, which led to a difficulty in communication. However, despite the communication

barrier Inga explained that she seemed to get accustomed to our mother's behaviour and found ways to adjust to the situation.

Elliot (2009) pointed out that to know that someone in the family is concerned when things are going badly is reassuring since he/she knows that she is not superfluous to the family but that he/she shows some level of commitment and consideration.

## **6.6 Worry**

### **My experiences:**

Dryden (2011) suggests that worry is most usually a functional state, which allows us to plan options and review possibilities concerning threatening situations. I experienced a sense of uselessness, which led to worrying. This was specifically portrayed in my inability to communicate with my mother which provided a challenge – the feeling of not knowing what to do with her and how to help her, feeling overwhelmed by my mother's change in behaviour and affect and having to function in the family context which I found myself in.

According to Steffgen and Gollwitzer (2007), worry is an involuntary process whereby negative thoughts and images repeatedly gain entry to awareness; I became a worrier to the point where the worry was imbedded in me because of my chronic worrying.

### **Inga's experiences:**

The primary function of the worry process is to prompt active coping, directed at reducing negative uncertainties (Timothy et al., 2007). But for my sister worry

became an involuntary and consistent habit due to the fact that she was often concerned and overly considerate of our mother. According to (Dryden, 2011) worry makes reference to interpersonal inappropriate behaviour that expresses physical and verbal concern for others, and furthermore, has both negative and positive components. So in this case, my sister's worry had both negative and positive aspects: the positive aspect was that she was able to care for our mother effectively; and the negative aspect was that she made it her responsibility to care for our mother, which resulted in my sister to become independent and parentified at a young age.

## **6.7 Care and Support**

### **My experiences**

My care and support for our family was implicit in the way I spoke and described the roles in the home environment. I made it my responsibility to look after my mother emotionally and to help in the household. Horowitz and Strack (2011) indicated that adolescents are affected by the problems they encounter in their dysfunctional family context and it follows that individual development occurs in the context of social change. It was evident that I made it my responsibility to take care of my mother, which in turn affected my social life negatively.

### **Inga's experiences:**

According to Steffgen and Gollwitzer (2007) adolescents tend to be happier if the parent provides emotional support during times of trials and as a result they learn to be independent, but if failure to access proper emotional support is evident between

the parent and the adolescent, Nay (2010) reports that the adolescent won't get a satisfactory relationship with the parent and as a result he/she is left to figure life out on his/her own (Nay, 2010). The former links with what we experienced, instead of receiving emotional support from our mother it became the other way round, we provided care and support to her, and as a result we became parentified adolescents (Horowitz & Strack, 2011).

## **6.8 Empathy**

### **My experiences:**

When I had gained knowledge of our mother's depression, I was able to imagine myself in my mother's place, and tried to understand her feelings. The aspect of understanding the feelings of others critically defines empathy in which one has a feeling corresponding to that of another's feelings (Dryden, 2011). Farrow and Woodruff (2007) describe that understanding is the ability to make sense of things.

### **Inga's experiences:**

She tried to put herself in our mother's position with the attempt to understand what she was experiencing, even though she did not fully understand she had an idea of what it was like to be depressed. As Lovallo (2005) identified, the perception of what it means to be empathic means to have a sense of self, a sense of others and an embodied relational process between the self and the other, which can be identified in imitative behaviour and engagement. The above links with my sister's actions of being considerate and empathic towards our mother.

As Farrow and Woodruff (2007) described “without self-awareness and awareness of the other” one cannot imagine oneself in another’s place (p.89).

## **6.9 Helplessness**

### **My experiences:**

The theme of helplessness highlighted the fact that caring for our mother on a deeper level demonstrated a commitment to the emotional, physical, behavioural, cognitive and social wellbeing of our mother (Welty, 2011). The experience of our mother’s helplessness made me helpless as well.

Abstract thoughts allowed me to introspect, and see myself in different ways – a carer, a guardian and a supporter (Timothy et al., 2007). Thus, I displayed a deeper emotional commitment to our mother even though at times I felt helpless. This theme was explicit in the way I tried to involve our mother in daily activities and made her feel worthy, but the attempts at times seemed futile and as a result her helplessness had a ripple effect on me as I ran out of ideas to help her.

### **Inga’s experiences:**

In essence the helplessness supports the notion that most parental depression affects adolescents’ interpersonal lives, impairing their social functioning by altering interpersonal behaviours and the quality of relating to others as described by Horowitz and Strack (2011). Both my sister and I assumed the parental role within the family context, which enabled our mother to be vulnerable and to withdraw socially. The impact of the situation perpetuated my sister’s helplessness and

frustration, which produced poor communication and detachment between our mother and my sister (Marcus, 2007).

## **6.10 Encouragement**

### **My experiences:**

I discovered a sense of personal autonomy by physically and emotionally encouraging my mother to engage in physically stimulating activities. Communication is regarded as important to tighten the relations between the adolescent and the parent, taking into account the mother's affect and behaviour (Dryden, 2011). In this sense, what I engaged in with my mother was beyond what I could offer. This impacted positively on her and me, and allowed me to view my role in a positive light and assisted me to have a positive effect on myself as our mother's carer (Elliot, 2009; Lovallo, 2005; Neuman, 2001).

### **Inga's experiences:**

The encouragement theme describes how engagement and encouragement can promote personal growth and a sense of confidence/self-assurance for the depressed parent (Timothy et al., 2007). Caring for our depressed mother was a new experience for both of us. My sister's experience of living with our mother allowed her to develop new ways of caring for her and our mother's helplessness seemed to add value to my sister's experiences and her self-esteem as an individual (Marcus, 2007).

Her strategy to encourage our mother to engage in activities was found a viable opinion because all of these activities encouraged and activated our mother and

destroyed her negative thinking by occupying her thoughts with other ideas and activities. Ashmab et al. (2002) found that the adolescents are more likely to interact with their depressed parent by using a connected, attached and encouraging manner in their attempts to assist their mother to feel self-reliant.

## **6.11 Understanding the Impact of Depression**

### **My experiences:**

Understanding the impact of depression highlighted the fact that I viewed my role as being carer of our mother. Horowitz and Strack (2011) indicated that parent-child relationships are recognized as bidirectional: both parent and adolescent are affected by each other. Accordingly in this study both our mother and I were affected negatively by the experiences in this context. Our mother's changes in affect and behaviour strained the interactions between us. It made it more difficult for each other to understand and respond sensitively to each other's behaviour (Nay, 2010; Scott & Scott, 1998; Welty, 2011).

### **My sister 's experiences:**

Understanding the impact of depression also highlighted that my sister was affected by the problems she encountered in her dysfunctional family context. Our mother's illness induced a negative reaction within the family context and promoted disturbed interactions, which further contributed to a circle of maladaptive interactions (Dryden, 2011; Lovallo, 2005; Steffgen & Gollwitzer, 2007).

## **6.12 Integration Of My Sister's and My Discussions**

We described our personal experiences of living with our depressed mother as difficult to deal with and were confused at times. We indicated that little was known about our mother's illness.

The work of Stahl (2008) as well as that of Horowitz and Strack (2011) described that the adolescents of parents treated for depression were likely to experience adjustment problems and that if the depressed parent also faced high levels of stressful life events, the rate of child disorders were higher. Accordingly, our stressors were found to be associated with our depressed parents' symptoms (Elliot, 2009).

It is through the family's support that the initial communication barrier and difficulty became less significant and confusing, as we seemed to "understand" the needs of our mother more accurately. This "understanding" is demonstrated through how we acknowledged that our mother was different and sick, and how we needed similar things for our mother. When considering the difficulties in communication, it is clear that this may have been a stressor that impacted negatively on our experiences (Lovallo, 2005; Steffgen & Gollwitzer, 2007). However, when we explained our experiences to each other, it was clear that we worked around the communication barrier and have adjusted to an extent in which we knew how to accommodate our mother.

The essence of the guilt theme supports the notion that Horowitz and Strack (2011) and Marcus (2007) describe that a family has a strong sense of togetherness that allows the family members to have a different outlook on present pressing matters beyond previous experiences. This implies that through our willingness to acquire

knowledge about depression, understanding of our mother's illness and communication between us and our mother, maladaptive interpersonal relationships were steadily resolved.

We see how parents' identity may have an impact on the experiences of the adolescents. As described by Frydenberg's theory (1997), the challenges and experiences adolescents are faced with are to deal and cope with them effectively, but at other times the impact can have a negative effect on the adolescents. In this study, we see that our experiences of not knowing what was going on with our mother and how to assist her may have contributed to the distress and worry we experienced.

Farrow and Woodruff (2007) indicated that empathy allows us to share other's feelings, to mimic without awareness and to form the basis of relationships and social learning. In line with Farrow and Woodruff (2007) living with our mother, we experienced the pain and despair, and sharing our feelings with our mother made us to remain emotionally and socially connected to our mother as we spent most of our time with her.

Furthermore, according to Horowitz and Strack (2011), parent-adolescent relationships are recognized as *bidirectional*: both parent and adolescents affect and are affected by each other, which means that interaction between the adolescent and his or her depressed parent in the context they live in involves reciprocally influencing one another. Thus, having an empathic attitude promotes connectedness and attachment between the parent and the adolescent (Dreyfus, 1976; Erikson, 1968; Frydenberg, 1994; Rogers, 1972).

Timothy et al. (2007) as well as Marcus (2007) describe that not all adolescents will experience the impairment of their parents' illness as a source of stress. They identified energy and engagement as mediating factors to stress. In the current study, the ability of the adolescents to engage in positive and energetic activities such as jogging, playing crossword puzzle, visiting family members and friends, with their mother may have had a buffering effect in terms of the stress they experienced (Nay, 2010). Through engagement with our mother, we experienced a sense of fulfillment, satisfaction and to some extent happiness in our roles, due to feelings of helplessness we became parentified adolescents in an attempt to be effective and helpful.

Frydenberg's theory (1994) describes that satisfaction through encouragement leads to positive results. In the present study, we see that the satisfaction experienced by us in engaging, caring for and encouraging our mother contributed to a positive experience of caring in general. We described our engagement with and encouragements to our mother as making us feel socially connected to her. Social connectedness through encouragement and communication has been described by Costello (2009) and Elliot (2009) as a contributing factor that can buffer the impact of stress in families. In line with Costello (2009), Dreyfus' theory (1976) further describes that encouragement can act as a protective factor which may allow families to cope more effectively with various stressors. Costello (2009) suggests that physical activities promote communication, which enhances encouragement between adolescents and their depressed parent. In this study, we engaged in physical activities with our mother, increasing the sense of connectedness between our mother and us.

The findings indicate that our experiences varied from positive to negative. Dreyfus' theory (1976) describes that too much or too little involvement of parents can inhibit the adolescents' achievement of independence, which implies that if the parents are only superficially involved in their adolescents' lives, the security that the adolescents need for healthy development is undermined. That was not the case in our family, since my father was fully involved with our development while our depressed mother had withdrawn from us emotionally, and isolated herself from us and her family of origin due to her continuing depression. Inga and I thus achieved independence successfully.

### **6.13 Conclusion**

An overview of the themes found in this study shows that the impact of parental depression reaches beyond the individuals involved, and it creates dysfunctions in the family and relational contexts. It is also mostly fitting to indicate that the parental depression affects adolescents' functioning in many ways, i.e. emotionally, behaviourally, cognitively and interactionally, therefore it can be understood in the context of a person's relationship with others, life events, her biology, emotions and patterns of thinking (Elliot, 2009; Nay, 2010; Papp, 2000; Welty, 2011).

It is clear that the impact of parental depression on adolescents plays a significant role in the way the adolescents experience their interaction with the parent. In this sense, the experiences of these adolescents living with their depressed mother in this study are seen to provide a negative impact interactionally, emotionally, cognitively and behaviourally. The adolescents initially could not communicate effectively with their mother, it raised the intense need to assume responsibility to

care for and support their mother, and as a result this role impacted negatively on the adolescents. Therefore, we see that the dysfunctions in the family contexts create maladaptation that impacts negatively on the family members (Ashmab et al., 2002; Horowitz & Strack, 2011).

## **CHAPTER 7**

### **CONCLUSION**

#### **7.1 Introduction**

In this qualitative study the researcher aimed to explore the experiences of two adolescents living with a depressed mother. The aims of the study were: firstly, to explore the emotional and social experiences of adolescents living with a depressed mother, secondly, to explore the impact the mother's depression had on the adolescents and the challenges they face, and lastly, to explore and examine their personal understanding of depression. The experiences of the adolescents were documented and analysed by using thematic analysis. Throughout this study, the voices of two adolescent girls, the researcher and Inga, her sister, who participated in this research study, were heard in order to obtain a full picture of how they experienced their mother's depression.

The three research aims will now be presented in conjunction with the outcomes of the research.

#### **7.2. Presentation of the three research aims and outcomes**

##### **7.2.1 The emotional and social experiences of adolescents living with a depressed mother**

Our mother's depression affected our (my sister and my), interpersonal lives, impairing our social functioning by altering interpersonal behaviours and the quality

of relating to others. Instead of engaging in social activities we made it our responsibility to care for our mother and as a result we spent less time engaging in social activities.

The experience was overwhelming for my sister and I. We were deprived of social interactions with friends and family members because we had to be physically and emotionally available for our mother most of the time to spend time with her. As a result we neglected our social lives, even visiting family and friends became minimal.

Even though the process was reciprocal, in which both our mother and we contributed to each other's difficulties, we suffered a great deal emotionally because our mother's negative and passive parenting style contributed to our adjustment problems. We had to learn new ways of dealing and coping with her condition and adjust to new family dynamics, which was an adaptive technique, which assisted us to cope within the family context, which resulted in us being mature and independent at an early age.

### **7.2.2 The impact the parent's depression had on the adolescents and the challenges they faced**

According to Whiffen (2005) adolescents are adversely affected by their depressed parent's emotions, cognitions, and behaviour, and it exposes them to environmental risk factors that hamper their functioning. In our case, our mother's depression interfered with the effectiveness of her parenting. She isolated herself away from us and she was not emotionally available for us due to her illness; and thus her ineffective parenting clouded our relations and interactions with our mother negatively, which resulted in maladaptive interactions. Our mother's depression induced negative reactions in the family context and thus promoted disturbed

interactions. The experience led us to assume the responsibility to be our mother's carers and parentified adolescents.

Furthermore, although we were going through our own intrapersonal and interpersonal challenges as adolescents, our mother's illness made it difficult to deal with her as our emotions fluctuated, we became confused, frustrated, angry, guilty, empathic and helpless. Thus, the emotional experiences we experienced with our mother had a negative impact on us, and our interrelation with our mother became impaired.

### **7.2.3 Exploring and examining the adolescents' personal understanding of depression**

Our understanding of depression automatically made us assume the role of support system and carers for our mother.

Change in our mother's behaviour and her interactional patterns made us notice that she was sick but could not understand what was going on with her. Our mother described how she felt and we were expected to assist and thus took responsibility.

Upon understanding our mother's condition we assumed the responsibility to care for her, and thus became parentified adolescents. Our understanding of her condition made us put her needs first over our needs (her needs as priority) including providing emotional support and physical care for her. Thus, the experience affected us negatively as we neglected our socio-emotional aspects of our lives in order to accommodate her.

Moreover, our mother's depression induced negative reactions within the family context and promoted disturbed interactions, which contributed to maladaptive

interactions, and these interactions impacted the family interactions as a whole. Parental depression impacts parenting, family functioning and family relationship negatively.

Although the adolescents' experiences of living with their depressed mother affected and impacted them negatively emotionally, behaviourally, cognitively, socially and interactionally; their experiences shaped them to be independent, mature and self-reliant at a young age which proved to have contributed positively to their development.

### **7.3 Results**

The following is an overview of the results that flowed from the most prominent findings pertaining to the adolescent's experiences of living with their depressed mother:

- The adolescents' lack of knowledge about depression deprived them of understanding their mother's illness and her state of being, and as a result it rendered them confused.
- Anger provided them with feelings of frustration and annoyance. Additionally, it prevented them from communicating with their mother effectively and damaged their interpersonal relationship between the adolescents and their mother.
- Guilt allowed them to view their mother's illness from a different angle. It assisted them to channel their responsibility into a positive endeavour, which added a positive experience.

- Communication barriers between the mother and the adolescents were viewed as being challenging and difficult. The adolescents experienced some frustrations when interacting with their mother, it was difficult to communicate with her.
- Experiencing a sense of uselessness towards their mother provided the adolescents with worry. Being overwhelmed by changes in her behaviour and emotions provided constant worry.
- The adolescents made it their responsibility to provide care and support for their depressed mother, which indicated a sense of personal autonomy, independence and role involvement.
- Being able to see the effect of the illness on their mother, the adolescents expressed a deeper connection by trying to understand what their mother was going through, which contributed to acquiring a positive attitude toward their mother's wellbeing.
- Feeling helpless was frustrating and painful to the adolescents. They initially expressed feelings of being limited in resources due to their own uncertainties but the adolescents showed a deep commitment to their mother's emotional, behavioural and social wellbeing. By involving their mother in emotional and physical activities with an attempt to feel helpful, proved to be working well under the circumstances.
- Given the context, the adolescents described their experiences of living with their depressed mother as having allowed them to develop new ways of caring for their mother. Encouragement played a role in assisting the mother to gain a sense of worth.

- The experience of living with a depressed mother has had a negative impact on the two adolescents' lives, as they had to learn to deal with their mother's illness at such a young age. Both the mother and the adolescents were affected by each other's behaviours, emotions and cognitions. Additionally, they were both affected negatively by this experience in this context.

#### **7.4 Recommendations**

Based on the findings and results of this study, the following recommendations may assist counsellors, psychologists and doctors to provide adolescents with much needed information when their mother suffers from MDD:

- The misconception that adolescents should assume responsibility of caring for their ill parents should be explained and clarified to them, since assuming a parentified role hampers their personal growth.
- Communication within the family context should be maintained in order to try to understand the needs of every family member.
- Extensive information about the parent's illness and comprehensive understanding of the illness should be acquired with the aim not only to find effective and convenient ways to assist their parent but also to provide shifts in the interactions and relations in the family context.
- The family should work as a unit in order to effectively assist the depressed parent.
- Professionals, i.e. doctors and therapists, should refrain from using complex terminologies when talking to patients and family members about the patient's

condition. Instead a simplified and understandable version should be used for the patient and family to understand.

- Family therapy should be sought to assist them to work as a family. Individual therapy should also be sought to assist them with keeping intact in their personal functioning.
- The adolescents should be made aware of the different ways they can contribute, shape and assist in their mother's wellbeing.

### **7.5 Suggestions for further research**

From the findings of the research study, the researcher suggests that:

- The emotional and behavioural impact of the mother's depression on her adolescents should be further explored.
- The parent's coping techniques should be elaborated in a future study with the aim of assisting the adolescents to find effective and appropriate ways of helping their mother emotionally and socially.
- Future studies could focus on a broader scale on interactional impact on family members within the family context.

### **7.6 Limitation of the study**

The researcher acknowledges that her own involvement and history as a participant may have impacted on the way in which the interviews were conducted, data was collected and interpretations were made. She acknowledges the study does not represent the absolute truth but rather a co-constructed version of the truth within a particular context.

The study's qualitative stance limits the generalizations that can be made regarding the experiences of adolescents beyond those who form part of the context of this study. For this reason, the study strictly presents a version of the experiences of two adolescents living with their depressed mother who were involved in this study.

Although all attempts were made to be considerate and sensitive to the needs of the adolescents involved in the study, some of the data collection methods used may have been less effective in obtaining data as it perturbed the memories of the adolescents and prolonged the process of this study. The use of semi-structured interviews was an attempt to be sensitive and to understand the world from the participants' perspective and to enable the participants to play a more active role in shaping the direction of the research.

### **7.7 Strengths of the study**

Considering the variety of available literature on parental depression and the impact it has on family members little research has been done on the impact of parental depression on adolescents. The researcher considers the design of the current study as well suited for an exploratory approach. A qualitative approach allowed the researcher to work inductively by exploring meanings as the study progressed and allowing the painful content to emerge in this particular research context. In this way, preconceptions about the findings and the ability of these preconceptions to guide the research approach were minimised as far as possible.

Another strength of this study was the use of methodological triangulation as a means to enhance the reliability of the data. A variety of methods, i.e. participation

observation, documentation and interviewing, were employed to collect data from the participants and attempts were made to help the researcher resonate and unfold the meaning of her own experiences by being given the voice to share her experiences.

The study is strongly grounded in personal experiences, and sensitivity to the needs of the participant researcher was of prime importance to her supervisor. This allowed the researcher to maximise on the quality and accuracy of the data collected, despite the limitations incurred by the participants' emotional experiences.

This study has enhanced the current literature available on the experiences of living with a depressed parent within a SA context. It has contributed to a better understanding of how emotional, cognitive, behavioural, developmental and social factors may impact on the way adolescents experience their depressed parent. The study has also highlighted that experiences may vary within particular contexts, and that future studies may need to be more specific in choosing similar contexts for exploring the individual adolescent's experiences.

Additionally, this study was a process that was managed with sensitivity and discretion, although therapy was not the primary aim, the interviews had therapeutic effects.

## **7.8 Conclusion**

This study explored the experiences of adolescents living with a depressed parent. The study also explored the emotional, behavioural and social impact the adolescents experienced, and further the psychosocial stressors associated with their context.

The findings of the research will make people aware of the enormity of the problem, hopefully resulting in doctors organising psychological intervention when dealing with adolescents in this situation.

The recommendations will serve to improve management and interactions in family contexts of depressed parents in order to promote healthy relationships in the household.

## REFERENCES

- Abramson, L. Y., Metalsky, G.L., & Alloy, L. B. (1989). Hopeless depression: a theory based subtype of depression. *Psychology Review*, 96, 358-372.
- Abramson, L.Y., Seligman, M. E. P., & Teasdale, J. D. (1978). Learned helplessness in humans: Critique and reformation. *Journal of Abnormal Psychology*, 87, 49-74.
- Adams, G. R., Montemayor, R., & Gullotta, T. P. (1996). *Psychosocial Development During Adolescence: Progress in Development Contextualism*, 6, 244-256.
- Allport, G. W. (1964). *Anxiety, depression and emotion*. New York: Oxford.
- American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4<sup>th</sup> ed.). American Psychiatric Association: Washington DC.
- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5<sup>th</sup> ed.). American Psychiatric Association: Washington DC
- Anderson, R. (2007). *Thematic Content Analysis: Descriptive Presentation of Qualitative Data*. Washington D.C.: Institute of Transpersonal Psychology.
- Angst, J. C. (1988). Clinical function of affective disorders. In R.J. Daly (Ed.). *Depression illness: Prediction of course and outcome* (pp. 1-47). Berlin: Springer- Verlag.
- Ashmab, P. A., Dawson, K. W., Panagiotides, H. A., Yamada, F. K., & Wilkinson, S. J. (2002). Understandings of depression: Increasing rates of depression. *Journal of the American Medical Association*, 261, 2229-2235.
- Babbie, E. (2001). *The practice of Social Research* (9<sup>th</sup> ed.). Thomson: Wadsworth
- Babbie, E. (2004). *The Practice of Social Research* (10<sup>th</sup> ed.). Thomson: Wadsworth.

- Babbie, E. (2007). *The Practice of Social Research* (11<sup>th</sup> ed.). Thomson: Wadsworth.
- Barlow, D. H., & Durand, V.M. (1999). *Abnormal Psychology: An integrative approach* (6<sup>th</sup> ed.). Belmont: Wadsworth.
- Barnett C, T., & Gotlib, I. H. (1988). Psychological functioning and depression: Distinguishing between antecedents, concomitants, and consequences. *Psychological Bulletin*, 104, 97-126.
- Beardslee, W., Bemporad, J., Keller, M. B., & Klerman, G.L. (1993). Children of parents with major affective disorder: A review. *American journal of Psychiatry*, 140, 825–832.
- Billing, A. G., & Moos, R. H. (1985). Children with unipolar depression: A controlled 1- year follow-up. *Journal of Abnormal Child Psychology*, 14, 149–166.
- Blazer, D.G., Kessler, R.C., McGonagle, K. A., & Swart, M. S. (1994). The presence and distribution of major depression in a national community sample: The National Comorbidity Survey. *American Journal of Psychiatry*, 151, 979-986.
- Bockian, N. R. (2006). *Personality-guided therapy for depression*. Washington DC: American Psychological Association.
- Boland, R., & Keller, M. B. (2009). The origin of sex difference in depression: bridging the gap. *International Review of Psychiatry*, 8, 295-332.
- Bowlby, J. (1969). Attachment and loss: Vol. 1. *Attachment*. Basic Books: New York.
- Bowlby, J. (1973). Attachment and loss: Vol. 2. *Separation*. Basic Books: New York.

- Bretherton, I., Fritz, J., Zahn-Waxler, C., & Ridgeway, D. (1986). Learning to talk about emotions: A functionalist perspective. *Child Development, 57*, 529–548.
- Bretherton, I., Ridgeway, D., & Cassidy, J. (1990). Assessing internal working models of the attachment relationship. In M. T. Greenberg, D. Cicchetti & E. M. Cummings (eds.) *Attachment in preschool years: Theory, Research, and Intervention* (pp. 273–308). University of Chicago: Chicago.
- Brown, G. W., Bifulco, A. T., Harris, T. O., & Bridge, L. (1986). *Life events and illnesses*. New York: Guilford Press.
- Brown, G. W., Harris, T. O., & Hepwoth, C. (1994). Life events and endogenous depression. *Archives of General Psychiatry, 51*, 525-534.
- Burke, P. J. (2003). *Contemporary social psychological theories*. Palo Alto: Stanford University Press.
- Burns, N., & Grove, S. (2001). *The practice of nursing research: conduct, critique and utilization (4<sup>th</sup> ed.)*. W. B. Saunders: Philadelphia, Pennsylvania, USA.
- Campos, J. J., Campos, R. G., & Barrett, K. C. (1989). Emerging themes in the study emotional development and emotional regulation. *Developmental Psychology, 25*, 394–402.
- Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. G. (1989). Finding order in disorganization: Lessons from research of maltreated infants' attachments to their caregivers. In D. Cicchetti & V. Carlson (Eds.). *Child maltreatment: Theory and research on the causes and consequences on child abuse and neglect* (pp. 494–528). Cambridge University press: New York.

- Cassidy, J. (1993). Emotion regulation within attachment relationships. In J. Cassidy & L. Berlin (Chairs) *Attachment and Emotions*. Symposium conducted at the meeting of the Society for Research in Child Development: New Orleans, LA.
- Cassidy, J., & Kobak, R. R. (1988). Avoidance and its relation to other defensive processes. In J. Belsky & T. Nezworski (Eds.). (1986). *Clinical implications of attachment* (pp. 300–323). Hillsdale, NJ: Erlbaum.
- Cavell, T. A., & Malcolm, K. T. (2007). *Anger, Agression, and Interventions for Interpersonal Violence*. New Jersey: Lawrence Erlbaum Associates.
- Cloitre, D., Katz, F. & van Praag, J. (1993). *Becoming critical: Education, knowledge and action research*. London: The Falmer Press.
- Cohn, J. F., & Tronic, C. J. (1989). *Psychiatric illness in women: emerging treatment and research*. Washington: American Psychiatric Association.
- Corey, G. (2005). *Theory and practice of counselling and psychotherapy* (7<sup>th</sup> ed.). Belmont: Thomson Brooks/Cole.
- Costello, A. J. (2009). *The Transmission of depression in families and children: Assessment and intervention*. New York: Routledge.
- Creswell, J. W. (1998). *Qualitative Inquiry & Research Design choosing among Five Traditions*. Thousand Oaks. CA: Sage.
- Creswell, J. W. (2008). *Qualitative Inquiry & Research Design choosing among Five Approaches* (2<sup>nd</sup> ed.). Thousand Oaks: Sage.
- Cruze, W. (1953). *Adolescents Psychology and Development*. The Ronald Press Company.

- Cumming, E. M., & Davies, P. T. (1995). The impact of parents on their children: an emotional security perspective. *Annals of child development, 10*, 167–208.
- Cumming, E. M., Davies, P. T., & Campbell, S. B. (2000). *Developmental Psychopathology and family process: Theory, Research & Clinical implications*. New York: Guilford Press.
- Davies, P. T., & Dumenci, L. (1999). The interplay between maternal depressive symptoms and marital distress in the prediction of adolescent adjustment. *Journal of Marriage and the Family, 61*, 238–254.
- Davies, P. T., & Windle, M. (1997). Gender- specific pathways between maternal depressive symptoms, family discord, and adolescent adjustment. *Developmental Psychology, 33*, 657–668.
- Denzin, N. K. (1997). *Interpretive interactionalism*. Newbury Park, CA: Sage
- Denzin, N. K., & Lincoln, Y.S. (2000). *Handbook of Qualitative Research* (2<sup>nd</sup> ed.). Thousand Oaks, CA: Sage.
- Downey, G., & Coyne, J. C. (1990). Children of depressed parents: an integrative review. *Psychological Bulletin, 108*, 50-76.
- Dowrick, C. (2004). *Beyond depression: A new approach to understanding and management*. New York: Oxford.
- Dreyfus, E. A. (1976). *Adolescence Theory and Experience*. Ohio: Merrill.
- Dryden, W. (2011). *Dealing with Clients' Emotional Problems in Life Coaching*. London: Routledge.

- Du Rocher, F. K., Schudlich, T. D., & Cummings, E. M. (2003). Parental dysphoria and children's internalizing symptoms: Marital conflict styles as mediators of risk. *Child Development, 74*, 1663–1681.
- Eberhart, N., & Hammen, C. (2009). Interpersonal predators of stress generation. *Personality and Social Psychology Bulletin, 35*, 544-556.
- Ehrenberg, A. (2010). *The weariness of the self: Diagnosing the history of depression in the contemporary age*. McGill-Queen's University Press.
- Elliot, G. C. (2009). *Family Matters: The importance of the mattering to family in Adolescence*. United Kingdom: Wiley- Blackwell.
- Ellis, C., & Bochner, A. P. (2000). Autoethnography, personal narratives, reflexivity. In N. K Denzin & Y. S. Lincoln (Eds), *Handbook of qualitative research* (2<sup>nd</sup> ed.) (pp. 733-768). London: Sage.
- Erikson, M. F., Sroufe, L.A., & Egeland, B. (1985). The relationship between quality attachment and behavior problems in preschool in a high-risk sample. In I. Bretherton & E. Waters (Eds.) *Growing points in attachment theory and research. Monographs of the Society for Research in Child Development, 50*, 147–166.
- Erikson, E. H. (1959). *Young man Luther: a study in psychoanalysis and history*. London: Hogarth Press.
- Erikson, E. H. (1968). *Identity: Youth and Crisis*. Delhi: Oxford University Press.
- Erikson, E. H. (1982). *The life cycle completed: A review*. New York: Newton
- Farrow, T., & Woodruff, P. (2007). *Empathy in Mental Illness*. California: Cambridge University Press.

- Fendrich, M., Warner, V., & Weissman, M. M. (1990). Family risk factors, parental depression and psychopathology in offspring. *Developmental Psychology*, 26: 40–50.
- Frydenberg, E. (1997). *Adolescent coping: Theoretical and Research Perspectives*. Brighton: Routledge.
- Goodman, S. H., & Gotlib, I. H. (2002). Children of depressed parents: Mechanisms of coping. *Journal of Adolescent Research*, 16, 355–371.
- Gotlib, I. H., Kurtzman, H. S., & Blehar, M. C. (1997). *The cognitive psychology of depression*. Psychology Press.
- Greenberg, L.S., & Watson, J. C. (2005). *Emotion-focused therapy for depression*. University of Michigan: American Psychological Association.
- Greene, R. R., & Kropf, L. F (2009). *Human Behaviour Theory: A Diversity Framework* (2<sup>nd</sup> ed.). New York: Transaction Publishers.
- Greene, R. R. (1999). *Human Behaviour Theory and Social Work Practice* (2<sup>nd</sup> ed.). New York: Walter de Gruyter.
- Gregory, T. (1999). Understanding Depression. *Patient Care*. 33, 19-21.
- Hammen, C. (1991). *Depression*. United Kingdom: Psychology Press.
- Hammen, C. (2003). Interpersonal stress and depression in women. *Journal Affective Disorders*, 74, 49-57.
- Hammen, C., & Brennan, P. A. (2003). Severity, chronicity, and timing of maternal depression and risk for adolescents' offspring diagnoses in a community sample. *Archives of General Psychiatry*, 60, 253–258.

- Hammersley, M. (1990). *Reading Ethnographic Research: A critical guide*. New York: Longman.
- Hammersley, M. (1998). *Reading Ethnographic Research: A critical guide*. (2<sup>nd</sup> ed.). New York: Longman.
- Hammersley, M., & Atkinson, P. (1995). *Ethnography, principles in practice*. London: Routledge.
- Henn, M., Weistein, M., & Foard, N. (2009). *A Critical Introduction to Social Research* (2<sup>nd</sup> ed.). London: Sage.
- Hoffman, C., Crnic, K. A., & Baker, J. K. (2006). Maternal depression and parenting: Implications for children's emergent emotional regulation and behaviour functioning. *Parenting: Science & Practice*, 6, 271-295.
- Horowitz, L. M., & Strack, S. (2011). *Handbook of Interpersonal Psychology: Theory, Research, Assessment, & Therapeutic Intervention*. San Francisco, CA: John Wiley & Sons.
- Ingram, R. E., Atchley, R. A., & Segal, Z. V. (2011). *Vulnerability to depression: from cognitive neuroscience to prevention and treatment*. New York: Guilford Press.
- Jaenicke, C., Hammen, C., Zupan, B., Hiroto, D., Gordon, D., Adrian, C., & Burge, D. (1987). Cognitive vulnerability in children at risk for depression. *Journal of Abnormal Child Psychology*, 15, 559–572.
- Joiner, T. E., Katz, J., & Lew, A. (1999). Harbingers of depressotypic reassurance seeking: Negative life events, increased anxiety and decreased self-esteem. *Personality & Social Psychology Bulletin*, 25, 630-637.

- Jourard, C. K. (1974). First episode major depression: few sex differences in course. *Archives of General Psychiatry*, 54, 633-639.
- Kaplan, R. (1983). Impact of urban nature: A theoretical analysis. *School of social sciences*, 8, 189–197.
- Kaplan, V.A., & Sadock, B. J. (2003). *Synopsis of Psychiatry: Behavioural Sciences/ Clinical Psychiatry* (10<sup>th</sup> ed.). Philadelphia: Lippincott Williams & Wilkens.
- Keller, M. B., & Shapiro, R. W. (1982). “Double Depression”: Superimposition of acute depressive episodes on chronic depressive disorder. *American Journal of Psychiatry*, 139, 438–442.
- Kelly, K. (2006a). Lived Experiences and Interpretations: The Balancing Act in Qualitative Analysis. In M. TerreBlanche, K. Durrheim & D. Painter (Eds.). *Research in Prattice: Applied Method for the Social Sciences*, (pp. 345-369).
- Kelly, K. (2006b). Calling It a Day: Reaching Conclusions in Qualitative Research. In M. TerreBlanche, K. Durrheim & D. Painter (Eds.). *Research in Prattice: Applied Method for the Social Sciences*, (pp. 370-390).
- Kessler, R. C. (2003). A population- based twin study of lifetime major depression in men and women. *Archives of General Psychiatry*, 56, 39-44.
- Kirschenbaum, H., & Henderson, V. L. (1989). Positive affect facilitates creative problems solving. *Journal of Personality and Social Psychology*, 52, 1122-1131.
- Kobak, R., & Sceery, A. (1988). Attachment in later adolescents: Working models, affect regulation, and perceptions of self and others. *Child Development*, 59, 135–146.

- Kreglinger, F. N. (1986). *Foundations of behavioural research* (3<sup>rd</sup> ed.). London: Holt, Rinehart & Winston.
- Kvale, S. (1996). *Interviews: an introduction to qualitative research interviewing*. California: Sage.
- Lerner, R. M., & Spanier, G. B. (1980). *Adolescent development: A life-span perspective* (1<sup>st</sup> ed.). New York: McGraw-Hill.
- Levinson, D. J., Darrow, C. N., Klein, E. B., Levinson, M. H., & McKee, B. (1978). *Seasons of a man's life*. New York: Knopf
- Levinson, J. L. (2002). *Depression*. Philadelphia: American College of Physicians.
- Lewis-Hall, F., Williams, T., & Panetta, J. (2002). *Sex differences in substance use disorders in psychiatric illness in women: Emerging treatment and research*. Washington DC: American Psychological Publishing.
- Lewison, P. M., Hoberman, H. M., & Rosenbaum, M. (1988). A protective study of risk factors for unipolar depression. *Journal of Abnormal Psychology, 97*, 251-264.
- Lindlof, B.F., & Taylor, C. I. (2002). Constructing a non-depressed: Women's accounts of recovery from depression. *Feminism and Psychology, 16*, 307-325.
- Loh, C. C., & Vostanis, P. 2004. Perceived mother-infant relationship difficulties in post-natal depression. *Infant & Child Development, 13*, 159-171.
- Lovejoy, M. C., Graczyk, P. A., O'Hare, E., & Neuman, G. 2000. Maternal depression and parenting behaviour: A Meta- Analytic Review. *Clinical Psychology Review, 20*, 561-592.

- Lovallo, W. R. (2005). *Stress and health: biological and psychological interventions* (2<sup>nd</sup> ed.). Thousand Oaks: Sage.
- Maguire, L. (2002). *Clinical Social Work: Beyond Generalist Practice with Individuals, Groups and Families*. Wadsworth Group: Brooks/ Cole.
- Marcus, R. F. (2007). *Aggression and Violence in Adolescence*. New York: Cambridge University.
- Maritz, J. E., & Visagie, R.G. (2011). A research watching and mentoring framework to nurture development of emerging researchers. *Acta Academia Suplimentum*, 2, 169–197.
- Marshall, C., & Rossman, G. B. (1989). *Designing qualitative research*. London: Sage.
- Maslow, A. H. (1970). *Towards a psychology of being*. New York: Van Nostrand.
- McFarlane, C. (2003). *Traumatic stress: the effects of overwhelming experiences on mind, body and society*. New York: Guilford Press.
- Monroe, M., & Reid, L. (2009). *Culture and depression*. New York: Oxford.
- Mouton, J. (2001). *How to succeed in you Masters and Doctoral Dissertation: A South African Guide and Resource Book*. Pretoria: Van Schaik.
- Murray L., Sinclair, D., Cooper, P., Ducournau, P., & Turner, P. (1999). The socio-emotional development of 5-year-old children of postnatally depressed mothers. *Journal of Child Psychological Psychiatry*, 40, 1259-71.
- Nay, R. (2010). *Overcoming anger in your relationship*. New York: Guildford Press.
- Neuman, W. L. (2000). *Social Research methods: Qualitative and quantitative approaches* (2<sup>nd</sup> ed). Toronto: Allyn & Bacon.

- Neuman, W. L. (2001). *Social Research methods: Qualitative and quantitative approaches* (3<sup>rd</sup> ed). Boston: Allyn & Bacon.
- Neuman, W. L. (2004). *Social Research methods: Qualitative and quantitative approaches* (6<sup>nd</sup> ed). Boston: Allyn & Bacon.
- Nosek, C. L. (2008). Managing a depressed and suicidal loved one at home: Impact on family. *Journal of Psychological Nursing, 46*, 37–38.
- Palazidou, E., & Tiffin, E. (2000). *Depression*. London: Mosby.
- Papaikonomou, M., & Nieuwoudt, J. (2004). Exploring parent's stories of coping with child's cancer: A qualitative study. *South African Journal of Psychology, 34*, 283-300.
- Parrish, M. (2010). *Social Work Perspectives on Human Behaviour*. New York: McGraw-Hill.
- Patterson, G. (1982). *Family coercive process*. Castilia: Eugene, OR.
- Papp, P. (2000). *Couples on the fault line*. New York: Guilford Press.
- Pearson, A. (1970). *The Cambridge handbook of forensic psychology*. New York: Cambridge University Press.
- Piccinelli, M., & Wilkinson, G. (1994). Outcomes of depression in psychiatric setting. *British Journal of Psychiatry, 164*, 297-304.
- Rapmund, V. J. (1996). *Social support and Depression in women: A constructionist Approach, 15*, 42–45.

- Richards, C. C. (2003). My Journey towards becoming a psychotherapist: An Autoethographic study (*Doctoral dissertation, University of South Africa-Pretoria, 2003*). *Dissertations Abstracts*, 47/03, 783. Pretoria: Unisa.
- Rogers, C. R. (1961). *On becoming a person: a Therapist view of psychotherapy*. Boston: Houghton Mifflin.
- Rogers, D. (1976). *Adolescence: A Psychological Perspective*. California, LA: Brooks/ Cole.
- Sadock, B. J., & Sadock, V. A. (2003). *Kaplan & Sadock's Synopsis of Psychiatry: Behavioural Sciences / Clinical Psychiatry* (9<sup>th</sup> ed.). Philadelphia: Lippincott, Williams & Wilkens.
- Schwartz, T. L., & Petersen, T. J. (2006). *Depression treatment strategies and management*. United Kingdom: Taylor & Francis Group.
- Scott, R., & Scott, W. A. (1998). *Adjustment of Adolescents*. London: Routledge.
- Seale, C. (1999). *The Quality of Qualitative Research*. London: Sage.
- Skoe, E., & von der Lippe, A. (1998). *Personality Development in Adolescence: A cross national and lifespan perspective*. London: Routledge.
- Soni, M. (2006). A correlation study between health locus of control and treatment adherence in haemodialysis patients. (Master's dissertation, Medical University of South Africa-Ga-Rankuwa, 2006). *Dissertation Abstracts*, 49/06,783.
- Sprinthall, N. A., & Collins, W. A. (1995). *Adolescent Psychology: A developmental view* (3<sup>rd</sup> ed.). New York: McGraw-Hill.
- Stahl, S. M. (2008). *Depression & Bipolar Disorder*. (3<sup>rd</sup> ed.). UK: Cambridge University press.

- Steffgen, G., & Gollwitzer, M. (2007). *Emotions and Aggressive Behaviour*. Toronto: Hogrefe & Huber.
- Sugarman, L. (2001). *Life-span development: Frameworks, accounts and strategies* (2<sup>nd</sup> ed.). New York: Taylor & Francis.
- Swartz, C. M., & Shorter, E. (2007). *Psychotic Depression*. New York: Cambridge University Press.
- Talseth, A. G., Lindseth, A., Jacobsson, L., & Norberg. (2001). The meaning of suicidal psychiatric in-patients' experiences of being cared for by mental health care nurses. *Journal of Advanced Nursing*, 29, 1034-1041
- TerreBlanche, M., Durrheim, K., & Kelly, K. (2006). First Steps in Qualitative Data Analysis. In M. TerreBlanche, K. Durrheim & D. Painter (Eds.) *Research in Practice: Applied Method for the Social Sciences* (pp. 320-344).
- Timothy, A., Cavell, J., Kenya, M., & Malcolm, T. (2007). *Anger, Aggression & Interventions for Interpersonal Violence* (2<sup>nd</sup> ed.). London: Routledge.
- Thomas, J. (1993). *Doing critical ethnography*. Newbury Park, CA: Sage.
- Van Maanen, J. (1983). Qualitative methodology. In Genzuk, M. (1999). *A synthesis of ethnographic research: centre for multilingual, multicultural research*. Los Angeles: University of South California.
- Welty, J. P. (2011). *Psychology of anger: Symptoms, cause and coping*. New York: Nova.
- Whiffen, K. W. (2005). Gender and marital differences in depression: the effects of chronic strain. *Sex Roles*, 34, 299-319.

- Whitney, D. K., Kuznir, A., & Dixie, A. (2002). Women in Depression: the importance of social, psychological and occupational factors in illness and recovery. *Journal of Occupational Sciences, 9*, 20-27.
- Wilhelm, K., Parker, G., & Hadzi-Pavlovic, D. (1997). Fifteen years on: evolving ideas in researching sex differences in depression. *Psychology Medicine, 27*, 875-883.
- Wolcott, H. F. (1988). Ethnographic research in Education. In R.M. Jaeger (Ed.), *Complementary methods of research in education* (pp. 185-249). Washington: A.E.R.A.
- World Health Organization (WHO). (2001). *World Health Report: New understanding, new hope*. Geneva: WHO.