A PASTORAL PERSPECTIVE ON DEPRESSION AMONG YOUTH IN SOWETO

by

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DECLARATION

I, ***Mwansa Claude Kimpinde*** **(Rev.)** hereby declare that this research, which I submit for the Doctor of Philosophy degree (PhD) in Pastoral care and counselling (Practical Theology) at the University of Pretoria, is my original work, and has not previously been submitted by me to any other University. All sources I used have been indicated and duly acknowledged by means of complete reference.

The title of this thesis is: **A PASTORAL PERSPECTIVE ON DEPRESSION AMONG YOUTH IN SOWETO**

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DEDICATION

This dissertation is dedicated to my late parents **Isaac Kisimba MWABA** and **Elisabeth Nonde KAKUNGU**, as well as to my family for their sacrifices and huge contribution to my life. This work that I dedicate to them will be like a candle that will not be extinguished.

Their constant motivation toward my education kept me moving forward. I have come this far because of their love, support, attention and patience.

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ACRONYMS AND ABBREVIATIONS

MDD	Major Depressive Disorder
DSM	Diagnostic and Statistical Manual of Mental Disorders
WHO	World Health Organization
ODIN	Outcome of Depression International Network
SAD	Seasonal Affective Disorder
PTSD	Posttraumatic Stress Disorder
CBT	Cognitive Behavioural Therapy
BT	Behaviour Therapy
MD	Mood Disorder
BAD	Bipolar Affective Disorder
UAD	Unipolar Affective Disorder
NHNE	National Health and Nutrition Examination
PDD	Persitent Depressive Disorder
BD	Bipolar Disorder
PD	Post-natal Disorder
CFS	Chronic fatigue Syndrome
SD	Somatisation Disorder
OCD	Obsessive-Compulsive Disorder
NBD	Neurobiological Brain Disease

SUMMARY

This study presents a pastoral perspective on depression among young people in the urban African context of Soweto, Johannesburg, South Africa. Depression is one of the more prevalent mental disorders. In African contexts depression is often equated with demon possession. The aim of the study is to develop a contextual and collaborative pastoral care approach. The main research questions concern the interplay between Western understandings of depression and African perspectives. The study explores depression among the young people of Soweto from an African perspective and aims to come to a deeper understanding of the way in which healing and support are approached in this context. The study investigates the ways in which young South Africans in Soweto cope with and understand depression and the culturally related phenomenon of “demon possession”, the ways in which the families of the afflicted young people in Soweto cope with and understand depression and demon’s possession. The existing therapeutic models are also investigated in order to ascertain how an African healing collaborative pastoral care method for depression and demonic possession can be developed. The experiences and methods used by professionals such as psychologists, psychiatrists, social workers and African spiritual healers and clergy are investigated. People from these fields who work with young people with depression in the context of Soweto, participated in interviews.

DEFINITION OF KEY CONCEPTPS

Depression	Depression is mood disorder which is chronic. From time to time the person feels sad, hopeless, and loses interests in once pleasurable activities (Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition 2013).
Pastoral care	Pastoral care is a ministry of church which focuses on the community of faith as an authorizer and source of care and upon the relationship between the clergy and caring community, the religious mission of the church to minister to the laity and care for their spiritual welfare.
Demon possession	Demonic possession is seen as a condition in which one or more evil spirits or demons inhabit the body of a human being and can take complete control of their victim at will.
Youth	Youth represents the phase between childhood and adulthood or maturity. It can include young adulthood.
Traditional healers	Traditional healers of South Africa are practioners of traditional African medicine in Southern Africa.
Clergy	People who are ordained by a Christian religious institution for religious duties.
Psychologist	A person who specializes in the study of mind and behaviour and in the treatment of mental, emotional, and behavioral disorders – a specialist in psychology.
Psychiatrist	A medical doctor who specialises in the diagnosis and treatment of mental illness.

Social worker	A person who provides social services and is employed by a private or government organization. They provide support for individuals, families, groups, and communities to improve people's social functioning and their overrall well-being.

CHAPTER 1

BACKGROUND

1.1 Introduction

This study investigates depression among young South African Christian believers in an urban African context. While serving a church in Soweto as pastor, I had two encounters, one in 2006 with a 25-year-old South African who was diagnosed with major depression and one in 2008 when I encountered a family whose 23 year old son was in a similar situation. After those experiences I was challenged to reflect more deeply on the problem of depression in the African context, especially among young people in Soweto where I worked.

The first encounter went as follows. One Friday a woman and her 25-year-old son, Dube (a pseudonym) came to see me in my capacity as pastor of the congregation. The young man looked untidy and desperate. He seemed confused. The mother told the story as follows: “My son is completing his degree in civil engineering at a local university. Three weeks ago, I received a telephone call from the university that I must urgently come and fetch my son because he has not been well. He was not able to sleep at night, was talking to himself, seemed to be seeing things, was suffering from a lack of concentration, and was neglecting himself. All of this seriously affected his studies.” Her powerlessness and desperation were evident. They had consulted with psychologists and psychiatrists. The diagnosis was major depression. In spite of the medication that was prescribed by the doctors, his situation did not improve. That was why they had decided to come and see me to seek spiritual help.

At the end of our conversation, I anointed him and made the sign of the cross on his forehead. From that moment Dube started screaming. He was so agitated that he threw himself on the floor where he made snake-like movements. The voice of a woman come from him, saying: “He belongs to me, I will never be out of him. He is my property.” This was said in Xhosa.

In an African frame of reference such a phenomenon would mostly be interpreted as “demon possession” for which the remedy would be a rite of exorcism. Firstly, the spirit would be asked to identify itself. In this case the voice answered that her name was Lila (a pseudonym). When Dube’s mother heard the name, she started crying and asked: “What do these people want in the life of my son?” She recalled an incident that had occurred some years before. In 2000 Dube had a girlfriend who fell pregnant and the assumption was made that Dube was the father. After six months Lila’s parents discovered that their daughter was pregnant. According to Xhosa tradition Lila was taken to Dube’s family. In Xhosa culture a pregnancy out of wedlock should be brought to the attention of the man’s family within the first three months. This had not been done since Lila had hidden the pregnancy from her parents. Dube’s family rejected the news and said that Lila's family should have acted according to the cultural procedures. They concluded that their son was not responsible for the pregnancy, but that Lila and her family were trying their luck with Dube’s family. Lila’s family were rejected and shamed. Lila’s family left, disappointed and angry and threatened the family of Dube. Dube’s mother thought that the threat might have set evil in motion which had caused the trauma and disruption in the life of her son and family. Dube’s mother was greatly troubled after having heard Lila’s name during the exorcism.

This narrative illustrates how a mental health problem such as depression can be interpreted in an African context. This case raised several questions that motivated me to search for an appropriate approach to pastoral care with people such as Dube. When symptoms of depression are encountered among people in an African context, they are usually dealt with either by means of cultural and spiritual healing administered in the African way, or with the help of Western psychiatric medicine. However, the point of departure of this study is that depression among people from African cultures cannot be approached solely from a Western or solely from an African perspective. Both perspectives are necessary, since the lives and formation of young urbanised African people are influenced by both. This poses a challenge to the field of practical theology and specifically in the case of this study, to pastoral care and counselling. The investigation addresses this challenge from a pastoral care perspective with the aim to contribute to the body of knowledge of pastoral care in African cultural contexts. The study aims to develop an appropriate approach to

pastoral care. The context in which the investigation will be undertaken is Soweto, which is a highly urbanised and a multi-cultural environment.

1.2 Problem statement

The interplay of Western and African cultural understandings of what is known as “depression” in Western contexts is a complex matter which complicates the helping process with African people who live in a Westernised environment and who suffer from what is diagnosed as depression. This study aims to contribute in this regard, specifically in the field of practical theology and its sub-discipline of pastoral care and counselling. The aim of this study is to investigate the experience of depression among young people who live in Soweto, South Africa, in other words a big city and township environment. The study explores how the phenomenon of depression among youth in Soweto is understood by professionals such as psychologists, psychiatrists, and social workers, as well as caregivers such as Christian clergy and traditional healers, who function as the custodians of spiritual and cultural beliefs. The study aims to come to a better understanding of African perspectives on the experience of depression and demon possession. The focus of the contribution is to understand pastoral care and counselling with people who suffer from depression from an African perspective, in order for pastoral care and counselling practices to be relevant, contextually appropriate and liberating. The aims of the study are as follows:

- to investigate depression among the young people of Soweto from an African perspective;
- to investigate African healing support structures with regard to what is termed “depression” in the Western world;
- to explore the ways in which young South Africans in Soweto cope with and understand depression and “demon possession”;
- to explore the ways in which the families of afflicted young people in Soweto cope with and understand depression and demon possession;

- to explore existing therapeutic models in order to ascertain how an African healing collaborative pastoral care method for engaging with people with depression can be developed;

- to explore the experiences and methods utilised by professional psychologists, psychiatrists and social workers, as well as those utilised by African spiritual healers and clergy who are confronted with the phenomena of depression and demonic possession among young people in the context of Soweto.

1.3 Literature overview and research gap

In this section existing research from American, European, and the Middle Eastern, Asian and African contexts will be perused. In contexts other than Western, factors such as cultural spiritual beliefs and demon possession must be considered. Sulmasy (2002:68) emphasises that "humans are fundamentally bio-psycho-social-spiritual beings". Different cultures and contexts express this differently. They have different spiritual ideals, institutionalized forms of religion and different ways of experiencing and expressing belief in a divine being. Spirituality is an integral part of being human. The philosophical underpinnings of religion and psychiatry are similar in the sense that both can be conceptualized as frameworks for understanding and describing "the human experience and human behaviour" (Boehnlein 2000:16). There has been a long-standing relationship between religion and psychiatry across the world's major religions (see Kinzie 2000:256). In many cultures, religious healing and rituals have been integrated and have served as complimentary practices (Baer 2001:12; cf. Neighbours et al. 1998:74; Snowden 1999:22; Hughes and Winthrob 2000:153). In the Buddhist and Hindu traditions, patients often seek care from Western-trained clinicians after having sought guidance from religious elders or gurus. These spiritual leaders are akin to a chaplain or pastoral counsellor in a Christian Western setting. Spiritual leaders listen to and offer advice to individuals who are experiencing emotional and psychological distress (Josephson and Peteet 2004:111).

The complexity of the relationship between religion and mental health can be seen especially in instances where recommendations for mental health treatment are in direct conflict with a person's religious or spiritual beliefs or the teachings of their faith

community. The person is then presented with the dilemma of having to choose which way to follow. More subtle divergences become clear when a mental health provider fails to acknowledge or appreciate the importance of the role that a person's religious or spiritual beliefs and practices play in their experience of illness and treatment (Josephson and Peteet 2004:113). A better understanding of these relationships can prepare spiritual leaders and mental health providers to address the complexities and overcome the obstacles that come in the way of appropriate and comprehensive care. Even in a highly Westernised context, Binion (1999:601-612) points out that some African American people tend to be sceptical about the biological basis of depression. They are wary of becoming addicted to antidepressants and prefer counselling and prayer as the treatment for depression. A study linking religious involvement with psychological well-being among African Americans, indicates that prayer is an important means of coping with serious personal problems (Binion 1999:602).

Spirituality can be understood broadly as referring to religious attitudes, experience, existential well-being, paranormal beliefs, and religious practices (McDonald 2000:153-197). Often a distinction is made between "religion" and "spirituality". Harold Koenig (1997:25) describes *religion* as "an organized system of beliefs, practices, rituals and symbols designed to (a) facilitate closeness to the sacred or transcendent (God, higher power, or ultimate truth/reality), and to (b) foster an understanding of one's relation and responsibility to others in living together in a community". Koenig (1997:27) describes *spirituality* as "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationship to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community". In believers' quest to ascertain the cause of depression and how to deal with it, some conclude that depression is the result of a loss of faith.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM–IV), a diagnosis of Major Depressive Disorder (MDD) requires that five or more symptoms be present, and those symptoms must persist for two or more weeks. Symptoms include depressed mood, anhedonia (an inability to derive pleasure from pleasurable activities or events), significant change in weight or appetite, changes in sleep

patterns, decreased concentration, decreased energy, inappropriate guilt or feelings of worthlessness, psychomotor agitation or retardation, and suicide ideations.

Depression as a significant mental health problem, is investigated in fields such as psychology and psychiatry. Characteristics include emotional, behavioural, cognitive, and somatic symptoms that often cause functional impairment (Roberts and Bishop 2005:132). From the perspective of psychoanalytic theory, Freud and Abraham (1993:1962) indicate a connection between mourning and melancholia (see Kay and Tasman 2006:79). According to Melanie Klein (1935:5), depression often involves the expression of aggression towards loved ones. Edward Bibring (2006:23) describes depression as a phenomenon that sets in when a person becomes aware of the discrepancy between extraordinarily high ideals and the inability to meet those goals.

Most of the literature on the topic of depression is from a Western perspective and context. The Greek *psyche* from which “psychology” and “psychiatry” are derived, is translated in religious terms as “soul” (see Sadock and Sadock 2007:47). This shared nomenclature suggests some common ground between religions (particularly Christianity) and mental health sciences. While religion and psychiatry use different vocabularies and methodologies to understand human experiences, their goals overlap and are often congruent. For example, both religion and mental health services seek to foster emotional well-being. They emphasize the importance of relationships (Levin and Chatters 1998). The point of departure of sociologists and anthropologists is that each culture with its specific norms, beliefs and behaviour of social groups, provides its members with ways of becoming “ill”, of shaping their suffering into a recognisable illness entity, of explaining its cause and of getting some treatment for it (Littlewood 1981:283-302). Thus, cultures influence the “language of distress”, for example the means by which personal distress is communicated to other people. Both the presentation of illness and others’ response to it, are largely determined by sociocultural factors.

Religion can play a role in helping patients cope with the stress of illness. Koenig (1997:18) explores the Christian tradition and the role of religion, spirituality, and psychiatry. In this context, Judeo-Christian worldviews and powerful religious beliefs and practices are interwoven with personal and familial histories. All of these shape understandings of health and illness (Heney et al. 2013:241). Regardless of a

person's religious tradition, coordinated spiritual and mental health care is important for holistic treatment. Mental health providers mostly refrain from addressing the spiritual needs of their clients. Clergy, on the other hand, are not trained to deal with mental health issues. Collaboration between clergy and mental health providers will therefore benefit the people in their care. For many people, to simply ignore their Christian values and beliefs in their mental health treatment, would be culturally incongruent at best and, at worst, it can devalue a significant source of support and cut them off from it (Kleinman 1980a:26).

It is a new trend in psychiatry that recognition is given that certain disorders can be related to spirits and phenomena of possession that have been identified all around the world. Pertinent to this study will be how demon possession and exorcism are understood in comparison to what is the Western world is termed "depression".

In the Middle East *Zar* refers to both the beliefs and the practices associated with a certain kind of spirit and is a type of healing cult. People of different ethnical origins, religious faiths (e.g. Muslim, Christian, Falasha) and geographical areas adhere to Zar. According to Rahim (1991:65), Zar is an expression of a psychological disorder, whereas Lewis (1991:111) considers it to be a therapeutic outlet for marginalized members of society. Boddy (1988:12) sees the Zar rite is a kind of "cultural therapy". The aim of the cult is to cure illness or turn around the misfortune caused by possession by the spirit Zar (Natvig 1987:671). According to beliefs of the Zar cult there is a great number of Zar spirits called lords, masters, angels, or blessed ones. When disturbed, they can take possession of human beings and cause some form of illness or deviant behaviour. The Zar ritual is designed to deal with this eventuality (Natvig 1987:57). Martin Malachi (1992:7) explains this phenomenon as follows: "The effective cause of possession is the voluntary collaboration of an individual, through his faculties of mind and will, with one or more of those bodiless, genderless creatures called demons" (Malachi 1992:7).

Scholars are pointing out that the centre of gravity of Christianity is shifting from the West to the two-third world that is Asia, South America and Africa. The reasons for this shift are varied and complex. Significant to this study is the idea of some who regard the function of demon possession as the release of tension in certain types of African social structures (Onyinah 2002:132). According to Opoku Onyinah

(2002:107-134), demonic possession is not a static condition, an unchanging state. One also does not become possessed suddenly. Rather, possession is an on-going process that affects the two faculties of the soul: the *mind* by which and individual receives and internalises knowledge and the *will*, by which an individual chooses to act upon that knowledge from the same frame of mind.

Recent studies on demon possession in Africa (see Geschiere et al (2005:21-27) show that it is no longer only seen as “traditional”, but rather as aspect of spirituality (Onyinah 2002:133). In his book entitled *Witchcraft, violence and democracy in South Africa*, Ashforth (2005:2) examines how most people in Soweto outside Johannesburg and other parts of democratic South Africa deal with their fear of so-called “evil forces” such as witchcraft. In his analysis, he indicates how this fear challenges both human rights and the democratic state. Leff et al (2001:7) explain that “liberation from political tyranny does not result in automatic freedom from the bondage of superstition and urban legend.”

The aim of this study is to explore the relationship between the mental health problem as diagnosed by Western medicine as “depression” and the phenomenon of demon possession, which is attested to, among others, in African cultures. The focus is the specific context of Soweto in South African. The object is to explore ways in which clinicians, clergy and spiritual healers can collaborate in order that an inclusive collaborative model of care can be developed that reflects the world and context of those who are in need of care.

1.4 Methodology

The focus of the discipline of practical theology is human lived experience and the theological reflection on that experience. There is a variety of methodological and theological approaches to this enterprise of engaging with human experience. This study in practical theology focuses specifically on the experience of a group of African young people. It aims to gain data from practice and bring that into discussion with the theoretical framework of the study. In the construction of the theoretical framework, the study ma use of insights from disciplines such as psychology, psychiatry and sociology. From the grassroots the practices of traditional healers are

explored. The aim is to develop a contextual pastoral response to the situation of young people in an African context who suffer from depression.

The paradigm of the investigation is postmodern. The epistemological point of departure is that knowledge as inherently contextual, pluralistic and local. From a postmodern perspective, objectivity is not possible. Knowledge is contextual and socially constructed. Therefore, local perspectives rather than grand narrative are the source of information in this study. Participants' perceptions, experiences and accounts of meaning-making take the central place. In a postmodern frame of thinking alternative voices are not silenced but heard and included. Their descriptions, the ways in which they make sense of, interpret and reconstruct the meanings that they attach to their socially constructed worlds (Denzin & Lincoln 1994:3) are regarded as invaluable data for the purposes of this investigation. For Nelson et al. (1992:2), the "choice of the research practices depends upon the questions that are asked, and the questions depend on their context" (Nelson et al 1992:2). The context will determine what is available and what the investigator can or cannot do in that context.

The approach of this study is qualitative, because the aim is not to examine or measure, but to emphasise the collaborative process and meaning making of the investigator and participants within their socially constructed reality. Through relationship the experience and theological meaning-making of the participants can be explored (see Denzin and Lincoln 1994:4). A qualitative investigation engages with things in their natural setting, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them. A wide range of interconnected methods can be employed to achieve this end (Denzin and Lincoln 1994:2).

Qualitative research has a typical way of understanding the world. According to practical theologians Swinton and Mowat (2007:32), the epistemology of a qualitative approach, is about generating knowledge from human experiences on the ground. Epistemology, from the Greek *episteme* (knowledge) and *logos* (words/speech), is concerned with the nature and scope of knowledge. This includes the limitations of knowledge (see Mason 2006:16). In a qualitative investigation the questions would be about the nature of knowledge of the other and how that knowledge is acquired.

Knowledge can be either knowledge that is automatically known apart from experience (*a priori*), or knowledge that is gained from human experience (see McLeod 2001:3). This study is interested in human experience in specific circumstances in a specific context in order to gain an in-depth understanding of that experience. According to Mowat and Swinton (2007:33), “knowledge of the other occurs when the research focuses is on an individual or group and explores in-depth the ways in which they view and interact with the world”. This is relevant to the field of practical theology, which deals with human experience. That human experience can be painful, is the specific concern of the sub-discipline of pastoral care and counselling in which this study is situated.

A sound epistemology is necessary for sound thinking and reasoning. The grounded theory approach has become firmly associated over time with qualitative research (see Glaser 1978:6). Cresswell (1998:56) explains it as follows: “The centrepiece of grounded theory is the development or generation of a theory closely related to the context of the phenomenon being studied” (Creswell 1998:56).

South African practical theologian, Olehile Buffel (2000:75, cf Trochim 2001), calls the research design “the glue” which holds an investigation together”. It also explains the elements of the investigation and the relationships between them. The design of this study explains the area of focus, the procedures of data collection, as well as the method of data analysis that is used. Diekman (1995:274) puts it as follows: “Data collection designs are a means to the end of collecting meaningful data.” The analysis of qualitative data can take several forms, reflecting the kind of data being used and the purposes for which they are being studied. Broadly speaking, the analysis of qualitative data tends to fall into one of the following categories:

- **Herative**

Rather than analysis being a once-off event that takes place at a single point in time, the analysis becomes an evolving process in which the data collection and data analysis phrases occur alongside each other.

- **Inductive**

Analysis tends to work from the singular to the general. From the detailed study of localized data, the analysis attempts to arrive at more abstract change generalised statements about the topic.

- **Researcher-centred**

The values and experiences of the researcher influence the analysis. The researcher's self-identity is treated as significant in relation to the analysis.

The theoretical framework of this practical theological study in the field of pastoral care will be based largely on the *hermeneutical approach* of Donald Capps (1990) which aims at understanding, as well as his model of *reframing* in pastoral counselling, and on the theory of *positive deconstruction* as developed by Nick Pollard (1997). Pollard (1997:44) articulates the aim of his approach as "the recognising and affirming of the elements of truth to which individuals already hold, but also help them to discover for themselves the inadequacies of their worldviews they have absorbed. The deconstruction is positive because it is done in a positive way to replace the existing worldview with something better". Such a theoretical framework will be appropriate for this study which aims to enter into the stories (understanding) of young people with depression in an African context and to find a positive way that is respectful of their worldviews (elements of truth to which they already hold) while helping them to discover for themselves the inadequacies of the worldviews they have absorbed. What they have absorbed includes elements of both Western and African truths and perspectives. Capps' model of "reframing" facilitates the positive reconstruction of a preferred life story while finding a way with the dual realities of the Western and African influences on their lives**.**

"Hermeneutics" is derived from the Greek *hermeneuein*, to make intelligible. The term has various shades of meaning:

- to say, to express something (as used by Aristotle in *On interpretation*);
- to translate from one language into another;
- to interpret, understand.

Hermeneutics, as it has developed in modern times, refers to the critical theory of interpretation, its principles, rules, methods, and limitations. It first appears in the title of work produced in 1654 in the context of protestant orthodoxy, J.C. Dannhauer's *Sacred Hermeneutics*, or *Method of Expounding the Sacred Scriptures*. At the beginning of the 19th century Friedrich Schleiermacher (1654) conferred upon it the status of a discipline, which was recognized as such in theology and philosophy. Its object can be seen narrowly as that which has a bearing only on the interpretation of written texts, or more broadly, with Schleiermacher, as that which is concerned with the understanding of all human discourse, written or oral, or even more broadly, with Dilthey (2009:25), as that which deals with every manifestation of the human spirit throughout history, in science, literature or art. For Heidegger (2017:7), hermeneutics becomes a procedure for understanding the structures of human existence. Today its meaning tends to be extended into a general theory of signs, or a general philosophy for interpreting all phenomena. Hermeneutics can therefore have a bearing on numerous disciplines. It is particularly relevant in the fields of philosophy, theology, jurisprudence, psychology, and social sciences. Though it has become an academic discipline, it is rooted in lived experience.

Hermeneutical reflection plays an important role in the interpretation of religious foundational narratives, sacred texts, rites, doctrines, and rules of piety. From a Christian theological perspective, the roots of hermeneutics are to be found in the New Testament. The Gospel of Luke shows Jesus *interpreting* the scriptures. In his encounter with the Ethiopian eunuch reading the prophet Isaiah, Philip the deacon puts *the* hermeneutical question: "Do you understand what you are reading?" (Acts 8:30). Paul emphasises the charism of interpretation (1 Cor 12:10; 14:26-28). Early Christianity was involved with hermeneutics: first by concrete questions about translation and the handing on of tradition, then more particularly by the need to give Christian interpretations of Old Testament texts and to relate the two Testaments to each other. "The letter kills but the spirit gives life" (2 Cor 3:6) became a hermeneutical rule which established the crucial distinction between the literal sense of the letter of the text and the spiritual sense hidden behind or beyond the letter.

For pastoral theologian, Donald Capps (2001:134), "hermeneutics" is the theoretical reflection on communication. If language is to be meaningful it must communicate

effectively. The spoken or written word is not the only form of communication. Signs, symbols gestures and attitudes also communicate. The spoken or written should not only be heard or read, but also understood. Hermeneutics is about understanding language by means of language. The verb *hermeneuō* which is found in biblical and extra-biblical Greek, means interpret or explain or translate (see Capps 2001:143-144). From such a hermeneutical perspective, as worked out by Capps, pastoral actions can be of "world-disclosive" value to an individual (Capps 1984:45). Through pastoral actions the individual comes to an understanding their world and their own and their culture's forms of meaning-making. The aim of pastoral care is to guide people to broaden their perspective on their world in order to be able to see beyond the limitations of their immediate situation.

After understanding, a next step toward healing would then be "reframing" as worked out by Capps in his 1990 work, *Reframing: A new method in pastoral care*. In this work Capps builds on the insights of psychologists Watzlawick, Weakland and Fisch (1974) which he calls "the third-dimension reframing" (Capps 1990:126). In accordance with Ricoeur's hermeneutical model, he considers "reframing" in pastoral care to be analogous to the notion of *mimesis* (Capps 1990:17; see Ricoeur 1984, 1985). The three dimensions essential to Capps' (1984:118) hermeneutical model of pastoral care are structure, pastoral self-understanding and pastoral action. Watzlawick, Weakland and Fisch (1974) distinguish between "first order change" and "second order change". To reframe or achieve second order change means to "change to a conceptual and or emotional setting or view point in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the same concrete situation equally well or even better, and thereby changes its entire meaning". Such second order change or "reframing" could bring meaningful change to the lives of the group of people on which this study focuses.

For eminent practical theologian, Don Browning (1991:36), practical theology should be based on critical reflection, on dialogue with Christian sources and with other communities of experience and interpretation. The aim is to guide action toward social and individual transformation. Such an approach requires that theories of pastoral care should be multifaceted and interrelated (Browning 1991:36). Practical theology has enjoyed a rich and varied relationship with hermeneutical theory, which

is theory of interpretation. For some practical theologians, hermeneutical theory provides a perspectival or epistemological orientation to their work; for others, it provides a methodological framework. For most, hermeneutical theory contributes to the work they do in both these ways. Some hermeneutical theorists insist that hermeneutics is not a “method”; it is theory about the human phenomenon of understanding. However, the deliberate and self-aware process of coming to understanding does have a positive outcome in practice and, in that sense, has the function of a “method”. For practical theology, hermeneutical theory therefore functions as both an informing perspective and a rich methodological resource.

Nick Pollard’s “positive deconstruction” can also be seen as both an informing perspective and a methodological resource. He explains it as follows (Pollard 1997:42): “Our Lord and Saviour, Jesus Christ, has left us a commandment, which concerns all of us Christians alike – that we should render duties of humanity, or (as the scripture calls them) works of mercy, to those who are afflicted and under calamity, that we should visit the sick, endeavour to set free the prisoners, and perform other acts of kindness to our neighbour, whereby the evils of this present time may in some measure be enlightened.” Pastoral care is one of the fields in practical theology that is particularly concerned with those in need for care. The method that it entails is aimed at insight into the inadequacies of worldviews that keep people trapped and the possibility to reframe and transcend them through understanding and a deconstruction that does not destroy but reconstructs something healthy and useful.

Empirical data for this investigation will come from participatory observation and qualitative interviewing. Five groups with different interests and involvement with the subject of the study, will provide a rich variety of perspectives on the issues involved. These groups will include:

- young persons over the age of 18 years who have experience of depression and reside in Soweto;
- clergy whose task is to provide pastoral care;
- people from the helping professions such as counsellors, psychologists, psychiatrics, social workers;
- a traditional healer.

The interview questions aim to extract information with regard to people's attitudes and knowledge of depression. In terms of the selection of participants, letters of invitation will be written to people who have been identified as having had sufficient experience of the matter at hand. This will include young people who have experience of depression, family members who have journeyed with them, a spiritual healer who has been involved with them (to acquire cultural insights regarding the phenomenon of depression in an African context), clergy from different denominations who minister in Soweto, healthcare professionals such as psychologists and psychiatrists, as well as social workers who have experience of working with young people with depression in Soweto. With regard to the relationship between depression and demonic possession, the input of family members and a traditional healer expert on Zulu or Xhosa culture and tradition will be valuable. The varied nature of the sample will provide rich and nuanced data.

Ethical issues of concern due to the sensitive nature of the topic include the anonymity of participants. They will be given pseudonyms and the information they provide will be treated in the strictest confidentiality. Written consent will be obtained from participants. They will be assured that they can withdraw at any stage without explanation or penalty. The information they have provided will then be destroyed. The welfare of participants and the community to which they belong is of the highest priority.

1.5 Chapter outline

Chapter 2 discusses the existing research on depression and demonic possession and identifies the implications for the specific group and context, namely young people in Soweto who suffer from depression.

Chapter 3 presents the empirical investigation of the study which will take the form of interviews with people from various interest groups who have expertise and experience with regard to youth in Soweto who suffer from depression. It also explores attitudes and beliefs with regard to a possible connection between phenomena such as depression and demonic possession, as experienced by young people in Soweto. The challenges faced by clergy of mainline churches, medical bodies and African spiritual healers with regard to depression in their context, will be investigated and presented.

Chapter 4 works out an approach to collaborative care. This will be based on Donald Capp's hermeneutical insights and the method of reframing as well as on the positive deconstruction method of pastoral care developed by Nick Pollard. These theoretical insights will provide a framework for devising a supportive collaborative method of care for young people who suffer from depression in an African urban context where both knowledge and influence from the Western medical world and from African traditional views have an influence on how depression and demonic possession are understood and experienced.

Chapter 5 presents the findings of the investigation.

CHAPTER 2
WESTERN "DEPRESSION" AND AFRICAN "DEMONIC POSSESSION"

2.1 Introduction

This chapter aims to explore whether a connection can be made between what from a psychological and psychiatric perspective is termed "depression" and African interpretations of this phenomenon, which often include descriptions in terms of demon possession and are treated by means of exorcism. Depression from a Western point of view and demonic possession from an African perspective could be seen as representing a clash of cultures. Young people in Soweto who suffer from what in Western medicine would diagnose as depression, have to deal with their situation within their traditional cultural context. Existing research that sheds light on this, will be explored in the chapter.

2.2 Depression

2.2.1 Historical developments

Since human experience has been documented there have been indications of symptoms of what today is called "mental illness". Soranus, the Roman physician wrote about patients "who believed they were God and refused to urinate for fear of causing deluge" (Mayhugh and Strom 1990:1116). During the Middle Ages, people with mental illness were seen as possessed by evil. Such persons were either destroyed or confined to an asylum where no clinical observations or treatments were undertaken (Mayhugh and Strom 1990:1116).

In the nineteenth century Benedict Morel (1809-1873), a French psychiatrist, used the term *Demence Precoce* for a mental condition which began in adolescence. The German, Karl Kahlbaum (1828-1999), used the term *Catatonia* and another German, Ewold Hecker (1843-1909) used the term *Hebephrenia* for extreme and bizarre behaviour. Other prominent works on the history of mental illnes in general and depression in particular were those of the German, Emil Kraeplin (1856-1926) and the Swiss, Eugen Bleuler (1857-1939) (see Kaplan and Sadlock 1991:320).

According to Carson (2003:54) the six persons responsible for the evolution of the concept of “depression” are Kraepelin, Bleuler, Meyer, Freud, Jung and Sullivan. For them, the study of depression should be regarded as similar to any other kind of pathology, such as organic or cellular pathology (Clinebell1984:12). This led to researchers examining the physical body in order to try and find clues as to the organic origin of this condition (Clinebell1984:12). The term depression referred to a kind of split-mindedness – a theoretical schism between thought, emotion and behaviour (Lim et al 2015; see Kaplan and Sadlock 1991:320). However, this caused confusion with split personality (now called Multiple Personality Disorder) which is a completely different type of mental disorder. Seriously mentally ill people were categorised in three diagnostic groups (Kaplan and Sadlock 1991:320):

- *Dementia Precox* – for those with hallucinations and delusions;
- *Manic Depressive Psychosis* – for those who experience episodes, followed by virtually complete remission;
- *Paranoia* – for the patients who have persistent persecutory delusions.

The neurobiological theory of depression is based on the premise that genetic and biochemical factors play a role in the etiology of depression. Genetic studies fall largely into two categories, namely “studies of relatives and the studies of twins” (see Burgess 1990:724). These studies indicate that relatives of people with depression have a higher risk of themselves developing depression than the general population. However, the higher prevalence of depression among relatives does not mean that genetic factors play a decisive role in the transmission of this predisposition. Burgess (1990:724) puts it as follows: “Much more transpires in families than the vertical passing on of genes.” Though there was strong evidence to suggest that genetic factors play a role, most of the patients in the studies did not have parents who suffered from psychosis (Burgess 1990:724).

2.2.2 The nature of depression

Depression is a mood disorder. It is a chronic condition where, over a period of time, a person would feel sad, hopeless, and lose interest in activities that were once pleasurable (DSM V 2013). There is a difference between feeling unhappy, which is part of the range of human emotion, and the mental condition of depression. From

time to time all people are sad about something in their lives or in the lives of the people close to them. Gradually those feelings dissipate, they feel comforted and can resume their lives. With regard to depression the trajectory is different. The sufferer is unable to adjust to the painful feelings and therefore suppresses the feelings to become emotionally dead. This means, in effect, that positive feelings that could have balanced the person's mood are not available to the person (Trickett 1996:4-5). About 5-10 per cent of the population suffer from major depression at any given time. It is estimated that about 15 per cent of people will develop a major depression at some point in their lives (Lurie 2007:41). Depression can take on the quality of physical pain. It is not an immediately identifiable pain, such as that of a broken limb for example. The mental discomfort of despair which inhabits a person's psyche can resemble the physical discomfort of being imprisoned in a strongly overheated room.

In everyday language the term "depression" is often used to denote sadness. In this sense, it is a mood state that most people experience from time to time, especially in the wake of setbacks or disappointments. This type of "depression" does not last long. It rarely affects people's ability to function. In clinical terms, however, it has a radically different meaning. It refers to a profoundly debilitating form of mental illness of which the precise diagnostic label is "Major Depressive Disorder" (MDD), though clinicians also simply call it "depression" for short (see Ilardi 2010:15). It is a syndrome that deprives people of energy, sleep, concentration, joy, confidence, memory and sex drive. They are unable to fully love, work and play. It can even rob them of their will to live. Over time, depression damages the brain and has an adverse effect on the body. The disorder has the capacity to destroy life (Ilardi 2010:36). Despite an increasing public awareness, confusion about depression still abounds. People often still underestimate the devastating effect of the disorder. For the person who suffers from depression knowledge can serve as powerful defence against the destructive impulse of self-blame (Ilardi 2010:37).

2.2.3 The effects of depression

About one in ten people will experience depression at least once during their lifetime. It can be a once-off occurrence, but for many it recurs from time to time. For others depression is a persistent, long-term problem (Jackson et al 2016). Depression is more common among women than men and is more likely to occur during early

middle age. Depression is one of the most disabling common mental health disorders, which often has its onset in adolescence. It characteristically runs a chronic course and is related to a cluster of health risk behaviours (Katon et al. 2010). Depression is characterised by “a specific type of alteration in thinking, feeling and relation to the external world”. The DISC-V (2013) has shown acceptable reliability and validity for the measurement of depression.

The mental health problem of depression can be devastating to people’s lives because of its “early onset in a sufferer’s life, and because of its destructive symptoms” (Kaplan 1991:30). Even though depression is seen as a single mental illness, this diagnostic category includes a variety of disorders. Depression comprises a group of disorders with heterogeneous causes and includes patients whose clinical presentation, response to treatment and the course of their illness differ (Kaplan 1991:32). Depression is a disturbance that lasts for at least one month and includes at least one month of active-phase symptoms – that is two or more of the following:

- delusions;
- hallucinations;
- speech disorders;
- thinking disorders;
- impairment of intelligence;
- writing peculiarities;
- disorganized speech;
- disorganized or catatonic behaviour.

Sub-types include paranoid, disorganized, catatonic, undifferentiated, and residual states (DSM V 2013:273). Depression is the most prevalent form of psychotic behaviour characterised by a “breakdown of integrated personality function, withdrawal from reality, emotional blocking, distortion of thought and behaviour” (Mohanty 1984:221). It is a disabling and most widespread of behavioural disorders also referred to as “mental illness”. According to Caroline Sheeve (2005), depression is often accompanied by emotions such as a sense of loss, failure, injustice and ill health. Joy and sorrow, growth and decay, light and darkness are part of life and even the negative aspect of each pair has a valid role to play in the greater scheme

of things (Sheeve 2005:27). However, for those who are prone to depression it becomes increasingly difficult to sustain hope and to experience the positive side of life. Life's ordinary struggles can then become unbearable. If an already negative period in a person's life is exacerbated by, for example, the emotional trauma of bereavement or severe financial loss, people can fear for their survival. The platitudes of well-meaning friends and loved ones do not alleviate their situation. They become increasingly convinced that no one understands what they are going through (Sheeve 2005:32). People who suffer from depression are not just "feeling sorry for themselves". Depression is a recognised medical condition with specific signs and symptoms, and it is the fastest growing epidemic in the developed world (Sheeve 2005:42-43). The World Health Organization (WHO) ranks depression at number five in its top ten lists of disabling illnesses.

The Outcome of Depression International Network (ODIN) study published in the *British Journal of Psychiatry* in 2001 compared the prevalence of depression in five European countries. The centres in Liverpool (UK), Dublin (Irish Republic), Oslo (Norway), Turku (Finland) and Santander (Spain) invited research participants from both urban and rural areas. They were adults between the ages of sixteen and sixty-four and were drawn from election rolls. A total of 8 764 people took part in the study, and it was found that the overall prevalence of depression was 8.56 per cent of which 10.05 per cent were women and 6.61 per cent men. In the United States a similar number of about one in ten people suffer from clinical depression at some time in their lives. The illness costs US$ 43.7 billion annually in worker absenteeism, reduced productivity and health care. Australian figures for depression show an overall prevalence of 16 per cent. The studies have shown that comparable numbers of people in various developed countries are affected by depression. Depression is more common in certain groups, such as students, the elderly and people who are unemployed.

Caroline Sheeve (2005:58) points out that certain terms are understood differently in academic usage than in ordinary language. In ordinary language people can, for instance, say that they are depressed when they are despondent, disappointed, lonely or bored. These are feelings that fluctuate. Mood, on the other hand, is more stable and deeply rooted. Mood colours people's view of the past, attitude with

regard to the present and future and affects their ability to cope with adversity. An estimated 350 million people in the world today suffer from depression (Gilbert 2009:234). Depression was first identified as a condition some 2400 years ago by Hippocrates in ancient Greece. He called it *melancholia.* The term “depression” comes from the Latin *deprimere,* which means “to press down”. The term was first applied to a mood state in the seventeenth century (Gilbert 2009:41). Well-known people throughout history such as the Hebrew King Solomon, Abraham Lincoln, Winston Churchill and the Finnish composed Jean Sibelius most probably suffered some form of depression (Gilbert 2009:41).

To a greater or lesser degree, all people have the potential to become depressed. All have the potential to become anxious, to grieve or to love (Gilbert 2009:39). Depression is not a condition that is restricted to certain groups (Adkin et al., 2009:39). The condition of depression is not a sign of human weakness. Depression is far more than just “feeling down”. It affects not only how people feel, but also how they think about things, their energy levels, concentration, sleep and their interest in sex (Gilbert 2009:42). Depression influences a great many aspects of people’s lives. It has a huge impact not only on the lives of persons who suffer from it, but also on their loved ones. It also has an impact on the broader society, for instance when people must take time off from work either because they themselves or someone in their family suffer from depression. By the year 2030, depression is likely to cause more disability and death worldwide than any other health problem except HIV/AIDS (Lurie 2007:39-40). Depression affects sufferers in the following ways (Lurie 2007:41):

- **Thoughts**

- A person suffers from a lack of interest.
- A person’s ability to concentrate declines.
- A person struggles to make decisions.
- A person is less optimistic and more pessimistic.
- A person’s level of motivation declines.
- A person suffers from low self-esteem.

- **Feelings**

- A person feels down and depressed.
- A person worries more.
- A person feels more anxious.
- A person is more inclined to suicide ideations.
- A person's ability to love is affected.
- A person's ability to experience pleasure is affected negatively, a condition that is called "anhedonia".
- A person deals with anger in a different way.
- A person experiences a sense of hopelessness.
- A person experiences helplessness.
- A person has guilt feelings that are not linked to anything specific.

- **The body**

- A person's sleep pattern changes.
- A person's appetite changes and weight is either gained or lost.
- A person's activity level changes.
- A person feels worse at a specific time of day, which called "diurnal variation".
- A person has less energy than usual
- A person's interest in sex diminishes.

2.2.4 Causes of depression

Two categories of causes of depression can be distinguished, namely *predisposing* and *precipitating* causes (Gilbert 2009:141). *Predisposing* or vulnerability factors are factors in a people's background that make them more predisposed to depression (Gilbert 2009:141). Depression can run in families. According to Shirley Trickett (1996:5) hereditary factors do come into play with some types of depression. Certain personality types, such as people who tends to worry, are more prone to depression. People who had a difficult childhood, for example, children who suffered neglect or were the victim of physical or sexual abuse, can also be more vulnerable to depression. *Precipitating* or trigger factors can be eventing a people's lives with which they struggle to cope. This can include illness, problems at the workplace, or problems in the family.

Depressed persons' brains, bodies and minds shift to different patterns of thinking, feeling and behaving. This is called a depressed brain or mind state (Gilbert 2009:141). The question is how and why this happens. According to Melvyn Lurie (2007:39), people become depressed for a variety of reasons. Factors include a genetic predisposition, a medical or psychiatric problem, family background, alcohol abuse and stress. Sometimes there no specific reason can be indicated. Lurie (2007:39) points out that, though various factors, such as family history or upbringing are described as "causes", it is more accurate to say that, they increase a person's vulnerability to depression rather than directly cause it. Mostly, a final trigger or event is required for depression to manifest in a vulnerable person. This final trigger can be a stressful life event such a losing employment.

Genetics is a factor in depression. Family tree studies over several generations have shown that there are clusters of depressed people in some families (Lurie 2007:41). However, it should be taken into account that some families have specific life circumstances and methods of raising children that could predispose family members to depression. Even where there is a family history of depression, it would require a stressful life event to trigger depression in a person (Lurie 2007:41). Some factors that play a role in the incidence of depression are now highlighted briefly:

- **Biological factors**

On a biological level depression was seen as the result of a metabolic disorder in which the glands play an important role and later genetic factors were included as one of the precipitating factors (Mohanty1984:34-36).

- **Hereditary factors**

The incidence of depression in families is higher than its random occurrence in the general population (Mohanty 1984:75). Biological and hereditary factors are closely related, though "biological" refers to those cases where there is no family history or depression. In the case of the designation "hereditary", on the other hand, the person who suffers from depression has relatives with depression. In this respect, susceptibility to depression is similar to other inherited traits in that some people in the family could inherit it and others not. There is a genetic predisposition to some categories of depression (see Ai and Ncdao 2015). Close relatives of sufferers of

severe bipolar depression are, for instance, more likely to suffer from a unipolar or bipolar depression than others. The study by Avenevoli et al. (2015) has shown that of people with no family history of bipolar or unipolar depression, only one out of every 100 will develop the bipolar kind and three out of 100 will develop the unipolar kind. On the other hand, among those people who do have a family history of unipolar depression, one in ten will develop the disorder. If they have a family history of bipolar depression, then one in five will develop it (Avenevoli et al., 2015).

The study by Cicchetti and Toth (1998) in which they compared identical twins with the same genes with non-identical twins who have different genes shows that, of identical twins, 67 out 100 will develop severe bipolar depression if their twin does. Whether they were raised in the same environment or apart seems to make no difference. Of the non-identical twins, only 23 out of 100 will develop the disorder if their twin does (Cicchetti and Toth 1998:123). It does not mean, however, that someone who is susceptible because of the genetic factor will develop the illness (Robert 2008:31).

- **Susceptibility**

Not everyone with the same lifestyle and who is exposed to the same events will develop a depressive illness. The different forms of depression are not caused the same factors (see Berton 2002:59).

- **Age**

The incidence of depression rises considerably during adolescence (Bonilla 2019:10; see Merikangas et al. 2010; Buchaine and Hinshaw 2013; Olfson et al. 2015). Adolescence is a critical developmental period when the onset of Major Depressive Disorder typically occurs in most individuals who are affected by the illness (Beauchaine and Hinshaw 2013; see Bonilla 2019:13). According to Merikangas et al. (2010), mood disorders are the second most common disorder among youth. In a study based on data from the National Health and Nutrition Examination Survey, which was done between 2009 and 2012, Pratt and Brody (2014) found that quite a number of young people showed moderate to severe symptoms of depression. Mojtabai, Olfson and Han (2016) analysed the National Survey on Drug Use and

Health Data from 2005 to 2014 to examine the prevalence of major depressive episodes among adolescents and young adults and had similar results.

Youth experience considerable changes during adolescence such as going through puberty and making social adjustments at home and school. During the developmental period of puberty, youth undergo biological and physical changes as they transition from childhood into adulthood (Beauchaine and Hinshaw 2013:48). Adolescents are faced with multiple developmental challenges such as to coping with physical changes in their bodies, resolving identity issues, and developing skills that increase autonomy. Studies have shown that early puberty is associated with a range of mental health problems such as depression, anxiety and aggression compared to youth who experience puberty later in their developmental trajectory (Copland et al. 2014; Lynne, Graber, Nichols, Brooks-Gunn, and Botvin, 2007; McCormick, Mckone and Mendle 2015). Adolescence is a time of considerable change when mental health concerns can arise for some youth (Beauchaine and Hinshaw 2013:45). Depressed adolescents are more likely to drop out of school, earn poorer grades, and have attendance problems compared to non-depressed adolescents (Hankin and Abramson 2002). Depressed adolescents are also more likely to abuse drugs and alcohol compared to non-depressed adolescents (Hankin and Abramson 2002; Hooper, Mier-Chairez et al 2016). Depressed adolescents are more likely to commit or attempt suicide compared to those who are not depressed.

At the other end of the spectrum, elderly people are also particularly susceptible to depression due to a loss of self-esteem and feeling useless and being a burden to society and their family. Loneliness and the loss of a purpose in life can make the elderly more susceptible to depressed moods (Kottler 1988:11).

- **Environment**

Certain life situations have been found to be closely associated with depressive illness (Joiner 1994:27). People who lost their mother before the age of 11 and those who lacked a close relationship, were more susceptible to depression (Glied 2002:25). Factors in people's social environment can exacerbate the situation of those who are susceptible to depression. If the situation in their workplace or relationships, for instance, are taxing, this can compound their problem. It is then

more difficult for them to think positively (Ross 2007:19). Another environmental factor that can contribute to depression is poor living conditions.

- **Triggers**

In most types of depression, it is triggered by a stressful incident of some kind. Though a specific incident may not be regarded as stressful by others, if it causes undue stress for the vulnerable person, depression can be the result. Even severe bipolar depression is thought by some to have been triggered by a stressful incident. According to Kleinman (1980a), some depressive episodes begin for no obvious external reason. The cause can then be a biological or chemical change in the body. Such a change can be triggered by certain foods or by an imbalance caused by hormonal changes. It can also be caused by changes in the person's biochemistry brought about by thought patterns and the resultant feelings. In some cases, such changes appear to be associated with stressful life events, but in other cases they are not. Some people's body system struggles to maintain an optimal chemical balance (Kleinman 1980b:11; see Merikangas 2009:89). Life events or changes that trigger depression often involve loss or personal threat.

- **Maintenance factors**

In some severe cases of depression, the person maintains the depression through their thoughts with regard to the incident that triggered the depression and through their own reaction to the depression. In such cases it is therefore not so much the actual trigger, which is most important, but rather the factors that perpetuate and deepen the depression. This includes factors such as personality traits and environmental influences. A tendency to see only or mostly the negative side of things can be a factor which maintains depression (Siegel et al. 1999). Someone who suffers from a depressive illness and also has a depressive personality, will find it much more difficult to manage their illness. The reason for this is that thoughts can influence the chemical balance in the human body. Negative ways of thinking can sustain depression.

2.2.5 Symptoms of depression

The physical condition of persons who suffer from depression is usually poor in the initial stages of their treatment due to lack of exercise, inadequate nutrition and sleep disturbances. They are frequently weak and emaciated (Mohanty 1984:24). The DSM V (2013:274) describes it as follows:

> The characteristic symptoms of depression involve a range of cognitive and emotional dysfunctions that include perception, inferential thinking, language and communication, behavioural monitoring, affect, fluency, and productivity of thought and speech, hedonic capacity, volition and drive, and attention.

The basic features of depression are a mixture of characteristic components and symptoms, which includes both negative and positive. It persists for a significant duration of time during a one-month period, with some signs of disorder persisting for at least six months (DSM V 2013:274). The signs and symptoms that are associated with marked social and occupational dysfunctional condition. Criteria D and E of the DSM V (2013:274) describe it as follows: “The disturbance is not better accounted for by depressed affective Disorder or a Mood Disorder with Psychotic Features and is not due to direct physiological effects for a substance or a general medical condition”. For people with an earlier diagnosis of Autistic Disorder (or other Pervasive Developmental Disorders), “the additional diagnosis of schizophrenia is warranted only if prominent delusions or hallucinations are present for at least a month” (Criterion F, DSM V 2013:274).

This scientific classification is not a mere cataloguing of phenomena. It provides an explanatory system which serves as a conceptual framework from which hypotheses about new orders of relationships can be generated (Shean 2003:30). The categorisations of depression are the following (see Shean 2003:31-32):

- the Simple Type;
- the Hebephrenic Type;
- the Catatonic Type;
- the Paranoid Type;
- the Acute Schizophrenic Episode;
- the Latent Type;

- the Residual Type;
- the Schizoaffective Type;
- the Childhood Type;
- the Chronic Undifferentiated Type.

Depression is not to be mistaken for youth psychosis even though in most patients the problem manifests soon after adolescence (Olfson et al. 2015). Steel (2006) puts it as follows: “The prediction of those cases in which the onset of the illness occurs before puberty does not appear to be too poor for the next few years. This later type continues to increase for some years after the fourth decade. According to Arieti (1966:52), it would be “impossible to predict from the early history of the patient whether he would develop a psychoneurosis, a psychopathic condition or a psychosis.” Those who are severely emotionally disturbed tend to be disoriented (Patel et al. 2017). However, when allowances are made for their inaccessibility and delusions, it was found that most depressed people were well oriented. They knew their identity, where they were, recognized people and could give the approximate date (Patel et al. 2017).

In mental health practice, diagnoses are made according to the criteria laid out in the *Diagnostic and Statistical Manual of Mental Disorders*. In the DSM the criteria for the diagnosis of a major depressive episode are fairly straightforward. The following nine core diagnostic symptoms are indicated (DSM-V: 2013):

- depressed mood;
- loss of interest or pleasure in all (or nearly all) activities;
- loss of increase or decrease in appetite/weight;
- insomnia or hypersomnia (greatly increased sleep);
- slowing of physical movements, or severe agitation;
- intense fatigue;
- excessive feelings of guilt or worthlessness;
- difficulty concentrating or making decisions;
- frequent thoughts of death or suicide.

For a diagnosis of depression at least five of these symptoms should be present most of the day, nearly every day, for two weeks or more. These core symptoms also must cause functional impairment or severe distress. The DSM includes guidelines to help clinicians distinguish between authentic cases of depression and other syndromes that can mimic the disorder, such as poor thyroid function, chronic fatigue syndrome, or some forms of substance abuse. The DSM-V (2013) indicates that clinicians should delay making a diagnosis for up to two months. When someone has suffered the death of a family member or close friend it is normal to experience at least some depressive symptoms, including a sad mood, thoughts of death and sleep disturbances.

Steve Ilardi (2010:180) points out that the DSM-V does not include the terminology that patients would use to describe their symptoms. Most of the sufferers would, for instance, use the word “pain” to describe the experience of depression. They describe emotional anguish that far out strips any experience they have had to endure in the language of physical pain. According to Botista (2012:45), some people are more vulnerable to depression, whereas others are more resilient. Those who are more resilient remain largely unaffected by depression even in the face of extremely stressful circumstances. Major risk factors and protective factors include the following:

- **Genes**

Depressive disorder cannot be attributed to genetics alone. Genes play an important role in determining who is at risk, but they do not account for everything. The stretch of DNA known as the *serotonin transporter gene* affects the function of serotonin, the chemical messenger that plays a major role in shutting off brain’s stress response circuits and reducing anxiety. The serotonin transporter gene comes in two versions, dubbed “long” and “short”. People with the short version of the gene have less effective serotonin function. As a result, they are more prone to feeling anxious and to suffering a runaway stress response. From early childhood, such individuals are prone to anxiety and are vulnerable to depression. In a recent large-scale New Zealand study, young adults with the short gene were found to be about two and half times more likely to become depressed when faced with severe negative life events. However, many people with no known genetic risk also become depressed. Fewer

than half of all cases of depression can be attributed to genetic factors. The environment – that includes all people's experiences – also plays a major role.

- **Mind-body relationship**

The mind-body relationship is an important aspect of psychological and possibly also physical illness. However, it often does not receive the attention it deserves. Body and mind are often seen and treated as separate entities. Attitudes in the medical world have tended to perpetuate this view. The sick part of the anatomy is treated, but the psychological and mental processes of the patient are not regarded as relevant to their healing and health. Emotions and behaviour are affected by changes in the body. In turn, they also affect the body. What people think, the expression on their face, even the way in which they move, can change the chemicals that are released in the body, and especially in the brain where emotions are controlled (Segal et al. 2002). According to Hutchinson (2007:23), it has been found that by working the muscles on the right side of the face positive emotions such as joy and light-heartedness can be triggered, whereas working the muscles on the left side of the face can result in negative emotions such as sadness. This can be attributed to the functions of the two hemispheres of the brain. Studies that compared the brain waves of people have found that those who have high electrical activity in the left frontal areas of the brain also tend to be of a cheerful disposition. According to Sawant and Zahra (2010) the most utilised classification concerning human brain waves is the one based on the recorded signals frequencies and includes the following: Delta waves, Theta waves, Alpha waves, Beta waves and Gamma waves. There is an inverse correlation between the frequency and the amplitude of the brain. High frequencies are usually associated with low amplitudes and vice versa (Sawant and Zahra 2010; see Canduso 2018/2019:66). On the other hand, those who have more activity in the right frontal area tend to be sad and to see the world in more negative terms. According to Hutchinson (2007:24), depressive illness is triggered by a bodily imbalance of some kind and it will not improve until that imbalance is corrected. This is usually achieved by means of anti-depressant drugs.

- **Child abuse**

The experience of severe childhood trauma can have a devastating long-term effect on a person, irrespective of genetics (Kennedy and Prock 2016). Gilbert et al (2009) point out that survivors of child sexual abuse, face formidable obstacles to reporting and disclosure. They tend to struggle with sexual identity, internalized homophobia, and gender-based stigma (see O'Leary and Barber 2008; Easton et al. 2014). Delayed disclosure, lack of support services, and lack of training among health care providers (Eston et al. 2014) can undermine assessment and treatment of men with a history of child sexual abuse. These constraints can be harmful for survivors of child sexual abuse in later life, thereby increasing their isolation and susceptibility to mental health problems such as depression. Children who have suffered physical or sexual abuse are more prone to depression. Early trauma can leave an enduring imprint on the brain, placing its stress circuitry on a permanent state of hair-trigger alert, and making it very difficult to shut off once activated.

- **Social support**

Some forms of experience can serve to protect individuals against depression. Human beings are predisposed to extensive person-to-person contact. The supportive presence of loved ones is a powerful signal from the environment that helps keep the brain's stress response in check. When such human support is absent even a pet can provide some protection against depression because it provides the comforting experience of close physical contact and warmth. This reduces activity in the brain's stress centres. A study by Brown, Meadows, and Elder (2007) has shown that people with strong social support networks are less likely to become depressed. Levels of depression symptoms correlate negatively with measures of social support. Depressed patients, including those with and without cardiac disease, report lower social support than non-depressed individuals (Bonilla 2018). Longitudinal community surveys and studies of psychiatric patients have shown that the symptoms of people with good support networks improve more rapidly and they are less likely to experience recurrences depression (Blaser et al. 1992). According to (Henderson et al. 1997), having even one supportive confidant – an emotionally close friend or family member – diminishes the risk of depression after a painful event such as separation, divorce, or the loss of employment.

Not all social contact is beneficial, however. Sometimes, as philosopher Jean-Paul Sartre (2008:87) pointed out: “Hell is other people.” The presence of a harshly critical, emotionally abusive spouse, for example, renders a person more vulnerable to depression, even more so than if they have no meaningful social connection at all. Some relationships are so psychologically toxic that they can keep the brain’s stress response networks in a perpetual state of overdrive, ever teetering on the edge of the depressive abyss.

- **Thoughts**

Another significant risk factor has to do with the way in which people think about things. That is because the way people react to events often shapes their feelings more than the events themselves. When something upsetting has occurred, it is natural to spend at least some time reflecting on what went wrong, what might have been done differently and what can be done to make things better. However, some people have an unhealthy tendency to brood on negative events. This kind of rumination keeps the stress circuits of the brain highly active. People who dwell on negative thoughts are more prone to depression. If a person learns how to short-circuit rumination, redirecting attention away from such thoughts and engaging in more rewarding activities, this skill can serve to keep depression at bay.

- **Gender**

The prevalence of major depression is higher in women that in men (Coryell 2011:1539; cf. Felicitas 2009:76). The study of Girgus and Yang (2015) shows a distinct relationship between gender and unipolar depression. The study among white women of clinical and community samples done by Dooley et al. (2013) indicates that twice as many women suffer from depression than white men. Similarly, several studies that have investigated the relationship between gender and depression among youth have found that girls reported more symptoms of depression than boys (Cooper et al. 2013; Dooley et al. 2015; Hankin et al. 1998). However, research studies investigating gender differences in depression among youth from culturally diverse backgrounds have been somewhat inconsistent.

Boys and girls get depressed at roughly the same rate during childhood and men and women also have about the same rate of depression in late adulthood (Felicitas

2009:79). In other words, the gender gap is pronounced during the reproductive years when sex hormone levels are at their highest. The female reproductive hormones estrogen and progesterone have an effect on mood and other depressive symptoms (Coryell 2011:1539). Specifically, when estrogen and progesterone levels drop suddenly, as they do during the premenstrual period and right after childbirth, mood and energy are also liable to plummet. Estrogen levels are volatile during the years preceding menopause. During this time women are particularly vulnerable to depression. Women with the high estrogen levels also seem to be more vulnerable to the experience of anxiety, and under some conditions, estrogen can even prime the brain's stress response. Among all known primate species, females experience anxious arousal readier than males do. This finding is consistent with the role of estrogen and other female hormones in promoting the stress response (Clinebell 1984:7). The increased prevalence of depression therefore correlates with hormonal change in women, particularly during puberty, prior to menstruation, following pregnancy and at perimenopause. Menopause, the physiologic or iatrogenic cessation of the menstrual period due to decreasing ovarian function (Dala and Agarwal 2015; see Onya and Otorkpa 2018:51-59), is another period in women's lives where hormone-related depression can occur.

Married women form the largest group of people to suffer from depressive illnesses. Though marriage is supposed to provide people with the close relationship they need, a bad marriage can be severely detrimental to a person's health and put them at risk of developing depression (McDonald 2000:68). Low self-esteem is another factor that makes a person susceptible to depression. Given the socialization of women in society, the inferior roles allocated to them and the constant messages of their lesser worth and value, they are more vulnerable to depressive illness (Patel and Kleinman 2003:81).

The data are drawn from studies of normative populations that were assessed either for Major Depressive Disorder (MDD) or for depressive symptoms. In general, psychosocial theories about the gender difference in depression rest on the bedrock of diathesis-stress models of psychopathology. One or more characteristics of individuals (diatheses) make them particularly vulnerable to depression when stressors occur in their lives. Gender factors can have an effect on both the

diatheses and the stressors, or in the interaction between them (Girgus and Yang 2015:53-54).

On the other hand, testosterone has been linked to a sense of well-being and to high levels of activity. In other words, the male reproductive hormone is a natural mood booster. It also tends to supress feelings of anxiety and blunt the perception of stress. Men are therefore less vulnerable to depression than women during adolescence and early adulthood when testosterone levels are at their highest.

- **Lifestyle**

People who exercise regularly are at much lower risk of depression than those are not interested in sports. Exercise modifies brain chemicals and offsets the depressive stress response. Other lifestyle factors provide a similar kind of protection. People who eat much fish and other sources of omega 3 fat are less vulnerable to depression. Those who are exposed daily to high levels of natural sunlight and those who get adequate sleep every night is also better protected against depression. Ilardi (2010:25-41) puts it as follows: “These four lifestyle factors, together with social connection and engaging activities, are at the heart of a therapeutic programme for cultivating a lifestyle that will enable a person to re-enforce key protective elements.”

- **Nervous illness**

The most common symptoms of nervous illness are anxiety and depression. These conditions that can occur alone or together. The feeling they produce range ranges from mild tension or being “down”, to symptoms so disabling that normal life is not possible (Trickett 1996:6).

2.2.6 Emotional Disorders (ED)

The absence of normal affectivity is one of the most outstanding characteristics of depression. Depressed people’s emotional reactions are “flat and anaemic” – so unnatural, in fact that it is extremely difficult for normal people to establish friendly rapport with them (Merikangas et al 2010). They seem, for instance, untouched by the tears of relatives, the death of parents and the success of their children (Merikangas et al 2010). They often simply keep “staring vacantly into space” (Mohanty 1984:27). They are solitary people who rarely associate or converse with

others. Even after staying in the same ward for years, they never exchange a word or learn the identity of follow patients. Each is exclusively occupied in their own private world (Merikangas et al 2010).

- **Delusions**

Delusion is a belief held to be true in the face of solid evidence to the contrary in the real world (Meier 2010:28). The delusions of people with depression can be compared to the dreams of other people. They do not attempt to substantiate, defend, or criticize their delusions. Delusions cannot be removed by an appeal to reason and logic (Mohanty 1984:23). Like the dreaming state of mentally healthy people, the mind of the person who has delusions is unhampered by rules of logic and probability; everything is possible (Mohanty 1984:23).

- **Hallucinations**

Hallucinations refer to “hearings, seeing or feeling things” which do not exist (Meier 2010:82). Hallucinations are more common in people who suffer from depression than in any of the other mental disorders (Mohanty 1984:39). Another predominant element among these patients is auditory hallucinations in the form of voices that vilify, threaten or flatter the patients (Mohanty 1984:39). These voices are associated with voices of relatives, friends and God. The voices can be clear or indistinct. Comparatively to visual hallucinations most do not persist. They tend to occur intermittently for short terms (Mohanty 1984:39).

- **Speech disorders**

Many of the sufferers are mute or barely communicative. They do not talk for a variety of reasons. Some simply have nothing to say to the outside world. Others are silent because their voices tell them to be silent. Some imagine themselves to be dead. Some do not open their mouth for fear of the consequences due to the poisonous quality of their words (Meier 2010:83). Others are over talkative, but their speech is “incoherent, repetitive, disconnected and irrelevant” (Meier 2010:84).

- **Writing idiosyncrasies**

Some people who suffer from depression never touch a pen or pencil, whereas others are prolific writers. The same types of abnormalities found in the speech of

severely depressed people, are also evident in their writings. They are repetitive, stilted and uneven (Mohanty 1984:22). Their outlines of thoughts are “disconnected and incomprehensible” (Mohanty 1984: 22).

- **Thinking disorders**

The thought patterns of depression “lack unity, organization and specificity of object” (Mohanty 1984:42). Secondary ideas, which are normally dormant in healthy people’s thinking, flow abandoned into the mainstream of thought.

- **Weakening of intelligence**

School records indicate that most people who suffer from depression are of average intelligence. The decline of various mental functions is not even but varies. Tests of vocabulary show less impairment than tests in other areas such as learning, memory, motor ability and abstract thinking (Mohanty 1984:243). The intellectual loss is not permanent. With effective help there can be sufficient recovery in the intellectual sphere (Mohanty 1984:243).

2.2.7 Types of depression

The group of conditions associated with the elevation or lowering of a person’s mood is extensive. A brief description of types of depression and categories will now be given:

- **Clinical depression or Major Depressive Disorder (MDD)**

Clinical depression is a mental health disorder characterised by a persistently depressed mood or loss of interest in activities, causing significant impairment in daily life. Possible causes include a combination of biological, psychological and social sources of distress. Increasingly, research suggests that these factors may cause changes in brain function, including altered activity of certain neural circuits in the brain. This depression requires a medical diagnosis. Persistent feelings of sadness or loss of interest that characterise Major Depression can lead to a range of behavioural and physical symptoms. These can include changes in sleep patterns, appetite, energy levels, concentration, behavioural patterns and self-esteem. Depression can also be associated with thoughts of suicide.

The type of depression that is a reaction to a stressful event in life is described as an adjustment disorder with depressed mood. Its symptoms tend to be comparatively few or mild. However, symptoms can include intensely depressed moods or even suicidal behaviour. This is an indication of Major Depressive Disorder (previously called major affective disorder or unipolar depression) of which the origin is more biological. Major Depressive Disorder is characterized by major depressive episodes. The symptoms of this disorder tend to be greater and more severe than those of adjustment disorder (Bimaher et al 1996:78). Binion et al (1999) identify other types of depression with major depressive episodes, which include bipolar disorder (previously called manic-depressive) and postnatal depression. Major Depressive Disorder and other types of depression with major depressive episodes are those that are most responsive to antidepressant medication (Binion et al 1999:284).

- **Persistent Depressive Disorder (PDD) or Dysthymia**

Dysthymia is a mild but long-term form of depression and is diagnosed when accompanied by at least two other symptoms of depression. Symptoms include a loss of interest in activities, hopelessness, low self-esteem, loss of appetite, low energy level, changes in sleep patterns and poor concentration.

- **Bipolar Disorder (BD)**

Bipolar Disorder, previously called Manic-Depressive Disorder, is associated with mood swings that range from depressive lows to manic highs. The exact cause of bipolar disorder is not known, but a combination of genetics, environmental factors and altered brain structure and chemistry can play a role. It can include symptoms such as high energy, less need for sleep and losing touch with reality. Depressive episodes can also include symptoms such as low energy, low motivation and loss of interest in daily activities. Mood episodes last days to months at a time and may can be accompanied by thoughts of suicide.

- **Postnatal depression (PPD)**

Postnatal Depression occurs after childbirth. Women who develop postpartum depression are at greater risk of developing major depression later on in life. The symptoms include insomnia, loss of appetite, intense irritability and difficulty bonding with the baby.

- **Exogenous depression**

Exogenous, reactive or neurotic depression is depression in reaction to life circumstances (Johnson et al 2010; see Darvill et al 1992:383-384). When the change in the person's life is visible for example, bereavement, divorce, loss of employment, it is understandable that such a person can also more easily become depressed about minor life changes that would not affect other people. There can be various reasons: they can have some "unfinished business" that has not yet been dealt with (see Kahn et al. 2008) or they may not yet have recovered from one setback when the next one is experienced (Helman 1994:90).

- **Endogenous depression**

Endogenous depression is caused by a fault in the body's chemistry (Johnson et al 2010:25). The reason for this is unknown. Though there may not be an obvious current reason for depression in the life of the person, there would probably be something in their past that precipitated their condition. Painful past experiences that are not expressed, do not simply disappear. They tend to surface when triggered. Suppressed feelings that are likely to cause depression include anger, frustration, sadness, guilt and the lack of a sense of self-worth.

- **Mixed depression**

The depression that most people display, is a mixture of symptoms. In other words, difficult life circumstances along with a reduced ability to cope because of neurosis. The Diagnostic and Statistical Manual of Mental Disorders describes depression with mixed features as characterized by subthreshold hypomanic or manic symptoms occurring during depressive episodes of either major depressive disorder of Bipolar I or II Disorder.

- **Agitated depression**

Normally depression is associated with a person slowing down. Agitated depression, however, is a condition where the person is extremely restless and anxious.

- **Smiling depression**

Some people go to great lengths to hide feelings of depression. Some use humour as a mechanism to cope with their pain and hide it from others. This is often called the “clown syndrome”: with smiling mouth and sad eyes.

- **Masked depression**

In masked depression the symptoms take a physical from, such as, for instance, backache, headaches or digestive upsets. The sufferer may not even realise that the cause of these troubles is in actual fact depression. The way in which depressive illness is classified has changed (Huang and Dong 2014:65). Previously depression was classified as either reactive or endogenous. Reactive depression was believed to have been caused by an event in a person’s life. In other words, the sufferer became depressed in reaction to something such as redundancy at work, bereavement or serious illness.

Endogenous depression, on the other hand, came over a person for no apparent reason. Nothing in particular had happened to the person (Marchal et al 2011). Endogenous means “coming from within”. Such depression was thought to the result of biochemical changes in the body, though it was unclear what would have caused that (Marchal et al 2011). Some experience a phase of being manic or euphoric, after which they sank into a phrase of deep depression. This used to be called “manic depressive psychosis”. Though outdated, these definitions are still considered useful. There are practitioners who still prefer the old system. It makes no great difference to treatment (see Avison 1992:33),

In the Diagnostic and Statistical Manual of Mental Disorders (DSM V 2013), the main distinction is made between *unipolar* and *bipolar* depressions. Unipolar means “one-ended”. This term is used to describe all forms of depressive illness where the sufferer feels “down”. Unipolar depressions do not have a manic phase because depression as such does not have a manic phase. People who have a manic phase are diagnosed with bipolar or “two-ended” depression. This shift in classification, has come about partly because research has shown that bipolar depression is a type of depression that features both a high and a low phase. However mild or severe these

phases are, they have more in common with each other than they do with any of the unipolar disorders that feature only a depressed mood.

- **Seasonal Affective Disorder (SAD)**

Seasonal Affective Disorder, commonly known as “winter blues”, is a recurrent depression which stars about the same time every year. When the amount of daylight diminishes in early autumn sufferers experience symptoms that become worse as the days shorten (Swendsen 2010). As long ago as the 19th century there were reports from France of a variation in the frequency of psychiatric disorders and suicides with changes in the seasons (Merikangas et al. 2009). Sufferers with this form of depression become ill when the days grow shorter and they are deprived of as much sunlight as they need. Many sufferers have found that talking holidays somewhere sunny in winter helps. According to Nolen-Hoeksema et al (1994), symptoms of this disorder are like those of unipolar depressive episodes. People want to sleep all the time. The feelings of depression will usually be at their worst in the afternoon and at night. Sufferers from SAD are, however, more likely than other depressive to have craving for carbohydrate foods such as cakes, potatoes and chocolate, and are therefore likely to gain weight rather than lose it. For depressive episodes to be classed as SAD in a person living north of the equator there must be a regular appearance of the depressive symptoms between the beginning of October and the end of November. Such people can recover completely or revert to a manic phase between mid-February and mid-April. The desire to sleep for long periods of time and the craving for certain foods are not dissimilar to the behaviour or animals that hibernate during the winter months. It usually starts with an increased need for sleep and a loss of concentration. Then it progresses to depression, anxiety, irritability and a loss of sexual interest. Other signs are aches and pains and a craving for sweet foods. According to Tickett (1996), when spring approaches the symptoms of SA Disorder improve and sufferers begin to recover and resume a normal life. For some, even though they feel better, the disruption caused by this condition year after year can lead to “ordinary depression” because it becomes increasingly difficult to resume their lives each spring. During the period that the disturbance lasted studies are interrupted, employment could be lost, and relationships could have suffered. Once the nature of the depression is recognized, measures can be taken to avoid it.

Therapy includes being out more in daylight. Severe sufferers can be exposed to full spectrum lighting on a regular basis. The pineal gland which is stimulated by light keeps the hormones balanced and prevents or alleviates the problem (Trickett 1996:4-6).

- **Mood Disorder (MD)**

A mild case of either mania or depression can go unnoticed. People would interpret them as “normal ups and downs”. In order for their fluctuations to be identified as a more serious condition, other symptoms should manifest as well (Kleinman 1977:76). The first assessment to be made is whether the person suffers from excessive moods or mood swings, which can indicate depression (Johnson et al 2006).

- **Bipolar Affective Disorder (BAD)**

Bipolar Affective Disorder is a form of depressive illness where the sufferer has periodic manic spells and periodic spells of depression. They can, for instance, have an inflated sense of who they are and then act out their lives as if they actually are that important person. This phase will usually come on suddenly and can last anything from two weeks to five months. The less severe form of the high that people with bipolar disorder can experience is called hypomania. People with hypomania have increased energy and are more active than usual. They do not have delusions or hallucinations. They do not lose touch with reality and know who they are. What can be a problem, however, is that they tend to overestimate their capabilities and fail to see the obvious risks involved in their ventures. For example, if they are in business, they may suddenly decide to expand in a way that is not practical or set up schemes for which they are ill prepared. Other forms of uninhibited behaviour include reckless driving, spending sprees, gambling and sexual adventures. They may also have many new ideas, but do not follow through on them. They are often very pleasant to be with but can become grumpy or impatient if they cannot do what they want. Such symptoms include agitation, an inability to concentrate, and disinterest in some aspects of life, particularly sex (Joiner 1994:128). During the depressive phase of bipolar disorder, sufferers can display manic symptoms, particularly over-activity and excessive talking (Kaltiala et al 2001). The depressive phase of bipolar affective disorder can last up to six months. The symptoms are like those of the unipolar depressive disorder, which are similar to manic phase however slight, is likely to be a

recurrent one; it is not usual to find people who have only a single such episode in their lives.

- **Unipolar Affective Disorder (UAD)**

Unipolar Affective Disorder manifests as periods of depression of varying degrees of severity. Whether the episode is classified as mild, moderate or severe, depends both on the number of symptoms, the type of symptoms and the severity of the symptoms. Should a person suffer from hallucinations and delusions the depression would probably be regarded as severe (Patel and Kleinman 2003:81). Another criterion for severity is the degree to which the sufferer is able to cope and continue with life. The less they are able to function, the more severe the illness is (Plante et al 2001). According to Weissman et al (2007), for a disorder to be classified as depression, there must be evidence of depressed mood. This mood may vary slightly throughout the day. The sufferer also cannot be cheered up. This is the distinction between unhappiness and depression. Unhappy people can be lifted out of their mood by circumstances, friends or something good that happens. Depressed people are largely unaffected by what goes on around them. They generally remain emotionally flat and unresponsive.

Depressive episodes, however severe, therefore include symptoms such as a loss of interest in and the inability to take pleasure from activities that the person usually enjoyed or activities that others enjoy. The inability to concentrate and memory lapses with regard to everyday things is another symptom. The cause is not a defect of memory but rather the lack of focus that prevents the brains from registering what goes on around the person. People also often take longer than usual to absorb information or to work things out. Simple tasks require much effort and are often abandoned because they are felt to be too taxing. Many depressed people lack energy and tire easily. They often do not get sufficient sleep. Their depression is often worse in the morning and they do not want to get out of bed. They often lose interest in food and feel generally listless and disinterested in life. Some, however, crave food and eat for comfort. The weight of people with severe depression depends on their particular relationship with food.

Low self-esteem is often a feature of people who are susceptible to depression. It becomes more pronounced during a depressive episode. Guilt feelings and a sense

that they are not worthy can also be related to low self-esteem. People with depression tend to see life as bleak, are pessimistic about the future. This is a major difficulty that has to be overcome in the treatment of depression. People with severe depression often harm themselves and have suicide ideations. Because of their sense of unworthiness and their bleak outlook on the future, they feel there is no points in living. They often think about suicide and ways of committing it, even though they may not actually do anything about it.

People with depression struggle to feel anything, including affection for others. They experience emotional flatness. They speak words and perform the actions, but without conviction of feeling. Some are intolerant of noise and bright light. The symptoms and their severity depend on the degree of depression. Categories of the levels of depression will now be discussed briefly.

- **Mild depression**

Persons who suffer from mild depression have a depressed mood and display a number of symptoms of depression, such as a diminished interest in life and things that would otherwise be regarded as interesting or enjoyable. The symptoms are, however, not severe. They can function in life and only appear to be in low spirits and possibly less sharp in their thinking (Donovan 2001:25). Though they reduce their activities, they will often continue doing essential things, such as going to work or caring for their family. They will, however, seem less conscientious about these things than previously. They can be upset because they feel they are not coping as well as they should because they feel too tired. Those with only a mild form of depression are inclined to feel that they are making fuss about nothing and should try and “pull themselves together”. They therefore do not always seek the help they need.

- **Severe depression**

People who suffer from severe depression struggle to function and tend to be unreliable (see Witting et al 2008:18-19). They lack the will to interact with or care for others. They are often restless and agitated, but do not do anything constructive. Their activities seem pointless. People in this state are unable to lead any kind of normal life. The more severe their symptoms, the less they are able to motivate

themselves to do anything about the problem (see Yen et al 2003:40). Depression mostly has a downward spiral. The more depressed people feel, the less inclined they would be to do anything positive and the deeper they sink into the depressive state (Donovan 2001:25). For such people the help of others is essential, since they cannot help themselves.

- **Recurrent brief depression**

Recurrent brief depression is similar to unipolar depression, but only lasts for a short time (Segal et al 2002). The question is whether this state can be seen as depressive disorder proper or whether it is something completely different. The average length of the depressed mood is only three days and few episodes last for more than a week. Because the episodes are so short, it is difficult to assess the effect of anti-depressant drugs (Sulmassy 2002:42). An important aspect of this disorder, however, is that it is recurrent. Mostly a following episode will occur between one and five weeks later. During a year episode can recur some 12 to 20 times. Although this disorder recurs roughly once a month, this stands in no relation to women's menstrual cycle since equal numbers of men and women suffer from this condition. The symptoms are similar to those of unipolar depression. The frequency of the episodes which are disruptive and unpleasant, contributes to a high risk of suicide.

- **Masked depression**

Some symptoms of depression are psychological, for example loss of self-esteem, inability to concentrate and a lack of feelings (see Mjtabai, Olfson and Han 2016). Other symptoms that are physical include disturbed sleep, changes in appetite, loss of sex drive, slowed speech, slowed movements and thoughts, and intolerance of light and noise. Masked depression is a form of depression that often goes unnoticed because, although the physical symptoms can be similar, the psychological symptoms are either lacking or are not mentioned by the person. It is suggested that such disorders are due to the same or similar physical causes as the other unipolar depressive conditions (Pratt and Brody 2014:23).

In the 19th century there was a disorder called neurasthenia, which was described as a disease in which the patient experienced severe fatigue. It was believed to be more common among the educated than the unskilled. The cause was thought to be

environmental. The condition was brought on by what is today regarded as stress factors such as emotional upsets, negative or traumatic experiences and work pressure. The cure was said to be rest. Neurasthenia is still diagnosed in oriental countries such as Hong Kong, China and Taiwan. In the West, however, fatigue is seen as a symptom rather than a disorder. Lewinsohn et al (1993) note that what is currently known as Chronic Fatigue Syndrome (CFS), bears a strong resemblance to what was called neurasthenia in the Victorian era. Chronic Fatigue Syndrome was first identified as a problem experienced by young people who were striving to climb the ladder of success rapidly and then contracted a viral infection. That is why it was referred to as “yuppie flu” in casual usage. The preferred technical term today is Chronic Fatigue Syndrome which provides an accurate description of the symptoms. In the life of the person who suffers from this condition, there will most probably have been some serious stress or pressure conditions which caused the onset of the disorder. People who suffer from Chronic Fatigue Syndrome exhibit many of the physical symptoms of depression, but mostly not the psychological symptoms. A conclusion has been that this is a form of masked depression (Lewinsohn et al 1993). Those who suffer from this condition are often reluctant to accept a psychiatric diagnosis because of the stigma that is attached to it.

- **Post-traumatic Stress Disorder (PTSD)**

Post-traumatic Stress Disorder is not a depression illness, but a sufferer can appear to be in a depressed in mood. Post-traumatic stress occurs after someone has been in a traumatic and utterly stressful situation. Examples include there having been the victim of violent crime, having been involved in a major disaster, or having witnessed the violent death of others. The disorder usually begins within six months of the traumatic event that triggers it. Symptoms include reliving the trauma in the forms of flashbacks. Other symptoms include insomnia, a lack of emotional expression and a tendency to avoid things which used to give pleasure. A person can also have suicide ideations.

2.2.8 Depression in children and adolescents

If young children suffer from depression parents and other adults often do not believe that that is at all possible (Angold et al 1993:150). Depression affects about two in

every hundred children prior to adolescence and around nine in every one hundred adolescents (Ciccheti and Toth 1998:88). More adolescent girls than boys are affected. They tend not to be able to find joy in activities that they once found pleasurable. They lose their appetite and their sleep patterns become inconsistent. Some gain weight because they seek comfort in food. The decline of child's school performance can be an indication of a depressive condition. Some adolescents harm themselves, whereas others have suicide ideations (Cicchetti and Toth 1998:88)

Heaton-Harris (2008) points out that boys may not have been raised to allow or show their feelings and emotions. That makes it difficult for them to admit to being upset or sad or to cry. Their inner turmoil then manifests in extreme irritability, boredom, destructive behaviour and self-harming. It is often difficult for adolescents to be diagnosed correctly with depression, since people often assume that hormonal fluctuations due to the life stage in which they find themselves, are the cause. Some adolescents, like adults, are not able to cope with the stresses and strains of their everyday life and depression is the result (Heaton-Harris 2008:35). This includes that they struggle to make friends, are bullied, and cannot to cope with schoolwork. Problems at home that can play a role include substance abuse, physical abuse, living in conditions of poverty, and being fostered or adopted. Physical and hormonal changes during puberty can create stress for the child. Having to change schools can also be highly stressful.

A young person can struggle to articulate their problem, with the result that those who care for them, remain ignorant of their condition. Parents who suspect that there might be something wrong, do not take the child for professional help, because they fear that they will be blamed. Shekethmeyster et al (2011) point out that the earlier the age depression hits, the greater the possibility that family members of the child have also suffered from depression at some point. Depression in young people is often occurs alongside other mental health disorders, such as anxiety, being constantly disruptive or abusing illegal substances. Physical disorders such as diabetes are also a possibility.

2.3 “Demon possession and witchcraft” in an African context

In South Africa in general and in particular Soweto, the particular context of this investigation, demonic possession, exorcism and spiritualism in various forms are prevalent. There are “deliverance ministries” in some Charismatic or Pentecostal churches. In traditional churches there is the traditional ritual, the so called “Imbizo” or ancestral call that takes place under the leadership of traditional healers who are the custodians of their cultural beliefs in that regards. These two phenomena make for a complicated situation when it comes to depression, especially for youth and their families. According to cultural beliefs, symptoms of depression are often interpreted as demonic possession. The various phenomena will now be discussed briefly.

2.3.1 Demonic possession

With the shift to modern and postmodern paradigms the idea of “demonic possession” fell out of scientific favour (Isaacs 2018:373). These ways of thinking have not presented answers to the phenomena associated with demonic possession. They have likewise been unsuccessful in developing an appropriate method of treatment for those who experience the signs and symptoms of classical possession. Though belief in possession has been rejected as superstition, phenomena associated with demonic possession do exist and has to be dealt with. Mark Crooks (2007:28, 45-76) defends the use of a traditional paradigm for understanding the phenomena associated with demonic possession. He suggests that demonic possession should once again be viewed as a valid phenomenon. He argues that denial in the form of changing a philosophical paradigm, does not negate the reality of an event. He does not find the recently adopted explanations of the naturalistic sciences to be more convincing than traditional views. Using what he calls a “post-anecdotal” method, Crooks shows that the ancient system of demonology is not only as adequate as the modern medical model but is even more effective in describing the phenomena of possession states. His approach is similar to the Jungian method of observing the psyche through the lens of myth and fairy-tale. This “post-anecdotal” method is analogous to the establishing of mythological contents of the psyche as “psychic facts.” The use of demonology to describe psychic facts is like Jung's

utilizing alchemical symbolism to do the same. To make what originated from within the psyche of less reality than what the psyche receives from the physical environment is merely a modern and postmodern materialistic bias. Such a bias should be tested, rather than accepted as a definition of “truth”. Jung (1959: para. 44) articulated it as follows: “To psychologize this reality out of existence either is ineffectual, or else merely increases the inflation of the ego. One cannot dispose of facts by declaring them unreal.” The human psyche is an entity that is difficult trap in a definition and the danger exists that some thinkers in effect demythologize the psyche out of existence. Crooks’ “Occam's razor” argument that demonology provides the simplest and best explanation of the phenomena associated with demon possession, adds even more credence to re-establishing the traditional, pre-modern, view of reality in general.

Kreeft (2018) identifies three philosophies that have guided Western thinking over the past two thousand years: traditionalism or pre-modernism, modernism or rationalism, and postmodernism, or what he calls “irrationalism”. In more descriptive language he calls these the philosophies of *moreness*, *sameness*, and *lessness*. *Moreness* could also be a description that fits mysticism, namely that there is more to the world than that which can be seen. *Sameness* is a rationalism (modernism) that conceives that all things are identical, or the same, to what we think they are. Kreeft (2018:9) interprets Hegel’s statement, “that which is real is rational and that which is rational is real”, as that: “we are know-it-all’s: what is inside our mind and what is outside match perfectly”. For this to be the case, “you must be either a genius, or very arrogant, or both (like Hegel)”. This reflects much of twentieth century thinking. Finally, there is the philosophy of *lessness*, or reductionism, which is strongly reflected in current thinking. It can be seen in medicine and psychology where behaviour and experiences tend to be reduced to neurological functioning and brain structures. Obviously, these three philosophies will lead to divergent understandings of the universe.

Traditionalism had almost completely fallen out of vogue by the middle of the nineteenth century, and modernism and postmodernism have dominated intellectual thought since then. In biblical and theological studies there was the move to demythologizing the Bible. If people in the modern era adhered to a belief in angels,

demons, and a spiritual realm as a reality beyond that of the material world, they were mostly psychologized. What was left was a moral and ethical religion that had as its aim to reach out to and alleviate societal needs, since these were the “true” rational realities that touched the lives of people. Kreeft (1988:167) calls for a return to a philosophy of life that can embrace reality and faith and that has an understanding of what it means to deal with existential evil both in society and within the individual.

To adequately work toward the healing of persons who are dealing with the demonic, a traditional understanding of the cosmos should be both embraced and seen from a new perspective. The contribution of this study is to build on the insights of Crooks, propose a pre-modern mythological understanding as is often utilised in Jungian circles, and articulate an “updated mythology” by means of which the psyche can be described again in such a manner that demon possession is no longer regarded as “odd”, but rather as a reality in the lives of some. This is a position taken against materialism and modernism and their point of departure that if something cannot be measured then it is not real.

St. John Damascene and Pseudo-Dionysus the Areopagite are best known for taking the literature on beliefs in angels and categorizing it according to *species* and *function*. The implications of this are many. Firstly, since the psychic dimension formed within the midst of the first heavenly condition – the abode of the angels – this psychic dimension would be easily influenced by the angels. Further, since the material dimension formed during the immaterial or psychic realm, the angels and demons are then able to manipulate and effect the material condition. From this point of departure, it is understandable that demons can affect human thoughts and infest an environment. It provides a framework for understanding incredible and seemingly unbelievable events such as the manifestation and disappearance of material items that could occur during exorcisms, as well as how demons can influence and even possess humans. From such an understanding the study can proceed to examining how possession affects the psyche. This can contribute to a better understanding of the vastly different, yet inextricably interwoven phenomena of psychopathology and demonic possession in an African context.

A psychotic person has difficulty distinguishing between the images of the imagination and those in the outer world and may experience hallucinations and delusions. If neurological issues are also involved the situation becomes even more confusing and complicated. Most neuroses are not mistaken as having a demonic component, but many psychoses are. Since the individual believes that he or she is hearing real voices from the outside, is truly seeing things and is experiencing things in his or her body that do not have an organic origin, these can easily be seen in certain cultural contexts as the activity of demons. The way to distinguish between mental illness and demonic activity is by investigating the whole spectrum of the symptoms that are exhibited. Demonic possession is comprised of signs and symptoms that are different from the signs and symptoms that constitute any of the psychotic syndromes (Isaacs 2009, 2018).

Demonic possession differs from demonic activity. The influence of the demonic on an individual's life is real. *The screwtape letters* by British author, C.S. Lewis, (2007) portrays the demonic interacting with the human psyche and physical body. The question is how this interaction will be named: temptation, obsession (or oppression), or full possession. Demons rarely interact directly with the ego. To do so would be to bring themselves into awareness which could lead to resistance by the individual. It is much more effective to work through a person's unconscious complexes or inner personality. Since the unconscious is the target, the ego is unaware that it is under the influence of something energized by the demonic. A demon does not literally, or concretely, enter a psyche but influences it from without. The demon will attempt to influence the unconscious aspect of the psyche and energize it to sway the ego and so control the body. If the person is often inhibited and controlled by his or her fears, then the demon may figuratively "speak" to a fearful inner personality (or complex), which the ego will then experience as potentially debilitating anxiety. The severing of this relationship is accomplished in exorcism. The second step focuses on the soul. This is accomplished through deep spiritual direction and psychotherapy.

Mark Crooks (2007:45-76) poses the question whether the phenomenon of demonic possession is not best described by a traditional rather than a modern naturalistic understanding. Whether possession is "real" or not, is a matter of perspective. Demons are rarely seen. The phenomena of possession are produced by the

afflicted person. The question is then whether what is observed and experienced is demonic or psychic? Is the loss of volition and the strange perception of the person influenced by a force from the outside or stimulated by an inner source? This is the problem expressed by the old Latin saying: “That which is received is received in the manner of the receiver.” Since all experiences are processed through the psyche, and are therefore a part of the psyche, the differentiation between the source of the image and thought, feeling, or other experience of the person, is made difficult. These all have a common recipient and route by which to travel into consciousness: the psyche.

A psychiatrist does not look beyond the psyche in order to discern whether another influence could be at work because that psychiatrist most likely does not believe in the existence of a spiritual world. The inquiry after the source of what is observed therefore halts at the psychic and organic levels without an open enquiry as to what might lie beyond. Hopefully, as scientific knowledge expands and Peter Kreeft's call to return to a philosophy of *moreness* is heeded, then spiritual and psychological explanations need no longer be in conflict can be viewed as aspects of one larger reality.

2.3.2 Witchcraft from a black African worldview

South African practical theologian, Elijah Baloyi (2018), in his work on witchcraft in the Limpopo communities, emphasises that witchcraft, demonic possession and exorcism have always been a reality within African traditions and spiritualities (see Kitshoff 1994:30). Matsobane Manala (2004:1503) puts it as follows: “In the minds of many African people there is no doubt as to the reality of witchcraft … For many African people it is an existential reality.” Illness, misfortune and disturbances are often attributed to evil spirits who are seen to be the cause of misfortune in a person’s life or in a family. This misfortune is seen to have been caused by a witch, wizard or sorcerer. It is believed that illness can be cured, misfortunes reversed and disturbances cleared away by means of exorcism, rituals, medicine and ceremonies conducted or given by witchdoctors, prayer healers or prophets. In other words, if the equilibrium of the person, family or society has become disturbed it can and should be restored (see Kitshoff 1994:30; Ferdinando 1999:43). Depression in African

contexts has therefore also often been connected to demonic possession, which is one of the characteristics of witchcraft. Once restoration has taken place, preventative measures should be taken for protection. If the affected person is so inclined, witchcraft can be used to take revenge on the person believed to have sent the evil spirits. Therefore, in Africa witchcraft is practiced as a preventative measure as well as a reversal of witchcraft (see Manala 2004:1503).

Many African people live in constant fear of witches and witchcraft. Manala 2004:150) puts it as follows: “Witchcraft raises intense fear and revulsion because it destroys human life, human community and shatters dreams and visions of individuals and societies”. Many African Christians also attribute evil to witchcraft (see Douglas 1984:102). Ejizu (1991:173) explains evil powers in this view as follows: “They are not only antithetical to a successful and fully enhanced life here on earth, they pose the greatest threat to the attainment of ancestorhood, which is the burning desire of most traditional people”. Acts such as cannibalism, necrophagy, bestiality and incest are believed to be practiced by witches at their initiation or in order to enhance their mystical powers (see Ferdinando 1999:101).

Apostolides and Dreyer (2008) point out that many African people believe that both mental and physical illness can be caused by personal sin, moral failure, the devil, demons/evil spirits (usually sent by witches), witchcraft or a specific ancestor who has become upset with them. A witch or witchdoctor then sends their ancestral spirits to the victim (Asamoah-Gyadu 2005:177; see Bate 1995:53; Maboea 1994:125; Oosthuizen 1992:119, 126). The spirits are then believed to have invaded the victims and caused them to suffer illness and misfortune, have nightmares and behave unnaturally (Asamoah-Gyadu 2005:167). It is believed that the demon/evil spirit must not only be expelled from the victim, but also from the community (Platvoet, 2000:84). The witchdoctor identifies and diagnoses the cause of the illness by using twigs or bones as divining dice (Hammond-Took 1989:114) and extra sight (this is when they are in contact with their ancestral spirits) (see Blier 1991:77).

Hammond (1989) points out that ancestral spirits play an important role in helping the witchdoctor to combat the victim’s ailments (Hammond-Took 1989:103-125).

Witchdoctors heal with the help of ancestors and/or make up *muti* for expelling the demon/evil spirits. Sometimes the *muti* is ground into a fine powder or snuff and is given to victims to inhale in order that they can sneeze out the demon/evil spirit.

Phaswana (2008:245) points out that there is a need for pastoral counselling for people who fear ancestral spirits and witches. According to Okeja (2010:8), even the most educated African people are not exempt from a belief in witchcraft. Because of the sharp increase in these kinds of killings, particularly in the Northern Province during early 1980s and 1990s, the Ralushai Commission was appointed in 1995, with its final report published in 1996. Even though no census was been reached, an estimated number of between 3000 and 5000 self-designated pagan witches were operating in South Africa.

The Mpumalanga Witchcraft Suppression Bill (2007) explains it as follows (see Baloyi 2018): “Witchcraft is the secret use of *muti*, zombies, spells, spirits, magic powders, water, mixtures etc, by any person with the purpose of causing harm, damage, sickness to others or their property.” Trapido (2010:1) points out that this definition was rejected by self-proclaimed witches on the grounds that it stereotypes witchcraft as harmful and portrays witches as being a danger to the communities in which they live and work. Another definition was given by Ralushai when testifying before the Truth and Reconciliation Commission in July 1999: “A witch is a person who is endowed with powers of causing illness or ill luck or death to the person that he (she) wants to destroy” (see Leff, Fontleve and Martin 2001:6). Others view witchcraft as the power of a person to do harm or influence nature through occult means (Makisto 2011:1). Olukoya (2004:174) sees a witch as a person who uses magic for evil purposes or who practises sorcery. For Maboea (2002:19), according to traditional African religion, sorcerers and witches are agents of disruption and destruction in the community.

Although the language and wording of these definitions differ, the essence remains that same: that the witch is someone who wilfully uses any *muti* or the magic of an evil spirit to do harm to or inflict ill-will on other people. The concept of “witchcraft” is known as *moloi* (Sepedi), *muloyi* (Tshivenda) and *noyi* (Xitsonga) (Petrus 2009:34).

The word *moloi* derives from the verb *loya,* which means “to bewitch”, and it is attributed to people who through sheer malignancy, either consciously or subconsciously, employ magical means to inflict all manner of evil on their fellow human beings (Petrus 2009:35). According to Ralushai et al (1996:4), these people destroy property, bring disease or misfortune and cause death, often entirely without provocation. Pauw (1975:233) and Olivier (1981:87) argue that witchcraft stems from an inherent quality, and it is widely believed that witches (who are mainly female) inherit their witchcraft powers and familiarity with the practice from their mothers.

2.3.3 The psychological effect of witchcraft on human lives

Counselling and exploring the fears, worries and concerns of the person affected by what they believe to be witchcraft, can help to relieve their pain (Phaswana 2008:81). Generally pastoral caregivers do not pay much attention to the physical and psychological aspects of witchcraft. Human touch, either through prayer (laying the hands on someone) or traditional African ways of healing, gives people hope. Christian believers hope that the pastor’s touch will protected them from evil spirits. This is one of the reasons why many black Christians flock to African Independent Churches and Pentecostal churches where the pastors lay hands on them and pray for protection for these people and their personal belongings. In the African context, the Christian pastor or pastoral counsellor is seen to replace the medicine person’s role in their lives. The pastor is now their counsellor and healer (Waruta and Kinothi 2004:93). LeClaire (2013:1) he argues that because of people’s fear of witchcraft, they remain preoccupied with witchcraft and this takes away their freedom to serve God in peace and with joy. Often people join churches not so much because they have embraced the Christian faith, but rather as a means to gain protection against the powers of witchcraft.

The other problem is that every bad thing that happens in a person’s life is summarily attributed to witchcraft. According to Ally (2015), witchcraft, in this way, represents a theory of misfortune which then guides the interactions between people. It provides them with explanations, steeped in the supernatural, for almost every misfortune. Witchcraft is blamed as a way to deflect the own responsibility for misfortunes. The result is that people live in fear. Among the Yoruba people in Nigeria, just like in

many other African tribes, witchcraft is believed to be one of the major causes of death. These beliefs go against the gospel of Jesus Christ who himself suffered with humanity and remains always with them in their suffering.

2.3.4 Spirit possession and psychotic disorders

In psychiatric parlance, something resembling the “alien control” of a person would be categorised as delusions, a key diagnostic criterion for schizophrenia (DSM-V 2013). It is often difficult to differentiating between spiritual experiences and psychotic disorders. It has long been recognised in the anthropological literature that pivotal to the distinction is the relevance of cultural and social norms. Psychiatry anchors its interpretation of norms in social consensus. Psychosis has been defined as “a failure of integrating sensory and extrasensory information into reality models accepted by the broad consensus of society, and that lead to maladaptive behaviour and social sanctions” (Nelson 1994:3). This is demonstrated in diagnostic criteria (Rowan and Dwyer 2018:448):

> The glossary of the Diagnostic and Statistical Manual of Mental Disorders (5th ed., DSM-V, American Psychiatric Association, 2013) defines a delusion as a false belief based on incorrect inference about external reality that is firmly held despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary. The belief is not one ordinarily accepted by other members of the person’s culture or subculture. It is this final caveat that reflects the recognition of the necessity to consider the subcultural conventions of reality, demonstrating that it is the community’s consensus of the experience as a cultural-bound phenomenon which legitimises it and distinguishes it from a pathology.

> The phenomenon of possession itself falls directly under the DSM-V 2013, Criteria A for Dissociative Identity Disorder (DID), which in its latest revised form now states the requirement for the evidencing of possession: “Disruption of identity characterized by two or more distinct personality states or an experience of possession, as evidenced by discontinuities in sense of self, cognition, behaviour, affect, perceptions, and/or memories” but again recognises the cultural and religious relativity of the phenomenon in stating “The disturbance is not an abnormal part of a broadly accepted cultural or

> religious practice." The contemporary psychiatric view of possession if accompanied by recurrent gaps in recall, distress, or impaired functioning, and is not attributable to substance use or medical condition, according to the DSM-V 2013, can be either pathological and non-pathological depending on whether it is embedded in a cultural or religious practice.

The final clause of criterion A validates the reporting of symptoms by those who are experiencing the transition. It states: "These signs and symptoms may be observed by others or reported by the individual." The emphasis on the evidencing of possession, the underlying belief systems and self-reporting demonstrates the need for greater clarity on how the individual discerns the experience of possession along cognitive, behavioural, affective, perceptual, but also cultural lines.

The emphasis is on understanding the nature of the phenomenon in relation to the belief system in which it is practised. The community in which it is regarded as a reality, defines the precepts of that reality. The religious and/or cultural community in which the phenomenon is seen as reality, not only defines the form in which the phenomenon is represented, but also how evidence of the phenomenon is constructed, transmitted, discussed, demonstrated, and recognised. Participants must understand the premise of the phenomenon in order to engage in the form in which it can be constructed (Bourguignon 2006). They should also develop a "cultural expertise" in order to master the culturally represented mechanisms for participation in the phenomenon (Halloy and Naumescu 2012). Given the highly culturally constructed nature of the phenomenon of demon possession, the ability to discern it also falls along clearly defined cultural lines.

2.3.5 Exorcism

Exorcism does not amount to speaking a magic formula. Exorcists keep three factors in mind when trying to liberate a sufferer from what ails them: the behaviour of the sufferer, the action of the exorcist, and the permission of God (Gabriele 1999:15). Liberation is achieved when the Spirit of God commands the demon to depart. The exorcist sees him- or herself as a servant of God. By invoking the name of Jesus Christ, the demon is expelled from the suffering person. For religious persons it is

God who does the work. The exorcist is an instrument in God's hands. Sicilian exorcist, Father Matteo La Grua (see Thomas 1993:42), puts it as follows: "Liberation is a gift from God, and God can liberate when God wants and how God wants, even without the intervention of human beings". The effectiveness of the exorcism, however, depends in large part on the co-operation of the sufferer and to a lesser extent on the faith of the exorcist (Thomas 1993:43). For any exorcism to work, victims must co-operate with the exorcist (Winston 1997:12). They must renounce the demon and any sins or actions that may have led them to become possessed. They also should pray and return to practising the sacraments. Not everybody has to be a Catholic, or convert, to become liberated, though some do (John 2004:33). Father Amorth who has exorcized Muslims and also, on rare occasions, Hindus nevertheless prays the ritual prayer by using the name of Jesus Christ. He puts it as follows: "I also ask them to fulfil their spiritual duties." For example, Muslims have the obligation to pray and so I tell them to do so. Otherwise I tell them to be a good person, an honest person who fulfils their professional and moral duties (Amorth 1999:75).

The sacrament of reconciliation is important. Ferber (2004:26) explains it as follows: "Exorcism can drive a demon out of a person's body; confession can drive evil out of a person's soul. Confession not only forgives but heals our soul and fills it with light". This process can be drawn out when the person has strayed far from God, or in some cases has joined a satanic cult. Another hurdle to overcome is the possessed person's inability to forgive. Sincere forgiveness, which includes prayer on that person's behalf and saying mass for that person's conversion, often breaks the deadlock and facilitates the healing (Amorth 1999:78).

The exorcist needs to have a strong spiritual core. Father Barmonte (see Baglio 2009:76) puts it as follows: "An exorcist must live an intense life of prayer and not be afraid". The exorcist should live a dedicated, disciplined spiritual life: "If you do not have the protection of your faith, how can you be able to fight? Praying, loving God, not committing sins – those are the weapons an exorcist use (Wiebe 2011:15). An exorcist's own description of his life and work is that he always finds himself between being admired and thanked by some and begin bitterly despised and persecuted by

others. Ministry, he says, is always done from the cross. If a priest is not willing to bear this burden, he should not accept this ministry (see Baglio 2009:77).

Matt Baglio (2009:77) discusses the historical background of exorcism in Rome. The Scala Santa or Church of the Holy Staircase has always held a unique place among the churches of Rome, drawing countless pilgrims over the years to its venerated Sancta Sanctorum (Holy of Holies), the personal chapel of the popes, which the devout reach by climbing a special staircase. These are believed to the very stairs from Pontius Pilates's palace in Jerusalem that Christ climbed on the day of his death. The stairs were brought to Rome by Helena, the mother of Emperor Constantine in the fourth century. Pilgrims climbing the twenty-eight steps can be glimpsed through small glass windows that supposedly reveal actual drops of Christ's blood (Baglio 2009:77-78). The Roman Catholic Church has a long association with exorcism.

For thirty-six years the monk, Father Candido Amantini, performed exorcisms at the Scala Sancta until he died in 1992. He was regarded as a holy man, an advanced exorcist. Father Candido had an open-door policy for those in need of exorcism. He tried to at least give them a simple blessing or even a reassuring pat on the shoulder. Baglio (2009) points out that some exorcists are known to have a special "gift" for healing or discernment, which is the ability to uncover the presence of a spirit. These gifts, called "charisms", are said to be distributed by the Holy Spirit to those who live devoted lives. Father Candido Amantini was an exorcist who lived such a devoted life. Supposedly, Father Candido could identify the presence of demonic possession simply by looking at a person's photo (Baglio 2009:82-83).

Lay people may also receive charisms. Some exorcists are gifted lay people who, in prayer teams, help others through their gift of discernment. The Second Vatican Council acknowledges the existence of these gifts but recommends caution (Baglio 2009:83):

> These charismatic gifts, whether they be the most outstanding or more simple and widely diffused, are to be received with thanksgiving and consolation … still, extraordinary gifts are not to be rashly sought after … in any case, judgment as to their genuineness and proper use belongs to those who preside over the church and to whose special competence it belongs, not

> indeed to extinguish the spirit, but to test all things and hold fast to that which is good.

Father Carmine's experiences with exorcisms changed his life. Baglio (2009:83) quotes him as follows: "I saw horrible things, he says. At one point during the exorcism, as the girl thrashed and screamed, her normally closed eyes I could see the hate, such pure hate that it hurt me very deeply." During the exorcism, he and his fellow seminarian also felt mysterious blows on their shins, as if someone standing in front of them had kicked them, yet no one was near (Baglio 2009:84). Eventually, towards the end of the exorcism, the girl began to vomit human sperm, accompanied by a stench that nearly forced Father Carmine out of the room. "I was scared to death, shocked," he says: "I realised that demons do exist, that the Devil is not that puppet with the horns that we see in comic books and laugh about. I had to reverse all my theological concepts which up to until that point was very superficial. I became aware that we are all under the threat of this enemy" (Baglio 2009:84).

Father Carmine was instructed by Father Candido's as to the qualities an exorcist should have. He has to try to live an evangelical, virtuous life, a life of prayer; he has to have knowledge, meaning that he has to study theology, the Bible. He also has to have experience. Exorcists should be respectful in their ministry of assistance for those who suffer. Father Carmine began performing exorcisms in 1987 (see Baglio, 2009:84-85). Exorcists, he said, study people's eyes, as they are the "windows to the soul". One of Father Carmine's criteria from discerning possession was whether the sufferer was able to look the exorcist in the eyes or not (Bagilo 2009:88). According to the Shepherd of Hermas (see Curtin 2018:27), every person has two angels close by: the angel of holiness and the angel of perversion. The challenge is to recognize the workings of these two since they both dwell within a person.

Rituals of exorcism vary from a more spiritual laying-on of hands by a clairvoyant exorcist, taking the entity into his or her own body and then expelling it, to the formal procedure outlined in the Catholic *Rituale Romanum*, a bad interpretation or practice of it, might add to a person's pain by making an existing condition worse.

The guidelines set forth in the *Ritual* clearly state that "the exorcist should not proceed to celebrate the rite of exorcism unless he has discovered to this moral certainty that the one to be exorcised is in actual fact possessed by demonic power".

In order to do so, the exorcist “must, above all, exercise necessary and extreme circumspection and carefulness. He must not be too ready to believe that someone tormented by some illness, especially mental illness, is a victim of demonic possession, [nor] should he immediately believe that possession is present as soon as someone asserts that he or she is in a special way tempted by the Devil, abandoned, or indeed tormented, for people can be deceived by their own imagination” (Baglio 2009:101). The discernment of spirit is far more than just an educated guess, not to be confused with intuition. According to Sicilian exorcist, Father Matteo Grua, discernment is one of the gifts that God gives to the faithful. It is like a *holy ligh*t that comes from God and which allows those who receive it “to see how God is present in things” (Baglio 2009:101). The Bible lists discernment as one of the nine spiritual manifestations, or gifts of the Holy Spirit, mentioned by Paul (I Cor 12:8-10).

The practice of discerning spirits has a long history in the Christian tradition. For mystics such as Ignatius of Loyola, it was a way to understand the impulses of the soul which, he claimed, was influenced by either good angels who desired the soul to be filled with “faith, hope, love and all interior joy that invites and attracts to what is heavenly”, or by demons who strive to impede the soul’s spiritual advancement with temptations of sin and desperation. Demons often disguise their attacks, sometimes even appearing as “angels of light” (Baglio 2009:101). The best way to differentiate between them, according to Ignatius, is to examine the result of the action. If the message is one that will lead to selfishness, hate or violence, its origin is evil, and it should be resisted. However, if the result is for good, then the source is God. *The Ritual* gives three signs that indicate the possible presence of a demon: abnormal strength, the ability to speak or understand a previously unknown language, and the knowledge of hidden things (Ferguson 1984:5). Yet even when these things are present, the exorcist should proceed cautiously. During the deliverance the following guidelines should be followed by the exorcist: “These signs can offer some indication, but since [they] are not necessarily [caused by the Devil], attention should be paid to other factors, especially in the realm of the moral and the spiritual, which can in a different way be evidence of diabolic intrusion.” The most common of these is an aversion to the sacred, for example, the inability to pray or say the name of Jesus or Mary, to go to mass, or to receive communion (Ferguson 1984:6). When both the

signs and the aversion to the sacred are apparent, the exorcist suspects that this might be a case of possession.

People seek help from an exorcist for several reasons. Relatives or siblings who know the sufferer and attribute the problems their loved one is experiencing to the intervention of devil are one such category. Many people who think they need the help of an exorcist in fact do not. Bagilo (2009:118) points out that much damage is done by well-meaning but overzealous people who convince others that they are possessed when this is not the case. This is particularly a problem in African contexts. Also in South Africa, which is the context of this investigation, spiritualism in all its forms is taking its toll. “Deliverance ministries” in some Charismatic or Pentecostal churches are done by people who lack of proper understanding or training and biblical theology on exorcism and demonic possession. Bagilo (2009:118) relates the following:

> One exorcist was visited by a parishioner convinced that her daughter’s problems were caused by an evil spirit. She’d gone to see a “ghost whisperer” who told the woman that indeed her daughter was suffering from a curse that could be removed for $1000. Upon hearing that there was an exorcist in diocese, the woman took her daughter to see him and after an initial interview, the exorcist uncovered a history of mental illness in the family, so advised the women to take her daughter was suffering from a demonic attack. The mother, however, was unconvinced and returned to the ghost whisperer and paid to have the curse removed.

Some mental illnesses can be mistaken for demonic possession. For this reason, exorcists should insist on a full psychiatric evaluation before proceeding (Klass 2003:39). The focus of this study is on how collaboration between clinicians, clergy and spiritual healers can benefit people who suffer. If a demonic presence is suspected, an exorcist can utilize the expertise of a team of professionals such as a psychiatrist, psychologist and even a neurologist to assist with the process of discernment (Martin 1992:17-18). This, however, will only be possible if the medical practitioner is open to the possibility of demonic possession or obsession (Martin 1992:18). Lynn (2005) puts it as follows: “The role of the psychiatrist is to make sure that these phenomena don’t have a natural explanation before jumping to a preternatural or supernatural on exorcism” (Lynn 2005:68). The aim of the study is to

explore from a pastoral perspective, the process of discerning what the actual problem is and of finding an appropriate solution.

Some people consult an exorcist because they are seeking attention rather than because they have a specific problem. This category is known as “pseudo-possession”. People who are faking, generally depict the evil spirit in a banal and superficial way. In cases where the possession is authentic the evil spirit or demon will manifest an understanding of theology and Church doctrine (Vaughn-Coaxum et al 2016). Some exorcists have techniques for weeding out cases of pseudo-possession. The exorcist will, for example, use regular water instead of holy water, or even read Latin prose out of a text instead of reciting a prayer, to see whether the person responds. A demon should not react to this because the objects are not sacred. If the person for instance states that the water is burning him or her, the exorcist knows the possession is fake. Only in extremely rare instances are people indeed suffering from some form of demonic attack (Tang et al 2016).

During the interview, the priest will usually ask the troubled people about their lives and when their problems started. The exorcist could suspect possession if it emerges that the person was dabbling in the occult of had visited magicians or card-readers (Osterreich 1966:5). Any physical symptoms are carefully examined. “I can draw conclusions from a certain behaviour that makes me suspicious,” explains father Carmine (see Bagilo 2009:104). “For instance, when someone doesn’t want to enter my office, when they have a look of hate, or when they don’t look at my face – little attitudes that with experience make me think, ouch, ouch ouch.” People do not usually attribute their problems to a demon. Instead, they typically go to several doctors and come away with several diagnoses, as did Dube’s family. It is only after having been persuaded by a friend or family member that they concede to consult an exorcist. Father Bamonte (see Bagilo 2009:104-105) explains it as follows: “This is one characteristic of a true possession: people seldom think they are possessed but attribute their problems to some other cause.”

Two areas, most commonly affected by evil influences are the head and stomach, resulting in terrible pains accompanied by the desire to vomit. Victims may also feel intense pain in other parts of their body, such as the kidneys or joints. The pain will then migrate, perhaps affecting their arm or neck the following day. Medicine has no

effect whatsoever (Roman Ritual 1964). According to Father Amoth, “one of the determining factors in the recognition of diabolic possession is the inefficacy of medicines, while blessings prove very efficacious” (Bagilo 2009:106). The person may also experience temporary numbness, or excessive hair loss.

Other than these physical symptoms, strange phenomena can also accompany a possession. In addition to intense aversion to the sacred, the sufferer typically has nightmares “so terrible that they don’t even want to go to sleep,” says Father Carmine. Hearing voices and seeing visions or having an urge to commit terrible acts such as murder or suicide, are common afflictions (Allison 1999:87). The sufferer can also be prone to sudden mood changes and experience a deep depression. Some believe they can also sense evil in people or know other people’s sins (Walker 1981:19). The presence of foul odours is another indicator, including the smell of sulphur filling the room (Walker 1981:20), as well as the temperature in the room dropping. During the interview, if the exorcist suspects something, he or she can conduct a simple service for blessing, such as: “Let us pray that Holy Spirit can come upon us to guide us through this process.” An exorcist can also pray surreptitiously in his or her mind while listening to the participant’s story (Ferrari 1997:15).

To determine whether a girl was possessed, father Nanni once said a prayer in his mind in French (see Baglio 2009:88). Immediately the girl who was sitting about ten feet away and with her back to him, spun around and her eyes rolled, revealing the whites. The, looking directly at him, she sneered in Italian: it is useless that you pray in that language because we know them all (Nanni 2004:35). In conjunction with the other symptoms, a negative reaction to a blessing or silent prayer during the interview process, is an indication that it would be appropriate to begin an exorcism.

Since some demons are stronger than others, meaning they can resist a simple prayer, some exorcists, claim that the only way to unmask the demon is by performing an exorcism (Nanni 2004:35). Because of the expressive nature of exorcism, however, the majority of exorcists’ frown on the practice of using the rite itself as a tool. Most demons will manifest with a simple prayer. There is no need to pray the whole Ritual. *The Ritual* should not be used as a tool (Langley 1980:226).

In the most difficult cases the person could be suffering from both mental illness and demonic possession. The demon’s presence can be masked by creating symptoms

that mimic mental illness. This is especially true in the cases of possession in which the demon attacks the victim's mind (Langley 1980:226). According to Father Bamonte, there are cases in which possession has an origin of pathology. Other cases in which the origin demonic, little obsessive thoughts and compulsive behaviours that can be innocuous and controllable, suddenly become invasive, insistent and continuous, heavily disturbing the psyche of the person (see Langley 1980:227).

A rule of thumb, according to Penny et al (1994), is that if the cause is natural, then the patient's condition will not improve dramatically with prayer. If the cause is demonic, however, a person's condition should improve after a visit to the exorcist. The person can then continue to seek the help of a doctor even after the exorcism (Penny et al 1994:627). There are various "natural" explanations for the phenomena that are called "demonic possession" by some. A host of mental illnesses and other psychological motivators can manifest similar symptoms (see Van Slyke 2004:70).

Depression, for example, is in some cases associated with hearing voices, sometimes accompanied by hallucinations and paranoid delusions. A person brought up in a strict religious environment could characterize these "voices" as demonic (Grob and Jeffrey 2006:111). People with bipolar disorder can suffer from paranoid delusions or their mood can fluctuate, sometimes violently so (Peck 1993:10). Likewise, when suffering from Somatization Disorder (SD), what used to be called hysteria, people will typically manifest various physical ailments such as nausea, depression, even hearing loss, with no identifiable physical cause. The subconscious can convince the conscious brain that there is disability when there is not. Those with Obsessive-Compulsive Disorder (OCD) feel tormented by obsessive thoughts or compulsions that compel them to act in ways they know are irrational (Russell, Jeffrey and Alexander 2007:64). Historically, epilepsy, from the Greek for "to seize and carry off", has been associated with spirit possession, as has Gilles de la Tourette's Syndrome, a disease characterized by uncontrollable tics, movements or speech. It is a neurological disorder caused by abnormal electrical activity in the brain (see Lewis 2003:93). Similarly, migraines can be responsible for visual sensations and auditory hallucinations (Baglio 2009) that may have caused accusations Lewis (2003) explains that of possession or beatific visions in the past.

“Disassociation is perhaps the most common way in which a person might feel possessed”. In simple terms, disassociation refers to a variety of behaviours that stem from a lack of cohesive spirit in his or her inner person (Baglio 2009:107-110).

In different societies, the “goal”-directed nature of demonic possession can also change, depending on the social cues that the victim receives. According to Spanos (2003:15), the Catholic exorcism in which the demon is addressed, “produces strongly cued demon self-enactments as a central component of the demon self-enactments as a central component of the demonic role.” Another example would be the person screaming that his skin is burning when the exorcist sprinkles him with holy water (Kelly and Henry 1968:58).

The prayer of exorcism itself is highly suggestive, according to father Gramolazzo. An example is when a priest wields a crucifix while saying: “I command you foul serpent to depart” and the accommodating “victim” would undulate in the manner of a snake. Numerous studies on which McNamara (2011) reflects have shown that, through suggestive methods, people can be convinced that they have experienced events that never took place. In one such study conducted in Italy by Crapanzano and Garrison (2005; see Baglio 2009:112), *Case studies in spirit possession,* people were made to believe that they had witnessed demonic possession or had somehow taken part in an exorcism.

When people go to consult an exorcist there is a role to be played by the sufferer. They either assume that role or they do not agree to be part of it (Beyertein 2009:64). All of this points to the potential pitfalls for a priest, untrained in psychiatric medicine and without the help of trained professional, who has to “diagnose” whether or not a person’s mental illness is caused by the presence of a demon or whether there are psychological causes for the person’s experience and behaviour. While similar traits could be mistaken for conditions that are symptomatic of possession, some more dramatic symptoms related to possession, such as the paranormal or “poltergeist-type” manifestations, are more difficult to explain (Bagilo 2009:113).

In the lore of exorcism, perhaps nothing is as infamous – because it is so spectacular – as the victim who vomits strange objects or copious amounts of fluid, sometimes even blood. A fictitious example is Linda Blairs’s projectile vomit in the film, *The Exorcist*. Another is Father Carmine’s case where the woman vomited sperm during

the exorcism (Baglio 2009:114). Such a phenomenon typically signifies a curse (see Baglio 2009:114). If people vomit objects such as finely woven hair or beads, and even blood clots, it is an indication of a curse as well. In the case of a curse that was imposed by striking a sharp object such as a pin or nail into a Voodoo doll, the victim could, for instance vomit up a nail (see Kelly and Henry 1968:20). According to exorcists these objects do not necessarily come from the person's stomach but materialize in the mouth. The person is therefore not harmed physically (Nanni 2004:24). According to father Nanni, spirits can modify the state of matter, even to the point of provoking "materializations". It is there spiritually. However, the person experiences it physically inside of them – a wasp or scorpion stinging, the pain of a nail. When the person vomits, the object materializes outside the mouth (Baglio 2009:166). Other exorcists have seen things such as pools of mysterious black liquid appearing on the floor, or live animals such as crabs or scorpions are vomited up. Father Carmine once saw woman vomit black saliva. On the other hand, psychotic patients also tend to swallow strange objects and expel them through vomiting. Exorcist should take this into account and not necessarily attribute such vomiting to possession (Langton and Edward 1949:233). If the curse was carried out indirectly, it often turns out that objects from home, such as pillows, when blessed and torn open, reveal strange objects as well, perhaps pieces of metal or bones wrapped in twine, or braided hair. Exorcists who find such objects usually say another blessing and burn them. Some objects, however, do not burn right away but need to be blessed repeatedly before they will ignite.

Demonic possession alternates between periods of calm and "moments" of crisis, when the demon manifests its presence – that is, takes over the person's body and speaks and acts through it. Between crisis moments during periods of calm the sufferer is able to live a quiet normal life.

Typically, the word "possession", has the connotation of an evil spirit dwelling "inside" a person. In the Biblical parable, when the unclean spirit has gone out of a person, it wanders through waterless regions looking for a resting place but finds none. Then it says: "I will return to my house from which I came." When it comes, it finds it empty, swept and put in order. It then goes out and brings along seven other spirits more evil than itself and they enter and live there (Matt.12:43-5). The message of the story is

to warn that, once a person is liberated, the demons could return. It is also an illustration of the belief that demons "reside" inside a person, almost as if the body were a physical home (see Partil et al. 2017). However, as Thomas Aquinas' (2007) writing on *being* and *essence* points out: a spirit does not occupy space. Therefore, when a demon who possesses a person is merely acting on that person. These "inputs" can be variety of things. The person can experience voices or noise, or even have thoughts. Baglio (2009:102) explains it as follows: "In this way, [the demon] tries to solicit the permission of our free will to evil, with the purpose of causing and reinforcing in us a growing dependence on him. The goal is always the same: to drive the person to desperation and isolation, to make him a willing 'slave' to the demon and sin." In the moment of the crisis the demon is there. The prayer of exorcism forces it to be present because it is provoked and forced to reveal itself (Nanni 2004:25). Many people can resolve their crisis state with a prayer of thirty to forty minutes. Fortea (2006) advises that, when the state of crisis begins, the exorcist should keep performing the exorcism until the demon gets tired and detaches itself from the person who is then released from the suffering. Exorcism is like hitting the demon with a bat. It suffers greatly. At the same time, it also causes pain and weakness to the person who is possessed. The demon even admits that it is better off in hell than during an exorcism (Fortea 2006:12).

How a spiritual being can feel pain when being touched with material sacred objects, is a mystery. Davies (1995:45) points out that "there is relationship between the matter and the spirit". When they enter a human body, they are not in one place but all over the body. It is as if they somehow penetrate the matter and as a consequence also suffer (Cuneo 2001:34-35). Augustine refers to spirits as though they have a physical form and Paul refers to spirits of the air. Though air is ethereal, it is still matter (see Gibson 2003:178). For the Roman Catholic Church, sacred objects such as holy water, blessed oil and a crucifix possess power because they carry the blessing of the Church. The object itself has no power. The power lies in Christ who himself has been "placed upon" the object that is used exorcism (Fortea 2006:126).

Exorcists are affected by the intense suffering they see during their ministries. Father Amorth (1999:154; see Baglio 2009:108) puts it as follows: "The strongest and most

lasting impression, for a beginner-exorcist, is encountering a world where suffering of the soul, more than of the body, is the norm". Father Gary was particularly moved by just how personal pain could be. Not only did it touch the individuals, but it affected the lives of their family, loved ones, and friends as well (Allen 1993:96).

Jesus asked for the demon's name when he dealt with the Gerasene demoniac (Mark 5:9). Early exorcists codified this in the 1614 *Roman Ritual. The Ritual* gives the following guidelines: "The exorcist should ask the number and name of the spirits inhabiting the person, the time when they entered into him and the cause". The demon tries to avoid confessing its name, because that would mean defeat (see Amorth 1999:36-37). A demon's name delineates the type of spirit it is. Sometimes the name is purely functional, such as *anger* or *lust*. Sometimes they have recognizable names from the Bible, such as Beelzebub or Asmodeus. Exorcists admit that there is a great deal of mystery to it (Baumeister 1997:84-85). For instance, sometimes the demon Asmodeus is present in several people over whom the same exorcist prays, but the demon does not recognize the exorcist. Sometimes it does happen that an exorcist who prays over a person, even in another part of the world, hears the demon say: "We fought each other five years ago in Jerusalem", referring to a previous exorcism of which the person over whom the exorcist is praying knew nothing (Fortea 2006:128). However, this is rare. An exorcist in Italy, for example, encountered Asmodeus three times in the same week without any acknowledgement from the demon that the exorcist had been recognized. The exorcist asks the demon to identify itself through the *Rite of Deliverance*, though the actual name of the demon is not that important. The name may, for example, signify "the army" of that evil spirit. Lewis (2003:97) explains it as follows: "All that matters is that they give you a name, any name, so long as they respond to it".

Some exorcists, however, prefer not to address the demon at all. Father Dermine, for example, does not even ask for the name of the demon because he does not believe it. He regards demons as liars, so he just continues with prayer as though the demon were not there. A demon sometimes gives a person's name, for example "Adam". There is a debate among exorcists as to whether the soul of a deceased person can intermediate a possession (Baglio 2009:109-111). The more theologically inclined exorcists say that is not possible. A deceased person's soul goes to heaven, hell or

purgatory. For others, for example exorcists who have spent some time in places such as Africa where the belief is widespread, find it possible. Father Nanni (2004) once prayed over a person who claimed to be the soul of a dead mafia boss. He later discovered that the person in question never existed. The demon then confessed that he had been trying to fool the exorcist (Nanni 2004:36).

Though some think that exorcism is a simple and quick procedure, it can last for days on end, until only one is left standing (Gary 2008:38). An American exorcist in Scranton, Pennsylvania, coined the expression “drive-through exorcisms” to describe the approach that the media and Hollywood films have made popular (Gary 2008:38). Many who visit exorcists are therefore looking for a quick fix. According to Father Gramolazzo (2007:147), people often do not understand what exorcism is about. Even a headache is seen as “demonic”. This means that people are not adequately informed. Father Gramolazzo (2007:147) likens exorcism to a journey: the exorcist acts as a “spiritual director” who helps the person to rediscover the grace of God through prayer and the sacraments. This is one of the reasons why exorcists believe that “God allows” people to become possessed in the first place. The goal is that God’ message should be conveyed and accepted. That is also why it often takes so long for people to be liberated. It is a journey of faith for the person, the family and the faith community. To educate people in this regard is not always easy for the exorcist. Baglio (2009:112) puts it as follows: “Half the battle is to change their whole purpose, so they do not see it in the light of getting rid of a problem but see it in the light of being more fully converted or being converted at all” (Baglio 2009:112).

The prayers of the exorcism weaken the power that the demon has over the individual. The healing, however, cannot happen without the full participation of the person (Amoth 2003:28). People who exhibit signs of possession are exhorted to go to confession weekly, to recite the rosary daily, and to receive the Eucharist. Walker is of the opinion that “exorcism is ten per cent of the cure; the remaining ninety per cent is the responsibility of the individual” (Walker 1981:20). There is a need for prayer, the sacrament, to live a life according to the gospel, and to use sacramental water, oil and salt (see Baglio 2009:120). According to Saint Alfonso de Liguori, people do not always get liberation, but they do get relief. People who in the past used to throw themselves on the floor just for a blessing, screaming and yelling, can

after years of exorcisms become calm and resume their personal and professional life (see Liguori 1981:39). Occasionally, they may experience a disturbance and return to the exorcist. People that in the past used to come every day or once a week, after a few years of exorcism may come only once every two months or every six months. In this sense there is a progressive improvement even though not a complete liberation.

According to Roy Baumeister (1997:36), some demons are be more difficult to cast out than others. Various factors play a role. One factor is the duration of the possession. A person who has been plagued since infancy and only seeks the help of an exorcist as an adult will struggle to find liberation since the demon has become a part of the person's identity (Baumeister 1997:36). The strength of the demon is another factor. The most difficult cases involve a curse. Father Carmine explains it as follows: "There remains a connection between the victim and the one who curses. In those cases, it's difficult because it's about the hatred of other people toward the affected person" (Baglio 2009:123). Father Bamonte (2000:123) explains it as follows: "It can happen that when a person who has been possessed for a very long time, gets close to God, he can be hit by a series of bad events. I know this may sound strange, but this is a good sign because it means that the demon is losing; that is why it is reacting likes that. You don't have to be discouraged; it is a good sign. I always say, 'don't fear demon, fear the sin'" (Bamonte 2000:123). When the exorcist prays and performs the ritual for the sufferer to return to God, the power of the exorcism begins to weaken the demon. There are several signs that indicate the demon is close to leaving. The voice becomes weaker during the exocism; that indicates that the sufferer will soon be free. After the exorcism the sufferer's life can be more normal (Nanni 2004:25).

During the deliverance the demon can give a sign that it is leaving. If the person has been put under a "spell", then the demon can indicate that liberation will come when a certain object is vomited. It can also be expelled through the anus or secreted through the skin. Another sign can be the demon says a prayer or recites a hymn to confuse the exorcist (Nanni 2004:27). In certain cases, the exorcist can ask for a sign that is directly connected to the suffering the demon is causing. Father Daniel once asked that a woman become pregnant as a sign of liberation, because the demon

had been preventing it. A month after the woman's liberation she became pregnant – something she had been trying to do unsuccessfully five years (Cuneo 2001:232).

Generally, an outward sign is not necessary, however. "If the person lives in peace, is no longer disturbed by the demon, can pray, and lives in the grace of God, you know she is liberated," explains Father Nanni (2004:29). If the crisis starts again, it means that the liberation was just temporary. As a precaution, many exorcists will therefore continue to pray over people a few times even after they have been liberated.

After the person has been liberated, the demon often tries to return. Exorcists generally offer a prayer of thanksgiving and ask the Holy Spirit to fill the void left by the departing spirit. The newly liberated person should then continue to live a Christian life and not fall back into the habits or sins that caused the possession in the first place. Should they relapse and become possessed again, it is often worse than before (see Matt. 12:43-5). In African cultures the modes of treatment for people who exhibit symptoms of depression are to send them to prayer homes, to visit a witch doctor or an exorcist. Ways to differentiate between depression and demon possession include the following:

- **Demon possession vs. aversion to religion**

According to Waterhouse (2011:57), demons have an aversion to Christ whereas people with Neurobiological Brain Disease (NBD) are often sincerely religious (Luca et al. 2017). Other differences are the following:

- **Irrational speech vs. rational speech**

The speech of the demons are normal and rational, whereas people with depression tend to speak in an irrational and incoherent manner.

- **Ordinary knowledge vs. supernatural knowledge**

Demons speak through people to convey knowledge that otherwise could not have been known to the person affected by the possession, whereas people affected by mental illness have no ability to know facts that they have not acquired through normal learning.

- **Natural vs. occult phenomena**

In cases of demon possession, the environment becomes frightening. It is felt by others who are present with the possessed person. In the case of mental illness only the persons themselves are affect, not bystanders.

- **The claim to be possessed**

Twenge et al. (2016) point out that “people with both clinical experience of mental illness and experience with demon possession find that those who claim to be possessed are very likely not possessed.” Demons wish to be secretive and do not voluntarily claim to be present.

- **Effects of therapy**

Waterhouse (2011:57) points out that “if prayer solves the problem, then it was probably not depression. If medicine helps alleviate the problem, it was not demon possession”.

This chapter aimed to illustrate similarities in the manifestations of spiritual experiences and psychopathology. In order to distinguish between them, it is necessary to ascertain in what way these phenomena are allocated meaning in individuals’ values and belief systems (see Fulford and Jackson 1997). The experiences of depression and of demonic possession will be contextualised by the participants through the interview questions in the following chapter. The literature on demon possession has revealed strikingly similar in forms of manifestation to psychotic symptoms as described in the DSM-V. The participants will describe their experience of depression or demon possession. The literature has made it clear that what seems to be psychotic phenomena, should be understood in terms of the cultural and religious practices of the individual who experiences them. Therefore, an understanding of the experiences of people will be of value to this investigation.

What is experienced and named as “demon possession” also exhibits properties that are distinct from psychosis. This chapter therefore provides an overview of the religious and cultural context in which the manifestations are experienced in order to gain an understanding of the forms that the phenomenon deemed to be “demon possession” can take. Bourguignon (2006:58) describes it as a religious phenomenon that can be distinguished from psychopathology.

CHAPTER 3

EXPERIENCES OF DEPRESSION AND DEMON POSSESSION

3.1 Theoretical framework

3.1.1 Introduction

Three theoretical perspectives form the framework of the investigation. The first is the Hermeneutical Pastoral Approach by Donald Capps (1984). The second the method of Reframing utilised Capps (1990). The third is Positive Deconstruction by Nick Pollard (1997). These approaches will be utilised to explain the differences among groups with regard to the topic of depression. Hermeneutics as an "approach assumes that sequential temporal orderings of human experience into narrative are not just characteristics of human but *make* us human" (Squire et al 2008:43). This chapter presents the empirical part of the investigation. Firstly, a theoretical orientation will be given and secondly, the methodology of this part of the investigation will be described. The purpose of this facet of the investigation is to come to a deeper understanding of how depression among young people and their family members in Soweto is experienced and what meanings are allocated to it. The efficiency of the different methods of coping with depression will be evaluated. The level of the people's knowledge of mental disorders in general and depression specifically, will be ascertained. Soweto is a cosmopolitan city with a large population of young people. The focus of this study is on those young people who are affected by depression and their families, as well as their religious and cultural environment. The interviews questions cover five thematic areas, namely:

- general understandings of depression in the specific context;
- the relation between depression and demon possession;
- the affected young people's perception and understanding of depression;
- a pastoral perspective on depression among young people in Soweto;
- insights from various fields regarding therapy and care.

The aim of this chapter is to reflect on people's experiences and meaning-making processes in a way that it grounded in their history and context (see Squire et al. 2008). In counselling theory reframing has been developed as a method, which makes it and intentional project. The counsellor cannot know in advance what the precise nature of reframing will be, since this will depend on the counselee. However, the counsellor utilises the method and can explain the aims to the counselee. The meaning that any event has for a person depends on the frame in which the event is perceived. When the frame is changed, the meaning changes (Capps 1990:10). When the meaning changes, the person's responses and behaviour also change. This study searches for an inclusive and collaborative model of caring for sufferers of depression where both Western understandings and African understandings of the phenomenon are relevant. In such a context, some form of cooperation among relevant experts, such as psychologists, psychiatrists, social workers, churches and traditional healers is needed in order to reframe current meanings that clash and work against one another, much to the detriment of those who suffer. Such a model will be developed in the following chapter of the study.

3.1.2 Reframing

The idea of reframing is not new. Fables and fairy tales of old often illustrate how insights and behaviour change as meanings change. According to Capps (1990:11), the time-honoured technique of reframing is now widely used in therapy "when a therapist tries to get a client to think about things differently, or see a new point of view, or take other factors into consideration". All of these amount to the reframing of events in order to guide a person to respond differently to the events. Capps utilises the insights of psychologists Paul Watzlawick, John Weakland, and Richard Fisch (1983) in their work, *Change: Principles of problem formation and problem resolution* and applies them to the field of pastoral counselling. Capps (1990:12) explains that "reframing differs in its objectives from every other pastoral care and counselling method in that it is designed to achieve a different kind of change." This study aims to apply the method of reframing in order to achieve collaborative change with regard to depression and the meanings attached to the phenomenon in the context that is investigated. Watzlawick et al. (1983; see Capps (1990:12) identify and explain two kinds of change as following, namely first order and second-order change. First-order

change occurs when a given system remains unchanged and individual change takes place within and unchanged system. Second-order change includes the modification of the system itself. Capps (1990:12) explains the difference as follows:

> A person who is having a nightmare can do many things in the dream – run, hide, fight, jump off a cliff – but no shift from any on these behaviours to another would ever terminate the nightmare. This is first-order change. Second-order change involves a shift from dreaming to waking. Wakening is not a part of the dream but change to an altogether different state: second-order change is a change of change. What occurs in second order change is not merely a shift from stasis to change, but a fundamental alteration in change itself. In first-order change, the more things change, the more they remain the same. In second order change, everything is different because the system itself is no longer the same. There are many situations in life in which first-order change is all we require. When the temperature in the room falls to an uncomfortable level, we can adjust the thermostat until we are comfortable again. More of the same eventuality achieves the desired effect. But in other situations of life, first-order change is insufficient. In these cases, it may become the problem, making matters worse than they were before remedial efforts were tried.

A common approach to the reduction or elimination of a problem is to introduce its opposite as a logical solution. Efforts to deal with the perceived problem by introducing its opposite will only result in a first-order change. Second-order change, on the other hand, is an action that alters the interactional system itself. Collaboration among groups who previously went their separate ways when it comes to helping young people with depression in a systemic context where both sets of meanings and actions are present, represents second order change. The aim is to provide effective, informed, holistic and balanced care and therapy to young people who suffered from depression or demonic possession in Soweto.

Capps (1990:13) points out that there is a difference between “difficulties” and “problems”. Difficulties are a fact of human existence. Some difficulties can be reduced or eliminated, while others are inescapable and must be accepted as the price a human being pays for existing at all. Suffering, evil, and death are difficulties. They are facts of human life. Diseases, oppression, and poverty, on the other hand,

are problems. Problems are situations that are created and maintained through the mismanagement of difficulties. There are basically three ways in which this mismanagement can occur:

A difficulty exists for which action is necessary, but none is taken. This mismanagement is called *simplification*. There are two forms of simplification. One is denial that a difficulty exists, often accompanied by an attack on those who disagree and who believe action should be initiated. The second is to acknowledge that there is small difficulty, but to insist that it may be disposed of by a quick or simple solution. Such mismanagement produces problems that not only fail to reduce or eliminate the difficulty but has its own set of negative effects.

Change is attempted with regard to a difficulty that is either unchangeable or non-existent. In this instance action is taken when it should not be. This kind of mismanagement is called *utopianism*. It too, can take one of two forms. The first is interjective utopianism: a person has deep and painful feelings of personal inadequacy for being unable to reach what are, in fact, unattainable goals (e.g., the goal of perfect happiness). Symptoms of this form of this form of utopianism are depression, dropping out, withdrawal, suicidal thoughts, divorce, alienation, and a nihilistic worldview.

The second is projective utopianism. It is a righteous moral stance based on the conviction of having found the truth and having the responsibility to change the world. The failure to attain a yet again unattainable goal is not a negative reflection on the righteous person, but on those who refuse to share their vision. Symptoms of this form of utopianism are righteous self-justification, paranoia, and the illusion of originality. The belief that one could have the solution to unsolvable difficulties provides the justification to behave in a hostile and uncivil way toward others. The person then becomes paranoid when others condemn them or take their solution lightly. The person finds that their solution is innovative and original. Nothing of this sort has ever been attempted (and failed) in the past.

These two forms of utopianism are similar in one important respect: the premise on which they are based are more real or genuine than reality as we know it. Thus, the idea that we might attain perfect happiness or solve the unsolvable is more real to us than experiential evidence that these goals cannot be achieved.

The point is not that goals should not be set, worked towards, and realised. Goals that are unattainable do not reduce or eliminate difficulties. They rather create problems that did not previously exist. The failure to attain perfect happiness leads to feelings of inadequacy that would not have developed if the impossible goal had not been entertained. By setting goals that require actions by others that they are unlikely to perform, unnecessary and unproductive animosities are created.

The mismanagement of action taken on the wrong level, is called *paradox.* That is when first-order change is attempted where the difficulty can only be changed on a second-order level, or second-order change is attempted when a first-order change would be appropriate. The attempted solutions are inherently paradoxical and incapable of producing second-order change. Instead, they imprison people in first-order change. When the paradoxical nature of these attempted solutions is revealed for what it is – a paradox – then another paradox can be introduced that enables the desired second-order change to occur. In this case, the second paradox has practical or therapeutic effects. Thus, unrecognised or unacknowledged paradoxes usually effects only first-order change, while the self-conscious use of paradox achieves second-order change. Paradox, when used with self-conscious intention, can also effect second-order change.

To “reframe” means, according to Capps (1990:17), “change to a conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the “facts” of the same concrete situation equally well or even better, and thereby changes its entire.” Second-order change effected here has four identifiable features. Second-order change is applied to what, in the first-order perspective, appears to be the solution. From the perspective of second-order change, this solution is the keystone of the problem itself. Instead of viewing the solution as genuine, an implementer of second-order change does something unexpected with it (Capps 1990:17). While first order change always appears to be based on common sense, second order change usually appears odd, uncommon sensical, unworkable, and impractical. Yet, by rejecting the obvious solution because it will only exacerbate the difficulty, paradox is used to shift the problem-solving process from first a first order to a second-order change. Here paradox is used

intentionally, whereas in first-order change, the paradoxical element is largely unreflective or unacknowledged, hidden under the guise of common sense.

Applying second-order change techniques to the proposed solution means that the difficulty is dealt with in the here a now. These techniques deal with effects, not their presumed causes. The crucial issue is what not the “why”. This may appear to be superficial since the reasons for the difficulty are not explored. Focusing on the “why” or a problem need to be discouraged entirely, but it can often result in an unnecessary and unproductive delay in dealing with the problem. So, the objectives of second-order change are most likely to be achieved not by probing deeply into why the situation came to be the way it is, but by coming up with a means to overcome the present impasse, and eliminate the problem, once and for all (Capps 1990:16). The use of second-order change techniques lifts the situation out of the paradox-engendering trap created by the circularity of the attempted solution and places it in a different frame. The key to this shift from unwanted first-order change to the desired second-order change is: *reframing* the situation.

Counselees often expect of counsellors to help them do improve the way in which they carry out whatever it is that they consider the “obvious” solution to be. The therapist whose goal is reframing, does not need to explain the deficiencies of the person’s approach, but can propose another approach. As this approach is based on a paradoxical reversal of the one which has been attempted, it usually makes little sense to the counselee. However, even as the counselee verbally resists this alternative, it has already begun to affect a change in the counselee’s perception of the situation (Capps 1990:18). Watzlawick et al 1973:119 team recommends a simple four-step method for approaching a difficulty or problem:

- Define the difficulty or problem in concrete terms.
- Investigate the solutions attempted so far.
- Define clearly the concrete change to be achieved.
- Formulate and implement a plan to produce this change.

The four steps will now be explained briefly:

Step 1

In the first step, it is important to distinguish between difficulties that have a solution and those that, for all practical purposes, do not. The problem-solving method developed by Watzlawick and his associates does not apply to difficulties for which there is no cure or known relief, such as the death of loved one. Rather than try and "fixt it", these insoluble difficulties are approached with the attitude of: "How can I learn to live with it?" The goal is to define a difficulty or problem in such a way as to ensure that it has one or more potential solutions.

Step 2

The formulation and implementation of a plan to produce the change involves a reversal of the previously tried solutions. Capps (1990:17) puts it as follows: "A careful exploration of these attempts at solutions not only shows what kind of change must not be attempted, but also reveals what maintains the situation that is to be changed and where, therefore, change has to be applied".

Step 3

A clear description of the change to be achieved safeguards against getting caught up in the wrong solution which compounds rather than resolves the difficulty. When, for example, the existing difficulty is considered to be so complex and deep-seated that only extremely complicated and extensive procedures hold any promise of producing change, an impasse is created. The counselee may contribute to this sense of complexity by stating the desired change in seemingly meaningful but in fact useless terms. Achievable change breaks the pattern of frustration caused by attempted solutions that have not produced the desired results.

Step 4

The plan devised to effect the desired change needs to fit the specific case. Every situation is unique, which means that every plan must also be unique. It requires imagination, playfulness. The counsellor may even appear foolish or even frivolous to the counselee, because of the paradox in the problem formation. On the other hand, although imagination and playfulness are often required in devising the plan, the imagination involved is controlled and disciplined. The plan is specific to the situation. It takes account of previous attempts to solve the difficulty. It embraces all the

relevant facts. Failures often result either from setting an unrealistic or inappropriate goal for change, or from encountering difficulty in motivating the counselee to carry out the proposed plan. Desperation is insufficient motivation for enacting the proposed plan. Counselees need to believe that a plan which seems foolish, can actually work. Often the counsellor has to improvise. However, improvisations that change the essence of the plan are discouraged because this is tantamount to sabotaging the therapeutic process itself (see Capps 1990:23).

Techniques are needed in order for reframing to be done successfully (Capps 1990:28). As with any technique it may at first seem unnatural, forced, and contrived. The danger is then to become so preoccupied with the method that the purpose or goal is left behind. However, techniques are indispensable for the accomplishment of tasks. Pastoral care and counselling is a task and therefore involves the use of techniques. The effectiveness of the caregiver will depend, in part, on how skilled techniques are used. Techniques for reframing will be described in this chapter and illustrated through the use of material from the case studies.

The use of paradox is especially helpful in therapy for phobias, compulsions, and unwanted behaviour patterns that are triggered by certain situations. This technique involves encouraging or instructing clients to wish for the very things they fear to happen. When they wish that it will happen, they discover that it does not happen because the wishing and the fearing are two opposites that cancel each other out. The technique of paradoxical intention (Capps 1990:28) has the following elements:

- **Identifying the worldview**

Most people seem unaware of the worldviews they have absorbed, which now underlie their beliefs and values. That is why people rarely articulate a worldview. They usually simply express a belief or live in certain way, without knowing or even thinking about the worldview from which their belief or behaviour derives. The first task of the process of positive deconstruction is to identify the underlying worldview. This requires us to have a grasp of a wide range of worldviews.

- **Analysing the worldview**

Once the worldview is identified, the next process is to analyse it. The question to be asked is: “Is it true?” The three standard philosophical tests of truth, namely coherence, correspondence and the pragmatic tests, are useful.

- **Affirming the truth**

Many people are uncomfortable with the idea that any non-Christian worldview might contain truth. Often the notion that Christianity does not have a monopoly on truth seems threatening. It is easier to believe that others are wrong and that the Christian outlook is totally right. However, worldviews so contain truth which should be embraced.

- **Discovering the error**

When a worldview is analysed by means of the three criteria of truth, the aim is not only to find and affirm truth but also to discover the errors of a particular worldview. Often a worldview is not coherent or does not correspond with reality, or simply does not work, or a combination of these. If the worldview has been identified, it us necessary to analyse what is valuable and should be affirmed and to discover its errors. Only then can people be guided to find this error for themselves. Then they too can become uncomfortable with their current view and change it.

Not all situations in which reframing is indicated in pastoral care and counselling will require a formal plan. Reframing can also be used more incidentally (Capps 1990:18). Reframing should adhere to the conditions of a person’s needs. The best reframes are ones which represent a valid way of looking at the world. Reframing is a hopeful art which builds on the idea that a person can break out of limiting preconception to a broader understanding of human possibilities. It shifts a person’s framework from a negative to a positive one. It achieves one or more of the following goals (Capps 1990:24-25):

- it identifies the motives, needs, desires or intentions of current or past behaviours and labels these positive;

- it discriminates between the motive and self-defeating behaviours so that new and more effective means to satisfy the actual needs of the client can be developed;
- it restructures experience so that new desirable experiences can be created in place of problematic behaviours, feelings and thoughts.

In a similar vein but coming from a different perspective, is the theory of positive deconstruction of Nick Pollard (2008), its purpose being to help people to deconstruct or "take apart" what they believe in order to look carefully at the belief and analyse it. The process is "positive" because this deconstruction is done with a positive goal in mind, namely, to replace it with something better (Polllard 2008:44). The aim of this study is to utilise this approach in order to come to a new understanding of depression and demon possession in an African context which is influenced by both Western and African worldviews and belief systems. The process of positive deconstruction recognizes and affirms the elements of truth to which individuals already hold, but also helps them to discover for themselves the inadequacies of their underlying worldviews. The aim is to bring their new insights into conversation with the gospel of Jesus Christ. The approach will be utilised to elicit a response of cooperation between professional clinicians, clergy and traditional healers as they consider grounds for collaboration though their fields of expertise differ so vastly. The goal is to provide effective care to the sufferers of depression and demon possession in an African urban context where opposing worldviews both have a strong influence. The theory of positive deconstruction also involves the four elements of identifying the worldview(s), analysing it, affirming the elements of truth which it contains, and discovering its errors.

The primary aim of the study is to explore a pastoral perspective on depression among young people in Soweto and how their everyday experiences define and shape their perceptions of themselves and how they believe others perceive them. This study aims at a better understanding of African perspectives on the experience of depression and the phenomenon of demon possession. The analysis of participants' experience of depression and demonic possession will elucidate the social change they have experienced in their lives. Positive deconstruction and

reframing of their stories will point the way forward. In particular, the study explores how the phenomenon of depression among youth in Soweto is understood by professionals such as psychologists, psychiatrists, social workers and caregivers such as Christian clergy and counsellors as well as traditional healers, the custodians of spiritual and cultural beliefs.

3.1.3 Phenomenological approach

A phenomenological epistemology was adopted in collecting and analysing the data. Priority was given to the lived experiences of the participants through their stories and their own knowledges of their reality. Fay (1996:20) explains it as follows: “Knowing an experience requires more than simply having it; knowing implies being able to identify, describe and explain”. Through this study the participants were afforded the opportunity to share their personal experiences of depression and demonic possession. Through this I gained insight into their lives and condition. It could be argued that truly understanding the experience of another is an impossible task. Investigators have their own politics and theories, particularly those who are socially positioned so differently to the participants. The meanings that others allocate to their experience is not easily understood. It inevitably requires interpretation by the investigator and this invariable take place in terms of the investigator’s own theoretical, cultural and religious positioning. All of this makes the phenomenological attempt to make sense of other’s experience rather problematic. Sensitivity is needed, and the ability to decipher the meanings they give to their experiences (Fay 1996:28). While I will never grasp the intimacies of how the participants experience their own realities of depression, our various interactions in Soweto where they live and their kindness, frankness and engagement with me in the telling of their stories assisted in me getting to “know” these young people. “Knowing” in this sense is being able to attach meaning to their experiences (Fay 1996).

3.1.4 Hermeneutical approach

The hermeneutical approach is not governed by specific, interrogative interview strategies. As such it cannot guarantee that the accounts of the participants “accurately reflect experience, and that they release ‘truth’ in a pure form untouched

by the assumptions and values of the investigator" (Mama 1995; 2006:81). I was only able to "know" what was related to me and to infer meaning with regard to the participants' experience. This I could only do within the limits of my own system of meaning-making. My position as the investigator in this study was not to question the factual accuracy of the participants' accounts, but rather to accept them as their experience and version of the truth. The value that informs this approach is typically that the investigator should not presume to question the frankness of the account. The person's own account is accepted as most relevant to study because it is meaningful to the teller. What this approach achieves is therefore a reasonably faithful reproduction of whatever assumptions people use to interpret their own experience. Whatever discourses research participants use to position themselves at the time is accepted (Holloway 1989:40). A hermeneutical approach aims to gain an understanding of what events, experiences and feelings mean to the participants, and how these meanings have contributed to their positive deconstruction and reframing of their current condition.

A hermeneutical approach provides a framework for investigating similarities between texts and human action, to reflect on the juncture between the wider historical background in which the participants find themselves, their social and community experience and experiences of their individual lives, terminating in an account of their condition and perceived position in their world (Capps 1984:12). This process of linking individual life stories to wider socio-religious and theological histories, is taken further in the various layers of analysis, particularly though the conceptual or analytic lenses that are brought to bear on the data.

An additional aim of the study was to afford the participants a chance to explore their own deconstructions and reframing their life-stories by creating their own new narratives. I aimed to provide the participants with an opportunity to better understand their condition, as "knowing involves some reflective element which merely having an experience does not require" (Fay 1996:22). The participatory aspect was present in the stage of the gathering of the data, in the hope that the participants would learn as much about themselves as I learnt about them (Fine and Torre 2006). Since most of the power lies in the interpretation and allocation of meaning, and in the analysis, theory-building and in the construction of publications,

participation in data-gathering is a long way removed from power-sharing, but still a major change from the complete exercise of power that has characterised traditional social and psychological study (see Mama 2006: 80). When people lack a critical understanding of their reality, which they do not perceive as interrelating constituent elements of the whole, they cannot truly know that reality. To truly know it, they would have to reverse their starting point: they would need to have a larger vision of the context in order to separate and isolate its constituent elements. By means of this analysis achieve a clearer perception of the whole (Freire 1996:85).

While events were recapitulated in the stories told by the participants, the focus in the interviews and analysis of this study was not on the accuracy of their accounts, but rather on how the participants experienced these proceedings and what they meant to them. Experience-centred study "rests on a phenomenological assumption that experience can, through stories, become part of consciousness and takes a hermeneutic approach to analysing stories aimed at full understanding" (Squire 2008: 41). This form of analysis locates meaning not only in what the interviewee says, but also in the interaction between interviewer and interviewee and the context in which the story is told (Squire 2008:41). With the aim of gaining an understanding of the "meaning" of a hermeneutic, experience-centred study often uses interpretation in order to prompt and recall memories and experiences (Squire 2008:41).

Stories are constructed through interaction with others and within the context of society and culture. Participants were asked to answer a broad introductory question aimed at uncovering their own views and experiences of how they came to be the people they are. Most of them were unable to speak about their lives without being questioned and prompted by me. This resulted in the participants' narratives being largely dialogic as they were formed in conjunction with me. Wengraf (2001:1) cautions that the interview process in research is often too easily believed to provide an insight into psychological, social and religious realities and therefore the participants' fixed or stable understanding of their condition. He argues that an interview provides "data only about a particular study conversation that occurred at a particular time and place" (Wengraft 2001:1).

In addition to this phenomenological objective, my intention was that the participants would have an opportunity to become “conscientized” (Freire 1996:178) and gain access to new systems of meaning-making thereby providing them with an opportunity to construct their narrative identities. Sandino (2010:178) argues that people’s stories not only provide access to their truths and experiences but also “offer us an opportunity to hear the self in the process of becoming through reflective narration” (Sandino 2010:178). In utilising hermeneutic methodology, it is necessary to acknowledge the limitations of the method.

A hermeneutic approach relies on the productive interpretive qualities of language, through which all people make sense of and communicate experience (Capps 1984:42). However, this dependence on language is challenging in that some experiences, particularly experiences with heightened emotional meaning, are difficult to articulate. Frosh (2013:97) argues that what lies beyond language may be as important, or even more important, than the story told. There is a further complication with language in the context of this study in that English is for some the participants a second or third language. The expression of emotive subjects may have been difficult for many to articulate resulting in meanings getting lost in translation. An additional shortcoming of the methodology is that a question interview produces one version of a life among many that could be told to different audiences at different times. This relation of difference would certainly have precluded some narratives, but it is also conceivable that this outsider status of the interviewer could have enabled some descriptions that would be taboo in the participants’ local community.

While hermeneutics as a paradigm continues to be critiqued as being “elusive, contested and indeterminate”, its functions include “an epistemology, a methodological perspective, an antidote to positivist study, a communication mode, a supra-genre a text-type” (Riessman 2008:183). In this study on a pastoral perspective on depression among youth in Soweto, a hermeneutic approach provided the appropriate framework for the participants to be able to reflect on various aspects of depression and demonic possession such as where they

experience belonging and isolation in their lives, how they are socially positioned and how they envisage and imagine their condition going forward.

3.1.5 Grounded Theory approach

Another useful theory for the purposes of this investigation is grounded theory. Originally developed in the 1960s by two leading sociologists, Glazer and Strauss (Creswell 1998:54; Trochim 2001:160), “grounded theory is an inductive research technique. It means that the theory developed from the study is based on or has its roots in the data from which it was derived” (Grove 2005:57). This mode of inductive analysis can be thought of as a theory that is derived from or “grounded” in daily experiences.

Grounded theory aims to conceptualize understanding through using empirical data. In a way, grounded theory involves the process of retrospectively formulating new hypotheses to fit data. This theory or mode of analysis attempts to create a new understanding based on the actual experience and perceptions of the participants from the ground. Strauss and Corbin (1996:73) point out that in grounded theory the researcher does not begin a project with a preconceived theory in mind. Instead, the researcher begins with an area of study that allows theory to emerge from available data. The mental health phenomenon of depression and the cultural religious idea of demonic possession as experienced by youth in Soweto were the focus of the collection of data regarding the relationship between these two ideas no preconceived theories exist.

The grounded theory approach is primarily associated with the analysis of interview transcripts although it can be used with a variety of types of qualitative data. The analysis requires a process of coding and categorizing the data. The goal of the analysis is to develop concepts and theories that capture the meaning contained within the data. The grounded theory approach is inductive in the sense that it seeks to use findings from instances as the basis for developing statements that apply at a general level. The grounded theory approach has become a popular choice of methodology among some theological researchers in recent times. It has been adapted by those engaged in small-scale projects using qualitative data for the study of human interaction, and by those whose research is exploratory and focused on a

setting. Grounded theory has come to mean slightly different things to different people. It has been a tendency, for researchers to adopt and adapt" grounded theory, and to use it selectively for their own purposes" (Hoddy 2018:123). There are, certain basics ideas associated with the grounded theory approach that remain constant. These are pointed out in this chapter. I draw principally on the writings of Hoddy (2018) to explain the use of grounded theory in this study. The focus is on those components of the approach that mark it out as distinctive and constitute its care components, as an approach to social research.

Grounded theory is an approach dedicated to generating theories. In this sense it contrasts with approaches concerned with testing theories and is different from research whose main purpose is to provide descriptive accounts of the subject matter. It is an approach that emphasizes the importance of empirical field work and the need to link any explanation very closely to what happens in practical situations in the real world. According to Kempster and Parry (2011, 2014; see Oliver 2011; Hoddy 2018:4), the approach directly challenges the value of theorising at a high level of abstraction and then doing some empirical work. Theories can rather be developed based on empirical research and gradually build up general theories that emerge from the data. If theories should be grounded, field work should be a fundamental part of the investigation. When a grounded theory approach is adopted, data collection takes place in the field, not only as the starting point of the investigation but throughout. The grounded theory approach is well suited to the needs of four kinds of research: qualitative; exploratory research; studies of human interaction; small-scale research, all of which are applicable to this study.

3.2 Empirical investigation

3.2.1 The participants and the process

Five groups of participants were interviewed. The first group consisted of five young people from Soweto. The second group consisted of six professionals: three psychologists and three psychiatrists. The third group consisted of three social workers. The fourth group consisted of three clergy. The fifth category was that of traditional healer and one person was interviewed. The eighteen participants all volunteered to take part in this study. This probably accounts for the high level of

engagement and enthusiasm that I experienced with both the young people and the professionals. All the young participants were between the ages of 18 and 35 years.

The study involved five groups of participants with whom in-depth interviews were conducted. This resulted in five sets of data. The study was initialised, by meeting the participants as a group and providing them with an introduction to the study and explaining the goal of better understanding depression and demonic possession from an African perspective over against a solely Westerns one. The aim, as explained, was to provide the space for the participants to reflect on the aspects of their personal experience of depression, what they believed was influential in making them the people they were today, both in their own eyes and in the eyes of others. Mama's (2006) caution that where formal interviewing procedures are conducted with set questions it often results in the participants being disempowered, was taken seriously. The aim was to create sufficient space for their own voice to be heard.

The interview consisted of two parts: a biographic part and an in-depth part. In the first part a single question was posed: "What your understanding of depression, all the events and experiences that have been important to you up until now and that have made you into the person that you are today." These uninterrupted interview segments varied markedly between the participants. Some spoke for 30 to 45 minutes and others were not able to speak at all without being prompted. Given that the interviews were conducted in English, the participants' second or third language, this may have hindered some of the participants to express themselves comfortably. In the subsequent in-depth interviews, I asked for explanations and encouraged further conversation on certain issues and events. They explained what depression had done to their lives.

The participants in this study had never before had an opportunity to simply tell their story in this way. As a result, it was often difficult for them to talk about themselves and their condition in great depth without being prompted. The effect was that I was drawn more deeply into the interviewing process. The experience was that they were "sharing" their experiences with me, not necessarily by telling me what I wanted to

hear, but rather making me an integral part of their story. I became the audience for their story and a witness to their experience on depression and demonic possession.

The interviews were semi-structured. The interview questions were informed by the theoretical framework of the study. The in-depth interview is an appropriate data collection technique for grounded theory research. Patton (2002:115) differentiates between the terms data collection method and data collection technique. On the one hand, data collection method refers to the systematic approach to data collection, on the other perspective, data collection technique refers to the art of asking, listening, and interpreting (see Patton 2002:112). This study made use of a specific data collection technique. The aim was to produce utility data from the ground and interpret the data in accordance with the phenomenon. During the process of data collection, a few key principles were observed. Because the aim was to gather in-depth information, rather than numerical or statistical information, the data number of participants was limited.

The data was analysed through the method of grounded theory with the aim to construct substantive theories (Henning 2004:114). The process was guided by the insights of Elder-Avidan (2009:33) who sees “data analysis as a dialogical, descriptive and explanatory, complex process aiming at creating an internal order, and searching for as many alternative explanations as the data allow, by extricating central themes, conceptualising them into core themes and identify typology.” The process of analysing data followed a funnel-like structure (see Harry, Sturges and Klingner 2005:3-13) with the aim to attain a clear description of African depressed youth’s coping mechanisms. Practical theologians, Swinton and Mowat (2006:57) explain the aim as follows: “This analysis is a process of breaking down the data and thematising it in ways which draw out the meaning hidden within the text”. The first step of analysing data in this regard involved a structured interpretation the empirical feedback from the respondents.

Interviews were conducted with persons from an African context who were affected by depression and demonic possession in order to ascertain their perspectives on the matter that is investigated. Five data groups were generated for analysis and interpretation. The first group was the young people in Soweto, the second the

clinicians, the third the social workers, the fourth the clergy and the fifth the traditional healer. The aim of the analysis of this data was to identify and understanding the meanings attached to the experiences described by the participants. Memories of certain occurrences can powerfully affect behaviour, attitudes, and self-concept. When a person encounters a new, unfamiliar life situation, he or she is especially attentive to, and strongly influenced by, what is happening. In the absence of general rules, memories of pinpointed events carry valuable information about how things work in the novel setting (Pillemer 2001:126).

The study process over a period of five years saw significant changes in me, and my own perspective on depression and demonic possession. Having spent most of my ministry in the South African context, my perspectives were very different from what they are now after the research experience. I ascribe a large part of this change to my interactions with the participants. Interacting with the participants and their stories of depression in such an intimate way, enabled me to develop a deeper empathy and understanding of the diverse depressed condition of others. In conjunction with this academic journey, I also travelled a personal journey which afforded me greater understanding of the hermeneutical process.

This study was guided by four key ethical principles: “autonomy, non-maleficence, beneficence and justice” (Wassenaar 2006:65). The first principle, autonomy, “finds expression in most requirements for voluntary informed consent by all study participants” (Wassenaar 2006:67). Participants were invited to take part in the research. The aim and purpose of the study was explained to them. They were required to sign a letter giving their consent to participate (Appendix II). The second principle, non-maleficence, requires that I, as the investigator, “ensure that no harm befalls research participants as a direct or indirect consequence of the research” (Wassenaar 2006:67). My aims were to deal sensitively with the participants through this personal and emotional journey of sharing their experiences. The third principle, beneficence, requires the investigator “to attempt to maximise the benefits that the study will afford to the participants in the research study” (Wassenaar 2006:67). After some time, they participated in an evaluation of the experience which contributed to their self-awareness and self-knowledge and the new knowledge could inform their perspective on depression and demonic possession. In accordance with the fourth

principle, justice, all participants were treated “with fairness and equity during all stages of the study” (Wassenaar 2006:68). I did not have a sense that the participants were telling me what they thought I wanted to hear, rather their experiences of the interviews left me feeling that they had appreciated the opportunity to speak about their condition in a safe space and felt encouraged and inspired by the fact that someone was taking a genuine interest in their experiences.

3.2.2 The interviews

Qualitative researchers are committed to acknowledging multiple realities and the fact that they cannot know at the outset of the research what the issues, perceptions and theory of the research will be. The aim is therefore to let the research “tell its own story” (Stake 1994:239). The primary objective with the interviews with the five groups of people was to ascertain what the experiences of the various groups were and how they allocated meaning to their experiences. Another objective was to ascertain what kind of care and support the young people with depression and their families were receiving from their community and faith community. The clinicians, social workers, clergy and traditional healer were asked about the causes of depression among young African people and how to deal with this condition effectively in an African context.

The responses to the interview questions are presented according to themes and the groups of participants. The five groups were given different sets of questions in order to correlate with their experience regarding depression among young people in Soweto.

Group one: **Young people who currently suffer from depression, or who have done so in the past and their families**

Question 1: Age is between?

Respondent 1: 26-35

Respondent 2: 18-25

Respondent 3: 18-25

Respondent 4: 26-35

Respondent 5: 26-35

Question 2: **What is your gender?**

Respondent 1: Female

Respondent 2: Female

Respondent 3: Male

Respondent 4: Female

Respondent 5: Female

Question 3: **What are your academic qualifications?**

Respondent 1: Degree Holder

Respondent 2: Student

Respondent 3: Diploma holder

Respondent 4: Diploma holder

Respondent 5: Student

Question 4: **What is your career?**

Respondent 1: Financial advisor

Respondent 2: Office manager

Respondent 3: Marketer

Respondent 4: Accountant corporate

Respondent 5: Bookkeeper

Question 5: which denomination do you fellowship?

Respondent 1: Methodist Church of SA

Respondent 2: Holy Jerusalem Church of Repentance

Respondent 3: Methodist

Respondent 4: Anglican Church

Respondent 5: Grace Bible Church, Soweto

Question 6: How do you understand depression in your own words?

Respondent 1: I think it has something to do with chemicals in the brain. When these chemicals lose some balance, it all affects your emotions and your source of belief.

Respondent 2: Its feeling unworthy, lonely, angry. I do not see the world as a happy place to live in anymore.

Respondent 3: To me depression is a state of dispiritedness or despondency – a state where you are detached as a result of being emotionally overwhelmed.

Respondent 4: Depression is when you are feeling sad, when you feel like crying all the time. Mostly you even find people around you make the feeling worse because they don't really understand what is happening to you. You also can't really tell what's happening.

Respondent 5: To me it's a mental illness that makes one feel worthless, you lose your appetite, you are tired all the time and you feel hopeless.

Question 7: How did you come to know that your condition is depression?

Respondent 1: This was diagnosed by the psychologist I visited in order to try to find answers to what I was feeling.

Respondent 2: Immediately after giving birth in 2012.

Respondent 3: The feeling of despondency was constant. I had no desire to get up and do anything. Everything seemed meaningless and a chore. All I wanted to do was to stay secluded and asleep. Life felt meaningless and those around me started to become very worried about me.

Respondent 4: I started realizing that I am sinking into depression, when I feel helpless, when the sadness was taking over, when I could hardly focus, and my daily routines were affected. I could hardly eat, could not concentrate on work and could hardly to get through the day.

Respondent 5: Personally, it started to see when I am engaging with things I have never done before like gambling and drinking alcohol. For me it felt like a new hobby, but it was rather excessive. The therapist pointed out that it was depression.

Question 8: From whom you first seek help when you realised that you were depressed?

Respondent 1: Psychologist

Respondent 2: Psychiatrist

Respondent 3: Social worker

Respondent 4: I spoke to the psychologist and at that time I still couldn't feel any better, then went to counselling with my local pastor.

Respondent 5: I went to psychologist who helped me to deal with what I was going through that time.

Question 9: Briefly describe what having depression is like for you?

Respondent 1: It is a very painful thing; you feel so helpless and worthless. You will feel like no one will ever understand what you are going through.

Respondent 2: It is like a death trap, stuck in a dark hole, trying to shy away from people. I no longer enjoying the things I used to enjoy doing.

Respondent 3: It was like living in a constant state of gloom and sorrow. It was like being in a cold dark place. It was mentally draining, and each day felt like one constant struggle. It was as though my shoulders were very heavy.

Respondent 4: I was feeling hopeless and sad all the time, feeling unworthy, feeling like you have been robbed, something is been taken away from you and you cannot really function normally. Mostly you think of death.

Respondent 5: Having depression for me is like someone who is in a place that has everything anyone could wish for but the person inside does not see nor enjoys it because her normal self is caged. There seems to be no way out. That feeling of hopelessness, dark room where only the affected sees and no one else understands.

Question 10: How long have you been feeling this way?

Respondent 1: 10 years

Respondent 2: 6-10 years

Respondent 3: 11 months

Respondent 4: Luckily in my case it didn't last long. It was a journey of three months and I must say, spiritual guidance played an important role in my recovery.

Respondent 5: For me it was five years in that situation.

Question 11: What do you think may be the cause of your depression?

Respondent 1: I had a difficult experience, when I was younger. I was abused and did not deal with it back then. Keeping it inside was a mistake.

Respondent 2: Rejection from my husband and daughter. They never considered my feelings.

Respondent 3: I think it was the result of my bad break up. I had given all of myself in the relationship that I was in and had lost myself. So, when it ended, I felt that I was all alone. I felt that I had lost the only thing that mattered to me.

Respondent 4: Losing so many things in life causes this. I remember I lost my daughter at birth and the twin brother was a premature baby. I stayed in hospital for weeks. Shortly after that I lost my job. I was retrenched. Then my marriage broke up. I invested all my savings and started a business. I trusted the wrong people and lost the business. To top it all my car got stolen and the insurance couldn't pay it off. All these things happened within a short period of time and I was overwhelmed.

Respondent 5: The causes of my depression were my upbringing and my marriage.

Question 12: Do you see a connection between your condition and demonic possession?

Respondent 1: As a Christian, I see these as two different things. Depression is a medical condition and demonic possession is more a spiritual condition.

Respondent 2: Yes, because when you are depressed you hear that voice that tells you are not worthy and should kill yourself.

Respondent 3: No

Respondent 4: Yes, I strongly believe that when you are depressed, there are demonic forces taking over. There are those voices that keep making you feel worse about your life. You find yourself in that dark place, a dark hole that nobody could understand.

Respondent 5: My condition was never a result of demonic possession because I knew exactly what was troubling me. I could get the right help and was healed.

Question 13: When you feel that you cannot cope where do you go for help?

Respondent 1: I have recently started running. This gave me a new perspective and diverted my focus. Running helps me regain and increase my stamina and energy.

Respondent 2: My spiritual mother, my therapist and my sacred place at home where I meditate and pray.

Respondent 3: There is a support group that I was told about and that is where I go for support.

Respondent 4: Before all these bad things happened to me, I was a light drinker of wine. During this time, I became a heavy drinker of wine. It was the only thing that kept me going, the only thing that would make me feel better at that point.

Respondent 5: I normally go for therapy, read Bible and pray.

Question 14: Other than speak to people, are there other things you do to feel better?

Respondent 1: I have created a support structure for myself. Joining a running club was the best thing.

Respondent 2: Singing gospel songs and doing household chores.

Respondent 3: I listen to music and just worship.

Respondent 4: Yes, there is that one thing, whether it is wrong or not, but it will keep you moving. In my case it is alcohol.

Respondent 5: I read, pray, exercise and do things that makes me happy, like shopping or holidays.

Question 15: Describe the emotional support you receive from family members, friends, your clergy, or traditional healer?

Respondent 1: My husband has been a pillar of support and strength. I have friends who also have been through depression. We always try to be there for each other as best we can.

Respondent 2: My spiritual mother emphasises that I can speak to God about anything, any time. God has also connected me to my therapist who has also brought light into my life.

Respondent 3: Family members have been very supportive and understanding. My friends also journey with me. They go to my support sessions with me. Having worked on my relationship with both family and friends, that helped me find meaning

in my life and helped me to begin valuing myself. I now feel a sense of connection to those around me.

Respondent 4: No, unfortunately I haven't really come across anyone, but I would hear testimony of people who became healed from depression just like myself.

Respondent 5: Family love and support and caring.

Group two: Professionals: Psychologists and psychiatrists

- **Psychologists**

Question 1: What is your gender?

Respondent 1: Female

Respondent 2: Female

Respondent 3: Female

Question 2: What is your occupation?

Respondent 1: Intern clinical psychologist

Respondent 2: Principal clinical psychologist

Respondent 3: Clinical psychologists

Question 3: In your opinion what is the root cause of depression among youth in Soweto?

Respondent 1: It may be because of social isolation, academic problems or pressure, low self-esteem, poor body image and behaviours like using drugs and alcohol. There may also be adversities such as traumatic life events and childhood hardships that could have had a negative effect on them.

Respondent 2: There are many possible triggers of depression among the youth. The most noticeable are trauma, academic stress, family dynamics and substance

abuse. In the Soweto region we also have significant poverty that impacts all aspects of the youth life, especially absent parents which means they must fend for themselves. Unemployment has led to youth partaking in negative activities which then impact mood.

Respondent 3: Social factors: unemployment affects the whole family, financial constraints, poor living conditions, poverty, interpersonal issues such as loneliness, social isolation, excessive time spent online vs study time or time spent with people. Bullying, including cyber bullying. Peer pressure: they are from different homes with different incomes. Poor attachment, loss of a loved one. Various forms of abuse and neglect. Parental / family relational problems, conflict relationships. Some have a genetic predisposition, low self-esteem, lack self-confidence and have poor relationships.

Question 4: What effect does depression have on the young people from Soweto who come to you for professional help?

Respondent 1: Alcohol use, drug abuse, smoking, relation problems, suicidal tendencies. There seem to be high levels of co-morbidity especially in young people. The elders generally do not understand or acknowledge depression as a condition and therefore it often goes unnoticed and is left untreated. Hence many of the youth turn to substances. We also see a high number of attempted suicides due to feelings of helplessness and hopelessness here at the hospital.

Respondent 2: There seem to be high levels of co-morbidity, especially substance abuse. Symptom of depression usually go unnoticed. Hence the youth turn up to substances. We also see a high number of attempted suicides due to feelings of helplessness and hopelessness. There is often family discord and a lack of understanding among siblings. Often depression causes suicidal tendencies in youth. Alcohol use, drug use, smoking, interpersonal difficulties. Other problems are violent behaviour, unemployment and isolation. I have observed self-harm and aggressive or destructive behaviour. Non-fatal suicide attempts, self-harming behaviour, decreased attention and impairment of their overall functioning, decreased self-care, aggression, poor performance of those who are at school.

Respondent 3: There is often family discord due to a lack of understanding of their condition. Low self-esteem, substance abuse, poor academic performance, poor relationships with family and friends, absconding from work or school.

Question 5: What methods of care do you utilize in the clinics and how do you collaborate with other caregivers in the community?

Respondent 1: Therapy, groups, psychiatric referral (medication), family therapy.
In the department of psychology methods are psychological intervention that may be individual, group therapy or family therapy. The regulars are often referred to NGO's such as FAMSA, SANCA and SADA. We also do psychotherapy with individuals, couples and families. We provide parental guidance.

Respondent 2: We offer psychotherapy. We sometimes refer people to NGO's such FAMSA, SANCA and SADA. Most of the time we use methods such as group therapy, referral to psychiatrists so that they can get medication and also family therapy. We do individual therapy, run support groups and provide family support.

Respondent 3: We provide supportive resources such as clinical psychologists. We provide individual, family and group therapy. We also provide emotional support and give education. Some people need to be admitted. We always work in collaboration with other care givers when there is a need for other services.

Question 6: How do you see depression in relation to demon possession?

Respondent 1: I think it depends on a person's belief system. If that is your belief, you will attribute a lot of the symptoms to bring controlled by a demon. Depression could be a result due to medical illness or because of life changes. Chemical imbalance. Cultural perspectives are vital to this community and can therefore not be discounted. We therefore try to also be guided by the family. If the family feels the person needs traditional cleansing as per tradition before or after our clinical intervention. Much depends on the people's religion. Those who are Christians and attend church services seem to draw comfort from that. Some of the clinicians affirm

that there is no relation, between depression and demonic possession. As supported by their clinical standard.

Respondent 2: Cultural perspectives are seen as a vital component in this community. We try also be guided by family. If the family needs traditional cleansing, then we give the option to do so before or after our intervention. I think it depends on a person's belief system. If people believe in demonic possession, they attribute certain phenomena to that. Depression can be due to a chemical imbalance. This would depend on the person's belief system and perspective regarding depression and religion. Depending on culture, background, belief system and subjective experience it might be relevant. It is important to be open to both Western and cultural ideas which thinking about depression or any other psychiatric illness.

Respondent 3: I don't see any relation between depression and demon possession. It is important to listen to the patient's understanding of the seen and unseen. How the family view this, their framework is important. There is a place for this in psychology as it offers an alternate view. Patients are not discouraged from accessing alternate methods of help, be it religious or cultural. It all depends on one's religion, those who are Christian share Bible verses, attend church services. That seems to help them.

Question 7: Do you have any pertinent observations regarding this topic?

Respondent 1: Depression symptoms do not happen at once. The feeling of hopelessness and worthlessness is mostly attributed with not being happy with life. The youth tend to self-harm when they are experiencing depression symptoms. All areas, the biological, cultural, psychological, psychosocial should be looked at.

Respondent 2: People's cultural beliefs must be considered even if it is not your own. Allow families to take up traditional healing if they wish. There must be a balance of working together in psychology and psychiatry or well as culturally.

Respondent 3: The church's pastor and traditional healers need to work together with clinicians. Maybe pastors and traditional healers discourage our patients from taking treatment such as psychotherapy.

- **Psychiatrists**

Question 1: What is your gender?

Respondent 1: Female

Respondent 2: Female

Respondent 3: Male

Question 2: **What is your occupation?**

Respondent 1: Psychiatrist

Respondent 2: Intern Clinical Psychiatrist

Respondent 3: Psychiatrist

Question 3: **In your opinion what the root cause of depression among may be youth in Soweto?**

Respondent 1: Unemployment, interpersonal violence, fragmented family systems, poverty, lack of employment opportunities, family factors and lack of support, HIV which either affects the young person themselves or a caregiver, poor relationships difficulties such as bullying. Poverty, lack of access to basic resources, impaired attachment with caregivers, lack of education and a prevalence to substance abuse and access to drugs.

Respondent 2: Lack of opportunities results in hopelessness. Poverty causes unfulfilled social expectations and conflict. In female patients the striking factors are multiple psychological stressors such as divorce, being a single parent. Some young people or children have to take up the emotional and physical responsibilities in the house. Lack of social support. Families are often not supportive, telling them to be strong and stop using their depression as an excuse.

Respondent 3: In my context the causes are often socio-economic factors, poor family support structures, the disintegration of families, domestic violence and sexual abuse. There is a severe lack of employment opportunities for the youth.

Question 4: What effect does depression have on the young people from Soweto who come to you for professional help?

Respondent 1: Most of the time, young patients that we received in our clinic were displaying symptom such as a decline in academic functioning, social isolation, substance abuse and alcoholism.

Respondent 2: Young people often feel that they are not seen or heard**.** They feel misunderstood**.** It sometimes results in psychosis. This impacts their memory and conception which, in turn, impacts their studies, their occupation, relationships, quality of life, their daily functioning. All of this can result in inappropriate behaviour, substance abuse, self-harm, poor insight and bad judgement and decisions.

Respondent 3: Young people are extremely vulnerable, often demotivated, and many of those who suffer from depression attempt suicide of have suicidal thoughts. They often turn to the use of substances.

Question 5: What methods of care do you utilize in the clinics and how do you collaborate with other caregivers in the community?

Respondent 1: I prescribe antidepressants, if indicated. If necessary, I will refer to a psychologist for psychotherapy.

Respondent 2: Depending on the case I will prescribe antidepressants. As far as collaboration is concerned, I prefer to refer my patients to psychologists. Other methods of care are support groups, individual therapy, art therapy. They are taught coping skills and are educated with regard to mental disorders. They are given emotional support and medication where necessary. Sometimes it is appropriate to involve social workers.

Respondent 3: In our clinic the following are the most used: Psychotherapy, educating them, giving them emotional support and collaborating with the family.

Question 6: **How do you see depression in relation to demon possession?**

Respondent 1: While respecting my patient's religious and cultural beliefs, depression has a neurophysiological basis and I explain this to my patients.

Respondent 2: I have heard of that in some cultures regarding depression, that there is a belief in some form of evil spirits that have invaded the body. Some also believe that depression is a punishment from God bestowed upon those who have sinned. The deepest form of depression is an undeniable sign of demonic possession in some cultures. I think it can also relate to when people try to control their own lives without God's help and then a person loses themselves, negative thoughts takeover and one can get in a very dark depression in which the devil/demon takes over and uses your vulnerabilities against you.

Respondent 3: There is no connection but many of our patients have strong cultural beliefs which need to be heard. But depression is a biological entity.

Question 7: **Do you have any pertinent observations regarding this topic?**

Respondent 1: Parents often first consult with a religious cultural healer. If the treatment prescribed does not have the desired effect or if the depression worsens for example if the patient becomes suicidal or psychotic, then the family may seek a consultation with a medical professional. They are less likely to do the follow-up.

Respondent 2: I have witnessed how patients come into the ward with psychotic features and express that witches and an evil spirit have possessed them. This comes out in auditory and hallucinating delusions. Causes are low socio-economic status, domestic challenges/problems, violence, separated for caregivers, a lack of primary caregivers in the home. At schooling, bullying, learning difficulties with poor support from teachers are a problem. They often feel misunderstood. There is a high number of non-fatal suicide attempts. Some suffer from psychosis, which impacts their memory and concentration. This in turn has a detrimental effect on studies or their occupation, on interpersonal relationships and the quality of their life and daily functioning. This often results in maladaptive behaviour such as substance abuse,

self-harm, risky sexual behaviour. They often show poor insight, bad judgment and make bad decisions. Many are unmotivated, attempt suicide or exhibit self-destructive behaviour. Many have behavioural problems and mood or anxiety disorders.

Depressed marginalized youth tend to get drawn into demonic cults and Satanism. These young people get involved in the cults and are at danger. They get involved in dangerous activities. They are presented to our unit as psychotic which settles as soon as they have been admitted. Patients often first consult with a religious/cultural healer. If the treatment prescribed does not have the desired effect or if the depression worsens, for example if the patient becomes suicidal or psychotic, then the family may seek a consultation with a medical/professional but, they are less likely to come for follow up. It is important to engage in the patient and family's belief system in order to holistically reach patients and to not forget about the medication. Often, rather than address the multiple social ills, medication is given. Depression is a real risk to both children and adolescents in our country. Most of these young people will have no access to treatment due to a severe shortage of services.

Respondent 3: Not really but it is important to engage the patient and family's belief system in order to help them to belief in medication. Depression is under-diagnosed, there needs to be more awareness amongst the community regarding the presentation of depressive symptoms, specifically among adolescents.

Group Three: **Social workers**

Question 1: **What is your gender**

Respondent 1: Female

Respondent 2: Female

Respondent 3: Female

Question 2: **What is your occupation?**

Respondent 1: Social worker (Director)

Respondent 2: Student social worker

Respondent 3: Social worker

Question 3: **In your opinion, may be the root or cause of depression among youth in Soweto?**

Respondent 1: So, if we just look at the past twenty years, because that is how long I have been here at this organization, and when I started, we were working with youth, and I started as a therapist here, so we were working with young people from Soweto. We didn't have offices based in Soweto, so youth from Soweto were brought here to the Parktown offices. I think, just on reflection, a lot of the young people that we worked with at that point in time, I don't think we always made an accurate diagnosis of depression, and a lot of the young people that we worked with came from backgrounds of adversity, so we saw that some of them came from single parent households, many of them actually, and often there was a lack of paternal presence but also a background of poverty and surrounded by a neighbourhood of violence, domestic violence, being exposed to substance abuse, either within the home environment or the immediate facility which they live, so there were many risk factors that these children were exposed to and we attributed a lot of their behaviour to these risk factors but I think some of the manifestations that they demonstrated were the withdrawn behaviour, a lack of interest in activities that they may have enjoyed previously, isolation, some of them becoming overly weepy, losing interest in their school work but also loss of appetite and some of the children we saw were also quite aggressive. I think, when I say that some of the diagnosis or decisions that were made in response to their behaviour were that youth were either identified as oppositional defiant, conduct disorder, anti-social, personality disorder and I do not think that was incorrect but I do not think that it was sufficient that there was a cluster of symptoms that could be attributed to depression as well, and that may not have been addressed or reflected in the actual understanding of the youth that were referred to us so in terms of further address or redress or referrals, I think those young people may have fallen through the cracks for their depression because, often young people are referred to us are from law enforcement agencies or authority figures or from educational institutions when the youth is seen to be bad or mad and when we unpack those layers we actually find a sad young people but I think

somehow, there is a reluctance to directly resort to the diagnosis of depression because I think there's been a stigma around depression and then as you so rightfully say, of course in the African culture depression is not something that is an accepted thing or an accepted diagnosis, people would rather believe in other forms of being inflicted by witchcraft or supernatural forces. I think there is been reluctance around that, of depression, but on reflection, I think a lot of young people that we have worked with have been sufferers of depression and some of them have been trauma induced and I think in some cases it may have been chemical or clinical depression and it is familial and hereditary because of family background but we also need to be aware that a lot of the counsellors and therapists and social workers that we have employed were not trained specifically to work with depression, the focus has been on victims of child abuse, child victims of trauma and working with that so that could, I think, answer the lack of response to depression.

Respondent 2: The sense of not belonging, being rejected, loss, not fitting in or lack of confidence, with the older youth, it could be a lack of employment. With everything that causes imbalance in the person life where they are stressed it easy for them to end up feeling depressed as they only think about the negative thoughts and believe it. They also have mood swings.

Respondent 3: For me many factors can be the cause of depression Some are a mood that is very low. Others can be an imbalance in the brain, feeling sad for a very long time, stressful life events and medical problems.

Question 4: What effects of depression do you observe among the youth of Soweto who come to you for professional help?

Respondent 1: It is what people are going to think: "Will people laugh at me?", "Will they think that I am crazy?" It is a stigma. It is also something that they are unable to understand – why they react in a certain way.

Respondent 2: An example is rejection or a loss. You feel that no one wants you. You have been rejected by maybe your parents, your peers where you do not fit in and they treat you as an outsider, not as part of them. You feel that no one wants you, no one cares, and that it is not worth it to live. Then some can become

withdrawn and not interact with other people. Anger can also cause depression because since you are so angry, you can now become angry with everybody, and you're even pushing the people close to you, who care about you, away. Also, the loss of appetite or eating a lot or sleeping a lot or sleeping less, and also a lot of negative thoughts where you think of all the negative things like: "I'm not worth it, I'm useless, what is the point for me to live." With all these negative thoughts, there is nothing positive that is encouraging them to move forward with life. They want to commit suicide as they do not have a reason to live.

Respondent 3: In our context as social worker symptom that we see all the time are: fatigue, self-harm, academic and social problems, excessive weight gain or loss.

Question 5: **What methods of care do you utilize the most in as social worker specifically, in comparison to those other care givers that you may collaborate with in the community?**

Respondent 1: You need to understand that ours is based on an ecological framework and ecological model of intervention, so we would use maybe a combination of different theoretical models but the one that would stand out is the person-centred in which the client is the centre of the intervention and the focus is on the here and now. So, it is your traditional conventional talk therapy, but we also use alternative mediums of intervention like art therapy, drama therapy, music therapy, with drumming or other musical instruments, but we're also open to cognitive behavioural therapy, group work interventions, family therapy in which we bring in all the family members. It is different strokes for different folks, it is not a one size fits all, it's not a trickle-down phenomenon. We would have to look at each child and each child is unique, they may all be victims of rape, for example, but each child's experience is unique and individual and how they've been supported, how they've dealt with it, how they're managing it in moving forward, how it is impacted their lives, and so obviously your intervention would have to be worked out accordingly, to the individual in question.

The drums that you use sometimes, is there any connection with the drums that Traditional healers (Sangomas) use?

Yes, you raised something very interesting, because if you look at the purpose of the drumming, it's to set the tone of ease, of calming people, of connection, connecting, and establishing repo and it's also to instil a sense of well-being. What does music do to the inner soul, to the psyche? It releases the endorphins, and the serotonin levels are increased or elevated, and the happy hormones feeling a sense of calmness, so I think there's method in this madness, there's a sense of logic for the Sangoma to use it and for somebody that comes from a therapeutic background or a healing background in a psychological sense, I think that the primary objective is the same.

Respondent 2: Counselling. We assist them to weigh other options and with how to deal with the problems that they are facing. At the same time, that is why I like the person-centred approach because it teaches us to allow clients to see what is best for them, as much as we are there and listening, even if we can see that this client, the route their taking is wrong but they believe it's the right one, we just have to agree.

It depends on the age, with the younger ones, it could be play therapy but with older ones we use talk therapy, in which we talk about their thoughts and how they could change them, what they way forward is or what they would like it to be like, mostly we work from the person-centred because they know better than us and they know what they want, so we are just there to assist them.

Can you explain what the person-centred theory is?

It is a theory, something that I am currently learning in a book by John K. Woods entitled, *Carl Rogers' Person-centred Approach: Toward an Understanding of Its Implications* about personal theories, so there are different theories in the book but where I study (at UNISA), we focus on the person-centred theory, not that we ignore the other theories.

Respondent 3: In our profession we often use counselling, trauma debriefing, play therapy and solution focus therapy, activities, praying and attending support group also does help.

Question 6: How do you see depression in relation to demonic possession?

Respondent 1: Depression comparatively to demonic possession is something extra-terrestrial beyond the power and control of a human being. On the other hand, depression as condition is manageable.

Respondent 2: When you study psychology, you are taught that depression is a mental disorder and when you go to religion, there are people that say it is demonic possession, when you consider Sangomas (traditional healers), they would refer to it as a person being bewitched or something related to witchcraft. According to me, I think there is a thin line between depression and demonic possession, from a psychologists' point of view, they would say it is a mental disorder because the person only thinks about all the negative things and then when they say they start hearing voices, those voices that they hear, they say that they are the only ones that hear them, no one else is there to hear them, and that is what will put them into a psychiatric ward to check or asses and say which type of mental disorder they have, but if you go to a more religious point of view, they will use a prayer to say that the person needs to start seeing things in a different way because, depression and bipolar, there is also a thin line between them because most of the behaviour that they show is almost similar because of the things that they see, they are just seeing it from their own point of view which is different from other people and also with bipolar it is the same thing, so that is why I say that there is a thin line between them because if you think of which voices are coming there and how they hear those voices an what they think of those voices.

Respondent 3: Both are treatable using different methods. Depression is more related to the cognitive thinking of a person whereas demonic possession is a supernatural attack.

Question 7: Do you have pertinent observations regarding this topic?

Respondent 1: I think everybody has a perspective on depression, and each school of thought may have their own perspective. Coming from a pastoral view, you may be

coming with the spiritual element of healing, but my understanding would be that it wouldn't be either or, it would be both and, spiritual and therapeutic, bringing in the element of counselling and of course bringing the help from our divine powers, and for me. I think that there is acceptance and belief that diagnosis does exist from the pastoral care, it's not disowning it or denying its existence and presence.

Respondent 2: Yes, I have engaged with certain clients, when I'm dealing with counselling and I can pick up that it is beyond my scope of practice, so I would refer them to a mental institution, but after the assessment.

Respondent 3: I can say not much, but I suggest that a clear understanding of the issues among youth in Soweto to be taken seriously or to be given appropriate attention because it sound to be taught accordingly to some of our clients that visits our facilities in regular basis.

From question 8 to 12 only respondents 1 and 2 were able to participate. The others were urgently called away on duty and were no longer available.

Question 8: How do you collaborate with others when you find that you have limitations in your ability to help?

Respondent 1: We don't have direct contact with traditional healers, but we would leave it to the family to deal with that. It is within their domain of power and control, to seek out what is best for them. They seek whom they feel would be able to assist them. We would not facilitate that. Our mission is to minimize secondary trauma to the young people. Our vision is: "Child abuse no more!" That is where we are and what we focus on. We provide any kind of support and do interventions such as counselling and helping the youth with legal matters. As far as traditional healers are concerned, we have the opportunity to engage with them and to share different perspectives. At no point do we actually deny their role in the lives of families, but at the same time, we haven't actually had any formal agreement to work together.

Respondent 2: I chose the church because the mother is a believer. Not only the mother, I'm also a Christian and I don't believe in traditional healers. I referred her to 'n psychologist because I felt the young person would need something that would calm her down. The psychologist would deal with it, I knew, because I worked with

that young person for a very long time. However, I could see that instead of the child becoming better, she would only be better for few days then she would get worse again. I realised that this is no longer something that I can assist with, so the person should go to the psychologist who will be able to assist her better, also because of the environment that was making her more depressed.

Question 9: What is your position as social workers on traditional healer?

Respondent 1: I think you raised a very important thing because this is not something that we have been privy to often. I think we have been rather isolated. Fortunately, the majority of the team are from the indigenous population groups so they would respect any observations from traditional healer. They would certainly allow families to take charge and either go back to a traditional healer (Sangoma) or a leader of a congregation, wherever they feel that they would get the necessary help. But it is implicit, I don't think it's explicit. There are no protocols for those kinds of interventions or referrals. Referrals are made to psychologists, psychiatrists or any other professional. Those exist in the protocol, but not this. I think it is an omission. It hasn't proven to be a problem, though, because of the implicit understanding that people have due to their background and where they come from. I don't think that people are averse to it in any way. They would embrace it. If I look at the team, I am sure that people would embrace that kind of help, but they will not actually say: "Can you take the young person to an alternative somebody, spiritually or whatever?" Maybe that is a good platform because in our orientation, induction and training we don't ever actually bring in traditional healers. We always speak about our therapeutic intervention and external referrals, but never of traditional healers. However, is not frowned upon. It's something that is accepted.

Respondent 2: I do not believe that much in it. There are people who believe in witchcraft and it works for them, and there are those people who believe in God and we pray, and we see that prayer work for us. So, I would say that we do fight certain spirits that are unknown, which can also come in the form of a dream, in which you find yourself fighting with somebody in a dream.

Question 10: Have you experienced a situation that involves demonic possession?

Respondent 1: In my work here, I have not experienced it, but outside of my work I have. I cannot say I do not believe in it. I do believe that it exists, but it is beyond the scope of my understanding, beyond the scope of my skills and expertise. That is not what I have been trained for. I would not even try and deal with something like that. I say to the people: “Do what you feel is best and seek help if you need to.” I would not be closed to that.

Respondent 2: No, just heard about.

Question 11: What is your understanding of what depression and demonic possession?

Respondent 1: That is something that we never go against: if families feel that their son or daughter is possessed, we are going to consider what they see as solutions in terms of helping them. We say to them: “That is fine, you can go and seek that help.” We rather continue and look at counselling and seek alternative forms of intervention. So, it’s not that we deny people’s beliefs or perceptions or values or cultural beliefs, because if we do that, we will lose them completely. They would not come back. So, it is about going with what they believe, but also keeping the door open for them to return to us.

Respondent 2: According to me, depression is mood disorder that causes a persistent feeling of sadness and loss of interest. Demonic possession is something like a direct action of the Devil, operating on an individual whose own sins had exposed them to this.

Question 12: When would you refer clients to a psychiatrist or psychologist?

Respondent 1: When I feel that it’s outside the scope of my skill and expertise, that I have limitations. We are trained and have some knowledge and experience, but sometimes you also need to concede that you don’t have all the answers and that

other people, other professionals and other healers may be able to assist. I think that is something that one needs to be open to.

Respondent 2: Yes, I would refer them. I remember one of the clients spoke about demonic things. I went to speak to my supervisor, I said: “I have this case that I am struggling with because this young person is talking about strange things.” We called in the mother and asked her about their beliefs at home. One thing about counselling is that you cannot put your belief into the client. You have to also find out about their background and then work from there. Apparently, the mother did go to church, but she said the child does not go to the church that she goes to. Whenever they would be praying at home the young person would walk out and not pray with them. We recommended that the mother take the young person to the church that they attend. We would never say go to a specific church, then you’ll be helped. We say: go to that church that you believe in, let the church people to assist this young person to get better. Another one was suffering from depression. She would hit the wall and cut herself, so we referred her to the psychologist. I am saying, you can refer. If you feel that something is interfering with your beliefs and that you’re struggling with it, then you speak to a colleague who does not mind taking it on. If I do have clients who believes in a traditional healer and there is a traditional healer that they think would work for them and they believe that they should go to see the healer, I will agree that they do that. If it does not work, then I would say in counselling: you weigh all the options. This is what we have to offer.

Personally, I do not believe in traditional healers, but I do respect people who do. I will not even interfere with their beliefs. As much as I do want to change them, it is not my place to force the change. As social workers we are taught to respect clients for who they are, with their beliefs. Whenever we work with them, we do not force our views on them. It has to be from their point of view, since it is their own experiences. At the same time, if it is a conflict with our beliefs, we are allowed to refer to another psychologist or another social worker who will be able to deal with it.

Group four: **Clergy**

Question 1: **What is your gender?**

Respondent 1: Male

Respondent 2: Male

Respondent 3: Male

Question 2: **What are your academic qualifications?**

Respondent 1: Degree

Respondent 2: BTh (Honours) Theology

Respondent 3: Certificate

Question 3: **What are your responsibilities as clergy towards people with depression?**

Respondent 1: The churches are responsible for its members and to take care of them while they are in need. The church plays a significant role among youth in Soweto in general. The church presently acts as the institution which provides pre-marital counselling, camps and seminars for married couples, youth retreats, career seminars, Vocational Bible School for children, organizes tours, Bible studies as well as spiritual care and guidance.

Respondent 2: It is to have a pastoral oversight over the members of our church, teach, minister to young people, preach and offer spiritual retreats.

Respondent 3: Ministering and pastoral care, counselling and teaching.

Question 4: **How would you define "depression"? Is it different to "demonic possession"? In what way?**

Respondent 1: Depression is because of the imbalance of chemicals in the brain. Depression can lead to the feelings of dejection and despondency. Demonic

possession cannot be a psychiatric or medical condition. Demonic possession is more a spiritual challenge.

Respondent 2: I see it as a mental condition or illness that renders a person unable to function well, physically or emotionally. People often have suicidal thoughts and are very tired. I think it is different from being demon possessed. Demonic possession, according my understanding, has to do with external forces or evil spirits that takes control over a person's behaviour. The person then acts out of control and out of character.

Respondent 3: They are related. Depression can start as a challenge due a physical or social problem. It can then proceed to envy or jealousy when the individual sees others mastering their depression. Envy can become toxic and demonic.

Question 5: What measures or support structures have you put in place to help depressed youth in your community?

Respondent 1: We have qualified doctors and professional counsellors in our congregation. The people assist us a great deal in listening and helping depressed youth and others. They also refer those that need more attention to the relevant services.

Respondent 2: In our church we have established a health desk where young people can go and speak with professionals. We have talks and awareness campaigns. That we do to bring about knowledge of the condition.

Respondent 3: We encourage and motivate them through the word of God. We have group motivational and one to one session.

Question 6: What are clergy doing to create awareness among young people in Soweto concerning depression?

Respondent 1: Depression is a serious matter in our community. It is also still an alien concept in most of our black communities. We try to create awareness around this topic and have conversations aimed to empower our people.

Respondent 2: We have talks and programs. We would ask a person to give an account of their journey with their condition. We also invite psychologists in our church to give presentations.

Respondent 3: We keep contact with young people through daily prayer meetings, WhatsApp prayer meetings, WhatsApp quarterly and motivational meetings.

Question 7: **Is the church aware of depression among the youth in Soweto?**

Respondent 1: Yes, we had to deal with high level of suicide in our community. Young people have a lot to navigate these days. The high unemployment rate, poverty, crime, abuse of drugs and physical abuse all play a role and lead to depression.

Respondent 2: Yes, I had to deal with a loss of a youngster through depression. He committed suicide. Another one is in the hospital and is receiving medication for depression. She is responding well.

Respondent 3: I think some churches are aware of what the youth in their communities are going through. There are some awareness campaigns against substance abuse, for tertiary education, against HIV and unemployment.

Question 8: **To what extent do you as church collaborate with other professionals or traditional healers with regard to depression and/or demonic possession? Is there a referral system in place?**

Respondent 1: We have the privilege of having professionals in our church. They help us with members who need help. They also utilise their networks in order to help with this challenge. We also have traditional healers in our church.

Respondent 2: Yes, we do have a referral system. In our data base we have the names of psychiatrists and psychologists we call when we have a case. I do not have contact with the traditional healers.

Respondent 3: I am in touch with other clergy through fraternal structures. I visit other churches for fellowship.

Group five: **Traditional Healers**

Question 1: **What is your academic qualification?**

Respondent 1: Diploma

Question 2: **What is your understanding of depression?**

Respondent 1: Actually, according to me depression is about overthinking something negative. Let's say for instance somebody stole your car and you think about it for the whole day or for the whole week. That puts you in depression because it irritates the mind. Take the example of a person who lies. Stress sticks to a person's mind and requires a person to have mental strength. Now how we do it in traditional healing is we have to call upon the person and sit them down and ask him or her directly what actually happened before you experienced the stress. The person tells their story. Human beings differ

Question 3: **According to you, is there a connection between demonic possession and what is called depression from a Western perspective?**

Respondent 1: No. A demon is something that enters a human being in certain ways, for instance people who dabble in Satanism. Let me put it in this way, I cannot really say where demons come from, but I will sense bad spirits when they make a person behave differently. In some cases, it's not really about demons. It might happen that you as an individual, maybe your parents, were supposed adhere to certain cultural basics, but failed to do so. It is when the ancestors start to react that people say this person has demons. But the person is not really suffering from any demons.

Question 4: **How would you proceed when you provide care to depressed youth in your community of Soweto?**

Respondent 1: When a family brings a depressed young person from my community to me, I start by assessing the case. I consult the ancestors to give direction on the person's condition and on what the type of traditional medicine is needed, as well as the requirements for the rituals that should be prepared for his case. From there, it may depend on what the direction I may be given by the ancestors. The person could be booked in for a number of days for the traditional cleansing or I will need a few more days for preparation and further consultation with the ancestors. So, when such events take place, most Christians – and I do not blame them, I'm never going to blame anyone – believe that a person has inherited demons. But that's not the case. It is because there are certain things that your core family has to comply with first. After having done what they were supposed to do, the behaviour they had before will no longer be there. The most important weapon against depression is communication and sports activities. Programmes for the youth that involve communication and sports will be my focus.

Question 5: **Have you collaborated with clergy or other professionals when a young person with depression has sought out your help?**

Respondent 1: No, my observation is that, they always consult us after they have explored all the other avenues. We are their last resort.

Question 6: **How do you go about providing care to youth with depression or demon possession in your community through your practice?**

Respondent 1: First, I must ascertain what kind of depression he or she has. Once I have done that it is simple for me. If the problem is with the ancestors, I must start there. If the depression is related to the ancestors, there is something we call *Igobongo* in Zulu, it's a mixture of "ancestors muthi". If you want to talk to them, you use that. They can show you that they are hearing you and accept what you are saying. If your ancestors are fast, they can talk to you directly without me. The

reason we do this, is for them to receive instructions and guidance. Some of the ancestors are liars but they won't tell you that. There's a difference between the ancestors and the current generation, the current generation deals with money and the ancestors deal with the truth. They want you to go and find out. We traditional healers are not all the same. Some are jealous. If they see your gift they will try and turn it around. I want to be honest with you, the reason why ancestors are not speaking to us the way they used to before is because there are so many things in Africa that have been destroyed by our own people. We need to change that and understand again that we live in this culture.

Traditionally there is no such thing as demon possession. What we experience is people who appear to be demon possessed while they suffer from setbacks. For instance, a person might look mad or do things which are unusual in the community but when the family conducts traditional cultural rites for that person everything returns to normal.

Question 7: **Is there any collaboration with other practitioners in your community when it comes to depression?**

Respondent 1: The first time I was invited to collaborate with others, I was asked how I heal people who have AIDS. The people who asked were from the government. There were also some psychologists. I told them that my practice is about following what I'm told by my ancestors. I don't do anything beyond that.

Question 8 **How do you communicate with your ancestors?**

Respondent 1: Through dreams

Question 8.1 **Do you have them often?**

Respondent 1: Yes. Today I woke up with some positive dreams, so I had to go and give the message to the particular family to whom the ancestors sent the message.

Question 8.2 **Do the ancestors talk only through dreams?**

Respondent 1: No, it is not always the same. As we are talking now, my ancestors can tell me something. Or they can talk to me through a dream.

Question 8.3 **How do you receiving the message, when the ancestors want to talk to you?**

Respondent 1: There is a sound in my ears, and they tell me that I must look elsewhere. They can write everything on the ground, and I will read it. Then I will tell my clients what the expectations of their ancestors are. Black people been taken out of their roots. It becomes difficult for them to enter into communication through a medium. With Christianity for instance, most black people don't understand Christianity, but we are Christians. We went into Christianity and forgot what we must do as black people. You are Claude Kimpinde. The Kimpinde ancestors want you to be who you are, but not forget them because you are here because of them. Now I don't mind a person being a Christian because Christianity is needed. I say that because I cannot start doing my traditional work without having prayed first. I must. And even after I have done what I did I again have to pray to thank God. I communicate directly with someone who has depression and ask him or her questions. That might bring us to the core of the depression.

Question 8.4 **Why do you say there is no demonic possession?**

Respondent 1: Because I don't believe in demons, regardless of our beliefs about that issue. Some people do believe in the existence of demons. When a person comes in you must be able to differentiate between demons and someone who is possessed by their ancestors who made them that way.

Question 8.5 **When someone steps into your place of practice, how do you know what type of depression they are experiencing?**

Respondent 1: I must feel it first when they come in, or even prior to that I know what they are here for.

Question 8.6 Do you feel just by sound or is something else telling you?

Respondent 1: You said that you are a pastor and being a pastor, you must have a spirit, depending on whether you are gifted, because if you are not gifted then you can't sense what I'm sensing. Let's say a person also wants to become a traditional healer. It requires that people have a call. Do you have a call when you are practising this or not? Most of us don't have a call. These days there are also many reverends who are not called but are just doing it. Maybe you had a call that's why you are a reverend, but your call must be based on your ancestry, that's my advice to you.

3.3 Analysis of empirical data

The following statistics of patients suffering from depression in the Baragwanath Hospital in Soweto are from a period of five years:

- in 2014 there were 53 patients with depression out of 254, which is 36%;
- in 2009 there were 30 patients with depression out of 225 patients, which is 18%,
- in 2015 there were 26 patients with depression out of 139 patients, which is 18%,
- in 2016 there were 12 patients with depression out of 74 patients, which is 19%;
- in 2017 there were 16 patients with depression out of 77, which is 18%;
- in 2018 there were 6 patients with depression out of 41 patients, which is 16%.

This record represents only a small number of families who dared to visit medical professionals with the problem of a family member with depression. There are probably many more who gave up hope without fully understanding the real issue at hand. Dube's case, the responses from the interviews and the statistics from the Baragwanath Hospital psychiatric and psychologic department, are all evidence of the reality of depression among young people in Soweto.

The data gained from the various interviews, as well as insights and statistics from existing research, have shown that more often than not, families are not equipped to

deal with the problem of depression. Some participants have indicated that domestic violence, poverty and other socio-economic factors exacerbate the problems associated with depression – both with regard to contributing to the causes of the young people's condition and as an impediment to creating an optimal environment for the recovery of the young persons.

The purpose of interviews with the first group was gain insight into the perceptions, experiences and understanding of depression of the young sufferers themselves. Results show that a three-quarter majority of the respondents have no in-depth knowledge of the classification and indicators mental disorders. The majority of the participants indicated that they were not biologically related to someone with depression. This can be interpreted in two ways. Firstly, that they could have some superficial knowledge of depression because they know people who suffer with it from the area or they could have heard people speak about the condition. Secondly, it is possible that their lack of knowledge is because people do not want any association with individuals with depression due to stigmatization. The slightest indication of a tainted family lineage would mean social rejection in that community. This would affect marriage alliances between families, for example, and would in general impede social interaction with others.

Most of the participants were familiar with the term "depression", but they have a wide range of understandings of what it entails. This is evident from their responses from the interviews. Some assume that is about have a "split personality", others regard it as a "curse". Some see it as "mental illness" and others have absolutely no idea what the term signifies. Most of the respondents indicated that they were aware of the prevalence of depression among young people in Soweto. However, even clinicians confessed that they sometimes fail to recognize the symptoms of depression in the initial stages. The responses show firstly that depression is present among young people in Soweto and secondly that people, other than clinical professionals, are generally are not well equipped to deal with the reality of either depression or mental illnesses.

Some interviewees indicated that, in their cultures, mental disorders are often still perceived as demonic possession, in other words as the result of some supernatural influence. Where there is a stronger emphasis on supernatural powers, it would be

difficult to identify depression and among young South Africans in Soweto and provide them with the necessary help. This then calls for attention from persons who are involved with matters of healing and fullness of life, such as psychiatrists, psychologists, social workers, pastors and traditional healers to develop a collaborative contextual response to the needs of the young people with depression in Soweto.

Participants articulated the cultural assumption that people who are taken to be demon possessed or victims of witchcraft, are to be treated by a traditional healer. They could consult a prayer warrior, exorcist or go to a prayer home. Symptoms of depression are most commonly attributed to either demon possession or witchcraft. Individuals who start behaving strangely can be suspected of either. In the cultural context there is rarely a suggestion that a medical doctor should be consulted. Three quarters of the participants reported that they had encountered people who were believed to be demon possessed. This could include persons with mental health problems. Less than a quarter responded with a negative, namely that they had never encountered such people.

One of the recommended treatments is to consult a prayer warrior and another is to consult a witch doctor. The witch doctor performs rituals or incantations. Their fee is rather expensive. Other treatments include whipping the people with tree branches and yet another is that the family deposits the person at a prayer home. Some of the respondents were aware of these things, but about half of them were unaware.

Depression often sets in during young adulthood. It is then mostly misdiagnosed as demon possession or being bewitched. The relatives do everything possible to help the sufferer. They are taken to prayer warriors, witch doctors or prayer homes. As time passes without any signs of improvement, they lose hope and accept it as part of their lives. This was evident from responses of participants. Half of them had knowledge of such instances where the suffering person was never healed and the person and the family accepted their condition as part of their lives, whereas 48% of the respondents answered “No”, they had not come across such an instance.

The problem is that not all people who are suspected of being possessed are in fact possessed. In the same vein, not all people suspected of being victims of a curse are indeed a victim of a curse. Demon possession is a common misconception and

explanation in cultural and spiritual term for the psychological and biological condition of depression. Misconceptions result in people not receiving the treatment they need. It is similar to when people are misdiagnosed and receive the wrong treatment in the medical world. In this instance too, collaborative care which includes expertise from the various fields – medical, psychological, psychiatric, social work, pastoral and traditional-cultural – can contribute to avoiding misconceptions that can adversely affect the condition and life of the person who suffers and get them the treatment they need.

The next steps are to explore what can be done in response to this challenge of depression and other mental disorders. This chapter has provided insights with regard to depression among young people in Soweto from a variety of perspectives.

CHAPTER 4

PASTORAL CARE WITH YOUTH WITH DEPRESSION

4.1 Introduction

This chapter aims to craft a pastoral care praxis theory for caring for young people in Soweto who suffer from depression or demon possession, depending on how their condition is diagnosed or designated. The aim is holistic care which attends to the physical, psychological, mental and spiritual aspects of being human. Holistic care requires of clinicians (psychologists and psychiatrics), social workers, clergy and traditional healers to collaborate and coordinate their efforts in order to improve the current framework of care. All persons who need help should be assisted effectively, regardless of their views of depression and demonic possession. There should be a joint effort and collaboration in order to provide them with counselling and care.

4.2 Positive deconstruction and reframing: A paradigm for pastoral care

The pastoral care method that is envisioned here is constructed within a theoretical framework of positive deconstruction and reframing. The primary source of pastoral theological reflection is concrete lived experience within a specific socio-historical context. The experience is that of young people who suffer from depression and the context is the African urban setting of Soweto. In this context, factors that affect these young people's quality of life and mental health include, among others, their struggle for survival, their struggle to be liberated from depression, alcohol abuse, child sexual abuse, unemployment, drug addiction and domestic violence. Deprivation on various levels continues to be the reality of young people in Soweto who suffer from depression. This became clear from the interviews. Another pertinent factor that affects their lives and their experience of depression is the cultural system in which they find themselves. The system includes imposed norms, values and sanctions that often deny their human dignity in society. They are seen as "polluted" people. Their struggle with depression often denies them the possibility to take advantage of economic and educational opportunities to improve their chances of finding a good occupation and make a good living. These young people in Soweto, as do many

others who suffer from depression, struggle to understand their condition. These issues are of concern for pastoral care in the contemporary Soweto context, since they are fundamental to the future well-being not only of the individuals who are affected, but of the community as a whole. Care is a concern of the whole community and specifically also of the whole faith community.

Science and religion have different responses to mental illness and to the phenomenon that is termed “demonic possession”. They have their own approaches and function in different ways. In some respects, their views and actions meet and converge, whereas in other aspects they operate in vastly different ways. Science requires proof and seeks logical explanations for observable phenomena. Religion transcends human experience and understanding. It calls for inner conviction and belief. In history there has been much antipathy and suspicion between them. As time progressed, psychiatry and psychology developed out of mainstream medical science. Their focus was the study of the human mind and the subconscious. For some Christian believers’ psychology and psychiatry were deemed “unchristian”. The great pioneer in the field, Sigmund Freud, was overtly negative about religion. Subsequently, the Christian understanding of mental illnesses was often limited. A better understanding of the relationship between religion/faith and psychology/psychiatry is needed for pastoral caregivers to provide adequate care for Christian believers who suffer from mental illnesses, particularly depression.

This chapter explores the experiences and meanings regarding depression and demon possession of the different groups of participants. The process is “deconstructive” since beliefs are deconstructed, taken apart. The aim is to ascertain how young people with depression are being cared for in their context of Soweto. A similar question would be valid for Africa in general. Give the story of Dube who was plagued by demonic possession at the beginning of this study and the experiences of the young people in Soweto who suffer or suffered from depression and receive medical help, both the African traditional and cultural beliefs with regard to depression and demonic possession and the fields of psychology and psychiatry from the Western world are of consequence. The positive deconstruction approach that will be followed here is “positive” because the deconstruction is done in a positive way. The aim is to replace current views and structures with it with

something better. The aim is not to break down people's structures of beliefs, but it is rather the positive search for truth. Seen through the lens of the pastoral theory of practice of Donald Capps (1990:10), "this is called reframing, changing the frame in which a person perceives events in order to change the meaning. When the meaning changes, the person's responses and behaviours also changes".

Because of the context of the investigation which is an urbanised African environment where traditional values exist alongside modern values and scientific insights, it is necessary to evaluate the interplay between Western perspectives on depression and African views on impaired mental functioning, which includes the label of "demon possession" that is often given to it. The "reframing" of old views and biases will make it possible for clergy, clinicians, social workers and traditional healers to collaborate for the well-being of young African persons who suffer from mental challenges, specifically depression. A reframed approach is necessary for an effective system to be developed in order to benefit young people who suffer from mental illness.

The primary focus is on the lived experience of the young people with depression. Their experiences are related in their stories of struggle, pain, and despair in a context of ongoing violence, injustice and discrimination. However, their reality includes stories of hope, survival and life. Experience is therefore the point of departure for this theological reflection. The danger of operating from the pastoral caregiver's experience as the point of departure is to be avoided. The shift will be made to the experience of the persons and a focus on their actual cultural context (cf. Watkins-Ali et al. 2008:67). In African contexts pastoral caregivers have been known to impose their own values and assumptions on the people for whom they care, rather than trying to understand the subjective meanings the people themselves allocate to their experience. The prevailing model of pastoral care in the Soweto is clerical in nature. In this clerical-based model of pastoral care the danger of imposing the pastoral caregiver's perspective onto the people is significant. Both the experiences and values of the young people and the expertise of clinicians should be sufficiently considered in a broader and more collaborative approach to the problem. Aspects such as the critical needs of the young people regarding survival, liberation

from their depression in interplay with traditional beliefs regarding mental illness are not always dealt with effectively.

With the combination of positive deconstruction and reframing, a liberative model of pastoral theology and care can be constructed. The aim is that young people who suffer from depression in this cultural context can be empowered to become the subjects of their own stories rather than their becoming the objects of projections and/or perspectives formed by other worldviews on depression and demonic possession. The particularities of those experiences should not be ignored. This affirms the relevance of the necessary change in the process of caring for young people in Soweto who suffer from depression. In the envisaged collaborative method of pastoral care, the traditional way of caring can be given its due attention for the sake of providing appropriate caring for sufferers in their African context.

4.3 African theology

African practical theologian and pastoral care specialist, Emmanual Lartey (1999), emphasises that the focus of pastoral theology is on care and the activity of caring. As such, the reflective and expressive activities of pastoral theology have been the sources of interpreting the caring activities of God and of the human communities (Lartey 1999:24). The experiences of the young people from Soweto who struggle with issues such as depression and demonic possession suggest that prevalent theologies have often failed to elucidate the contextual needs of these young people, their families and their communities. They have failed to provide the right theological language and raise pertinent theological questions to critically discern the understanding of Western approaches to what is termed “depression” and traditional African views on what is termed “demon possession”. The historical and existential experiences of depression, which remain the central concern for these young people, are not addressed adequately by these theologies or by the care-giving activities of their human communities (see Leemamol 2010:388). In the traditional model of pastoral theology in the South African context, classical Western theologies and approaches to existential issues have been the sources of interpreting the caring activities of God and of the human communities. These theologies have failed to provide a useful understanding and interpretation of the contextual needs of the

young people who suffer from depression in context of the Soweto community. They have failed to provide theological language and raise pertinent theological questions to critically discern the situational needs of these African people. The historical and existential experiences of depression are not addressed seriously or comprehensively by these theologies.

Classical Western theology, which was salvation focused, conceived of its mission of evangelism in dichotomized spirit/matter categories (Blando et al. 2007). Historical existential concerns and needs were not at the centre of its missionary work. Later, African Christian theology began to focus on traditional, cultural values and belief. In a new paradigm of African pastoral theology, African theology is an important theological resource which will be utilized to interpret the experiences of the young people in the context of Soweto who suffer from depression or have experienced demonic possession. Pastoral theology takes into account the cultural experiences of the young people who suffer from depression. Its aim is their liberation from socio-economic and spiritual bondage. Unlike the classical Western theology that dispossessed African people of their culture by branding it as “heathen” and “evil”, African theology affirms it and utilizes it as an important source for articulating African spirituality and experience of the divine.

African theology also conceives of God in African terms – God as an African God, one who experiences African people’s pain and anguish. When the image of the suffering servant of Isaiah is applied to Jesus whose sufferings on the cross included mockery, contempt and rejection, young African people who suffer can identify with Jesus and see him as “one of them”. African people, just like Jesus, have endured all kinds of suffering and rejection. That had been part of their daily lives. Jesus’ experiences on the cross can be understood in terms of African suffering. On the cross Jesus feels forsaken. This experience is also true for African people who experience themselves as forsaken and abandoned. This is the core of the African people’s experience which is reflected in their inner consciousness. These experiences are the basis of African Christology and form the primary source of African religious knowing. In times of crisis, members of the Soweto Christian community are most likely to turn to their clergy for hope and strength.

African theology can become an important resource for the assessment of the pastoral care needs of African people. It can help pastoral care providers to assess the situation of care seekers in their wider context. Salient themes such as liberation and care will not be seen in either clinical or spiritual terms, but the totality of the human person will be taken into account. African theology can be a resource for understanding the crisis in which these young people find themselves, in between two paradigms and worldviews. It can provide the language for asking the appropriate questions, such as: how are the forces of depression and demonic possession limiting the lives and choices of young people, and: where is God for them in their situation? Do their images of God in their current situation foster a connection with the divine? In their time of suffering, young people who suffer from depression can be empowered by imaging God as an African God, the one who is familiar with pain and despair. African theology can also provide interpretive norms such as liberation and cultural belonging for guiding pastoral care actions with and for young people who suffer from depression in the context of Soweto. Pastoral caregivers who utilize positive deconstruction and reframing should keep asking whether their assessments of the situation and their strategies of intervention serve the greater goal of the young people's liberation from that which has enslaved their lives, be it depression or demonic possession, and whether they are constructively contributing to a sense of belonging in their culture and context.

4.4 Pastoral theological method

In the classical paradigm of pastoral theology and care, theological insights and knowledge drawn primarily from Scripture, systematic theology and other theological traditions were applied to pastoral care situations. Later it was theoretical knowledge of psychology and the practices of psychotherapy that dominated in (American) pastoral care with less regard for the resource of theology in developing theoretical perspectives on the practices of pastoral care (Lartey 2006:123). Contrary to these earlier paradigms, African pastoral theological method is derived from a communal contextual paradigm of pastoral theology and care (see Schwarzbaum and Thomas 2008:21). In this approach, social and cultural contexts are the focus of and a highly relevant resource for pastoral care. Concrete experience forms the point of departure for pastoral theological reflection. From this perspective there follows a critical

engagement with theological and psychological sources of knowledge and their theoretical perspectives and interpretations. Such reflection on pastoral care practices yields new knowledge that makes it possible to revise theological, psychological and cultural interpretations of African experiences so that more effective pastoral care practices can be fashioned to address the contextual problems and challenges of the young people with depression who live in the context of Soweto. This represents a cycle of pastoral praxis (see Ayrookuzhie 2007:33).

For an African pastoral theological method to be developed insights from the fields of African theology, psychology, liberation theology and African cultural studies can be utilized. The aim is to come to a deeper understanding of the problem which has contextual and cultural foundations. Any activity of pastoral care that does not engage the ideologies of the environment and the ways in which they are expressed systemically, has but limited insight into the needs of people in an African context who suffer. These theoretical perspectives guide and shape pastoral care practices.

The tendency to globalise and normalize one's own culture and impose it on the non-dominant culture was particularly evident in the "Eurocentric enterprise that has fuelled centuries of modernity. Such hegemonic attempts were pursued quite overtly in the period of Western expansion, but even now often continue in subtle ways" (Clarke 2001:181). Both the young people with depression in Soweto and their culture at large have been judged and degraded by dominant Western views and practices. African cultures have been labelled as primitive, inexperienced, heathen and therefore incompatible with Christianity. The gods, priests, myths and cultic practices of Africa were assimilated and subordinated in a hierarchical fashion in a in a process of cultural subjugation and denigration (see Ayrookuzhiel 1986:4). The Christian symbol system was identified with God while the African symbol system was suspect. For the God of life to be introduced, the demons of death had to be displaced so that no trace of the old religious and cultural symbols of African spirituality should remain (Clark 2001:181).

The focus of an intercultural paradigm for pastoral care is to create space for people from the underside of history to affirm their culture, experience and identity by

deconstructing the dominant ideologies and narratives that have assumed a normative and hegemonic role in the multicultural South African context of which Soweto represents a microcosm.

4.4.1 Pastoral care functions

In their work, *Pastoral care in historical perspective*, Clebsch and Jaekle (1994) point out that healing, sustaining, guiding and reconciling have been important pastoral functions operative throughout the Christian era (see Keane 2007:32). They identify different historical periods and suggest that in each of the historical period one pastoral function tended to be prominent as the religious, psychological and intellectual arena changed (Valmiki 2003:39). While these traditional pastoral functions will continue to play an important role in ministry, the particular communal contextual needs of the African people require that pastoral functions be expanded to include *liberating*, *empowering* and *nurturing*. Ed Wimberly (2000:74) was among the first pastoral theologians to introduce liberation as one of the goals of pastoral theology. Archie Smith (1982) further develops the liberation theme in his work, *The relational self: Ethics and therapy from a Black Church perspective,* where he develops guidelines for a Black liberation pastoral ministry. Watkins-Ali (2008:121) describes the liberating function as “action, including political activism that works toward the elimination of oppression” (Watkins-Ali 2008:121).

Liberating as a pastoral care function in the context of Soweto involves dismantling the systemic aspect and structure of depression for the realization of full humanness. Liberation of oppressive and depressing systemic forces is the goal and aim of pastoral ministry in an African community. This involves the conscientization of the African people. They must become aware of the many ways in which they have internalized standing ideologies, values and worldviews that limit their abilities and options for change and realization of their full humanness. The process of conscientization can well be facilitated by positive deconstruction and reframing.

The *empowering* function of pastoral care involves a strong advocacy role. This is particularly needed on behalf of young people who suffer from depression in the African context of Soweto because they are caught between cultures and worldviews

while they suffer much and often fail to understand their suffering. With regard to the healing and reconciling functions, H. Oral Brown (2015) in the introduction to his book, *Wounded warriors of time*, describes healing as “binding up the wounds; repairing damage that has been done as the result of disease, infection or invasion; restoring a condition that has been lost”. For the Soweto communities this is only possible when the oppressive dominant Western system and its values has been positively deconstructed and reframed as something that can be compatible with African worldview, culture, thought and spirituality. This is a wider understanding of the healing function of pastoral care in relation to the African people’s contextual experiences of depression.

In the same vein, the *reconciling* function of pastoral care is described by Ed Wimberly (2000:18) as “regenerating broken relationships” which, he cautions, can only be achieved when “hierarchy and unjust relationships are made just and equal”. Thus, the healing and reconciling functions of pastoral care have a broader context than the personal and interpersonal.

4.4.2 Counselling approaches: A historical perspective

Counselling as it emerged as a profession in Western societies, is particularly rooted in American culture (Juris 2001:24). Many of the counselling theories were developed in the latter years of the 20th century. They drew on research in mainstream white Western US culture (Cox 2001:181). Counselling theories and therapies such as the psychoanalytic, behavioural, humanistic, or cognitive-behavioural strains were very much shaped by the Euro-American value system and reflect its mores, customs, philosophies (Clarke 2001:181). Draguns (2008:24; see Derald et al 1996) points out that this makes them “ethnocentric and monocultural.” Trusty et al (2002:6) identify the main values that underlie the counselling enterprise as: optimism, individualism, egalitarianism, the glorification of social mobility and encouragement of personal change. Important variables such as culture, gender, race-ethnicity, socioeconomic status, environment, discrimination, institutional barriers, socialization, person-environment-fit, and the like are largely ignored. These counselling approaches have “focused on understanding human universals and individual characteristics and traits, but neglected understanding the role of shared customs, traditions, values and

beliefs from cultural influences" (Sara et al 2008:4). They have taken an *etic* perspective – from outside the social group. The assumption is that psychological disorders are found in all the cultures and diagnosis as well as treatment will be equally applicable to all cultural contexts. Therefore, there was no need to make the diagnosis or the treatment culture specific (Derald et al 2003:31). Although these approaches purport to be focused on "universal traits" and are therefore to be applicable to all individuals, the theories are in fact embedded in a very specific cultural context (Schwarzbaum and Thomas 1990:4). Therefore, these theories and counselling approaches are not value neutral. When therapists and counsellors apply these theories to people of non-Euro-American values systems, they transmit Euro-American values, and this then becomes a form of cultural oppression (Sue et al 2003:4).

The professions of psychology and counselling have unwittingly perpetuated oppression. Those who differ from the norm were especially disadvantaged (Trusty et al 2002:3-5). These professions have been used as "tools of discrimination and oppression." (Trusty et al 2002:6). Counselling and psychotherapy have done great harm to culturally diverse groups by invalidating their life experiences, by defining their cultural values or differences as deviant and pathological, by denying them culturally appropriate care, and by imposing the values of a dominant culture upon them (Sue and Sue 2003:34). Psychology began as a science that was concerned with individual differences, but it soon was turned into a science about the norms of behaviour and social functioning. Those norms were used to judge those who did not fit in with them (Trusty et al 2002:3-5).

A multicultural approach to counselling aims to deconstruct this by taking two different trajectories: the universal or transcultural counselling approach and the culture-specific counselling model. Clemont Vontress (see Moodley and Walcott 2010) is one pioneer in the field of counselling who has taken a broader and more inclusive *universal* or *transcultural* approach (Fukayama 1990:1). This approach assumes that "existing psychological theories and techniques are robust enough to have universal applicability for ethnic or cultural groups living in the United States" (Gross et al. 1998:26). It emphasizes the "universal elements of counselling that all

cultural groups tend to share. Examples are discrimination, identity development, validation and empowerment, communication, social class differences, acculturation, transference, and countertransference" (Wanda and Lee 2007:7). The universal approach therefore embraces a Western-based counselling theory and its helping strategies. It is applied cross-culturally. It is seen as universally effective. A client-cantered approach is seen to provide all that is necessary for effective counselling with any client, regardless of culture or ethnicity (Fisher et al 1998).

Proponents of the other trajectory, the *culture-centred* approach argue that "counselling and psychotherapy must be practiced within the context of a particular culture" (George at al 2000). According to them, a universal approach to counselling obscures the real problems as well as their origins. In relation to racism such a broad view approach to multicultural counselling "allows dominant cultural group individuals to avoid a focus on themselves or at least a focus on racism in the situation" whereas a more "limited perspective might be better able to explore the possibility of this." It is the task of the counsellor or therapist "to gain cultural expertise about the specific groups they will encounter in their work".

This model of counselling takes the multiple dimensions of identity into account. People are understood at the individual level, at the group level, and at the universal level. At the *individual* level people are understood in terms of their unique biological constitution as well as their unique experiences (Sue and Sue 2004:45). At the *group* level, people's race, gender and ethnicity are recognized. At the *universal* level the focus is on biological or physical characteristics and commonalities or life experiences such as love, sadness, birth and death that are shared by all human beings.

The point of departure of the model is that, historically, the field of counselling and psychotherapy has not paid adequate attention to the identity of people at the group level. Therefore, this model of multicultural competency focuses primarily on the group identity of people, even though it maintains a theoretical position that a holistic approach to understanding people requires that all the three dimensions of identity be recognized in counselling interactions (Sue and Sue 2004:48-49). This model

espouses a broader more active and subjective role for counsellors which includes teaching and advocacy (Sue and Sue 2004:50). This broader role is also espoused in the communal contextual and intercultural paradigm of pastoral care and counselling. Pastoral care and counselling in the communal contextual and intercultural paradigms are not limited to one-to-one counselling but includes a broader socio-political involvement for pastoral care providers. Lartey (1999:2), for example, highlights the need for a more active involvement of pastoral care providers, to include symbolic actions such as protests and marches. Watkins-Ali (2008:13) also envisions an advocacy role for pastoral care providers in African American context. This model underscores that the personal problems of people should be seen in relation to the systems and institutions in which they are embedded. The larger sociocultural context should be understood. Any effective solution is only possible when change is also actively pursued in those systems and structures that contribute to the personal problems. Counselling interactions in the tripartite model of counselling are congruent with the cultural value systems of the clients. This model rests on the following three competencies (Pembroke 2017:73):

- The first competency is for therapists and counsellors to become aware of their assumptions, values, and biases.
- The second competency is for counsellors and therapists to understand and share the worldviews of their clients. Sometimes this may require the therapist engage to educate himself or herself about their cultural background.
- The third competency is appropriate intervention strategies and techniques. For example, counsellors are encouraged to utilize therapeutic interventions that do not violate the cultural norms and practices of people from diverse backgrounds.

The prevailing models of pastoral care in the Soweto context have either degraded indigenous South African cultures or treated them as irrelevant to the goals of the ministry of pastoral care. By ignoring potential cultural resources, the prevailing models have failed to adequately address the issue of depression and demonic possession among young people. The tripartite approach to counselling alerts pastoral care providers to affirm and recover African cultural resources to build a life-

giving psycho-social-spiritual personal and communal identity that facilitates both survival and liberation. The model points out that pastoral care providers should pay attention to much more that the individual particularities of the counselees' experiences. By emphasizing the need for pastoral care providers to be aware of their own biases, assumptions and values, this model reduces the dangers of pastoral care providers from different cultural backgrounds.

4.5 Multicultural pastoral care and liberation

4.5.1 African Psychology

African psychology is another important resource for an African-based intercultural pastoral theology and practice. In the contemporary context of Soweto, the ministry of pastoral care among young people who suffer from depression does not utilize the theoretical perspectives and insights from the discipline of African psychology. It is true that the field of African psychology is new and still evolving. It has yet to make its presence felt among the various disciplines in the broader area of African culture and religion. For the last two decades African theologians have been pointing out the need for an in-depth focus on psychology and the African condition. Strategies are needed to address the specific psychological problems and challenges of this cultural context with its tumultuous history (Paswan 2004:45). From the perspective of African psychology, it is clear that a diverse range of psychological challenges face young people in Soweto who suffer from depression. Many of these are the direct result of the internalization of oppressive messages and cultural behaviours with regard to their condition. Psychological problems include low self-esteem, self-blame, an alienated psyche and internal conflict. On the cultural front they are burdened by misunderstandings with regard to what depression is and how it manifests. They are often labelled and socially ostracized.

Unlike many current psychological theories that tend to see the source of the problem inside the person (Neuger 2006:36), African psychologist Paswan (2004) has shown that the source of the problem is more often than not the oppressive structure of the prevalent system and its irrational definitions of depression. It should be clarified that the psychological problems that the African young people experience

are not “a disability” or “a personality deficiency”, but rather survival adaptations or harmful adjustments to prevailing unhealthy systems. They are generally not given room to understand and accommodate African cultural perspectives and African psychology and embrace the alternative perspectives of traditional beliefs that can provide them with a different orientation.

Most of the literature on psychology, psychopathology and counselling indicates the mid to late 1800s as the time when the academic field of psychology was founded (Johnson 2010:76). However, the earliest form of sophisticated “psychologies” in the West is usually ascribed to Greek philosophers such as Plato, Aristotle and Epicurus (Johnson 2010:77). They were the pioneers of decrypting human nature, vital ills and their reparation, “on the basis of personal experience and severe reflection in light of prior thought” (Johnson 2010:99). Their field of investigation and examination included the “composition and inner structure of human beings – memory, reason, sensation, appetite, motivation, virtues and various forms of human maturation” (Johnson 2010:101).

From the beginning of modern science and till today, the relationship between science and Christianity has been complicated. Christian believers and psychologists were frequently at loggerheads and “have regarded each other with mutual suspicion” (Koteskey 2008:122). Furthermore, some clergy resisted newer findings that put old beliefs into question. A famous example is that when Copernicus proposed that the earth and other planets revolved around the sun, the church insisted that humans as the “crown of God’s creation” are the centre of the universe (Koteskey 2008:123).

Augustine is often seen as the first great Christian psychologist. His understanding of human beings was based on the philosophical tradition inspired by Plato (Johnson 2010:24). Another Christian scholar with a more refined approach than Augustine was Thomas Aquinas who integrated the “best of Augustinian and Aristotelian traditions and produced an influential body of psychological thought, covering the appetites, the will, habits, the virtues and vices, the emotions, memory and the intellect” (Johnson 2010:25).

Since the Middle Ages, many Christian scholars such as “Bernard of Clairvaux, Symeon the New Theologian, Gregory Palamas, Anselm, Bonaventure, Duns Scotus, Walter Hilton, Julian of Norwich, William of Ockham and Thomas á Kempis” began writing on psychological and soul care topics (Johnson 2010:25). After the middle ages, Christian philosophers continued to reason more carefully about the human subject “in works of great psychological significance, including those of René Descartes, John Locke, George Berkley, Thomas Reid, Joseph Butler, Gottfried Leibniz and Blaise Pascal”. Among them were those who have strongly influenced modern psychology as we know it today (see Assari and Caldwel 2018:14). Søren Kierkegaard, possibly the most significant Christian psychology, used the word “psychology” to describe some of his works and also “wrote substantial psychological works during his lifetime” (Johnson 2010:98). In a period of ten years he described the “nature of personhood, sin, anxiety and despair, the unconscious, subjectivity, and human and spiritual development from a deeply Christian perspective” (Kotesky and Johnson 2010: 98).

Psychology has been seen and labelled as hostile to religion, like many of the other sciences. This can be seen in the relationship of Sigmund Freud to religion. However, some psychologists, such as Carl Jung, were “sympathetic towards religion” (Watts 2002:61). Freud’s central theme about religion was that the concept of God develops from the “individual’s experience and psychic needs” which turn out to be potentially productive (Watts 2002:61). Studies such as that of Ana Maria Rizzuto (1979; 2009) indicate that “people’s personal backgrounds can shape their thinking about God” (Watts 2002:62). According to German theologian, Paul Tillich (1952), “Freudian ideas about religion can be taken as providing a cautionary how easily ideas about God can become trapped in limited human conceptions” (Watts 2002:63). Eminent German psychology scholar Carl Gustav Jung (1938:45) explains it as follows:

> Since religion is incontestably one of the earliest and most universal activities of the human kind, it is self-evident that any kind of psychology which touches upon the psychological structure of human personality cannot avoid at least observing the fact that religion is not only a sociological, or historical phenomenon, but also something of considerable personal concern to a great number of individuals.

He describes religion, as the Latin word denotes, as an observation of what Rudolf Otto (1924) called “the numinous”, "that is, a dynamic existence or effect, not caused by an arbitrary act of will” (Jung 2003:66). For Jung, “religion is a peculiar attitude of human kind, which could be formulated in accordance with the original use of the term *religio* that is, a careful consideration and observation of certain dynamic factors, understood to be ‘powers,’ spirits, demons, gods, ideas, ideals or whatever name man has given to such factors as he has found in his world powerful, dangerous or helpful enough to be taken into careful consideration, or grand, beautiful and meaningful enough to be devoutly adored and loved” (Jung 2003:66).

4.5.2 Psychiatry and Christianity

Yochelson (1999:5) describes psychiatry as “that branch of medicine which involves the study of the mind and the prevention and healing of mental disorders” and religion as being about human beings’ “attitude towards God and man and the universe” (Yochelson 1949:26). Therefore, both fields have a common frame which is, humans in relationship (Yochelson 1999: 32). In earlier times, there were no social institutions specifically devoted exclusively either to healing or to science. They were both seen as what can be termed the “religious context” (Klausner 2006:36). Over time science evolved as an independent field alongside religion, followed by medicine as an independent branch of applied science (Klausner 2006:37). The recognition of psychiatry as a speciality within medicine is recent development. Religion also underwent similar differentiation, with the pastoral care office emerging as a specialized ministerial role which otherwise was “intertwined with sacerdotal and educational activities” (Klausner 2006:39).

The later suspicion between science and religion concealed their former common roots. However, each formed and informed the world in which the other lived. The world of theologians was overshadowed by the sciences. Some theologians accepted the growing “scientific revelation of the physical universe and awaited archaeological authentication of Holy history and philosophical insights in Holy Writ” (Klausner 2006 34). Many a scientist had a religious upbringing. Some were the children of ministers. As the twentieth century dawned psychiatry and religion were at times intertwined to some extent, but “there was scant awareness of the roots knotted around one another” (Bleuler 2005:26). Both psychiatry and religion are

popular in their own ways today. Despite the historical origins of this popularity phenomenon, like parallel lines, many had the notion that these two fields are destined “to extend onward with no possibility of a meeting point” (Gassert et al 2004). The words “psychiatry‟ and “religion‟ evoke stereotyped images which “contain facets that are antithetical” (Gassert et al 2004:87). As a result, many Christians have the impression that psychiatry by nature is irreligious which meant that a religious individual has no need for psychiatry (Gassert et al 2004:88).

The growth of psychiatry in the present-day world is phenomenal. No speciality of medicine has been so widely publicized (see Gassert et al 2004). Furthermore, if theories from psychiatry and psychology provide a better understanding of human beings and can develop more effective treatments for conditions such as depression, then the fields should be appreciated (Gassert et al 2004:89). The rise of psychiatry also had an impact on clergy and, in particular, pastoral caregivers. Attempts are sometimes made to counter theoretical insights from psychiatry with theological arguments (Gassert et al 2004:89). Such efforts adversely affect the communication between these two fields. The role of psychiatry is to deepen the understanding of how people grow and change. Yet whenever clinical psychiatry provides new insights about human development, religious people are often the last to avail themselves of this knowledge, One of the main reasons for this is the still “widespread notion that psychiatry is irreligious which has its commencement of distrust between religion and science in general and Freud and religion in particular” (Gassert et al 2004:90). Karl Menninger later clarified that what Freud said was not that religion was a delusion. Religion is like art and music – it can be an illusion (Gassert et al 2004:91) Freud also did not negate religious experience as false or non-existent. However, certain forms and expressions that were developed in the name of religion, were indeed harmful. Biblical figures such as Isaiah, Jeremiah, Micah, Hosea and Jesus also thought that. Empty and harmful forms of religion have been criticized and will continue to be criticized.

Although both science and religion aim to discern truth, they do so in different ways. Psychiatry as a “branch of medical science is free from religious obligation” (Gassert et al 2004:92). Being religious then becomes a personal choice rather than a requirement. So, a religious leader is often asked the question whether a Christian

believer can and should seek psychiatric help or is there a danger that they can lose their faith. For Collins (2997:73) that answer to that is simple: “Not if their faith amounts to anything”. It is not the task of a practising psychiatrist to either build or tear down the faith of patients (Feldman 1997:100).

The dialogue between religion and psychology has been stagnant owing to “lack of sympathetic interest‟ from both the sides. This gap in dialogue is the result of ignorance of the other on both sides (Watts 2002:67). In the past the values of psychology and theology often clashed. “Guilt” is an area where there have been distinct differences. Watts (2002:68) explains that this is because “some people in the Christian tradition emphasizing its value in leading to repentance, but with counselling psychology seeing it as a personal problem”. This conflict can dissipate once the differences between realistic guilt and neurotic guilt is understood (Watts 2002:69).

Another is of suspicion by psychology is the religious *Numinosum* – which refers to either a quality of a visible object or the influence of an invisible presence causing a peculiar alteration of consciousness. A simplistic summary of the mutual suspicion would be the “psychology seems to have placed too much emphasis on the individual” whereas religion tends to focus more on the “social dimension of the gospel” (Watts 2002:69). Some also regard psychology as “explicitly secular”, which leaves no place for religious belief and that “it has its own prejudices and unexamined assumptions” (Watts 2002:70-71). However, a “Christian approach to psychology alongside the currently predominant secular approach” is entirely possible (Watts 2002:70).

4.5.3 Liberation psychology

Although ideas pertaining to liberation were in abundance during the latter part of the twentieth century, liberation psychology was conceived primarily by Ignacio Martín-Baró (2008:27), who was a priest as well as a trained social psychologist (Montero and Sonn 2009:3). He formulated his ideas in an article titled, “Towards a psychology of liberation,” in the *Bulletin of Psychology* published by Central American University in 1986. The article argues for the construction of a new transformative psychological practice for oppressed peoples (Montero and Sonn 2009:3). Martín-Baró (2008:27) outlined three basic tenets of liberation psychology:

- a new goal;
- a new epistemology;
- a new praxis.

The most valuable goal of psychology, according to Martín-Baró (2008), is to focus its theoretical and practical energies on the "needs and suffering of the majorities who are numbed by oppressive life circumstances" (Martin-Baro 2008:28). He argues that there is a link between the individual person's psychological problems and the wider social, political and economic contexts in which their lives are embedded. He intends for psychology to gain clarity in understanding the relationship between psychic and social structures, ideologies and discourses that force people into "marginalized dependency" and "oppressive misery" by taking away "their ability to define their own lives." Fragmentation and apathy reduce people into a state of submission and they no longer expect anything from life (Lester 2003:94). Liberation psychology is amenable to the communal contextual and intercultural model of pastoral care that this study is developing for African communities in general and with regard to the psychological struggles of young people who suffer from depression in the context of Soweto in particular, because such an approach attends to people's historical, cultural and social realities.

Martín-Baró (2008:27) articulates the goals of liberation psychology as that the oppressed require knowledge of what is not yet present in their current state of oppression but will be present in the tomorrow of their liberty. Truth is not to be found but made (Martín-Baró 2008:28). Truth is be constructed, not as "a matter of thinking for them (the poor and oppressed) or bringing them our ideas or solving their problems for them; it has to do with thinking and theorizing with them and for them" (Martín-Baró 2008:28). The communal contextual and intercultural model of pastoral care that this study envisages has a similar goal. Oppressed people are also subjecting of history rather than as mere objects of either history or of pastoral care. The clerically based traditional model of pastoral care has not taken seriously their perspectives or experiences in framing pastoral care practices. Such pastoral care

practices have as yet largely denied people the subjective status that they have and deserve as human beings.

In his quest to develop a new epistemology, Martín-Baró was certainly influenced by Paulo Freire's pedagogy of the oppressed. It should be emphasized that Paulo Freire refers to "pedagogy *of* the oppressed" and not *for* oppressed. The subjectivity of oppressed people is maintained through this language. Ideas from liberation theology are evident: just as liberation theology has underlined the fact that only from the poor is it possible to find the God of life enunciated by Jesus, a psychology of liberation has to learn that only from the oppressed will it be possible to discover and build the existential truth of the Latin American peoples (Payne 2006:19). Martin-Baró is not suggesting that all knowledge be discarded, but rather proposes that existing knowledge be relativized and critically revised from the perspective of the poor and the oppressed (Martin-Baró 2008:29)

4.5.4 Psychology in need of a new praxis

Martín-Baró challenges psychology to a new praxis "to place itself within the process alongside the dominated rather than alongside the dominator" (Martín-Baró 2008:30). It is not easy to leave a role of technocratic or professional superiority and to work hand in hand with community groups. However, if this new type of praxis that transforms people and reality, is not developed, it will be difficult to develop a liberative psychological practice (see Nylund 2003:388). He calls upon the psychologists to take a stand for the oppressed people and make ethical choices. However, the call to take sides when dealing with oppressed people can, for psychologists, social workers or clergy, create an unhealthy and harmful "us or them" dynamic which will not contribute positively to the transformation of communities. Further, such a paradigm also has the potential to replicate the strategies of the dominant and not succeed in breaking the cycle of domination (Payne 2006:19). There is a need to rather work in an integrative and dialogical manner.

4.6 Narrative approach

Narrative therapy is a relatively new approach to counselling developed by Michael White, David Epston and others. The point of departure is that "the basic process by which people understand the experiences of their own lives and those of others is the

narrative" (Holland 2001:1). In this context "narrative" means "an account of an event or events". It can refer to storytelling as well as to the story itself (Payne 2006:19). A person's "self-story" is a first-person narrative through which persons define who they are. This is based on their memories of history, their present life, their roles in various social and personal settings, and their relationships (Payne 2006:19).

Narrative therapy is informed by postmodern thinking, which sets it apart from traditional approaches to counselling and therapeutic practices. David and Debora Nylund (2003:389) explain that traditional therapies that are often informed by positivism and/or liberal humanism, assume that the therapist can be objective in identifying problems, discovering their causes and making "interventions" to improve the lives of clients. From this perspective problems such as depression, anxiety, or abuse are typically described as individual pathologies that can be attributed to specific conditions. However, from a postmodern perspective, objective knowledge is not possible. Rather people's immediate, day-to-day, concrete personal experience of their lives are primarily knowable. This is expressed through the stories that are told to others and themselves about their lives (Nylund and Nylund 2003:389).

In narrative therapy the therapist shifts his/her focus from the inside the human person to the human person as embedded in their sociocultural milieu. Narrative therapy is guided by the fundamental philosophical view that people's interpretations and experiences of reality are socially constructed. Social constructionism "invites us to be critical of the idea that our observations of the world unproblematically yield its nature to us, to challenge the view that conventional knowledge is based upon objective, unbiased observation of the world" (Burr 1995:47). This approach stands in direct opposition to positivism and empiricism, which hold the view that what exists is what human being perceive to exist (Burr 1995:47). In other words, postmodern approaches concede that human perception is a subjective process, and so also is the activity of description and explanation of the world. The interpretation of one's environment, the process of meaning making, occurs through the medium of language. Language is therefore foundational to the construction of the reality.

Both the external interactions with people and internal mental processes are referred to as a “discourse”. Discourses can be seen as systems of meaning, ways of representing oneself and one’s social world. This not only constitutes what people think and say, but also what they feel, desire and do (Burr 1995:47). Discourses are structured narratively. The narrative is the result of a mental process by which the input from the senses is organized into story form. This takes place in relation to a person’s social world, other people and institutions (Gergen 1985:75). People’s interpretation of their environment, their process of meaning making, occurs through the medium of language. Lester (2003:94) puts it as follows: “Social constructionist thought focuses on language as foundational to the construction of the reality.”

Studies on narrative theory and narrative psychology have shown that the human personality is storied (Sarbin 1986:57). Narrative theory, therefore, provides a whole new way of understanding how human personalities are formed, how people think of themselves and construct and interpret the world around them. Narrative therapy, which is built on this theory, displaces the objectivist approach of a modernist worldview that pervades the traditional models of counselling and therapeutic processes. It invites human persons into a relational framework of therapeutic work, regarding them as subjects, as a source of knowledge and as co-constructors in the process of meaning-making in therapy. Instead of seeking a historical truth, narrative therapy is predominantly concerned with meaning and interpretation. In this quest for meaning and interpretation, it is the counselee, and not the counsellor, who is considered the expert, in contrast to traditional approaches to counselling and therapy where the therapist is assumed to the expert. This shift in emphasis is particularly relevant for non-dominant communities who are seeking help with problems that occur in the context of a disempowering relational dynamics with dominant social groups.

The task of narrative therapy, therefore, is to introduce and interlace non-dominant perspectives and experiences into language in order to create an authentic, empowering and therapeutic interpretative lens for non-dominant communities. This epistemological shift immediately alters the meaning-making process. When they are telling their story, oppressed people are telling of themselves – their values,

convictions, beliefs, and their stories become a medium of understanding and knowing (White and Epston 1982:11). In Neuger's (2001:27) words, "knowing" helps people generate new language and a new interpretative lens. In this way it creates a new reality. The potential to create a new reality is not diminished even though their stories saturated with problems and oppressive forces. Old Testament scholar Phyllis Trible (1984:2) puts it as follows: "Even sad stories are able to generate new beginnings. That is possible because in speaking and hearing that new things happen". That is possible because it is "in speaking and hearing that new things happen" (Eberhardt 1996:16).

The focus of the narrative approach is to identify the problem, name it, and then locate it in the map of people's lives as they narrate their story. Narrative therapist helps people to separate themselves from the problem – to "externalize" the problem and an entity "out there" which affects but does not define one's life. This strategy of externalization is the hallmark of narrative therapy. In the words of Gerald Monk (1997:26), "people are people and never have problems in and of themselves". Telling one's story is an empowering experience. After that the problem is externalized. The therapist carefully examines the story for "unique outcomes". Unique outcomes are those elements of the story that contradict the problem story. They are exceptions to the dominant story. When those unique outcomes are brought to the attention by the therapist, it opens op the opportunity for people to resist the dominant story and find creative solutions (Payne 2006:70).

By telling their stories people can create and establish a community of members with similar experiences who are able to participate in each other's experiences. According to Tom Boomershine (1987), narrating stories creates community. Forgetting stories implies depletion, exhaustion and poverty. Stories, then, are basically about connecting people. The oppressed see their own lives in the story of others and recognize a commonality of experience. Narrative therapy creates the possibility of a therapeutic relationship where people are participating as social agents. It opens a window for creating communities that can reclaim their agency and subjectivity and engenders a collective consciousness, a context of familiarity which leads to friendship (Boomershine 1988:18-20). In contrast, forgetting stories implies

depletion, exhaustion and poverty (Buechner 1991:31). Stories, then, are basically about connecting people; the oppressed see their own lives in the story of others and recognize a commonality of experience. The result is a therapeutic relationship (Smith 2007:75).

Narrative therapy provides a framework for the communal contextual and intercultural model of pastoral care that this study envisions for the South African communities. Narrative therapy is particularly useful for addressing the cultural contextual experiences of the young people of Soweto in relation to the depression and/or demonic possession that has forced them into silence and social and cultural isolation. Their voices have been submerged and silenced by the dominant discourses that give meaning shape their experiences of reality. Positive change can come when their stories are listened to with empathy and their views are accorded value. Facilitating young people who suffer from depression to narrate their life story in the presence of an empathic listener can be a liberating experience for them. Through empathetic listening African discourses can gain voice, authenticity and power to give meaning and structure to the deconstruction of dominant discourses. Young people in Soweto who suffer from depression can learn to interpret their stories and gain a new perspective on their perspective. This can empower them to generate new language, find a new interpretive lens and co-create their own new reality (Nirmal 1998:219). Language not only describes the cultural reality, but also informs, influences, and to a certain extent determines that reality (Nirmal 1998:219). By deconstructing the dominant discourses, young people who suffer from depression can learn to interpret their stories and experiences from their own perspective.

In summary, the perspectives of narrative psychology and liberation psychology are resources for developing constructive counselling approaches for a communal contextual and intercultural model of pastoral care. Narrative psychology and liberation psychology are relevant to oppressed communities such as young South African people because they draw attention to the social structures, discourses and ideologies that deny people the ability to define themselves and the world around them. One of the important tasks that is common to both therapeutic approaches is to

deconstruct the dominant discourses and ideologies that serve the interests of the Western communities. Through the process of deconstructing these hegemonic cultural ideologies, oppressed people can interpret reality from their perspective and engage in transforming actions that can liberate their existence. The strategy of conscientization is effective to empower and liberate people. The most important aspect of the tripartite approach to counselling is its intervention strategies and techniques that affirm rather than violate the cultural norms and practices of the people in the counselling relationship. In this study I present an intervention strategy that affirms the cultural norms and practices of the African people and operationalizes an African liberation theology.

4.7 Responses to mental health problems

Despite the tremendous technological and material advancements in the world today, there are areas in the world where people are completely cut off from the rest of the world. They still practise traditional ways of living and surviving. Some centuries ago, prior to development of modern sciences, people had no knowledge of medical sciences and treatments. The treatment for the sick and suffering were crude and lacked sophistication. The treatment for the mentally ill was even worse because "there were no effective methods for controlling their actions or helping them find relief from their inner torment" (Collins 2007:648). Some of the more popular treatment practises for the mentally ill was that they were, "whipped, starved, chained, seared with hot irons, dunked into freezing water" (Collins 2007:648). Such actions were justified on the basis that the patients were demon possessed and the torture would make their body uninhabitable for the demon(s). At times holes were made in the patient's scull in order to let the tormented spirits out. This was done without anaesthetics. Clergy allowed all these methods which were accompanied by exorcisms, "especially in treating disorders that had a strong physiological basis" (Collins 2007:648).

As an exploration is made into the field of psychology and Christianity and traditional belief or practice it is critical to note that all these fields are different as they possibly can be. Psychology has a hierarchal structure" like any other scientific discipline with research findings at the bottom (Watts 2002:74). In the scientific discipline, "the research findings are always made in the broader context of theories" and at the top,

embedded in scientific world views (Watts 2002:75). There are more chances of "encountering incompatibility with theology" the reason being, "partly because theology and detailed research findings are so different in character that there is hardly any scope for them to agree or disagree with one another" (Watts 2002:76).

There are a variety of approaches within psychology and Christian theology alike. In the former, "there are introspections methods that were important at the inception of psychology as a discrete discipline, and that have begun to come back into vogue in the form of 'account analysis'" (Watts 2002:75). On the hand there are also the "behaviourist methods that came into prominence after the First World War as a reaction against introspections and have been championed by B.F. Skinner" (Watts 2002:75). It is "the more philosophical end of theology that intersects with scientific disciplines such as psychology" (Watts 2002:76).

This section focuses on the how clergy deal with parishioners who suffer from depression and what their pastoral care entails. The section compares how clergy in different parts of world respond to the challenge of depression. Switzerland is notably one of the most advanced countries in the world with a high literacy rate. A brief overview of their attitudes and practices with regard to depression will give a valuable indication of what can be done. A sociological study in the early part of the 2000s among the general population in Switzerland revealed that 4% of the population identify themselves as atheist, 32% belong to Christian communities, 12% are members of other religious communities and 52% believe in a supernatural force but are not members of a religious community (Mohr and Huguelet 2013:134). Surveys conducted by Department of Psychiatry of Geneva indicate that spirituality and religious practices are evident from the lives of people who are suffering from non-affective psychotic disorders. Furthermore, study shows that "a third of the patients with depression were very highly involved during the first years of their illness in a religious community, and 10% of the whole samples were involved in minority religious movements" (Mohr and Huguelet 2013:134).

Other studies have also shown that religious practices were common among psychiatric patients in Europe and in North America alike. The only thing lagging behind is the recognition and consideration of this fact in psychiatric research (Mohr and Huguelet 2013:134). In a review of four psychiatric journals from 1978 to 1982,

2.5% of the articles included religious measures (Mohr and Huguelet 2013:135). An even lower result of 1.2% was found between 1991 and 1995. Reasons why religious aspects are not included in psychiatric research include “a lack of education on religion or spirituality for mental health professionals, and the tendency to pathologize the religious and spiritual dimensions of life by mental health professionals” (Mohr and Huguelet 2013:136). Another possibility for neglecting the religious dimension in psychiatry can be the “rivalry between medical and religious professions that comes from the fact that both professions deal with human suffering”.

In the recent years there have been changes with regard to explorations on the implications of religion and spirituality in the field of mental health (Mohr and Huguelet 2013:137). The World Health Organization (WHO) considers “spirituality, religion and personal beliefs” a crucial area for attaining quality of life. The frequency of delusions and hallucinations with religious significance varies in different countries. A series of studies conducted with inpatients in Europe and compared to other countries worldwide shows variations. In Germany the prevalence of religious delusions is 21%, in Japan 7%, in Austria 21% and in Pakistan 6%. The USA shows a higher prevalence of religious delusion and hallucinations, namely 36% (Mohr and Huguelet 2013:138). These studies indicate that culture influences the interpretation of the experience of psychosis. With regard to paranoid delusion, “the persecutors were more often supernatural beings among Christians than among Muslims and Buddhists” (Mohr and Huguelet 2013:137).

The connection between religious beliefs and practices and psychotic illness has prompted scholars to investigate. The religious delusions and hallucinations often lead to violent behaviour (Mohr and Huguelet 2013:136). Bennett (1980:123) points out that there are cases where “religiously deluded people have taken statements literally in the Bible to pluck out offending eyes or cut off offending body parts; and antichrist delusions have led to violent behaviours”. There are also occasions where patients “attribute psychotic symptoms to supernatural entities and refuse medication” (Mohr, Huguetet 2013:137).

Religious delusions can easily be associated with demon possession since in all diagnostic categories, demonic attributions are evident. They tend to form a “part of complex causal attributions of mental illness that must be interpreted against the

background of cultural and religious factors" (Mohr and Huguelet 2013:138). A study conducted in Switzerland among a group of people who belong to "Protestant subcultures and present a high salience of religiousness" (Mohr and Huguetet 2013:139), showed that many of them found demons to be the cause of mental health problems and "82% of highly religious patients suffering from psychotic disorders said they believed in the influence of evil spirits and two-thirds of them sought help through ritual prayers for deliverance or exorcism" (Mohr and Huguetet 2013:139).

In the Old Testament, there are references to Moses and the other prophets repeatedly warning against activities such as divination, sorcery and idol worship (Virkler 1988: 281). Similarly, in the New Testament demons are regarded as personal, fallen, spiritual beings that are stronger than human beings but weaker than God. They were seen as capable of oppressing and possessing human beings (Virkler 1988:281). In order to distinguish between demon possession and other mental illnesses, the following characteristics are described by Meier et al (2010:260):

- Demon possessed people have more physical strength than other people.
- Demon possessed people respond differently when the name of Jesus is spoken to people with psychological problems.
- There is a change of voice when the demon speaks.
- Demon possessed people can perform supernatural acts.
- People with demon possessed speak rationally whereas individuals with psychological problems do not.
- Those who are possessed often have a history of occult activities such as participating in séances or Satan worship.
- Demon possessed individuals do not respond to therapy (Meir et al 2010:260).

Oesterreich (1930:54-56) also identifies characteristic features of demon possession. For him, most striking characteristic features of demon possession is the change in the persons' personality. They seem invaded and governed by a strange new soul. The second characteristic is their change in voice. The normal tone of the parent body is suppressed and transformed into a deep and heavy bass tone. The third

characteristic feature is that the new voice does not speak according to the spirit of the normal personality but that of the new one.

New Testament authors discredited physical and mental illnesses due to demon possession (Virkler 1988:281, 282). They distinguished between the state of being demon possessed and that of mental illnesses. There are as many as 17 instances in the gospels and in the book of Acts which refer to the matter (Virler 1988:282). They distinguish between “demonically caused and non-demonically caused illness in their discussion of healing” (Virkler 1988:282). Both categories of people were healed unconditionally, but the mode of healing was different. The former was healed by casting out the demons out of the possessed whereas the latter was healed by other means (Virklet 1988:282).

It is often believed that a person is either demon possessed or mentally ill, but it is difficult to make that distinction because the “symptoms arising from psychopathology and demonization overlap to a considerable extent” (Virklet 1988:285). The reason is that symptoms that are seen as an indicator for demon possession are also found in psychopathology (Virklet 1988:285).

God created human beings in God’s image and, despite all the brokenness in the world, no physical or mental health disorders can change that. Though there was no knowledge of mental disorders and their treatments as they are known today, the Bible does provide insight into human nature, showing the human condition before God. It provides an understanding of human suffering and offers hope (Collins 2009:635).

4.8 Pastoral care perspectives

4.8.1 Introduction

The condition known as “depression” is understood differently among different cultures, ethnic groups and people of different socio-economic backgrounds. The sufferers that are the focus of this study come from various backgrounds regarding cultural, economic position, ethnicity and social level. However, all of them grew up in a difficult environment and suffered spiritually, emotionally, psychologically, economically and otherwise. They therefore live with the psychological and emotional

scars of a traumatic youth. They seek healing and restoration for themselves so that they can, in turn, become agents of healing and restoration.

In this section focuses on pastoral care. It is the task of pastoral caregivers to provide effective care for all the individuals and communities they serve. The aim is to prepare a ground, where care givers will be given a special attention to the sufferers. This will be allowing them to regained dignity and confidence after the traumatic tragic experience of depression, within their families. This will allow care givers to be able with respect and compassion to journey with the young people sufferers from depression or demonic possession. Kaplan (1991:11) explains the multifaceted nature of pastoral work as follows:

> The arena of pastoral work is multifaceted and full of surprises, unexpected problems and opportunities for profound insight into the human situation. It is an arena within which the pastor is privileged to be with people where they live and breathe, succeed and fail, relate intimately and experience alienation; It is the down-to-earth world of the human living.

This means that caregivers are called to journey alongside God's people in their distresses and joys, moments of peace and turbulence in order to give them support, encouragement and to "hold their hand" as they proceed through the dark valleys of life. According to Kaplan (1991:11), caregivers are challenged to do their work in a way that will be liberating. The other challenge is to create an environment in which the caregiver and the person who seeks help can develop a healthy and healing relationship. Healed people, one by one, contribute to the healing and transformation of society (Kaplan 1991:11). The caregiver's focus is on the empowerment of the person, bringing the voiceless to voice and, if necessary, becoming the voice of the voiceless and their prophet to the powerful.

All of the respondents agree to a certain extent that the church can be a place of healing and restoration for those who are depressed. It can also be a place of healing and caring for the youth in Soweto who suffer from depression. However, in their experience, the church does not necessary meet the needs of young sufferers of depression. This has become evident to the clergy as pastoral caregivers who aim to provide a support structure within the church and community to care for young people sufferers of depression and their families.

The pastoral care method developed in this study aims to empower young people who suffer from depression so that they can regain their dignity and develop confidence in themselves. The faith community should be a space that nurtures the growth and development of its members. It should challenge negative areas in individual members' lives and affirm positive areas. A pastor journeys alongside God's people offering support, encouragement and prophetic witness when the need arises.

4.8.2 A new framework for a pastoral care praxis

Positive deconstruction and reframing form a useful point of departure for pastoral care in the context of Soweto because these approaches provide an adequate framework for a liberating African pastoral care. The models of care presently utilized in the Soweto context have failed to address certain critical areas of care, liberation and counselling. They are at a loss when it comes to dealing with the link that is made in the culture between the internal and external conditions of depression and demonic possession. Pastors who work in the Soweto context generally have an inadequate understanding of the condition of depression that manifests among the young people. Pastoral care models generally focus solely on care and do not address the other two critical needs, namely the need for liberation and the need for belonging.

The personal problems with which the young people who suffer from depression and their families struggle, should be seen in the larger socio-cultural context. The pastoral approaches of positive deconstruction and reframing are appropriate for this challenge. Both the internal and the external source of the depression should be addressed in order for liberation and the complete emancipation of the African people to be achieved. The communal resources of the faith congregations should be utilized fully to serve the pastoral care needs of the young people with depression and their families. Cultural resources should be valued, affirmed.

This study contents that when pastoral care practices among the young people with depression in the context of Soweto utilize the cultural resources of the South Africans people, there will be better outcomes. Through culture affirming practices from a liberation psychology perspective and intentional conscientization sufferers,

their families and communities can achieve insight into the multitude of ideologies and discourses that have served to subjugate the young people and keep them in a cultural of silence. These tools focus on the internalized depression of the Soweto youth. Through conscientization the young people can find solidarity in their communities and work towards the transformation of their social order to make it just and equal for all communities to exist in life-affirming ways.

A narrative approach along with the methods of positive deconstruction and reframing in pastoral care provide an effective strategy for identifying, deconstructing and changing dominant cultural narratives. The clergy in Soweto can view the church not only as the object of their pastoral ministry, but also as a partner and a valuable resource for offering effective pastoral care to young people who suffer from depression. This calls for a rethinking of pastoral care with young people who suffer from depression in Soweto. The young people themselves should be mobilized to resist the forces of oppression and work towards their own liberation. One of the most debilitating effects of the current situation is that the community is divided. They do not form a cohesive force to resist the oppression to which they have been subjected. The internal division sabotages any effort to give strong voice to their demands and representation in the public arenas.

Soweto clergy should utilize the cultural capital represented by the young people and their families. The church will have to develop and articulate a clear theological understanding of the relationship between gospel and culture. This study has shown how African culture can be an important resource for building up not only the young people who suffer from depression, but also building up the whole community in its uniqueness. Soweto clergy should identify ways in which people's African culture can be reclaimed and affirmed to become a medium through which the gospel message can be communicated effectively and experienced authentically. The liberative and nourishing elements of the African culture can be put to service for the purposes of meeting the socio-cultural needs of the Soweto young people. Another important strategy of pastoral ministry can be to collaborate with secular authorities and other religious Soweto movements, organizations and bodies to address the many needs for care in the context of Soweto. Collaboration is essential is the needs of young

people who suffer from depression in the context of Soweto and their families are to be met.

4.8.3 Creating a caring environment of trust

Through informal and formal interaction with care givers and those who suffer from depression, I have found it that it was very challenging for the young people to trust and feel sufficiently safe to open up to a pastoral caregiver. They do not know what to expect. It is therefore necessary that their distrust and fear be dispelled by pastoral caregivers and a safe environment is created in which they can tell their stories in order to work towards healing, liberation and transformation. I observed a level of distrust within local congregations which caused people to be unable to open up and tell the stories of their traumatic experiences and the subsequent depression they have been suffering for years. They experience shame and therefore fear to share their story with anyone. The lack of trust and safety is a major impediment to their progress. The challenge is to create an environment of trust so that God's people can share their stories of hurt and pain. Trust is a "firm belief in the reliability, truth, ability, or strength of someone or something" (Oxford Dictionary 2001:901). It is "to put one's confidence in a person or thing" (Knight 2005:338). An environment of trust is needed in the church if those who suffer from depression will have the confidence to share their stories openly without fear or suspicion and stigma.

The deep-seated distrust of the young people who suffer from depression is not limited to the pastoral caregiver but extends to the faith community and the local community as well. As a result, people who are suffering with depression and have had experiences with what is deemed to be demonic possession, do not find it easy to share their stories within the congregation. They fear that they will be discriminated against, victimized and stigmatized. This does not alleviate their suffering but perpetuates it. One of the young people mentioned that the silence surrounding depression is frustrating to them. This problem can be addressed effectively if the church intentionally creates an environment of trust where people can express their pain and struggles without fear of victimization, discrimination and stigmatization by the wider community of faith.

In order to create an environment of trust those in leadership will have to act with the utmost integrity dealing with confidential matters that come to their attention. It means that they will have to take seriously the call to shepherd God's people in a manner that brings about transformation, healing and restoration. For this empathetic care is needed. It also means that they their own lives should display the kind of character that is worth imitating by the rest of the community. Their attitude should display Christ-like qualities. A God-honouring, Christ-like disposition and attitude will create an environment of trust within the church. An attitude of humanity rather than pride and deeming themselves "better-than" the suffering other is needed to create and maintain an environment of trust and confidence that would induce people who are in need to call on and accept the necessary help from religious leaders. Young people in Soweto who suffer from depression will find it easier to share their stories in such an environment. As they share their stories, they can progress toward the healing that they so desperately need. For a faith community and community to be trustworthy and able to create a safe environment for people who suffer with depression, education and awareness are needed.

4.8.4 Education and conscientization

This study has shown that issues surrounding depression among the young people in Soweto affect not only them, but also their families, the broader community and the faith community in which they worship. This is because the members form one body, the body of Christ. The body is a unit, though it is made up of many parts, they form one body. Therefore, education is necessary if every member, also people who suffer from depression or those who are suspected of demon possession, is to be fully accepted and treated with love and care.

There are many possible ways to create awareness and educate people in the church environment. Some examples are workshops, sermons and a teaching series, Bible study sessions, liturgies and songs/hymns that are appropriate for such a purpose. (Murry 2006:111). Educational programs should be implemented with sensitivity. Information should be accurate and presented in a professional way. An attitude of love and compassion and a deep concern for the human rights and dignity of all people, is needed for such education to be effective and bring about the desired results. Educators should challenge the abuser, affirm and support the abused and

persuade a lifestyle change in all people. They should re-examine the conditions that promote abuse and violence in families and advocate for Christian values that call for behavioural change in individuals, families and congregations. Other crucial matters include gender and the empowerment of young people. The church is called to examine critically “some of the cultural, customary and sexist practices that have been perpetuated in certain circles of society” (Murry 2006:110). Failure to do this would continue to render depressed young people vulnerable to their circumstance and in conflict with their families and surroundings.

Education and conscientization by the church would strengthen its prophetic ministry and empower those who sufferer with depression. It should communicate a clear message that young people who suffer from depression should not be rejected, stigmatized, labelled, and discriminated against in any way by the church. It should also communicate a message of love, care, acceptance, grace and compassion to those living and struggling with issues of depression and demonic possession. Education with the aim to empower people who suffer, constitutes a challenge to the whole body of Christ to examine itself. Such a self-examination should flow from a deep reflection and understanding of how people are affected by depression and the positive or negative role that families and the community can play in their experience.

Part of education and conscientization in a community involves the sharing of testimonies by those who sufferer with depression. Their stories would give hope to those who are still struggling and nurture faith in those who have lost it through trauma. Through sharing their testimonies people who sufferer with depression can regain a sense of strength, confidence and dignity in themselves. They can be empowered to go out and face their challenges with courage, knowing and feeling that they are supported by the community. When opportunities for testimonies are opened, people should also be given space to express their lament regarding their experience of pain and trauma. Wimberley (2004:162) points out that lament is expression of the moans of the soul that arise from life’s struggles and losses. Lament is brought to speech in prayer.

The church can also facilitate the creation and development of support groups. People with experience of depression can come together to share their stories and encourage one another meaningfully. However, such groups should not only be

aimed at those who sufferer with depression but could also be spaces where perpetrators are challenged to change their behaviour. They would hold each other accountable and pray for each other. On their journey they would seek guidance, love, compassion and the opportunity to make right where they harmed others through their actions.

Education and creating awareness would involve more than just teaching people about depression. It would involve the whole community of faith and challenge them to standing in solidarity together before God, crying out for God's intervention and assistance. It would also involve that the church establishes ministries that will train and empower clergy as pastoral caregivers to become counsellors and mentors to young people who sufferer with depression. It involves tailoring education to the needs of the sufferers so that their brokenness can be addressed adequately.

Local churches should be intentional in designing and conducting healing services for the benefit of those in their midst who suffer. The benefit would be that people who find it difficult to speak to a counsellor on one-to one basis could get the opportunity to express their pain openly in worship. For this the empowerment and training of worship leaders, ministers, council members and all involved with the life of the congregation would be needed.

4.8.5 Destigmatization

Stigma can be described as "a mark or sign of disgrace" (Oxford Dictionary 2001:824). It is a sign of social unacceptability associated with a deep sense of shame. If communities and faith community attach stigma to certain conditions and actions, those who suffer will not be able to come forward and share their stories and experiences for fear of being judged, rejected and discriminated against. Until stigma is eradicated, it will remain difficult for young people with depression to have the sense of belonging and acceptance that they so desperately need from their faith community and the broader community.

Destigmatization in this regard would imply that young people who suffer with depression will be treated with dignity, love and compassion. Then they can feel that they are fully human, created in the image and likeness of god. This means that they would know and accept themselves to be people of worth and dignity, equal to all others in the community. This will communicate to them the strong message that they

are still God's own beloved children who need not be ashamed of themselves because of the condition over which they have no control. *Destigmatization* would also mean that perpetrators and abuser have an avenue to come forward and be ministered to as well. Their behaviour will be challenged, but graciously and lovingly. Their humanity will be respected. They will receive the opportunity to change and embrace a new kind of life. *Destigmatization* will mean for the sufferers that the message of the gospel is communicated in manner that brings about healing and transformation.

4.8.6 Support groups for sufferers and families

Support groups for young people who suffer with depression and their families have the following aims (MacNutt 1974:19): "To transform individuals into a real personal relationship with Jesus Christ through the baptism of the Spirit; to heal relationships and to build community – especially in the family and the neighbourhood community, and, to transform society by healing relationships of injustice and oppression." Every local church in Soweto can be a centre of healing and a support structure by taking seriously its mission toward those who suffer. This would include young people who suffer with depression who live in their communities and worship in their churches. Christian believers are called to proclaim the gospel of Jesus Christ for healing and transformation (Pollard 1997:43).

However, because of the special nature, depth and gravity of the condition of depression, a special effort should be made to address the issues associated with the condition. People that are trained specifically to deal with depression and manifestations of what is deemed to be demonic possession are needed in the church. They can refer people to other professionals when they are faced with a situation for which they deem themselves ill-equipped. Challenges about depression specifically, include a lack of support structures, which is a widespread problem throughout Africa. Masaga (2005:239) advocates for the establishment of a professional counselling centre in Tanzania that has the specific aim to provide care for clergy. Waruta and Kinoti (2005:230) also make a case for clergy care with specific attention to their personality and ministry. These centres should be places of healing, restoration and transformation. Pastors often feel ill-equipped to deal with the trauma that affects their congregants.

4.8.7 Welfare, advocacy and support

The church has a mission to be a visible sign of Christ's presence in the world. According to Nasimiyu-Wasike (2008:35), the vitality of the church depends to an extent on the health and integral well-being of the society and culture in which it operates. Therefore, it is the church's salvific mission to promote and foster healthy and healing human relationships at a public level (Waruta and Kinoti 2005:133). This means that the church can and should partner with all other organizations that seek to advance the cause of the sufferers of depression. These partnerships need to go further to the political and social service arenas. The church can take part in secular activities that speak against violence and abuse within families. One example is the 16 days of activism against alcohol and substance abuse.

Not only should the denomination educate people about the devastating effects of depression among the youth in Soweto, it should also advocate for the rights of the young people who have been traumatized by incidents in their lives. The church should be proactive in addressing issues relating to Christian values and respect. At least one respondent is of the view that families should not be divided or damaged before something is done to help them. Young people with depression should be cared for specifically and intentionally, not only by the church but also by the society. For this to happen, the church must be the voice of the voiceless and the conscience of society. A main responsibility of the church is to care for people who suffer, and this includes young people who suffer from depression. The church should develop ministries that are specifically aimed at this group of people in need. The church could, for instance, establish a recovery or rehabilitation centre for those who suffer from depression.

Churches can partner with organisations that focus on helping people who suffer with depression and also hold accountable those who do not live up to their mandate in terms of delivering acceptable service to people who desperately need these services. The church should follow the example of Jesus, who challenged the causes of detrimental conditions in society. The church's responsibility in all of this is one of loving liberation rather than judgement (see Waruta and Kinoti 2005:133). Churches should be at the forefront of addressing the issue of depression with families and communities in order to fulfil its mandate to preaching good news to the poor,

proclaiming freedom to the captives, recovery of sight to the blind, releasing the oppressed and proclaiming the year of the Lord's favour (Luke 4:18-19).

CHAPTER 5

FINDINGS AND RECOMMENDATIONS

5.1 Introduction

The purpose of this final chapter is to present the findings of the study, as well as recommendations for further studies. This study presents a pastoral perspective on depression among young people in Soweto. The objective of the study was to contribute knowledge to the field of practical theology about the interplay between Western understandings of depression and an African perspective. What is referred to as “depression” in Western contexts is often seen to be “demon possession” in African contexts and named as such. The five groups of participants in this study had their own subjective and diverse experiences of depression among young people in Soweto. The interplay between Western and African understandings of “depression” and “demon possession” respectively, is complex. The experiences of the five groups of participants who were interviewed, shed light on this complex relationship. The aim of the study is to provide guidelines for pastoral care with young people in an African context who suffer from depression and to find a way for pastoral care to function effectively, taking both Western medical insights and African cultural beliefs and practices into consideration. The study utilized two pastoral approaches, namely reframing and positive deconstruction, as frameworks for understanding and affecting change with regard to harmful social cultural discourses.

The five groups of participants who were interviewed, were chosen because of their experience of depression in the context of the Soweto community. One group of participants consisted of young people with depression and their family members. All were aged between 18 and 35 years. The other groups were made up of clinicians such as psychologists and psychiatrists, as well as social workers. The group of clergies was made up of persons from different denominations who work in Soweto. The last category for the empirical investigation was that of traditional healer.

Stigmatisation and shame are key factors in the lives of young people who suffer or suffered from depression. The interviews questions explored the participants' different experiences of depression and focused specifically on their unique points of view, ideas, motives, beliefs and feelings regarding the phenomenon of depression. The aim was specifically to ascertain how they navigate African views and practices and Western approaches regarding depression. They were invited to narrate their experience with depression from the viewpoint of their specific profession and expertise. The aim was to remain congruent with each participant's context and continually refer to the text of each written story while interpreting the data provided by them. In this way new meanings were created.

The study also aimed to ascertain how depression impacts young people in Soweto and their families and communities. Another aim was to obtain an in-depth understanding of caring practices within the community regarding young persons who suffer from depression, since the context of Soweto comprises a communal rather than an individualistic culture. The need became clear in the course of the investigation: people who suffer with depression need focused treatment from medical professionals, love and concern from family members, and pastoral care and counselling from the faith community. The paradoxes and conflicting interpretations and expectation with regard to depression and demon possession in an African context necessitate a collaborative approach by professionals, clergy, families and traditional healers to meet the challenge presented by the phenomena of depression and demonic possession in African contexts in general, and specifically amongst young people in Soweto who were the focus of this investigation. The study has found that such collaboration among professionals, traditional healers and clergy is not yet taking place in any structured or purposeful way. If the needs of the sufferers for pastoral care, counselling and therapies and the need of families for support are recognized, the change and collaboration can be brought about.

This study aimed at a better understanding of the phenomena of depression and demon possession among young people in Soweto and the effects of these phenomena on individuals, faith communities and communities in order to ascertain what the role of pastoral care for these persons and their families would entail. It was found that depression was often caused or exacerbated by factors in the

environment, such as extreme trauma, drug abuse, alcohol abuse, poverty, unemployment, family violence, sexual abuse and the like. This means that the focus cannot only be on the individual person who suffers from depression. The treatment cannot just focus on the inner person and their psyche. A broader vision was needed.

Depression is a fact of life in modern society. If this problem is to be addressed effectively, family structures and all possible resources should be consolidated in order to facilitate progress and maybe even healing on the part of the person who suffers from depression. Depression should therefore not just be understood and treated as a psychological matter. The perspectives of faith and cultural tradition have a contribution to make. Therefore, collaborative efforts are needed in order that all resources can be utilized effectively to alleviate the situation of young people with depression in a Christian African context. From psychological, psychiatric, sociological, theological and traditional cultural perspectives a collaborative effort should be made to provide adequate care to young people who suffer with depression and also to those young people in African cultural contexts whose condition is named “demon possession”. A triangular collaborative and inclusive model of caring was explored in this study.

5.2 Findings

The focus of the study was on pastoral care and the pastoral role in collaborative care for young people who suffer with depression in Soweto. In other words the emphasis was on the competencies of the pastor and the pastor’s relationships firstly with the suffers themselves and their families, secondly with the faith community of which the pastor is the leader and whose calling it is to function as an adequate care and support system for sufferers, and thirdly with other caregivers in their various fields of expertise as a collaborative effort to provide holistic care for those in need. The emphasis was not, for instance, on the other professional caregivers and their roles or relationships with those who suffer and their families. Such an emphasis would fall beyond the scope of the field of pastoral care but could provide valuable insights into the complex problem of adequate care for the young people with depression in a context where they are often caught between worlds.

In order to distinguish the multiple genres of mental disorders and recognize patients with depression symptoms, some education is needed. People should be briefed and made aware of the realities of mental illness and how to deal with its various forms. This should be done by the relevant experts and the bodies that are capable of organizing such events.

Out of respect for cultural traditions and the sensitivity of the matter, I did not go into detail with regard to some of the relevant African rituals. I acknowledge that my presentation of the data at my disposal was, in this regard, selective. The interpretation of data was likely to be coloured by my own perceptions and values as an insider who shares some commonalities with the cultural understandings of depression in the township context.

The outcomes of the study also have implications for educationalists and school psychologists. Besides the family, they are the people who have daily interaction with young people who suffer from depression and will have to provide a different kind of help and care than clinicians, social workers, clergy and traditional healers. The tendencies of African cultures to marginalize people with mental health problems is exacerbated in high schools where young persons are often marginalized for much fewer radical differences and traits than mental illness. The growing body of literature on school bullying can investigate this matter further. School psychologists who work in an African environment will have to know and understand the connection that is often made in culture between mental illness and demon possession in order to be able to effectively support students with mental health problems at school. With a better understanding of both depression as a metal health condition and cultural views, attitudes and behaviours with regard to demon possession, these professionals can be truly empathetic and culturally competent when working with diverse Africans youth and their families. School of psychologists can be a good source of information for further investigation on this topic. School psychologists can assist young people with depression to develop coping skills. They are in a position to do speak on behalf of these young people, and to facilitate and implement school-based mental health prevention and intervention efforts for young people.

Many of the ministries of the churches in Soweto have been booming – family ministry, children's ministry, youth ministry, women ministry. However, the churches in general have not made much headway with the issue of adequate care for people with mental health problems in general and depression in particular. Churches tend to focus on other many aspects but remain silent when it comes to depression. This study aims to contribute to meaningful change in this regard. One goal is that families can be better equipped by the church for dealing effectively with a mental health crisis such as depression should it occur in their family. Crisis, the loss of health, bereavement, natural calamities or mental disorders are part of life and will, at times, affect families. They should be equipped for that in order to deal with the setback as effectively as possible for the benefit especially of the family member who is hardest hit by the calamity.

When a person begins to exhibit strange behaviour, family members are worried and frustrated. There world has been turned upside down and often they do not know how to respond to the situation. Some initial reactions include anger, resentment, perplexity, fear and guilt. They see the person exhibiting a completely different personality or living as though in another world. The family wants to help the person and get things back to normal again. Medical professionals too, often miss the initial signs of depression because of variables in the symptoms. Only when the person has breakdown does the problem become apparent. The suffering gradually becomes more bearable when it is shared with people who care.

The study has shown that it is critical that mental health professionals receive comprehensive training not only in their field of expertise, but also to develop cultural competence for providing services to young people with depression who are from an African cultural context or, as is the case in Soweto, from a multi-cultural context. Because African perceptions of reality are not narrowly positivistic and scientifically oriented, mental health problems cannot be addressed from a narrowly positivistic and scientific perspective. The need for holistic care which includes a spiritual perspective and is approached from various spheres and disciplines, necessitates a collaborative effort by care providers. Such a collaborative method can be worked out and refined in further studies and should be included in the curricula of the various

facilities where care providers are trained. Practitioners who work in African contexts need training and guidance for how to help young people who suffer from depression to understand their condition both from a Western scientific perspective and through and African lens in such a way that the best and not worst of both worlds can be utilized to provide care.

No human does anything to “deserve” the condition of depression. Not only the person, but the whole family suffers. Even though the condition is severe and has severe effects on the person and the family, they should not feel totally helpless and despondent. Many things can be done to either facilitate recovery or to alleviate symptoms. The best ways should be found. Even severely affected people tend to respond to care, love and sometimes also a firm challenge. The person with the condition should not be deemed or treated as incompetent and unable to take care of themselves. Such an attitude would be a direct obstruction on their road to recovery or improvement. Positive treatment increases their potential to overcome or improve their condition. They should know and feel that they are neither deserted nor desperate. A saying used at Chris Hani Baragwanath Hospital is: “What you expect, you will get.”

Accomplishing some work and completing tasks can contribute positively to a sense of self-worth and human dignity of the person who suffers from depression. However, if the task or the work overwhelms them and make them feel incompetent and helpless, then work and tasks will have the opposite effect. Therefore, family members should be aware and be trained to find the correct balance between leaving the person to do things and assisting them. Some persons who suffered from depression do not want to leave their bed due to a lack of psychic energy. They can sleep for many hours, even days. During such a spell, the tender assistance from family members can help them to gradually begin to move again: sit, stand and walk.

Family members can also be of assistance in helping affected persons to keep themselves clean and tidy. They can try to get them moving and provide necessities such as a toothbrush, a hairbrush, and the like. The person who sufferers from depression can also be ushered to the shower where the water already running and have fresh, clean clothing laid out for them. In these ways’ family members can be of

assistance. If their behaviour is demeaning and belittling that will only erode the person's self-esteem and exacerbate the depression. Christian love and genuine compassion are called for.

People with depression have a sense of guilt. They feel that they have done something wrong and that they are at fault. Family members and pastoral caregivers should assure them that they are not guilty of anything, nor did they do anything to cause or exacerbate their condition. Caregivers distinguish between true guilt and false guilt. True guilt is the appropriate response when a person has done something harmful with the knowledge that they were doing. False guilt develops due to the feelings of low self-worth or when people fall short of impossibly high expectations, they set for themselves. People with depression tend to develop false guilt. They feel they are not good. Support from family members and adequate pastoral care can help to eradicate unhealthy false guilt over time.

For people in a crisis or unpleasant life situation humour can be of great therapeutic value, such as the term "comic relief" indicates. However, misplaced humour or levity intended to "cheer up" or "lift the spirit" of a family member with depression can have the opposite effect. The person with the condition does not feel "cheered up", feels guilty about that and resents the efforts to force change in them.

Despite numerous problems that have to be dealt with in the family of a person who suffers from depression, the feelings and personhood of the individual is of the utmost importance. Both the feelings of the person and realities of life and facts of the matter should be recognised. If the persons feel guilty for being a burden on the family, those feelings should not just be ignored. Family members should not impose pressure on the sufferer while giving them the impression that they are supportive.

It is important to consider the feelings and personhood of the sufferer, however there are times when focussing on problems and facts are more constructive than getting close emotionally. People are often feel emotionally overwhelmed even though they function outwardly in a guarded and controlled way. When the acute symptoms appear, that emotional barrier breaks and the person is flooded by feelings. Negative feelings feed further negative feelings in a downward spiral toward self-destructive behaviour. People who suffer from depression tend to become suspicious when others try to get emotionally close to them. They feel that their privacy is being

violated. This makes it difficult for family members, friends and other supporters to know and do what the depressed person requires of them. This is a complicated situation for family members who are not trained in the field of psychology. That is why education and support from professional in various fields are so necessary.

5.3 Recommendations and further investigation

Churches can become centres of education and providers of social and spiritual support. Seminars for young people can be initiated. The various individuals, functions and ministries can identify what their contribution could be to help young people who suffer from depression. These entities include Sunday school, youth group, women group, young couples' group, older persons and families who take on a mentoring role and impart the wisdom of their experience to younger people. By being intentionally and actively involved with this issue and through education and example, churches can also contribute to changing harmful cultural perceptions and practices with regard to people with depression.

Because the mental world in which people with depression live is so all-absorbing and all-consuming, it is not easy to try and relate them. They are simply not interested in forming relationships with others. Another explanation for their reticence can be that they are so vulnerable to external stimuli and hurt, that they draw back from relationships as a form of self-protection. It is not easy to empathize with people whose condition is so baffling to others. However, well-meaning others can "learn" to recognize the feelings that accompany or can be the result of the person's disturbed thinking and mood. Churches see education and the upliftment of people as their task in the world. All kinds of educational seminars are organized by church for different interest groups. It is important include education on mental health in this.

The church can set up a home for people who sufferer, where they can receive help and pastoral care. Another area of outreach to people who suffer with or are affected by mental health problems, is support groups for the people themselves and for families. In these groups' families can be facilitated to share their experiences and help and support one another.

The onset of mental health problems in a family can be sudden. People are not prepared for it and both the person who suffers from the condition and their family feel helpless and vulnerable. Pastoral care and counselling for the sufferers and their families can serve to help them through the phase of adjustment and learning. It can also open the way for spiritual renewal. Pastoral care provides people with the opportunity to speak about their difficulties. This often brings relief and greater clarity as to the way forward.

Discernment is an important first step of dealing with people with mental health problems. Without an understanding of the issue, it would not be possible to provide adequate pastoral care. Often even church people, out of ignorance and fear of the unknown, are still prone to cling to beliefs such blaming a “curse” for the setbacks in life. This is where spiritual leadership, education and advocacy for the downtrodden, are needed.

In the existing research on depression in African, the opinions are divergent. Some scholars suggest that young people in Africa are more prone to depression than young people from Western cultures, whereas others argue the opposite. The reasons given for a higher prevalence in Africa are conditions such as neighbourhood violence, poverty, drug and alcohol abuse, unemployment, family conflict and violence. The impression of this study is that the incidence of depression among young people is rather evenly distributed. The debate itself could be an illustration of how quickly it is to assume that greater problems, including mental health issues, would exist in Africa than elsewhere.

However, an understanding of how people in marginalized communities’ express symptoms of depression, can provide a clearer picture with regard to the experiences of young people in Soweto who suffer from depression. Large samples of black middle school students are rarely studied in the depression literature. This gap in the literature is addressed in this study because the current study sampled a small number of youth population in Soweto, which significantly contributes to the literature regarding depression that impact this young people in Soweto.

The sample of this study was fairly small, especially with regard to the young people who suffer from depression themselves. The reason for this was that the study elected to focus to a large extent on care and caregivers, and not entirely on those who suffer from depression. The data would therefore be greatly enriched if subsequent studies would further investigate the experiences of the young people themselves. Other areas of interest would include:

- the ways in which they cope with their depression;
- factors such as trauma that contributed to the onset of depression;
- factors that exacerbate their condition;
- social cultural aspects such as shame and stigma to which they are exposed and that contribute to the tragedy of their exhausting and often isolated young lives.

Richer descriptions of their experiences and realities will be invaluable when adequate care is envisioned by the collaborative team of professionals. Another possibility for further investigation is to compare the experiences of young people from different cultures and identify how cultures deal differently with the reality of depression among young people. Harmful cultural attitudes and practices can then be identified, their effects contemplated in reflections on adequate care, and life-giving cultural resources can be utilized to the fullest. Valuable information can also be gleaned from studies that investigate the experiences of children who in some way or another have suffered the impact of depression on themselves and their family. This would contribute to coming to a more holistic understanding of a condition that has a wide effect, from individuals to families, to communities, to society. The study has shown that mental illness is often associated with demon possession. An area for future research could be to investigate in depth the positive and harmful traits in cultural beliefs and practices for people with mental health problems.

Areas for future research would include the interplay between Western understandings of depression and the diverse perspectives from different African cultures. Though not touched upon in this study, there is overwhelming evidence of a high prevalence of depression among young people from lower socio-economic

backgrounds. Since the onset of depression is in late adolescence and early adulthood a great responsibility of care rests on the shoulders of family members. Treatment plans are best devised by clinicians. However, in African contexts scientific and medical care alone will not suffice. A contextual pastoral response in which the elements of spirituality and cultural context are included, makes the total care that is provided more holistic and better suited to African life that one facet of care alone would be able to accomplish. In this way the church has a significant role to play in the area of mental health and well-being. When the church intentionally educates about mental health, this can counteract the persistent cultural stigmatization and marginalization of people with mental health problems. Then those who are already suffering and their loved ones who suffer with them, will not also have to live in fear and alienation. Along with spiritual care it is also the task of the church to engage constructively with the social condition of the people and eradicate all forms of injustice. It is a just and gracious God that the church serves.

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APPENDIXES

Appendix 1

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

LETTER OF INTRODUCTION AND INFORMED CONSENT FOR PARTICIPATION IN ACADEMIC RESEARCH

Title of the Study:
"A pastoral perspective on depression among youth in Soweto. "

Researcher:
Rev. MWANSA CLAUDE KIMPINDE
University of Pretoria
+44 74 47 508 786
Jeanclaude.onyx@gmail.com

You are cordially invited to participate in an academic research study due to your experience and knowledge in the research area, namely "**depression among youth in Soweto"**. Each participant must receive, read, understand and sign this document *before* the start of the study.

- **Purpose of the study**: The purpose of the study is to investigate the experience of depression among youth who are also Christian believers and live in Soweto, South Africa; in other words, a big city and township environment. The study explores how the phenomenon of depression is understood by caregivers such as Christian clergy, counsellors, as well as traditional healers, who function as the custodians of spiritual and cultural belief. This study aims to create a better understanding of African perspectives on the experience of depression and demon possession. The aim of the study is to contribute to the field of pastoral care and counselling, specifically for people diagnosed with depression in an African context. The results of the study may be published in an academic journal. You will be provided with a summary of the findings on request. No participants' names will be used in the final publication.

- **Duration of the study**: The study is being conducted over a period of three years and its projected date of completion is the 15/12/2019.
- **Research procedures**: The study aims to investigate depression among youth in Soweto from an African perspective. Individuals who have witnessed young people struggling with depression will be interviewed. The strategies young people use to reconstruct their lives will be investigated. The aim of the study is to come to a holistic approach where youth who suffer from depression are concerned.
- **What is expected of you**: During this study, you will be interviewed regarding your personal experience with depression or depressed youth in Soweto. Your participation will require approximately 60 minutes of your time.
- **Your rights**: Your participation in this study is completely voluntary. You may stop participating at any time without stating any reasons and without any negative consequences. You, as participant, may contact the researcher at any time to clarify any issues pertaining to this research. The respondent as well as the researcher must each keep a copy of this signed document.
- **Confidentiality**: All records of participation will be kept strictly confidential, such that only my supervisor and I will have access to the information. Your name will not be used directly or indirectly in any of the records and, therefore, your anonymity is guaranteed. The results of this research will be reported in a written research report, as well as an oral report during class presentation. Information about the project will not be made public. Should you choose to withdraw the relevant data will be destroyed.

WRITTEN INFORMED CONSENT

I hereby confirm that I have been informed about the nature of this research.
I understand that I may, at any stage, without prejudice, withdraw my consent and participation in the research. I understand that there will be no form of remuneration for my participation. I declare that I have had enough opportunity to ask questions.

Respondent: _____

Researcher: Rev. Mwansa Claude Kimpinde

Date: --- / ---- /2019

Contact number of the Researcher:

+44 74 47 508 786
Jeanclaude.onyx@gmail.com

Appendix 2

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Topic:

"A pastoral perspective on depression among youth in Soweto"

Interview questions for young person's currently dealing with depression, or who have experienced depression before

Demographic information

1. Your age is between

   18-25 [ ] 26-35 [ ]

2. What is your gender?

   Male [ ] Female [ ]

3. What are your academic qualifications?

a. Certificate holder [ ]

b. Diploma holder [ ]

c. Degree holder [ ]

   Other, please specify……

4. What is your career ?.....

5. Which church denomination do you fellowship in?
   ……

6. How do you understand depression in your own words?

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7. How did you come to know that your condition is depression?

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   ……
   ……

8. From whom did you first seek help when you realized that you were depressed?

Psychologist [ ] Psychiatrist [ ] Social worker [ ] Clergy [ ] Traditional Healers [ ]

9. Briefly describe what having depression it is like for you.

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10. How long have you been feeling this way?

0-11 month [ ] 1-5 years [ ] 6-10 years [ ] longer than 10 years [ ]

11. What do you think may be the cause of your depression?

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12. Do you see a connection between your condition and demonic possession?

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13. When you feel that you cannot cope where do you go for help?

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14. Other than speak to people, are there other things you do to feel better?

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15. Describe the emotional support you receive from family members, friends, your clergy, or a traditional healer

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Thank you in advance for your participation.

Appendix 3

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Topic:

"A pastoral perspective on depression among youth in Soweto"

INTERVIEW QUESTIONS FOR FAMILY MEMBERS

Demographic information

1. What Is your gender

   Male [ ] Female [ ]

2. What is your marital status?

   Married [ ] single [ ]

   If otherwise indicate…….

3. What is your occupation?

   ……..

4. Which church do you fellowship?.....

5. In opinion what is depression?

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6. Give a reason why youth are depressed in Soweto especially the case of your relative?

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7. In your opinion, what are the effects of depression among youth in Soweto?

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8. From your perspective, what the clergy or Traditional healers should do to restraint depression among youth in Soweto?

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9. In your opinion, what are the effects of depression among youth in Soweto?

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10. What are your roles as family member and your contribution toward the crisis of depression or demon possession?

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……Thank you for participation

Appendix 4

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Topic:

"A pastoral perspective on depression among youth in Soweto"

QUESTIONNAIRE FOR PROFESIONALS

(Psychologists, Psychiatrists, Social Workers)

1. What Is your gender

   Male [ ] Female [ ]

2. What is your occupation?

   ……..

3. In your opinion what may be the root cause of depression among youth in Soweto?

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4. What effects of depression do you observe among the youth of Soweto who come to you for professional help?

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5. What methods of care to you utilize the most in as clinician specifically in comparison to those other caregivers that you may collaborate with in the community?

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6. How do you see depression in relation to demon possession?

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7. Do you have any pertinent observations regarding this topic?

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…… Thank you for your participation

Appendix 5

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Topic:

"A pastoral perspective on depression among youth in Soweto"

INTERVIEW QUESTIONS FOR CLERGY

Demographic information

1. What is your gender?

   Male [ ] Female [ ]

2. What are your academic qualifications?

   a) Certificate holder

   b) Diploma holder

   c) Degree holder

   d) Other (please specify)

   e) Which church do you lead?.....

3. What are your responsibilities as clergy?

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4. How would you define "depression"? Is it different to "demonic possession"? in what way?

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5. What measures or support structures have you put in place to help depressed youth in your community?

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6. What are you doing to create awareness among youth concerning depression?

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7. Is the church aware of the various effects of depression among youth in Soweto?

   Yes [ ]; No [ ]

   If yes, please describe some of the effects of depression among youth in Soweto that you have had to deal with

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8. To what extend do you as church representative collaborate with other professionals or traditional healers with regards to depression and/or demonic possession? is there a referral system in place?

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……Thank you for participation

Appendix 6

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Topic:

"A pastoral perspective on depression among youth in Soweto"

INTERVIEW QUESTIONS FOR TRADITIONAL HEALERS

1. What are your academic qualifications?

   Certificate holder….

   Diploma holder…….

   Degree holder……...

   Other (please specify)…….

2. What is your understanding of depression?

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3. According to you, Is there a connection between demonic possession and what is called depression in the western perspective?

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4. How would you proceed when you provide care to depressed youth in your community of Soweto?

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5. Have you collaborated with clergy or other professionals when a young person with depression has sought your help?

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6. How are you going about to provide care to demonic possessed youth in your community through your practice?

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……Thank you for participation

Appendix 7

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

MEDICAL ADVISORY COMMITTEE

CHRIS HANI BARAGWANATH ACADEMIC HOSPITAL

PERMISSION TO CONDUCT RESEARCH

Date: 25th October 2019

TITLE OF PROJECT:

A pastoral perspective on depression among youth in Soweto.

UNIVERSITY: Pretoria

Principal Investigator: Rev MC Kimpinde

Department: Practical Theology/Psychiatry

Supervisor : Prof Y Dreyer

Permission Head Department (where research conducted): Yes

The Medical Advisory Committee recommends that the said research be conducted at Chris Hani Baragwanath Academic Hospital. The CEO / management of Chris Hani Baragwanath Academic Hospital is accordingly informed and the study is subject to:-

- **Permission having been granted by the Committee for Research on Human Subjects of the University of the Witwatersrand.**
- The Hospital will not incur extra costs as a result of the research being conducted on its patients within the hospital
- The MAC will be informed of any serious adverse events as soon as they occur
- Permission is granted for the duration of the Ethics Committee Approval.

.....
Recommended
(On behalf of the MAC)
Date: 25/10/2019

.....
Approved/~~Not Approved~~
Hospital Management
Date: 25/10/2019