THE PERCEIVED IMPACT OF CHRISTIAN BELIEFS IN COPING WITH DEPRESSION

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ABSTRACT

The association between the experience of depression and the use of religious coping methods has been widely researched in recent studies. However there is a dire need in this area of research in South Africa. Further most of the previous studies have been quantitative in nature limiting the subjective aspect of the depressive experience.

The current study was undertaken to explore the perceived impact of religious beliefs on the individual's coping with depression. The sample used was a convenience sample of Christians from various denominations with a history of depression or a current diagnosis of depression. A semi-structured interview was conducted to collect the data from volunteers who agreed to participate, and a thematic analysis method was used to analyze the data.

The findings of the research revealed that the use of religious coping methods can have both beneficial and detrimental effects on the individual's experience of depression. Conversely it was found that depression can also have both positive and negative impact on the individual's faith. Furthermore this study has highlighted the importance of the individual's appraisal of their depressive experience which in turn influences the form of religious coping methods (either positive or negative) that would be used.

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DECLARATION

This dissertation was undertaken at the school of Psychology, University of KwaZulu-Natal, Pietermaritzburg. Unless specifically indicated to the contrary in text, this dissertation is a product of the author's own work.

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CHAPTER 1: INTRODUCTION

> "Depression is as old as the human race and rare is the person who has not felt its touch. Sometimes, suddenly without apparent reason we feel unbearably sad. The world turns grey, and we taste bitterness in our mouth. We hear a bell that tolls our passing, and we reach out for a comforting hand, but find ourselves alone. For some of us this moment is no more than a fleeting moment, or something we can dispel with common-sense thoughts and practical actions, but for some of us this experience becomes a ghost whose unbidden presence mars every feast, or, worse, a prison whose walls, though invisible, are quite impenetrable" (Rowe, 1996, p.3).

Depression is a large and growing mental illness that has received a lot of attention from various research studies. It has been discovered that depression is not just a physical illness but that it affects the emotional, spiritual and psychological wellbeing of an individual suffering from it (Beck & Alford 2009; Cole, 1978, Blatt, 2002; Freud 1975e in Blatt, 2002; Pargament, 1997). Although depression may have a biological genesis, it is usually experienced psychologically (Jamison, 1996). The extent or the intensity of its effects on the individual's wellbeing can be thoroughly understood through the subjective experiences of those people who have gone through depression.

Numerous studies (Beck & Alford, 2009; Hood, Spilka, & Gorsuch, 1996; Pargament, 1997; Sadock & Sadock, 2007) have attempted to understand this mental illness focusing on aetiology, treatment and different ways of coping. Findings have revealed that one of the ways through which depressed people cope with depression is making use of religion or religious beliefs. Through its benefits of giving a sense of meaning to events and the reframing of potentially

stressful events, the use of positive religious coping has been shown to have some important implications for the treatment of depression.

Empirical studies (Harrison, Koenig, Hays, Eme-Akwari & Pargament, 2001; Kruse, 2005) have been conducted on the relationship between religious coping and depression, with findings revealing a correlation between religious coping and an improvement in the depressive symptoms. But a need has arisen to understand how those clinically depressed patients cope with the illness and the impact of this coping. Recent studies (Ellison, Fitchet, Rian & Salluna 2009; Harrison et al., 2001; Kruse, 2004; Murphy & Fitchet, 2009; Pieper, 2004) have shown a positive link between religious coping and psychological wellbeing. Furthermore these studies have shown lower rates of depressive symptoms to be associated with positive religious coping, although the direction of causation is unclear. Alongside these findings have been studies that dispute these findings where a positive link was found between religious coping and increased depressive symptoms.

Previous research studies have explored the use of religious coping methods in people with depression. However due to their quantitative nature, they have failed to explore the subjective experiences of people with a history of depression. Furthermore, these research studies have highlighted the finding that the use of religious coping methods can have both positive and negative outcomes with regards to the experience of depression. Further, these studies have failed to indicate the pathways through which religious beliefs help or hinder the recovery from depression.

The study reported in this thesis seeks to explore the subjective experiences of people with a history or present diagnosis of depression. It also aims to explore how religiously depressed people perceive the impact of their religious beliefs on coping with depression. This study aims to address the following research questions: 1) What is the subjective experience of clinically

depressed people? 2) What sorts of coping mechanisms are used by clinically depressed religious people? 3) For clinically depressed people using religious coping methods, what form do these coping mechanisms take? 4) What is the perceived impact of religious coping on the experience of depression? 5) Does the experience of depression have any impact on the individual's faith?

CHAPTER 2: LITERATURE REVIEW

2.1 Depression

2.1.1 Introduction

Depression is a serious mental disorder that has received a lot of attention over the years. It can manifest in a large variety of symptoms and is associated with many factors including chemical imbalances in the brain. The DSM –IV-TR (American Psychiatric Association, 2000, p. 327) characterizes depression as follows:

> "Depressed mood....markedly diminished interest or pleasure....significant weight loss/ weight gain....insomnia/hypersomnia....psychomotor agitation/retardation....fatigue....feelings of worthlessness/ inappropriate guilt....diminished ability to think/concentrate....recurrent thoughts of death".

According to the National Institute of Mental Health (NIMH) statistics (2008), approximately 20.9 million American adults or about 9.5% of the population aged between 18 and older have a mood disorder. Major depression is the leading cause of disability in the United States affecting approximately 14.8 million adults which is about 6.7% of the general population in a given year. The probability during one's lifetime of developing a major depressive disorder is 5-12 percent and 10-25 percent for males and females respectively (American Psychiatric Association, 2000).

Unlike other developed countries, South Africa has lacked the objective information on the prevalence of mental disorders due to a "handful of epistemological needs assessment surveys" that have been conducted (Williams, Herman, Stein, Heeringa, Jackson, Moomal & Kessler,

2007, p.1). This is inspite of accumulated factors predisposing South Africans to high risks of mental disorders (Williams et al., 2007). Prior to democracy in 1994, South African social policies were racialized, fuelling political violence, victimization and the anti-apartheid struggle (Dawes, 1990 in Williams et al., 2007). The violence that grew as a struggle against the existing system left a lot of people in South Africa with scars of victimization and a culture of violence, creating an environment conducive to the high risk of mental disorders (Williams et al., 2007). In the post Apartheid era, South Africa has many characteristics that can be associated with an increased prevalence of emotional distress. These are: high rates of violence with crime and gender violence increasing exponentially; the country's harsh economic circumstances; a high risk of HIV/AIDS and the unpredictable threat of trauma and life threatening injuries from mining (Dinan, McCall & Gibson, 2004; Dunkle, Jewkes, Brown, Yoshihama, Gray, McIntyre & Harlow, 2004; Seedat & Steyn, 2000; Maiden, 2005).

As a response to South Africa's characteristics, Williams and his colleagues (Williams et al., 2007) recently conducted a survey on the prevalence of mental disorders. The findings of the survey indicated that major depressive disorder is the most prevalent disorder and a major contributing factor in teenage suicides (Williams et al., 2007). There is also increasing evidence that major depression impacts the course of HIV infection, which is rampant in South Africa (Olley, Seedat, Nei & Stein, 2004). It is hypothesized that one in eight teenagers commit suicide in South Africa and a large number of these cases is precipitated by a depressive episode (Olley et al., 2004). Although findings in the survey indicated no gender differences in the overall prevalence for the mental disorders, Williams and his colleagues (Williams et al., 2007) found that women were at a higher risk of having a mood disorder and an anxiety disorder. Furthermore findings indicated that men were more at risk for substance abuse disorders.

The emotional distress in our country seems to subject its people to high risks of suffering from mental disorders especially major depressive disorder, and the findings from the survey conducted by Williams and colleagues (Williams et al., 2007) are a confirmation of that fact.

Although depression is a recognized clinical syndrome, there is yet to be found a completely satisfactory explanation for its puzzling and paradoxical features (Beck & Alford, 2009). The subjective aspect of the depressive experience gives rise to the contrast between the depressed person's image of himself or herself and the objective facts. Despite the torment experienced as a result of the self-debasing ideas, the depressed patients are not swayed by objective evidence or logical demonstration of the unreasonable nature of their ideas (Beck & Alford, 2009).

2.1.2 Descriptive concepts of depression

Early psychological conceptualizations typically attributed depression to the unconscious loss of a loved object/ self-esteem within a framework of intrapsychic constructs, including affective states such as being hurt, neglected, rejected, or disappointed (Cole, 1978, Freud 1975e, in Blatt, 2002, Fenichel, 1945 in Blatt, 2004). Beck and Alford (2009) described depression using the following attributes: 1) A specific alteration in mood: sadness, loneliness, apathy. 2). A negative self concept associated with self-reproaches and self-blame. 3). Regressive and self-punitive wishes: desires to escape, hide or die. 4). Vegetative changes: anorexia, insomnia, loss of libido. 5). Change in activity level: retardation or agitation.

The psychodynamic understanding of depression as defined by Sigmund Freud and expanded by Karl Abraham (Sadock & Sadock, 2007) involves the following key elements namely: the disturbance in the infant-mother relationship predispose one to subsequent vulnerability to depression; depression is linked to real or imagined loss of an object; as a defense mechanism the

departed object is introjected in order to deal with the distress connected with the object loss and; because the lost object is regarded with a mixture of love and hate, feelings of anger are directed inward at the self which manifests as depression. Similarly Melanie Klein (1934, as cited in Beck & Alford, 2009) believed that the predisposition of a person to depression was not dependent on a series of traumatic incidents but on the mother-child relationship in the first year of life. In her description of the predisposition to depression, she highlighted the child's defensive technique of denying the complexity of his or her loved object by seeing the loved object as either all good or all bad which is characteristic of the adult manic depressive person (Klein, 1934 in Beck & Alford, 2009).

In contrast Bibring (1953, as cited in Beck & Alford 2009) viewed depression as an affective state characterized by loss of self-esteem, due to frustration of a need for love and affection as well as other aspirations. Rado (1928), like other earlier writers, understood depression as involving self-esteem. He described depressive people as people with intense narcissistic needs and unstable self-esteem who react with angry rebellion at the loss of their loved object and then restore their self-esteem by punishing their ego by their superego through introjecting the bad part of the bad object. In 1961 Schwartz (as cited in Beck & Alford, 2009) attempted to construct a unitary formulation of manic-depressive reactions by expanding on Rado's (1928) viewpoint. He suggested that manic-depressive reactions occur when a person with excessive, unsatisfied narcissistic needs, introjects attitudes of those responsible for the „deprivation'. In adult life increased stress creates a sense of loss that is identified with earlier deprivation. He asserted that in depression, inhibition and immobilization are a denial of the capacity to carry out the aggressive impulses.

Contrary to earlier writers Blatt (2004) used depression to describe a character or personality style with an unusual susceptibility to dysphoric feelings, a vulnerability to feelings of loss and

disappointments with an intense need for contact and support, and a proclivity to assume blame and responsibility as well as feeling guilty. From this premise two types of depression can be identified with each based on one of the two very different fundamental mechanisms of psychological development (Blatt, 2004). The first one is a depression focused primarily on interpersonal issues such as dependency, helplessness and feelings of loss and abandonment. In this kind of depression the orientation of the person with depression is towards the other and thus referred to as anaclictic depression. In contrast the second type of depression is derived from a harsh punitive superego that is focused primarily on self-criticism, concerns about self-worth, feelings of failure and guilt where the orientation is towards the self which Blatt (2004) refers to this type as introjective depression.

The primary feelings in anaclictic depression are helplessness, weakness, depletion, being unloved, fears of abandonment and intense wishes to be soothed and cared for, helped and protected (Blatt, 2004). It is also characterized by a dysphoric tone stemming from feeling unloved, unwanted, neglected and abandoned (Blatt, 2004). Dominant are fears and apprehensions of being abandoned and a sense of helplessness in being able to find gratification and comfort (Fenichel, 1945 in Blatt, 2004). A sense of well being is derived from a continual supply of love and assurance (Blatt, 2004). These symptoms of anaclictic depression express the individual's feelings of being unloved and uncared for. Depression for these individuals is usually precipitated by the loss of a loved one either through sickness, death or childbirth (Beck, 1983 in Blatt, 2004).

Contrary to anaclictic depression, introjective depression is hallmarked by themes of guilt, atonement, forgiveness, unworthiness, feeling unloved and failing to live up to expectations (Blatt, 2004). Exceedingly high ideals, an overly harsh superego, a keen sense of morality and intense commitment which result in self-scrutiny and evaluation are the primary expressions of

introjective depression (Blatt, 2004). It is expressed in extensive demands for perfection, a proclivity to assume responsibility and blame, and feelings of being unable to achieve approval, acceptance and recognition (Blatt, 2004). In this type of depression, the depressed individual becomes self-critical, self-loathing and intensely involved in activities designed to compensate for feelings of inferiority, worthlessness, and guilt (Blatt & Shichman, 1983 in Blatt, 2004). In comparison with anaclictic depression, introjective depression involves a high level of psychological development with a greater capacity for internalization, the major defense being introjection and identification with the aggressor (Blatt, 2004). Relationships are highly ambivalent and the person struggles to integrate contradictory feelings.

Both these two types of depression (the dependent and the self-critical) highlight the subjective state of the depressive experience and the depressed individual's perception of the experience. Unlike other researchers and writers who focused on the descriptive aspect of depression which is vital in terms of diagnosis and conceptualizing, Blatt (2004) focused on the life experiences that are central in depressive experiences as a way of giving understanding to the nature of depression. His work placed more emphasis on the subjective experiences of depression in an attempt to integrate theoretical knowledge and practical experience. The various theoretical explanations of depression converge at one particular point of discussion, this being a consensus that depression centres on issues of perceived loss, either of a loved object or self-esteem and that such people are predisposed to depression based on their infant-mother relationship. Although stressful events are not necessarily precipitants to depression, when a person perceives the event as the loss of a loved or a highly esteemed object, then the perception may precipitate depression.

Blatt's (2004) work on the subjective experience of depression as discussed above highlighted the debilitating effects of the illness on an individual's well being. He has however failed to indicate or reveal the coping mechanisms utilized by those people going through the depressive

experience. Religion on the other hand has been found to be one of the more useful strategies people use to deal and cope with stressful circumstances (Hodges, 2002; Pargament, Maton & Hess, 1992).

2.1.3 The experience of depression

People experience depression differently, but one common factor is the incapacitating effect on the individual's mental, psychological and emotional wellbeing. Jamison (1995 as cited in NIMH, 2008, p.1) described the experience as follows:

> *"Depression distorts moods and thoughts, incites dreadful behaviors, destroys the basis of rational thought, and too often erodes the desire and will to live. It is an illness that is biological in its origins, yet one that feels psychological in the experience of it; an illness that is unique in conferring advantage and pleasure, yet one that brings in its wake almost unendurable suffering and, not infrequently, suicide."*

Other writers have referred to it as a prison where one is both the punished and the punisher (Rowe, 1996). In her book about the depressive experience, Rowe (1996) made a distinction between being unhappy and clinically depressed. She asserts that when an individual is unhappy s/he is able to seek and receive comfort needed to ease emotional pain as well as the ability to self-soothe. However when an individual is going through the depressive experience neither the sympathy nor concern of others nor the ability to self-soothe is available. She postulates that the depressive experience is like a wall between the individual and the external environment such that efforts made to offer solace and comfort by other people are thwarted by the wall and they are unable to reach the suffering individual. Furthermore the individual inside the wall is not

receptive to any comfort but rather punitive towards him/herself through cognitive thoughts and deeds. Ridge (2009) supported this description in his book about recovery from depression based on the subjective experiences of people he interviewed in his study. He postulates that no book or article can ever describe the experience in a way that allows the observer to fully understand the experience; only the person going through the experience is able to understand. He elaborates this statement by arguing that depression is an illness of "interiority" in the sense that it affects the person's cognitive, emotional and physical wellbeing which can only be experienced by the affected person alone (Ridge, 2009). The depressive experience has been referred to as an illness of the mind in so much as it changes the individual's perception of the world and the people around them (Ridge, 2009; Rowe, 1996).

The experience of depression experience has also been referred to a state of paralysis or "shut down", where the depressed individual is unable to move and the body is overwhelmed emotionally to a point where it (the body) is unable to cope with the demands of the stressor (Ridge, 2009 p.49). In this state the depressed individual is unable to think, make sense of what is happening and process the information in a manner that necessitates coping mechanisms. It has also been referred to as a living hell when considering the incapacitating effect of the experience in so much as it is hallmarked by feelings of dejection and desolation (Ridge, 2009). The transition into depression is usually experienced as a downward spiral of distressing emotions, thoughts and bodily sensations (Beck, 2002). More often it is followed by an overwhelming cluster of negative thoughts, emotions, distortions in the way people view themselves, chemical changes in the body and physical symptoms (Ridge, 2009). People who experience depression often report an ineffable but distinct emotional state that is marked with feelings of hopelessness and worthlessness (Sadock & Sadock, 2007). It is often described by depressed people as an "agonizing emotional pain", yet with the inability to cry (Sadock & Sadock, 2007 p.543). Some

depressed people may withdraw from family and friends and lose interest in previously enjoyed activities; some report difficulty in finishing tasks (Sadock & Sadock, 2007).

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2.2 Religion and mental health

Religion has been found to play a major role in helping people make sense of what they are going through as well as promoting mental health (Pargament et al., 1992). In view of the social functions of religion, especially those which impact on the mental health of people, religion has been found to provide a sense of meaning and purpose in life; some kind of hope that the illness one is going through and even death is working towards the person's good. (Alcock, 1990; Roberts, 1992). Having a sense of meaning and purpose can be a vital component in one's mental health. Praying for divine intervention, and believing in a caring God gives one a sense of hope, and anxiety about the future seems to be reduced (Hodges 2002; Pargament et al., 1992). It can counter feelings of powerlessness and promote greater optimism and a better acceptance of suffering and misfortune (Hood, Spilka & Gorsuch, 1996).

Religion has also been found to offer a sense of belonging, and enhancing the individual's sense of identity through involvement in church activities and common beliefs. The individual becomes part of a group of believers who share the same values as well as providing some social stability where people with the same belief are guided with moral values that emphasize unity and harmony for the society as a whole (Roberts, 1992). From this premise religion can be referred to as a unifying phenomenon in terms of common beliefs and commitments which regulate societal norms and define morality (Roberts, 1992). Several studies (Hayden & Gross, 1990; Schumaker, 1992) have been conducted on the connection between religion and mental health where findings indicated a positive relationship between religion (having religious beliefs, attending church

services, frequency of prayer, religious salience) and the following: mental health, ability to tolerate chronic pain and an improvement in self-esteem. These studies suggested that the more people made use of religion to deal and cope with stressful events, the more improvements were noticed in their mental well being, ability to cope with chronic pain and self esteem. This was due to their benevolent reappraisal of the stressful events, support from their congregation members and their belief that they were not alone but God was with them as they coped with their stressful events. (Judd, 1985 in Pargament et al., 1992; Pargament et al., 1992). Religious beliefs and practices also may assist individuals in framing or making sense of events or conditions, in as much as potentially stressful circumstances may seem less threatening to one's identity or sense of self (Ellison et al., 2009) These findings also suggested that the people who were of a religious faith were able to cope better with mental illness as compared to those who were not religious. Similarly religion has been found to act as a buffer against stress and provide meaning to patients suffering from chronic illness (Schumaker, 1992). According to these studies religion seems to play a vital role in an individual's mental being by providing meaning, a sense of hope and comfort in the midst of suffering, systems of support and mutual aid (Vanderpool, 1992). Involvement in religious organizations has been found to assist individuals in the coping process by providing access to three different types of resources namely: spiritual support, social support and opportunities for community service (Carleton, Esparza, Thaxter & Grant, 2008). Spiritual support is regarded as helping the individual in feeling a greater sense of connectedness to a higher power which gives the individual a framework with which to better understand events in their lives (Carleton et al., 2008). Similarly Pargament and Maton (2000) suggested that involvement in religious communities and church activities allows individuals to access these resources which are in turn helpful for dealing with stress.

Although several studies (Carleton et al., 2008; Hayden & Gross, 1990; Pargament et al., 1992; Pargament & Maton, 2000; Schumaker, 1992) have indicated a positive relationship between religion and mental health, alongside these findings there have been other studies (Alcock, 1992; Pargament, 1997) that dispute those findings, revealing a negative relationship between the two variables. Alcock (1992) argued that religion can be detrimental to an individual's mental well being. He argued that some religions can be so dogmatic and controlling that the individual becomes dependent on the leader for his/her self-worth. In his work on the dysfunctional aspects of religious beliefs, Alcock (1992) contends that the emphasis on sin fosters guilt and condemnation in the individual who commits sin. He elaborates and highlights that most of the followers of authoritarian religion often regard themselves as insignificant and powerless as compared to their God who is all powerful and flawless. This, he argues, promote feelings of worthlessness and poor self-esteem. This study was supported by Pargament's (1997) findings in his review of literature on the reasons people turn away from religion. He suggested that people who feel abandoned by either their congregation or God may also experience hopelessness, despair, resentment as well as poor mental health.

Despite the contrast in the findings, there seems to be a consensus that there is a relationship between religion and the mental health of people and that religion can be a source of distress as well as a solution in coping (Pargament et al., 1999) What these studies have failed to show is the role of religion in mental health or mental illness, or the exact pathways through which religious belief and practice impact on mental health and illness.

2.3 Religion and depression

In addition to the more general research between religious belief and mental health, researchers have explored the specific relationship between religion and depression. Robert and Spilka (1992) found a link between religion (religious commitment, religious activeness, social support from church members and a strong belief in a higher power) and depression where the former was found to alleviate depression by helping the individuals to deal with their anger, reducing guilt and loneliness, and interpersonal anxiety. According to Stack, (1992) there are three levels at which religion may affect depression based on different hypotheses. These are: 1) the social cohesiveness hypothesis asserts that religion offers social support through social networks which may include emotional, cognitive and material benefits which may lower the risk of depression. 2) The coherence hypothesis argues that religion fosters a sense of hope instead of despair and 3) the theodicy hypothesis contends that religion gives meaning to experiences so that illness is viewed in a positive light. A study by Hodges (2002) investigated the theodicy hypothesis by examining the relationship between church attendance, meaningfulness of religion and levels of depression, and found significantly lower rates and levels of depression among adolescents who find meaning in life through their religion. Because a sense of hopelessness is common among patients with depression, a sense of meaning found in religion may foster hope and enable the depressed person to cope with depression (Beck, 1967). Koenig (1990) found evidence in his study that commitment to religious beliefs and activities is related to lower levels of depression. This finding has been supported by various studies (Harrison, Koenig, Hays, Eme-Akwari & Pargament, 2001; Kruse, 2005) where a positive relationship was found between religion (i.e commitment to God through church attendance, finding meaning through religious beliefs) and lower levels of depressive symptoms. A recent study conducted by Pieper (2004) supported the findings by

showing a positive link between religious coping, psychological well being and lower rates of depressive symptoms. Belief in a concerned God has also been shown to be associated with lower depressive symptoms by reducing hopelessness (Murphy & Fitchet, 2009). In their study on the belief in a concerned God as a predictor for response to treatment, Murphy and Fitchet (2009) found that a strong belief in a concerned God provided healing and support for people in the isolation of depression. .The findings indicated that those of a religious faith find solace and support in a caring God.

Religion has also been found to affect depression through facilitating social support. For example, religious people going through depression are able to share values and feel supported by a community of believers through prayer, singing or meditating together (Maton, 1989 in Hodges, 2002). Depressed people often report the loss of emotional attachments, which can lead to withdrawal from social contacts. Being involved in spiritual communities provides a sense of unity and strengthens emotional support (Beck, 1967; Hodges, 2002). Religious beliefs and practices may also help individuals in framing events in such a way that potentially emotionally taxing circumstances have less effect on their emotional and psychological well being (Ellison et al., 2009).

Being involved in religious activities and having a sense of support from other religious members in the church promotes a sense that one is not alone and alleviates feelings of despair (Ellison et al., 2009; Schnittker, 2001; Yohannes, Koenig, Baldwin & Connolly, 2008). It has also been found that religious girls attending religious services and being involved in church activities were less likely to develop depression (Miller & Gur, 2002 in Carleton et al., 2008) The belief in a concerned God, being involved in religious activities, and perceiving adverse circumstances as „working out for good' for the depressed individual alleviates feelings of hopelessness, anger and guilt by encouraging the individual to look beyond the stressful circumstances and focusing on the

meaning of the experience (Ellison et al., 2009; Hodges, 2002; Wright, Frost & Wisecarver, 1993). People who view life through these religious lenses may experience feelings of optimism, hopefulness and intrinsic self-worth (Ellison et al., 2009). These extensive studies suggest that the presence of religious beliefs and attitudes which include involvement in spiritual communities and attendance at church ceremonies alleviates depressive symptoms. Various studies (Beck, 1967; Ellison et al., 2009; Hodges 2002; Koenig, 1990; Robert & Spilka 1992; Wright et al., 1993) have found an inverse association between religion (religious salience, religious attendance and seeking comfort from religion) and depressive symptoms, and it appears that social support from church members and family plays an important role in shaping the individual's experience and the meaning attached to it (Ellison et al., 2009).

Contrary to these findings is a study by Hood (1992) which found that more fundamentalist religious outlooks may lead to a greater sense of isolation and depression. This was supported by several studies (Olszewswki, 1994 in Hodges 2002; Pieper, 2004) which found higher levels of depressive symptoms among people of a religious faith. Entwistle (2004) has argued that religion can be detrimental to the individual's mental health when it impedes the individual from seeking help for a chronic illness in the hope that their faith in a healing God will help them instead. This belief exacerbates depressive symptoms where the individual feels that their God is punishing them for sins committed and that it is God's will that they suffer in order to learn (Entwistle, 2004).

Although various studies have indicated contradictory findings with regards to the association between religion and depression, suggesting that religion can have two conflicting effects on the experience of depression, the fact that there is an association however between the two concepts cannot be overlooked. The quantitative nature of many studies only reveals the general connection between religion and depression, but fails to explore specific aspects and finer nuances of the

subjective experience of religion and its role in the experience of depressive symptoms. Whether or not religion helps or impedes recovery from depressive symptoms remains unclear. Understanding the coping mechanism that helps the individual deal with the mental illness is pivotal when considering the individual's subjective experience of the mental illness, their sense of meaning in terms of the experience through their religious belief system and the change or recovery from the mental illness.

2.4 Coping

2.4.1 Definitions

In reviews of mental health and attempts to alleviate the effects of chronic illnesses on the social, academic, occupational and spiritual wellbeing of people, much work has been done on ways to assist those suffering from chronic illness and mental illness by looking at ways in which they cope. The study of coping has grown tremendously as researchers explore ways in which people approach the critical events in their lives, ranging from day to day stressors to coping with chronic illnesses. The study of coping attempts to add value in terms of alleviating the effects of chronic illness on mental wellbeing. It assumes that all humans encounter difficulties and trials pressurizing them beyond their capabilities and triggering a process of coping and that the individual is a proactive agent engaging in choices (Harrison et al., 2001).

Various researchers have described the phenomenon of coping drawing on different viewpoints. Friedman, Chodoff, Mason and Hamburgh (1963, as cited in Pargament 1997) defined coping as the mechanisms utilized by an individual to deal with a significant threat to his psychological stability and to enable him to function effectively. Lazarus and Folkman (1984, p.141) on the other hand defined coping as "constantly changing cognitive and behavioural efforts to manage

specific external and/ internal demands that are appraised as taxing or exceeding the resources of a person". From this definition there is a suggestion that coping is a continual and adaptive process utilized by an individual to deal with challenging demands from their environment. It has also been described as the use of strategies for dealing with actual or anticipated challenges and their negative emotions (Aldwin, 1994). Common to the various definitions of coping is the struggle to deliberately live with and adapt to the difficult situations people find themselves in.

Although varying in their description, each viewpoint on coping explains how the individual meets a situation and their efforts to adjust to it. Coping is viewed as a dynamic process that is focused on stressful or challenging situations (Lazarus & Folkman, 1984). Lazarus and Folkman (1984) state that coping is not merely a response to stressful events or situations but it is influenced by the individual's subjective cognitive evaluation and interpretation of the event which subsequently influence emotional arousal. At its core, coping is a transactional process of exchange and encounter between an individual and a situation within a particular context (Pargament, 1997). This transactional process is focused on "thoughts and awareness that impact the overall individual stress response an individual can have in his or her mind and body" (Matthieu & Ivanoff, 2006, p.5). The focus is also on the individual's subjective evaluation of the event which then mediates the response to the stressful event (Lazarus, 1999 in Matthieu & Ivanoff, 2006).

There are two processes that seem to be involved in mediating the person-environment relationship: (1) *the cognitive appraisal,* which involves an individual's evaluation of the event in terms of harm and (2) *coping*, which involves the individual's management of the demands of the person-environment relationship and the emotions arising from it (Lazarus & Folkman, 1984). The cognitive appraisal process is about evaluating an event in terms of its effect on the

individual's wellbeing and it consists of two processes: firstly the primary appraisal involving the "perceived control of the situation and the resources available to the individual" (Lazarus & Folkman, 1984, in Michell, 2004, p.18). The evaluation of the encounter can be viewed as being relevant or irrelevant, benign positive or positive (Matthieu & Ivanoff, 2006). The secondary appraisal process is the individual's analysis in terms of his/her ability to cope or deal with the situation (Matthieu & Ivanoff, 2006). This leads to specific coping strategies to manage a perceived stressful situation.

According to Lazarus & Folkman (1984) the coping strategies are either problem-focused or emotion-focused. Problem-focused coping involves the individual's efforts to handle or manage the perceived stressful event; it involves decision making, the choice of situation-specific resources and utilizing those resources in a manner that achieves the individual's goals of coping with the event or situation (Matthieu & Ivanoff, 2006). The individual is active in the process as they plan and execute their plan in a way that protects them from the perceived stressful event. Emotion-focused coping, on the other hand, involves cognitively reframing the stressful event in a positive manner such that potentially stressful situations are viewed in a positive way in order to necessitate coping with the emotional demands of the situation (Matthieu & Ivanoff, 2006). The individual is passive when employing an emotion-focused coping strategy in comparison with the former. However some coping strategies such as seeking social support may be regarded as problem-focused and emotion-focused coping strategies simultaneously (Vitaliano, Maiuro, Russo & Becker, 1987). The two coping strategies are used by most individuals either simultaneously or individually depending on the situation and how it is cognitively appraised (Lazarus & Folkman, 1980 in Michell, 2004).

The individual's cognitive appraisal of the situation plays a pivotal role in the selection of a coping strategy. Whether the individual would choose to be active in coping (i.e. employ

problem-focused coping strategies) or passive (i.e. utilize emotion-focused coping strategies), that is determined by an individual's evaluation of his /her perceived control or lack of control over the situation or not. Central to the concept of coping is possibility, suggesting that the individual is able to look beyond the distress faced and begin to see themselves or their situation in a different way, or to respond to that situation in a different way. The key point in coping is that the individual chooses a way to handle his/her circumstances, which makes coping both an active as well as a passive process in which an individual makes choices to deal with circumstances or stressful events.

2.4.2 Coping with stressful events

When faced with chronic illness people use various ways to cope with the long-term effects of the illness. When experiencing chronic pain, individuals may hold on to certain beliefs which include a sense that everything is out of control. They may also have concerns about the present and the future which leads to feelings of hopelessness and social isolation (Robertson, Smith, Ray & Jones, 2009). However people do not face stressful situations without resources, they are often relying on an orienting system of beliefs, and practices which affect the way they deal with emotionally and physically demanding situations (Hood, Spilka, Hunsberger & Gorsuch, 1996). In their coping process, this orienting system is turned into „concrete situation-specific appraisals' which help them cope with the situation. (Hood et al., p.378).

Building upon the work of Lazarus and Folkman (1984) it can be assumed that coping is a continual process. The individual is continually making sense of the situation using their orienting belief system which offers resources that bolster the coping mechanisms used to deal with stress. Different people use various ways of coping with stressful situations depending on

their resources available. In a study conducted by Sanru and Sijian (2007) on the coping strategies utilized by stroke survivors it was found that emotional support from families, constructing positive recovery and maintaining family patterns, were some of the strategies used to cope with stroke. Problem solving as a coping strategy has been found to be effective in situations where change is a possibility and in reducing anxiety and depression (Lui, Ross Thompson, 2008; Sanru & Sajian, 2007). Problem-focused coping strategies are more likely to be effective in situations or events that are controllable (Lazarus & Folkman, 1984; Mischell, 2006). Alternatively emotion-focused coping strategies may be more appropriate in events that are uncontrollable or beyond the individual's perceived control of the stressor.

2.5 Religious coping

When faced with chronic illness people utilize different coping mechanisms and religion or religious beliefs are one of the methods used. Although other researchers regard the use of religious beliefs or religion as an aspect of coping, Pargament (1997) emphasized and regarded the use of religious beliefs or religion in coping, as a form of coping in itself and termed it "religious coping". The study of coping and the involvement of religion in the coping process has received a lot of attention as researchers explored mechanisms which people utilize when faced with stressful events or circumstances in their lives. The relationship between religion and coping is the subject of a growing body of psychological research. For many people the use of religion as a coping strategy appears to have positive effects in dealing with stressful life events and coping with chronic illnesses (Pargament et al., 1998; Robertson et al., 2009). The relationship between religion and coping has been described by Pargament (1990, as cited in Pargament et al. 1998) in three ways: religion forms part of the belief system of many people; religion can shape the coping

process and religion can be shaped in turn by the coping process. The belief that God is involved in one's life despite the chronic state the person finds themselves in, seems to bolster the coping mechanisms of people suffering from chronic illnesses (Gallup 2003, in Robertson et al., 2009). People also turn to religion as a form of coping when it is „available and accessible' to them or forms part of their belief system (Pargament, 1997 p. 162).

Extensive research (Harrison et al., 2001; Lui et al., 2008; Pargament, 1997; Robertson, 2009; Sanru & Sajian, 2007) has been done on religious coping in terms of its effects on mental wellbeing and findings suggests that the use of religious coping when faced with challenging events helps people, through redefining the stressor as benevolent and beneficial to the individual. In order to understand the concept of religious coping, the use of different researchers' definitions in encapsulating the meaning is essential.

2.5.1 Definitions

Koenig (1992) described religious coping as the dependence on religious belief or activity to deal and adjust with emotional or physical distress. It is common among older adults, but a recent study has shown that even younger people (for instance teenagers) make use of religious coping to deal with stress (Koenig, 1992; Wright et al., 1993; Szewczyk & Weinmuller, 2006). In his study of religious coping Pargament (1997) contends that religious coping is not just the inclusion of religion in the coping process but that it is a specific form of coping in itself. He distinguishes between three methods of religious coping based on the individual's approach to problem solving in the context of their relationship with God. These are: collaborative, the deferring and self-directing approach. In his description of the collaborative approach, Pargament (1997) referred to it as an active approach where the responsibility for problem solving between the individual and

God is mutual. In this approach the individual approaches the coping process in partnership with God.

Contrary to the active approach is the deferring approach which is passive in a sense that it shifts the responsibility for problem solving to God. In this approach the individual takes the passive role in coping efforts. Alongside these is the self-directing approach which is based on the "belief that God has provided or will provide the skills necessary for coping" and that the individual must take an active role and use those skills for problem solving (Fabricatore, Handall, Rubio & Gilner, 2004, p.93; Pargament, 1997). The perception of God's involvement or non-involvement in the depressive experience seems to play a pivotal role in determining which approach will be used by the individual when dealing with stress (Pargament, 1997).

The collaborative approach to religious coping has been found to be a useful method as compared to the other approaches (Fabricatore et al., 2004). Being religious may not be sufficient in protecting the individual from distress but the ability of the individual to utilize their religiousness and incorporate their beliefs in the coping process, has been found to bolster coping with stressful events (Fabricatore et al., 2004).

2.5.2 Nature of religious coping

Understanding and explaining religious coping is essential to understand the relationship between religiousness and mental health, and also the relationship between stressors and mental health (Pargament, 1997; Fabricatore et al., 2004). Religious coping implies that the person is incorporating their relationship with God into their coping efforts. It is said to be multi-dimensional in the sense that it assists people in a search for various significant ends in stressful

times and these may be a sense of meaning and purpose, emotional comfort as well as enhancing interpersonal relationships and physical health (Pargament, Smith, Koenig & Perez, 1999).

Empirical studies investigating the association between religious coping and mental health have made use of a range of measures of religiosity, e.g. frequency of prayer, religious salience, congregational attendance and faith in God, yielding different findings. While these various measures of religious belief and practice may be implicitly reflective of religious coping, there may also be specific attempts to use religion as a coping mechanism. These studies tended to measure the individual's belief or religious practices but failed to specifically measure the use of religious coping methods in association with mental health. In response Pargament and his colleagues (Pargament et al., 2000) developed an instrument called the Brief Measure of Religious Coping (RCOPE) which was used to measure the individual's use of religion in dealing with stressful events. This instrument was designed to assess five religious coping functions:

1) Finding meaning in the face of suffering and battling life experiences;

2) Providing an avenue to achieve a sense of mastery and control;

3) Finding comfort and reducing apprehension by connecting with a force that goes beyond the individual;

4) Fostering social solidarity and identity; and

5) Assisting people to give up old value objects and find new sources of significance.

Although the RCOPE is considered to be efficient in its measurement, it has its limitations in terms of assessing the role of religion in coping, as it fails to specify the manner in which the individual uses religion to understand and deal with stressful situations (Pargament et al., 2000).

The subjective experience is the key element in order to understand and to know how an individual reframes and appraises a stressful event to facilitate coping (Gathigia, 2006).

In his review of literature, Pargament (1997) highlighted the broader aspect of religious coping and identified different methods of religious coping which individually have implications for adjustment in critical times of life events. Amongst them is the collaborative religious coping method which has been associated with an improvement in physical and mental health of elderly patients in institutionalized care (Harrison et al., 2001; Pieper, 2004). In contrast the self-directing and deferring religious coping methods have been linked with an increase in depressive symptoms and poor physical and mental health (Harrison et al., 2001; Hills et al., 2005; Pieper, 2004). The various religious coping methods appear to be interrelated in that people do not use them individually but utilize them in combination with each other when faced with life events (Pargament et al., 1999). Pargament (1997) and his colleagues (in Pargament et al., 1999) developed an instrument focusing on the different religious coping methods and their patterns of interrelationship rather than on one religious coping method. There were two patterns of coping that emerged: the positive and the negative.

The pattern of positive religious coping methods is described as the one indicating a secure relationship with God, a belief that there is meaning to life, a sense of connectedness with God and others (Pargament et al., 1999). It is a form of coping with a perception of God as caring and loving. The individual in this pattern uses religious coping methods that are centred on a partnership with God in problem solving, looking to God for strength and guidance, attributing the stressful events to a greater purpose etc. (Herbert, Zdaniuk, Schulz, Scheier, 2009). Positive religious coping strategies include seeking comfort through a mutual relationship with a concerned God, prayer, religious reframing and meditation (Pargament, 1997).

This pattern of religious coping is comprised of the following religious coping methods:

1. Benevolent religious appraisals - redefinition of stressor as beneficial;
2. Collaborative religious coping - seeking control through partnership with God in problem solving;
3. Seeking spiritual support - searching for comfort and reassurance through God's love and care;
4. Spiritual connection - seeking a sense of connectedness with transcended forces;
5. Religious purification searching for spiritual cleansing through religious activities;
6. Seeking help from clergy or church members - searching for solace and comfort from congregational members;
7. Religious helping - attempting to provide comfort to others;
8. Religious forgiveness - looking to religion for help in letting go of anger, hurt and fear associated with an offence;
9. Reappraisals of God's powers - redefining God's powers to influence the situation.

Research supports these strategies for the promotion of well being, life satisfaction and the moderation of pain, anxiety and depression (Jenkins & Pargament, 1995 in Robertson et al., Pargament, 1997).

In contrast the negative religious coping pattern is described as "the expression of a less secure relationship with God, a tenuous and ominous view of the world", a sense of being insulated from God and others and a struggle for spiritual connectedness (Pargament et al.,1999 p. 712). Centred

in this pattern of negative religious coping is a perception of God as uncaring, punitive and abandoning. The religious coping methods utilized in this pattern are hallmarked by anger towards God, spiritual discontent, punitive religious reappraisals and interpersonal dissatisfaction (Pargament et al., 1999). Following are religious coping methods that are part of this pattern:

1. Punitive religious reappraisals – redefining the stressor as God's punishment for sins committed;
2. Demonic religious reappraisals – redefining the stressor as the act of the Devil;
3. Spiritual discontent – expressions of confusion and dissatisfaction with God;
4. Self-directing religious coping – seeking control through individual initiative rather than God;
5. Interpersonal religious discontent – expressions of confusion and dissatisfaction with clergy members.

This pattern of negative religious coping methods has been associated with poor physical and emotional wellbeing, increase in depressive symptoms, lower life satisfaction and impaired quality of life (Harrison et al., 2001; Hills et al., 2005; Pieper, 2004; Robertsons et al., 2009). Alongside these studies Herbert et al. (2009) found that these negative religious coping methods predict worse mental health and life satisfaction among women with breast cancer.

Pargament (1997) viewed the religious coping process as a continual process and suggested that it flows in terms of two steps. The initial step is when the person implicitly asks themselves about the meaning and the relevance of the event to them. Their additional appraisals then come to the fore in deciding whether it is a threat or a challenge. In the case of a threat the individual focuses on anticipated difficulties s/he would encounter and ways to deal with them, whereas if it is perceived as a challenge, the person would see the likelihood of future growth and development.

Pargament (1997) highlights the differential role of religion in the appraisal process, as the person can either regard the event as God's intentional action to teach them a lesson or punishment through daily failures. The perception of the event is very important as it determines how the person would adjust and deal with the situation. The second step of the religious coping process is where the individual attempts to deal with the stressful event by doing various activities, including prayer, seeking support from church members etc. By praying the religious person is said to be doing something active which is making an appeal to the highest power possible for overcoming misfortune and suffering (Hood et al., 1996). This is considered constructive as it prompts the individual to adopt new ways to solve problems (Hood et al., 1996). The pattern of religious coping that would be chosen by an individual is determined by the perception or the appraisal of the event. In the appraisal process, if the person regards the stressful event as God's intentional act to teach them something, they are likely to use the positive religious pattern of coping and likewise if their appraisal of the event is that God is punishing them, they are likely to make use of negative religious coping methods (Pargament, 1997; Hood et al., 1996).

The various studies (Hood et al., 1996; Pargament, 1997; Pargament et al., 1999; Hills et al., 2005; Robertson et al., 2009; Szewczyk & Weinmuller, 2006) noted one important aspect in the religious coping process, which is the role of the individual's perception in dealing or coping with any stressful event and the search for meaning in the experience which drives the coping process. There seems to be no specific order suggested by the discussed studies which can be regarded as a process that would be followed by a religious person faced with stressful events. However it is suggested that coping is a continual and adaptive process, that seem to involve various aspects, namely: the individual's orienting system, the search for meaning, the appraisal process of the event and, the choice of religious coping methods (positive or negative).

2.5.3 Religious coping with stressful life events

Hood et al. (1996) viewed stress (whether it involves loss, threat or challenge) as reflecting a situation in which meaning, control and self-esteem are in jeopardy. In their view they argued that a person faced with stressful situations has difficulty in making sense of the situation, or is unable to master it or evaluates him/herself negatively in relation to the circumstances. Religious coping is one way that the individual makes sense of the situation through the primary appraisal process in which the individual translates their orienting system into coping strategies relevant to the situation (Hood et al., 1996; Pargament, 1997). A person of a strong religious faith when faced with stressful situations is likely to turn to religion as a coping strategy by translating their orienting system into situation specific appraisals.

Religious coping methods have been said to mediate the relationships between an individual's general orienting system and the outcomes of a stressful event (Pargament, 1997 cited in Pargament et al., 1999). In his review of literature Pargament (1997) asserts that when faced with stressful life events, the individual's belief system is translated into a specific religious form of coping which then seems to have a direct implication on the individual's health. It has been found that the higher the stress levels, the more people are likely to turn to religion or use religious coping as it gives meaning to the experience and assurance that they are not alone (Szewczyk & Weinmuller, 2006).There is a growing realization that religious coping can affect various aspects of an individual's life (Hills et al., 2005). This effect also extends to patients with chronic and life threatening illnesses who struggle with fear, anger, and physical discomfort and changing self-images (Hills et al., 2005). One's religious beliefs may have a profound impact on how the

individual copes with the suffering that so often accompanies advanced diseases (Hills et al., 2005; Robertson et al., 2009).

2.5.4 Religious coping with depression

Several studies (Harrison et al., 2001; Lui et al., 2008; Pieper, 2004; Robertsons et al., 2009; Sanru & Sajian, 2007) conducted on people with a current diagnosis of depression, exploring the relationship between religious coping and depression, have found lower rates of depression to be associated with the use of positive religious coping. These studies suggest that people who employ religious coping tend to cope better because of a reframing of the experience of depression, social support from other church members, talking about the experience and anticipating a good outcome of depression (Harrison et al., 2001; Pieper, 2004), all of which are associated with religious coping. The evidence is mounting that positive religious coping is beneficial for patients going through depression as investigated by the various studies (Fabricatore et al., 2004; Graham, Furr, Flowers & Burke, 2001; Hills et al., 2005; Koenig, 1992; Pargament, 2007; Robertson et al., 2009; Pieper, 2004; Szewczyk & Weinmuller, 2006; Wright et al., 1993).

Given the extensive research it becomes pivotal to understand why people turn to religion or use religious coping methods especially those going through a depressive experience. Pargament (1997) postulated that people turn to religion or use religious coping because it is accessible to them and available to them as it forms part of their belief system. Various studies (Fabricatore et al., 2004; Graham et al., 2001; Harrison et al., 2001; Hills et al., 2005; Koenig, 1992; Lui et al., 2008; Pargament, 2007; Pieper, 2004; Robertsons et al., 2009; Sanru & Sajian, 2007; Szewczyk & Weinmuller, 2006; Wright et al., 1993) have indicated the relevance of religious coping methods in dealing with stressful events and especially its relation to depression.

The experience of depression according to Blatt (2004) is marked with feelings of hopelessness, helplessness, despair, loneliness, depletion of emotional resources, being unloved, fears of abandonment and intense wishes to be soothed and cared for, helped and protected. Blatt (2004) also asserts that depression is hallmarked by feelings of guilt, atonement, forgiveness and unworthiness as well as a search for meaning in the experience. Religious coping has been found to fulfill some of these feelings by providing a sense of meaning and purpose in the experience which alleviates anxiety about the future, (Alcock, 1992; Robertsons et al., 2009). The idea that one is not alone in the experience, but that God is in control, gives a depressed person a sense of hope, comfort and alleviates helplessness and despair (Hodges, 2002). The religious activities a depressed individual engages in as part of their coping process, enhances support from other church members which offers emotional comfort, facilitates interpersonal relationships and physical health (Pargament et al., 1999). It can also counter feelings of powerlessness and promote greater optimism and a better acceptance of sufferings and misfortune (Spilka et al., 1985). Reframing the experience and perceiving God in benevolent terms has also been found to strengthen the depressed person's sense of meaning in the experience, thus bolstering their coping.

By comparison, religious coping has also been found to be associated with an increase in the experience of depressive symptoms suggesting that those people who made use of negative religious coping methods experienced more feelings of hopelessness, helplessness, feelings of being abandoned by God, fears about the future, loneliness and despair, anger towards God etc. (Harrison et al., 2001; Hills et al., 2005; Pieper, 2004; Robertsons et al., 2009). In this kind of religious coping the individual's perception of God as uncaring, unloving and abandoning, increases punitive reappraisals of the event and reframing the event as God's punishment to the depressed individual (Hood, 1992). This negative appraisal of the event where God is perceived

as punitive and abandoning has been found to lead to a greater sense of isolation exacerbating depressive symptoms by leading the individual to feel that God is punishing them for sins committed and the punishment is necessary for them to learn (Hood, 1992; Entwistle, 2004). Alongside these studies is the use of religious coping methods in a manner that induces a passive role in coping where the individual's access to available help facilities may be impeded by their belief that God is their healer and seeking help would be an indication of their weak faith (Entwistle, 2004). This coping strategy may push the blame to the depressed individual inducing guilt feelings and the exacerbation of the depressive symptoms.

The perception of God as caring or uncaring, loving or unloving, embracing or abandoning seems to have a huge impact in determining which pattern of religious coping methods will be used. The choice of a religious coping method is associated with different outcomes: increase or decrease in depressive symptoms as investigated by various studies (Entwistle, 2004; Fabricatore et al., 2004; Graham et al., 2001; Harrison et al., 2001; Hills et al., 2005; Hood, 1992; Koenig, 1992; Lui et al., 2008; Pargament, 2007; Pieper, 2004; Robertsons et al., 2009; Sanru & Sajian, 2007; Szewczyk & Weinmuller, 2006; Wright et al., 1993).

Although the studies have shown associations between the use of religious coping methods and depressive symptoms, they failed to indicate the depressed individual's view of their experience and how their perception influenced the choice of the religious coping methods used.

2.6 Conclusion

Psychodynamic theories have hypothesized that depression is about loss, whether real or imagined, of the self-esteem, loved object, or resources. This review of literature has shown that depression is the leading cause of disability in the USA, highlighting the debilitating effects of the

subjective experience of the illness. Depression has received a lot of attention from various studies due to its chronic nature, and its effects on the individual's physical, emotional and spiritual well being. Considering these incapacitating effects, the research has been extensive in finding out how individuals cope with depression. When faced with stressful situations, people use various ways to cope or adjust to the stressor. One of the strategies used is religious coping methods which have been found to be useful when faced with stressful circumstances (Fabricatore et al., 2004; Graham et al., 2001; Hills et al., 2005; Koenig, 1992; Lui et al., 2008; Pargament, 2007; Robertsons et al., 2009; Sanru & Sajian, 2007; Szewczyk & Weinmuller, 2006; Wright et al. 1993). People going through the depressive experience tend to use religion to obtain solace and comfort as it helps them to make sense of their experience through redefining it in benevolent terms or as God's punishment to them for sins committed (Hodges, 2002; Hood, 1992). This sense of purpose and meaning has been found to bolster coping among people going through depression.

Various studies supported this notion by finding a relationship between the use of religious coping methods and a decrease in depressive symptoms. Alongside these studies have been various contradicting studies which have also found a negative relationship between the use of religion and depressive symptoms. These studies have highlighted the importance of perception in the coping process, that the choice of a religious coping pattern (whether positive or negative) was determined by how the experience was appraised and defined. Where the individual perceived the experience in benevolent terms a positive religious coping method was chosen to cope with the experience. Inversely where the experience was perceived as God's punishment for sins committed, a negative religious coping method was chosen which according to studies was associated with an increase in the depressive symptoms (Entwistle, 2004; Hood, 1992; Pieper, 2004).

Although studies have indicated positive and negative associations between religious coping and depressive symptoms, these studies have been quantitative in nature, often limiting the exploration of the subjective aspect of depression, including how the individual perceived their experience and how this influenced their coping process. Further, much of the research has been conducted in the United States and Europe, with little if any research done in Southern Africa. This study will attempt to bridge the gap in the research by looking at the role of religion in the coping process of people going through depression. This would be done through the exploration of their perception of the experience of depression and how their perception influenced their coping in terms of outcomes. In order to explore the subjective aspect of the experience a qualitative design has been chosen for this study to allow for a fuller account and explanation of the depressive experience. The religious coping literature indicates that people are far more likely to see their God and congregation as a source of love and support rather than a source of pain and punishment (Pargament et al., 1992). Alongside these findings are studies that dispute this assertion, maintaining that people blame God and are angry with him for having abandoned them when they needed Him the most (Entwistle, 2004; Hood, 1992). On the basis of this literature review, the hypothesis in this study was that people going through a depressed experience will make use of positive religious coping methods to help them cope with depression while others will make use of negative religious coping methods.

CHAPTER 3: METHODOLOGY

3.1 Rationale for the study

Depression has been extensively researched recently, showing the incapacitating effects on an individual's psychological wellbeing.

The National Institute of Mental Health statistics (2008) revealed that about 9.5% of the population aged between 18 and older have a mood disorder with major depression as the leading cause of disability. As a recognized clinical syndrome, depression interferes with an individual's academic, financial, occupational and psychological well being (American Psychiatric Association, 2000). However in spite of the rich world of knowledge around depression, there has yet to be found a completely satisfactory explanation of its paradoxical features (Beck & Alford, 2009).

In view of the debilitating effects of depression on the individual's wellbeing, the issue of coping becomes pivotal. One of the strategies that people suffering from chronic illnesses, especially depression, use has been found to be religion (Pargament, 1997). Religion has been found to provide a sense of meaning and purpose in life, some kind of hope that the illness one is going through is working towards the person's good. (Alcock, 1992; Roberts & Spilka, 1992). Pargament (1997) claimed that people experiencing depression tend to use religious coping because it is part of their belief system and compels them to reach for higher power. Religious coping has also been found to alleviate depression by helping the individuals to deal with their anger, reduce guilt and loneliness, and interpersonal anxiety (Robert and Spilka 1992).

Various studies (Harrison, et al. 2001; Kruse, 2005) have attempted to understand the phenomenon by looking at the relationship between depression and religion; results indicated that the use of religion as a coping strategy alleviated the depressive symptoms and facilitated recovery. These findings have been supported by other studies (Cummings, Neff & Husaini, 2003; Pieper, 2004) indicating that religious coping is associated with lower rates of depressive symptoms, better physical health, mental health (e.g. decreased depression and self-efficacy), a sense of belonging and a concrete sense of support that serve to enhance mental wellbeing. Contrary to this association are studies that have shown a positive link between religious coping and increased depressive symptoms (Harrison et al. 2001; Pargament 1997).

While there has been research on depression in religious people, many of these studies (Entwistle, 2004; Fabricatore et al., 2004; Graham et al., 2001; Hills et al., 2005; Koenig, 1992; Lui et al., 2008; Pargament, 2007; Robertsons et al., 2009; Sanru & Sajian, 2007; Szewczyk & Weinmuller, 2006; Wright et al. 1993) have examined the relationship between religious coping and depression using structured instruments and quantitative designs. The use of structured instruments limits the exploration of the more subjective and novel aspects of the depressive experience as well as the mode of coping utilized by the depressed individuals. On the other hand, the use of a qualitative design allows an in-depth exploration of the phenomenon and is better at giving rich details that are difficult to explore through quantitative designs. Although extensive research has been done on the relationship between depression and religion, there is little research done on the phenomena using qualitative designs. This creates a gap in knowledge with regards to the subjective experience of depression as well as the coping mechanisms employed to deal with its debilitating effects.

By focusing on the perceived impact of religious beliefs on coping with depression, this study aims to understand more about the relationship between depression and religious beliefs.

3.2 Aims of the study

This study aims to explore whether and how people who are diagnosed with clinical depression use religion/spirituality as a form of coping, and the effect of this coping. It further aims to explore the perceived impact of religious beliefs on coping with depression. This research tries to answer the following questions:

1. What is the subjective experience of clinical depression?
2. What sorts of coping mechanisms are used by clinically depressed religious people?
3. For clinically depressed people using religious coping methods, what form do these coping methods take?
4. What is the perceived impact of religious coping on the experience of depression?
5. Does the experience of depression have any impact on the individual's faith?

3.3 Research design

A qualitative method was chosen in order to conduct an in-depth exploration of the subjective experience of depression in religious people. Banister, Burman, Parker, Taylor and Tindall (1994) viewed qualitative research as a debate rather than a fixed truth. It uncovers the nature of a person's experiences of a phenomenon, to understand what lies behind that phenomenon about which little is yet known (Strauss & Corbin, 1990**)**. A qualitative design is useful as it

provides novel and fresh perspectives. In comparison to quantitative methods, qualitative methods are better at giving rich details of phenomena that are difficult to convey (Strauss & Corbin, 1990). Due to the fact that this study aimed to explore the perceived impact of religious beliefs on coping with depression, open-ended, loosely structured interviews were the most suitable method to achieve the study's aim. This form of investigation has been described as suitable for investigating stress and coping (Marks, Murray, Evans & Willig, 2000 in Gathigia, 2006).

Unlike quantitative methods that tend to impose meaning and rarely take into consideration the uniqueness of human experience, qualitative research is contextually sensitive, persuasive, and relevant (Henwood & Pidgeon, 1992 in Gathigia, 2006). Due to the flexibility of qualitative methodology, the research is conducted in an open and unstructured manner rather being based on previous research studies (Gathigia, 2006).

3.4 Sample

Table 1: The details of the research participants

Participant	Gender	Age	Church affiliation	Race
Participant A	Female	49 years	Grace International Church	White
Participant B	Male	72 years	Anglican Church	White
Participant C	Female	23 years	House of Jubilee Church	Black
Participant D	Female	43 years	The Pillarship Church	White
Participant E	Female	44 years	House of Jubilee Church	Black
Participant F	Female	29 years	House of Jubilee Church	Black

The sample was drawn from religious people living in Pietermaritzburg, KwaZulu-Natal, South Africa, with a history of being diagnosed and treated for depression. Due to the difficulty in obtaining people who are both religious and suffering from depression, convenience sampling was used for this study. Only people who had been diagnosed with clinical depression and who belong to a Christian denomination were invited to participate. The participants were recruited on a convenience basis as reliance was on the willingness of the participants to volunteer and consent to be interviewed. Participants were obtained through letters of invitation given to practicing Psychologists around Pietermaritzburg and through invitations on a notice board of one local church in Pietermaritzburg. Ideally it would have been better to have a representative sample in terms of gender, race and age to ensure variability of accounts however that became practically impossible.

All interviewed participants were regular church members who were involved in religious activities in their respective churches. The interviewed participants' involvement in church activities became pivotal in determining the extent to which these participants were actually religious. In total, six participants were interviewed.

3.5 Procedure

Contact was made with five psychologists practicing in Pietermaritzburg inviting them to pass on these letters of invitation to any depressed, religious clients, inviting them to participate in the study. If participants showed interest, the psychologists responded via e-mails and gave contact details. Participants were then contacted and appointments were made. In terms of other invitations, church Pastors of local churches were approached, permission was requested to post the invitation letters on their notice-boards. Only one local church Pastor granted permission and agreed to include the invitations as part of the announcements for the day. Interested participants gave their contact details after church and were then contacted to make appointments.

On the day of the interview, written consent was obtained prior to the interview from participants (See Appendix 1). Participants were interviewed at a place suitable and convenient for them, to ensure that they were comfortable with the environment and that privacy was maintained. Most of them were interviewed in their own homes while some preferred to be interviewed on their church premises. It was explained to the participants that they were under no obligation to participate and that there would not be any consequences should they withdraw at any point. They were then briefly informed about the rationale of the study and that the interview would be recorded. Written consent as well as consent to record

the interview was obtained to participate. Participants agreed to participate although there was no monetary gain. The interview duration was between 50-100 minutes.

3.6 Data Collection

One-on-one interviews were used as they are effective in providing in-depth data. The participant would also feel comfortable sharing sensitive information that they may not necessarily have been at ease sharing in a larger group. A semi-structured interview format was used (See Appendix 2). Some predetermined questions were posed to each participant but the participants were soon invited to give a narrative account of their experience of depression. Open-ended questions were used, with probing and clarifications done where it was deemed necessary.

The participants were invited to give a detailed account of their experience of depression, their religious history, and the perceived impact of faith on depression, the perceived impact of depression on faith and how they coped with the experience of depression. Many people have a natural instinct to give a narrative story of their experiences thus allowing the account of their experience to unfold logically and take whatever form they find comfortable (White, 1989 in Riessman, 1993). Participants were able to give a detailed account of their experiences and to organize responses into lengthier stories, as described by Riessmann (1993).

3.7 Data Analysis

The data analysis method used in this study is thematic analysis. Thematic analysis is a process of analyzing data through encoding qualitative information (Boyatziz, 1998). A theme is a pattern found in the data/information, that describes, organizes and interprets the phenomena being studied (Boyatziz, 1998). It may be identified both at the manifest level (directly observable in the information) or the latent (underlying the phenomenon) level. This process is about translating the qualitative information into a language that can be understood and critically evaluated by other researchers. "It enables observer to use a variety of information in a systematic manner that increases accuracy and sensitivity in understanding and interpreting observations about people, events etc." (Boyatzis, 1998, p. 5). It serves as a bridge between qualitative and quantitative methods.

Developing the ability to use thematic analysis involves four distinct stages (Boyatzis, 1998). Firstly the researcher must be able to "sense themes" that is to recognize a codable moment where a researcher is open to all information. Secondly, the researcher must train themselves to use themes or codes reliably; this involves recognizing the codable moment and encoding it consistently. Thirdly the researcher must develop a code to capture the essence of his/her observation. Fourthly the researcher needs to interpret the information in such a way that it contributes to the development of knowledge. This stage requires some theory or conceptual work and often involves some form of presentation and a conversion into quantitative data.

Boyatzis (1998) highlighted obstacles to the effectiveness of thematic analysis. The first is projection, where the researcher imposes his/her own ideology, values and conceptualization into the raw data. Secondly, the sampling process becomes crucial and the sampling procedure needs to be evaluated critically as the raw material that the researcher is processing may be contaminated by other factors or variables that the researcher is not aware of.

According to Braun and Clarke (2006) there are six phases of thematic analysis which involve moving back and forth between texts, as it is a recursive process. It was Braun and Clarke's (2006) phases that informed the analysis of the current study.

1. Interview audiotapes were transcribed verbatim. Transcripts were read and re-read to get an overall sense of the data. Notes were taken across the whole data set and ideas were marked for coding.

2. Initial codes were generated for each of the aims of the study across the whole data. The coding process was done manually using highlighters, underlining to identify text. Individual extracts of data were coded in many different themes as it was seen fit.

3. Different codes were grouped together into potential themes and individual extracts of data were collated within the potential themes. Different themes were assembled together in terms of their relationship and overarching themes were identified.

4. Themes were reviewed in relation to the entire data set and it became clear that some of them could not be used as they did not have enough data to support them. Some collapsed into each other forming one broader theme while some had sub-themes as they were too broad. Data within themes were checked for meaningful coherence and a distinction between different themes was ensured. The themes were re-read to ensure that they captured the entire data set.

5. Define and renamed themes: each theme was explored in order to identify the essence of what the theme is about and what part of the data it captures. This process was done by looking at the collated data extracts in each theme and looking at their coherence and the narrated story they were telling. A detailed description of each theme was written in terms of the „story' that was told as well as how the story fitted in the broader „story' of the data. It

was also checked as to how the themes related to the aims of the research study and the research question.

6. Lastly the results were reported. Extracts from the data set were presented in order to provide sufficient evidence to demonstrate the prevalence of each theme.

3.8 Ethical Considerations

The purpose of the research was explained to the participants briefly and participants were given the opportunity to ask questions. Once they were happy with the research aims and process, written consent as well as consent to tape the interview was obtained prior to proceeding with the interview. Participants were informed about their voluntary participation and that there were no consequences for withdrawing at any time. Due to the subjective nature of the study, participants were encouraged to indicate to the researcher at any point if they felt that they could not discuss specific topics.

Confidentiality was ensured by using pseudonyms in the tapes and participants were informed that the tapes would be stored in a secure place and that only the researcher's supervisor would have access to the tapes. To ensure confidentiality, participants were informed that their participation would be anonymous and that they do not need to identify themselves in the tapes. Due to the intensity of the interview process, participants were informed that they can freely withdraw at any time during the interview should they feel that they could not continue.

Exploring the perceived impact of religious beliefs on coping with depression can be potentially distressing in nature so the interviews were conducted in a manner that was sensitive and with less discomfort. Participants were ensured consistently that they could

withdraw at any time should they feel that the interview was taxing them emotionally. Arrangements were made for referral to a Psychologist should it be deemed necessary. Only one participant found the interview emotionally taxing, and was referred to Town Hill Hospital for further assistance.

3.9 Validity and reliability of the study

The choice of a qualitative study which aims to „explore, discover and understand' as opposed to quantitative research which „describes, predict and verify empirical data', has inherent threats in terms of validity and reliability of the data (Ulin, Robinson, Tolley & McNeill, 2002, p.31). The difference in the aims of the two research methods necessitates that different criteria be used to evaluate the quality of the research studies. In terms of quantitative research, the criteria widely used are: validity, reliability, objectivity, precision and generalizability (Ulin et al., 2002). On the other end the fundamental criteria for qualitative data is trustworthiness (Lincoln and Guba, 1985 in Ulin et al., 2002), which is measured by the extent to which data analysed is credible, dependable, confirmable, and transferable (Ulin et al., 2002). Due to the qualitative nature of the current study, the researcher used the above-mentioned criterion of trustworthiness, which served as a guide to produce qualitative data. These aspects were the following:

3.9.1 Credibility

Credibility refers to the validity of the study which in qualitative methods focuses on confidence in the accuracy of the findings and understanding of the context (Ulin et al., 2002). In other words, the researcher should be looking at two aspects: 1) whether there is a logical relationship in the findings (i.e. are they consistent in terms of the explanations they

support?) and 2) whether the findings are grounded and substantiated by the narrative data (Ulin, et al., 2002).

To deal with the threat to validity of this current study, semi-structured interviews were conducted in order to ensure the consistency of the findings. By structuring the same questions, the researcher aimed to utilise a uniformed method to elicit responses from participants while the open-ended questions allowed an in-depth exploration of the phenomena and understanding of the individual context. A thematic analysis method was also used to ensure consistency in the findings by looking at themes within the data and coding them consistently. Individual extracts were coded into themes and various themes were grouped together in terms of how they were related to the aims of the study and the research question.

3.9.2 Dependability

Dependability in qualitative research is the methodological parallel to reliability in quantitative research. Reliability of data in quantitative studies is the extent to which results can be replicated with the use of the same processes to obtain them (Ulin et al., 2002). For qualitative researchers this refers to the dependability of the data. A qualitative researcher needs to pay special attention to the consistency of the research process and following carefully the rules and conventions of qualitative methodology (Ulin et al., 2002).

With regards to the current study, the researcher followed the guidelines as outlined by Ulin and his colleagues (Ulin et al., 2002) in terms of ensuring dependability of the results. To ensure dependability of the research process, the research questions had to be clear and logically connected to the research purpose and design. The consistency of the research process is one of the key aspects that address the dependability of the data.

To address this concept, the researcher conducted interviews herself to avoid multiple fieldworkers using data collection protocols that are not comparable (Ulin, 2002). The semi-structured interview questions gave structure to the interviews such that the questions are clear and connected to the research purpose.

3.9.3 Confirmability

In terms of the confirmability of the study, the researcher had to ensure that objectivity was maintained throughout the research process. Conducting interviews became intense and the sensitivity of the research challenged the objectivity of the researcher, making it difficult for the researcher to make a distinction, between personal values and those of the research participants. To address the threat to confirmability of the data, reflexivity was applied by the researcher in order to deal with the matter. Through consultation with the supervisor and debriefing with other colleagues, the researcher was able to constantly monitor objectivity and thus ensuring that the research data was confirmable.

3.9.4 Transferability

Transferability can be seen as a degree to which findings of a specific research study conducted in a specific context can be transferred to other contexts (Miles & Huberman, 1994 in Ulin, 2002). It is the ‚qualitative analogue to the concept of generalizability' (Ulin, 2002, p. 32). With regards to the current research, the size and the method of sampling used (i.e. convenient sample), had implications to transferability. The results in this study need to be interpreted with caution, as research findings are a reflection of the views of a small sample of clinically depressed people who hold Christian beliefs. The implication is that the research findings can only be utilized to explore and understand the perceived impact of Christian

beliefs in coping with depression. Furthermore the research findings can not be utilized to address transferability in other contexts (i.e. race, gender and various denominations.

3.10 Reflexivity

Conducting research is inevitably approached from a specific standpoint and qualitative research is subjective and thus making it difficult at times for the researcher to maintain objectivity throughout the research process. The researcher's priority in conducting the interviews was to ensure that participants were not subjected to any harm and a minimum of discomfort as they shared their experiences. Although the participants knew that there were no rewards for participation, they still agreed to participate in the research study and cognisance was taken of the potential harm the interviews may cause. Help was given to those participants without psychotherapists in terms of referral as deemed appropriate. The sensitivity of the research topic forced the researcher to constantly review any bias judgement in the analysis of data and this was done through consultations with a supervisor and processing through debriefing with other colleagues.

CHAPTER 4: ANALYSIS OF DATA

4.1 The experience of depression

Participants described their experience of depression in various ways which led to the four themes emerging which are: being in a dark phase/hole; self-image of worthlessness, self-hatred and distrust of others; loneliness and losing control. These themes will each be reported and described below.

4.1.1 Being in a dark phase/ black hole

All participants described their experience of depression using words such as “dark hole’, „cloud’, seeing things through a „dark screen’, being trapped in a „black hole’. Together these metaphors suggest that depression is an unbearable experience of darkness, such that one is unable to see beyond being depressed or having hope of recovering. As part of the experience of darkness, many participants included feelings of entrapment where one cannot see a way out and is marked with feelings of helplessness and hopelessness. For example participant E (a 44 year old black woman’s) response gave a good account of her experience:

> *...it’s dark, I feel like I’m in dark cup, I can’t move, it’s stifling. When I look around I can’t see where to go in every way. Depression is that feeling that you need to hide at all times, stay in your own cocoon/ cup where there’s no positive thoughts about you, everything is negative. .... a place that is so dark and difficult to come out from, where even when one shouts no one can hear .*

In this quote the participant described her experience not only as darkness, but as a darkness that was paralysing, stifling and entrapping, where one is insulated from being able to contact others. However in the quote there is also a hint of a choice to stay in this dark place, which is revealed in her use of the word "hide" suggesting that person may use the darkness to hide from the world which may have seemed overwhelming for them. It may appear that the feeling of being in this dark place is overwhelming but also because of the paralysing effect one is likely to choose to stay in it although there may also be a need to come out. A 72 year old white man described his experience as follows:

> *There one is melancholy, just that feeling of sadness, it's as if you look out on a bright sunny day, you look out of the window and there you put a wash of dark over it. Everything you see, you see it through that dark screen; it's that kind of melancholy which affects everything so that when I was at my worst nothing seemed worthwhile or worth living for. I had this image before 2001 that I was travelling along on the road I was on a journey and on my right hand side I don't know why but the cloud was there alongside. As I moved the cloud would move, when I stopped the cloud would stop but the cloud was always there. But in 2001, that cloud came and descended on me and I really was lost in the dark. I just lost all my normal senses, my normal enjoyment.*

In contrast Participant B described his experience of depression as darkness that was like a veil placed in his eyes, clouding his perception and judgement of things. This darkness seemed to have been marked with helplessness and hopelessness and thwarting his ability to fight or stripping him with the motivation to fight as indicated by his use of the phrase „nothing seems worthwhile' In the quote there is a sense that the experience of depression had been longstanding but manageable until it got to a place where it was overwhelming.

Similarly the majority of the participants described the experience as an incapacitating experience as revealed by the 43 year old white woman:

> *You literally, it feels like you're clawing your way out of this black hole. Not literally but metaphorically but it really feels like you're clawing your way out this black hole and you're using every little inch of your perseverance you may have I mean.*

In this quote participant D described her experience in a way that indicated the debilitating effect of the depressive experience on the individual's tenacity to fight back. All of the participants' experiences seemed to capture the unbearable state experienced by individuals going through depression. Others described it as a place where one's body goes through a shut down mode making it impossible to do anything. Most of the participants seemed to refer to this dark place where one is stripped of all meaning and will to live and it seemed like nobody could see them and they also could not see anyone that offered assistance to pull them out of that state. In their description of the „dark phase' the participants referred to it as a place where one is unable to move, to think or even find any enjoyment in anything. Due to the inability to see literally in this dark phase, it seemed to suggest an emotionally incapacitating or paralysing state marked with intense feelings of helplessness and hopelessness where one loses the tenacity to fight back.

The feeling of entrapment highlighted the frustration of things being out of control for the depressed individual and created a yearning for rescue as one participant clearly described it: "an agonising hell, groaning and yearning for blessed days" (a 43 year old white woman). But ironically the various extracts also suggest some solace or comfort in the darkness. Some described it as a place where there's a need for quietness as sound becomes overwhelming for them. One of the participants uses the word "hide" to describe the dark place, suggesting that that there is some choice to use the darkness as a place to avoid the world.

4.1.2 Self-image of worthlessness

A common theme that emerged as participants described their experience of depression is a self-image of worthlessness which was marked with self-doubt and self-hatred, even including hatred of their appearance. In comparing themselves to others who were not depressed, participants tended to view their inability to do things for themselves as evidence of their worthlessness and not even deserving to be helped. Some participants with recurrent depressions seemed to regard themselves as stupid and being losers unable to overcome their own weaknesses. For some participants, this negative sense of self even showed itself in self-hate, of even hating own appearance. In their description they referred it to a state where one doesn't see anything good about themselves or the condition they're in. The self-hatred involved a constant struggle where self defeating thoughts would echo in their minds as to their uselessness as human beings. As they tried to fight back against the self-hate, self-doubt seemed to reinforce feelings of worthlessness and started the cycle of self-hate over and over. Alongside the negative self-image, some participants tended to perceive other people as malicious and spiteful which resulted at times in the depressed individual withdrawing from others, making it difficult for them to access help in times of need. Further, their view of others as malicious and spiteful to them reinforced their own sense of worthlessness. . Participant C (a 23 year old black woman) described her experience in this way:

> *You start thinking negative about everything... Even the way you see yourself changes. With me I think the things that never used to bother me as I grew up like being small bodied. I would look at myself in the mirror and I'll start saying things like 'I hate my hair, I hate my eyes, I just hate my body, everything I hate this and that. As you get dressed you don't even care how you're dressed coz you hate everything about you*

Participant C described in detail the extent of her self-hate that in the depressed state nothing seemed worthwhile doing or observing. It also seemed that her self-perception was marked with self-hatred even to a point of loathing herself. Similarly some of the participants commented that things that never used to bother them before became issues. They started feeling preoccupied about even the most minute things which made them wonder about what could be wrong about them as such issues seemed not to be a concern to the people living amongst them. It seemed that in the depressed state, because of their negative sense of self-worth, they felt justified and deserving to be depressed when viewing themselves from the perception of self-hate and worthlessness. The person's sense of poor self-worth included doubting their own abilities. This seemed like a common theme as one of the participants clearly put it when she said:

> *Err it also affected my self-image, got to my self-worthiness. I thought gee... I could really do nothing. Now I can't even think how to make a sandwich so I hated myself for that and that was scary" (a 49 year old white woman).*

The sudden realization of the person's inability to perform basic tasks seemed to have had a significant negative impact on their self-worth reinforcing their feelings of worthlessness and self-hatred. However in the quote there seems to be a highlight of the fear that emanated from the sudden realization that one would have to depend on others which may have come as a shock to the depressed individual possibly reinforcing feelings of worthlessness. Participant E seemed to have had a similar experience:

> *I feel useless, I'm nothing, I'm not the same as other people. Even when I think of saying something I don't say it coz I think I'm nothing, I'm not the same as others. When I look at myself I belittle myself, even when there's a suggestion, I'm scared to*

comment cause when I talk there's this thought that comes that why did you talk, who on earth are you, what do you have? (A 44 year old black woman).

The above quotes reveal that depression involves a depletion of all sense of self-worth which is marked by negative self-talk reinforcing the depressive states. It would appear that there is a cycle where the person perceives themselves as worthless and stupid; with constant self-defeating thoughts the person tries to dispute these thoughts through actions. As they fail the self-defeating thoughts would condemn them, reinforcing feelings of worthlessness. On evaluating their failed efforts to move out of the depressed state, they seemed to condemn themselves for their inability to succeed further reinforcing feelings of worthlessness which then led to the development of self-hate**.** One participant referred to it as "everything you see, you see it through that dark screen". This statement suggests that their view of the world and others in that depressed state seemed distorted which in turn clouded their judgement of other people's actions.

4.1.3 Interpersonal alienation and loneliness

One of the things that poor self-image, as discussed earlier seemed to have had an effect on was interpersonal relations with other people. It seemed that the self-defeating thoughts did not only hinder the person's efforts to get out of the depressed state but also limited the person's interaction with other people. It appeared to have been marked with feelings of insecurity, self-doubt and the perception of other people as malicious in their actions. Some of the participants referred to the depressive state as a time that seemed to be marked with mixed feelings that on one end the depressed individual longed for emotional support but simultaneously wanted to be left alone. The poor self-image and self-hatred seemed to have

thwarted their efforts to access help, feeling unworthy to receive help from other people. The perception of other people as malicious in their attempts to help the depressed people is encapsulated in the following quote of a 23 year old black woman:

> *It feels like you're invisible like you're going through a trance, like you feel like even if someone is doing something good for you, you don't see it as being good. You always feel defensive, you always feel like you're trapped. You feel like people are always are plotting against you because of one disappointment. You lose trust in people; you become insecure about a lot of things. If a person comes up to you and say 'you looking beautiful this outfit suits you". You start having insecurities of like why is the person saying this to you, maybe they want something from you.*

In this quote Participant C described her experience using the word „invisible' suggesting that in the depressed state one feels alienated from their surroundings, but also some contentment in the alienation so much so that efforts by other people to salvage the individual from the situation are perceived as malicious. This perception of other people as malicious coupled with self-doubt and insecurity seemed to have caused the depressed individuals to withdraw from social interactions with other people reinforcing feelings of worthlessness. For some of the participants it appeared that they became oversensitive to anything that the other people would do or say based on their perception of people as malicious. The following quote is a description of how a 44 year old black woman felt about her experience:

> *You know even when one looks at me I feel like people are looking at me in a particular way, even here at church I'm even scared when people look at me I feel like I need to hide always so people won't have to see me.*

It would seem that the oversensitivity towards other people was marked with being self-conscious as evidenced in the above quote. Also in the quote Participant E used the words „scared' suggesting that there was a wish to be ignored by other people when amongst them as recognition created discomfort for her. It appeared that avoidance of social interactions was a defensive mechanism utilized by all of the participants in their depressed state as an attempt to protect themselves from a world they perceived as malicious. It would however seem that as they withdrew from the world into their „cocoons' as discussed earlier, feelings of insecurity were reinforced and their distorted perceptions not challenged further reinforcing their feelings of worthlessness.

The withdrawal from social interactions with other people and the perception of other people as malicious in their actions meant alienation for the depressed individual resulting in feelings of loneliness. Many of the participants bore testimony to the fact that their avoidance of the world left them feeling alone and dejected. They described this feeling as extremely intense that at times they were unable to see the help that was at their disposal from other people. A 49 year old white woman explained it this way:

> *I felt extremely lonely and I was afraid I couldn't think straight. I felt I couldn't cope and the fear of not coping came with it*.

In the above quote Participant A described the intensity of her loneliness in that not only was she feeling lonely but that loneliness meant that she had no one to turn to or receive help from, suggesting that at that point she needed help. Some participants felt that they were the only people going through that state and that no one else has ever gone through such an experience, which made them feel different from others thus limiting their interactions with other people. Others referred to it as that feeling of "being invisible" and "on your own". They described it as a place where nothing seemed to make sense and felt that there was no

one to make sense of what was happening to them which exacerbated their feelings of loneliness. Many of them likened the loneliness feeling to that of being in a „dark hole' as discussed earlier; the feeling of entrapment marked with hopelessness and helplessness. A 43 year old white woman explained her ordeal in this way:

> *....the strongest thing that I felt was humiliation, because you feel like 'why am I going through this' you look at everyone else and they seem fine and you feel like the only one in the world going through this. When you are going through depression you feel like you're on your own...*

In the quote it seemed that for participant D the feeling of loneliness was a reinforcer that she was different in comparison to people around her. She used the word „humiliation' suggesting that not only did she feel lonely but the depressed state put her in a place where to other people, her image might have been dented.

A 44 year old black woman expressed her loneliness in this way:

> *I feel alone. Sometimes I even pick up the phone without knowing who to call. So I feel like I'm in a round dark container and I'm all alone. At that time I just wanna be alone. Who cares, who cares, that's what comes to mind, who cares?*

In contrast to the other extracts participant E described her loneliness as a feeling that sort of gave her the sense that other people were uncaring towards her. However in the quote is a sense that although she might have felt lonely, there's also a need or choice to be there in that lonely state as perhaps it was serving some purpose of protecting her from the possible feeling of rejection. Some of the participants seemed to have similar experiences, that in their loneliness their efforts to reach out to other people were thwarted by their perception of people not caring. This perception of other people not caring appeared to have reinforced the

feelings of hopelessness and helplessness clouding their judgement in seeing the efforts of others lending their helping hands. Alongside the reported feeling of loneliness was a sense of being different from others, which also made the depressed individual to feel that they were weak as compared to other people.

4.1.4 Losing control

All of the participants reported a sense of "losing control or losing their minds" as one of the states they went through in their experience of depression. They described this experience as a feeling that one is at the mercy of others who make decisions for them. It is marked with an inability to think properly, make decisions and impaired judgement. A 43 year old white woman described her experience saying:

> *My particular thing was and I think this is common to everyone who's going through depression that they think that they've got no control. They've got no control over their minds, no control over their lives, that they feel that they are a burden to others. It's a very frightening thing to be in that place where you feel like you've lost your mind I mean it's a scary place to be and you can't think properly, you can't make decisions. So you try and get control in small ways I think this is where OCD develops from this...*

In the quote participant D described the helplessness enveloped in the depressed state and the fear emanating from the knowledge that one had lost their independence and autonomy to do things. All of the participants seemed to have been more unsettled by the thought of losing their autonomy and independence and finding themselves at the mercy of the very same people whom they perceived as being uncaring towards them. The feeling of lost control

seemed to have exacerbated their depressed state. Some of them highlighted that the self-defeating thoughts as discussed earlier reinforced feelings of helplessness and loneliness which further reinforced their sense of lost control in their lives.

The experience of being depressed as discussed through the above themes highlights the debilitating effect of depression on the individual's various areas of functioning. All participants described their experience referring to it as being in a dark phase where nothing seemed worthwhile and it was marked with hopelessness and helplessness. Some referred to it as a stifling place where one is unable to move or shout. In their description they likened it to a state of entrapment which seemed paralysing such that they felt insulated from contacting other people for help. Some referred to it as a state where all judgement seemed to be clouded with this dark screen that seemed to cover their view of things and thwarted their efforts to reach for help from the people around them. It appeared that as they felt hopeless and helpless in the depressed state it seemed to have created a negative self-image which was marked with self-doubt and self-hatred. It seemed that in comparison to other people who were not depressed they viewed their inability to cope with the situation as evidence of their worthlessness which resulted in self-hatred even to the extent of highlighting to them their inability to perform basic tasks they used to master.

Due to their poor self-image they also even felt unworthy of the help from other people and various other sources of help. This poor self-image exacerbated by self-hatred seemed to have caused them to alienate themselves from the world especially other believers. The interpersonal alienation from other people seemed to have been marked by feelings of insecurity, self-doubt due to their poor self-image, and perception of other people as malicious. The perception of other people as malicious seemed to have impeded their efforts of accessing help resulting in feelings of loneliness and dejection. In their description of their

loneliness, ironically there seemed to be a hint of a choice also as they find solace and comfort in it, helping them to avoid possible rejection in their attempts to seek help. It seemed as though the loneliness became overwhelming for them as they realized they could not perform even the most minute tasks as compared to when they were not depressed. This sudden realization reportedly put them in a state of loss of control and this was exacerbated seemingly by their self-defeating thoughts that became a daily struggle for them They referred to this phase as an intense phase for them as they found themselves having to seek help from the very same people they simultaneously perceived as being malicious and uncaring. This in turn reinforced feelings of worthlessness and hopelessness exacerbating their depressed state.

These discussed themes collaboratively highlight the incapacitating effects of depression on the individual's overall functioning as revealed through the experience of the willing participants. One participant, a 43 year old white woman referred to the overarching feeling encapsulated in the experience as follows:

> *...an agonising hell, groaning and yearning for blessed days. Uhm... it leaves somebody emotionally naked and vulnerable, in a state of fragmentation and humiliation. I felt like I was stripped bare of all meaning in a sense of losing all that I treasured. Emotionally crippled, unable to feel love, joy and comfort. I felt bare and naked for all to see my brokenness.*

The above quote highlights the magnitude of perceived loss, depletion of emotional and physical resources to cope so much so that the depressed individual feels in a state of vulnerability to a world they perceive as malicious. The depletion of resources, especially emotional resources, seems crippling which might have reinforced feelings of worthlessness, impeding the individual's efforts to access available help. It then becomes interesting to find

out how in spite of their depleted resources the depressed people find ways of coping with the experience.

4.2 The perceived impact of faith on the experience of depression

With regards to the perceived impact of faith there were two aspects considered: the negative aspect and the positive aspect. In terms of the negative aspect the following two themes emerged: inability to access help and lack of support from other believers. With regards to the positive aspect of faith three themes emerged namely: faith gave strength and hope, faith gave a sense of God caring and faith gave a sense of meaning to the experience. These themes will be discussed in detail individually.

4.2.1 The negative aspect of faith

4.2.1.1 Inability to access help

All of the participants reported that at the initial phase of their experience of depression it seemed difficult for them to access help from various sources of support because of their faith. This was because, as believers, they regarded depression as an unacceptable experience. Some even referred to depression as a sense of being „weakened in the faith'. In terms of their beliefs they could not request support or help for depression, such as medication and psychotherapy, as they believed that God should be their sole source of support and healing. Therefore, accessing help from a professional would indicate that their faith in God had diminished. A 49 year old white woman explained her experience as:

I don't think it could actually happen to one of us that knowing such a great God we have, we can still get into depression and it seems absolutely impossible. And uhm I then thought that my faith had weakened to a state where I couldn't cope with life you see it even affected that area of my life.

In this quote Participant A described her disbelief and shock at the realization that as a believer, she could be vulnerable to depression too. It seems that her faith in God was stable but her faith in herself as a believer was shaken in that there was a glimpse of self-blame that she was responsible for what was happening to her. Similarly a 23 year old black woman described her experience as follows:

I couldn't go to other Christians because... when I would say things like 'I'm not alright I've got a headache', they'll say things like 'hey what's wrong with you it's like you're not a prayerful person' you know it would be like ouch! That made me realize that if they can't handle my headache, how much more if I were to tell them my problems?

The experiences of these two women indicate how difficult it was for them to reach to other fellow Christians for help, let alone seeking help from professionals. All of the participants reported similar experiences. Many blamed themselves for not being strong enough to handle trials that come in their Christian lives. Accessing help for these participants was evidence of their wavering faith in God, and was also revealing to other Christians their lack of faith. This resulted in a lack of social support, and having to cope with depression alone. Some participants reported that the common belief that depression only happens to people with little or no religious belief, acted as a barrier to them seeking help. For most participants it took reading about depression, or talking to people who understood depression, to begin to

question their familiar assumptions, and to begin to consider the possibility of requesting help.

4.2.1.2 Alienation and lack of support from other believers

Most of the participants reported that because of the issues just described, they found themselves unable to receive support from other believers, or even to have an ongoing relationship with these people who had previously been so important to them. Many reported feeling judged and discriminated against by other believers. The perceived lack of the support they longed for which included being prayed for, being understood and treated well, and being included in fellowship meetings. One of the participants, a 49 year old white woman, shared her experience in this way:

> *I had a lot of judgement from people mainly I think because they didn't know what clinical depression was. Often there's also an understanding unfortunately especially in the Christian church that one is not supposed to be depressed which can make one feel very bad, but it's err. It's err...ignorance more than anything else. I had experiences where people did not want to talk to me (giggles) even people in church didn't wanna talk to me because they didn't know what to do with me.*

In the quote participant A described her experience or treatment she received from other Christians as judgemental and attributes their prejudice to lack of knowledge with regards to clinical depression. The perceived lack of support is attributed to helplessness by other Christians who may have felt incapacitated to deal with or offer help to the depressed. Some attributed the perceived lack of support to the common belief that depression only happens to those of little faith. A 44 year old black woman described her own experience in this way:

In this faith you have to be strong cause other saints that you fellowship with usually say maybe you haven't prayed enough so many of the times you are hurt and judged by other Christians. So if you are judged by other Christians, you get to a point where you say, I'm useless why do I keep believing? And it's usually the people you perceive as better than you then you ask yourself why am I believing?

These two women's experiences reflect the experiences of many other participants. Some of the participants described that not only did they find a lack of support, but that the attitude of fellow Christians often exacerbated their feelings of depression. The impact of the criticisms and condemnation by other believers seemed to carry much weight because it tended to echo self-criticism and self-hatred of those who were suffering from depression.

As reported earlier one of the experiences of depression was a negative sense of self-worth, the responses and attitudes of other believers often seemed to reinforce and perpetuate poor self-esteem and self-defeating thoughts. The perceived lack of support or opposition also seemed to reinforce feelings of loneliness which are experienced in the depressive state as hindering recovery.

4.2.2 The positive impact of faith

4.2.2.1 Faith gave hope to go on

All of the participants reported that in spite of the negative effects just described, their faith helped them more than it hindered their experience. The following quotes give a full description of the experience:

*I believe that because God is looking after me, after us because He's looking after all of us. I believe that because if He had let me go I don't know, if I had let Him go I don't know where would I be today and I know it's never His desires to let us go. The fact that He kept talking, He kept counselling me, He kept on knowing what was exactly wrong with me on any particular given day it was of utmost importance. It gave me hope. It reaffirmed me as a person. My self-worth improved which I had lost at the time and I felt all the things that I was worried about, all the things I was concerned about when I was depressed He gave me His view of it and counselled me out of the hole I was in and to me that is all that is essential (*A 49 year old white woman).

*...my religious faith has been more helpful than a problem more particularly over the years as I grow old. It gives me at least a meaning to life or something to look to even beyond this life. So yah it does add a dimension of meaning to life for me. So I've been helped more. I mean sometimes if I didn't have this space / faith I don't know how I would have coped (*A 72 year old white man*).*

Many of them used the expressions such "as the glimmer of hope" to describe the faith that kept them going, or reported that their faith gave them meaning in the face of hopelessness and despondency. Some participants described how their religious faith enabled them to frame depression as having some positive purpose that God was allowing them to go through. All participants described how the Bible provided a sense of hope, encouragement and assurance in their depressed state, especially by reminding them that they are not alone, but supported by God. These experiences stand in marked contrast to the responses of other believers which were so negative and critical. Earlier it was described that depression was

like a black hole. For some participants their faith provided the support to begin to emerge out of the „black hole'.

4.2.2.2 Faith gave a sense of being cared for

In contrast to the experience of opposition, loneliness and isolation that they experienced from other Christians, many of the participants attested to the fact that their faith gave them a sense of God's relational caring, even or especially when they felt alone. In fact, their description of God as another person in their lives who cared for them seemed to provide the best support and encouragement for them. In their confusion about what was happening to them and why it was happening, there seemed to be a calming effect that came from knowing that God was with them in the situation. A 49 year old white woman referred to her experience as follows:

> *As soon I started reaching out to God again I felt... I just knew I was in good hands. I just went through a lot of confusion at the time and the fact that I didn't let go of God is what I believe really worked for me. I felt protected in the fact that He was looking after me even when I couldn't pray.*

In the previous section it was reported that the Bible was often found to be a great consolation to many participants when they were depressed. But it seemed to especially be those parts of the Bible that reassured them of God's care and relationship with them that was most important. The belief that one's life was in God's hands, often revealed in the Bible, seemed to provide particular consolation.

As one participant said, quoting the Bible

*Fear not I am with you, even if you go through deep waters I am with you, you will not drown. Even if you go through the fire you will not be burned. (*A 49 year old white woman)

and another said:

I will never leave you nor forsake you I will always be with you (A 72 year old man).

Some even mentioned that reciting parts of the scriptures increased that sense of God being present with them.

4.2.2.3 Finding meaning in depression

One of the common findings to emerge was the attributional effect of their Christian faith, in dealing with their depression. Strikingly, many described how their understanding of their Christian faith gave particular meaning to their experience of depression. This focused especially on their belief that as Jesus Christ suffered on the cross; they were also participating in his suffering. They described how Christ bore the cross and was afflicted in the flesh just so everyone can have eternal life and would suffer no more. This belief founded in the Bible seemed to have given most of the participants the assurance that there was an ultimate meaning in their suffering, in the form of their identification with Christ. A 72 year old white man described his experience in this way:

One of the things that deepened and expanded in my understanding of God was moving from a focus in God as a mighty creator to a focus in God as the wounded God who in Jesus became the helpless. For me I came to see wounded people finding help in a wounded God. It was this concern of God having become weak in Jesus on

the cross and in so doing coming close to people who so they have the sense of companion who knows what their situation is like. It's this idea of the weakness in God and it's Biblically sustainable in some of the saying that 'when we are weak we are strong'.

The idea of „seeing God as the wounded God who in Jesus became helpless' had a significant effect on the participants who in their helpless state could identify with Jesus on the cross. This understanding confirmed in most of them that there was a specific purpose for their going through their tough depressive experience. A 43 year old white woman shared her own experience and understanding in this way:

I think it's useful for people to understand the new covenant, with Jesus coming and making himself real to us, going through the pain and feeling at the depth of despair on the cross that God had deserted him. That is God relating to us in a stronger sense that we can't now say that God doesn't know what we experience and also coz God is in us. God is in us, God is feeling our pain in us. When I could see it like that I said ok it's not this God that's looking down on us and saying look they all suffering in there, it's a God who's been through it already and being victorious and he's going through with us as we suffer the pain .

The process of the participants framing their experience as being „like Christ' in their sufferings seemed to have significantly bolstered their ability to cope. Some used metaphors such as "being refined through the fire as gold that's refined in the fire so it can glow and its best to be seen" to describe this process. They saw their experience as God preparing them

for something greater that until they themselves have gone through it, they can never be effective in helping others in the same situation.

The perceived impact of faith on the experience of depression seems to have had a negative and positive aspect which followed a specific pattern. It may seem (as reported by all of the participants) that at the onset of their depressive experience, their faith became a barrier for them to access help. This was apparently based on a common belief that depressive experience was an indication of a weakened faith, thus reportedly participants were more likely to have feelings of self-blame and took responsibility for their depressive state. The criticism and condemnation received from other religious people, based on this common belief reinforced their inability to access help. It also alienated them from significant people and left them feeling alone as participants perceived significant others as uncaring and unloving towards them.

The perceived lack of support from significant others forced the participants to rely on one constant, being God who according to them promised to always being there for them through the scriptures in the bible. It may seem that as they relied in God through meditating on the scriptures in the bible and prayer, their faith in God was restored in so much as it challenged their previous perceptions about the depressive experience as well as the meaning attached to it. This change in perception seem to have alleviated feelings of self-blame and assisted them in re-involving themselves in church activities, which put them at a better position of accessing and receiving help from church members and significant others. Some of them attributed the depressive experience to identification with Christ, who on the cross was also alone with no support. This attributional effect seem to have given them hope and helped them to cope with their depression.

4.3 The perceived impact of depression on faith

In examining the impact of depression on faith, there were two themes that emerged namely: The depression negatively affected the person's faith in God, and the experience brought the person closer to God. The above-mentioned themes will be discussed in detail.

4.3.1 Depression negatively affected the person's faith in God

The majority of the participants reported that their experience of depression negatively affected their faith in God to a point where they doubted the very existence of God. In their description of their depression they referred to it as the testing of their faith, where confusion and unbelief hallmarked the experience. This perceived impact of depression on their faith seemed to challenge their belief system to an extent of even seeing their God as uncaring and unloving. As a 72 year old white man put it:

> *I had all sort of questions about God, about why God would let this happen to me, where's God in all of this*

The hopelessness arising from depression seemed to distance them from God and included bargaining with God in an attempt to search for a purpose in the experience. This search for a purpose was reportedly preceded by blame and disappointment in God who was perceived as unloving and uncaring. The blame of and disappointment in God occurred against the backdrop of their previous belief in a loving God who could not have allowed His people to go through suffering. Most of them referred to depression as a state where they felt that God had abandoned them. It would appear that the experience of depression shifted their perception from a loving and caring God to a punitive God who wanted to teach them a lesson for disobedience or mistakes done. Below is a 44 year old black woman's experience:

I see Him looking the other way not even noticing me, forsaken me and never have loved me. I even tell Him that God you brought me here on earth to be a laughing stock, you didn't bring me here because you loved me. I even tell Him that you Jehovah are a liar. You said you don't lie but I see you being a liar. When those times come I see Him as God who's a liar and who's unfaithful to me. Why me, why did you allow me to go through such misery, why did you choose me, which means you don't love me, you're bad and have favouritism. You can't bring people on earth so they can be a laughing stock for others and be everyone's ball to play with. It becomes like that.

In this quote the participant described her disappointment in God who abandoned her at a time where she needed him the most. Even further she could not recall a time when she had ever felt the love and caring from him. She described her experience as a time where she questioned the faithfulness and integrity of God in honouring what is written in the Bible. It would also appear that she attributed her depressive experience to the unfair favouritism of God who might have chosen her amongst other people to go through the depressive experience due to his punitive nature towards her. A 43 year old white woman described her experience this way:

I felt like God had deserted me. You don't even have an interest in God, you don't care about a god because nothing makes sense that was the thing about me... while I was going through it I didn't feel like my faith sustained me in any way and I felt like Jesus when He was on the cross and He said 'My God, my God why have you deserted me'.

Many of the participants had similar experiences, some even referred to their experience as a time of helplessness at the realization that what they had believed over the years about God

who cares suddenly did not make sense. Some of them compared themselves to Christ who was deserted by God on the cross. This perception of God as the deserting God created a barrier in their relationship with God and exacerbated feelings of hopelessness. Considering that all of the participants seemed to have experienced alienation and lack of support from significant others, this feeling of being abandoned by God reinforced feelings of helplessness and hopelessness.

4.3 2 Depression brought the person closer to God

Although they appeared to have been in a state of despair, all of them paradoxically found themselves still seeking counsel from the same God they perceived as having abandoned them. They referred to this process as a turning point in their lives. As they wept and bargained with God, something happened that strengthened their faith and gave them hope in the midst of despair. Many of them referred to it as a time where they saw a ‚glimmer of light' in their dark phase or a ‚confirmation that God still cares'. Despite the sense of abandonment by God, each of them had a significant moment where they realized that they were not alone and that God was in control. A 49 year old white woman described her experience as follows:

> *One thing that I can show you is a picture one of my children drew for me at a time when it was bad, I hadn't spoken to them about how I was feeling. I needed to know that God had heard me and He knew what I was fighting against and that it wasn't my fault in necessarily that I landed where I was and uhm. One of my children who was 12 drew a picture for me.... It's a person fighting fatigue, post traumatic distress and that child did not know what that word meant and uhm... fear of life, uhm... a whole*

lot of other things. He drew it a picture standing with a sword and he said God has heard you. In the Bible the word of God is referred to as the sword of the Spirit. I just knew that, that was one of the turning points for me.

In the above quote it seemed that Participant A in her bargaining state actually found solace and comfort in a caring God who appeared to have used different accounts to indicate his caring. It may appear that in her bargaining state as some of the participants reported, she anticipated that anything out of the ordinary would be an indication to her that God had heard her prayers. The majority of the participants described the turning point process as a phase where they no longer perceived God as having deserted them but rather saw God as caring and loving. It was at those turning points that they experienced themselves „getting closer' to God. The perception of a growing closeness with God seemed to have bolstered their coping. A 49 year old white woman described her experience as follows:

As soon as I started reaching out to God....It brought me to a much deeper walk with God than I had before...I got to know his character better. I got to know His care better.

In this quote this woman described her experience highlighting the perceived growing closeness with God that seemed to have resulted from her seeking counsel from God. It is as though for this 43 year old woman and for some participants the depressive experience seemed to bring them to new, more positive realizations about God which strengthened their relationship with him. Some described this experience as a deepening in their faith insinuating that their belief in God reached new heights or rather that it was strengthened through the experience of depression as described by the 72 year old white man:

I think what happened was that there was a deepening of my faith and I came to see God in terms that I hadn't previously been so aware of.

This experience of new and positive realizations about God seemed to have had a significant impact on coping with the depressive experience as it revealed to them the relational aspect of God. This realization of God's relational caring seem to have been significant especially considering that as discussed previously, perceived lack of support from other people was one of the things that exacerbated the negative effect of depression on their faith. Some of the participants referred to it as some sort of connection as a 26 year old black woman described it:

It actually got me closer to Him, coz I could connect more with him. I didn't have any other distraction I had Him; I could only run to Him. Everything around me had failed so the best thing was to run to Him cause He has never failed me.

While most of the participants reported needing to be alone, away from other believers and involvement in church activities as they went through their depressive experience, they simultaneously described their need to „reach out to God' through prayer, getting involved in church activities and meditating on the scriptures in the Bible. For many of them seeking counsel in God gave them comfort and hope through their dark phase which bolstered their coping.

It would seem that as they perceived a growing closeness with God, through the positive realization of God, their perception of God as a punitive and deserting God as discussed previously also changed. Some of them described this change in perception having resulted in their developing compassion and empathy for those whom they perceived as going through the same experience. Some described the change as having effects on their decision making

processes as well, where they found themselves being selective of who they associated with (i.e. selecting friends who would add value in their lives while cutting ties with those they perceived to be ‚toxic' in their relationship with God). Some described their experience as a time where they learnt how to pray for themselves and that helped them not to rely on other people to pray on their behalf.

Strikingly, as discussed earlier all of the participants described their depressive experiences as a phenomenon that negatively affected their religious faith for instance one of the hallmarks was their perception of God who deserted them and was uncaring towards them. This perception of God who is uncaring seemed to have been generalized to other people who were perceived likewise. However in their bargaining state with God, hope seem to have been restored as they experienced a shift in perception and saw God reaching out to them through different accounts referred to as markers or turning points in their experiences. Ironically the same depressive experience that brought about feelings of hopelessness and despair, seem to have brought them closer to God as well, as they experienced solace and comfort from a God who became relational with them. This paradigm shift led to the experience of new and more positive realizations of God which then bolstered their coping mechanisms.

4.4 Religious coping with depression

4.4.1 Prayer and meditating on God's Word

Many of the participants described how they coped with depression by prayer and meditating on the scriptures in the Bible. Most of the participants seemed to have found prayer as a powerful tool that gave them the sense of God caring and evoked the experience of being listened to. Examining what it is or was about prayer that enhanced their coping with

depression revealed various aspects. Prayer provided what one of the participants described as „that space to breathe'. This could be seen as a cathartic phenomenon, insofar as they could vent their hopelessness and frustration in a safe way to a God that was non-judgemental. Given the isolation and exclusion from church friends described earlier, one of the challenges they faced was finding someone with whom they could talk, and who would understand what they were going through. For many participants, prayer was seen as a relationship between them and God, where they could find the care and support that they could not find elsewhere. A 44 year old black woman's experience gave a good account on the role of prayer in her distress:

> *Prayer nothing else, it's prayer. When I wake up in the morning I say God I can't face this day alone, help me to be able to face people, to accept myself, to be the same as them. Yah, yah it helps me at times cause God shows me that I'm valuable.*

Alongside prayer, meditating on God's word in the Bible was an important means of coping for many participants. Interestingly some participants framed this in terms of a battle against depression by referring to the scriptures as „weapons' used to fight or counteract the self-defeating thoughts that became part of their daily struggle. It seemed that through their meditation on the scriptures they were able to counter the self-defeating thoughts that were part of depression, replacing them with more positive and affirming thoughts derived from the Bible. For example, one participant quoted that at times when she struggled with thoughts of being weak and stupid, she would challenge those thoughts with a text/saying in the Bible, „my strength is made perfect in your weaknesses', which would immediately give her a sense of relief and strength. Similarly a 23 year old black woman described her experience as follows:

I think the best thing to do even for anyone who might go through depression in future is to nourish themselves with the word of God that's the only thing that pulls you back...I had to come to church and feed on the word. I had to go home feed myself with the word and God's things.

In this quote the 23 year old draws on the language of food and eating to describe the effect of reading the Bible. It is as if being depressed for her was a state of starvation, and reading the Bible provided nourishment and sustenance for her depressive experience. For many of the participants meditating on the scriptures resulted in them finding solace and comfort in a caring God. It would seem that going through the depressive experience had depleted most of their emotional resources and reading scriptures in the Bible was helping them and gave them strength they needed to cope with the experience.

4.4.2 Being involved in church activities and support from others

Earlier it was described that one of the most difficult aspects of depression for many religious people was the experience of exclusion and isolation where they perceived other people as not being supportive towards them. This process seem to have resulted in them feeling lonely and helpless where for some of them it even impeded their efforts to seek help from other people and professionals. The experience of exclusion and isolation was for some of the participants beneficial insofar as it sheltered them from a world they perceived as being malicious. However, parallel to this, many participants reported the importance of again being involved in church activities and interacting with other believers. Although this was difficult at first, for reasons described earlier, for most of them re-involvement in church

activities provided them with valued social support which was longed for but perceived as lacking. A 29 year old black woman shared her experience below:

> *My church...played a big part in my life. Immersing myself in the things of God, it's been my hospital. My church has been my hospital and I do believe that I found my healing there.... Actually I got most of my healing from those associations with friends and the church. Those were the two places that I went to cause sometimes at home the environment would be so depressing that you needed to get out. So to be able to go to friends and church was like a breath of fresh air.*

In this quote the participant described the stifling effect of the depressive experience and refers to social support in terms of re-involvement in church activities and supportive friends as rescuers from her stifling environment. She used the metaphor of a hospital to describe the effect of social support in her depressive state. It is as though being in the depressive state made her feel physically sick and re-involvement in church activities gave her relief from her illness. Other participants seemed to have had the same experience as evidenced by their reports of the benefits of their involvement with other believers. For most of them re-involvement in church activities not only gave them relief and healing from the feelings of entrapment but also seemed to have alleviated feelings of worthlessness which were evident in the experience of depression.

The majority of the participants highlighted various ways in which other people used to demonstrate their caring which for the depressed individuals were significant in „pulling them' from their dark phase. For some of them the practical help offered by friends had a positive effect on their experience, for instance one participant described her experience in this way:

I had a lot of help from my friend who would say well if you can't clean your house I'm gonna come and bring my helper and we'll do something together. If I couldn't drive somewhere they would take me (A 49 year old white woman).

For this woman having that social support not only pulled her from her depressive state but helped her manage some of the practical tasks she could not perform in her depressive state. Many of the participants pointed out that the social support they received from family members and friends gave them strength to „stand on their feet again'. A 72 year old white man described his experience as follows:

They visited me, they send me cards, and they phoned me. On a couple of occasions they sent meals....they prayed for me and also they weren't demanding of me, that's the important thing. I had a point where I could no longer do the things I previously did. And I was never made to feel like you shouldn't be like that you should be like, I was never under any pressure to do the sort of things I had done before cause they had a full understanding of my condition.

For this participant the unconditional support and demonstrated love he received from church members played a significant role in his coping with depression. For him the non-judgemental expectations from other people seem to have helped him by not re-enforcing feelings of worthlessness. A young 23 year old black woman highlighted the persistence of friends in helping her against her will as one thing that helped her pull through, she described it this way:

I think the friends, the friends I kept in my life. They pushed through for me, they would pray with me. I knew that even when I was tired and I couldn't pray there was

someone praying for me. They would call me anytime and come to my house by force especially when I wasn't feeling like company. They pushed by force. To have someone like that in your life, you get by.

It would seem that the fact that other people demonstrated their support through various deeds in spite of being perceived as malicious by the depressed individuals, communicated unconditional love and caring and was perceived as such by the depressed. This change in perception by the depressed individual seemed to have bolstered coping in as far as it created an opportunity for them to access the available help.

CHAPTER 5: DISCUSSION

This research aimed at exploring when and how people who experience clinical depression use religion/spirituality as a form of coping. It further aimed to explore the perceived impact of religious beliefs on coping with depression. Below are some of the questions this research attempted to answer:

1. What is the subjective experience of clinical depression?
2. What sorts of coping mechanisms are used by clinically depressed religious people?
3. For clinically depressed people using religious coping methods, what form do these coping mechanisms take?
4. What is the perceived impact of religious coping on their experience of depression?
5. Does the experience of depression have any impact on the individual's faith?

5.1 What is the subjective experience of clinical depression?

The majority of the people interviewed described their depressive experience as a "dark phase", a place where the individual could not see any hope and was marked with despair and a sense of helplessness. Some of them referred to it as a stifling place, with feelings of entrapment where they could not move or do anything. Together these metaphors seemed to

suggest that depression was experienced as an overwhelmingly incapacitating experience, in which the individual could not see beyond the depressive episode or find hope for recovery. The inability to see or find hope for recovery was part of a sense of hopelessness and despair for these individuals. Many reported feeling insulated from other people due to the paralyzing and stifling effect of „the dark phase'. Furthermore most of the participants reported that their perception of the world changed so much that they perceived the world as malicious and/or felt overwhelmed by the demands of daily tasks. Reportedly they felt a need to hide from people and the world as a defense against a world that was experienced as overwhelming.

These findings are in accordance with Sadock and Sadock's (2007) description of depression as an overwhelming yet distinct emotional state marked with feelings of hopelessness and worthlessness. This is also supported by Ridge's (2009) findings on the subjective experience of people who were depressed where depression was referred to as „hell', „shut down mode' and „dark hole'. In his study, Ridge (2009) interviewed participants who experienced depression as a paralyzing emotional state where the individual could not seek nor receive help from other people. Rowe's (1996) description of the depressive experience also supported the findings in this study. She likened it to a „wall' that is between the depressed person and other people. In her distinction between feeling sad and depressed she asserted that in the case of feeling sad the individual is able to seek and receive comfort from others, whereas in the depressed state one is insulated from being able to contact others and the ability to self- soothe is unavailable. This is due to the perceived barrier between the person and other people which seemed to have been created by the depressive experience (Rowe, 1996).

Some of the participants in the present study described the depressive experience as a darkness that seemed to cloud and distort their judgment and perception of people and situations. For most of them this distorted perception resulted in their perceiving others as malicious in their actions. In response, withdrawing from others became an ideal defense as it seemed to protect them from the world they perceived as malicious. However, the bi-product of this withdrawal seemed to be loneliness and being put at the mercy of their negative persecuting thoughts. The feeling of entrapment for most of them reportedly thwarted their efforts to fight back and their negative perception of others insulated them from seeking and accessing available help. This process exacerbated feelings of worthlessness and helplessness as they felt that they were losing control in coping with the depressive experience.

These findings provide evidence for Jamison's (1995) description of depression as a distortion in the emotional, physical and psychological wellbeing of a person. In his study he asserted that depression demolishes the „basis of rational thought and often erodes' the individual's will to exist (Jamison, 1995 p.6). Furthermore various researchers (Beck 2002; Ridge, 2009; Sadock & Sadock 2007) have found that depression involves a distortion in the way people view themselves and a tendency for the depressed individuals to withdraw from social interactions with friends and family members.

It is evident from the findings that depression is an overwhelming experience that affects the cognitive, emotional and psychological well being of an individual. However few studies have been done to explore the phenomena using a qualitative measure which then limits the in-depth exploration of its debilitating effects on the individual's wellbeing.

5.2 What sorts of coping mechanisms are used by clinically depressed religious people?

Most of the participants reported that prayer and meditating on the scriptures of the Bible were some of the coping methods they utilized in order to deal with the depressive experience. Prayer enabled them to communicate with God and to maintain a relationship with Him. This stands in contrast to their isolation from other relationships. Prayer gave them a sense of God caring and being listened to in a non-judgmental manner, which provided a sense of support in their hopelessness and frustration. Some of them even referred to it as a "space to breathe" in the stifling place they find themselves in. Again this stands in contrast to the experience of other people being malicious and uncaring.

Meditating on the scriptures of the bible provided a means to counter the self-defeating thoughts that became part of their daily struggles. Some of them even referred to the scriptures as "weapons" through which they fought their battle of negative thoughts and feelings of worthlessness. For some of them the scriptures in the Bible provided some form of nourishment as if their depressed experience had been a state of starvation and depletion of emotional resources. Reportedly as they read and meditated on the scriptures, they experienced a renewal of their strength and faith in God which had weakened due to their sense of hopelessness and helplessness. They also found comfort and solace as they identified with what was written in the scriptures.

These findings were in accordance with other studies (Hodges, 2002; Pargament, 1992; Pargament, 1997), which found that by praying for divine intervention, and having a sense of there being someone who cared, gave them a sense of hope so that anxiety about the future seem to be reduced. Similarly Hood, Spilka and Gorsuch (1996) found that prayer countered feelings of powerlessness and promoted greater optimism. It also promoted a better

acceptance of suffering and misfortune among religious people going through stressful situations. Hood et al. (1996) found prayer to be one of the ways in which religious people cope with depression, as it offered new avenues to solve problems.

Alongside prayer, some of the participants reported re-involving themselves in church activities as one of the coping methods used. This seemed helpful for most of them as it gave them a sense of belonging and allowed them to receive help from other people whom they previously perceived as being malicious in their actions. It also provided them with social support which was longed for but perceived as lacking. For some of them it alleviated the feeling of loneliness that resulted from isolation and exclusion, as they took comfort in the knowledge that they were not alone but had people who cared for them and were willing to help. Reportedly they find themselves regaining their self-worth gradually as they felt useful in their church community.

The findings in this study support those of Maton (1989, as cited in Hodges, 2002) who found religion to act as a unifying phenomenon, where religious people going through depression were able to share values and felt supported by a community of believers through prayer, singing or meditating together. Being involved in spiritual communities provides a sense of unity and strengthens emotional support for the depressed individuals who experience a loss of emotional attachment through their withdrawal from social contacts (Beck, 1967; Hodges, 2002). Religious beliefs and practices may also help individuals to reframe events in such a way that potentially emotionally taxing circumstances have less negative effects on their emotional and psychological wellbeing (Ellison et al., 2009). The involvement in religious activities and having a sense of support from other religious members in the church promotes a sense that one is not alone and alleviates feelings of despair (Ellison et al., 2009; Schnittker, 2001; Yohannes et al., 2008).

It is evident from the findings that prayer and involvement in religious activities either function as religious coping mechanisms or have a huge impact in bolstering coping among people experiencing depression. When looking at the clinical picture of depression (feelings of hopelessness and helplessness; loss of emotional attachments; feelings of isolation and dejection) it becomes important to consider in treatment the role of religious beliefs or religion in bolstering coping mechanisms for people going through depression.

5.3 For clinically depressed people using religious coping methods, what form do these coping mechanisms take?

The majority of the participants reported taking a passive role in their recovery, through their belief that their God would heal them. This passive role left them feeling hopeless and helpless with anxiety about the future, and became a hallmark of their experience. In their search for meaning, they could not understand how a good God could allow them to go through such an incapacitating experience. They perceived God as punitive, uncaring and abandoning, punishing them for sins they committed. Some of them reported that they attributed their depressive experience to a lack of faith, which made it difficult for them to access available help. It would also seem that their belief in a healing God impeded their efforts to access available help from professionals as it was regarded as an indication of a weakened faith. This perceived lack of faith for some of them led to social withdrawal, isolation and non-attendance to religious activities.

The passive role taken by the majority of the participants in their coping, seemed dysfunctional when coupled with the perception of an abandoning and uncaring God. The majority of the participants were left feeling guilty of sins committed, which their God was

now punishing them for. Furthermore it exacerbated their depressive symptoms. In their efforts to atone for their sins, they searched for meaning through meditating on the scriptures and praying to God for answers. Most of them referred to a turning point in their experience, where they were bargaining with God in search of meaning and purpose. In that process something would happen or a scripture in the Bible would indicate to them that God was with them and understanding what they were going through. For most of them these experiences changed their perception of God as punitive, uncaring and abandoning to a God who is loving and caring. For most of them, this change in perception allowed them to seek help from family and friends.

The majority of the participants reported that the change in their perception of God's involvement in their experiences bolstered their coping so much that it strengthened their connection with God. For some of them the re-connection with God (who had been perceived as abandoning and uncaring) strengthened their relationship with God to such a point that they viewed their depressive experience as a reflection of Christ's sufferings which in turn led them to a deeper connection in finding meaning and purpose. This re-discovered meaning and purpose bolstered their coping and enabled them to understand that as Christ had adversity, so by virtue of their being connected to Him, they also would recover from their depressive experience. This reframing of the depressive experience gave most of them hope and comfort in the knowledge that they were not alone but with a higher being who understood what they were going through. Some of them reported that in their isolation, they found comfort and solace in a caring God. The perceived closer relationship with God and His Son enabled the participants to vent through prayer and to receive comfort and solace through the scriptures in the Bible. Furthermore the depressive experience was reframed in

benevolent terms (i.e. God who was allowing them to go through the depressive experience in order to emerge from the experience as better people).

These findings echo Pargament (1997) who suggested that people turn to religion because it is available to them and forms part of their belief system. Roberts (1992) and Pargament (1992) found that religion gave a sense of purpose and meaning in the depressive experience, some sense of hope that what one is going through is for the person's good and therefore bolstered coping among people going through depression. The findings in Entwistle's (2004) study also indicated that turning to religion in times of crisis may be detrimental to the individual's wellbeing, especially when by taking a passive role and allowing God to heal them, it prevents them from seeking help. This is further exacerbated by the guilt resulting from self-blame, that what one is going through is a result of a lack of faith or sins committed (Entwistle, 2004). In his work on the dysfunctional aspects of religious beliefs, Alcock (1992) contended that the emphasis on sin fosters guilt and condemnation. He elaborated that most of the followers of authoritarian religion often regard themselves as insignificant and powerless as compared to their God who is all powerful and flawless, which can promote feelings of worthlessness and a negative self-esteem. Similarly Pargament (1997) suggested that people who feel abandoned by either their congregation or God may also experience hopelessness, despair, resentment as well as poor mental health.

A related study by Hood (1992) found the use of negative religious coping methods (i.e when individuals condemn themselves for what they are going through) may lead to a greater sense of isolation and depression. This was supported by several other studies (Olszewswki, 1994 in Hodges 2002; Pieper, 2004) which found higher levels of depressive symptoms among people of a religious faith who made use of negative religious coping methods. Similarly Entwistle (2004) argued that religion (i.e the use of negative religious coping

methods) can be detrimental to the individual's mental health when it impedes the individual from accessing available help for chronic illnesses in the hope that their faith in a healing God will help them. This belief exacerbates depressive symptoms when the individual feels that their God is punishing them for sins committed and that it is God's will that they suffer in order to learn (Entwistle, 2004). This was revealed in this study's findings where participants reported their reluctance to seek help in the hope that instead their God would heal them.

Pargament (1990, as cited in Pargament et al. 1998) asserted that the belief that God is involved in one's life despite the chronic state the person finds themselves in, seems to bolster the coping mechanisms of people suffering from chronic illnesses through the belief that one is not alone in the experience and being able to reframe the experience in benevolent terms (Gallup, 2003 in Robertson et al. 2009). However Pargament also argues that religious coping is not just the inclusion of religion in the coping process but that it is a form of coping in itself as it consists of various coping methods and involves a lot of decision making. He argued that when people are faced with stressful situations, they are likely to utilize one or a combination of the three methods of religious coping, based on the individual's approach to problem solving in the context of their relationship with God. These are: collaborative (where the individual approaches the coping process in partnership with God); deferring (which is passive in a sense that it shifts the responsibility for problem solving to God) and self-directing (where the individual uses the available resources) for problem solving approaches (Fabricatore, Handall, Rubio & Gilner, 2004; Pargament, 1997).

Various studies (Harrison et al., 2001; Hills et al., 2005; Pieper, 2004) have found that depressed people who make use of the deferring approach where the individual becomes passive in the coping process, experience an exacerbation of the depressive symptoms. The

findings in the present study concur with these findings as participants who reported using the passive role in the coping process reported feeling hopeless and helpless. The state of helplessness and hopelessness was coupled with a perception of God as being punitive and abandoning which then exacerbated their depressive symptoms. However the use of a collaborative approach by depressed people has been found to bolster coping and alleviate depressive symptoms (Fabricatore et al., 2004). This study's findings have also confirmed Fabricatore's et al. (2004) findings with participants reporting that as they approached their coping with a perception that God was involved in the process, it facilitated their efforts to access available help and encouraged them to read scriptures in the Bible which offered comfort and alleviated their depressive symptoms.

The findings have shown that coping with depression for religious people can take three forms; the passive/ negative religious coping methods, the active/ positive religious coping methods or a combination of both. Each form results in a different outcome with the passive exacerbating depressive symptoms and the active alleviating the depressive symptoms. The findings also highlighted the role of the nature of the relationship between the depressed and their God in determining which form of coping will be used when facing with a stressful situation.

5.4 What is the perceived impact of religious coping on the experience of depression?

One of the important aspects of the findings is the impact of religious belief on appraisal processes in depression, which further impacts on the experience of the depression itself. The findings show that religious belief can lead to either a negative or positive appraisal of the

depression. In the case of a negative appraisal, many participants were initially inclined to interpret their depression as a punishment from God for their sins. They perceived God as having abandoned them by allowing them to go through the depressive experience. This in turn led to feelings of guilt, self-blame and anger towards God. It also hindered their efforts to access help as they felt that their punishment was justified in that they had to go through depression until they had atoned for their sins. Others reportedly blamed themselves for having a „weakened faith' and so believed that strengthening their faith in God would help them recover.

Other people reportedly suggested that depressed individuals were responsible for and deserved to be in the depressed state due to their wavering faith. This appraisal left most of the participants feeling alone, at the mercy of their perceived punishment from God, their own thoughts of self-blame and discrimination by other Christians who (based on a common belief that Christians don't go through depression) judged the depressed as having sinned. This reported condemnation experienced by other Christians seemed to have had such a huge impact on the depressive's already self-critical thoughts, that depressive symptoms were inevitably exacerbated.

For the majority of the participants, the depressive experience challenged their preconceived ideas of a caring God (which was associated with mental well being instead of suffering). There seemed to be a contrast between their perception of a caring God and their depressive experience, which led to confusion as they could not comprehend how a caring and loving God would allow them to go through such an agonizing experience. Some of them even referred to their depressive experience as a time when they felt that their God had turned his back on them when they needed Him most. Reportedly this process resulted in the exacerbation of the depressive symptoms. However many reported that because of their

overriding belief in a fundamentally good and caring God they were later inclined to reappraise their depression in positive terms as sharing in the sufferings of Christ. This positive reappraisal of the situation led to most of them reportedly experiencing a sense of God in the form of Christ being involved in their situation and the interpretation for some of them was that just as Christ had conquered death, they too as followers sharing in his sufferings, will vicariously overcome depression. This process also involved a search for meaning in the depressive experience which would be done through prayer and meditating on the scriptures of the Bible. Subsequently, the participants experienced, through the interpretation of scriptures in the Bible, or by people reaching out to them, that they were not alone and the gesture was interpreted as God's caring for them. This evaluation process led most of them back to their perception of God as caring and loving, which in turn resulted in their use of benevolent coping mechanisms as described by Pargament (1997), where they reappraised the depressive experience as a process of becoming better people. This sense of meaning in the depressive experience bolstered their coping and alleviated their depressive symptoms.

These findings are in accordance with Lazarus & Folkman's (1984) argument that coping is partly a function of the individual's subjective cognitive appraisal and interpretation of the situation, which in turn subsequently influences an emotional state. It is regarded as a transactional process of exchange between an individual and a situation within a particular context (Pargament, 1997). The emphasis is on the individual's subjective cognitive evaluation/appraisal and interpretation of the stressor which then mediates the response to the stressor. The individual's cognitive appraisal of situations, as well as their appraisal of their personal resources, plays a crucial role in determining the coping strategy to be utilized in the management of the stressor (Matthieu & Ivanoff, 2006).

Lazarus & Folkman (1984) also highlighted the importance of perception in the individual's evaluation of the situation suggesting that if the situation is perceived as harmful and within the individual's means of control a problem focused coping strategy would be used. This is where the individual is active and uses the resources available to them in order to cope and deal with the situation. Conversely if the individual perceives the situation as overwhelming and beyond their capabilities of coping, they are likely to use an emotion-focused coping strategy which tends to be passive. Centred in both these coping strategies is the pivotal role of the individual's perception of the stressor. The findings in the current study concurred with these studies Lazarus and Folkman's (1984) and Matthieu and Ivanoff's (2006) findings on the importance of perception.

The findings in this study also echo the description of negative religious coping methods reported by Pargament, Smith, Koenig, and Perez (1999). In their study on the patterns of religious coping methods, Pargament and his colleagues (Pargament et al., 1999) described the pattern of negative religious coping methods as an expression of a less secure relationship with God, a tenuous view of the world, a sense of being insulated from God and other people as well as a desire for spiritual connectedness. They also argued that centred in this pattern of religious coping is a perception of God as uncaring, abandoning and punitive with anger towards God, spiritual discontentment, punitive reappraisals and interpersonal dissatisfaction hallmarking the experience. Again this was supported by the current study's findings. The findings also support those of other studies such as, Harrison et al. (2001); Hills et al. (2005); Pieper 2004 and Robertsons et al. (2009) where this pattern of negative religious coping methods was found to be associated with poor physical and emotional wellbeing, increased depressive symptoms, lower life satisfaction and impaired quality of life.

Some of the participants reported the use of a collaborative coping strategy where they approached the coping process in partnership with God. They perceived their God as being involved in the attempt to cope with their depression, which gave them hope and alleviated their depressive symptoms. This perception of God's involvement led them to read about their depression in books and attempt to do some activities they had stopped doing due to their sense of hopelessness. Some of them reported that the sense of „being in God's hands' gave them courage to do things knowing that even if they failed, they would still find protection and comfort in his hands. This confidence in a God who cares led to the use of another religious coping method which was seeking spiritual support from family members, members of the congregation and some even went to their Pastors. Contrary to the common belief held by the participants that Christians do not get depressed, which for most of them impeded their efforts of reaching out for help, some participants were able to talk about their depressive experience and were able to receive help. They were able to re-involve themselves in religious activities and that increased the level of support and sense of belonging in turn alleviating depressive symptoms and concomitant feelings of loneliness. For most of these participants, they perceived their relationship with God as secure and their sense of connectedness with God and others as being restored.

These findings are in accordance with Pargament and colleagues (Pargament et al., 1999) in their study of patterns of religious coping, where they described the positive religious coping pattern as an expression of a secure relationship with God, a belief that there is meaning to life as well as a sense of connectedness with God and others. Herbert, Zdaniuk, Schulz and Scheier (2009) supported this description when they found in their study that the individual in this pattern of religious coping utilizes religious coping methods that are centred on a partnership with God in problem solving, looking to God for strength and guidance and

attributing the stressful events to a greater purpose. Various studies (Jenkins & Pargament, 1995 in Robertson et al., 2009; Pargament, 1997) have found that the use of positive religious coping methods is beneficial in the promotion of life satisfaction and the moderation of pain, anxiety and depression. Similarly various studies (Harrison et al., 2001; Lui et al., 2008; Pieper, 2004; Robertsons et al., 2009; Sanru & Sajian, 2007) conducted on people with a current diagnosis of depression, explored the relationship between religious coping and depression and found lower rates of depression to be associated with the use of positive religious coping. Further, these findings suggested that the use of religious coping among depressed people bolsters their coping through the reframing of the experience in benevolent terms, social support from church members and the anticipation of a good outcome from the depressive experience (Harrison et al.; Pieper, 2004). The findings of this study concurred with these studies and participants perceived their use of positive religious coping methods as having helped them in coping with the depressive experience.

5.5 Does the experience of depression have any impact on the individual's faith?

For many participants the experience of depression had both a negative and a positive impact on their faith. With regards to the negative impact, some of the participants reported how the depressive experience affected their faith to an extent that they doubted the very existence of God. All of the participants referred to their depressive experience as a testing time for their faith. This is due to the fact that depression challenged most of their previously held beliefs about God, for instance, that a God who loved them would never allow anything hurtful to happen to them. Reportedly they found it difficult to see how a caring and loving God would allow (or cause) them to go through such a depression. Reportedly the common belief held by the participants, stating that, going through a depressive experience is an indication of a

weakened faith or sin, coupled with the stigma attached to being depressed as a person of a religious faith, made some of the participants conclude that they must therefore have a limited faith which is in turn responsible for their depression. For the majority of them their faith in God gradually decreased as they lost trust in God who, according to their perception, had disappointed them by allowing them to go through such an experience. Furthermore, some reported that they were made to feel that their prayers were not effective, especially when other church members showed amazement at their unchanging situation. This subtle blame by other church members for their ineffective prayers, seemed to have had a huge impact on their faith as it echoed their own unbelief in the healing powers of their God. For some of them, the chronic state of their illness exacerbated their doubt and unbelief in a God whom they had perceived as a healer. This led to feelings of hopelessness and the sense of being abandoned by God at a time when they needed Him the most.

Although the majority of the participants experienced an initial negative impact of depression on their faith, all of them reported that subsequent to that there was a phase where they realized that despite the hopelessness and criticism from other church members, God was still their only hope. Some even referred to depression as a deepening of their faith in so much as they began to experience closeness with God that they had never had prior to their experience of depression. For some of them, the experience of depression led them to the realization that suffering, rather than separating them from God, was instrumental in bringing them to a deeper and closer relationship with God. This represented a challenge to the previously more narrowly defined faith. Some of them reported learning how to pray and not relying on others to pray on their behalf, finding meaning in the religious activities instead of just doing them as part of a routine, and developing compassion for others going through difficult times. For these participants, their belief system was modified in that they reportedly understood that

their God was with them even at times when they felt as though he had abandoned them. The findings reveal that for many of these participants it was a surprising discovery that being depressed could be a pathway to a deeper faith in God rather than, a separation from God.

Overall, this study found that the religious faith of participants was both negatively and positively affected by their experience of depression. When initially faced with depression their faith inevitably changed negatively because it did not make sense to them to have a caring God and yet experience the agony of depression. Their appraisal of the situation was that their God had ceased to love them and thus their faith in him decreased. Paradoxically, however, in the midst of their depression they began to reappraise their illness depression as a meaningful experience in relation to God, which in turn impacted on their religious understanding. Further, this lead to the experience of a God who could care for them even in the midst of depression.

CHAPTER 6: CONCLUDING REMARKS

6.1 Implications

The findings in this study have revealed the subjective experience of depression in such a way that highlights the incapacitating effect of depression on the individual's emotional, cognitive, social and psychological wellbeing. The findings have also highlighted the role of religious beliefs in both enhancing and hindering coping with the depressive experience.

The study has established that a reciprocal effect of religious faith on depression and depression on religious faith exists, and a potentially important role is played by religious coping in both improving and worsening depression. The findings also highlight the need for a close collaboration between psychologists, pastoral counsellors and clergy in working with depressed individuals.

Furthermore the findings also revealed that the use of religious beliefs in coping with depression can have both detrimental and beneficial effects. In the light of this, careful attention needs to be given to the impact or the role that religious beliefs have on the individual's recovery from depression. However the findings seem to suggest that people of a religious faith are more likely to use and benefit from positive religious coping methods in their coping with depression. This finding concurs with other studies which find that the use of positive religious methods is associated with an alleviation of depressive symptoms.

The study has also shown the various pathways through which religious beliefs impact on depression. One of the most important of these is the way in which religious affiliation makes

social support systems available. Various church group members are a useful resource for people going through the depressive experience.

6.2 Limitations

Firstly the small convenience sample cannot be used to generalize the findings about religious coping of people going through a depressive experience. A small sample was used owing to the difficulty in finding clinically depressed people who are of a religious faith willing to volunteer. Furthermore due to the stigma attached to depression in the religious community and the emotional taxing aspect of telling the story about one's experience it became difficult to find a larger sample. Future research need to consider a bigger sample to address the concept of transferability of the data to other contexts.

Secondly, participants' stories may have been influenced by social desirability in a sense that they may have overplayed the positive role of their religious beliefs in helping them to recover.

Lastly, data was collected through the use of interviews, and due to the sensitive nature of the experience, it may have been difficult for the participants to talk freely. It may have been difficult for participants to talk freely about their experience of depression due to the sensitive nature of the experience. In addition, participants could only give the subjective experience of their quality of life during and after the experience of depression. In future studies it would be essential to consider other methods of measuring the pre-morbid functioning of participants in order to ascertain both the role and the pathways of religious coping mechanisms in people who are currently experiencing or have a history of depression.

6.3 Recommendations

It is evident from the findings of this study that further research is needed in this field. As most of the research studies have been done in the UK and USA, there needs to be more research done in South Africa that will capture the South African experiences and the vast scope of religious practices. Future research also needs to be done with larger and more representative samples so that results can be generalized.

This study only involved a sample of Christians who were depressed. Future studies need to include members from other religious faiths in order to compare the forms and pathways of religion in coping with depression.

It would also be interesting to find out whether the coping methods used differ in terms of age, religious affiliation and gender.

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APPENDIX 1: LETTER OF CONSENT

School of Psychology

P/Bag X01 Scottsville

PIETERMARITZBURG, 3209

South Africa

Dear Participant

My name is Nondumiso Mphambo and I am conducting research for obtaining a Masters degree in Clinical Psychology at the University of KwaZulu-Natal. The research is based on the perceived impact of religious beliefs on coping with depression. There are many research studies recently which investigate various aspects of depression and some of these studies investigate how people cope with the experience of depression.

One of the ways in which people cope with depression is through their religious faith and there are findings indicating that this type of coping may be helpful in living with depression. It is imperative to conduct research in this area as the experience of depression is a very difficult and incapacitating illness which affects all areas of functioning to the depressed individual. There has also been little research conducted on this issue.

Participation in this research entails an audio recorded interview at a place and a time that is comfortable and suitable for you. The interview will take about 40-60 minutes of your time. Participation is voluntary and you can withdraw from it at any time that you feel uncomfortable and there will be no consequences for your withdrawal. While you may be asked about your experience of depression, your religious affiliation and age, your personal identity information such as name, Id. number will not asked for as such will remain anonymous. However, you have to complete the declaration below for the purpose of ethics.

Once you have participated in the study and responded to all the questions, the audio tape will be stored in a lockable cupboard where access will only be limited to me and my supervisor. The tapes will be analyzed and a report will be written. Once the report has been written the tapes will be destroyed and should you wish to view the results, you are more than welcome to contact me and I will present the findings to you.

Thank you for your co-operation

Kind Regards

Nondumiso Mphambo — Graham Lindegger

_____ — _____

Masters student — Research Supervisor

School of Psychology

P/Bag X01 Scottsville

PIETERMARITZBURG, 3209

South Africa

Phone: +27 33 2605335

Declaration of consent:

I …… (Full names of participant) accept to voluntarily participate in a research about the perceived impact of religious beliefs on coping with depression.

As a participant I am aware that the information I provide will be treated confidentially and am not obliged to disclose private information. I am also at liberty to withdraw at anytime from the research with no consequences for doing so. It is to my knowledge that the interviewer will attempt to minimize any risk or discomfort that may arise. I am aware that the interview will be tape recorded and anonymity will be kept.

The data will be kept securely stored and the findings would be available at my request.

SIGNATURE OF PARTICIPANT DATE

……. ……

(Please note that you can take time to read, understand and question the information before giving consent)

APPENDIX 2: INTERVIEW QUESTIONNAIRE

Interview Guiding /Prompting Questions:

- Have you been clinically diagnosed with depression?
    - When?
    - What made you realize you were depressed?
    - Are you taking any treatment?

- Please tell me about your religious affiliation and belief?
    - Which one?
    - How important is your belonging to the religious affiliation?
    - Can you tell me about the history of your religious belief?

- Tell me about the story of your experience of depression?
    - How did you become depressed?
    - What was it like to be depressed?
    - How would you describe depression to someone who has never felt depressed

- Has your religious faith affected your depression: made it better or worse?
    - How has being religious affected your experience of depression?
    - Can you share some detailed examples with me

- Did your feeling about God or your religious belief change when depressed?
- Do you think your religious faith made a difference?
- Did it have positive effects?
- If yes how? Can you please give me some examples?
- What was it about your religious faith that helped or made depression worse?
- Did it have any negative effects?
- If yes how, please give me some examples?

- Did other religious people understand your depression?
- Are there other things that helped you to cope with depression besides your religious affiliation?