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Building resilient families: Developing family interventions for preventing adolescent depression and HIV in low resource settings

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Abstract

Depression contributes significantly to the global burden of disease in low and middle income countries. In South Africa, family members may be at elevated risk for depression due to HIV and AIDS, violence, and poverty. For adolescents, resilience-focused prevention strategies have the potential to reduce onset of depression. Involving families in promoting adolescent mental health is developmentally appropriate, but few existing interventions take a family approach towards prevention of adolescent depression. We conducted a qualitative investigation from 2013-2015 to inform the development of a family intervention to prevent adolescent depression in South Africa among families infected or at risk for HIV. Using focus groups with adolescents and parents (k=8, n=57), and interviews (n=25) with clinicians, researchers, and others providing mental health and related services, we identified context-specific factors related to risk for family depression, and explored family interactions around mental health more broadly, and depression specifically.

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Findings indicate that HIV and poverty are important risks for depression. Future interventions must address linguistic complexities in describing and discussing depression, and engage in the social interpretations and meanings placed upon depression including bewitchment or deviations from proscribed social roles. Participants identified family meetings as a context-appropriate prevention strategy. Family meetings offer opportunities to practice family problem solving, involve other family members in communal parenting during periods of parental depression, and as forums for building Xhosa specific interpretations of resilience. This study will guide the development of Our Family Our Future, a resilience-focused family intervention to prevent adolescent depression (ClinicalTrials.gov #NCT02432352).

Keywords

depression; prevention; family interventions; resilience; South Africa

Depressive disorders are leading causes for global burden of disease in low and middle income countries. These disorders significantly diminish quality of life, and rank as the second highest contributor to years lived with disability worldwide (Ferrari et al., 2013). Adolescents are at increased risk for depression if parents are affected by depression given the biological and environmental factors linked to family depression (W Beardslee, Versage, & Clastone, 1998; Birmaher et al., 1996; Sullivan, Neale, & Kendler, 2000). In these families, parent-child interactions and other aspects, such as family functioning that contribute to protective family environments for adolescents prevention, are adversely affected (England & Sim, 2009; Lovejoy, 1991). Rates of depression increase rapidly between early- and mid-adolescence (Angold, Costello, & Worthman, 1998; Ge, Conger, & Elder Jr, 2001; Lewinsohn, Clarke, Seeley, & Rohde, 1994).

Given the association between age of depression onset and adolescence, early- to mid-adolescence is an ideal period for prevention. In this period, fostering protective factors and building resilience can have long term protective implications for the life trajectory (Beardslee, 2012). Family interventions are a developmentally appropriate approach for preventing depression among adolescents. This is a time when most adolescents still live with families, and families, especially parents, have a strong influence on adolescent motivations, decisions, and behaviors relating to health. For most adolescents, families are best positioned to tailor communication on mental health information to meet their unique needs, to teach and reinforce healthy coping skills, and to create environments that foster mental health resilience (Beardslee, 2011). Resilience is a complex concept often defined as the multi-dimensional psychological and social processes related to thriving in spite of adversity (Masten & Obradović, 2006; Southwick, Bonanno, Masten, Panter-Brick, & Yehuda, 2014; Ungar, 2012). Within the family unit, enhancing the skillful navigation of accessing resources has been proposed as a means to foster family resilience (Ungar, 2010).

In South Africa, little is known about family interactions around depression, in part due to the paucity of epidemiological mental health data in South Africa. To date, only one nationally representative survey (the South African Stress and Health Study) of mental health disorders has been conducted, and with a sole focus on adults (Stein et al., 2008).

However, other local community-level studies indicate that specific South African factors such as HIV are highly correlated with depression (Kuo, Operario, & Cluver, 2012). Furthermore, several studies indicate family dynamics are related to depression and HIV. For example, one study indicated that poor child psychological functioning was associated with parental or caregiver depression symptoms (Lentoor, Asante, Govender, & Petersen, 2016). Other studies showed that depression affects parenting dynamics among HIV affected families (Lachman, Cluver, Boyes, Kuo, & Casale, 2013), and that family interactions – such as social support and functioning – can both positively and negatively affect depression outcomes among those living with HIV (Wouters, Masquillier, & Le Roux Booysen, 2016).

Several systematic and narrative reviews summarize existing efficacy of family interventions for adolescents with depression (Kaslow, Broth, Smith, & Collins, 2012; Siegenthaler, Munder, & Egger, 2012; Young & Fristad, 2015). However, the majority of these interventions were developed in high-resource country settings. We were unable to identify any empirically tested family interventions with a prevention focus for adolescents in South Africa, or ones that specifically addressed prevention of depression in a community setting for this age group for families infected or affected by HIV. Transportability from high resource settings to South Africa may be problematic due to unique factors such as the history of apartheid, high rates of HIV and AIDS, orphanhood, violence, and poverty (Delany, Jehoma, & Lake, 2016; World Health Organization, 2013; Thompson, 2014; UNAIDS, 2015). There are also significant health system differences (Petersen & Lund, 2011) and mental health human resource shortages, including only 0.27 psychiatrists and 0.31 psychologists per 100,000 people in South Africa (World Health Organization, 2011). There is a need to explore how social and economic context, language, and culture might affect design and approach for family interventions to address adolescent depression within the South African setting (Becker & Kleinman, 2014; Kirmayer & Swartz, 2013). Given this evidence gap in preventing adolescent depression more generally, and in South Africa specifically, we conducted a qualitative investigation to better understand (1) how context impacts understanding of mental health and illness, especially specific to depression among families infected and affected by HIV (for example, through AIDS orphanhood or living in high HIV incidence communities in South Africa); (2) how families interact around issues of mental health and illness; and (3) to inform design of a future family intervention to support adolescent resilience and to prevent depression. Understanding how family risk and protective factors for prevention of depression onset, and mechanisms that can strengthen family resilience for depression, is vital information for design of contextually appropriate interventions.

Method

Setting

Khayelitsha, the primary research site, is one of the largest urban townships in South Africa. Located just outside of Cape Town, Khayelitsha has an approximate population of 391,749 people, the majority of whom are Xhosa (90%) (Statistics South Africa, 2011). Three-quarters of households have monthly incomes less than R3,200 (equivalent to $320 at an exchange rate of R10 to $1) (Statistics South Africa, 2011). Antenatal HIV prevalence is

33%, among the highest in South Africa (Cape Town Government, 2014). Violence is significant; Khayelitsha police stations have the highest rates of murders (n=354) and sexual criminal offenses (n=617) nationwide (O'Regan, Pikoli, Bawa, Sidaki, & Dissel, 2014). Khayelitsha also has important mental health resources including a district hospital and five Community Health Centers. Each center is staffed with two trained mental health nurses.

Study Procedures

We gathered data from k=4 adolescent focus groups (n=30) and k=4 caregiver focus groups (n=27). Focus group participants were recruited from clinical sites serving HIV infected individuals and at a community-based organization working with youth at risk for HIV. All study participants lived in Khayelitsha. Adolescents were eligible for inclusion in the study if they were 13 to 15 years of age. Parents (or guardians) were eligible for inclusion in the study if they were: (1) 18 years or older; and (2) responsible for childcare for at least one adolescent 13 to 15 years of age in their household. Trained bi-lingual research team members provided verbatim verbal explanation of consent and assent forms. Written parental consent and child assent were obtained independently. Focus group discussions were conducted in isiXhosa (isiXhosa refers to language, Xhosa refers to the ethnic group) or English depending on participant preference, and led by a primary facilitator and a secondary facilitator/notetaker. Focus groups discussions lasted 1 to 1.5 hours, were digitally audiotaped, and guided by a semi-structured agenda probing for the following themes: (1) contextual factors that affect mental health and illness; (2) understandings of mental health and illness including depression; (3) lived experiences of depression including impacts on the family; (4) desires for a family prevention program around adolescent mental health including barriers and facilitators to intervention engagement; and (5) conceptualizations of resilience and strategies for fostering resilience for mental health promotion.

We also conducted in-depth interviews with key informants (n=25) including researchers, clinicians, and individuals providing mental health or other related services to families in Khayelitsha Township. Key informants were eligible if they were: (1) 18 years or older; (2) had 3 or more years of experience providing services or conducting research with adolescents or parents from Khayelitsha Township; and (3) had expertise in mental health or related issues. An initial seed-pool of key informants was generated with local researchers. Additional key informants were identified using participant driven sampling with each key informant acting as a "seed" who referred other possible participants within their network (Gile & Handcock, 2010). Consent was documented in writing. In-depth interviews were conducted in isiXhosa or English, lasted approximately 1 to 1.5 hours, and were digitally audiotaped. Interviews were guided by a semi-structured protocol exploring similar themes as focus groups. Each participant received 80-100 Rand for time and travel. All procedures were approved by ethical review committees at Brown University (Protocol #1207000666) and University of Cape Town (Protocol #HREC 072/2013). Participant characteristics are summarized in Table 1.

Data analysis

Verbatim transcripts were translated from isiXhosa to English prior to entry into NVivo (QSR International Pty Ltd, 2012). Open-coding, axial coding, and coding of marginal

remarks facilitated development of a codebook (Strauss & Corbin, 1998). All transcripts were coded by two individuals. Meetings were held to resolve coding differences between these coders using a consensus method. Coded texts were compiled under specific codes and sub-codes. Codes with common meanings were clustered into themes that appeared consistently among most participants. These themes comprised the foundation for the analyses and results presented here.

Results

Context specific risks for depression

Endemic HIV increases risk for adolescent depression—Participants described the generalized HIV epidemic in the study community as an important context specific risk factor for depression. Adolescents described struggling with depression after being diagnosed with HIV. As a young person, an HIV diagnosis was linked to a loss of future hope and risk for depression onset:

> "Some think that they have reached the dead-end since they are infected with HIV, especially if one is not taught about it and the death stages and time of when you have HIV to AIDS. Some think that they have no life. They are – some go – when they have HIV they go and hang themselves, killing themselves because they have the disease." (Adolescent Focus Group 2006)

An HIV diagnosis elevated risk for depression due to social isolation and fear of death:

> "I had a client once – a Xhosa client, actually two of them, that became HIV positive, and it was a very hard journey with them to understand what the illness was. The boy child went on behaving as he had done before. The girl became more careful with what she did, sort of stayed at home, and didn't go off anymore and that sort of thing. They were both from Khayelitsha …. With the girl, it was, again, it sort of was definitely a sense of depression that set in. The boy it was just being scared, scared of the process dying and how it will be painful and the last stages of it." (Interview 1311, Community Health Worker)

Participants also described how family HIV increased adolescent risk for depression. For example, adolescents taking care of sick parents, experienced depression, linked to fear of parental death:

> "To me it feels bad, my heart aches as if she looks like she would leave me …. I also feel bad. When she is seriously sick I don't go to school, I nurse her …. I too felt the pain that my mother felt when she was sick but I already knew that she was going to pass away. I used to help her with a happy face …. When your mother is sick, death is the last thing on your head, when you're both sleeping and you wake up in the morning and realize she has died." (Adolescent Focus Group 2006)

In families where parents were sick with HIV but had not disclosed their status, parental illness became a source of confusion, worry, and depression for adolescents:

> "She [the mother] hadn't disclosed to the 12 year old, and the 12 year old was drawing very sad pictures. Then eventually they persuaded the mother that they

> should tell her. The 12 year old wasn't HIV positive. They then had a discussion and the 12 year old said that she was terrified because her mother had been sick, her younger sibling had died. She said, 'Am I also gonna die? I don't know what's going on here. Why people are sick and why people are—why my family is dying?' To her it was a huge relief to have discussion around it, because at least she could—it was still sort of difficult for her to find out that her mother was positive. Because it was during a time when there was less roll-out of ARV's, but at least she then knew why her younger sibling had died, and she knew that she was unlikely to die because she wasn't infected, well not from HIV anyway." (Interview 1811, Researcher)

In situations where parents did disclose their HIV status, some adolescents described the burden of keeping their parent's HIV illness a secret from others: "*You cannot tell your neighbours if your parents are HIV. You can't trust your neighbours with that information*" (Adolescent Focus Group 1906). Struggles around disclosure impacted development of positive coping mechanisms (such as social support) for mental health that could exacerbate risk for adolescent onset of depression. This was especially the case for adolescents who were HIV infected themselves:

> "I know the HIV positive teenagers struggle a lot with disclosing status. What that means in a relationship and whether they can trust someone to speak about that. The idea of being different if you're HIV positive is a big one and some teenagers get teased quite a lot …. that can also then make them open to being abused physically and verbally obviously." (Interview 1511, Doctor)

Poverty creates feelings of inadequacy and learned helplessness linked to family depression—Poverty was another important factor in South Africa linked to adolescent risk for depression. Participants described how the inability to meet basic needs were sources of psychological distress:

> "Stress is made also by being poor in the house, sometimes you have no food, maybe you are dependent on the social grant, so the grant isn't enough to feed the children in the houses. Even my child …. even last weekend he wanted koks [shoes]. I don't have money to buy the koks because the child has to play in a [soccer] match and his friends have them, so that made me very stressed and I couldn't concentrate at church because of the stress I had till now and I sleep with an aching heart because there is the grant money but it is not enough to also fit for the koks. Meanwhile he is serious of going to [soccer]. Then I said to him 'then let's go and borrow the koks from someone else so that you can play well at [soccer]". So I am saying that stress is made by various things, even my high blood pressure increases. I'm telling you that I am stressed as we speak; my neck is sore and far worse, I am unemployed and everything depends on me in the house. Stress is caused by such things and may lead to depression." (Parent Focus Group 0309)

For parents in particular, severe poverty combined with poor prospects of employment were linked to feelings of inadequacy in their role as providers and caretakers. Overall, poverty and feelings of parental inadequacy could lead to depression and suicidality:

> "Children asking their struggling parents for things they can't afford stresses the parents. So to avoid such, they drown their sorrows by hanging themselves or go steal or it's better if they would throw themselves in front of a train." (Parent Focus Group 0309)

While the above relates to parental psychological stressors, participants went on to describe how these family stressors translate to adolescent distress. For example, one participant described learned helplessness that can contribute to adolescent risk for depression:

> "There's a sense of passivity that has come to a lot of the families. For instance, there's also this learned helplessness which is around the youth, that particular groups of people that you are talking about, 13 to 15 year olds, where especially those who are out of school. There really is a sense of, what is the word for it now? For giving up. Also amongst the parents, because they're not working and they haven't worked in a long time. There is a sense of depression, but it's also difficult to distinguish between that and passivity. This passivity which have, you know, people who've just given up." (Interview 1311, Community Health Worker)

HIV and poverty emerged as important context specific risk factors contributing to depression.

Intervention content needed to increase understanding of mental health and illness

Local 'idioms' for depression in isiXhosa—Participants also indicated that future interventions should address idioms that represent local terminology describing depression. For example, all participants described 'depression' as a word rarely used among Xhosa. Instead the idiom of 'stress' or 'everything is too much' was used to describe depression. A key informant described hearing these terms in mental health service provision, saying:

> "'I'm too stressed. I can't think. I can't do this. I can't.' It's like everything is too much. That's how they describe it. It's like everything is too much. I can't now do anything. When they come at that level, they knew—you understand that, okay, now need to help the person and pick what is really going on. The first thing that they will tell, 'I'm too stressed.' They will say sometimes, 'You're sick.' They will say that. They will see that you are sick, but they can't really say what is it. They don't use the word 'depression.'" (Interview 1211, Social Worker)

Similarly, parents confirmed that, "*People who are depressed, they call it stress"* (Parent Focus Group 1207). Likewise, adolescent focus group participants stated, "*I only know that when someone is stressed it is called depression"* (Adolescent Focus Group 1906). The use of idioms such as stress were common substitutes for depression in both parent and adolescent focus groups. Key informants explained that 'stress' and other idioms may be appropriate substitutes for the work 'depression' because the term 'depression' had poor linguistic equivalence in isiXhosa: "*There's no word in Xhosa that describes depression. It's depression in English, but in Xhosa there's no word that people associate with [depression], I don't know, that explains the depression. People use different words"* (Interview 1211, Social Worker). Some informants acknowledged a generational difference, with bi-lingual adolescents more likely to use the word 'depressed.'

However, in other cases, the idiom of ‘stress’ and ‘too much’ described a range of mental illnesses including, but not limited to, depression. For example, a key informant said:

> “The one word that encapsulates everything, if you just say stress people get it, right? I know that stress encompasses a whole host of things. When people I know in Khayelitsha talk about stress or I was experiencing stress, you know that this person is speaking—there are a number of underlying things that are being spoken to. This could be depression, this could be anxiety, there could be social issues that this person is experiencing and is using this one word, stress, to pretty much cover the whole spectrum of these things.” (Interview 1711, Psychologist)

These findings suggest that there is linguistic complexity in discussion of depression in isiXhosa.

> “In terms of the language to capture the word ‘depression’ it’s not a directly translatable word or concept in Black African culture even though many people have been westernized by traditional people who are more traditional. The whole concept of acknowledging “I am depressed and this makes me feel sad” it’s not a straightforward thing …. having just seen what I have around the whole conceptual idea of depression in a more traditional society, people may be more receptive to speaking about trauma and distress, and it may be useful to incorporate that.” (Interview 1111, Psychiatrist)

Idioms should be used with care and attention to meaning to limit confusion between depression and other mental illnesses. Key informants went on to describe that among isiXhosa speaking South Africans, generic phrases such as ‘stress’ should function as a signal to service providers to probe for the meaning of the idioms being used. As one service provider described, upon hearing the term ‘stress’, “*You understand that, okay, now [I] need to help the person and pick [apart] what is really going on*” (Interview 1211, Social Worker). As such, terms like ‘stress’ should signal that additional probing of the patient is needed: *“Then, when you unpack, you find out that it’s all the symptoms of depression. Even though you can still put to the person that, “Okay, what you had is depression,” for them, they don’t really understand”* (Interview 1211, Social Worker). Key informants suggested that future interventions should take an approach that focuses on detailed symptom descriptions of depression prior to introducing the term depression to ensure the idioms being used are not conflating depression with other mental illnesses: “*Symptoms are very much aligned with the DSM. There’s nothing unusual. It’s easy from the symptom picture that you get, to be able to discern that look this is obviously depression, tearfulness, restlessness”* (Interview 1711, Psychologist). Another key informant eloquently described the utility of a symptom-focused approach to psycho-education:

> “When people can’t sleep, they can’t sleep. When people don’t eat, they don’t eat. When people can’t concentrate on something they like doing, and when people don’t enjoy—I think—are there particular cultural narratives around it, of course. That’s very important to explore, but it doesn’t change the substructure, of, I think of depression.” (Interview 611, Researcher and Psychologist)

Although idioms should be used to ensure local terminology familiar to participants, careful use is needed to limit linguistic confusion with other mental illness and facilitate more effective intervention.

Poor understanding of the mental health spectrum—Key informants described depression as being so common in the study community, that depression was normalized: "*depression is so endemic that the staff member, our staff members do not recognize depression"* (Interview 1311, Community Health Worker). Despite high prevalence of depression in the study community, parents and adolescents had poor understandings of the mental health spectrum, including little awareness that there were distinct illnesses such as depression. When parents discussed depression, they conflated depression with symptoms of other severe mental illnesses, most likely schizophrenia:

> "Depression is the worst of them all in my opinion …. because a person that suffers from depression can kill and can also say a lot to implicate him/herself. People that suffer from depression are very violent, they don't want to take medication. They are constantly thinking that someone or people are after them. I was told by this other woman that I was lucky to have escaped [the mentally ill person] unharmed because she is very violent; that is depression for you. When you mad and when you well people can't believe it's still the same person." (Parent Focus Group 1207)

Similarly, adolescents were likely to describe symptoms of severe mental disorders when asked about depression:

> "I once listened, this guy was talking as if there was another person but he was that other person so he would talk and respond to himself at the same time mmmm..... That was very freakkyyyy." (Adolescent Focus Group 1906)

Together, discussions indicated a need for future intervention content to explore the concept of mental health more generally, and the mental health spectrum specifically.

Intervention adaptations needed to address context specific interpretations of depression—Participants went on to describe context specific interpretations regarding the causes of depression. Some believed that bewitchment caused depression:

> "I've come across it quite a number of times, that there's a description of a snake in the stomach. She took the person to a sangoma [traditional healer]. Then the sangoma gave her really awful things to drink, and she vomited out the snake …. I don't know exactly if this is a cultural illness, the snake in the stomach, but it's been reported to me probably four times in the time that I've worked in the township communities where those particular symptoms have come out." (Interview 1311, Community Health Worker)

Other social interpretations of illness, although not specific to depression, but generalized to poor psychological health included demon possession and requiring traditional healing:

> "When people or children then experience mental health problems like talking to themselves, drinks, all this strange behavior and all of that they believe that the person's demon possessed or is amafufunyane. Amafufunyane means something in

> you, the demon ….it's demon in English. Amafufunyane is demon in English, yeah. You are demon possessed, that's why you're acting—they believe we must take you to a traditional healer ne or to a sangoma, traditional healer. They give you a muthi [traditional medicine] that you must use and they tell you things that you must go home and perform and all of that. For them, mental health is not something that is first line [treatment] when something wrong happens. For a long time, they will stick into that. Even if they come for help into the mental health institutions, you will still hear them talking about amafufunaye and for them it's like—it's an episode that is going to end. They don't associate mental health as a lifelong illness. They think that it's going—it's an episode that is going to happen and then, therefore, you're going to be okay afterwards. It takes long for them to understand that okay, it's not demons. It's mental health and, therefore, we must get them education from those in education because they first believe that they must go for their traditional leaders and use the muthi. Yeah. When you take the history you will find out that maybe the person has been sick maybe for four, five years. They have been going to this sangoma or traditional healer. It's for them, it takes time for them to realize that this sango—this is not for sangoma or for tradition healer. We must go for Western medication." (Interview 1211, Social Worker)

Finally, depressive symptoms were sometimes interpreted as deviations from expected social roles. For adolescents, internalizing behaviors were at times misinterpreted as 'good' behaviors, and externalizing behaviors as 'bad' behaviors:

> "A child presenting with symptoms with depression—with symptoms of depression, like unable to sleep and maybe eating too much and not have the energy and all of that, they will label that child as a lazy child. 'Why are you so lazy?' It's like they don't understand. Therefore, they don't go look for help. So the way it's interpreted as different in different cultures. They will say it's a lazy child. They will say, maybe say in Xhosa the child is unyabile, like you are quiet and withdrawn. They would interpret now you've changed, but in Xhosa it's not a nice word. If I say to you, unyabile, it's like you're not active, but the meaning of it in Xhosa it's not a, it's not nice. They will also—some children, act out in behaviors. Then they will say you are disrespectful. You're rude and therefore you need to be disciplined and the only discipline way that most people Xhosa-speaking know is giving a hiding. They will think that, 'Oh, this child has changed and now you're very rude and disrespectful.'" (Interview 1211, Social Worker)

This misinterpretation of adolescent depressive symptoms as behavioral problems was further exacerbated by the fluidity of households due to labor migration and surrogate parenting in the context of high AIDS-related orphanhood:

> "The child will move from family member to family member, so it's never picked up because as soon as the child starts acting up or starts withdrawing completely and refusing to go to school or whatever, the child is passed on to the next relative …. You see, the thing is if you look at what happens when a mother dies, even in the home, the children have to sit quietly in a corner. There's usually some family member that comes in that will make sure they eat and that they are supported and

> that sort of thing. They are witness to the whole crying and upsetness of the family and all of that, but they have to be quiet and good children, so for them the internalization of trauma is kind of, I think, often the silence that they're not allowed to act out and cry and whatever." (Interview 1311, Community Health Worker)

Family interventions to prevent depression should address negative social interpretations of mental illness including depression. Certain interpretations of mental illness can exacerbate stigma and delay engagement with mental health services. Interpretations of illness may also lead to multi-modal health seeking behavior from both western medical sources and *sangomas* or traditional healers:

> "They first start with going to the clinic. In the clinic they present with headaches and whata, whata, whata and the doctor will say, "Nothing's wrong with you." Gives you pain blocks. The client will then say, "But I still feel this pain despite this pain block." They will then consider going to a traditional healer. Then they'll get some assistance from the traditional healer. Depending on how the treatment they get from the traditional healer goes, they might then go back to the clinic or the hospital and seek assistance there again. The two places where an individual first go is to the clinic and/or the traditional healer. Then the doctor might at some stage refer them to a mental health practitioner. However, what I'm realizing now as there is now a presence of mental health practitioners in the clinics. People now realize that in the event—especially if let's say there's been a bereavement and following the bereavement a client is still not feeling themselves. There's now an understanding that I can actually go for counseling." (Interview 1711, Psychologist)

These context specific beliefs regarding causality of depression need to be addressed in future family-based intervention to ensure timely access to care when needed, and to encourage implementation of positive coping mechanisms.

Depression adversely affects family interaction

Adolescents at risk for depression are more likely to be from families with depression given biological and environmental factors linked to family depression (Beardslee, 1998; Birmaher et al., 1996; England & Sim, 2009; Sullivan et al., 2000). In families where parents are experiencing depression, family dynamics that can protect adolescents from depression onset – such as communication, family functioning, and family bonding – are disrupted.

Depression diminishes family communication—Parents described how depressive symptoms adversely affected family communication, in general, and specifically around the family's experience of psychological distress:

> "I told my children that I was diagnosed from depression and they saw me because I could not sleep at all. The one who is doing grade 12 said that I should go to the doctor because at school they were taught about the depression and its stages and it is dangerous. I even lost my baby because of the depression and I did not know anything about it…. I do not even have a relative here but as much as I talk about it, the more it gets out. I also do not think that it can be easy for me to tell my child

about it, because it's not easy to talk about high blood and depression. The high blood and depression are more dangerous than HIV but it cannot be as easy to talk about them." (Parent Focus Group 1207)

There were a variety of reasons for diminished communication. Among families affected by both parent and adolescent depression, parents elucidated that disclosing they had depression to children was difficult because of fears that children would not be mature enough to understand parental illness: "*sometimes they [parents] feel that it is in their interests not to tell their children because they are young for that*" (Parent Focus Group 0309). Key informants had similar perspectives on why parents chose not to communicate with their children about depression:

"I think one of them in my experience is around not being sure themselves what's going on and also not thinking that the child will understand that I am stressed. The child may not understand, the child is young, what do they know anyway being the child." (Interview 1711, Psychologist)

Parents described a perception that communication about their illness might result in children developing psychological distress: "*I am always thinking about it because maybe this might have an effect towards her life if I explain the reasons why I am sick. I think she will become stressful more them I am"* (Parent Focus Group 2008).

Depression can present challenges to family functioning and bonding— Participants described depression as a challenge for family bonding. A key informant involved in delivering group-based depression treatment described how depressive symptoms, including irritability, alienated parents from their children:

"The experiences of the mothers in the current group that we have is that they themselves are sitting with a lot. Most suffer from a one mental illness or another; most of them suffer from depression. However, because they themselves—they're always so overwhelmed with what needs to be done in the household and meeting the basic needs, making sure that the family is taken care of. They almost forget that capacity for self-reflection is somewhat diminished. Again the only thing that they become aware of is the physical manifestations i.e. of anger. I find that I'm short and I'm stressed. Again would come up to the fore. This is what they'll feel, this is what they'll experience and the fact that they just seem to constantly be tired. There's no discussion with the child that I am depressed. It's just pretty much carrying on and finding themselves being very short with their child, being very impatient, being very angry all the time. Constantly feeling weighed down without having an understanding of why. Because they themselves don't know why until such a parent then meets up with the mental health professional and says, 'You have depression.'" (Interview 1711, Psychologist)

Adolescents described being attuned to parental symptoms, honing in on those that most affected their interactions with parents. For example, adolescents described the most difficult symptoms to deal with, which included irritability, saying, "*They are always angry"* (Adolescent Focus Group 1906) or "*They become irritable that sometimes they just lash out on your for no reason*" (Adolescent Focus Group 0107); diminished social engagement such

as, "*He walks aimlessly* (Adolescent Focus Group 0107)"; and forgetfulness including, "*When she or he think about something, they forget quickly* (Adolescent Focus Group 1906)," "*qiqa strongo* [absent minded] (Adolescent Focus Group 0107)," and "*They isolate themselves* (Adolescent Focus Group 1906).

Breaking the family silence around mental distress is crucial for adolescent resilience—Parent focus group participants emphasized that breaking the silence around parental illness was crucial for ensuring the mental health of children in the household:

> "It's hard for children sometimes, you have a problem in the house but you choose not to tell him, keeping it from him and he might end up hearing it from outsiders. It is important to let him know so that he can be able to deal with it step by step. You could also seek help from the counsellors as to pour it out while your children have been prepared psychologically. Once they have been examined, then the next step will depend on their overall responses. They should be told if a parent is sick and they should be given all the details, for them knowing what's wrong with parents will ultimately help them to stay aware from activities that could lead them to similar situation." (Parent Focus Group 0309)

Communication helped to address children's confusion, fear, and self-blame. One parent – suffering from depression – explained that communication helped combat her child's fear that her depression would lead to death:

> "I told my first born that I am sick and the reason why I am sick and she was so shocked but I managed to explain to her. She thought that I was going to die but I told her that it was not like that. I encouraged her to focus on her school work because I will never die early. At that time I was so depressed but I did want her to know that, until today I am here and healthy now. She told others and they understood it as I explained it to her." (Parent Focus Group 1207)

Parent focus group participants described that communication about parental illness could be a source for re-bonding and parental resilience:

> "There will be a good relationship between you and your child only if you interact with each other about the matter you discuss. There will be no relationship if you do not listen to each other and that also mean that there should be a bond between each parent and child. By doing that as parents we will never become sick but sometimes it seem as if the bond is on one side where it supposed to be on both sides to decrease the illness in parent." (Parent Focus Group 1207)

Context specific strategies for mental health resilience and positive coping

Participants identified context appropriate strategies for developing family and adolescent resilience to mental health. One idea centered on the creation of a family narrative as a starting point for building resilience to depression. One key informant described how building family communication skills could facilitate a sense of a solidarity among family members:

> "I really feel that the families need to be encouraged to really just communicate with one another. To see each other and to see each other and talk to each other. Also be encouraged to take care of themselves. To say, 'What is happening for you? What are you feeling? How can you best take care of that mom? How can you best be supported in order to take care of these things?' Because once a mom feels supported in that, feels supported along with them. This space that opens up to be able to see and hear and actually listen to the child. If mom feels overwhelmed, if mom and dad feel overwhelmed and too stressed to the capacity to be able to listen and hear and see the child becomes real complicated. They struggle with that because there's so many competing things. However, what can mitigate the fact that mom feels overwhelmed is if mom talks about what happened. If mom is able to talk about what's going on, with the family. Talk to the family [and] as a family strategize on how best to work through what needs to be worked through. I think there's lots of social problems, lots of communities in Khayelitsha struggle with money, financial pressures. They struggle with paying necessities. If families can pull together and talk about their struggles and draw on each other's strengths, that could be helpful." (Interview 1711, Psychologist)

Participants described family meetings as a common practice among Xhosa families, and a context specific method for developing family coping strategies to facilitate adolescent challenges around health:

> "We use a lot of group, family group conferences …. It works very well because it's also traditionally quite a good way of working, but not just involving the parents and the children, but the broader family and the children. That works extremely well. It's been proven over and over in South Africa to be a good way of resolving things or dealing with things." (Interview 1311, Community Health Worker)

Similarly, another key informant confirmed that family meetings were particularly appropriate platforms for discussing family issues within the cultural context:

> "Maybe create a structure where there's family meetings. You speak about issues that are affecting the welfare of the family. Parents should take up, maybe, one or two spots and speak about specific topics, you see?" (Interview 1211, Social Worker)

These family meetings could create a space to build family resilience, which was conceptualized by participants as "*positivity*" (Adolescent Focus Group 0107) and as families that "*think highly of themselves"* (Adolescent Focus Group 2006). Actions of families that foster adolescent resilience included *"ukuthanda [love],"* *"inkathalo [care],"* *"ukubakhathalela [care for more than one person],"* *"ubumbano [unity],"* and *"ukwamkelana [acceptance]"* (Adolescent Focus Group 20062013; Interview 811). Another important resilience concept was '*ubuntu*'. This concept was described in a variety of ways, but specific to mental health, *ubuntu* was described as reciprocity among social networks. A key informant explained further, stating, "*It means that you have to do onto me what you'd love done onto you"* (Interview 311, Social Worker). This reciprocity was viewed as mutual caretaking within the family, the notion of, "*Adults taking care of the children. Children*

taking care of the adults. When you see the person with bags you go for help. Not expecting anything in return" (Interview 311, Social Worker). Importantly, the concept of *ubuntu* described social cohesion that was specifically leveraged as a way to cope with depression: "*if you are depressed for example, you don't have any energy, ever. You would love if at least there was someone out there looking after your children. That's social cohesion"* (Interview 311, Social Worker).

Discussion

This exploratory qualitative study identified factors in South Africa that affect the future design of family interventions to prevent adolescent depression. South Africa has the largest HIV epidemic globally (UNAIDS, 2014), exacerbating risk for poor psychological outcomes. For adolescents, receipt of a diagnosis of a life-threatening disease early in the life trajectory was tied to loss of future orientation. Similarly, familial HIV led to communication challenges as well as implementation of healthy coping strategies for psychological distress. Poverty also presented challenges for adolescents, introducing uncertainty regarding how adolescents and their families would meet basic needs such as food and education. These challenges often made parents feel inadequate and introduced stressors that impacted family communication, bonding, and functioning, all linked to risk for adolescent depression onset. Other South African studies provide further evidence that exposure to parental HIV illness, AIDS orphanhood, poverty, and other adverse childhood experiences are linked to elevated risk for poor psychological outcomes (Carey, Walker, Rossouw, Seedat, & Stein, 2008; Cluver, Gardner, & Operario, 2007; Cluver, Operario, & Gardner, 2009; Cluver, Orkin, Boyes, & Sherr, 2015; Cluver, Orkin, Gardner, & Boyes, 2012; du Plessis, Kaminer, Hardy, & Benjamin, 2015). While familial risks for depression have been well established (Beardslee et al., 1998; Birmaher et al., 1996; Sullivan et al., 2000), our findings underscore South African risk factors that contribute to risk for poor psychological outcomes including depression. These findings suggest family interventions are especially warranted for adolescents from families experiencing psychological distress because rates of onset are higher for these adolescents (Weissman, Wolk, & Goldstein, 1997; Weissman et al., 1984; Williamson et al., 1995). Findings from two meta-analyses evaluating the efficacy of prevention for depression generally, and among adolescents specifically, reinforce this conclusion; in these meta-analyses, selective and indicative prevention for depression were more effective than universal approaches (Cuijpers, van Straten, Smit, Mihalopoulos, & Beekman, 2008; Horowitz & Garber, 2006).

Findings also indicate that family interventions to prevent adolescent depression need tailoring for South Africa to ensure acceptability and engagement in the South African context. This includes a need to recognize 'idioms of distress' including shared ethnopsychologies that can facilitate effective communication in preventive interventions (Kaiser et al., 2015). For example, findings indicate a need to both understand context specific idioms such as 'stress' and 'things being too much', to use these common idioms in discussing depression, and to embed exploration of what these idioms represent in a transcultural mental health intervention approach (Swartz & Kilian, 2014). Participants suggested a focus on symptoms could help facilitate a common starting point for discussing mental health and illness and overcome any challenges created by taking an approach

focusing on simple linguistic equivalence for depression among isiXhosa speakers (Swartz & Kilian, 2014). Careful formative work can inform design of interventions, including providing information on how to incorporate terminology used to participants into intervention materials. Furthermore, interventions need to develop an understanding of the mental health illness spectrum – from health to distress to disorder – and engage in families' social and personal meanings of illness (Fernando, 2014). In the South African context, interventions need to address interpretations of mental illness as bewitchment and other social meanings placed upon illness symptoms as failures in social roles or 'bad' adolescent behavior. Another strong theme that emerged were barriers that parent and adolescent mental distress and/or stigma presented for family communication, functioning, and bonding. These family mechanisms are particularly important for promoting optimal adolescent mental health outcomes. As such, family interventions may want to build skills and efficacy in family communication, functioning, and bonding. While disruption of family dynamics is common among families experiencing mental distress anywhere, participants identified context appropriate methods to foster adolescent mental health in the South African context. For example, the strategy of utilizing family meetings provided a context appropriate approach that facilitates healthy family coping strategies. Furthermore, culturally-specific concepts of resilience need to be incorporated into future family interventions for adolescent prevention of depression. The detailed findings, summarized above can inform design of a preventive intervention for depression in South Africa. Equally important, and worthy of careful consideration early in the design phase of interventions, is how to develop interventions that can be eventually brought to scale in low and middle-income countries. Emerging tools – including for example, the UN OneHealth Tool (Chisholm et al., 2016) – can contribute to careful design early in intervention research to ensure that later in the research and clinical pipeline, interventions are appropriate for health systems in settings such as South Africa (Rathod et al., 2016).

Limitations of this study include the context specific findings, which may not be representative of family intervention needs in other settings and with other populations. Future research should focus on incorporating these context specific insights into intervention design, and test the acceptability of interventions among South African families. Strengths of this study include the focus on resilience. Much of the literature, particularly for children infected or affected by HIV, has focused on understanding psychological risk profiles among South African children. However, these is growing recognition that some at risk children remain resilient (Collishaw, Gardner, Lawrence Aber, & Cluver, 2015), and that a better understanding of these children's resilience can inform design of preventive interventions (Betancourt, Meyers-Ohki, Charrow, & Hansen, 2013; Skovdal & Andreouli, 2011) including how children thrive in spite of exposure to poverty, familial HIV and AIDS, violence, and other adverse childhood circumstances. We recognize that an individual or family may exhibit resilience in one aspect of life, but not the other, and that observable resilience may change across time. We also acknowledge that there may be costs associated with exhibiting resilience, and that fostering resilience is not a substitute for the structural and social interventions needed to address the health inequities faced by vulnerable individuals and families. However, the concept of resilience is complex and understanding how it may manifest differently across different contexts and cultures is vital.

Developing our understanding of resilience – including appropriate cultural constructs and strategies – can help inform the design of future strength-based prevention programs for adolescent mental health. Resilience can be developed through a multidimensional process and fostered through multiple pathways. Developing resilience-focused family interventions for adolescents in low- and middle-income settings complements existing approaches in prevention science, currently dominated by risk reduction frameworks. A resilience-focused approach to prevention recognizes and fosters the ability of families to thrive despite contexts of adversity.

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References

Africa, S. S. Statistics South Africa: Latest Key Indictors. 2011. Retrieved from http://www.statssa.gov.za/keyindicators/keyindicators.asp

Angold A, Costello E, Worthman C. 1998; Puberty and depression: the roles of age, pubertal status and pubertal timing. Psychological Medicine. 28(1):51–61. [PubMed: 9483683]

Beardslee W. 2012; Developmental Risk of Depression: Experience Matters. Child and Adolescent Psychiatric Clinics of North America. 21(2):261.doi: 10.1016/j.chc.2011.12.001 [PubMed: 22537726]

Beardslee W, Chien P, Bell C. 2011; Prevention of mental disorders, substance abuse, and problem behaviors: a developmental perspective. Psychiatr Serv. 62(3):247–254. DOI: 10.1176/appi.ps.62.3.247 [PubMed: 21363895]

Beardslee W, Versage E, Clastone T. 1998; Children of affectively ill parents: a review of the past 10 years. Journal Am Academy Child Adolescent Psychiatry. 31:1132–1141.

Becker AE, Kleinman A. 2014; The history of cultural psychiatry in the last half-century. Psychiatry: Past, present, and prospect. 74

Betancourt TS, Meyers-Ohki SE, Charrow A, Hansen N. 2013; Annual Research Review: Mental health and resilience in HIV/AIDS-affected children – a review of the literature and recommendations for future research. Journal of Child Psychology and Psychiatry. 54(4):423–444. DOI: 10.1111/j.1469-7610.2012.02613.x [PubMed: 22943414]

Birmaher B, Ryan ND, Williamson DE, Brent DA, Kaufman J, Dahl RE, Nelson B. 1996; Childhood and Adolescent Depression: A Review of the Past 10 Years. Part I. Journal of the American Academy of Child & Adolescent Psychiatry. 35(11):1427–1439. DOI: 10.1097/00004583-199611000-00011 [PubMed: 8936909]

Carey PD, Walker JL, Rossouw W, Seedat S, Stein DJ. 2008; Risk indicators and psychopathology in traumatised children and adolescents with a history of sexual abuse. Eur Child Adolesc Psychiatry. 17(2):93–98. DOI: 10.1007/s00787-007-0641-0 [PubMed: 17876504]

Chisholm D, Heslin M, Docrat S, Nanda S, Shidhaye R, Upadhaya N, Lund C. 2016; Scaling-up services for psychosis, depression and epilepsy in sub-Saharan Africa and South Asia: development and application of a mental health systems planning tool (OneHealth). Epidemiol Psychiatr Sci. :1–11. DOI: 10.1017/s2045796016000408

Cluver L, Gardner F, Operario D. 2007; Psychological distress amongst AIDS-orphaned children in urban South Africa. Journal of Child Psychiatry and Psychology and Allied Disciplines. 48(8):755–763. DOI: 10.1111/j.1469-7610.2007.01757.x

Cluver L, Operario D, Gardner F. 2009; Parental illness, caregiving factors and psychological distress among children orphaned by acquired immune deficiency syndrome (AIDS) in South Africa. Vulnerable Child and Youth Studies. 4(3):185–198. DOI: 10.1080/17450120902730196

Cluver L, Orkin M, Boyes ME, Sherr L. 2015; Child and Adolescent Suicide Attempts, Suicidal Behavior, and Adverse Childhood Experiences in South Africa: A Prospective Study. J Adolesc Health. 57(1):52–59. DOI: 10.1016/j.jadohealth.2015.03.001 [PubMed: 25936843]

Cluver LD, Orkin M, Gardner F, Boyes ME. 2012; Persisting mental health problems among AIDS-orphaned children in South Africa. Journal of Child Psychology and Psychiatry. 53(4):363–370. DOI: 10.1111/j.1469-7610.2011.02459.x [PubMed: 21883206]

Collishaw S, Gardner F, Lawrence Aber J, Cluver L. 2015; Predictors of Mental Health Resilience in Children who Have Been Parentally Bereaved by AIDS in Urban South Africa. J Abnorm Child Psychol. doi: 10.1007/s10802-015-0068-x

Cuijpers P, van Straten A, Smit F, Mihalopoulos C, Beekman A. 2008; Preventing the Onset of Depressive Disorders: A Meta-Analytic Review of Psychological Interventions. American Journal of Psychiatry. 165(10):1272–1280. DOI: 10.1176/appi.ajp.2008.07091422 [PubMed: 18765483]

Delany, A, Jehoma, S, Lake, L. South African Child Gauge 2016. Cape Town: 2016. Retrieved from

du Plessis B, Kaminer D, Hardy A, Benjamin A. 2015; The contribution of different forms of violence exposure to internalizing and externalizing symptoms among young South African adolescents. Child Abuse Negl. 45:80–89. DOI: 10.1016/j.chiabu.2015.02.021 [PubMed: 25804436]

England, M, Sim, L, editors. Depression in Parents, Parenting, and Children: Opportunities to Improve Identification, Treatment, and Prevention. Washington DC: National Academies Press; 2009.

Fernando S. 2014; Transcultural psychiatry and mental health. Critical Psychiatry and Mental Health: Exploring the Work of Suman Fernando in Clinical Practice. 13

Ferrari AJ, Charlson FJ, Norman RE, Patten SB, Freedman G, Murray CJL, Whiteford HA. 2013; Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. PLoS Med. 10(11):e1001547.doi: 10.1371/journal.pmed.1001547 [PubMed: 24223526]

Ge X, Conger RD, Elder GH Jr. 2001; Pubertal transition, stressful life events, and the emergence of gender differences in adolescent depressive symptoms. Developmental Psychology. 37(3):404–417. DOI: 10.1037/0012-1649.37.3.404 [PubMed: 11370915]

Gile K, Handcock M. 2010; Respondent-driven sampling: An assessment of current methodology. Sociological Methodology. 40:285–327. [PubMed: 22969167]

Government, C. T. City Health HIV, AIDS, STI, and TB Plan 2012/2013. Cape Town: Metro District Health Services; 2014. Retrieved from https://www.capetown.gov.za/en/IDP/Documents/Statutory%20compliance%20plans%202012/AnnexI_City_Health_HIV_Aids_STI_and_TB_Plan_20122013.pdf

Horowitz JL, Garber J. 2006; The prevention of depressive symptoms in children and adolescents: A meta-analytic review. J Consult Clin Psychol. 74(3):401–415. DOI: 10.1037/0022-006x.74.3.401 [PubMed: 16822098]

Kaiser BN, Haroz EE, Kohrt BA, Bolton PA, Bass JK, Hinton DE. 2015; “Thinking too much”: A systematic review of a common idiom of distress. Soc Sci Med. 147:170–183. DOI: 10.1016/j.socscimed.2015.10.044 [PubMed: 26584235]

Kaslow NJ, Broth MR, Smith CO, Collins MH. 2012; Family-based interventions for child and adolescent disorders. Journal of Marital and Family Therapy. 38(1):82–100. [PubMed: 22283382]

Kirmayer LJ, Swartz L. 2013:3.Culture and Global Mental Health. Global mental health: principles and practice.

Kuo C, Operario D, Cluver L. 2012; Depression amongst carers of AIDS-orphaned and other-orphaned children in Umlazi Township, South Africa. Global Public Health. 7(3):253–269. DOI: 10.1080/17441692.2011.626436 [PubMed: 22081931]

Lachman J, Cluver L, Boyes M, Kuo C, Casale M. 2013; Positive parenting for positive parents: HIV/AIDS, poverty, caregiver depression, child behavior and parenting in South Africa. AIDS Care. 26(3):304–313. [PubMed: 23930647]

Lentoor A, Asante K, Govender K, Petersen I. 2016; Psychological functioning among vertically infected HIV-positive children and their primary caregivers. AIDS Care. 28(6):771–777. [PubMed: 26829395]

Lewinsohn PM, Clarke GN, Seeley JR, Rohde P. 1994; Major Depression in Community Adolescents: Age at Onset, Episode Duration, and Time to Recurrence. Journal of the American Academy of Child & Adolescent Psychiatry. 33(6):809–818. DOI: 10.1097/00004583-199407000-00006 [PubMed: 7598758]

Lovejoy M. 1991; Maternal depression: effects on social cognition and behavior in parent-child interactions. J Abnorm Child Psychol. 19(6):693–706. [PubMed: 1791274]

Ltd, Q. I. P. NVivo (Version Version 10). QSR International Pty Ltd; 2012.

Masten A, Obradović J. 2006; Competence and resilience in development. Annals of the New York Academy of Sciences. 1094(1):13–27. [PubMed: 17347338]

O'Regan, C; Pikoli, V; Bawa, N; Sidaki, T; Dissel, A. Towards a safer Khayelitsha: Report of the Commission of Inquiry into allegations of police inefficiency and a breakdown of relations between SAPS and the Community of Khayelitsha. 2014. Retrieved from http://www.saflii.org/khayelitshacommissionreport.pdf

Organisation, W. H. Mental Health Atlas 2011. Geneva: 2011. Retrieved from

Organisation, W. H. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. 2013. Retrieved from http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1

Petersen I, Lund C. 2011; Mental health service delivery in South Africa from 2000 to 2010: one step forward, one step back. S Afr Med J. 101(10):751–757. [PubMed: 22272856]

Rathod SD, De Silva MJ, Ssebunnya J, Breuer E, Murhar V, Luitel NP, Lund C. 2016; Treatment Contact Coverage for Probable Depressive and Probable Alcohol Use Disorders in Four Low- and Middle-Income Country Districts: The PRIME Cross-Sectional Community Surveys. PLoS One. 11(9):e0162038.doi: 10.1371/journal.pone.0162038 [PubMed: 27632166]

Siegenthaler E, Munder T, Egger M. 2012; Effect of Preventive Interventions in Mentally Ill Parents on the Mental Health of the Offspring: Systematic Review and Meta-Analysis. Journal of the American Academy of Child & Adolescent Psychiatry. 51(1):8–17.e18. DOI: 10.1016/j.jaac.2011.10.018 [PubMed: 22176935]

Skovdal M, Andreouli E. 2011; Using Identity and Recognition as a Framework to Understand and Promote the Resilience of Caregiving Children in Western Kenya. Journal of Social Policy. 40(03):613–630. DOI: 10.1017/S0047279410000693

Southwick S, Bonanno G, Masten A, Panter-Brick C, Yehuda R. 2014; Resilience definitions, theory, and challenges: interdisciplinary perspectives. European Journal of Psychotraumatology. 5:25338.

Stein D, Seedat S, Herman A, Moomal H, Heeringa S, Kessler R, Williams D. 2008; Lifetime prevalence of psychiatric disorders in South Africa. British Journal of Psychiatry. 192:112–117. DOI: 10.1192/bjp.bp.106.029280 [PubMed: 18245026]

Strauss, A, Corbin, J. Basics of qualitative research: Techniques and procedures for developing grounded theory. 2nd. Thousand Oaks, CA US: Sage Publications, Inc; 1998.

Sullivan PF, Neale MC, Kendler KS. 2000; Genetic Epidemiology of Major Depression: Review and Meta-Analysis. American Journal of Psychiatry. 157(10):1552–1562. DOI: 10.1176/appi.ajp.157.10.1552 [PubMed: 11007705]

Swartz L, Kilian S. 2014; The Invisibility of Informal Interpreting in Mental Health Care in South Africa: Notes Towards a Contextual Understanding. Culture, Medicine, and Psychiatry. 38(4):700–711. DOI: 10.1007/s11013-014-9394-7

Thompson, L. A history of South Africa. 4th. New Haven: Yale University Press; 2014.

UNAIDS. The GAP Report. Geneva: 2014. Retrieved from

UNAIDS. Country Factsheet: South Africa. Geneva: 2015. Retrieved fromhttp://www.unaids.org/en/regionscountries/countries/southafrica

Ungar M. 2010; Families as navigators and negotiators: Facilitating culturally and contextually specific expressions of resilience. Fam Process. 49(3):421–435. [PubMed: 20831769]

Ungar M. 2012; Researching and theorizing resilience across cultures and contexts. Preventive Medicine. 55(5):387–389. [PubMed: 22884666]

Weissman M, Wolk S, Goldstein R. 1997; Offspring of depressed parents, 10 years later. Arch Gen Psychiatry. 54:932–940. [PubMed: 9337774]

Weissman MM, Wickramaratne P, Merikangas KR, Leckman JF, Prusoff BA, Caruso KA, Gammon GD. 1984; Onset of major depression in early adulthood. Increased familial loading and specificity. Arch Gen Psychiatry. 41(12):1136–1143. [PubMed: 6508504]

Williamson DE, Ryan ND, Birmaher B, Dahl RE, Kaufman J, Rao UMA, Puig-Antich J. 1995; A Case-Control Family History Study of Depression in Adolescents. Journal of the American Academy of Child & Adolescent Psychiatry. 34(12):1596–1607. DOI: 10.1097/00004583-199512000-00010 [PubMed: 8543531]

Wouters E, Masquillier C, Le Roux Booysen F. 2016; The Importance of the Family: A Longitudinal Study of the Predictors of Depression in HIV Patients in South Africa. AIDS and Behavior. 20(8): 1591–1602. [PubMed: 26781870]

Young AS, Fristad MA. 2015; Family-Based Interventions for Childhood Mood Disorders. Child and Adolescent Psychiatric Clinics of North America. 24(3):517–534. DOI: 10.1016/j.chc.2015.02.008 [PubMed: 26092737]

Table 1

Participant characteristics

	Adolescents (k=3, n=30)	Parents (k=3, n=27)	Key informants (n=25)
Ethnicity and population group			
Black African	100%	100%	48%
White			44%
Coloured			8%
1st Language			
isiXhosa	100%	100%	44%
English			36%
Afrikaans			19%
Other			1%
Age (mean, range)	13.7 years (13-15 years)	43.4 years (20-61 years)	41 years (28-67 years)
Gender			
Male	90%	4%	24%
Female	10%	96%	75%
Trans	0%	0%	1%
Education (mean)	Grade 6	Grade 8	—
Grade 12			24%
Bachelors			36%
Masters or above			40%
Orphaned	1/3	—	—
Relationship to caregiver			
Biological parent	63%	—	—
Extended family or other adult	37%		
Socioeconomic status			
Employed	—	18%	—
Government social welfare grants main source of household income		63%	