A Sociological Analysis of Rhodes University Students' Understanding of Depression.

By

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ABSTRACT.

Using the theoretical framework of symbolic interactionism, this research sought to analyse and explore how Rhodes University students, both depressed and not depressed, understand depression, and how their understanding influences their interaction with people who do suffer from depression. For the purposes of this paper, eight participants were involved in an in-depth interview process. Out of the eight participants, six of them suffered from depression while the other remaining two participants had never suffered from depression, but they were close to someone who had depression. The findings of this research varied, some understood depression as a mental disturbance, others understood it as a condition that affects your emotions, and others understood it as a multifaceted condition that is highly subjective and cannot be understood using standardized measures. The participants' personal experience and introduction into a new environment, in this context, university, changed their understanding of depression. The change in how they understood depression correlated with the change in how they interacted with depressed people.

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List of Acronyms

APA	American Psychiatric Association
GBD	Global Burden Disease
SADAG	South African Depression and Anxiety Group
WHO	World Health Organization

Chapter 1: Introduction.

1.1 A brief introduction on depression within the South African context.

The primary aim of this research was to understand and analyse how Rhodes University students, both those who have personally experienced depression, and those who have never suffered from depression, understood the condition. The dominant understanding of depression is that it is a clinical condition which affects an individual's cognitive, affective and behavioral functioning (America Psychiatric Association [APA], 2013: 155; Kleinman, Good & Good, 1985: 9; Marsella *et al*., 1985: 301). The symptoms that are often associated with depression include feelings of sadness, unhappiness, worthlessness, inability to concentrate, significant weight loss or weight gain or loss of appetite, hyper-insomnia/ insomnia and suicidal ideation (APA, 2013: 161). Depression can occur in episodes, with inter-episode remission, and in some cases, it can be chronic (Karp, 1996: 82; Trivedi, 2004: 12). As a result, the symptoms and the duration of depression can cause an impairment in the individual's social and occupational life, as well as other important aspects of their lives (APA, 2013: 16; Cabassa, 2007: 499; DePaulo & Horvitz, 2002: 8;). In recent decades, depression has been considered as one of the leading causes of death across the globe (Murray, Lopez & World Health Organization 1996: 1; Thomas & Seedat, 2018: 22; Ustun, 1999: 1315). In 2002, it was found that approximately 15 million people suffer from depression within their lifetime. It is furthermore estimated that by 2020, depression will be the second highest cause of death, after that of coronary diseases, and one of the leading causes of suicide (DePaulo, 2002:6). Regardless of this, when it comes to understanding the symptoms and original causes of depression, there are many varying aspects to consider. Depression is a complex multifaceted condition because people's experience of it can be highly subjective and influenced by their historical context, personal beliefs, cultural, linguistic and environmental settings (APA, 2013: 166; Karp, 1996: 28; Wernicke, Pearlman, Thorndike & Haaga, 2006: 771). And this is highly evident in the South African context which has a history of human rights violation, racial segregation and repression, poverty, violence and so forth (Kale, 1995: 1254).

Before the First World War, attempting suicide, which is one of the most dominant results of depression, was considered a criminal offense in South Africa, and it was punishable by hard labour or 3 months in prison (Parle, 2007: 204). In 1868, the Natal Custody of Lunatics Act 1 was passed, and its first clause stated that, if an individual attempts suicide, they are fit to be diagnosed with a mental condition and be admitted to a psychiatric institution (Parle, 2007:

204). In 1961, the Union of South Africa passed the Mental Disorders Act 38 of 1916, which argued that "a mentally disordered or defective person shall mean any person who in consequence of a mental disorder or disease or permanent defect of reason or mind, is incapable of managing himself or his affairs or is in consequence of such disorder or disease or defect a danger to himself or others." (Parle, 2007: 204).

However, even with the passing of time and the decriminalization of suicide, the subject of depression in some communities in South Africa still remains taboo and stigmatized, and people who are sufferers of depression and other forms of mental illnesses are still considered social deviants who are a danger to themselves and to others. (Lund *et al.,* 2008: 52). This is due to South Africa's history with colonial psychiatry, which identified mental health conditions as a deviation from societal norms and ultimately deemed it an abnormality (Parle, 2007: 15). During the mid-nineteenth and twentieth century, there was a great evolution in scientific studies, whereby science was regarded as the objective fact (France, Lysaker, & Robinson, 2007: 411; Huang & Fang, 2016: 759; Kemp, Lickel & Deacon, 2014: 48; Van Praag, De Kloet & Os, 2004: 91). This led to the pervasive development of scientific racism, whereby science was a method used to produce evidence of the inferiority of the African psyche in the pursuit of political agenda and various forms of social control by the apartheid government. It was used to propagate segregation and oppression of people who resided in South Africa who were not white. (Parle, 2007: 16; Swart, 1998: 103).

Since, at that time in South Africa, there was a mainstreaming of the scientific approach to treating depression and other mental health conditions, there was also a universalization of treatment options, which included the adoption of the western medical approach to depression (Parle, 2007: 17). This subsequently meant that the contextual approach to depression was completely erased, whereby gender, race, ethnicity, ideological beliefs and so forth, were not taken into consideration (*ibid*). Colonial psychiatry hence made little to no effort in trying to understand the diverse cultures in South Africa, and the conceptions towards depression that Black people and other minority groups that resided in South Africa had. South Africans, especially Black people, are more likely to consult traditional healers when they are having mental health problems (Flisher *et al.*, 2015: 157). This highlights the importance of understanding the meanings people attach to concepts and conditions, specifically in this case depression, because those meanings can influence how people in a community/ individuals interact with someone who is depressed, and the type of treatment intervention that is made available to them (Akyeampong, Hill, & Kleinman, 2015: 24; Flisher *et al.*, 2015: 146;

Kleinman *et al*., 1985: 3). For example, if people believe that depression is caused by witchcraft, or psychological problems, they are more likely to relate and interact with people who are depressed based on that understanding. Thus, using the South Africa contextual framework, this study seeks to understand the meanings that Rhodes University students attach to depression and how they interact with people who are depressed based on those meanings. This study was conducted at Rhodes University, in Grahamstown.

1.2 Aims of the Research.

As noted above, the primary aim of this research was to understand and analyse how Rhodes University students, both those who have personally experienced depression, and those who have never suffered from depression, understood the condition. The majority of the participants for this research have been diagnosed with depression. They hence drew most of their understanding of depression from their personal experience. All the participants, including those who have never suffered from depression, drew most of their understanding of depression from interacting with other individuals who are/were depressed, and from exposure to information about depression in the university environment. In pursuing the primary aim of this study, I also explored the role of culture, community, language and environment in determining how people understand depression and relate to those who are depressed based on these understandings. Thus, I also aimed at determining whether or not people's community identity (home community/ Rhodes University student community) has a role in shaping new meanings and understandings of depression, and to understand how these new meanings influence an individual's change of interaction, during their interaction process with someone who is depressed.

Participants included four male and four female students between the ages of twenty and twenty seven, and these were from different ethnic backgrounds - one male and one female black students, one male and one female coloured student, one male and one female white students, one female Indian student, and one male Asian student. The participants' understanding of depression varied because of their personal experiences and social identity. Their understanding and meaning of depression included the following: understanding depression as a mental disturbance, depression as a mood disorder, and depression as a multi-faceted medical condition. The gender and racial diversity of this study was purposive in order to provide an in-depth understanding of different approaches to depression, and how these approaches influenced different interaction processes with people who are depressed. This input furthermore provided insight into how people's generated meanings of depression were able to

change when they entered a new environment, and how these changes in meaning impact the participants' behaviour towards depressed people. In short, the central objective of this research was to find out how the participating students understand depression, both as a concept and a disorder. The following objectives are addressed in this thesis:

1. How individuals understand depression and how that understanding is generated from interaction with others and from personal experience.
2. Whether or not participants knew of anyone with depression and how they interacted with them.
3. It also sought to understand the factors that culture, race and ideological beliefs play on how people from their home communities understand depression, as well as the influences that these roles have on how they interact with people who suffer from depression.

1.3 Research Design and Methodology.

In order to gather an in-depth understanding of the participant's views and experiences of depression and their interaction with people who are depressed, a qualitative research design was ideal for this study. A qualitative research method is suitable in examining questions about norms, values, morality and the creation of meanings (Tracy, 2013: 5). The sampling method that was used for this research was maximum variation (heterogeneity) sampling, which Patton (2002: 235) explains as a sampling method that shows "important shared patterns that cut across cases and derive their significance from having emerged out of heterogeneity". Maximum variation identifies similar features and variables of a phenomenon that is experienced by a diverse group of people. From this diversity it constructs a holistic view/understanding of a phenomenon even though it has been derived from a variety of approaches and studies that adopt different designs in their attempt in explaining that given phenomenon (Patton, 2002: 235). Some participants were recruited via social media networks, such as Facebook, and others were approached on campus.

The data collection method used was in-depth interviews with eight Rhodes University students, all of whom were over the age of 18 years, and as stated above, came from different ethnic groups and communities. Six of the participants were diagnosed with depression in their early adult years, and their inclusion in this research helped provide valuable insight into the participants' experiences with depression. The interviews took place at Rhodes University campus. The reason for this setting is because Rhodes University has a diversity of students

from different parts of South Africa, Africa and other parts of the world. This made it a suitable setting for this study because one of the aims of the research is to obtain a variety of views on depression. Each interview took 20 to 30 minutes. The study was guided by the Rhodes University ethical standards for social research, and ethical clearance was granted by the Rhodes University Ethics Standards Committee.

The transcribed data was interpreted using applied thematic analysis, which identified key themes in the texts, and analysed the text based on those broad themes, which in some instances furthermore consisted of sub-themes (Greg, 2012: 17).

1.4 Theoretical underpinnings.

This research was guided by George H. Mead's symbolic interaction theory. Symbolic interactionism consists of three premises, the self-concept, meanings attached to human behaviour, and the relationship between society/community and the individual (West & Turner, 2010: 79). The mind is viewed as one of the most important aspects during interaction because it is able to formulate ideas, but most importantly, it has self-consciousness which enables the individual at hand to reflect on their thoughts, ideas, beliefs and behaviours (Mead, 1936: 290). Self-consciousness allows people to be able to shape their worldview through the generation of meanings which they attach to concepts, objects, actions and situations (Mead, 1934: 135-136). These meanings are communicated to others through the use of gestures/signals. These gestures can be symbolic or non-symbolic, with the predominant symbolic gesture being that of language (Blumer, 1970, 1978, 1986; Mead, 1934: 47; Turner, 1988). Thus, the meanings that people have regarding depression can be reflected through their language use during the interaction process, and these meaning do not only reflect individual beliefs, but the collective beliefs of the communities which the individuals are found in. These beliefs and understandings of depression are able to change as the individuals get exposed to new communities, new knowledge and new discourse conventions, as well as through further interaction with those who are in their social environment (Mead, 1934: 135-136).

1.5 Dissertation Outline.

Chapter 1 is an introduction for to the dissertation, and it provides a brief overview of depression in South Africa. It also outlines the study objective and a brief discussion of the theoretical framework, the research design and methodology used.

Chapter 2 is the literature review on studies and different approaches to understanding depression. It also provides an overview of depression in Africa, and how language, culture and ideologies have an impact on people's understanding of depression.

Chapter 3 is discusses symbolic interactionism and the rationale for using it as study's theoretical framework.

Chapter 4 provides the data thematic analysis and interpretation, which addresses the participants' understanding of depression, the causal origins of depression, and the influence that language, culture and ideologies have on people's understanding of depression and their interaction with depressed individuals. This chapter also provides an analysis into how people's understandings and meanings of depression can change over time, and the factors that lead to that change.

Chapter 5 provides a conclusion of the study, and this is followed by references and appendices.

Chapter 2

Depression: A Contextual Approach

2.1 Introduction.

The aim and focus of this chapter is to review the existing literature on depression, in relation to the research question of this thesis. It will first provide a brief overview of how different paradigms and theoretical approaches try to understand depression, its causes and treatment interventions. It will then expand the discussion on how this thesis will approach the meaning of depression, that is, depression as a debilitating condition, which has various expressions across cultures, societies and time. The variation on how people understand depression is influenced by their contextual factors. These factors include, history, culture, language, communities and ideological beliefs. People's understanding of depression is able to change as they are exposed to new meanings, information, interactions and personal experiences.

2.2 An overview of different paradigms to understanding depression.

The definition of depression is multifaceted and transcends disciplines. The concept of depression can be understood through the application of various multidisciplinary explanations. These include biological, psychological and sociological explanations. There are various approaches that have been used in the attempt to understand the nature and existence of depression, and how depression should be assessed, including procedures and instruments that should be used in gaining more knowledge and understanding thereof. A few of these approaches include the post-positivist paradigm and the interpretative paradigm. A paradigm can be understood as a perception or school of thought about a world view, which informs how research is conducted, and the data interpreted. It can also be viewed as a platform in which the scientific community constructs and communicates intellectual knowledge (Huang & Fang, 2016: 757; Kivunja & Kuyini, 2017: 26).

The positivist paradigm's approach maintains that there is an objective reality. In this, it maintains that knowledge about depression can be obtained through the use of scientific methodologies like randomized case trials and/or single case evaluations (Beck, Ward, Mendelson, Mock & Erbaugh, 1961: 54-55; Chilisa & Preece, 2005: 23; Huang *et al.,* 2016: 758; Kivunja *et al*., 2017: 30). This approach includes a highly standardized classification system which tries to distinguish depression from other forms of mental illnesses. The classification is published in the *Diagnostic and Statistical Manual of Mental Disorders*

(American Psychiatric Association [APA], 2013: 155; Huang *et al.*, 2016: 758). Examples of the post-positivist paradigm, that seek to understand depression, include biological and cognitive approaches.

The biological approach towards understanding depression emerged in the mid-20th century. It hypothesised that mental illness, such as depression, is caused by chemical imbalances in the brain, and should hence be treated with prescription drugs (France, Lysaker, & Robinson, 2007: 411; Huang *et al.,* 2016: 759; Lewis, 2012: 1; Van Praag, De Kloet, & Os, 2004: 91; Thoits, 2009: 107; Ustun, 1999: 1315). Another discovery was the identification of monoamines which exist in the central nervous system and act as neurotransmitters (France *et al*., 2007: 411). It was discovered that monoamine oxide inhibitors in the brain were degrading other monoamines such as dopamine, noradrenaline and serotonin, thus disrupting the functionality of the monoaminergic systems in the brain (France *et al*., 2007: 411; Huang *et al*., 2016: 759; Van Praag *et al.,* 2004: 91; Ustun, 1999: 1316). As a result, anti-depressants were introduced in 1958 to ensure the activation of the monoaminergic transmission in the brain, which would ultimately reduce the effects of depression/depressive symptoms (Huang *et al.,* 2016: 48). This biomedical approach towards depression embodies the understanding of depression as a chronic illness. It encourages de-stigmatization by attributing the illness to uncontrollable causes and thus alleviating blame from the individual suffering from it. (France *et al.,* 2007: 412; Kemp, Lickel & Deacon, 2014: 48; Van Praag *et al.*, 2004: 91).

The cognitive/psychological approach towards depression understands depression as a disruption of an individual's cognitive functioning, which affects one's thought, behavioural and emotional functionality, resulting in an individual suffering from a depressive episode (APA, 2013: 155; Huang *et al*., 2016: 758). It can also be understood as an emotional disorder which is defined according to a conglomeration of symptoms that an individual experiences, and therefore can be referred to as a symptom burden (APA, 2013: 160-161). A symptom burden consists of affective, behavioural, cognitive and somatic symptoms, with the mood being that of persistent unhappiness (APA, 2013: 161; Disner, Beevers, Haigh, & Beck, 2011: 468; House, 2003: 197). It can be diagnosed using the systematic classification of the Diagnostic Statistical Manual of Mental Disorders and can be tested using highly scientific and standardized testing instruments such as the Beck Depression Inventory and the Cognitive Model of Depression, to name a few (Beck, 2008: 970; Disner *et al*., 2011; 467; House, 2003: 189).

The interpretivist paradigm differs significantly to that of the positivist and post-positivist paradigm in its theoretical assumptions. The interpretivist paradigm tries to understand the reality according to subjective human experience. Its epistemological assumption is subjective, its ontology relativist, its methodology naturalist, and lastly, its axiological assumptions are balanced (Chilisa *et al*., 2005: 29; Kivunja *et al*., 2017: 33). Symbolic interaction is one of the Interpretivist paradigm approaches to depression. This approach explores ways in which people generate their meaning and understanding of depression (Huang *et al.,* 2016: 760). The symbolic interaction approach to depression focuses on how social and cultural systems can have an impact on people's mental health (Swartz, 1998: 101). Through the lens of this approach, depression is not only caused by an individual's personality traits or biological factors, but it is furthermore influenced or caused by social situations, which vary cross-culturally, linguistically and socially (Horvitz, 2009: 7).

2.3 Understanding Depression.

Depression is a debilitating condition which disrupts a person's physical ability to function. Examples of such functions include: performing minor tasks like dressing or walking and other daily activities (DePaulo & Horvitz, 2002: 8). Depression does not only affect the individual suffering from it, but it also affects family members, friends, and colleagues who have a relationship with the depressed individual (Cabassa, 2007: 499; DePaulo & Horvitz., 2002: 9). Depression is an occasional illness which consists of irregular symptomatic episodes that can last for weeks, months or years, and are interspersed with periods of less or no depressive symptoms (DePaulo *et al*., 2002: 10; Huang *et al*., 2016: 758; Karp, 1996: 26). Inter-episode remission results in significant changes in cognitive function, with each episode displaying a variety of symptoms (APA, 2013: 155). When the depressive symptoms occur at the same time, the functional impairment that occurs is worse than that of a major depressive disorder, and in severe circumstances, it may be required that the individual is prescribed anti-depressant drugs in order to recover from such depressive symptoms (APA, 2013: 155). Since the episodes are irregular, it may take years for the individual to realize that they are ill, or under unfortunate circumstances, they may never come to realize it (DePaulo *et al*., 2002: 10; Trivedi, 2004: 12; Karp, 1996: 82). Even though depression may occur at any age, its onset is more common during puberty and becomes more evident in the 20s (APA, 2013: 165).

The dominant understanding of depression is that it is a clinical condition, which is characterised by cognitive, affective, somatic and behavioural symptoms. It is furthermore commonly perceived that it is caused by a malfunction of the nervous system neurotransmitters

and neuroendocrine, and sometimes it is believed to be caused by a genetic vulnerability (Huang *et al*., 2016; Kemp *et al*., 2014; Kleinman, Good & Good, 1985: 9; Marsella, Sartorious, Jablensky, & Fenton, 1985: 301). However, even though depression is predominantly understood through the Western medical lens, its manifestation and experience is highly subjective and the social response to it varies across cultures (Disner *et al*., 2011:468; House, 2003:197). For example, when an individual is experiencing an abnormal chemical imbalance in the brain, they need to interpret their experiences and translate them into active behaviour in order to elicit a social response from other social agents who are within that individual's social environment (Marsella *et al.,* 1985: 301).

Language plays a significant role on how people interpret and convey their subjective experiences, and different cultures have different language references to depression. Therefore, how depression is experienced and understood cannot be universalized due to a variety of global cultures and languages (Hecht *et al.*, 2001: 431-2 & 444; Kleinman *et al.*, 1985: 2; Swart, 1998: 100). A conceptual understanding of depression can be understood as cultural, because it presents a specific worldview which also determines its treatment. For example, it can be grounded in Western intellectual tradition, which encourage Western medical interventions such as prescription drugs and psychotherapy, or it can be grounded in indigenous knowledge where treatment interventions include traditional healers and diviners (Akyeampong, Hill, & Kleinman, 2015: 24; Kleinman *et al*., 1985: 3; Flisher, Dawes, Kafaar, Lund, Sorsdahl, Myers, Tom & Seedat, 2015: 146).

It is also important to note that some cultures adopt a religious approach to understanding and explaining depression. For example, in Buddhism and Islam, salvation is said to be found in suffering, therefore depression is experienced as a religious episode rather than an illness (Kleinman *et al.*, 1985: 3). This is because it is viewed as a consequence of living in a world that is unjust. The experience of depression is thought to cause empathetic understanding in a person (Kleinman *et al*., 1985: 3). Depression is also believed to be caused by exposure to stressful and traumatic life events such as poverty, interpersonal feuds, racism, crime and many other social aspects (Alemi, Weller, Montgomery & James, 2017: 178; Beiser, 1985: 313; APA, 2013: 166; Horwitz, 2009: 6). There are also physiological or genetic factors that cause depression. For example, individuals with family members who suffer from depression are four times more likely to experience it than the general population (APA, 2013: 166; Van Praag *et al*., 2004: 60).

Since depressive symptoms are highly subjective in experience due to the influence of the cultural and linguistic environmental setting of an individual, it manifests itself and is experienced differently based on an individual's personal beliefs and understanding of depression (Karp, 1996: 28; Kleinman *et al*., 1985: 2; Wernicke, Pearlman, Thorndike & Haaga, 2006: 771). Depression can manifest itself physically through headaches, gastrointestinal problems, psychomotor activity changes and other symptoms (Trivedi, 2004: 12; South African Depression and Anxiety Group [SADAG], 2016: 2; Swart, 1998: 100). It can also manifest itself emotionally through feelings of sadness, unhappiness, guilt, feelings of worthlessness and hopelessness. And lastly, it can manifest itself mentally, through hyper insomnia, inability to think straight or concentrate, suicidal ideation, fatigue and other presentations (APA, 2013: 160-161; SADAG, 2016: 2).

The Global Burden of Disease (GBD) study, which began in 1990 and was commissioned by the World Health Organisation, covered more than 187 countries and found that depression was one of the leading causes of death and disability. It is estimated that by 2020 approximately 7 in 10 people, mostly in developing countries, will die from depression-related conditions (Murray, Lopez & World Health Organization 1996: 1; Thomas & Seedat, 2018: 22; Ustun, 1999: 1315). The GBD study shows that depression is a global health problem and epidemiological data on depression will help in understanding the different causes and perceptions of depression (Ustun, 1999). In addition, epidemiological data based on depression is important in helping scholars understand how different demographic groups understand and experience depression. It is also important for etiological studies and various treatment methods (Beiser, 1985: 273; Ustun, 1999: 1317).

2.4 Depression in Africa.

Depression is more common in developing countries, with African countries said to be responsible for about 16% of the cases of global depressive disorders (Thomas *et al.*, 2018:22). For example, South Africa's prevalence rate of depression is 9.7%, and only less than 25% of the population who are suffering from depression have access to mental health care services and/ treatment (Thomas & Seedat, 2018: 22). Psychiatry in Africa was introduced in a racial colonial context, which means that psychiatric observations were and are still informed by racial prejudice, bias and discrimination against Africans (Akyeampong *et al*., 2015: 24; Swartz, 1998: 103). Psychiatry during colonialism did not only scientifically interrogate mental disorders amongst Africans, but it was also used to negatively explain African cultures and to understand the African psyche without recognizing Africans as humans with full agency (Parle,

2007: 8). For example, one psychiatrist during the colonial period produced a generic understanding of the African individual and psyche by arguing that "the psychology of the African is essentially the psychology of the African child. The pattern of this mental development is defined by the time he reaches adolescent and little remains to be said" (Carothers & World Health Organisation, 1953: 106). This analysis portrayed Africans as inferior and the medical research findings were used as evidence of Africans' inferiority to that of Europeans (Weinberg, 1965: 250). Psychiatry during colonialism often focussed on the interaction between culture and biology, and sought objective evidence to justify racist science and biology in its study of depression and other illnesses amongst Africans (Akyeampong *et al*., 2015). This was because it was used as a political tool aimed at maintaining the idea of European cultural and biological superiority, which was inevitably used as a means to justify European hegemony within Africa (Parle, 2007: 6; Swart, 1998: 103).

However, during the 1950s and 1960s, psychiatric literature in Africa began to change since most African countries were gaining independence (Akyeampong *et al*., 2015). The originally biased, racist and discriminatory views that were overtly expressed in the colonial psychiatric literature were being challenged and replaced. It became evident that the psychiatric disorders and manic depression that were believed to exist exclusively among Africans were also common in Western countries too (Parle, 2007: 16). Depression hence transcends race, gender, age and urban-rural divides. The shift in research and practice on depression became more inclined towards biological approaches to depression, as this was spurred on by the discoveries in bio-medical interventions and the introduction of anti-depressant treatment (France *et al*., 2007: 411; Huang *et al.*, 2016: 759; Kemp *et al.*, 2014: 48; Van Praag *et al.*, 2004: 91). This led to the global dominance of the American *Diagnostic Statistical Manual of Mental Disorders*, which is currently in its fifth edition (Akyeampong *et al.*, 2015: 35).

During colonialism and apartheid, South Africa experienced racial discrimination of mental health services, as whites received much better health care than that of blacks. Furthermore, the majority of practicing doctors were white males (Baker, 2010: 88; Parle, 2007: 303; Obuaku-Igwe, 2015: 118). This resulted in misconceptions regarding depression and other mental illnesses and led to harm and negativity towards people who suffer from depression (Lund *et al*., 2008: 52). These misconceptions included beliefs that depressed people were lazy, crazy, weak, and violent and should be isolated from the public because they were dangerous (Lund et al., 2002: 52; Brooker-summer, 2014:5; Hugo, Boshof, Traut, Zungu-Diwaryi & Stein, 2003: 719). The lack of qualified mental health care workers, especially in primary health

care, with as little as 0.9% registered psychiatrists in South Africa, also contribute to the high prevalence rate of depression, making it an imperative need to integrate depression into primary health care (Thomas *et al.*, 2018: 22).

Long after independence, most African countries such as Nigeria, Ghana, Kenya, Tanzania, Rwanda, Chad, Burundi, Mozambique and Sierra Leone are still left with unsatisfactory mental health services (Akyeampong *et al.*, 2015: 37). For example, Nigeria, which had a population close to 140 million in 1996, had less than 110 psychiatrists (World Psychiatric Association, 2016) In 2015, Kenya's population of approximately 44 million people, had one doctor per 10 000 residents (Meyer & Ndetei, 2016). According to the World Health Organisation (2011: 3) statistics, Tanzania, which had a population of approximately 57.3 million people, had only 0.04 psychiatrists in 2015; Ghana currently has only 3 psychiatric hospitals in the country which are located in Accra and Ankaful (World Health Organisation, 2007: 25) whereas Mozambique, Burundi, Sierra Leone, Chad and Rwanda have only one psychiatric hospital (Akyeampong *et al*., 2015: 37). In contrast, South Africa has more mental health institutions and psychiatrics than most African countries. For example, post-1994, South Africa has an estimated population of approximately 56.7 million people which is served by 150 trained psychiatrists, and in South Africa rural areas, at 0.03% per 100 000. (Parle, 2007: 304).

In 1997 the South African government published the *White Paper for the Transformation of the Health System in South Africa*. This aimed at integrating community-based mental health care services with other forms of health care services, at national, provincial, district and community levels (Department of Health, 1997). In 2003, the government published *Policy Guidelines on Child and Adolescent Mental Health*. These guidelines include 5 intervention strategies, namely, the promotion of environments that are safe, sensitive and supportive, access to mental health care services, development of skills, access to counselling, and the provision of information. These services were to be implemented and accessible from primary levels – which include community clinics all the way up to specialist levels. In 2003, the government also commissioned a report that integrated adolescent and child mental health care services. This listed 3 objectives: 1. Promote rehabilitation and treatment for children who are at high risk of experiencing mental illnesses; 2. Conduct regular assessments on the effectiveness of the mental illness program interventions; 3. Distribute mental health education and early intervention strategies in various locations across the country, and integrate mental health education in youth, justice, education, social care and voluntary sectors like non-governmental organizations (Flisher *et al*., 2015:147).

Although the South African government's approach to depression is biomedical, the common ideological belief amongst the majority of the South African black population is that mental health problems are caused by the supernatural, such as witchcraft or ancestral calling (Akyeampong *et al.*, 2015: 24; Brooke-Summer, Lund & Petersen, 2014: 3; Flisher *et al.*, 2015: 157; Samoullhan & Seabi, 2010: 75). Traditional healers like isangomas and inyangas are often consulted regarding most mental illnesses, mainly because they are easily accessible (Flisher *et al.*, 2015: 157). There are about 200 000 traditional healers and diviners in South Africa, with one traditional healer for every 500 South Africans (Flisher *et al.*, 2015: 157). For example, a study by Sorsdahl *et al.* (2010) found that 11% of the participants consulted traditional healers for mental health problems before consulting western mental health care facilities. Since traditional healers are easily accessible to most South Africans, the government has established legal structures that recognise African traditional medicine. These include *The Traditional Healer Practitioners Bill*, and the *National Policy on Africa Traditional Medicine in South Africa.* These legal structures aim at regulating and promoting traditional healing practices and other forms of indigenous knowledge (Department of Health, 2007; Department of Health, 2008).

Even though the South African government tried to normalise depression and other mental conditions by introducing a variety of contextual treatment interventions and laws that protect mental health care service users, depression in South Africa is still associated with negative conceptions. These negative conceptions stigmatise and discriminate against people who are sufferers, causing some people to resist identifying themselves as depressed and/ seeking health care interventions (Department of Health, 2007; Department of Health, 2008; Hugo *et al*., 2003: 15; Horwitz, 2009: 15; Flisher *et al.*, 2015: 157; Lund *et al*., 2008: 47). However, in recent decades, there has been a change in the understanding and conceptualization of depression. This is due to the help of medicalization, particularly in the 1990s and 2000 (Horwitz, 2009: 15; Kemp *et al.*, 2014: 48). Medicalization refers to the process where social problems are identified as medical problems which require treatment (Horwitz, 2009: 15). It is aimed at improving people's willingness to seek professional help and treatment, as well as to alter social definitions and understandings of depression that may be harmful towards people who suffer from it (Kemp *et al.*, 2014: 48; Wyatt, 2012: 11). For example, a study titled *Mental health policy development and implementation in South Africa: a situational analysis* by Lund and colleagues (2008) argues that the public's negative perceptions of depression and other

forms of mental illness is due to misinformation, media sensationalism, and lack of support from one's family and community due to cultural beliefs and ideologies.

Another reason includes the shortage of mental health services. Due to the public perception of depression, the World Health Organisation saw it necessary to release the 2001 report on *mental health: understanding, new hope*. This report aimed at redefining depression and other forms of mental illness with the goal of influencing public opinion and perception on the subject matter (World Health Organisation, 2001: ix). The report emphasised the influence of biological, environmental, economic, social and genetic factors in causing depression, and sought to show how the same factors can cause physical illness. It is hence imperative to understand that depression is synonymous to physical illness, as both illnesses have the capacity to disrupt the lives of the affected individuals, their loved ones and their communities (World Health Organisation, 2001: ix). The South African Mental Health Care Act 17 of 2002 took its lead from this report, and furthermore emphasised the need to involve the community at large when addressing depression and other mental health conditions. This involvement aims at making mental health mainstream, and it furthermore ensures that the rights of individuals suffering from depression are upheld (South African Mental Health Care, 2002: 11-13).

Even though the South African government has tried to tackle depression among the youth by issuing different policies on adolescent and child mental health, the youth in South Africa, especially in university spaces, still struggle with depression (Hamad, Fernald, Karlan & Zinman, 2007: 538). For example, a study, conducted by Hamad and colleagues (2007) used the Center for Epidemiologic Studies Depression Scale and Cohen's Perceived Stress Scale on different demographic groups, and found that, although depression affects everyone, it is more common amongst demographic groups with fewer resources, as well as that of university students. A similar study was conducted in Nairobi, Kenya on 923 randomly selected students. These students were assessed using the Centre for Epidemiological Studies Short Depression Scale . The study found that depression was high amongst university students, and those who identified as depressed were more likely to engage in binge drinking and smoking (Othieno, Okoth, Peltzer, Pengpid & Malla, 2014: 120). Another study conducted at Florida State University found that between 20-40% of Law students suffer from depression by the time of their graduation. The study found that students did not attend class because they were depressed and were unable to function properly. The study also found that depression among students is 8-15 times higher than that of the general population (Temple, 2012: 23-24). This finding

makes it evident that depression amongst university students is universal and needs further investigation.

2.5 Language, culture and ideology.

Currently, the understanding of depression varies across cultures and languages. As a result, experiences of depression are different in the way in which they manifest themselves as they change based on cultural meanings and linguistic references attached to them in a variety of environmental settings (Swart, 1998: 100). The ethnography of communication, which originated in the 1960s, provides insight into how culture is a communicated phenomenon which is constituted through verbal communication (Gumperz & Cook-Gumperz, 2007: 15). Communication provides us with context-bound everyday language that enables us to analyse and situate semantics and grammar during interpretation, along with underlying cultural presumptions; thus, verbal and non-verbal communication act as a vehicle of forms, structures and processes that convey meanings on people's perceptions and relations to the world (Gumperzet *et al*., 2007: 18; Hecht *et al*., 2001: 432).

Language creates, preserves, expands, validates and expresses ideas which have culturally prescribed meanings about human social phenomena and experiences, which makes it inextricably intertwined with social identity. Through interaction, it is able to manifest a diversity of communication and linguistic communities (Hecht *et al*., 2001:431-2 & 444). Linguistic interactions can show a relationship amongst individuals, which can be understood and referred to as *relational identity*. A relationship between a group of people can be referred to as *communal identity* (Hecht *et al*., 2001: 430). Identity can be understood as an individual characteristic and how the individual views him/herself. Within interaction, the way in which individuals express themselves and communicates with others is an enactment of their identity (Hecht *et al*., 2001: 430). Individuals are informed by their identity about what makes them belong to their group, and what differentiates them from others. Culture shapes identity, which through language, the individual's sense of self and relation to others is negotiated and renegotiated (Nunan, 2010: 3). People's daily interactions with others are influenced by shared pre-existing cultural systems and social structures. However, through the continuous process of interaction, people's pre-existing ideas about the world and social phenomena are able to change, as they are exposed to new ideas, personal experience and new information (Craig, 2007: 84; Nunan, 2010: 3). The relationship that exists between the individual and those with whom they identify, can be made explicit through language, a collective understanding on what depression is, what it constitutes and how it can be treated. However, these meanings are able

to change and evolve as discourse conventions among the community members progress, but most importantly, because of human reflexivity (Aksan, *et al.*, 2009: 902; Blumer, 1986: 2; Freese & Burke, 1994: 5; Mead, 1934: 160-161; Mead, 1939: 192; Turner, 1988: 77; West & Turner, 2010: 79).

Discourse conventions can be defined as "various features of speech, termed contextualization cues or contextualization conventions, whose purpose is to add context to utterances with which they are associated. Shared knowledge of these conventions greatly enhances the smooth flow of verbal communication." (Atkinson, 1990: 59). Discourse conventions are learned and acquired during interpersonal interaction. When individuals enter a different environment, new society, or different group, there is a high probability of them learning new discourse conventions and adopting a new language of interpersonal contact (Gumperz *et al*., 2007: 26). This is because relationships/interactions are performative. Since these performances are guided by language and social behaviours which are unique and informed by the culture in which the individual exists, the meanings and understandings they have about depression are able to change and acquire new connotations through further interaction (Gumperz *et al.*, 2007: 27; Sahlstein & Noller, 2001: 372).

The understandings that have been attached to depression play a crucial role on the linguistic connotations that people adopt towards depressed individuals, and these connotations shape the interaction process (Griffin, 2012: 5; West *et al*., 2010: 79). This process can be understood as *lay appraisal*, which means that even before the involvement of a health worker or the individual is officially diagnosed with depression, their community/people around them are already aware that there might be something wrong with them (Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999: 1328). With this awareness, people then make decisions based on how the interpersonal interaction between them and the depressed individual should be; these perceptions are rich with cultural stereotypes and misconceptions about depression and other forms of mental illnesses (Link *et al*. 1999: 1328). The community's understanding of depression can either encourage or prevent people from seeking professional help and treatment (Hugo *et al*, 2003: 715). For instance, during the 19th century, which was the period of rapid industrialization in America, it was believed that rapid urbanization and immigration were one of the main causes of depressive disorders and, as a result, mental health care institutions were built with the aim of removing depressed people from the disordered life of urban areas (Link *et al*., 1999: 1328). It is evident therefore that the American society's understanding of depression during that period influenced how its societal institutions were

structured, and how the people within that society related to people who were experiencing depressive episodes.

Cultural conceptions of depression have consequences on stereotypes, seeking help and the type of treatment intervention that is made available in the given social environment. Sometimes these stereotypes are negative and use discriminatory language that perpetuates stigma against people suffering from depression (Link *et al*., 1999: 1328). Public understandings of depression include beliefs that people get depressed because they are weak, because of their bad character traits, or because they have been bewitched. That or it is God's will for them to be depressed or they angered the ancestors, therefore they are getting punished, or they have a genetic defect, or they are depressed because of a stressful life event (Alemi *et al.*, 2017: 178; Brooke-Summer *et al.*, 2014: 3; Hugo *et al.*, 2003: 716; Link *et al*., 1999: 1330). These understandings influence the linguistic references that are used towards people who are suffering from depression, and these references include perceiving them as violent, disorganized, destructive, lazy and so forth (Brooke-Summer *et al*., 2014: 3; Lund *et al.*, 2008: 52). How people understand and conceptualize depression influences how they relate to depressed people, and sometimes this perpetuates stigma, stereotypes and misinformation. Take for example the idea that the lack of physical symptoms means that one is not sick enough therefore there is no need for them to seek treatment (Hugo *et al.*, 2003: 719).

In a study conducted by Wernicke and colleagues (2006: 771) on the perceptions of depression among people who have never been depressed and those who have recovered from depression, it was found that people with a history of depression were more likely to empathise with those that are depressed, whereas those who have no history of depression fail to display any empathy for their depressed friends or relatives. People who have never been depressed seem to have difficulty in understanding how debilitating and distressing depression is to those who are experiencing it (Wernicke *et al.*, 2006: 772). For people who have never experienced depression, their misunderstanding that depression is synonymous with sadness inevitably influences their perception of it and their relationship to people who are depressed. Since people who have never been depressed do not fully understand the impact that depression has on their relatives and close friends, they cannot provide them with the support or health care services that are required (ibid).

Another study conducted by Amankwaa (2003) on post-partum depression on black American women, found that cultural beliefs have the ability to influence how social structures/

institutions understand depression. This is because these beliefs influence the distinctive language that is used to relate to depression and to transmit information and knowledge among the public about depression and health care systems (Amankwaa, 2003: 24). Therefore, understanding cultural beliefs and language use about depression helps in ensuring the provision of appropriate healthcare and education for the public. However, cultural interpretations can change overtime, and the meanings that have been generated about a concept, may change and vary based on the context and particular community (Alemi *et al.*, 2017: 178; Horwitz, 2009: 8; Swartz, 1998: 7 & 10).

It is necessary to have a cross-cultural study of depression because it can reveal a variety of experiences, labels and healing interventions, and how the understanding and perception of the concept is open to cultural change. Through social interaction, social actors have the ability to change the meanings and cultural perceptions of depression (Lewis, 2012: 69). Hence Alemi and colleagues (2017: 177) argue that "culture is a system of symbolic meanings that shape both social reality and personal experience and influence the experience of depression and decisions about treatment". When trying to understand depression, it is important to understand cultural meanings and ideologies that have been shaped around it, because these ideologies can also determine the treatment interventions that are available for the person experiencing depression (Alemi *et al*., 2017: 178). This is because there is a diversity when it comes to physiological reactions, healing practices, interpersonal connections and collective identifications of depression and other mental health problems (Lewis, 2012: 69).

In some cultures, depression can manifest itself somatically rather than emotionally. For example, in Asian cultures, depression is understood/expressed as tiredness, while in Mediterranean and Latino cultures it manifests itself as a headache, and in Hopi Native American cultures it is understood as heartbrokenness (Lewis, 2012: 69). Since there is a variety of understandings about depression cross-culturally, treatment interventions also vary. Treatment interventions might range from western medication, like the use of psychiatric institutions, anti-depressant medicine and psychotherapy, to more culturally specific interventions such as African traditional medicine, ancestral calling (ubusangoma), and furthermore ideological interventions like religion (Alemi *et al*., 2017: 178).

Studies on depression have been conducted in other parts of the world. For example, a study conducted by Alemi *et al*. (2017) on the Afghan refugee explanatory models of depression, sought to understand the general population's conception of depression and its aetiology. The

study found that the majority of the participants adopted a situational belief model in their understanding of depression, whereby they believed that depression can only be understood within the context in which it occurs (Alemi *et al.*, 2017: 178). This supports the notion that context is important in the generation of meanings and understandings regarding depression. Since as humans we exist within a variety of contexts, that means our understandings and meanings of depression are highly subjective.

The understanding of depression can also be influenced by ideologies that are reinforced through interaction in the communities they exist in. According to Dawes (1985: 56) ideology can be defined as a "pattern of beliefs and concepts (both factual and normative) which purport to explain complex social phenomena with a view to directing and simplifying socio-political choices". Since ideology is influenced by a set of pre-existing beliefs that are normative to a particular community, it informs people of that community about what and how they should think, thus determining what should be considered normative and non-normative (Dawes, 1985: 56). An example of using ideology in understanding depression is religion, and South Africa has a very diverse religious landscape. According to the *General Household Survey* conducted in 2013 by Statistics South Africa, the religious profile indicated that 87% of the South African population identified as Christian/Judeo-Christian (Schoeman, 2017: 3). Therefore, people's ideological beliefs of depression include beliefs that depression is caused by an individual's spiritual disconnection to God and that spirituality plays a great role in helping an individual cope with and heal from depression (Sorajjakool, Aja, Chilson, Ramírez-Johnson & Earll, 2008: 521). In a similar study conducted by Ellison and Flannelly (2009) on the relationship between depression and religion among 607 African Americans, it was found that people's understanding and ability to cope with depression was influenced by their religious beliefs, and they believed that their healing could be attributed to their participation in religious activities (Ellison *et al.*, 2009: 568; Pawar, 2018: 460). Therefore language, culture and ideological beliefs have a great influence in people's understandings and the meanings they attach to depression.

2.6 Conclusion.

There are different approaches on how people understand depression. These approaches can be biological, sociological or psychological, and they are influenced by a variety of factors like culture, ideology, language and history. Cultural systems and social identity can have an impact on how definitions/understandings of mental health problems are shaped, and the social responses from these generated meanings can influence intervention strategies that people

adopt to address depression (Scheid et al., 2009: 8). As a result of a variety of cultural systems and social identities, depression can be understood differently across cultures, which influences differences in social responses to it among different social groups, and how those social groups interact with people who are suffering from it (Horwitz, 2009: 14). The meanings attached to depression are hence inconsistent, and they are able to change according to time and place, as new meanings keep on being generated with further interaction taking place (Busfiled, 2000: 547).

Chapter 3

Theoretical Framework

3.1 Introduction.

This chapter discusses George Herbert Mead's theory of symbolic interaction, a theoretical framework that underpins a sociological analysis of depression. It starts with a brief history of Mead's theoretical standpoint and his analysis of human social interaction, and then discusses other theories and approaches on how meanings are generated and transferred to others during the interaction process.

3.2 Symbolic Interaction.

This study draws on Mead's (1863-1931) theory of symbolic interaction in analysing individual's understandings of depression. Mead is one of the founding fathers of pragmatism, and his theory on how the mind and self emerges out of the social interaction process became significant for communication studies, and became the foundation of the symbolic interactionist school of thought in sociology and social psychology (Mead, 1934: 1). His analysis of the interaction process involved the adoption of the *triadic matrix* concept, which is a concept that describes the dynamics of the interaction process (Turner, 1988: 74). The *triadic matrix* involves three process: (a) when an organism is in an environment, it sends communication signals to other organisms using gestures; (b) when other organisms become aware of these gestures, they respond by altering their movements within their environment, thereby sending a signal to the original sender; (c) on receiving this signal the original sender also responds by altering their behaviour, thus completing the triad (Mead, 1934: 76-81; Turner, 1988: 74).

Although Mead uses a homogenous explanation of the interaction process, he nonetheless recognises that human interaction may contain some elements of the triad, and is significantly different from non-human behaviour, like reflexivity and consciousness (Mead, 1934: 137). Firstly, he argues that humans adopt conventional gestures which bear complex meanings for both the sender and the recipient (Turner, 1988: 75). Secondly, he notes how humans have the ability of mentally interpreting other people's conventional gestures and assume a course of action others would like them to pursue. Thirdly, he points out that humans have a sense of self and rationality and the ability to introspect, which enables them to use both their own and others' gestures as a guideline for the responses they would like to give. Fourthly, he notes how

humans have the capacity to talk to self by *imaginatively rehearsing* normative behaviour and responses, for appropriate circumstances. Finally, he argues that humans can analyse their own behaviour/gestures and those of others, and mentally generate appropriate responses which align with assumed perspectives on a variety of community attitudes (Mead, 1934: 1, 47 & 67; Turner, 1988: 75).

Mead identified two levels or forms of social interaction, namely: non-symbolic and symbolic interaction (Blumer, 1970: 285). Non-symbolic interaction is when an individual responds to another individual's action/gestures/signals, whereas symbolic interaction involves the interpretation of these signals by the recipient according to the way that they assume the sender would like the signal to be interpreted (Blumer, 1970, 1978, 1986; Mead, 1934: 47; Turner, 1988). Symbolic interaction is founded on three main arguments: the first argument is that humans relate to objects and symbols according to the meanings and interpretations they have attached to them; the second argument is that these meanings are generated from the interaction a person has with other people; the third argument is that these meanings are modified during the interpretation process and according to subjective experiences of different individuals that are involved in the interaction process (Aksan, Kısac, Aydın & Demirbuken, 2009: 902; Blumer, 1986: 2). Symbolic interaction involves individuals having to reinterpret and redefine actions/ behaviour of others and from one's self, which makes meanings change overtime as they constantly are regenerated and readjusted (Blumer, 1970: 285; Turner, 1988: 75). The redefinition that occurs during human interaction results in new objects, new concepts, new forms of behaviour and new relations (Blumer, 1970: 286).

Hence the interactionist school of thought argues that human behaviour cannot be explained using universal theoretical principles and philosophy, but through the understanding of relative human interactions, and these interactions are complex and shaped by personal motives, which are subjective and cannot be standardized (Aksan *et al*., 2009: 902; Lewis, 1980: 158). This means that, within the interaction process, individuals are active agents who consciously engage with signals and interpretation of signals in their environment, which they can manipulate in pursuit of their own goals (Lewis, 1980: 158; Mead, 1939: 3-25). Mead argued that the individual's reflexivity and rationality can be influenced by their self-conception and identity, which influences how they signal, as well as interpret the signals they receive from others (Turner, 1988: 75). An individual's self-conception is affirmed and confirmed by the signals they get from others, and when their self-conception is not affirmed, that individual's impulses for affirmation are heightened and directed towards themselves, which leads to

introspection and considerations of self (Mead, 1934: 160-161; Mead, 1939: 192; Turner, 1988: 77). Turner (1988: 86) adopts the concept of *folk assumption*, which argues that people's behaviours can be organized and categorised into roles that are identifiable and consistent. The way in which people interact in their social environment can reveal their role in that specific environment, and the role of those they are interacting with; and the difference in roles can influence how a person sends signals and how they interpret signals that are sent to them by others (Mead, 1934: 160-161; Turner,1988: 86).

The symbolic interaction process therefore, has three broad categories namely, the mind, the self and role taking (Turner, 1988: 102). The mind which is conscious and consists of the ability to mentally rehearse future consequences of the individuals' behaviour, and this ability is influenced by how that individual understands meanings that are generated during the interaction process, and interprets signals (Mead, 1934: 47; Turner, 1988: 102). The mind influences self-conception, which arises out of social experience and is affirmed by how an individuals' signals are interpreted by those they are interacting with; this sense of self and affirmation affects and determines the individuals' role taking and role making during the interaction process (Mead, 1934: 1; Turner, 1988:104). Without these three processes, human interaction would be impossible.

In his *Philosophy of the Act*, 1939, Mead argued that the relationship between the individual and the environment is analogous; individual activity influences the social environment and the social environment influences the social process of behaviour, and both of them are able to change and transform each other (Mead, 1934: 130; Mead, 1939: 215 & 364). However, it is important to understand that interaction does not only occur within a homogenous group, therefore, to advance our understanding, we need to take into consideration role taking that occurs in diverse cultural environmental settings, whereby an individual adopts a variety and complexity of roles that overlap between culture, ethnicity, race, gender and socio-political and economic status (Denzin, 1992: 75). If we understand interaction as a process that occurs within a homogenous group of people who have shared meanings, and who interpret gestures, words and actions in a similar way, we might overlook the complications and conflicts that might happen in the interaction environment, due to differences in the role of those who are interacting (Denzin, 1992: 76). For example, where roles might cut across ethnicity and race, and when gender and class differences are involved, this is because a difference in roles means that there will be a variety of meanings and interpretations, which in some cases might cause a conflict of interest. Mead's work on symbolic interaction is often simplified and does not take

into consideration modern day's complex multicultural interaction setting, and how within the interaction process we must consider and analyse processes that relate to discrimination, prejudice, exclusion and difficulties for minority groups to access political, economic, health and educational institutions (Denzin, 1992: 76). Hence the need to examine multiple role taking that occurs in a multicultural setting, giving rise to complexity and heterogeneity within the interaction process of contemporary communities (Denzin, 1992: 77).

The mind needs to be understood and analysed in social terms where it is regarded as evolving within the social process that exist in the matrix of social interaction (Denzin, 1992: 77; Mead, 1934: 133). Whereby individuals can critically reflect on their inner dialogues and subjective experiences; and are also able to observe constraints and opportunities that exist in their social environment; lastly, are able to differentiate between people's words and actions (Denzin, 1992: 77; Redmond, 2015: 10). Upon reflecting on these discrepancies, individuals can be able to respond through multiple role taking, where they remake their role in a social setting to achieve their ideal and to avoid communication breakdown during the interaction process (Denzin, 1992: 77). Role making therefore, involves reconstituting one's role to be able to deal with constraints one might encounter in their social setting.

The development of self and roles is forged using language and socially derived meanings that are created during the interaction process (Freese & Burke, 1994: 5; Mead, 1934: 191-192). The self, identity and role are mutually inclusive and require the individual to be proactive during interpersonal interaction, for a difference to occur, and to be reactive for the interaction to make a difference to them (Freese & Burke, 1994: 5). Through language, humans can have shared meanings, agency and be able to reflect on their words and actions, and those of others (Freese *et al*., 1994: 5: Mead, 1934: 191-192).

Language is a social instrument which is important for symbolic interaction to take place (Mead,1934: 191-192). It acts as a vehicle that transmits cultural knowledge and as a means of gaining access on how other people think, and can be implicated in phenomena like intergroup bias, social interaction, personal identity, social stereotypes, shared group perceptions and so forth (Bavelas, 2005: 181). Language, like consciousness, is one of the important means of communication that distinguishes humans from other organisms (Argyle, 1969: 63; Mead, 1934: 137). Pavlov described it as a "second signalling system whereby we respond to stimuli in terms of their symbolic meaning rather than their physical attributes" (Argyle, 1969: 63), which means that, we create concepts for symbols that we have generated, and the way in which

we understand those concepts and symbols (linguistically), influences how we interact with them (Aksan *et al*., 2009: 903; Argyle, 1969: 63; Mead, 1934: 135). This makes language important on how human behaviour is coordinated and controlled, and how culture is developed and transmitted (Argyle, 1969: 64). Language and verbal communication is an important aspect of human interaction because its intention is to convey information by communicating a message that has agreed meanings between those who are interacting (Argyle, 1969: 64; Mead, 1934: 195).

Most importantly, linguistic transmission plays a significant role in the creation of culture (Argyle, 1969: 78; Denzin, 1992: 27). Culture can be understood as "a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – using symbols, language, art and ritual" (Swartz, 1998: 6). Culture is a process of being a social individual and abiding by the rules of society, and cultural interpretations change overtime (Swartz, 1998: 6). Culture embodies a "shared language which symbolises and categorises events; a shared way of perceiving and thinking about the world; and agreed forms of non-verbal communication and social interaction, which make cooperation possible" (Argyle, 1969: 78). Since language is embodied in culture and influences a certain perception and understanding of the world, it also plays a role in influencing how people think and act based on their cultural world view (Aksan *et al*., 2009: 902; Argyle, 1969: 79; Denzin, 1992: 27). Cultures are different, and their linguistic communication varies cross-culturally (Argyle, 1969: 85), which means that the way in individuals interpret, understand and relate to social problems also varies significantly across cultures, because of the influence of social structure, which is made of roles from different social groups which engage in a pattern of social interaction, that generates societal meanings and norms (Argyle, 1960: 89; Denzin, 1992: 27). Culture shapes factors that define an individual's identity, like moral values, norms, political principles, ethnicity, religious beliefs and so forth (Horwitz, 2009: 7).

Emile Durkheim (1858-1917) one of the founding fathers of sociology, argued that societies define and describe what is pathological as a way to reinforce what people of that society should understand as normal, this also assists the society in distinguishing the normal from the abnormal (Busfield, 2000: 544). Differences between a norm and a pathology vary cross-culturally, linguistically and across social groups, which makes understandings and perceptions

about mental illness and depression culturally and socially relative (Argyle, 1969: 85; Busfield, 200: 544: Horwitz, 2009: 7). Foucault's argument on depression is that of a social construct, where it is perceived as a symbol in which concepts and meanings are attached to it, and these concepts and meanings are inconsistent and change based on the context they exist in, and through the generation of new meanings (Busfield, 2000: 547). Lastly, Parsons argued that depression should be understood as a form of social deviance, because it deprives the person suffering from it with the ability to be fruitful and productive, as per societal expectations (Busfield, 2000: 545; Thoits, 2009: 120). These sociological conceptions of depression are important because they contextualise it and try to explore how people in society should understand and relate to it.

3.3 Conclusion.

The mind is important for the interaction between the individual and their social environment, because through communication and linguistic behaviour, people are able to realise their potential for use of symbolic gestures/ signals (Mead, 1934: 191-192). Due to reflexivity, people are able to continuously engage in the interaction process, while simultaneously reflecting on how they understand and interpret their pre-existing ideological beliefs and generated meanings about the world and social phenomena around them (Nunan, 2010: 3).

Chapter 4

An analysis of participants' different understandings of depression

4.1 Introduction.

This chapter discusses the meanings that the participants for this research have generated about depression from their different symbolic interaction processes. These meanings will be linked to relevant literature on mental health and symbolic interaction. It will start by discussing participant's understanding of depression, its symptoms and its causal origins. It will then discuss how the meanings that the participants have about depression emerged, either from personal experience, or as a result of interacting with others in a new social environment. The manner in which meanings are generated and constantly evolve, makes it evident that humans are social agents, and each newly generated meaning has an impact on the interaction process, and that impact can either be conducive to others mental health, through the introduction of appropriate treatment measures, or detrimental.

In this research, six out of the eight participants have experienced depression, and their meaning of depression was influenced by both their subjective experience and their interaction with others. For the other two participants, their understanding of depression was influenced by their interaction with those who are depressed, especially their relatives. For both depressed and not depressed participants, it is interesting to see how their understanding of depression varies significantly from the common beliefs held by their communities. This difference can be attributed mostly to their coming to Rhodes University where they have found new discourse conventions and have acquired new knowledge on depression.

4.2 Understanding the meaning of Depression.

Depression is a term that can mean different things to different people depending on their personal experience with it. It can influence how individuals feel and communicate with others due to a change in their cognitive mechanisms, which are manifested through language use and self-perception during interpersonal interaction (Bernard *et al.*, 2015: 2; Karp, 1996: 28; Parker, 2004: 1). Depressive symptoms are experienced at extremes, and include low self-esteem, sadness, change in sleep patterns, change in mood control, change in appetite and weight, change in capacity to experience pleasure from daily activities, suicidal ideation, loss of motivation and drive, increase in fatigue, feelings of hopelessness and substance abuse (APA, 2013:155 SADAG, 2016:2).

The participants for this research were from different racial groups, and some of them have never personally experienced depression, however, their understanding of depression was similar, and the symptoms that they associated with depression were the same symptoms that are found in the DSM-5 diagnostic criteria (Parker, 2004: 1-3). Some participants understood depression as a mental condition which negatively affects cognitive functioning, and which impacts on behavioral and emotional functioning, and disrupts daily activities. The participants who understood depression as mental condition said the following in defining depression:

> It's a mental disturbance that comes from stress.
>
> Thami, September 2018, Grahamstown.

> My understanding of depression is that it's a mental condition, common symptoms include an inability to get up in the morning, constant weariness, difficulty functioning every day, normal routines kind of go out the window, you are very sad most of the time, sometimes there isn't a reason or you can't identify why you are feeling so sad or miserable but you just are. I don't know how to put it fully into words, but it's this emotional state and you can't necessarily get out of it by yourself.
>
> Karen, September 2018, Grahamstown.

It is also important to note how the participants understood depression as a condition that affects your emotions and mood. This meaning of depression, believes that depression makes a person feel sad, helpless, suicidal, fatigued, unable to function properly and so forth. The participants who understood depression as a condition that affects your emotions and mood, responded by saying:

> Depression to me is more than sadness, it's something higher than sadness. It's you feeling miserable like giving up on life, and giving up on everything, you just want to lock yourself in your room. I think I once kind of experienced what depression is. I wasn't sad, I was more than sad. I didn't like myself anymore, it was like self-hatred, and I was just locking myself in my room. I have this cousin and I think he is depressed, he just blames everyone for everything, he is miserable, he is seldom happy with his life.
>
> Elizabeth, September 2018, Grahamstown.

> Depression is a feeling of very *low self-esteem*, which does not go away. Feeling that you are inadequate, you don't feel good enough. From what other people have explained to me, it is *sadness* all the time. It was described as drowning.
>
> Jack, September 2018, Grahamstown.

> Depression is one term for a wide range of negative mood disorders with varying symptoms and diagnostic criteria. At its basic level, it is characterized by sustained periods of very low mood or bursts of low mood in between other moods to the point of dysfunction in a person's life. It is associated with reduced quality of life, reduced performance, self-harm and suicidality.

La u-Po, September 2018, Grahamstown.

> I guess, you can call it *being sad,* like being sad for a while…*Helplessness* is one of things that add to the depression.

Siyabonga, September 2018, Grahamstown.

> My understanding of depression is when you feel *alone, feel sad, upset, not being able to get up in the morning, where the bare minimum is a lot to do,* for me that's depression, when *you can't function* properly.

Ashwin, September 2018, Grahamstown.

The participants understood depression in more or less the same way, and they acknowledged that depression is a multifaceted condition, and a highly subjective illness. Therefore, as many researchers note, the treatment interventions for depression should be contextualized to align with people's subjective beliefs and understandings of it (Karp, 1996: 28; Kleinman, Good & Good, 1985:2; Wernicke *et al.*, 2006:771). And as the participants said:

> Depression as a whole is a very miscommunicated and misunderstood word, because it has very different aspects in the illness.

Chloe, September 2018, Grahamstown.

> I think that depression is multifaceted like personalities.

Karen, September 2018, Grahamstown.

Since depression is multifaceted and its experience is subjective, that means, there are differences between the types of depression that people experience and the social responses that they get, because depression can either be transient or long-term (Disner *et al*., 2011: 468; House, 2003: 197; Marsella *et al*., 1985: 301). Transient depression can resolve itself and it often does not require medical intervention, while intrusive and persistent depression can be debilitating and require professional help and treatment intervention (Parker, 2004: 7). For example, one participant mentioned that he experienced depressive symptoms at the beginning of the second semester, and he was able to deal with the symptoms without medical intervention:

> I think there are certain things that I have noticed about myself that could possibly say that there might be *a chance that I was depressed*. I felt so demotivated over the last couple of weeks, I even got a letter, a warning for skipping classes, if you get a warning for skipping class then you are in trouble. I knew something was wrong, I had a wake-up call. I only went to two lectures of one module. Just two out of 3 weeks, two days in 3 weeks, I just knew something was wrong, also the fact that I wasn't fazed [Rhodes slang for not being bothered] about not going to lectures, and that's not who I am, so clearly there was something wrong.

Ashwin, September 2018, Grahamstown

For other people however, depression can be a very debilitating condition as observed in the cases of Chloe and Siyabonga's mother whereby they were unable to function. Professionals had to be involved in administering appropriate interventions that would help reduce their depressive symptoms.

> I started out with a lot of self-harming, and it kind of went into bulimia…. I started drinking a lot… I am actually a sufferer of depression and I am medicated…I have chronic depression, I don't have episodic depression.

Chloe, September 2018, Grahamstown

> My mother, I didn't know at the time that she was depressed, but afterwards she told us that she had been depressed… but in her case it ended up being a hospitalizing case, and she told me that she spent some time in hospital… mom had to spend a week or more in hospital… she had to go to a psychologist.

Siyabonga, September 2018, Grahamstown

In some instances, depression is experienced as a world view that entails a pessimistic outlook towards ones' self and the world, as well as through physical symptoms and a series of illnesses (Beck, 2008: 970). Sometimes people might not be aware that they are depressed even though they might be aware that something is wrong (Karp, 1996: 82). For example, the case of Siyabonga's mother where she had no idea that she was experiencing depression, even though she had been experiencing depressive symptoms for a long time:

> [Speaking about his mother] What she told me is that she didn't know what was happening to her, she just had symptoms like always being tired, burning out and stuff like that, and just all round being depressed or sad for a long while … but then when she went to a psychologist and told them what is happening she was also surprised that she is depressed.

Siyabonga, September 2018, Grahamstown

In some cases (or communities) depression can be left undiagnosed or untreated due to the shame associated with it. In other instances, individuals must try several treatment options before obtaining the one that works for them, with certain cases requiring non-medical interventions (Parker, 2004: 7). For example, Chloe had to try several treatments before finding one that was effective for her. Karen's depression was untreated because of the taboo associated with it in her home community. Chloe and Karen shared their experiences with depression as follows:

> I would get diagnosed wrongly, and medicated wrongly, which made a lot of things worse. Now I am medicated correctly, in my opinion.
>
> Chloe, September 2018, Grahamstown

> I grew up in an Indian community where it [depression] was very taboo. I asked my step dad for help, he was like "you will get better, you will be fine", and I thought it was quite funny for someone who has depression and know what it's like, but you won't take me to see the doctor.
>
> Karen, September 2018, Grahamstown.

As in the case of Siyabonga's mother where she experienced feeling sad or depressed for an extended duration, depression can be chronic or episodic and can lead to substance abuse, insomnia, social isolation, and suicidal ideation (DePaulo & Horvitz, 2002: 10; Huang & Fang, 2016: 758; Karp, 1996: 26). Increased substance use or substance abuse is linked to depression because some people may use substances as a way of numbing their depressive symptoms or as an outlet and/or form of self-medication (Othieno *et al.*, 2014: 120). Symptoms like insomnia, agitation and anxiety which are a result of emotional turmoil and cognitive confusion are also a way that depression manifests itself (Berman, 2009:519). As one participant noted how she used alcohol as a way of numbing her depressive symptoms, and another used drugs (marijuana) as medication for her depression, and yet another participant stated that some people who were depressed, turned to alcohol and sexual activities as a way of numbing their emotional pain:

> I started drinking a lot which was problematic, and then one night my boyfriend brought me home and my mother saw me very drunk, and she was very shocked because she didn't know these problems that I had.
>
> Chloe, September 2018, Grahamstown

> When I look back I was very unhappy. I used weed [cannabis] a lot in my third year because I couldn't sleep as well as much as I used to sleep, at night I couldn't sleep because I would just overthink, it was terrible.
>
> Karen, September 2018, Grahamstown.

> So, you tend to resort to a lot of numbing activities like alcohol, sex sometimes, people do a lot of numbing activities, so you numb the pain, and when you deal with it, it's a lot.
>
> Ashwin, September 2018, Grahamstown

In some cases, depression can eventually lead to suicide, and according to the DSM-5 it has been associated with high mortality rates, with suicide being the leading cause. The National

Comorbidity Survey (NCS) carried out by Kessler and colleagues (1999), had a nationally representative population of 8098 people between the ages of 15 -54, who were screened for a lifetime prevalence of suicide attempts; and 5877 of the respondents screened positive. Of all participants who were screened positive, 13.5% of the participants stated that during the duration of their depression they had suicidal ideation, and 4.6% reported that they had attempted committing suicide in the past. A third of the participants reported that their suicidal attempt was serious and they were lucky to survive (Berman, 2009: 510-518). Suicidal ideation is closely linked with depression and it can be found in the form of verbal threats, as well as in written form, ultimately resulting in the person eventually committing suicide (APA, 2013: 160-161; SADAG, 2016: 2). The above survey is supported by some of the participants in the current study who stated that they know people who had told them about people with depression who had committed suicide. Other participants had directly interacted with depressed individuals who were suicidal. For example, Karen had direct contact with someone who was depressed and had suicidal ideation, while Siyabonga was exposed, on social media, to someone who was suicidal due to depression, and Jack's father's friend committed suicide because of depression:

> One of my best friends… had bipolar and she would have these depressive episodes all the time…she was suicidal a lot of time and it was very hard to see someone that you care about in that state.
>
> Karen, September 2018, Grahamstown.

> This year on social media, there was a group, a private group, and the administrator sometimes spends time reading people's posts, not just on the group, but his friends as well. He once posted a screenshot of someone's post, and said 'can we look into this thing, this dude's posts seems a bit worrisome, they seem to be suicidal'.
>
> Siyabonga, September 2018,
>
> Grahamstown

> *My father* would acknowledge that depression is a thing because he hates the idea of suicide as he lost a friend to suicide.
>
> Jack, September 2018, Grahamstown.

Furthermore, a study by Furr, Westefeld, McConnell and Jenkins (2001:97-100) on depression and suicide among university students, had similar findings with regards to how the participants of this research understood and experienced depression. Some of the results from the study indicated that 53% of the participants experienced depression, and 9% attempted or contemplated suicide. These results were supported by other researchers who performed

similar studies on depression among university students, whereby they found high rates of depression among students at higher institutions of learning, (Hamad, Fernald, Karlan & Zinman, 2007:538; Temple, 2012:23-24; Othieno *et al.*, 2014:120). These studies are relevant with regards to the current study because not only were they conducted in a university environment, but the results from these studies bear similarity to the experiences of the participants in this study. Three the participants shared their experiences of depression at university level:

> A lot of my friends at Rhodes also had mental illnesses.
>
> Karen, September 2018, Grahamstown.

> You can actually tell when someone is stressed, at the same time since we all are in a demanding environment, university, it has its things, I think the higher you go up, the higher the demands get… You can get depressed over low marks… I've seen people at a university setting, they end up being depressed…people talk a lot more now, especially on social media like on Rhodes Confessions page where people talk about depression.
>
> Siyabonga, September 2018, Grahamstown

> I do know a lot of people with depression, in fact I wouldn't be surprised if a lot of people that I already suspect would come to me and say that they have depression, we are at university. University is one of the most intense places, because it has such a high standard and a lot of people end up suffering from depression.
>
> Jack, September 2018, Grahamstown.

It is evident from the participants' quotes that depression is not an uncommon condition and subject among university students, because the students have either experienced it themselves or know someone else who is suffering from it. Those who do not suffer from depression might be exposed to it from interacting with other students, and on campus student web pages such as the Rhodes Confessions 2018.

4.3 Understanding the aetiology of depression.

Hans Selye coined the term 'stress' which was included in scientific discourse in the 1930s, and it referred to "anything that puts wear or tear on the body, usually noxious environmental stimuli" (Thoits, 2009: 107-110). Selye hypothesized that recurrent exposure to unfavorable environmental conditions might cause a person to become susceptible to illness (and sometimes death), due to their inability to cope with stressful conditions. Hence people who are exposed to negative life circumstances and chronic strain are at a higher risk of suffering from depression in their lifetime (Alemi *et al.*, 2016: 178; APA, 2013: 166; Beiser, 1985: 313;

Horwitz, 2009: 6; Link *et al.*, 1999: 1330). Both Selye's and other scholars' hypothesis regarding stress is supported by the participants' understanding and explanation of the aetiology of depression:

> A pile up of stress. Depression is just stress, just an *over* stress, with another meaning.
>
> Thami, September 2018, Grahamstown

> I had depression last year, because of stressful life events.
>
> Jack, September 2018, Grahamstown.

> There were some years of my life where it was very difficult for me, I struggled with a lot of emotional pain from my childhood, from my mother's death, I was in a very complex family situation, it was a very toxic environment and that affected my mental state a lot, the death, the grieving, having to carry on not knowing how my future is going to turn out, not having anyone to look after me or financially take care of me and having all that pressure on myself, that was during high school, most of my depression was during high school.
>
> Karen, September 2018, Grahamstown.

> There are things that you can be depressed about, with my mom she mentioned that it was because a lot of my family had just passed away and she didn't take the time to mourn their death.
>
> Siyabonga, September 2018, Grahamstown

The participants' experiences with depression and its causal origins were mainly related to stressful life events. However, they also acknowledged that unfavorable environmental conditions can play a role in the onset of depression. This is supported by Mead's argument found in the *Philosophy of the Act*, where he argued that people are able to influence the environment they exist in, and in turn that environment can also influence them and the social processes of their behavior (Mead, 1939; 215 & 364). For example, one of the participants said that some Rhodes University students find the university environment as oppressive and needing change. These students become activists, and are emotionally stressed when they fail to effect change. This may lead to depression, as the participant argues:

> If for instance you are one of those who demand that 'Rhodes need to change its name' and that doesn't happen, or one of those who cry that 'there are a lot of problems for women here, in terms of women getting raped and women not being taken seriously' and you see no change in that sort of environment, and you're like 'what can I really change, what can I change'. You will just realize that you can't change anything and you will feel helpless. That's probably one of the reasons most people might be depressed, because they are in an environment where they don't see themselves being able to change anything and their situations is just hopeless, and they shut down a bit. Everyday being in the same environment and you can't affect much, and you are

> hearing about more and more incidents. That's how an environment might affect you, in terms of your emotions.
>
> Siyabonga, September 2018, Grahamstown

For this reason, the social environment becomes an important aspect to consider as one of the causes of depression. This is because uncontrollable stressful life events that occur in an environment can be responsible for the onset or reoccurrence of depressive symptoms. The social responses from others, whom the depressed individual interacts with, can also have an influence in determining the recovery or relapse of their depressive symptoms (Joiner & Timmons, 2009: 324). This argument is supported by the Integrative Cognitive-Environmental Model, which argues that, the occurrence and reoccurrence of environmental stressors results in the disruption of normal healthy behavioral patterns, interpersonal relationships and social roles (Cappeliez & Flynn, 1993: 2). This disruption then triggers a negative emotional response from the affected individual. This triggering occurs because of their inability to transform the environment they exist in, and reverse the effects of the stress that they are experiencing, which leads to an increase in internalized conversations with self, heightened self-awareness and self-criticism, resulting in dysphoria (Cappeliez & Flynn, 1993: 5). The increase in dysphoria and self-awareness of the individual has the ability to elicit behavioral, interpersonal, cognitive and emotional responses associated with depression (Papageorgiou & Siegle, 2003: 243). This experience is evident in one of the participant's experience of depression as she shared an account of how she did not know that she was suffering from depression. She noted that she often had self-talk to figure out what was wrong with her. Her increased self-awareness resulted in her drinking alcohol a lot more, as a way of dealing with what she was feeling. She started researching mental illnesses and realized that she was suffering from depression when her mother took her to see a psychologist:

> When I first discovered that I actually have a mental illness I was with a friend, and I was asking him 'you know how there is different voices in your heard which start arguing about different things, like, how do you choose which one to follow?' and he told me, 'I don't have different voices in my head, like you, you don't have voices in your head'. I am actually mentally ill, let me go and research these things, and I just have so many, uhm, different varieties of what I thought mental illness was and I started drinking a lot… and I was talking to myself and I was having conversations with myself.
>
> Chloe, September 2018, Grahamstown.

From this experience, people who were close to Chloe, like her parents, viewed Chloe's behaviour as socially unacceptable, hence the decision to take her to see as mental health

professional. From Chloe's account, we can see how her social skills were disrupted due to being unable to express in language what she was going through, and when she did, she was misunderstood. It is evident that, the disruption of interpersonal, cognitive and emotional skills affects the social skills of the depressed individual. Social skills can be defined as "the ability to express both positive and negative feelings in the interpersonal context, without suffering consequent loss of social reinforcement" (Segrin, 2000: 382). This can be understood as positive behaviors that are reinforced by others through symbolic interaction, and depression behavior creates a deficit in this area. When people are going through depression and other mental health conditions, their communication and social skills are disrupted, and those who are within their environment (and not depressed), are likely to perceive this behavior as socially unacceptable (Segrin, 2000: 381).

Social skills and communication skills for people who are going through depression can be cultivated or hindered by the social environment that they exist in, and the community in which they are a part of (Joiner & Timmons, 2009: 322). For example, a longitudinal study on depressed people from various cultural backgrounds found that cultural norms play a role in the individual's degree of self-silencing and negative self-conceptions (Jack & Ali, 2010: 3-6). In certain cultures, like the African and Asian cultures, norms associated with socio-emotional functioning, which include viewing the individual as inherently defined by their social context and interdependence with others, are prominent (Chentsova-Dutton & Tsai, 2009: 364). When an individual is experiencing depression, which results in their social withdrawal and inability to maintain interpersonal relationships, they are viewed by their community as social deviants, leading to their ostracization until they decide to abide to societal norms again (Berman, 2009: 519; Chentsova-Dutton & Tsai). An example of this can be found in Asian cultures, as an Asian participant said:

> Due to a cultural link between depression and the unknown and low productivity, people who are depressed find themselves further isolated, ostracized or ignored.
>
> Lau-Po, September 2018, Grahamstown

In some instances, due to the fear of receiving an unfavorable response from the community and the close people that the person interacts with, some people might try to repress their depressive symptoms, as illustrated in the following accounts:

> The situation at the time was emotionally taxing for my mother, but I laughed at her, I think I was laughing because I was blaming her for being depressed, I was like 'actually it's all your fault you know'.

Siyabonga, September 2018, Grahamstown

> Most of the people in my home town try to hide and repress it, and they make fun of the fact that you have depression and they just write it off as being silly, or being someone who is seeking attention. And that is reinforced through the language that they use.

Chloe, September 2018, Grahamstown

The three above quotes from Lau-Po, Siyabonga and Chloe, have three emerging themes on the symbolic interaction theory, namely, self-concept, meanings attached to human behavior and the relationship between the individual and their community (West & Turner, 2010: 79). Furthermore, self-concept refers to when people who suffer from depression, and who know that depression is not an accepted condition in their community, repress it through the application of the self-silencing. Meanings attached to human behavior relate to when people have assigned meanings about depression, and these meanings are projected during the interaction process (West & Turner, 2010: 79). For example, a participant in the current study blamed his mother for being depressed. Lastly, the relationship between the community and the individual, which is highly defined by assigned meanings/norms, is when people from the community have a collective understanding of what depression is, and what it constitutes, and those meanings are made explicit during the interaction process, through the use of language (Mead, 1934: 160-161; Turner, 1988: 77). An example of this is how some people from one of the participant's community denigrate the experiences of people living with depression because of their own assigned meanings and understandings of the condition. Considering that Mead's theory of symbolic interaction suggests that people's behavior towards an object, a concept or other people is based on the meanings that humans have generated and assigned during interaction. Interaction is defined by Griffin (2012: 5) as a "continuous process of language and symbols in anticipation of how the other will react". This means that we interact to create meanings that will make sense about the world around us, in order to communicate ideas about it and about the people in it (Denzin, 1992: 27).

4.4 "We all have depression, but we push through it": Language, Culture and Ideology.

Moder and Martinovic-Zic, in the book *Discourse Across Language and Cultures* (2004: 2 & 9), argued that, as humans, we have the ability to capture and convey events which are complex and abstract, into simple words, because of our communication abilities which distinguish us from other organisms. This means that, when an idea or concept exists in the brain of an

individual, it can be easily transmitted from one person to another, and might even develop in the process and become different versions; ultimately ending up invading a large population group, creating a culture (Moder & Martinovic-Zic, 2004: 2). Culture therefore, can be formed and transformed through contagious ideas which are transmitted during interaction, and what originated abstractly becomes translated into behaviour. Culture is defined as a system of shared objects, beliefs and activities by a group of people, which materializes when a community shares the same social space, history, worldview, evaluation and behavioral patterns, which are communicated through a common/ shared discourse (Judd, 2002: 10).

The common discourse enables people to make sense of their lives, and to have shared meaning with others about certain social aspects of their lives. This shared meaning informs how people react/ behave in a socially acceptable/ expected manners, which resonates with their larger social context, forging their identity (Hecht *et al.*, 2001: 430). The forged identity is able to inform that which makes you belong to your group and what differentiates you from others. Culture, as an identity and a part of our communities, negotiates and renegotiates through language, our sense of self and relation to/ with others. Through language and communication, culture becomes multifarious, changeable, and sometimes conflicted (Hecht *et al.*, 2001: 431-3 & 444). Culture constantly evolves and changes because as individuals, we are reflexive and continually engaging in a process of reflecting on our understanding and interpretation of our pre-existing ideas about the world and social phenomena, as well as our personal experiences (Nunan & Choi, 2010: 3). Our daily interactions with other people are highly influenced by pre-existing social structures and cultural systems as well as patterns which we share with them. As individuals, we are part of social groups which have different forms and patterns of interaction, and unique rules at the core of their socio-cultural traditions. As a result, the language that people use during interaction is able to relay their underlying beliefs and worldview, and how they interact with others (Craig, 2007: 84; West *et al.*, 2010: 31). Participants for this study argued that people around them, in their home community and at Rhodes University, used language to explicitly state their understanding of depression, an example of this is Chloe's experience with some of her lecturers:

> Our lecturers aren't really helping. They sometimes tell us 'use your depression to create artwork', however, depression means you *can't function*. Some of the comments that I have heard is that 'we all have depression, but we push through it.' But I am like, you clearly do not have depression. And I think it's really because they are misinformed, and they see it as an emotion instead of an illness/ condition that is physically happening to you, forcing you to feel very shitty.

Chloe, September 2018, Grahamstown

Chloe's above experience resonates with the finding in Wernicke *et al's*. (2006) study on *Perceptions of Depression Among Depressed and Never-Depressed Individuals*, that people who have never personally experienced depression have difficulty in understanding how debilitating the condition is and how it affects people's ability to function. However, unlike Chloe's lecturers who understood that there is a mental health condition called depression, some people do not acknowledge its existence, and that too is reflected in the language that they use. As illustrated in Chloe's account on her father:

> My dad though my mom had explained to him that I had depression, and was drinking a lot, he said 'No she doesn't have depression, she was just drunk'. And every time my mom has spoken to him about it he would just say 'oh, she was just very drunk, she was seeking attention or she is not really sick, she is just feeling down'. He doesn't accept the fact that I have a mental illness, he just bypasses the subject.
>
> Chloe, September 2018, Grahamstown

Chloe's experience with her father, of understanding depression and the language he used in reference to it, is similar to Jack's experience with his father, who also strongly rejected the existence of depression. Jack shared his experience saying that:

> My dad would get angry if someone were to come to him saying they have depression, he has a very short tempter, because he doesn't want to believe that depression is an actual thing, or it exists. It's a naught issue in his eyes...he would say that it's something that is all in your head
>
> Jack, September 2018, Grahamstown.

In relation to such experiences, Moder and Martinovic-Zic (2004:9) argue that people's beliefs, understandings and meanings that they attach to concepts, objects or other people, cannot be perceived as isolated personal beliefs, because they are in fact, a reflection of their communities. And these ideas, beliefs, understandings and meanings are generated and spread through the interaction process. Participants share similar experiences with their communities, as illustrated in the following account:

> Where I come from, you could lose someone or something major to you, but everyone will just be like 'you need to move on as quickly as possible', you are not allowed to feel, you are not allowed deal with that reality, you are not allowed to deal with your pain…. People will say things like 'get over it' 'oh my goodness it's not a big deal'.
>
> Ashwin, September 2018, Grahamstown

Community beliefs of depression which are made explicit through language and behavior, are also evident in the accounts of two participants - Jack and Karen. Jack's community and his close family members, even though they know about depression, they still do not recognize it as a valid illness. Hence Jack, when asked about his community's knowledge of depression, responded by saying:

> I am very isolated from my neighborhood and my community, but my gran is very old school and she nursed in the 1950s to the late 70s, that was when medical science in South Africa was very, I don't want to say primitive, it did not fully acknowledge depression from my understanding and most research studies on depression are very recent, which means my gran did not have that much access to it, so she probably would say that depression is something that is in your head or 'take a walk you will be fine', that kind of thing
>
> Jack, September 2018, Grahamstown.

The inability of some white community members to acknowledge depression and its adverse effects, is echoed by another participant, Karen. She was in a relationship with a Rhodes University student, whose family reside in Grahamstown, and who she believed displayed symptoms of a mental condition. However, during her interaction with the ex-boyfriend's mother, she realized that the mother did not believe in the existence of depression, and she did not acknowledge that young people can be depressed. Karen shared her experience by saying:

> I know that here in Grahamstown, there's a family I already told you about, my ex, his mom doesn't believe in depression, I don't think she believes in depression because if you interact with this person [ex] you can actually tell that something is not right, you can tell they need help or something, even from just talking you can tell there is something wrong. I even heard her [the ex's mom] saying she doesn't believe that teenagers can be depressed, it's just angst, and it doesn't make sense to me because her own son very clearly has some kind of mental problems. As evident from his constant failures, drug abuse, alcoholism and inability to have a long lasting proper relationship, and maybe, even though she has known him longer than me, maybe she just can't see that, because of her inability to even acknowledge that depression exists.
>
> Karen, September 2018, Grahamstown.

It is evident from Chloe, Jack, Ashwin and Karen's accounts that the way in which community members understand depression has an impact on their interaction with those who are depressed, especially the language used about depressed individuals. These linguistic references and behaviours have underlying cultural connotations, which can either lessen or exacerbate the depressive symptoms (Link *et al.*, 1999: 1328). As evident in the participant's above accounts, linguistic references that people use with regards to depression and to people who are depressed, have underlying cultural and ideological connotations about the beliefs of

that specific cultural community. Culture exists within the members of communities and ethnic groups through values, norms and ideological beliefs, as well as through their patterns of behavior and daily interaction; culture has the ability to shape psychological thought processes, emotions and behavior (Chentsova-Dutton & Tsai, 2009: 364).

Durkheim's study on suicide is often regarded as one of the first studies on the sociology of mental health. In this study he compared suicide rates in different European countries during the 19th century, and the results showed a correlation with different social characteristics in the populations of these countries (Scheid & Brown, 2009: 9; Simpson, 2005: xxvii). Durkheim's study focused on how social integration and social institutions can have an influence on a person's mental health and their likelihood of committing suicide, the results concluded that people who were isolated were more likely to commit suicide than people who were socially integrated (Simpson, 2005: xiv). This was because social integration promoted conformity to societal norms which lowered the levels of social deviance and social ostracization by increasing social support within the person's social networks (Scheid *et al.,* 2009: 10). Cultural values also play an important role because they provide meaning and social cohesion that is shared within the social group, these cultural values can either be conducive or detrimental to a person's mental health (Scheid *et al.,* 2009: 12).

Durkheim's study was supported by the results of the study that was conducted by Phillips and Henderson (2006) on *Religion and Depression among U.S College Students*, which found that, religious affiliation encouraged collectivity and interaction with people who had similar beliefs and values, people who belonged to collective groups like religious organizations had low levels of depression and found it easier to cope with depression. This was because collective groups helped the individuals to make sense of the world and to give meaning to their social situation, and based on that meaning, provide intervention strategies that will assist them in dealing with their health problems (Phillips & Henderson, 2006: 166). Both studies' findings are confirmed by one of the participants' experiences with their community:

> My community is constructed as very collectivist, but rigid in its thinking. Therefore, every person's efforts should be focused on the work at hand and their societal role.
>
> Lau-Po, September 2018, Grahamstown

Depression, however, can be understood differently across cultures, which results in varied expressions between people of different ethnic and cultural groups, and the way in which those

people relate to those who suffer from depression (Scheid *et al*., 2009: 14). Even though all the participants came from different communities and ethnic backgrounds, the overall belief of the participants is that depression is a western concept, as culturally, depression can be attributed to a variety of things like laziness, witchcraft, curses, ancestral calling and so forth, depending on the culture. As some participants said:

> Depression is sometimes considered a Western disease that never existed in our community until the West showed up.
>
> Lau-Po, September 2018, Grahamstown

> People have this idea that depression is a white thing and mental illness at large is usually attributed to super powers like witch craft… The idea that there are some people in the community who don't like you, so they did this to you, like it's just bad luck, so you are cursed basically.
>
> Ashwin, September 2018, Grahamstown.

> They said that my cousin is depressed because of amadlozi (ancestors), and considering that ekhaya (at home) we don't do that kind of stuff, but then people from outside, which is the community they would come and say amadlozi are calling her.
>
> Thami, September 2018, Grahamstown

The participants' experiences with their communities' culturally diverse understanding of depression, were similar to the study by Mosotho, Louw, Calitz, and Esterhuyse, (2008) on *Depression among Sesotho Speakers in Mangaung, South Africa*. Mosotho and colleagues' study was conducted on Sesotho speakers in South Africa, in order to evaluate the influence of culture on how people experienced symptoms of depression. It included 100 participants who were already diagnosed with depression and evaluated them using the Psychiatric Interview Questionnaire . The study found that depression is a culturally diverse phenomenon, and for Sesotho people, it manifested itself through palpitations, headaches, constipation, tight chest, dizziness, as well as through hallucinations and delusions whereby a person heard voices in their heads and believed that the ancestors were calling them, or they were being bewitched (Mosotho *et al*., 2008: 41).

In Brooke-Summer and colleagues' study (2014) on *Perceptions of Psychosocial Disability amongst Psychiatric Service Users and Caregivers in South Africa*, even though the study was aimed at assisting mentally ill people with Psychosocial Rehabilitation (PSR), it found that people's understanding of mental illness is able to influence how they interact with mentally ill people. The study found that some people who were suffering from mental illness believed that their family thought that they were pretending to be ill in order to be a burden to them, and

this lack of understanding and support exacerbated the illness (Brooke-Summer, Lund & Petersen, 2014: 4). Another finding was that some family members ill treat people who suffer from mental illness, like verbal abuse, ignoring them when they need help, denying them food and not allowing them to leave the house. This ill treatment was not only from family members, in some instances it was from the community, whereby mentally ill people would be negatively labelled as crazy, accused of committing crime, and denied service in shops. Sometimes the community members would take advantage of the mentally ill person by engaging them in unpaid work. The study found that females were particularly vulnerable because some of them would be sexually violated (Brooke-Summer, Lund & Petersen, 2014: 5).

The Mosotho *et al*. (2008) and Brooke-Summer, Lund and Petersen (2014) findings are similar to some of the participant's experiences, because they show how people's preconceived beliefs and generated meanings about mental health problems, including depression, can influence their interaction with people who suffer from mental health problems. For example, Thami shared how her community members interacted with her cousin who was depressed:

> They distanced themselves because they thought she was violent, demon possessed, like religiously, it was blamed on demons, but culturally it was sangoma (traditional healing) stuff. Those that were there, they were afraid of her, and uncomfortable around her, it wasn't easy.
>
> Thami, September 2018, Grahamstown.

Echoing Thami's cousins' experience of being ostracized by the community because of depression and community beliefs about depression, Lau-Po shared his household community's understanding of depression and behavior towards depressed people:

> Psychological care is heavily stigmatized and it is considered to be for crazy people only. People who disclose depression in my home community generally find no comfort or positive outcomes from the community itself and must look elsewhere for positive outcomes. Therefore, people who are depressed do not disclose it. When they do, it is usually met with ignorance, disbelief and ostracization.
>
> Lau-Po, September 2018, Grahamstown

Another participant, Elizabeth, when asked about her community beliefs on depression, shared that:

> My home community think depression is a serious thing, so they wouldn't define it as depression, so they would sweep it under the carpet, because it's something to be ashamed of.

Elizabeth, September 2018, Grahamstown

The meanings that people generate and attach to depression and other mental health conditions, influence how people, either individually or as a community, interact with those who suffer from depression, and the kind of treatment intervention that is made available (Akyeampong, Hill, & Kleinman, 2015: 24; Kleinman *et al.,* 1985: 3; Flisher *et al*., 2015: 146).

There are three common approaches to treating mental health problems, that is, the biological, social and psychological approaches. Which means that, treatment interventions for depression can be biological, psychological or cultural/ideological (Pilgrim, 2009: 63). Cultural and ideological beliefs constitute spirituality. Spirituality is a belief that our lives have meaning beyond our mortal existence, which enables people to make sense of some aspects of their lives, whereby what some people might consider irrational and psychopathological, spiritual people might view it in a non-rational positive way (Morgan, 2008: 40; Platz, 2006: 201; Pilgrim, 2009: 63). Platz (2006: 201) argues that, spiritually is something beyond the human physical realm, even though some people might understand depression as a medical condition, to others it might have spiritual connotations. When a person is depressed, the body is believed to be unleashing its spiritual power and the person is undergoing a spiritual anointing (Platz, 2006: 201). In some cases, people's experience of depression might be believed to be demon possession and not spiritual anointing. Inasmuch as mental health issues might be considered to be illnesses in medical discourse; in some contexts they are not illnesses, but rather constitute cultural practices and traditions (Parker, 2008: 40) like ancestral calling, or special calling to be a traditional healer. However, through globalization, which is a process of universalizing particular tendencies and beliefs into local contexts, in contemporary society, local contexts' meanings and understandings of depression have been recomposed, deconstructed and reconstructed, and transformed to align with the understanding and meanings of the international community (Parker, 2008: 40). However, it is important to include a fourth religious or spirituality approach, which also offers an explanation to the causes of depression and also provides interventions (Pilgrim, 2009: 63). This contextual approach to depression is clearly understood by some participants who advocated for the exploration of non-western approaches into treating depression. When asked about the treatment interventions for depression, some of the participants argued that treatment interventions should be contextualized to accommodate people's diverse beliefs and cultural ideologies. Participants had the following to say on depression and diversity:

> I feel people should educate themselves around depression before they approach people with depression.
>
> Chloe, September 2018, Grahamstown

> We can't undermine the non-western way of dealing with depression because there are people who actually believe in these things and if it helps them, then why not? And take into consideration a holistic view of how you will heal from it, do your medical western doctors, do your sangoma, do your church and see what works for you and then you will be the one who makes an informed decision as to how you are going to approach healing yourself. I don't want to undermine other sources of dealing with depression, I don't want to mainstream western medicine as the only way, find what works for you on how to deal with it, but most importantly, deal with it in ways that are productive when it comes to your healing.
>
> Ashwin, September 2018, Grahamstown

> If you feel as though the medication route is not working for you, I don't see why you shouldn't explore other alternatives, I think it's down to personal choice. If you believe that going to a traditional healer or finding some coping mechanisms like music therapy then take it, I don't think that medicine is an only option and other options should be ruled out. I think that depression is multifaceted like personalities.
>
> Karen, September 2018, Grahamstown.

Other participants mentioned different approaches to treating depression, which are the biological and psychological approaches. The biological intervention to depression includes electro-compulsive therapy, medication and psychotherapy, with the most prevalent treatment being medication, for example, psychotropic drugs like anti-depressants (France, Lysaker, & Robinson, 2007: 411). As one of the participants said:

> I think that definitely you should go to a doctor so that if it's something like a chemical imbalance, medication can rectify that most of the time, sometimes you have to get more than one type of medicine before finding the right medication.
>
> Karen, September 2018, Grahamstown.

Another participant believed that a more psychological approach to depression would be the best option. Psychological interventions include the incorporation of inter-personal methods like conversations, to ameliorate depression (Pilgrim, 2009: 99). These psychological interventions are sometimes referred to as counselling, talking treatments or psychological therapy. The participant argued that talking more about what is depressing you might help in lessening the depressive symptoms or curing depression altogether:

> With my mom it got dealt with by her going to hospital. She obviously took some pills and spoke with psychologists. So I think, personally it would have to be dealt with by just talking and coming up with ways so that this person can offload whatever problem

> that causes them to be depressed. But I think some mental illnesses need to be treated with pills, I think, but with depression you need to talk, and probably take some pills too.
>
> Siyabonga, September 2018, Grahamstown

Cultural beliefs and language reference to depression help in ensuring the provision of appropriate health care and in educating the public about depression and the variety of treatment options (Amankwa, 2003: 28). However, these may be subject to change and redefinition as people engage in the interaction process. From the participants' diverse views, it is important to note that there is no standardized measure in treating depression, because it is a highly subjective condition. People might experience it differently, in alignment with personal beliefs and values. Therefore, it is important to adopt a contextual multifaceted approach in the understanding and treatment of depression.

4.5 Human agency and reflexivity: changing meanings of depression.

Dawes (1985) in his study *Politics and Mental Health: The Positions of Clinical Psychology in South Africa*, defines ideology as "a pattern of beliefs and concepts (both factual and normative) which purport to explain complex social phenomena with a view to directing and simplifying socio-political issues". This definition suggest that ideologies are influenced by a set of pre-existing beliefs that are normative to that particular social environment or community, and inform what people think and how to think, which means that ideologies are able to determine what should be considered normative or deviant (Dawes, 1985: 56). For example, from labelling theory, mental health conditions are understood as a violation of social norms, because illnesses like depression, force you to deviate from social norms of productivity and fulfilment of social roles (Thoits, 2009: 120). As a result people who suffer from mental health illness are viewed and treated as deviants. Labelling can play a role in shaping ideologies that individuals and the public hold about depression and other mental health conditions, and it informs how people interact with those suffering from these conditions (Pilgrim, 2009: 68).

However, since humans are reflexive beings with agency, their preconceived ideas are able to evolve and change in time and place when they are exposed to new knowledge and information (Gumperz & Cook-Gumperz, 2007: 27). Siyabonga, one of the participants, argued that people are reflexive, and even though they know their shared community beliefs, their reflexivity allows them to make conscious decisions regarding whether they would like to adhere those community beliefs, or they would like to take a completely different stance:

> Back in kwaMashu, there was a dude who was mentally challenged, handicapped or whatever, and he used to like to live in the bush. …People thought he was crazy, because he lived in the bush, didn't shower and didn't dress in a way that people in the community would expect a normal person to dress. …You know, some people would think that mentally ill people are dangerous but that's because they've been told that people who are crazy might be dangerous, most of the reactions are personal-based, and stem from personal experience, it depends on you as a person if you believe other people when they tell you stuff about mentally ill people… I don't think people would react uniformly, the reaction is in line with the kind of person that you are, because some people feel the need to stay away from that dude.
>
> Siyabonga, September 2018, Grahamstown

Siyabonga's idea about human reflexivity is echoed by another participant. Lau-Po's understanding of depression is significantly different from the collective understanding of his community, because he adopts a Western view of depression, which deviates from his Asian cultural beliefs. When asked about depression and his interactions with people who are depressed, Lau-Po responded by saying that:

> I am a psychology honours student and have encountered it in my studies. I have also directly experienced severe depressive episodes. I interact with people who have disclosed depression to me as I would anyone else, but I take slightly more effort to contact them regularly and check up on them, or occasionally link-up for a meal and touch base. This is something that I do not always do with people who have not disclosed depression to me. This is because depression is isolating and sometimes, a nudge is needed to socialise. Socialising with friends while depressed is linked to positive outcomes.
>
> Lau-Po, September 2018, Grahamstown.

Lau-Po's understanding of depression which he acquired from his Psychology studies, is significantly different to his community beliefs. This enables him to interact differently with people who are depressed. His adoption of a different understanding of depression means that how he interacts with people who are depressed is different and deviates from the behavioral norms of his home community.

The above discussed reflexivity is supported by Mead's (1936: 149 & 290) ideas on human agency and that people's lives are constantly evolving, and their reality is continually reconstructed into new emergent situations. As a result, individuals are constantly adapting to these changing conditions. He further elaborates that if our lives were not constantly exposed to new situations and new environments, our behavior would be habitual, and not reflexive. As one of the participants said:

> We're living in a society that expects so much from us, that expects us to conform to its norms…humans aren't designed to be robots, they have agency and they don't fall in line, and hate being told what to do.
>
> Jack, September 2018, Grahamstown.

Mead (1934: 135-136) in *Mind, Self and Society*, further argues that people are products and not preconditions, whether biological or logical, of interaction, as he argues that "the self is something which has a development, it is not initially there at birth, but arises from the process of social experience and activity, that is, develops in the given individual as a result of his relations to that process as a whole and to other individuals within that process". This means that, people's sense of self develops from the continuous interaction process, and their ideological beliefs and conceptual understandings are able to evolve as further interaction with others takes place. Most importantly, this occurs because of their reflexivity and ability to make their own decisions (Mead, 1934: 136). Symbolic interaction is influenced by past and present experiences, and the meanings that are generated are not static, instead they change and evolve as new meanings are continually generated from further interaction (Turner, 1988: 75). Mead's arguments on the acquisition of new information and knowledge during interaction, and the changing meanings is echoed in the participants' understanding of depression, which is from their interaction with others, as well as their introduction into a new environment, Rhodes University, in which their new generated meanings of depression has changed the pre-existing meanings attached to depression:

> My understanding of depression wasn't from personal experience, I wouldn't think I've been depressed before, I wouldn't think so. I have to say, it's from hearing about it from people.
>
> Siyabonga, September 2018, Grahamstown

> I think it's from personal experience and seeing other people, usually when someone tells their story about being depressed.
>
> Ashwin, September 2018, Grahamstown

> I think I discovered depression reading novels and then through encountering people later on in life.
>
> Karen, September 2018, Grahamstown.

Other participants' new understandings of depression were generated from their exposure to other people's experiences, and from being introduced into new environmental settings, whereby their pre-existing meanings were able to change, which influenced and changed the

way in which they interacted with people who suffer from depression. Siyabonga shared his experience on how he interacted with someone who was depressed after he learned about depression, which was different to his interaction with his mother, before he was exposed to new knowledge about depression:

> When that dude said he is depressed it also brought back those times where I reacted the way I did with my mom, and I now know that I could have reacted better. So with that dude I tried to be a bit more helpful, I wasn't insensitive or skeptical, and my interaction with people who say they are depressed and my reaction to their situation changed because of the experience with my mom, and being exposed to it.
>
> Siyabonga, September 2018, Grahamstown

Another participant, Thami, who like Siyabonga, also never personally experienced depression, shared how interaction with her cousin who was depressed, was different from how her community interacted with her, due to differences to information exposure. She shared this by saying:

> Personally, for me it was different, because I would like to say I knew because I did psychology, so I know these things do exist, so I learnt about that, and I got to react differently from people who never got a chance to learn about it.
>
> Thami, September 2018, Grahamstown

It is therefore important to realize and acknowledge the impact that Thami's introduction into a new environment whose understanding of depression varied from that of her home community, had on her own understanding of depression. Her initial understanding of depression and interaction with a depressed individual, which were influenced by her community's ideological beliefs, were able to change and align with the new meanings that she found in the university environment.

4.6 Conclusion.

It is evident that people are social agents and the meanings that they generate about social issues, which are sometimes shared by their communities, are subject to change because of their social experiences. Most importantly, change occurs because of their introduction into new environments where they acquire new knowledge and new generated meanings, as well as from interacting with people from different social backgrounds. It is interesting to note that how participants understood depression and interacted with people who were depressed was completely different from the experiences and understandings of their home communities. This can be greatly attributed to their introduction into a university environment which acknowledges depression, and has a diversity of students and staff who have personally

experienced depression and are willing to share their understanding and treatment of depression. Some participants were able to use their own personal experience of depression to understand it, while some participants drew on other people's experiences of depression to understand what it means to be depressed. This means that, both personal experience and symbolic interaction are significant in the formation of meanings, but people's ability to make personal choices is what determines their understanding of depression. This is because as reflexive individuals, people are able to filter from all the abundant information and knowledge about depression, the meaning and understanding of depression that they would personally like to adopt.

Chapter 5

A Conclusion

The aim of this research was to analyze the experiences and views that Rhodes University students hold about depression, and how the understanding of depression shape their interaction with people suffering from depression. This research was contextualized within George H. Mead's symbolic interaction theory, involving the concept of self, the generation of concepts, the language that is used in reference to depression, community beliefs about depression and how those beliefs can change over time and with environmental change. The research strategy that was applied was a qualitative research design, and the method that was used to obtain information was in-depth interviews with four male and four female participants from different ethnic and socio-economic backgrounds. Some of the participants had been diagnosed with depression since high school, and they continued to experience depression at Rhodes University during their undergraduate years. Other participants had never been diagnosed with depression, but they have had close relatives living with depression and on medication.

It was found that participants held similar, as well as different understanding and experience of depression. For example, two female participants were negatively affected by how their experience with depression was misunderstood by their relatives, and in one case, by a lecturer. This means that they experienced depression as a subjective illness, and that treatment should accommodate individual's diverse experience of depression. The interaction that they received from others who knew about their depression was often negative, and this influenced how they interacted with those who are depressed. They interacted with other depressed individuals in a more positive, supportive way, which they believed, based on their experience with depression, was a more effective way.

As discussed above, participants who had experienced depression, and despite coming from different racial backgrounds, shared similar experiences. For example, their relatives and communities did not openly discuss issues relating to depression and other mental illnesses, because they were considered taboo. And their exposure to a new environment, Rhodes University, and to new information and knowledge about depression, allowed them to move away from their community members in the sense that they were able to be open about depression and interact in a more positive and open manner with depressed people. This was illustrated by one participant's account who only understood depression from her personal experience and not from her community. She was able to draw on her personal experience

when interacting with individuals with depression, and this interaction was significantly different from how her home community had interacted with her. She has a cousin who has depression, and she treats him differently from the way he is treated by others in the community. She believes that her treatment helps to combat his depression symptoms. This means that the role of personal experience in the creation of meanings around depression is evident in the participants' accounts, and this supports Mead's argument that people's interaction with others can also be influenced by their past and present personal experiences (Turner, 1988: 75).

Another participant shared how he has always been exposed to information about depression, but had never fully understood it and its impact until he personally experienced it. His experience with depression is similar to Wernicke *et al*. (2006: 771) finding that people who have never personally experienced depression were more likely to not fully understand the condition, and those who have experienced it, were more likely to sympathize with others who are also experiencing it. This is supported by Mead's argument that meanings are not static, because people are able to redefine their ideas, behavior and relation to others because of the exposure to a new environment or experiences (Blumer, 1970:286).

Other participants derived their understanding of depression from interacting with people who were suffering from depression. One participant believed that her cousin's untreated depression had caused her to be mentally disturbed. One of the main reasons she believed that depression was a mental disturbance, was because of how it disrupted her cousin's cognitive and behavioral functioning. Her cousin's disruptive behaviour caused the community to label her as deviant and socially distanced themselves from her. However, due of her acquired knowledge and new information about depression from the university environment, this participant was able to interact differently with her cousin. She stated how her community believes that black people do not suffer from depression because it is a white concept. What the western medical profession defines as depression is attributed to supernatural powers like witchcraft, demon possession or ancestral calling among most black communities. She then argued that how she understood depression and how she reacted to her cousin's experience with it, was due to her exposure to new knowledge and information about depression as a psychology student. She had had an opportunity to learn about depression and the various medical treatment interventions. This experience is supported by Mead's argument that the process of symbolic interaction entails the re-interpretation and re-definition of one's behaviors, thoughts and meanings to objects/ concepts. This re-interpretation and re-definition

of meanings results in change and readjustment, ultimately producing new concepts and new forms of behavior (Blumer, 1970: 285-286).

Another participant, who has not personally experienced depression, had similar experiences as the one discussed above. His understanding of depression was drawn from his mother's severe and debilitating depression. Before the experience with his mother, who had been hospitalized with depression, he did not believe that depression was a serious condition. His exposure to new information and knowledge about depression, at Rhodes University, enabled him to have a new understanding of the condition, and was able to act differently to people with depression. This further proves that, introduction to a new environment with different discourse conventions, is able to change an individual's perceptions of the world, and the meanings that they attach to objects and concepts. This change in perception and understanding also produces a different behavioral change that is in line with this new understanding. This participant's new understanding of depression changed how he interacted with people who are depressed, he is more supportive of them and willing to learn more about their condition.

All the participants' understanding of depression changed when they interacted with individuals suffering from it. And they all came from communities that either did not acknowledge the existence of depression or ignored it, but their perception and knowledge of depression changed when they went to Rhodes University. This is evidence that the meanings that are generated about a concept or a social phenomenon change over time, and new meanings are generated. This study shows that human reflexivity play a significant role in meaning creation and understanding, because through human reflexivity and the sense of self, people are able to generate new meanings that inform better treatment of others, especially those suffering from depression.

5.1 Limitations and recommendations.

Conducting this study elicited a variety of interesting areas which could be considered for exploration in future studies. For example, more research on depression among South African University students, and especially the impact it has on their academic performance, should be conducted. The exploration could include the relationship between depression and the institutional culture in universities. This is because some of the participants mentioned that the university environment can be one of the causal factors of depression, and most of the participants knew more than one university student who suffers from depression or other mental-related health condition. A Common feature of most of the participants who shared

their experience with depression within the university space, was diminished interest in their studies, and feelings of demotivation and not wanting to go to class. Since this study had only eight participants, its wider implications are greatly limited. However, it has provided significant and valuable insight into how students understand depression, and how their understanding can be influenced by both personal experience and interaction with those suffering from depression. It has also provided insight into how people's generated meanings are not static but are open to re-generation and re-definition.

Bibliography.

Akyeampong, E., Hill, A. G. & Kleinman, A. M. (Eds.). (2015).*The culture of mental illness and psychiatric practice in Africa*. Bloomington: Indiana University Press.

Aksan, N., Kısac, B., Aydın, M. & Demirbuken, S. (2009). Symbolic interaction theory. *Procedia-social and behavioral sciences*, Vol. 1(1), pp. 902-904.

Alemi, Q., Weller, S.C., Montgomery, S. & James, S. (2017). Afghan refugee explanatory models of depression: Exploring core cultural beliefs and gender variations. *Medical anthropology quarterly*, Vol. 31(2), pp.177-197.

Amankwaa, L. C. (2003). Postpartum depression, culture and African-American women. *Journal of cultural diversity*, Vol. 10(1), 23-29.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5®)*. American Psychiatric Pub.

Argyle, M. (1969). *Social Interaction*. London: Methuen & Co LTD.

Atkinson, D. (1990). Discourse analysis and written discourse conventions. *Annual review of applied linguistics*, Vol. 11, pp. 57-76.

Baker, P. A. 2010. From apartheid to neo-liberalism: health equity in post-apartheid South Africa. *International journal of health services*, Vol. 40 (1), pp. 79-95.

Bavelas, J., B. (2005). 'The two solitudes: reconciling social psychology and language and social interaction.' In: Fitch, K., L. & Sanders, R., R. (eds.) *Handbook of language and social interaction*, pp. 179-200. New Jersey: Lawrence Erlbaum Associates Publishers.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J. & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of general psychiatry*, Vol. 4(6), pp. 561-571.

Beck, A. T. (2008). The evolution of the cognitive model of depression and its neurobiological correlates. *American journal of psychiatry*, Vol. 165(8), pp. 969-977.

Beiser, M. (1985). 'A study of depression among traditional Africans, urban North Americans, and South East Asian refugees'. In: Kleinman, A., Good, B. J., & Good, B. (Eds.) *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder* (Vol. 16) pp. 272-298. California: University of California Press.

Berman, A. L. (2009). 'Depression and suicide'. In: Gotlib, I., H., & Hammen, C., L. (eds*), Handbook of depression second edition.* London: The Guilford Press. Pp. 510-530.

Bernard, J. D., Baddeley, J. L., Rodriguez, B. F. & Burke, P. A. (2016). Depression, language, and affect: an examination of the influence of baseline depression and affect induction on language. *Journal of Language and Social Psychology,* Vol. 35(3), pp.317-326.

Blumer, H. (1970) 'Sociological implications of the thought of George Hebert Mead'. In: Stone, G. P. & Farberman, H. A (Eds.) *Social psychology through symbolic interaction,* pp. 282-293. Massachusetts: Ginn-Blaisdell Publishing Company.

Blumer, H. (1978). 'Society as symbolic interaction'. In: Manis J, G. & Meltzer, B. N (Eds.) *Symbolic interaction a reader in social psychology third edition*, pp. 97-103. University of Michigan Allyn and Bacon.

Blumer, H. (1986). *Symbolic interaction perspective and method*. London: University of California Press.

Brooke-Summer, C., Lund, C. & Petersen, I. (2014). Perceptions of psychosocial disability amongst psychiatric service users and caregivers in South Africa. *African journal of disability*. Vol. 3 (1), pp. 1-10.

Busfield, J. (2000). Introduction: rethinking the sociology of Mental Health. *Sociology of health and illness*, Vol. 22 (5), pp. 543-558.

Cabassa, L. J. (2007). Latino immigrant men's perceptions of depression and attitudes toward help seeking. *Hispanic journal of behavioural sciences*, Vol. 29(4), pp. 492-509.

Cappeliez, P. & Flynn, R. J. (1993). *Depression and the social environment: Research and intervention with neglected populations*. London: McGill-Queen's University Press.

Chentsova-Dutton, Y. E. & Tsai, J. L. (2009). 'Understanding depression across cultures'. In: Gotlib, I. H. & Hammen, C., L. (eds), *Handbook of depression second edition*. London: The Guilford Press. Pp. 363-385.

Carothers, J. C. & World Health Organization. (1953). *The African mind in health and disease: a study*

in ethnopsychiatry. Geneva: WHO.
Chilisa B. & Preece, J. (2005). *Research methods for adult educators in Africa*. Cape Town: Pearson Education.
Craig, R. T. (2007). 'Communication theory as a field'. In R. T. Craig and H. L. Muller (Eds.), *Theorizing communication: readings across traditions*. California: Thousand Oaks, Sage. Pp. 63-98
Dawes, A. (1985). Politics and mental health: the position of clinical psychology in South Africa. *South African journal of psychology*, Vol 15 (2), pp. 55-61.
Denzin, N. K. (1992). *Symbolic interactionism and cultural studies: the politics of interpretation.* John Wiley & Sons.
DePaulo Jr, J. R. & Horvitz, L. A. (2002*). Understanding depression: what we know and what you can do about it*. New York: John Wiley & Sons.
Department of Health. (1997). White paper for the transformation of the health system in South Africa. *Government gazette*. Vol, *382*(17910), pp. 1-140.
Department of Health. (2003). Policy guidelines on child and adolescent mental health. *South Africa*, pp. 1-26.
Department of Health. (2007). The traditional healer practitioners bill. *Government gazette*, Vol. 511 (30660), pp. 1-25.
Department of Health. (2008). Draft policy on African traditional medicine for South Africa. *Government gazette*, Vol. 906 (31271), pp. 2-47.
Disner, S. G., Beevers, C. G., Haigh, E. A. & Beck, A. T. (2011). Neural mechanisms of the cognitive model of depression. *Nature reviews neuroscience*, Vol. 12(8), pp. 467.
Gumperz, J. & Cook-Gumperz, J. (2007). "Discourse, cultural diversity and communication: a linguistic anthropological perspective". In: Kotthoff, H. and Spencer-Oatey, H. (eds.) *Handbook of intercultural communication* Vol. 7, pp. 13-29. New York: Walter de Gruyter GmbH & Co publication.
Hamad, R., Fernald, L. C. H., Karlan, D. S. & Zinman, J. (2008). Social and economic correlates of depressive symptoms and perceived stress in South African adults. *Journal of epidemiology & community health*, Vol. *62* (6), pp. 538-544.
Hecht, M., Jackson II, R. L., Lindsley, S., Strauss, S., & Johnson, K., E. (2001). "A layered approach to ethnicity, language and communication". In: Robinson, W., P. and Giles, H. (eds.) *The new handbook of language and social psychology*, pp. 429-449. Chichester: John Wiley & Sons publication.
Horwitz, A. V. (2009). 'An overview of Sociological Perspectives on the definitions, causes and responses to Mental Health and Illness'. In: Scheid, T. L & Brown, T. N. (Eds.) *A handbook for the study of mental health 2nd edition*, pp. 6-19
House, A., (2003). Defining, recognizing and managing depression in neurological practice. *Practical neurology*, Vol 3(4), pp.196-203.
Huang, Y. T., & Fang, L. (2015). Understanding depression from different paradigms: Toward an eclectic social work approach. *The British Journal of Social Work*, Vol. 46(3), pp. 756-772.
Hugo, J. C. Boshof, D. E. L. Traut, A. Zungu-Diwaryi, N. & Stein, D. J. (2003). Community attitudes toward and knowledge of mental illness in South Africa. *Social psychiatry and psychiatric epidemiology journal*, Vol. 38, pp. 715-719.
Ellison, C. G. & Flannelly, K. J. (2009). Religious involvement and risk of major depression in a prospective nationwide study of African American adults. *The journal of nervous and mental disease*, Vol. 197 (8), pp. 568-573.
Flisher, A., Dawes, A., Kafaar, Z., Lund, C., Sorsdahl, K., Myers, B., Tom, R. & Seedat, S. (2015). ' Children and adolescent mental health in South Africa'. In: Akyeampong, E., Hill, A. G., and Kleinman, A. M. (Eds.). (2015).*The culture of mental illness and psychiatric practice in Africa*, pp. 144-162. Bloomington: Indiana University Press.
France, C. M., Lysaker, P. H. & Robinson, R. P. (2007). The" chemical imbalance" explanation for depression: Origins, lay endorsement, and clinical implications. *Professional psychology: research and practice*, Vol. *38* (4), pp. 411-420.
Freese, L. and Burke, P.J. (1994). Persons, identities, and social interaction. *Advances in group processes*, Vol 11, pp.1-24

Furr, S. R., Westefeld, J. S., McConnell, G. N. & Jenkins, J. M. (2001). Suicide and depression among college students: A decade later. *Professional Psychology: Research and Practice*, Vol. 32(1), pp. 97-100.

Griffin, E. (2012). *A first look at communication theory eight edition.*. New York: McGraw Hill.

Jack, D. C. & Ali, A. (Eds.). (2010). Silencing the self across cultures: Depression and gender in the social world. New York: Oxford University Press.

Joiner Jr, T. E. & Timmons, K. A. (2009). 'Depression in its interpersonal context'. In: Gotlib, I., H., and Hammen, C., L. (eds), *Handbook of depression second edition*. London. The Guilford: Press. Pp. 322-339.

Judd, E. (2002). *Cross-cultural communication: An ESL training module*. Chicago: Board of Education of the City of Chicago.

Karp, D. A. (1996). *Speaking of sadness: depression, disconnection, and the meanings of illness*. New York: Oxford University Press.

Kemp, J. J., Lickel, J. J. & Deacon, B. J. (2014). Effects of a chemical imbalance causal explanation on individuals' perceptions of their depressive symptoms. *Behaviour research and therapy*. Vol. *56*, pp. 47-52.

Kessler, R. C., Borges, G., & Walters, E. E. (1999). Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity *Survey. Archives of general psychiatry*, *Vol*. 56 (7), pp. 617-626.

Kleinman, A., Good, B. J. & Good, B. (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder* (Vol. 16). California: University of California Press.

Kivunja, C. & Kuyini, A. B. (2017). Understanding and Applying Research Paradigms in Educational Contexts. *International journal of higher education*, Vol. 6 (5), pp. 26-41.

Kramsch, C. (1998). Language and culture. Oxford: Oxford University Press.

Lewis, B. (2012). *Depression: Integrating science, culture, and humanities*. New York: Routledge.

Link, B. G., Phelan, J. C. Bresnahan, M. Stueve, A. & Pescosolido, B. A (1999). Public conceptions of mental illness: labels, causes, dangerousness, and social distance. *American journal of public health*, Vol 89 (9), pp. 1328-1333

Lund, C., Kleintjes, S., Campbell-Hall, V., Mjadu, S., Petersen, I., Bhana, A., Kakuma, R., Mlanjeni, B., Bird, P., Drew, N. & Faydi, E. (2008). *Mental health policy development and implementation in South Africa: a situation analysis*. Phase 1 country report. Cape Town: mental health and poverty project.

Marsella, A. J., Sartorious, N., Jablensky, A. & Fenton, F., R. (1985). 'Cross-cultural studies of depressive disorders: an overview'. In: Kleinman, A., Good, B. J., & Good, B. (Eds.) *Culture and depression: studies in the anthropology and cross-cultural psychiatry of affect and disorder* (Vol. 16) pp. 299-324. California: University of California Press.

Mead, G.H. (1934). *Mind, self and society*, Vol. 111. Chicago: University of Chicago Press.

Mead, G.H. (1938). *The philosophy of the act*. Morris, C. W., (ed). Chicago: University of Chicago Press.

Meyer, A. & Ndetei, D. (2016). *Providing sustainable mental and neurological health care in Ghana and Kenya: workshop summary*. Forum on Neuroscience and Nervous System Disorders; Board on Health Sciences Policy; Board on Global Health; Institute of Medicine; National Academies of Sciences, Engineering, and Medicine. Available from: https://www.ncbi.nlm.nih.gov/books/NBK350312/ [Accessed: 14 September 2018].

Moore, M. H (ed.) (1936). *Movement of thought in the nineteenth century*. Chicago: University of Chicago Press.

Moder, C. L. & Martinovic-Zic, A. (Eds.). (2004). *Discourse across languages and cultures (Vol. 68)*. Amsterdam: John Benjamins Publishing.

Morgan, A. (ed.). (2008). *Being human: reflections on mental distress in society*. United Kingdom: PCCS Books.

Mosotho, N. L., Louw, D. A., Calitz, F. J. & Esterhuyse, K. G. (2008). Depression among Sesotho speakers in Mangaung, South Africa. African Journal of Psychiatry, Vol. 11(1), pp. 35-43.

Murray, C. J., Lopez, A. D. & World Health Organization. (1996). *The global burden of disease: a*

comprehensive assessment of mortality and disability from diseases, injuries, and risk factors in 1990 and projected to 2020: summary.
Nunan, D. & Choi, J. (2010). *Language and culture: reflective narratives and the emergence of identity.* New York: Routledge.

Obuaku-Igwe, C. C. (2015). Health inequality in South Africa: a systematic review. *African sociological review*, Vol. *19* (2), pp. 96-131.
Othieno, C. J., Okoth, R. O., Peltzer, K., Pengpid, S. & Malla, L. O. (2014). Depression among university students in Kenya: prevalence and sociodemographic correlates. *Journal of affective disorders*, Vol. *165*, pp. 120-125.
Papageorgiou, C. & Siegle, G. J. (2003). Rumination and depression: Advances in theory and research. *Cognitive Therapy and Research*, Vol. 27(3), Pp. 243-245.
Parker, G. (2010). *Dealing with Depression: A Common Sense Guide to Mood Disorders*. Australia: Allen and Unwin.
Parle, J. (2007). *States of mind: searching for mental health in Natal and Zululand, 1868-1918.* Scottsville: University of Kwazulu Natal Press.
Patton, M. Q. (2002). Qualitative research and evaluation methods (3rd ed.). Thousand Oaks, CA: Sage.
Pawar, D. P. (2018). A study of spiritual intelligence, depression and anxiety among undergraduate students. *Indian journal of health & wellbeing*, Vol. 9(3), pp. 459-463.
Phillips, R. & Henderson, A. (2006). Religion and depression among US college students. *International Social Science Review*, Vol. 81(3/4), pp. 166-172.
Pilgrim, D. (2009). *Key concepts in mental health, second edition*. London: SAGE.
Platz, G. (2006). 'Spirituality, madness and the man who lost a thousand masks'. In: Barker, P. and Buchanan-Barker, P., (eds), *Spirituality and mental health: breakthrough*. London: Whurr Publishers. Pp. 200-208.
Van Praag, H. M., de Kloet, E. R. & van Os, J. (2004). *Stress, the brain and depression*. Cambridge: Cambridge University Press.
Redmond, M. V. (2015). Symbolic Interactionism. *English technical report and white papers*, Vol. 4, pp. 1-36.
Sahlstein, E. & Noller P. (2001). "Interpersonal relations". In: Robinson, W., P. and Giles, H. (eds.) *The new handbook of language and social psychology*, pp. 371-382. Chichester: John Wiley & Sons publication.
Samouilhan, T. & Seabi, J. (2010). University students' beliefs about the causes and treatments of mental illness. *South African journal of psychology*, Vol. 40(1), pp. 74-89
Scheid, T. L & Brown, T. N. (Eds.) *A handbook for the study of mental health 2nd edition*. Cambridge: Cambridge University Press.
Schoeman, W. J. (2017). South African religious demography: The 2013 general household survey. *HTS teologiese studies/theological studies*, Vol. 73 (2), pp. 1-7.
Segrin, C. (2000). Social skills deficits associated with depression. *Clinical psychology review*, Vol. 20(3), pp. 379-403.
Simpson, G. (ed). (2005). Emile Durkheim, suicide: a study in sociology. London: Routledge Classics.
Sorajjakool, S., Aja, V., Chilson, B., Ramírez-Johnson, J. & Earll, A. (2008). Disconnection, depression, and spirituality: a study of the role of spirituality and meaning in the lives of individuals with severe depression. *Pastoral psychology*, Vol. 56 (5), pp. 521-532.
South African Depression and Anxiety Group. 2018. *SADAG depression anxiety leaflet press pdf*. Available from: http://sadag.org/images/brochures/SADAG_DEPRESSION_ANXIETY_LEAFLET_PRESS.pdf [Accessed: 27 June 2018].
South African Mental Health Care Act 17 of 2002. Pp 1-61 Available from: http://www.hpcsa.co.za/Uploads/editor/UserFiles/downloads/legislations/acts/mental_health_care_act_17_of_2002.pdf [Accessed 27 June 2018].
Swartz, L. (1998). *Culture and mental health: a Southern African view*. Cape Town: Oxford University Press.
Temple, H. S. (2012). Speaking up: helping law students break through the silence of depression. *ABA journal*, Vol. *98*, pp. 23-24.

Thomas, E. & Seedat, S. (2018). The diagnosis and management of depression in the era of the DSM-5. *South African family practice*, Vol. 60(1), pp. 22-28.

Thoits, P. A. (2009) "Sociological Approaches to Mental Illness," in Scheid, T. L. and Brown, T. N. (eds) *A handbook for the study of mental health: social contexts, theories, and systems. 2nd ed*. Cambridge: Cambridge University Press.

Traditional Health Practitioners Act, No. 42 of 2007. Available from: https://www.gov.za/sites/default/files/a22-07.pdf [Accessed 13 September 2018] .

Trivedi, M. H. (2004). The link between depression and physical symptoms. *Primary care companion to the Journal of clinical psychiatry*, Vol. 6 (1), pp. 12-16.

Turner, J. H. (1988). *A theory of social interaction.* California: Stanford University Press.

Ustun, T. B. (1999). The global burden of mental disorders. *American journal of public health*, Vol. 89 (9), pp. 1315-1318.

Weinberg, S. K. (1965). Cultural aspects of manic-depression in West Africa. *Journal of health and human behaviour*, Vol. 6 (4), pp. 247-253.

West, R. & Turner, L. H. (2010). *Introducing communication theory: analysis and application fourth edition.* New York: McGraw Hill.

Wernicke, R. A., Pearlman, M. Y., Thorndike, F. P. & Haaga, D. A. (2006). Perceptions of depression among recovered-depressed and never-depressed individuals. *Journal of clinical psychology*, Vol. 62 (6), pp. 771-776.

Williams, N. (2002). 'Taking the role of multiple others'. In: Denzin, N. K (ed.) *Studies in symbolic interaction*, Vol. 25, pp. 75-90.

Wyatt, W. J. (2012). Medicalization of depression, anxiety, schizophrenia, ADHD, childhood bipolar disorder and tantrums: scientific breakthrough, or broad-based delusion? *Advances in medical sciences*, Vol. 26 (1), pp. 10-21.

World Health Organisation Report. 2001. *mental health: new hope, new understanding.* Available from: http://www.who.int/whr/2001/en/whr01_en.pdf?ua=1 [Accessed 27 June 2018].

World Health Organization. (2011). *Mental health atlas 2011-department of mental health and substance abuse.* Available from http://www.who.int/mental_health/evidence/atlas/profiles/tza_mh_profile.pdf [Accessed 23 October 2018].

World Health Organisation. (2007). Mental improvements for nations development: Ghana, a very progressive mental health law. Available from: http://www.who.int/mental_health/policy/country/GhanaCoutrySummary_Oct2007.pdf?ua=1 [Accessed 23 October 2018].

World Psychiatric Organisation. 2016. *Association of psychiatrists in Nigeria (APN).* Available from: http://www.wpanet.org/detail.php?section_id=5&content_id=238 [Accessed 12 September 2018].

Appendices

Appendix 1

Participant Consent form (Interviews)

Name of researcher: Tadala Kadula

Brief description of the research topic: A Sociological Analysis of individual's Understanding of Depression at Rhodes University.

Declaration

1. I confirm that the purpose of the research and the nature of my participation have been explained to me verbally or in writing.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason - however I commit myself to full participation unless some unusual circumstances occur, or I have concerns about my participation which I did not originally anticipate.
3. I understand that data collected during the study, will be used by the researcher and that my personal details gathered during this research, especially my name or identity, will be kept private.
4. I agree to be interviewed and to allow audio or video recordings and transcriptions to be made of the interview.
5. I have been informed by the researcher that the tape recordings will be erased once the report is written.

Signature of participant:

Signature of the researcher: 

Date: / /2018

Appendix 2

Interview questions

1. Please provide me with an overview of your understanding of depression.
2. How did you come about this understanding? Was it from personal experience or through your interaction with others?
3. Do you know anyone who is depressed?
4. Do you know anyone who you think is depressed?
5. What makes you think that person is depressed?
6. Are they on medication?
7. How do you interact with people who have depression?
8. How does your home community interact with people who are going through depression?
9. Do you think your ethnicity plays a role on how you understand depression?
10. What role does culture, race and ideological beliefs play on how people from your home community understand depression?
11. What role does culture, race and ideological beliefs play on how people from your home community interact with people who have/think they have depression?
12. Based on your personal understanding/ experience with depression, how do you think it should be treated?