CULTURAL VARIATIONS IN THE PRESENTATION OF DEPRESSION IN FEMALE PATIENTS AT VALKENBERG HOSPITAL

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ABSTRACT

Depression is a significant problem for both developed and developing countries. Local and international literature indicates that there are culturally mediated differences in presentation that contribute to more women being diagnosed with depression than men and to the predominance of particular features of the illness in different settings. The aim of this archival study was to explore the presentation of depression across race groups in female patients at Valkenberg Hospital in the Western Cape. The narratives of patients' presenting complaints were obtained from the history taking notes in 46 hospital files, comprised of three sets of 15 files belonging to Black, White and Coloured patients, and one file belonging to a patient of Asian origin. Thematic analysis was used to analyze the narratives. Findings revealed that patients across race groups viewed depression as occurring in and resulting from interpersonal problems. However, White and Coloured patients also related their main problem to emotional distress, which was the main trigger for seeking help. Black patients reported difficulties in coping with life stressors as their main complaint, and frequently cited experiences of gender based violence. Distress seems to be tolerated until it manifests in behavioural disturbances. It was found that Black patients sought help only when their behaviour became disruptive for those around them. It was also observed that depression with psychotic features and a co-morbid HIV diagnosis were reported most frequently among Black patients. There were thus similarities and differences in the presentation of depression across race groups. Patients' understandings of depression are mediated by various socio-cultural factors.

DECLARATION

This work has not been previously submitted in whole, or in part, for the award of any degree. It is my own work. Each significant contribution to, and quotation in, this dissertation from the work, or works, of other people has been attributed, and has been cited and referenced.

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CHAPTER ONE

INTRODUCTION

> *"'Dysphoria'—sadness, hopelessness, unhappiness, lack of pleasure with the things of the world and with social relationships—has dramatically different meaning and form of expression in different societies . . . Describing how it feels to be grieved or melancholy in another society leads straightway into analysis of different ways of being a person in radically different worlds"* (Kleinman & Good, 1985, p. 3).

It has long been estimated that mental health in South Africa is poorer than that of people elsewhere (Kale, 1995) due to poverty, social and political instability, racial and gender inequality, domestic and social violence, as well as HIV/AIDS; factors which are known to greatly increase the risk of developing disorders such as depression (Husain, Gater, Tomenson & Creed, 2004; Lorant et al., 2003; Moosa et al., 2005; Tomlinson, Swartz, Cooper & Molteno, 2004). Policy development and implementation require accurate information about the current mental health status of the population with regard to the distribution of disorders. Knowledge of the variations in the clinical features of disorders across populations and within subgroups makes a vital contribution to our understanding of various contextual aspects of mental health (Stacey, 1997). A well recognized deficiency of the mental health services in South Africa is the lack of mental health professionals who are both proficient in patients' language and knowledgeable about their culture (Kale, 1995; Msomi, 1997; Swartz, 1998). This is particularly problematic for the detection of depression as language barriers hinder appropriate communication, and a limited understanding of patients' culture means that clinicians are not able to recognize any culturally mediated differences which may exist in the clinical presentation of depression. Adequate understanding of all forms clinical communication is not simply desirable but is an essential part of mental health care delivery (Drennan, 1999).

In his foreword to Swartz's book, "Culture and mental health: A South African view", Kleinman (1998, in Swartz, 1998) expressed a hope that such a book would stimulate interest in issues of culture and mental health in South Africa, as well as encourage research into how these issues relate to inequality and structural discrimination. Depression is likely to be the most researched topic within the fields of psychology and cross-cultural psychiatry, yet new discoveries into cultural aspects of depression are still being made (Dominic, Kleinman & Kleinman, 2007).

Studying depression across cultural groups is fraught with challenges, the most difficult being the task of defining depression (Falicov, 2003). While the term depression is commonly used to refer to experiences of distress, often with an assumption of a shared understanding of what it means, it is a complex concept, and how it is defined and understood has implications for how it is responded to by professionals and lay persons alike. Depression can denote a mood or feeling state that all or most human beings experience at some point in their lives. It can also mean a symptom of a number of psychiatric disorders described by the American Psychiatric Association (APA) such as Bipolar and Schizoaffective Disorders (APA, 2000), or a depressive disorder in its own right that consists of a mood disturbance, psychomotor changes as well as a variety of somatic and vegetative disturbances (Kleinman & Good, 1985; Kleinman, 2004; Marsella, 2003; Pilgram & Bentall, 1999; Swartz, 1998). There have also been efforts to distinguish depression from other psychological states, and "clinical depression" has been distinguished from the depressed mood occurring within a continuum of normal psychological functioning/states (Pilgram & Bentall, 1999). It has even been argued that the term depression should refer only to the syndrome that requires the presence of several symptoms, rather than to both the disorder and the symptom (Montgomery, 1990, in Pilgram & Bentall, 1999). These variations in meaning pose major challenges for clinicians and researchers, as well as lay persons (Marsella, 2003; Pilgram & Bentall, 1999; Swartz, 1998; Tilbury, 2007).

While depression is notoriously difficult to define within a culture, it is even more difficult to define across cultures (Tilbury, 2007). Within psychiatry depression is a feature of the various Mood Disorders, which include Depressive (unipolar depression) as well as the Bipolar Disorders (Bipolar I Disorder and Bipolar II Disorder). It can also feature in Mood Disorders Due to a General Medical Condition and in Substance-Induced Mood disorders. A Major Depressive Episode (MDE) is the characteristic feature of Major Depressive Disorder (MDD), Bipolar I Disorder and Bipolar II Disorder. The depressive disorders include MDD as well as Dysthymic Disorder and Depressive Disorder Not Otherwise Specified. Dysthymic disorder is characterized by a chronically depressed mood and a diagnosis of Depressive Disorder Not Otherwise Specified is made when patients do not meet the criteria for MDD or Dysthymic Disorder. MDE has a varied symptom picture that is characterized by the presence of a depressed mood and/or loss of interest in activities. The diagnosis of depression is further complicated by the fact that the disturbance in mood does not need to be sadness, but can also be irritability or anger, particularly in children and adolescents (Reid Minot, 1986). As a result the DSM-IV TR (APA, 2000) requires that the mood disturbance also be accompanied by four other symptoms, as well as the fulfillment of other criteria, for the diagnosis of MDE to be made (Pilgram & Bentall, 1999).

There have been debates about which features of depression are to take primacy over others in its diagnosis and various authors have assigned primacy to different phenomena (Pilgram & Bentall, 1999). While many argue that a mood disturbance is the chief symptom, others have argued that the prominence of somatic symptoms in some settings and cultures should be recognized (Binitie, 1975; Gaw, 1993, in Kirmayer & Young, 1998; Kleinman, 1982; Kleinman, 2004; Orley & Wing, 1979; Raguram, Weiss, Keval & Channabasavanna, 2001; Ryder, Yang & Heini, 2002). Others also emphasize cognitive features of depression in their work (Beck, 1977, in Pilgram & Bentall, 1999). The fact that a depressed mood is not a necessary criterion to make the diagnosis suggests that there is some recognition that the subjective experience of a depressed mood is not always a primary symptom of this disorder (Swartz, 1998).

In the following chapter I review relevant literature, beginning with a description of the worldwide prevalence of depression. This is followed by a discussion of gender differences in prevalence and their various explanations, as well as socio-cultural issues implicated in the predominance of depression among women. The chapter then discusses depression prevalence across race group, and reviews literature on culture and how it mediates both the expression of depression and diagnostic processes. It concludes with a review of social constructionist theory as it applies to this study.

Chapter three describes the methodology, beginning with a rationale for the use of the qualitative research methods which is followed by a description of the research setting. It then discusses the archival methods used for data collection, and describes how thematic analysis was used to analyze the data. Chapter four presents the major themes found in the study and discusses how these findings relate to the literature. Chapter five provides a summary of the findings and a discussion of their implication. Methodological limitations and recommendations for further research are also discussed.

CHAPTER TWO

LITERATURE REVIEW

The aim of this chapter is to provide a review of the literature on cultural and racial aspects of depression. The first section will discuss the prevalence of depression worldwide, as well as differences across racial and cultural groups. This will be followed by a discussion of gender differences in depression, the main explanations that have been offered these differences, and the socio-cultural factors that mediate the risk for depression. Next I outline research findings on the experience and presentation of depression across different racial groups. The following section will present an overview of the literature on the interface and relationship between culture and mental health, in general and depression more specifically. It will also explore cultural issues in the use of the Diagnostic and Statistical Manual of Mental Disorders, fourth edition-text revision (DSM-IV-TR) (APA, 2000), the classification system for diagnosing mental illness used in South Africa. In the last section I outline social constructionist theory which has provided the frame for this study, and I discuss its application to this study.

As discussed in the previous chapter, depression forms part of a picture of a number of disorders. Making sense of how various studies have used it is made difficult by the fact that while some authors specify a diagnosis in accordance with the DSM-IV-TR (APA, 2000) others refer to the term depression without clarifying what they are referring to. Some of the studies reviewed below do not explicitly state which aspects of depressive disorder they were exploring. Therefore when one looks at prevalence rates it is not clear whether they refer to a depressive episode, a Major Depressive Disorder, depression as a feature of other mood disorders or to depressive symptoms.

DEPRESSION PREVALENCE

Depression is one of the most common and debilitating mental disorders around the world, with far reaching health and economic implications. The World Health Organization has predicted that by 2020 depression will constitute one of the greatest global health problems, resulting in significant social and economic costs (Murray & Lopez, 1996). Depressive disorders are reported to be the leading causes of non-fatal disability worldwide (Murray & Lopez, 1996) and days lost owing to depression exceed those for all other disorders (Broadhead et al., 1990, in Scott & Dickey, 2003). Increasing research on various aspects of depression has revealed that it is a greater public health problem than previously predicted (Geenberg et al., 1993, in Scott & Dickey, 2003) and estimated prevalence rates have continued to increase with further research. For example, in the 1990 Global Burden of Disease (GBD) study by the World Health Organization (WHO), the global prevalence of depression was estimated to be 10.4% (Murray & Lopez, 1996; Murthy, Bertolote & Epping-Jordan, 2001). It was also reported that depressive disorders accounted for between 10.7 % and 15% of years lived with disability, with unipolar depression accounting for 3.7% of total disability-adjusted life years (Murray & Lopez, 1996).

Although the estimates above are themselves high, a replication of the GBD study conducted a decade later indicated that unipolar depression in fact accounted for 4.46% of total disability-adjusted life years (Üstün, Ayuso-Mateos, Chatterji, Mathers & Murray, 2004). In addition, recent studies have found a high incidence of depression in people between the ages of 20 and 25 years, a section of the population that was overlooked in previous research. Earlier studies based their findings on an age of onset for depression of 37 years, which underestimated its prevalence (Üstün et al., 2004). While there is consensus that depression places an enormous burden on both developed and developing societies, literature on comparative prevalence rates seems to report inconsistent and sometimes contradictory findings.

Research conducted in various settings in developed countries has consistently reported high rates of depression (Murray & Lopez, 1996). For example, Hasin, Goodwin, Stinson and Grant (2005) reported lifetime and 12–month prevalence rates of major depressive disorder in an American sample of 13.23% and 5.28% respectively. In a review of findings from community surveys in 10 countries, Weisman et al. (1996, in Simon, Goldberg, Von Korff, & Üstün, 2002) found a lifetime prevalence of 5.2% in the United

States, 9.6% in Edmonton, Canada, 11.6% in Christchurch, New Zealand, 16% in Paris, 19% in Beirut and 1.5% in Taiwan.

Some literature has also found a high lifetime prevalence of depression in developing countries such as Cuba (40%), the Dominican Republic (39%), Uganda (21%), Bangkok (19.9%) and Mexico (19%) (Bolton, Wilk & Ndogoni, 2004; Garcia-Alvarez, 1986, in Bolton et al., 2004). Slone et al. (2006, in Fleischer, Fernald & Hubbard, 2007) reported lower 12 – month prevalence rates in Mexico (6%) and Brazil (5%). However, other studies have found depression prevalence to be lower in rural than in urban settings (Colla, Buka, Harrington & Murphy, 2006). The accurate comparison of prevalence rates between countries is complicated by the fact that many of the studies do not specify whether the areas researched are rural or urban. While some studies report 12-month prevalence rates, others report lifetime rates. Furthermore, as indicated above, some studies looked at depression as part of other depressive disorders or mood disorders while others focused on Major Depressive Disorder on its own. For example, Demyttenaere et al. (2004, in Fleischer et al., 2007), reported a prevalence rate of 1% mood disorders in Nigeria which included Bipolar I and II, Major Depressive Disorder (MDD) and Dysthymia. Other studies have found higher prevalence rates in African countries such as Uganda (17%) (Ovuga, Boardman & Wasserman, 2005) and Zimbabwe (12%) (Abas & Broadhead, 1997, in Fleischer et al., 2007). It is unclear whether these findings were of unipolar depression or included other depressive and mood disorders.

In South Africa Williams et al. (2008) has reported MDD (4.9%) to be one of the most prevalent psychiatric illnesses. Fernander et al. (2006) found a 4% prevalence of Dysthymic Disorder and 3.4% of MDD in Khayelitsha, Cape Town. However, Triant (2002) reported even higher rates of MDD (13%) and other depressive disorders (32%), and Ben-Arie, Swartz, Teggin & Elk (1983) reported a depression prevalence of 16% in Mamre. Despite these differences in reported prevalence rates, there is consensus in the literature that depression is a serious worldwide problem. Additionally, gender differences have been found in rates of depression across time and setting (Kuehner, 2003).

GENDER AND DEPRESSION

The female preponderance in depression prevalence

Literature indicates that the prevalence, incidence and morbidity risk for depressive disorders are higher in females than in males, beginning at puberty and persisting throughout adult life (APA, 2000; Falicov, 2003; Kuehner, 2003; Piccinelli & Wilkinson, 2000). The average estimated ratio is 2: 1 for current and lifetime episodes of depression (Falicov, 2003; Kuehner, 2003; Piccinelli & Wilkinson, 2000). Evidence of gender differences in depression has been found internationally across different settings in developed countries such as the United States (Hasin et al., 2005; Hopcroft & Bradley, 2007) and Australia (Australian Institute of Health and Welfare, 2000, in Fullagar & Gattuso, 2002), as well as in developing countries such as Mexico, Brazil, Chile, India, Nigeria (Hopcroft & Bradley, 2007), and South Africa (Hopcroft & Bradley, 2007; Fernander et al., 2006; Stacey, 1997). Gillis, Welman, Koch and Joli (1991, in Kale, 1995) found 99% of female participants in their study to be clinically depressed, with depression found in only 25% of males.

A number of explanations have been proposed for the gender difference in unipolar depression. It has been argued that women tend to report depressive symptoms such as sadness and anhedonia, which are favored by current diagnostic tools, while men present with symptoms such as irritability, low stress tolerance and antisocial features (Kuehner, 2003; Piccinelli & Wilkinson, 2000). However, biomedical theories of genetic and hormonal influences, as well as psychosocial theories that focus on risk factors deriving from women's oppression and disempowerment, have been the most influential explanations (Kuehner, 2003; Stoppard, 2000). Factors such as culture, race, poverty, low education, immigration status and exposure to violence have also been highlighted as important social moderators of the risk for and experience of depression between the sexes across cultural groups (Beauboeuf-Lafontant, 2007; Brown & Harris, 1989; Kuehner, 2003; Riolo, Nguyen, Greden & King, 2005).

Biomedical explanations

Although research in psychiatry has focused on biological explanations of depression, the evidence for gender differences in depression is limited (Stoppard, 2000). While it is reported that genetic influences predispose women to develop MDD more than men (Kendler & Prescott, 2000), findings from most of the genetic studies contradict this hypothesis (Beddington, 1996, in Stoppard, 2000) and indicate that genetic effects between the sexes are at best minimal. Others have found no sex differences in heritability between the sexes (Sullivan, Neale & Kendler, 2000). Hormonal changes have been reported as better explanations for the emergence of gender differences in depression during puberty, but this explanation seems to only apply to adolescents (Angold, Costello, Erkanli & Worthman, 1999, in Kuehner, 2003; Kuehner, 2003; Nolen-Hoeksema & Girgus, 1994). Cultural differences in the theorized association between puberty, hormonal effects and depression have also been reported and other explanations indicate that endocrine stress reactions and neuropsychological processes are also implicated (Kuehner, 2003).

There is now some agreement in the literature that the available biological explanations cannot adequately account for the higher rates of depression in women (Beddington, 1996, in Stoppard, 2000). Recent research has shown that the interaction between hormonal changes in young females and social factors explain considerably more of the variance than biological factors alone (Kuehner, 2003). Particular emphasis has been placed on the effects of intra-psychic risk factors and risk factors related to psychosocial gender issues (Stoppard, 2000).

Psycho-social explanation

Psycho-social explanations for depression in women have focused on the joint effects of personality traits and environmental influences. Adolescent girls face a considerably greater number of stressful experiences and tend to develop personality traits and ways of viewing the world which increase their vulnerability to depression (Nolen-Hoeksema & Girgus, 1994; Piccinelli & Wilkinson, 2000; Stoppard, 2000). These psychological factors along with the wider socio-political issues related to gender roles place a greater burden on women in most societies and seem to provide better explanations for their increased risk for depression (Beauboeuf-Lafontant, 2007; Kuehner, 2003; Stoppard, 2000).

Gender identity and notions of femininity, as well as roles and norms that are transmitted and maintained through socialization and cultural practices, have also been viewed as contributing to both women's increased risk for and their likelihood to be diagnosed with depression (Beauboeuf-Lafontant, 2007; Falicov, 2003, Stoppard, 2000). Relationships with others are said to be central to women's psychological development and shape women's experiences as well as their sense of self (Stoppard, 2000). One model holds that from adolescence women are encouraged to be self-silencing and self-sacrificing, and to hide important aspects of their experiences which might be incongruent with the images of femininity that exist in their socio-cultural contexts (Beauboeuf-Lafontant, 2007; Stoppard, 2000). And while images of femininity may vary in different cultures, they are all created by cultural practices and discourses that encourage women to act in certain ways (Beauboeuf-Lafontant, 2007; Stoppard, 2000; Falicov, 2003). It has been argued that women are also encouraged to express their distress through help-seeking rather than acting-out behaviours, in order to maintain relationships (Beauboeuf-Lafontant, 2007; Falicov, 2003).

The research that informs the above explanations is primarily based on White, middle-class women and a blanket application of these explanations would assume the universality of gender experiences (Beauboeuf-Lafontant, 2007; Falicov, 2003; Kiguwa, 2004). However, such an assumption would overlook the effects that factors such as culture, race, low education, exposure to violence and poverty have in shaping gender roles and feminine norms in different settings (Beauboeuf-Lafontant, 2007; Falicov, 2003). And while all women are exposed to gender-related psychosocial stressors and inequality, Black women's adversity is further confounded by racial and class inequalities (Kiguwa, 2004; Ramphele & Boonzaier, 1988; Stoppard, 2000). Black women have to contend with considerably greater forms of structural disempowerment that subject them to socioeconomic marginalization and hardship (Beauboeuf-Lafontant, 2007; Falicov, 2003; Kiguwa, 2004).

Over the years, Black women around the world have adopted the idea that being a Black woman means being strong and able to quietly endure difficulties (Beauboeuf-Lafontant, 2007; Kiguwa, 2004), a view that that may lead to increased risk for depression (Beauboeuf-Lafontant, 2007; Stoppard, 2000). Discourses of strength are evident in South African history and are encapsulated in the Zulu phrase *"wathint'abafazi wathint'imbokodo"* (which translates to *you touch [mess with] a woman, you touch [mess with] a rock*). This was used by women during the struggle against apartheid and continues to influence ideas of Black womanhood in this country.

Images of femininity are maintained within the gender roles that women are socialized into (Beauboeuf-Lafontant, 2007; Kiguwa, 2004; Stoppard, 2000). According to Stoppard (2000) many women view the roles of wife and mother as central in their lives, and the pressure that women face to fulfill these roles often place them at increased risk for depression. While gender roles within marriage seem to have a protective effect on men, they have been shown to result in considerable amounts of stress for women in some cultures. In addition, females who enter the job market often face challenges of job discrimination and inequality along with role overload and conflict when they attempt to balance this with the demands of domestic life (Piccinelli & Wilkinson, 2000). For Black women in South Africa, these issues are further complicated by the frequent absence of father figures in the family, placing full parental responsibility on women (Kiguwa, 2004). Violence, HIV/AIDS and social instability also have serious psychological implications that place Black women at higher risks for depression (Kiguwa, 2004; Moosa et al., 2005). In a sample from Cape Town, it was found that women who had experienced recent intimate partner violence were more likely to suffer from depression. Subramaney (2006) also reported rates of MDD to be higher than those of Post Traumatic Tress Disorder (PTSD) after a trauma in a sample of women in Johannesburg.

While gender differences in depression exist across both developed and developing societies, this issue is not as clear cut as suggested by most research findings, and some disparities in the female preponderance across cultural groups have been reported (Kuehner, 2003; Maier et al., 1999). A number of researchers have found the gender difference to be less pronounced and even absent in societies where female roles are valued in the same way as male roles (Hopcroft & Bradley, 2007; Kuehner, 2003; Piccinelli & Gomez Homen, 1997; Piccinelli & Wilkinson, 2000).

Colla et al. (2006) have found lower levels of depression among women living in rural compared with those in urban areas. These differences have been attributed to urbanization, which causes the break down of the traditional protective mechanisms of social groups, as societies become modernized (Colla et al., 2006). In South Africa, rapid urbanization has large numbers of women moving to urban areas in search of work (Ramphele & Boonzaier, 1988). Currently fuelled by rural poverty, this contributes to increased numbers of poor women living in the townships and informal settlements around the Cape metropolitan area.

There has been increasing recognition of the importance of the role played by the factors discussed above in the etiology, manifestation, course and prognosis of depression in women (Ayalon & Young, 2003; Brown & Harris, 1989; Kleinman & Good, 1985; Swartz, 1998; Riolo et al. 2005). The differences in the female predominance were moderated by cultural factors, suggesting that depression prevalence may differ across race groups.

RACIAL DIFFERENCES

The concept of race and the use of racial categories are still controversial and many have argued that racial classifications are based on socially imposed criteria of difference (Appiah, 1994; Khalfani & Zuberi, 2001; West, 1988)[1]. However, race has long been recognized as an important factor in all aspects of mental health care (Bains, 2005). In

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[1] Racial categories were derived through classifying people according to characteristics such as skin colour, hair texture, descent, language and behaviour, and were therefore criticized social constructions that were often created to serve oppressive political ends (Appiah, 1994; West, 1988).

developed societies such as the United States and Australia, racial and ethnic minority groups face a range of social stressors such as poverty, limited access to resources and negative effects of migration, which have been associated with psychological distress, and are risk factors for psychiatric illnesses, especially depression (Plant & Sachs-Ericsson, 2004; Tilbury, 2007). In developing societies, however, it is mainly members of non-Western cultures who make up majority groups and tend to suffer increased socio-economic adversities. While racial differences in depression prevalence have been reported in various studies, findings have overall been inconclusive (Cohen et al., 2005; Riolo et al., 2005).

A number of international and local studies have reported racial differences between various groups. Plant and Sachs-Ericsson (2004) found higher rates of major depression and more depressive symptoms in minority group members compared to a White sample. On the other hand, Riolo et al. (2005) found that White-Americans have a higher lifetime prevalence of Major Depressive Disorder, while African- and Mexican-Americans were found to have a higher prevalence of Dysthymia. Stacey (1998) found higher rates of depression among Whites compared to Blacks in a sample in South Africa. Other research, however, has found little or no racial differences in depression prevalence. Equivalent rates of depression have been reported between African-Americans and Caucasian-Americans (Weissman, Bruce, Leaf, Florion & Holzer, 1991; Zung, McDonald & Zung, 1988), as well as among White-Americans and French-speaking African-Caribbeans (Cohen et al., 2005).

As discussed above, comparing prevalence rates across race groups is also complicated by the fact that some research has compared racial differences in depressive symptoms, while other studies focused on depressive disorders. This may explain some of the contradictions reflected in the literature as some studies have demonstrated that racial differences in the prevalence of depressive symptoms do not equal differences in depressive disorder between the same groups (Ayalon & Young, 2003). These authors found lower rates of pessimism, dissatisfaction, self-blame, and suicidal ideation, and a greater sense of punishment and weight change in African-Americans compared to

Caucasian-Americans. Similarly, Yeung at al. (2004) found that while Asian-Americans had a higher prevalence of major depressive disorder compared to White- or Hispanic-Americans, the prevalence rates of depressive symptoms across these groups were comparable.

Contradictory findings have also been reported in research comparing prevalence between White and Asian people. While earlier studies consistently reported low rates of depression among people of Asian descent (Chan & Lai, 1993; Kessler et al., 1994, in Yeung at al., 2004; Ryder et al., 2002; Weissman et al., 1996, in Weissman & Gameroff, 2002), recent research seems to indicate that rates of depression in this population are in fact higher than previously estimated. For example, Yeung at al. (2004) found the prevalence of Major Depressive Disorder to be equivalent or even higher in Chinese- than White-Americans. Overall research findings on depression prevalence across race groups are inconclusive. Where differences have been reported, studies have failed to discover consistent differences that are not accounted for by socioeconomic differences (Falicov, 2003), and the effects of culture on the presentation of depression.

CULTURE AND MENTAL HEALTH

The frequent use of concepts such as Western and Non-Western culture in research may lead to the assumption that culture falls neatly into these two opposing categories. This may inadvertently promote group stereotyping, as well as the neglect of individual needs and the subtle but important variations within cultures (Lakes, Lópes & Garro, 2006). These concepts are not clearly defined, although some associate Western culture with developed societies or European influences and non-Western culture with African, Asian and other developing societies (Hook, 2004; Lakes et al., 2006). Furthermore, reference to racial and ethnic categories in cross-cultural research has been criticized for creating the impression that culture is defined along racial boundaries (Lake, Lópes & Garro, 2006). Racial categories do not necessarily correspond to cultural groups, and the use of these two concepts may reduce the complexities of culture to racial differences (Appiah, 1994; Sloan et al., 2001, in Sam & Moreira, 2002).

Most urban Africans have been acculturated into Western ways of life (Swartz, 1998), and finding a truly rural African setting that is untainted by other cultures has become more and more illusory (Hook, 2004; Swartz, 1998). Distinguishing cultural boundaries in the multicultural and multiracial South African setting seems an impossible task. And while the cultural practices and beliefs of different race groups might have evolved in relative isolation due to past racial segregation, desegregation and urbanization has encouraged an increased interaction between people from different racial, ethnic and cultural backgrounds as they tend towards sharing living spaces and exposure to multiple cultural influences (Bhugra & Mastrogianni, 2004). The Western Cape has the highest level urbanization in the country, and its local neighboughhoods play a key role, along with ethnic, class and racial identities, in the formation of cultural identity (Cornelissen & Horstmeier, 2002). Therefore, racial and cultural identities no longer evolve in isolation but are influenced by other groups. This increased cross – cultural and racial interaction also highlights the problems inherent in categorizing people into distinct racial, ethnic and cultural groups (Boonzaier, 1988; West, 1988).

Increased awareness of cultural diversity in various countries, including South Africa, has raised interest in exploring the cultural framework of mental illness, particularly how culture shapes the content and meaning of symptoms, as well as how it informs the diagnostic system (Mezzich et al., 1999).

Defining culture

The concept of culture has been the subject of the work of anthropologists and other social scientists for generations, and efforts to define it continue to preoccupy academic work today (Swartz, 1998). It has been defined and used by various disciplines in differing ways. Early anthropologists gave a general definition of culture as shared patterns of life that define social groups (Kleinman, 2004). Numerous others have offered definitions that have expanded on these ideas as well as introduced other aspects of culture. In their critical review of literature on cultural psychopathology, Betancourt and López (1993) presented a definition of culture as the values, beliefs and practices that relate to a given ethnocultural group. Helman (1994) proposed that culture was a set of guidelines which individuals inherit as members of a particular society, and which tell them how to view the world and behave in it. These guidelines are transmitted generationally through various artifacts such as language and art (Helman, 1994). Others have argued that culture is not a thing, but rather a process by which ordinary activities acquire emotional and moral meaning (Kleinman, 2004). More recently, social scientists have highlighted the dynamic nature of culture as an important defining aspect, emphasizing that interpretations of cultural guidelines are subject to change as the circumstances in which they are applied change (Swartz, 1998). Among the various definitions there seems to be an agreement that culture is learned and shared, that it is dynamic and ever-changing, and that it moderates the way people structure and respond to their internal and external environments (Bhugra & Mastrogianni, 2004; Betancourt & López, 1993; Kleinman, 2004; Marsella, 2003).

In this study I have adopted Marsella's (2003) definition in which he describes culture as the learned meanings and behaviors that are shared in social activities and contexts, which have both external (i.e., artifacts, roles, activity contexts, institutions) and internal (i.e., values, beliefs, attitudes, patterns of consciousness) representations, and are subject to continuous change and modification in response to changing internal and external circumstances. Viewed from this perspective, an exploration of the presentation of depression across cultural groups would in fact be an exploration of different cultural expressions of depressive experiences (Kleinman, 1977).

Culture and the expression of emotional distress

The notion that emotions are universal because they are innate and biological has been rejected by those who argue that emotional experiences are influenced by the meaning they are given within social interactions in various cultures (Kirmayer, 2001; Kleinman & Good, 1985). The fact that these states are communicated through language seems to prioritize cultural influences over biology (Wierzbicka, 1999, in Tilbury, 2007). While experiences such as loss are universal (Kirmayer, 2001), and basic emotions such as sadness, anger and fear have been recognizable across cultures (Ekman & Friesen, 1978, in Tilbury, 2007), the words used to describe these emotional categories differ (Tilbury, 2007; Swartz, 1998). Furthermore, the different ways in which people make sense of these experiences influence how they respond to them (Kirmayer, 2001).

In the West negative affective experiences such as feeling sad, angry, shy, anxious or even emotionally unstable, have been medicalized into pathological experiences that require some form of treatment (Tilbury, 2007). Positive emotion and feeling good about the self are emphasized as normal and healthy ways of being (Falicov, 2003). However, disturbances in mood are not viewed as mental illness problems in all cultures, but as moral and social ones (Kirmayer, 2001). Some even argue that the notion of happiness as a normal and desirable state is a peculiarly American conception (Wierzbicka, 1999, in Tilbury, 2007). People from different cultures experiencing the same emotion may respond to it in dramatically different ways, according to the cultural meanings they attach to the experience (Tilbury, 2007). As an example, sadness and loss of pleasure in the things of the world and in social relationships are two essential features of a Major Depressive Episode that have negative connotations in Western cultures but have positive ones for Buddhists who view these experiences as steps towards spiritual enlightenment (Kleinman & Good, 1985).

This issue is further complicated by the fact that the expression of emotions is also influenced by cultural norms which moderate how people show emotions in different settings (Kirmayer, 2001; Kleinman & Good, 1985). The Kaluli people of Papau New Guinea value the dramatic expression of sadness and grief, which is in direct contrast to the Balinese people who conceal fluctuations in emotions in order to preserve an image of a refined inner self (Kleinman & Good, 1985). Many have argued that to translate pathologies of emotion across cultures is itself a culture-bound activity because the tools used in this process underpin Western practices (Tilbury, 2007).

Culture and depression

Over and above mediating the ways in which emotions are expressed, culture also provides categories of emotional experience which emphasize some feelings and make others more difficult to articulate (Dominic, Kleinman & Kleinman, 2007; Kirmayer, 2001; Kleinman & Good, 1985), therefore compounding cultural differences in how emotional distress is expressed. It has been suggested, for example, that many people from non-Western cultures experiencing emotional distress such as depression, present it in ways that differ from Western norms (Kirmayer, 2001). Research has confirmed this, and significant cross-cultural differences in the experience and expression of depression have been reported (Manson, Shore & Bloom, 1985; Manson & Kleinman, 1995, in Dominic et al., 2007).

The DSM-IV-TR (APA, 2000, p. 353) states that 'culture can influence the experience and communication of depressive symptoms'. Many have attributed the low rates of depression in some racial and cultural groups to culture-mediated differences in how people from non-Western settings understand, experience and present depressive states (Dhadphale, Ellison & Griffin, 1983; Kirmayer, 2001; Kleinman, 1982; Kleinman & Good, 1985; Ryder et al., 2002; Weissman et al., 1996, in Weissman & Gameroff, 2002). Research has previously indicated that people from Western cultures present with psychological and cognitive symptoms of depression (such as a dysphoric mood, loneliness, and sadness), while individuals from non–Western cultures, especially those of Asian and African descent, predominantly report somatic symptoms of fatigue, sleep disturbance and weight loss, which often complicates diagnosis within Western medical settings (Binitie, 1975; Gaw, 1993, in Kirmayer & Young, 1998; Kleinman, 1982; Kleinman, 2004; Raguram et al., 2001; Orley & Wing, 1979; Ryder et al., 2002). The DSM-IV (APA, 1994, p. 324) also states that 'in some cultures, depression may be experienced largely in somatic terms, rather than with sadness or guilt'.

This notion has been criticized for perpetuating stereotypes of non-Western cultures as psychologically unsophisticated (Issac & Janca, 1996; Kirmayer & Young, 1998). Others suggest that the use of somatic symptoms says more about the social and cultural context in which distress is communicated than about cognitive limitation (Kirmayer & Young, 1998). And while it is now recognized that the somatic presentation of distress is as common in Western as in non-Western cultures (Issac & Janca, 1996; Kleinman & Kleinman, 1985; Kirmayer & Young, 1998; Ryder et al., 2002), specific bodily idioms of distress and somatic experiences such as pain, dizziness, heaviness in the head or chest, are used to communicate emotional pain in depressed non-Western people (Dominic et al., 2007; Patel, Abas, Broadhead, Todd & Reeler, 2001; Tilbury, 2007).

Other differences include self-deprecation and guilt, which are reported to also make up the depressive picture of Africans (Binitie, 1975; Orley & Wing, 1979). A consistent finding in the literature has been that people from non-Western cultures also link their depressive experiences to family problems and disruptions in social harmony (Dominic et al., 2007; Fry & Nguyen, 1996; Karasz, 2005). This trend seems wide spread, and has also been found among African-Americans (Ayalon and Young, 2003). The implication is that the diagnostic system does not cover the full range of symptoms present among the various cultural groups in which it applies. Some have also cautioned that without the use of in-depth clinical interviews, many depressed people from non-Western culture may be misdiagnosed (Sam & Moreira, 2002). Marsella (2003) suggests that we rethink the assumptions and practices underlying Western psychiatry and psychology, which are used worldwide.

The DSM-IV-TR as a diagnostic system

The concepts of mental health and illness are no less complex than that of culture (Swartz, 1998), and while the term 'mental' appears as part of the title of the DSM-IV (APA, 2000), physical distress also features in many mental disorders, as does emotional distress in physical disorders. While the concept of mental disorder lacks a clear definition that can be used in all situations, the DSM-IV-TR currently defines it as clinically significant behaviours, or psychological syndromes or patterns that occur in an individual and are associated with present distress or disability (APA, 2000, p. xxxi).

The DSM-IV-TR (APA, 2000) is the primary diagnostic tool used by mental health practitioners in South Africa and in most of the world. It was created out of a need for a universal diagnostic system that could categorize and classify mental disorders, and enable clinicians and researchers around the world to communicate about patient diagnosis, to guide treatment plans and inform research initiatives (Thakker & Ward, 1998).

While the theoretical basis of the DSM is not clearly explained in it, its diagnostic categories are informed by the Western-cultural biomedical model of illness (Mezzich et al., 1999; López & Guarnaccia, 2000; Thakker & Ward, 1998), which views human beings as sharing a common physiology and psychopathology (Pilgrim & Bentall, 1999; Thakker & Ward, 1998). This model favours the view of disorders as fundamentally biological, and emotional distress as related to underlying physical pathology (Swartz, 1998; Thakker & Ward, 1998). The DSM's diagnostic categories, therefore, represent a universalistic view of mental illness (Mezzich et al., 1999; López & Guarnaccia, 2000; Thakker & Ward, 1998; Thakker, Ward & Strongman, 1999). Lewis-Fernandez and Kleinman (1995) note that the use of the DSM has grown worldwide, surpassing that of other diagnostic tools. Given that approximately 80% of the human population belongs to non-Western societies, it has been argued that this diagnostic system could not be a truly international tool if it is based solely on Western conceptions of mental illness (Thakker & Ward, 1998), and its cross-cultural application is limited (Dominic et al., 2007).

As an effort to improve its cultural applicability, the DSM includes an acknowledgement of its cultural limitations, a recognition that people may present with different features of a disorder such as depression, as well as recommendations that clinicians should be sensitive to patients' different languages, values and behaviours when using it (APA, 2000; Thakker & Ward, 1998). However, many have argued that this is insufficient acknowledgement of the cultural variations in the presentation of mental illness (Dominic et al., 2007; Thakker & Ward, 1998). Western conceptions of abnormality in behaviour and mental state are tacitly applied during the use of DSM, and experiences that might otherwise be viewed as normal or even healthy in other cultures are interpreted as abnormal and pathological within the medical setting (Kleinman & Good, 1985; Mezzich et al., 1999).

Most clinicians around the world are trained using the DSM-IV. They interpret patients' presenting complaints according to the criteria and symptoms specified within it and tend to describe depression using a primarily medical discourse which invariably moves it into the sphere of control of Western medicine (Bäärnhielm, 2002; Thakker & Ward, 1998; Thomas-McLean & Stoppard, 2004). Bäärnhielm (2002) found that patients' somatic manifestations of emotional distress were interpreted using psychological and psychiatric explanations. It was found that patients' illness beliefs and understandings changed as a result of contact with health care institutions (Bäärnhielm, 2002). Clinicians also use their clinical judgment, which is informed by psychiatric training, to make sense of patients' illness presentations. They therefore, introduce narratives that fit with psychiatric discourses and accommodate psychiatric interventions (Bäärnhielm, 2002; Thomas-McLean & Stoppard, 2004). Over and above the clinical judgments, other cultural variables such as the race, gender and cultural background of both clinician and patient have been found to influence clinicians' interpretations of patients' presentations (Wright, Meadow, Abramowitz & Davidson, 1980). Psychiatrists from different countries seeing the same patient have been known to arrive at different diagnostic conclusions (Swartz, 1998).

The impact of socio-cultural factors on the development of depression is also not explained by the diagnostic categories in the DSM (Dominic et al., 2007; Karasz, 2005). Thomas-McLean and Stoppard (2004) found contradictions in physicians' understandings of depression as they try to reconcile their bio-medical understanding with the recognition of the complex role played by socio-cultural factors on how the disorder develops. They concluded that the diagnosis of depression was a more complex undertaking than what current medical conceptualizations suggest (Thomas-McLean & Stoppard, 2004).

THEORETICAL FRAMEWORK

This section will discuss the social constructionist perspective as the theoretical framework on which this study is based and will then look at how it applies to this study. Throughout the 20th century developments within the mental health field were informed by positivist research, which assumes that social and mental phenomena are characterized by stable, pre-existing patterns that can be measured and accurately described through objective scientific investigations (Durrheim, 1997). According to this position, what things really are is essentially knowable and can be accurately measured (Durrheim, 1997; Foster, 2003; Foster, 2004). Only questions that can be answered through empirical methods are viewed as valid research questions (Durrheim, 1997; Hayes, 2004). From this perspective, psychiatric practice is based on the assumption that the external world is real and unvarying and mental illness is a collection of natural diseases that can be studied and accurately described (Durrheim, 1997; Pilgrim & Bentall, 1999). The names and descriptions of disorders are seen as reflecting real measurable illnesses in the world.

The social constructionist position emerged in the postmodern era as a critique against the positivist ideology (Durrheim, 1997, Foster, 2003; Foster, 2004). It asserts the idea that, rather than existing inherently in the world, our understanding of objects and experiences are created through shared cultural and social practices and with language is the main process through which this constructive process occurs (Durrheim, 1997; Foster, 2003; Foster, 2004). Rather than merely describe what things naturally are, we actually create our meaning of things through a shared use of language (Durrheim, 1997; Willig, 2003). The implication of this view is that multiple understandings of experiences such as emotional distress can exist, and that these are also created through socially shared discourses (Terre Blanche & Durrheim, 1999).

Social constructionist research aims at uncovering the social, historical and collective nature of the processes through which meaning is ascribed to things (Durrheim, 1997). Discourse analysis is the primary method used to deconstruct psychopathology and to interpret the meaning behind texts, talk, conversation and symbolic systems through unpicking language (Foster, 2003). However, it has also been acknowledged that social constructionists' emphasis on discourses and language as the main processes through which meaning is created neglects the role played by factors such as the physical nature of bodies and objects, the power of institutions to control access to resources, as well as various other social conditions which shape people's actions and understandings

(Cromby & Nightingale, 1999; Pilgrim & Bentall, 1999; Sims-Schouten, Riley & Willig, 2007). These factors open possibilities but also impose constraints and influence how discourse creates meaning by moderating which discourses arise in different social conditions and settings (Cromby & Nightingale, 1999; Foster, 2004; Sims-Schouten et al., 2007).

As discussed above, the disorders and diagnostic categories reflected in the DSM-IV are social constructions of Western biomedicine, and are therefore Western cultural idioms of mental experiences (Pilgrim & Bentall, 1999; Swartz, 1998). Furthermore, it has also been argued that concepts such as race, culture and gender identity are representations created and maintained through shared cultural practices and discourses.

In summary, depression is a common mental illness with detrimental effects around the world (Murray & Lopez, 1996). It is a major cause of disability and places severe burden on developed and developing societies. While some research has reported variations in depression prevalence across regions and race groups, the literature is inconclusive. Women have also consistently been found to be more affected by depression than men, but the gender difference seems to be less pronounced in some cultural groups. Furthermore, there are indications in the literature that experiences of depression and variations in prevalence are moderated by certain socio-cultural and demographic factors. Social constructionist theory understands experiences and the meanings we ascribe to them as created through the shared use of language as well as other cultural practices. The analysis of discourses of illness can therefore reveal how disorders such as depression are understood and experienced in different cultural groups (Cromby & Nightingale, 1999; Durrheim, 1997, Foster, 2003; Foster, 2004).

AIMS OF THE STUDY

The aim of this study is to explore the presentation of depression in women from different racial groups. Through analyzing the narratives of depression in clinical files, I will explore common features and differences in the expression and presentation of depression, as well as in how the presentations are interpreted by clinicians. I will also explore the impact of socio-cultural factors on the depressive experiences of the women in the sample.

Significance of the study

Depression is as a global health problem, and has severe mental health and economic implications particularly for women. A spectrum of demographic, socio-cultural and environmental factors are associated with the aetiology, exacerbation and maintenance of depressive experiences and disorders, and moderate the variations in prevalence found across different regions and race groups. South Africa has a diverse cultural milieu, consisting of several and often intersecting cultures. Given the reported impact of cultural factors and the implications for its diagnosis and management, it is important to investigate whether internationally reported differences in illness expression also exist in psychiatric hospitals in this country. Ayalon and Young (1998) caution that misdiagnosis of patients from different racial groups may result from lack of knowledge about possible variations in the manifestation of depressive symptoms across racial groups. Enhancing this knowledge is likely to improve diagnostic accuracy. It is hoped that this study will help in producing better understanding of this disorder and add to the limited African based literature on this subject.

CHAPTER 3

METHODOLOGY

This chapter will outline the research methodology used in this project, starting with a brief discussion of the qualitative research paradigm within which the study is situated. A brief description of the research setting will be followed by a discussion of the use of archival data. The next section will describe the procedures used for data collection and methods used to analyze the data, and the last part will outline ethical considerations.

RATIONALE FOR THE USE OF A QUALITATIVE RESEARCH DESIGN

Qualitative research is a broad field that includes a range of diverse and complex methods and activities, which overlap in theory and technique (Braun & Clarke, 2006; Silverman, 2001). The paradigm emerged out of dissatisfaction with the reductionism inherent in positivist science. It recognizes the complex and dynamic nature of our social world (Terre Blanche & Durrheim, 1999). Broadly defined qualitative methods are used to study human action from the perspective of the social actors themselves and research is often conducted in their natural setting (Babbie & Mouton, 2001). Qualitative methods provide a deeper understanding of phenomena as they occur in their natural setting and enable researchers to explore the meanings that people ascribe to these phenomena (Denzin & Lincoln, 2000; Silverman, 2001). They are interpretive in nature and recognize that the researcher plays a key role in the research process (Babbie & Mouton, 2001; Denzin & Lincoln, 2000).

For this study qualitative methods will help provide a deeper understanding of patients' multiple experiences of depression as they are presented to clinicians during clinical interviews. Most importantly, these methods have enabled me to explore depression as it is experienced by the patients. The multiple meanings of depression that emerge from patients' narratives will allow me to explore differences and similarities in meanings of depression experiences. This paradigm has encouraged me to reflect on and acknowledge the impact that I as the researcher had on this study throughout the research process.

Qualitative research has often been criticized as lacking the validity and reliability of quantitative research measures (Delamont, & Atkinson, 2004; Silverman, 2001, 2003). While validity and reliability are important aspects of all research, they are approached differently in the qualitative paradigm. The issue of validity in qualitative research has also been called the problem of anecdotalism and qualitative researchers have been criticized for using small segments of the data to provide evidence for their statements (Hardy & Bryman, 2004; Silverman, 2003). Validity can be obtained through a number of techniques. The researcher can use more than one example to demonstrate phenomena observed in the data. They can also actively seek out and analyze deviant cases (deviant case analysis), ensure that statements and generalizations are able to apply to all relevant data collected (comprehensive data treatment) and maintain continuous reflexivity (Delamont, & Atkinson, 2004; Hayes, 2000; Silverman, 2001; 2003). Lincoln and Guba (1985, in Golafshani, 2003) and Patton (2001, in Golafshani, 2003) hold the position that the validity of a study is sufficient grounds for assuming its reliability. This study used textual data recorded in hospital records, which is unfiltered through the researcher's notes, and is therefore more reliable (Silverman, 2001).

THE RESEARCH SETTING: A BACKGROUND OF VALKENBERG HOSPITAL

Valkenberg Hospital is a large, government-funded tertiary institution situated in Cape Town, South Africa. Together with its associated psychiatric hospitals, it is the chief provider of specialist psychiatric services to the Cape Peninsula and a major psychiatric referral centre for the Western Cape Province. The hospital was established in 1891 and initially provided psychiatric services to White patients only. It began admitting patients from other racial groups in 1916. Valkenberg Hospital currently services a wide catchment area that includes communities that are predominantly inhabited by different racial groups[2], such as Fishoek, Rondebosch (predominantly White middle class), Gugulethu (mostly Xhosa-speaking Africans) and Mannenberg (Coloured). Most of the staff, including clinicians and nurses, speaks English and/or Afrikaans and most

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[2] The racial categories include Black (or African), Coloured and White, and reflect those that have been used in precious studies in this setting (Msomi, 1997).

interventions are carried out in English. Where language barriers arise between patient and clinician during the clinical interview, nurses and/or family members are often used as interpreters.

THE RESEARCH DESIGN

Archival methods

Archival research methods are techniques of collecting data that do not require the direct participation of subjects, but instead involve the analysis of documents and textual material as sources of data (Marshall & Rossman, 1999; Ventresca & Mohr, 2002). In their classic sense, these methods were used in the investigation of historical texts and documents produced by, about and for organizations and institutions (Ventresca & Mohr, 2002). However, they are also used to investigate contemporary documents and to supplement other research strategies. This study used already captured data that also reflects organizational talk. Files belonging to institutions like hospitals also contain talk and social discourse that reflects institutional culture and practices (Riles, 2000, in Ventresca & Mohr, 2002).

The archival method has been a useful way of collecting data for this study because it is unobtrusive as the data has already been captured in hospital records (Marshall & Rossman, 1999). No patients or clinicians were directly involved in the study. There was also no research bias as both the patients and clinicians were not aware that this data would later be used for a study. The normal process of history taking was therefore not interfered with. The hospital format used to record patients' histories captures a lot of demographic and other information that was useful for this study. Furthermore, hospital files also capture important additional information about organizational practices adopted during the clinical interview and diagnosis process.

However, some risks to using this method were also identified. Information recorded in the files is influenced by organizational practices that determine how patients' narratives are represented (which is often in Maudsley format), as well as which information is captured. The researcher has little knowledge and control over the conditions under which the data is recorded. The use of translators during the clinical interview is not always noted, making it difficult to distinguish which narratives were translated. This has implication for analysis and interpretation as meanings can be vastly altered during the translation of emotional words (Swartz, 1998). Furthermore, it is not always clearly indicated when the narratives are the exact words used by patients and when they have been paraphrased by the clinicians. Therefore the data captured in files and analyzed for this study reflects patients' narratives as they have been understood and interpreted by the clinicians. There is also a risk that the information captured in the hospital files might be insufficient for the study (Hayes, 2000). However, while paucity in the recorded narratives may compromise the quality of the data, the inclusion or omission of certain information also reflects important organizational practices. Marshall and Rossman (1999) caution that the picture of the phenomena can get distorted when data obtained through unobtrusive measures are used in isolation or without proper reflection. Despite these shortcomings, the archival method was the easiest and most suitable way of capturing narratives of depression as they are presented on admission to hospital without influencing them, while also capturing important diagnostic practices as they happen naturally.

Data collection

Sampling procedure

A purposive sampling technique was used to collect 3 sets of 15 hospital files, each set comprising files from Black, White and Coloured[3] depressed patients (Babbie & Mouton, 2001). Only 1 file was obtained for patients of Asian descent, a group that formed part of the category referred to as Other in this study. 46 files made up the total sample for the data source. These racial categories are representative of most of the patients treated at Valkenberg Hospital. I looked for and selected the first 15 files from each of the race

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[3] These racial categories are based on terminology used in The Population Registration Act of 1950 (repealed). However, they are not absolute. Many people have changed their racial classification from one group to another and some groups, for example Coloured, include a wide variety of people (Afghan, Egyptian, Malaysian, Mozambiquian, and even Chinese) (Khalfani & Tuberi, 2001). Although controversial, these categories are still used in research as well as in the social and political sectors because the structured inequalities that resulted from their use continue to have notable social and psychological implications on the various race groups.

Data analysis

Thematic analysis

Thematic analysis is a poorly demarcated but widely used method of analysis in qualitative research (Braun & Clarke, 2006). According to Braun and Clarke (2006), it is the most basic and most fundamental of qualitative analytic methods, and provides the skills and techniques that are useful in conducting many other forms of qualitative analysis.

In my analysis I have also paid attention to the discourses used in the depression narratives. While, the main aim of analysis was to search for common themes in the data, I have also analyzed how some themes emerge within the language that is used in the social practice of both the patients and the clinicians (Braun & Clarke, 2006; Potter, 2004). Analysis, therefore, not only involved the search for patterns in themes across data sets, but also included the analysis and interpretation of how the language used in the narratives may have helped to create particular meanings (Braun & Clarke, 2006). This form of analysis helped unpick the ways in which various socio-cultural factors shaped the use of language and the meaning ascribed to depression (Braun & Clarke, 2006; Potter, 2004). The analysis of discourses was of particular use for this study because it helped clarify how depression is constructed through the words/talk used to describe and explain it, and how various understandings of depression eventually become institutionalized as "truth" that gain factual status (Durrheim, 1997).

Process of analysis

Although there is no universally agreed set of methodological procedures for applying thematic analysis, the steps outlined below are widely used and are an adaptation of guidelines suggested by Braun & Clarke (2006) for thematic analysis, as well as those recommended by Willig (2003) for analyzing discourse. While these steps have been presented as a set of distinct procedures, the analytic process was cyclical and certain steps were revisited.

The first step was to read and reread the data carefully without any attempts to analyze it (Braun & Clarke, 2006; Willig, 2001, 2003). This process started during data capturing and was an important first step as it allowed me to become familiar with the texts, to experience the effects of the different discourses in the texts and to become aware of what the text is doing (Braun & Clarke, 2006; Coyle, 2007; Willig, 2001, 2003).

The second step was to generate codes from the data by identifying and highlighting sections that were possible indicators of main themes related to the research focus (Braun & Clarke, 2006; Coyle, 2007; Willig, 2001, 2003). Relevant sections of the text were highlighted and copied into separate folders. Discourses that were related to the research focus, and which occurred frequently, were identified and coded. Related codes were collated and placed in the same folders (Braun & Clarke, 2006). This is a useful method of analyzing when examining a large data set. Codes were organized into related groups and placed in folders. Printed versions of the data were also coded by using different coloured highlighters to underline recurrent terms phrases and metaphors. This helped provide a visual representation of the patterns of themes and discourses across the data set (Parker, 1999; Terre Blanche & Durrheim, 1999).

The third step involved generating themes for analysis (Braun & Clarke, 2006). These emerged mainly from the coded data, and were draw from ideas that appeared most frequently across data sets (Braun & Clarke, 2006). Themes were also derived from segments of the data that captured important aspects of the research focus (Braun & Clarke, 2006), as well as from those that have emerged in other relevant studies.

The fourth step was to review all the collated extracts for each theme to ensure that they formed a coherent pattern (Braun & Clarke, 2006). After this I reviewed the whole data set again. This step is important because it ensures that the main themes identified reflect the meanings evident in the whole data set, and also helps pick up on any relevant codes that may have been missed (Braun & Clarke, 2006).

The sixth step was to identify the essence of each theme, to define what the themes were about and then to name them. This was done through identifying the main idea reflected by all the coded extracts that made up each theme, as well as through reflecting on how each theme related to the overall focus of the study (Braun & Clarke, 2006; Potter, 2004; Terre Blanche & Durrheim, 1999).

The seventh step was to analyze how the different words and phrases and descriptions making up the codes were used in different narratives, and what meaning they conveyed. These meanings were then related to other relevant literature as well as to various socio-cultural factors (Braun & Clarke, 2006).

REFLEXIVITY

According to the qualitative research paradigm the researcher does not maintain a neutral role but influences both the process and the findings of the research. Researchers are therefore encouraged to continuously reflect on the effects they have on the study as part of the research process (Denzin & Lincoln, 2000; Parker, 1999). Researchers determine the research focus, the context of the research, as well as the theoretical frame and methodology, factors which greatly influence research findings (Brewer, 1994). They are active in identifying issues of interest and how they interpret data is influenced by the understandings and practices they share with others, as well as their relationship to data and phenomena observed (Denzin & Lincoln, 2000; Parker, 1999).

My decision to focus on cultural and gender issues in depression have been influenced by my identity as a Black woman and training clinician who has worked in a Female Unit of a psychiatric hospital. I am interested in how women from different backgrounds experience depression. My interpretations of the data have been informed by the theory and methodology I have learned during my psychology training. My observations as well as what I report on have been affected by these interests. While the themes I have reported on have emerged from the data, I have found other observations more noteworthy than others, which have therefore not been reported.

ETHICAL CONSIDERATIONS

Ethical clearance was obtained from various research committees; the Humanities Faculty (UCT Department of Psychology), the UCT Department of Psychiatry and Mental Health, Faculty of Health Sciences, as well as the Associated Psychiatric Hospitals (APH). Permission to access hospital patient files was obtained from the Superintendent of Valkenberg Hospital.

Regarding patient confidentiality, no patients are directly involved in the study. Since only patient folders were used to obtain data a number of steps were taken to protect patients' anonymity. No identifying data that might reveal the identity of patients was collected. Each folder was assigned a number to ensure confidentiality and anonymity of patients, and all the results are reported anonymously.

CHAPTER 4

ANALYSIS AND DISCUSSION OF RESULTS

This chapter will discuss the findings of the study, which I have chosen to present together with the discussion, as done by other qualitative researchers (e.g. Strebel, 1993; Shabalala, 2004, Shefer, 1998). Overall, there were both similarities and differences in the presentation of depression across the different race groups. These findings both confirmed some trends in presentation and contradicted other trends found by researchers elsewhere.

Depression related to situational factors

Interpersonal problems as the cause of emotional distress

Interpersonal problems were, overall, the most common complaints and were reported by women from all race groups. In their narratives patients made links either implicitly or expressly between these problems and their depressive symptoms. For example, a patient with suicidal ideation:

> *"...explained that her problems started 2 years ago when she found out that her husband had an extra-marital affair and a 12 year old son." (Colored)*

Another patient:

> *"...explained that her mother committed suicide 10 years ago: 'I'll never forgive her!' The patient feels as if her mom took the easy way out...Things fell apart after that, she was never able to hold down a job steadily, severely depressed-attempted suicide." (White)*

For most patients across race groups these interpersonal problems seem to be accompanied by emotional experiences which include feelings of betrayal, rejection and disappointment. Another woman reported feeling *"unsupported and uncared for"* and explained that:

> *"...she first got depressed when her husband had an affair with the maid and had children with her. Her husband married the maid in 2000, and she still finds it difficult to accept this...[patient became tearful and cried]..." (Coloured)*

Another patient further reported that:

> *"...she found out that her husband had a baby with another woman after a one-night stand...She was unaware of this and only found out the night before the woman went into labour. She feels worthless, that it is her fault he had a child with another woman because she could not fall pregnant. They had been attending a reproduction failure clinic...She thinks that he did this because she was unable to fall pregnant naturally."(White)*

The above patient seems to have assumed the blame for her marital problems, and saw her inability to conceive as a failure to fulfill her role of being a mother. As a result it seems that she then saw her inability to give her husband children as failure to fulfill her role as a wife. This may have resulted in her belief that she is *"worthless"*, and that her husband's infidelity was justified. Other narratives also confirmed that partners' infidelity was a major contributor to patients' experience of a negative self image. One patient, reported feeling *"worthless and guilty"* and stated that the infidelity was *"...her fault" (Coloured)*

Other patients seemed to experience their partner's infidelities as a breach of trust, and seemed to feel a deep sense of abandonment. A Black patient, who was admitted after 3 weeks of suicidal thoughts stated that *"...my boyfriend let me down"*. In another patient's file it was explained that:

> *"...her depression started 2 years ago when she found out that her husband had an extra-marital affair and a 12 year old son. They had been married for 21 years and have 2 children. This news came as a shock as she had assumed fidelity in the marriage. It was also the first time that her husband heard that he has a son. She says that she now finds it difficult to trust him and to accept...Since then she has been feeling depressed. She needed him to be there, but he wasn't."*

The breach of trust in the relationship resulted in the patient experiencing distress which she saw her husband as having been complicit in. Thus this patient was able to ascribe the blame elsewhere.

While the above quotes reflect distress resulting from intimate partner relationships, in other cases the symptoms were linked to conflict with family members, which seemed to precipitate depressive symptoms. One patient stated that:

> *"Her husband... is not the father of her son. In august her son was arrested after a robbery. She heard about it two days later...The patient's family was angry that she did not inform them. The patient took an OD of 46 tablets and ended up at C23." (Black)*

Another patient reported that:

> *"The current illness began when she experienced great disappointment with one of her sons. He has been the only one to matriculate and begin his tertiary studies. He had to stop studying because of financial constraints but he told her that he would work to get money to carry on studying. In April he was fired from his job for stealing and she has now lost hope for the future." (Coloured)*

Family conflicts were often triggered by other stressors, which placed a complex burden on women. The above patient reports having financial stress and linked her depressive experience (*"lost hope for the future"*) to the disappointment caused by her son when he lost his job. She experienced this level of disappointment because her hopes for her children's future were frustrated by the fact that her family was not supporting her efforts to improve their lives.

Almost all patients, across racial groups, saw their depressive experiences as resulting from multiple interpersonal problems that are experienced as psychological stressors. They viewed distress and depressive experiences as a feature of situations and relationships, rather than as purely internal, biological states. This view has previously been suggested to be prevalent among Western people (Lutz, 1985). The fact that there were no differences here across race groups, seems to contradict this idea, and may be an indication that Western culture in not homogenous. Kirmayer (2001) has also found that disturbances in mood and affect are, in many other cultures, not viewed as mental health problems but as social and moral ones.

These findings also contradict those reported by Karasz (2005) who suggests that situational and relational conceptions of depression are more prevalent among patients from non-Western cultures. The view that depressive symptoms are reactions to pathogenic situational stressors rather than as symptoms of a medical disorder was the most prominent presentation in patients' narratives. Patients associated stressful life events with the resultant distress and depressive experiences. This confirms similar associations between significant life events and the onset of depression made both in developing societies (Patel et al., 2001), and in more developed Western societies (Brown, Harris & Hepworth, 1995, in Patel et al., 2001). The current findings indicate that these associations are a major feature of how patients present with depression.

Despite the equality laws enshrined in the South African Constitution, many women are still severely disadvantaged and experience gender, class, racial and economic discrimination (Kiguwa, 2004). Power relations and the position women occupy in interpersonal relationships also cause emotional distress (Beauboeuf-Lafontant, 2007; Ramphele & Boonzaier, 1988). The patients associated their depressive experiences with their partners' infidelity in ways which reflected their subjective experience of disempowerment within intimate relationships (Kiguwa, 2004; Stoppard, 2000). The experiences of rejection, hopelessness, and lack of control within relationships reported by the patients in this study, echoes Burr and Chapman's (2004) findings of similar complaints in a sample of South Asian women in the UK. However, the current findings differ from theirs in that these discourses were used by patients across race groups.

Taking on additional roles

The loss of significant others was also cited as a major source of distress by a number of patients across race groups, and a few of them were still struggling to cope with losses even a few years after they occurred. A few of the Black and Coloured patients further reported having to take on additional roles within the home as a result of loosing breadwinners, as shown below:

> *"I've been depressed since my mother died in 1997. I haven't got over it... don't know why...I'm now the breadwinner, it's my house and I have to live in the back yard... My family is the problem". (Black)*

> *"...she had been feeling sad since her father died 9 months ago. After her father's death her siblings and family started fighting over her father's estate and other family members began abusing his possessions. The patient also said she was sorry for her flaws. (Coloured)*

The distress experienced by patients after the loss of spouses and parents is, among Black and Coloured patients, further compounded by the need for them to take on additional roles, often in order to meet the family's financial needs. The burden of assuming further responsibility within the home also often resulted in interpersonal conflict among family members. Patients tended to take responsibility for these conflicts, which resulted in feelings of guilt and causing some patients to feel *sorry for [their] flaws.* Women have been socialized into accepting certain roles as intrinsically feminine, including that of nurturer (Beauboeuf-Lafontant, 2007; Kruger, 2002, in Kiguwa, 2004; Stoppard, 2000). Stoppard (2000) argues that women are also expected to take on the primary responsibility of caring for children and siblings, as well as other family members. While many women find satisfaction in their various domestic roles, when these are coupled with the stress of poverty, experiences of loss and interpersonal conflict, they become burdensome (Doyal 1995, in Stoppard, 2000) and often precipitate depression.

Beauboeuf-Lafontant (2007) argues that for Black women, acceptance within the family and community is dependent on the support and care that women show to others. They therefore feel obliged to not only take on roles of provider, but also those of caregiver. The pressure women may feel to be patient and long suffering increases their risk of becoming distressed, frustrated and confrontational, but may then cause them to experience guilt when they become involved in interpersonal conflict (Chesler, 1974, in Kaguwa, 2004; Beauboeuf-Lafontant, 2007).

Gender based violence

Most of the Black patients linked their current distress and other depressive symptoms to traumatic experiences that often occurred in situations where they had little or no control. The narratives here reflected severe emotional, sexual and physical abuse by intimate partners and other family members. In one file it was stated that the patient:

> *"...feels that her past experience of being raped by her step father between the ages of 4 – 5 is keeping her from making decisions and taking control of her life. She's been unable to talk about this, even when at Lentegeur. She complains of feeling down in the last few months."(Black)*

It was later reported that this patient had started ruminating over her past abuse after her boyfriend threatened to sexually abuse her daughters. For some patients the abuse had taken place a few years before their admission, but was still a source of great distress. In many cases patients presented the trauma, rather than the distress it caused, as the primary complaint. In some files it was reported that:

make them particularly vulnerable to a range of psychiatric disorders especially depression (Mackenzie, 1992, in Stacey, 1997; Subramaney, 2006). Stacey (1997) found gender based violence to be a major predisposing factor for a range of neurotic disorders including depression among women in psychiatric hospitals in the Western Cape.

In particular, Black women have certain vulnerabilities that result from what Howitt and Owusu-Bempah (1994, in Kiguwa, 2004) refer to as triple oppression deriving from disempowerment at the gender, race and class level. Rates of gender-related power inequality and violence have been found to be highest among this population (Kiguwa, 2004). While urbanization has encouraged some level of cultural hybridization (Bhugra & Mastrogianni, 2004; Swartz, 1998), there are still distinct cultural and racial differences in the lived experiences of woman in this country as in other settings (Falicov, 2003). Therefore, while depression is a socially and interpersonally embedded problem for women across different race groups, higher levels of violence, and other contextual experiences may result in a greater incidence and more severe experiences of psychiatric conditions such as depression among Black women.

Triggers for seeking help

Feeling unwell: Depression as a problem of emotion

Coloured and White patients tended to use words such as *feel that* and *feel like* far more than Black patients when describing their presenting problem. They linked experiences related to the loss of loved ones and problematic relationships to feelings which were often described as bad, rather than as depression:

> *"I've been feeling bad since my father died" (White)*

> *"Last night I felt bad seeing my husband getting dressed to go out with his girlfriend, and decided to end my life."(Coloured)*

For most of the Coloured and White patients the subjective experience of *feeling unwell* was a signal that something was wrong. A number of these patients recognized that they depression as an emotional problem, is similar to Karasz's (2005) and Kleinman's (2004) findings that the representation of depression as a feeling is observed predominantly in Westerners, but is not shared by persons from non-Western cultural groups. And while Coloured people are not considered to be Western, their use of emotional language could be due to the fact that they may be more exposed to Western culture than Black patients and their perspectives have been influenced by this exposure.

The tendency of Western individuals to focus on internal disturbances and to attribute depression to emotional problems has been found in different settings (Beiser, 1985; Falicov, 2003; Kirmayer, 2001). However, racial differences in the use of emotional language observed in this study suggest that the emotionality of depression is not a focal point in Black patients' narratives of depression, who, in contrast, emphasized the situational problems discussed above, as well as socially disruptive behaviours. While the open expression of emotional experiences is a widely accepted practice in Western cultures, many people from non-Western cultural backgrounds do not view emotional problems as legitimate or even appropriate issues to bring to health care practitioners (Falicov, 2003; Kirmayer, 2001).

Socially disruptive behaviour

Most of the Black patients reported behavioural problems as the main reasons for coming to the hospital. It was only when patients' behaviours were affecting others around them that they were viewed as problematic and abnormal. This seemed to prompt family members to take patients to hospital. The narratives seem to suggest that patients saw the behaviour as the problem. A young Black woman was brought to the hospital only when her *"behaviour became unmanageable at home"*. The records indicate that an aunt stated that:

> *"...she just sits in house talking to herself. She hears voices saying 'they are going to kill you'. She is refusing to eat food, has conversations with herself." She needs to be prompted to wash and change her clothes, and even to go to the bathroom. ..." (Black)*

In another file it was stated that:

> *"...she sees an old woman and a small child who pass derogatory comments, telling her 'you are mad, why don't you kill yourself.' She hears their footstep when she does not see them."*

When the patient referred to in the first quote was able to speak two weeks after admission, she explained that her boyfriend had '***hurt her***', but denied having a mental illness and requested to go home. Experiences of emotional distress, although present, were not sufficient triggers for seeking help among Black patients. Instead, Black patients seemed to only seek medical attention when the emotional distress started manifesting externally through extreme behaviours that indicate psychotic processes. It also seems that patients and their families tolerate these behavioural disturbances until they become socially disruptive and unmanageable, and start causing domestic and social disharmony. Only then are these presentations of depression viewed as abnormal and considered problematic enough to require medical help.

Socially disruptive behaviours were not reported as a prominent feature of depressive presentation among White or Coloured patients. However, the emphasis of socially disruptive behavior in the presentation of depression is not peculiar to South African Black patients but has also been found in other African counties, as well as elsewhere. In a sample from Uganda, Okello (2006) also found that it was only when others defined the patients' behaviours as socially disruptive that psychiatric help was sought for depression. Dominic et al. (2007) observed a similar trend in an Asian sample who reported symptoms such as irritability and bad temperedness as most distressing because they disrupted the social harmony within the home. This pattern therefore, seems to be a feature of depressive presentation in various non-Western groups.

While people from non-Western cultures around the world, including South Africa, have systems of vocabulary for emotions (Beiser, 1985; Swartz, 1998), Black women may be less likely to spontaneously use emotional language in describing their depression experience because they live in a context which views this as deviating from the image of a good strong woman (Beauboeuf-Lafontant, 2007; Kiguwa, 2004). As a result emotions are ignored until they manifest through behavioural symptoms. However, another explanation for these differences in presentation could be that patients may present to primary care physicians in ways that may result in misdiagnosis, and their depression may then go untreated. Schweitzer and Nazareth (2002, in Triant, 2002) reported that depression was detected in only 7.6 % of primary care consultations in Cape Town, a figure that does not correlate with the higher rates of depression that have been found (Ben-Arie et al., 1983; Triant, 2002). It therefore seems that while the DSM-IV-TR (APA, 2000, p. 353) states that 'cultures also may differ in judgments about the seriousness of experiences', it does not adequately emphasize the extent to which this occurs and does not highlight the importance of the implications.

Psychotic symptoms

The disruptive behavoiurs reported by Black patients were in access of those described in the DSM–IV (APA, 2000) as part of a depressive illness, and seem to suggest psychotic processes. In one folder it was merely stated that the patient:

> *"...presented with abnormal behaviour....walking around at night, with visual and auditory hallucinations..." (Black)*

One family also reported that the patient had been showing:

> *"...abnormal behaviour, she was not sleeping, walking around at night, talking to herself, was rude to her family." (Black)*

It was the abnormal behaviour that was the main complain, but when the patient was apsychotic and could be interviewed, she reported that she was *"worried about her children"*. On further probing she admitted to being HIV positive and reported that her husband had died of AIDS. She then became emotional and:

> *"...starts crying when saying this, she stomps her feet and says 'Nkosi Yami' [My God]. The patient has never before spoken about their sadness or illness"*

Although the subtypes of the depression diagnosed were not always indicated in the files, 8 Black patients were diagnosed with MDE with psychotic features, and only 3 Coloured patients and no White patients were indicated as having received this diagnosis. It could be hypothesized that the delay in help seeking among Black patients may eventually lead to a psychotic process. The findings also suggest that Black patients tend to present with a more severe form of depression compared with patients from other race groups. Another implication of this presentation picture is that depression among Black patients may be misdiagnosed as a psychotic illness, and the depression and its underlying psychosocial stressors may go unattended. Furthermore, in a psychotic state, patients are unable to coherently describe their illness experiences, forcing clinicians to rely on their own observations and the reports of others, when making a diagnosis. This might compromise the accuracy of diagnoses made. The problem of depression in the Black population group might therefore be far greater than currently estimated.

Pressing on: a problem of coping

The word cope was used most frequently in the narratives of Black patients, who tended to emphasize the need to cope with their various life stressors. The words "can't cope" were used by a few clinicians reporting what patients said and they would then go on to elaborate on the problems that patients were struggling to cope with. Some patients reported their difficulties in coping with life problems as their main presenting complaints. For some women it was reported that they went for help because:

> *"...she couldn't cope anymore and one of the women in the community suggested that I see a doctor.... she thought she was well...but then realized that for a long time she was someone who always kept things to herself... 'always pretended to be happy." (Black)*

> *"The patient says she can't cope with her life and with problems with her family..." (Black)*

While White and Coloured patients were aware of their emotional distress and saw it as a signal that they needed help, some Black patients convinced themselves that they were well and felt fine. In the first quote above it appears that the patient deceived herself about how she had been feeling, that she was aware of her feelings and forced herself to *"keep things to herself"* and *"[pretend] to be happy"*. It took her suicide attempt and admission to hospital for her to admit to being unwell.

The word cope was used most frequently by Black patients to describe their need to cope with adversity and their inability to cope was often the trigger for help seeking. The way in which the term cope was used reflects a pattern reported by Beauboeuf-Lafontant (2007) in which Black women saw this need to cope as integral to their identity as Black women. It seems that most Black patients pushed themselves to cope in contexts of severe interpersonal and traumatic stress. They therefore tended to use discourses of coping in their narratives to emphasize that their inability to cope was a greater problem that required attention more than their internal emotional states. It could also be argued that the inability to cope is seen as a problem because it creates even further distress. Beauboeuf-Lafontant (2007) argues that such discourses of coping reflect the notion of strength as a cultural mandate that gives Black women guidelines for their behaviour, interaction with others and responses to life. Notions of a good and desirable Black woman as one who is selfless and has deference for others (Beauboeuf-Lafontant, 2007) result in women adopting a role in which they disavow and negate their own emotional distress. They may therefore view the experience of emotional distress as a failure to conform to ideals of strength and present the failure to cope with various problems as the main complaint.

However, this explanation contradicts that put forward by Sastry and Ross (1998, in Marsella, 2003), who argue that persons from non-Western backgrounds do not experience depression resulting from a loss of personal control because their cultures cultivate practices of selfless giving to family from an early age. In particular, Black women have been socialized to focus on others rather than on themselves and referring to one's internal experiences is not common practice and may be perceived in a negative light. However, it is the expectations created by these practices that lead to women being overburdened and silenced from complaining.

The recorded narratives in this study suggest that although they do not frequently use emotional language to describe their depressive experiences, Black patients were aware of the emotional basis of their problems. They did not talk spontaneously about emotions because their socio-cultural context discouraged open and frequent use of emotional language which, according to Beauboeuf-Lafontant (2007), is often viewed by Black women as a sign of weakness. These women are then silenced and isolated from structures that can provide appropriate help and relief for them. These notions are further perpetuated by and may themselves perpetuate the construction of depression as a White illness, and promote myths that Black women do not get depressed (Beauboeuf-Lafontant, 2007).

The use of bio-medical language

Medical language was not used frequently by the patients and the terms used were restricted to words such as *depressed, sad, poor sleep*, which, while they described actual experiences, mainly reflected depression symptoms as defined in the DSM-IV. These terms were used mostly by White and Coloured patients. Only a few Black patients used this language. A middle aged woman who had previously been treated for depression at a general state hospital, described her current illness as being *"bad depression."* In a file of a young woman who was at a tertiary educational institution and lived in a predominantly White/integrated area, it was stated that:

> *"...she rang the psychologist after an argument with her partner...was overwhelmed with emotions and that caused her to be depressed. She was also angry at her partner and herself, and wants professional help. She was at [name]*

> *Clinic for 6 months. 1 week after her discharge she took an OD of tablets." (Black)*

While White and Coloured patients tended to name their experience as depression, they used the word depression or low mood to describe emotional experiences, rather than to describe a mental or psychiatric illness. It seems that most patients saw their depressive experience as an emotional experience related to situational problems, rather than as a as a bio-psychiatric or mental illness. This contradicts past findings in Western societies (Keyes, 1985), where depression was described as a biological or neurological problem (Karasz, 2005).

Most of the patients who described their illness using medical discourse in this study had had prior contact with psychiatric services. They therefore adopted the labels they had previously been exposed to in medical and psychiatric settings, and seem to have assimilated them into their vocabulary and their already established conceptual understandings of depression. One of only two Black patients who named their depression had previously been in therapy, where she is likely to have learned that her problem was depression. Conceptions of depression were therefore also strongly mediated by variables such as education, occupation, and area of residence. This seems to indicate that a biomedical understanding of depression is shaped within spaces and social contexts with a strong Western cultural influence (attending university, living in an "integrated area").

However, the majority of biomedical discourse found in the files was used by the clinicians who described patients' presenting complaints using terms which reflected the DSM-IV language. Some clinicians merely listed the depression symptoms that are described in the DSM-IV. In one file, a clinician stated that:

> *"On admission patient presented with a 6 month history of anhedonia, low energy, poor concentration, attention and memory, poor appetite, insomnia" (White)*

Other files contained statements such as:

> *"The patient gave a dysphoric account of why she is in hospital (Black)*

> *"Patient was crying a lot – low mood, sleeps about 4 hours a night – poor sleep, low energy, poor concentration, low libido, poor self-esteem, guilt."(Coloured)*

Even when patients used psychiatric labels for their depressive experiences, they still understood them as primarily emotional, situational and interpersonal problems. Therefore, not only were there differences in the perspectives of patients from different race groups, but there were also important differences in the understandings of depression held by patients and clinicians. Clinicians made sense of patients' reported subjective experiences and their mental states using their clinical judgment, which is influenced largely by the bio-medically based DSM-IV. They used psychiatric nosology to interpret and represent patients' presenting complaints as mental disorders in a similar way to that found by Bäärnhielm (2002) and Karasz (2005). Some patients' complaints were then worded to reflect the depressive symptoms or disorder that the clinician believed the patient was describing. Presented in this way, patients' problems can therefore be treated through bio-medical/psychiatric interventions. In some files clinicians merely listed the symptoms that qualified the patient for a diagnosis of depression without noting the full details of patients' presenting complaints.

The institutional setting within which the interviews were conducted also formed an important context that mediated the *"construction of depression"* through discourses. Institutional practices are therefore, a powerful social and cultural milieu that further mediates how people's understandings of illnesses are presented and represented. The implications are that the interaction between patient, clinician and the institution is "an intercultural encounter" (Kirmayer, 2001, p. 22), in which each party's understanding of illness must be considered. Current institutional practices, however, seem to still favor bio-medial perspective above those held by patients.

Although the language proficiency of clinicians was not specifically indicated in the files, most clinicians who conducted the interviews were English speaking, with only a few of them proficient in Xhosa or in Afrikaans as a second language. All the Black patients in the study and two thirds of the Coloured ones had indicated that they were not first language English speakers. The use of untrained translators may therefore disable the expression of particular discourses. The translation of emotional words from one language to another can be complicated and needs to be performed by trained professionals. For example, Swartz (1998) indicates that the Xhosa word of emotion can also be taken to mean kindness. Language barriers between clinicians and patients served to further limit the clear expression of non – psychiatric discourses of depression. Despite numerous recommendations for the provision of interpreters and the training of clinicians who are proficient in patients' home languages and knowledgeable about their culture (Bolton, 2002; Msomi, 1997; Swartz, 1998), English continues to be the main language of assessment and treatment, and may hinder effective communication and disadvantage non-English speaking patients.

In some cases patients were referred from other institutions with incorrect diagnoses which appeared to have been based on only the behavoural aspects of their presentations. In one file it was reported that the patient had been referred with a note which stated:

> *"...symptoms of 'Schizophrenia' have now been present for many years, becoming worse in 2004 after her 7 years old son was sodomized at a fair." (Coloured)*

The inverted comas may be an indication that this was a direct quotation from a statement made by someone, either by the previous treating clinician, the patient or her family. It could also indicate that the clinician questioned the accuracy of this diagnosis. However, the clinician was able to re-diagnose the patient with depression and she was successfully treated. This suggests that clinicians do not merely accept diagnoses given or suggested by others during the referral process, but scrutinize these for accuracy and base their own diagnoses on the information they receive and the observations they make during the clinical interview.

Somatic and other symptoms

Most of the patients also spontaneously volunteered various symptoms as bothersome subjective experiences and reasons for seeking help (e.g. disturbances in eating and sleeping, as well as suicidal thoughts/attempts). While the analysis of symptom distribution across different race groups was not the focus of this study, some interesting observations were made and warrant some comment.

A few patients reported a number of somatic complaints, mainly headaches, neck stiffness, dizziness and fatigue. Patients tended to use statements such as *"pain in my head"*, and described their head as feeling *"like it's going to explode"*. Somatic complaints were used as physical metaphors, and were linked to various social and interpersonal problems. One patient related her headaches to *"thinking a lot about her problems"*.

Only a small number of patients presented somatic complaints as their main problem, and there were no observed differences in this presentation across race groups. Patients used somatic complaints as metaphors which described physical experiences as the effects of social and interpersonal problems. The lack of racial differences in the use of somatic complaints confirms international findings that they are predominant both in Western and in non-Western settings similar to South Africa (Issac & Janca, 1996; Kleinman & Kleinman, 1985; Patel et al., 2001). Patients were also able to link these somatic complaints to underlying emotional distress (Kirmayer & Young, 1998).

However, Black and Coloured patients tended to use somatic complaints (such as pain in the head, dizziness and heaviness in the chest) as bodily idioms of distress to communicate emotional pain, as has been found in other research (Dominic et al., 2008). In one file it was stated:

> *"...she feels like she could not breath, she shakes and has a saw chest" (Coloured)*

> *"Patient presented at SCPD with heartburn. Sometimes she gets up in the morning with a headache. Depressive symptoms were then elicited." (Black)*

> *"She says she has been feeling 'not right' since the baby was born. Feels her head is not clear. 'It feels like it's going to explode'." (Coloured)*

These terms were not found in the narratives of White patients, thus confirming trends reported by Kleinman and Kleinman (1985) and Patel et al. (2001) that despite the cross-cultural use of somatic complaints, certain idioms are only used by non-Western patients to communicate depression.

Overall, *suicidal ideation/attempts* (31 patients), *poor sleep* (29 patients), and *loss of appetite* (18 patients), were found to be the most frequently reported symptoms. While no statistical analyses were performed, and important variables such as education, income, cognitive impairment and age were not controlled for, there were no notable differences found in the number of patients who complained of appetite disturbances across the race groups (Blacks = 5, Whites = 5, Coloured = 6, Other = 1). This trend in presentation differs from patterns that have been observed in the American samples where people from non-Western cultural backgrounds were much more likely to complain of problems with appetite compared to their Western-cultural counterparts (Blazer, Landerman, Hayes, Simonsick, & Daunders, 1998).

Other Observations

Depression and HIV/AIDS

A co-morbid HIV diagnosis was noted in 6 files of Black patients and was not indicated in patients of other race groups. This observation corresponds to findings that both HIV and depression are associated with social factors such as low socioeconomic status (Moore et al., 1999, in Olley, Seedat, Nei & Stein, 2004), which are most prevalent among Black women in this country (Kiguwa, 2004). MDD is a common psychiatric complication associated with HIV (Moosa et al., 2005; Olley et al., 2004). The relationship between depression and HIV is a complex and often cyclical one, and the diagnosis of depression in HIV-infected persons is often obscured by the presence of similar physical and somatic symptoms, which may lead to depression going undiagnosed in some patients (Moosa et al., 2005). It is therefore imperative that HIV-infected patients who complain of fatigue, low libido, insomnia and other somatic symptoms also be screened for depression (Moosa et al., 2005).

Recognition of psychosocial stressors

Some clinicians seemed to recognize the importance of psychosocial stressors during the clinical interview and documented them in separate sections in the files. This may be an indication that clinicians have begun adopting a bio-psychosocial approach to conceptualizing and treating depression (Falicov, 2003).

While many patients across all racial groups who cited psychosocial stressors in their presenting problems were referred for psychotherapeutic interventions, these interventions were given far less frequently than medication. The fact that patients are being referred suggests that the impact that psychosocial factors have on depression is being recognized. This practice differs from that reported by Triant (2002), who found that clinicians at a primary care clinic in Cape Town focused on responding to somatic symptoms at the expense of psychological ones. This may be an indication that clinical practice has improved in this regard over the years. However, the recognition of the importance of psychosocial factors observed in this study may also be a factor of these clinicians' access to resources such as academic information and the support of multidisciplinary teams, which are available at tertiary level institutions but are still scarce at many primary care clinics.

It was further observed that fewer Black patients received a psychotherapeutic intervention when compared to their White or Coloured counterparts, despite the fact that a large number of the Black patients had reported serious psychological trauma as precipitants for their depression. A number of reasons could be postulated for these trends within the hospital, including the fact that many of the Black patients were psychotic when they were admitted to the hospital. This would certainly limit their capacity to engage in any meaningful psychotherapeutic process However, even after the psychosis had resolved these patients did not receive therapeutic intervention. Systemic factors such as bed pressure and the quick turnover of patients within the particular therapeutic unit they were admitted to, language barriers, as well as the limited numbers of psychologists in the unit, may all be contributing factors.

Furthermore, the hypothesized consequence of Black women's need to be strong is that their denial of the role of emotional experiences in depression may challenge traditional psychotherapy models that require patients to reflect on their feelings. Encouraging these women to recognize and talk about emotional experiences would be a powerful healing process. However, enabling them to do so will require that we recognize and learn more about the role that the ideas of self-negation and the need to be strong play in mediating depression in South African women.

In one case a Black patient received and benefited from psychotherapy. In her discharge summary it was stated that she:

> *"...has attended all groups and has benefited particularly from individual therapy which has given her a chance to explore some of her feelings surrounding the losses in her life. Highly motivated, shows initiative." (Black)*

However, this patient had recognized that she needed help and was encouraged to come to the hospital. Her proactive response to depression suggests that she may have been less affected by the need to appear strong, and may have been better able to focus on her emotional experiences.

CHAPTER 5 – CONCLUSION

The current study sought to explore the presentation of depression in female patients from 4 different racial groups at Valkenberg Hospital. It employed an archival method to collect data from patients' presenting complaints recorded during history taking interviews. 46 files of patients diagnosed with depression were used. The depression narratives were then analyzed using a form of thematic analysis which also included an examination of how the language in the narratives helped convey particular understandings of depression.

Summary of findings

Patients seemed to use multiple explanatory models to understand depression, and there were notable similarities as well as important differences in the clinical presentation of depression in women from different race groups at Valkenberg Hospital. The findings revealed that across the race groups, patients seemed to share an understanding of depressive experiences as occurring in and/or resulting from various psychosocial factors rather than from biological ones. Most women linked their distress to problems with partners and other family challenges. However, White and Coloured patients made a more explicit link between their presenting complaint and their emotional distress. They seemed to understand depression as an emotional problem and were prompted by internal experiences of distress to seek medical help.

Although Black patients made implicit links between emotional difficulties and presenting problem, they did not highlight emotional experiences in their presenting complaints. They often did not seek professional help for emotional distress but seemed to silently endure it until it manifested in socially disruptive behaviour. They tended to present the failure to cope with various psychosocial stressors as the primary complaint and some seemed to even deny internal experiences of severe distress. It was often when depression was severe enough to precipitate psychotic symptoms that Black patients sought medical help for it. There was also a high incidence of traumatic gender based violence and co-morbid HIV infection reported in the narratives of Black patients which were directly linked to depressive experiences. While there were no notable differences in frequency of somatic complaints reported by patients across race groups, Coloured and Black patients tended to use similar idioms and linked somatic distress to psychosocial problems.

The issue of language presents further problems in the re-presentation of patients' narratives in biomedical terms within the medical setting. Patients, mostly White and Coloured, tended to use biomedical/psychiatric words to name their experiences. These words were often adopted after previous contact with psychiatric services. Institutional practices seem to impose bio-medical discourse and this encouraged an understanding of depression as a psychiatric illness. Clinicians used psychiatric terms to rephrase and represent patients' presenting complaints according to DSM-IV-TR, and therefore co-constructed patients' depressive experiences. The use of English as the main language of assessment and treatment as well as the absence of trained interpreters creates language barriers between the patient and clinician which make the expression and recognition of other cultural understandings of depression more difficult.

Therefore multiple cultural factors helped shape the conceptual models and representations of depression, and a number of interconnected discourses were used by various patients and by clinicians to describe depressive experiences. The comparisons I have made between the findings of this study and other research are tentative because the racial groups examined in this study are not the same as those compared in other literature and, as discussed earlier, the concepts of Western and non-Western culture are not clearly defined. Understanding how culture shapes depressive experiences in this country is further complicated by the fact that the increased interaction between various cultural, racial and linguistic groups in this country also encourages the shared cultural meanings which are modified in response to changes in people's external circumstances (Marsella, 2003). Patients' shared understandings of depression in the current study suggest that meanings of certain aspects of depressive experiences may also be influenced by a South African culture, which is neither purely Western nor non-Western.

Implications of the findings

There was consensus across racial groups that depression experiences were embedded in psychosocial experiences. Clinicians need to pay attention to the details of these experiences during history taking interviews, in order to get a fuller understanding of the illness experiences of patients.

Culturally mediated practices such as denial of emotions and gender based violence are particular socio-cultural problems which confound the presentation of depression in Black women. These factors account for the differences in depression presentation between Black, White and Coloured patients and seem to contribute to delays in diagnosis, and may even lead to misdiagnosis. The findings suggest that many Black women may be suffering from depression but delay in seeking help. Many women recognize that they are struggling but force themselves to cope. While it may be that many women are being treated successfully at primary care level, these help seeking trends may contribute to depression going unrecognized and untreated, or being misdiagnosed. Community based interventions that would facilitate open public dialogue that would help to de-stigmatize and recognize depression, as well as when and where to seek help.

Language barriers between clinicians and patients still persist. The lack of trained interpreters affects adequate communication of illness experience and may lead to inappropriate diagnosis. Clinicians need to be aware of the various psychosocial factors in which patients' depressive experiences are embedded, which would better guide appropriate treatment interventions. In addition, current discrepancies between patients' and clinicians' understandings may affect the alliance and collaboration necessary for an effective therapeutic relationship. There is still a great need for mental health teams that are proficient in the language of patients being serviced and who are aware of socio-cultural factors that impact on illness processes.

The imperative to provide mental health services which are accessible to persons from all cultural groups means that services providers must possess some cultural competence and sensitivity at both the assessment and intervention levels. Clinicians and physicians, particularly at primary care level, need to be more aware of these and to become acquainted with patients' expressions of and meanings associated with different illness experiences (Bäärnhielm, 2002).

Limitations of the current study

This study used data from clinical notes written by clinicians after history taking interviews with patients. Clinicians apply bio-medically informed knowledge and judgment when assessing and diagnosing patients, and inevitably interpret and record the narratives of patients using biomedical language. Apart from direct quotations, it was often not clear whether the words stated in the files were those spoken by the patient, a translator or the clinician. The data therefore did not just reflect patients' understandings and explanations of depression, but also reflected these as they had been interpreted by the clinicians. While these factors pose methodological limitations, they also expose the process through which depression is presented, interpreted and re-presented during the clinical encounter. The study also used data from people who had already met the DSM-IV criteria for depression. It was therefore only the narratives of patients who presented in a way that fitted the DSM-IV perspective of depression which were explored.

Recommendations for further research

There is need for a study that will draw from a non-clinical sample to explore how people from different racial and cultural groups understand and respond to emotional distress and depressive experiences, as well as to investigate the presentation of depression in people who have not yet been diagnosed with depression. This may provide more insights into reasons for delays in seeking help and the possible alternative remedies that may be used currently by people who do not find their way into formal clinical settings. While there has been much international work done on the relationship between gender roles and depression, there is a need for more South African research that will explore the complex relationship between women's conceptions of womanhood, their lived experiences of and attitudes towards gender roles, and psychiatric illness. Furthermore, it seems that for cross-cultural research to be meaningful and useful in this country, we need to re-examine how people define their racial and cultural identity.

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APPENDIX A

Data Capturing Form

(03/2008)

Date of Birth:

Date of Admission:

Age on admission:

Race:

Language:

Occupation:

Residence:

Marital status:

Diagnosis: **Axis I**
Axis II
Axis III
Axis IV
Axis V

Presenting complaint:

Findings and management (as on discharge summary):

Treatment (as on discharge summary):

Future plans (as on discharge summary):

APPENDIX B

TRANSCRIPTION CONVETIONS

… = text has been left out

[name] = manes of institutions or clinics that have been removed