AN EXPLORATION OF INDIAN MUSLIM WOMEN'S CONSTRUCTIONS OF DEPRESSION

By

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DECLARATION

I, **Safia Yusuf Dockrat (16305770)**, declare that this mini-dissertation **(*An exploration of Indian Muslim women's constructions of depression*)** is my own work except where I used or quoted another source, which has been acknowledged and referenced. I further declare that the work that I am submitting has not previously been submitted before for another degree or to any other university or tertiary institution for examination.

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ON THE 23RD DAY OF MARCH 2021

ETHICS STATEMENT

I, **Safia Yusuf Dockrat (16305770)**, have obtained the applicable research ethics approval for the research titled ***Indian Muslim women's constructions of depression*** on the 1st March 2017 (reference number: GW20161116HS) from Prof Maxi Schoeman, the Deputy Dean of Postgraduate Studies and Ethics, in the Faculty of Humanities at the University of Pretoria[1].

[1] A copy of the original letter has been attached as an appendix, on page 102, for reference.

ABSTRACT

Depression is a serious mental health condition which affects millions of people around the world. The biomedical model of illness categorises depression as a clinical disorder and primarily physiological in origin. However, conceptions of mental health such as depression may vary contextually because they are shaped by cultural understandings of illness. Research is encouraged to further investigate the context and culture of those affected, in an effort to better respond to local realities and psychologies.

A qualitative research approach was utilised in this study, with social constructionism as its paradigmatic point of departure. One in-depth semi-structured interview was conducted with five South African Indian Muslim women from the greater Johannesburg area. Thematic analysis was used to interpret the interviews. Four main themes surfaced; *what depression is and is not, causes of depression, treatment and stigma*. Each main theme included various sub-themes. In addition, *culture* and *gender* arose from the analysis, as influential constructs across these themes. These themes highlighted the complexity and importance of culture and gender on the constructions of depression, for these women. These findings encourage the inclusion for cultural sensitivity in treating Indian Muslim women, and responding to the broader community's needs. This can assist mental healthcare professionals to integrate culture and gender, as constructs, in offering more effective and appropriate treatment for lay understandings of depression, to respond to local realities. Furthermore, these findings add to a growing body of research which attempts to broaden and deepen understandings of mental health and culture, to better respond to patient's needs.

Keywords: Depression, South African Indian Muslim women, culture, gender, social constructionism, thematic analysis

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CHAPTER 1

INTRODUCTION TO THE STUDY

1.1 Introduction

This chapter presents an introduction to my research study. It begins with the background and motivation for the study. Thereafter, the aim and purpose of the study, as well as the research question and methodology, will be highlighted in this chapter. The final section presents a brief overview of the remaining chapters in this dissertation, before concluding.

1.2 Background and motivation for the study

Depression is a serious mental health condition that affects more than 264 million people worldwide, with more women affected than men (WHO, 2020). At its worst, depression can lead to suicide which is the second leading cause of death in 15-29 year olds (WHO, 2020). According to the World Health Organisation (2020), depression is a leading cause of disability across the world, and is considered a major contributor to overall global burden of disease. It's severity and continued impact globally necessitate continued research to inform deepened understanding and effective intervention thereof. The biomedical model of depression, utilised in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), understands depression as primarily physiological in origin (Pouchly, 2012). The DSM 5 (APA, 2013, p.155) includes a category of eight differing but similar disorders, grouped under the term "depressive disorders". The common features of all these disorders are "the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (APA, 2013, p. 155). The differences among the different classifications of depressive disorders concerns issues of duration, timing and/or aetiology. However, conceptions of mental health such as depression may vary contextually because they are shaped by cultural understandings of illness (Cinnirella & Lowenthal, 1999; Payne, 2009). Therefore, in order to understand depression within context, cultural factors ought to be explored.

Culture shapes the expression of psychological disorders and plays a role in the occurrence of culture-specific syndromes (Matsumoto & Juang, 2004). According to Kleinman (2004), the confrontation, management and discussion of depression varies among social worlds and what shapes this is practices and meanings embedded in culture. Culture influences the experience of symptoms, the languages used to report them, treatment decision, doctor–patient interactions, the likelihood of outcomes such as suicide, and the practices of professionals (Kleinman, 2004). As a result, some conditions are universal and some culturally distinct, "but all are meaningful within particular contexts" (Kleinman, 2004, p.951). This emphasis on the importance of culture in understanding mental illness is echoed in the DSM-5 (APA, 2013). The revised manual incorporates a greater cultural sensitivity throughout and includes questions about culture, race, ethnicity, religion and geographic location in the cultural formulation interview guide (APA, 2013). For these reasons, it is increasingly important that psychology responds to the issue of a historically predominant Western approach (Ratele et al., 2004) to mental illness by further exploring the experiences and perceptions of these illnesses amongst different cultures.

In line with an increased cultural sensitivity, the *Journal of Social and Political Psychology* began a special section on the theme of "Decolonising Psychological Science" in 2015. In breaking down the process of decolonising psychology, it is argued that part of this process requires an indigenisation approach. This refers to researches drawing upon local knowledge to modify 'standard practice' to produce psychologies that are more in line and responsive to local realities (Adams, Dobles, Gomez, Kurtis & Molina, 2015). Pillay (2017) concurs with this and further emphasizes the need to challenge the relevance of our research topics, methods, assumptions and analyses. Thus, it becomes apparent that in order to research and treat depression locally, the culture and context of the individual affected is essential to a comprehensive understanding and treatment thereof. Whilst this research does not intend to directly address the process of decolonising psychology, it does honour the objectives of indigenising forms of knowledge. More specifically, in relation to the local realities of the South African Indian Muslim community.

Within South Africa, the Indian Muslim Population is a well established community. The arrival of the first Indians in South Africa can be traced back to 1860. Between 1860 and 1911, thousands of Indians arrived as indentured labourers (Vahed, 2002). Today, the Indian community in South Africa represents one of the highest concentrations of Indian diasporas, outside of India (Seedat-Khan, 2013). The three religious groups that arrived in South Africa were Muslim, Hindu and Christian. The South African Indian Muslim community represents a unique culture comprised of both Hindu and Islamic influences. In India, the assimilation of cultural practices and beliefs of the Islamic and Hindu faiths resulted in a common Indian identity. Since South African Indian Muslims originated in India, this new common Indian identity and beliefs were inevitably passed down to this group (Ally, 2008). As a result, presently, there are many similarities between Hindu and Muslim beliefs and practices in South Africa. Hence the beliefs and ideas that are portrayed by the South African Indian Muslim population do not necessarily represent a solely Indian or Muslim perspective, rather, it is the culmination of both the Hindu and Islamic beliefs and practices that have been enmeshed over decades. This results in a unique South African Indian Muslim culture. Seedat-Khan (2013) explains that the shared difficulties that the original Indian indentured labourers suffered, brought them together in the spirit of community, family, religion and culture. The difficulties faced by Indians, is argued to be the reason that they sought to recreate their culture and religion in South Africa (Vahed, 2002). Not only does this emphasise the importance of culture in this community, but also explains the unique enmeshing of Muslim and Hindu practices, under the broader South African Indian Muslim culture.

In relation to deepening our understanding of depression, within a cultural context, research *has* been conducted amongst the South African Muslim Indian population (Ally & Laher, 2008; Bulbulia & Laher, 2013; Mohamed-Kaloo & Laher, 2014; Laher, 2014). However, little has been carried out in the South African Muslim Indian female population. In many cultures across the world, women have a lower social status than men (United Nations Development Programme, 2016) and this is argued to increase their vulnerability to mental health problems (Douki et al., 2007). Whilst diluted, the patriarchal history of Indian culture continues to influence gender relations amongst Indian men and women in South Africa (Seedat-Khan, 2013). Globally, depression has been shown to affect more women than men (WHO, 2020).

Laher, Bemath and Subjee (2018) conducted a study aimed to explore the understandings that South African Muslim females have of Major Depressive Disorder (MDD) with a focus on cultural and religious factors that may underlie these understandings. They argue that Muslim Indian women, in particular, appear to experience certain vulnerabilities and challenges in relation to depression due to certain cultural beliefs and practices in their communities. It is thus important to further explore understandings of depression among South African Indian Muslim women and their propensity for help-seeking behaviour. In so doing, these understandings can aid in developing culturally-appropriate and effective interventions and treatments (Laher et al., 2018).

From the background information provided, it is evident that culture plays a significant role in the understanding and treatment of depression. Within South Africa there is a pressing need for research to address the local realities of South Africans. The South African Indian Muslim population has a unique culture. Within the culture, women have a unique identity and experience. Further research is required to explore and understand the perceptions of depression amongst South African Indian Muslim women. It is in light of the lack of research within this population, that this study sought to explore the constructions of depression amongst South African Indian Muslim women. In the remainder of the chapter, I will further elaborate on the aims of the study as well as the research question. Thereafter, the necessity and value of the study as well as the methodological overview will be discussed in more detail.

1.3 Aims of the study and research question

The *aim* of the study is to explore how South African Indian Muslim women construct depression. The objective is to utilize social constructionism as theoretical lens in order to elucidate the intersections of gender, culture and depression for this specific population. Through this study the researcher wishes to contribute to localized knowledge of constructions of mental health in South Africa. I intend to explore Indian Muslim females' understandings and perceptions of depression, including its aetiology and treatment and the influence of culture and gender on these understandings and perceptions.

The following research question was formulated to guide the present research study:

“What would a qualitative study situated in social constructionism reveal about South African Indian Muslim women’s constructions of depression?”

1.4 Methodological overview

This study used a qualitative research method. Thematic analysis was used to explore the constructions of depression amongst five South African Indian Muslim women. Social constructionism was the theoretical lens from which, these constructions were understood. A non-probability, convenience sample strategy was used to recruit participants. Leaflets were placed at the local Indian Muslim doctor and local grocery store, in central Johannesburg, to invite women to be interviewed. After the first two participants had contacted me from the adverts, snow-ball sampling was then utilised in order to reach the remaining three participants. The five participants were between the ages of 22 and 50 years old. All of the participants self-identified as Indian Muslim women, residing in the greater Johannesburg area, within the Gauteng province. All the participants spoke English fluently. This facilitated the interview process, and allowed for the subtleties of language and discourse to be appreciated. The importance of language and discourse is central to the social constructionist paradigm. A single in-depth semi-structured interview was conducted with each female participant, in English. This interview allowed the participants the freedom to use their own language to express their opinions and use as much or as little detail as they liked to develop idea and reflect on their constructions. These interviews were transcribed verbatim and then analysed by employing thematic analysis. The themes identified were then discussed in detail, in Chapter 5; the findings and discussion chapter.

1.5 Necessity and value of this study

This research aims to explore the issue of culture in understandings of mental illness and specifically depression. The proposed study is justified first and foremost because of the lack of similar research conducted within this population group. Recently, Laher (2014) has argued that in South Africa there is a pressing need for healthcare practitioners to be sensitive to non-Western cultural meanings and expressions of mental illness in order to better understand and aid clients. It has also

become more evident that culture, gender and mental health intersect in a complex manner, and this is especially important in developing countries (Andermann, 2010). The South African Indian Muslim culture is unique and this suggests that research ought to be carried out specifically for this group. From psychology, there are few studies on the South African Muslim Indian population (Laher & Khan, 2011; Mohamed-Kaloo & Laher, 2014) and only one study was located, that explored similar constructs, amongst Indian Muslim women (Laher et al., 2018). Understanding how South African Muslim Indian women view depression is important because it may enhance our knowledge of the meaning depression may have in their specific culture. Practically, being a female researcher in such a conservative community, conducting interviews with women would be more comfortable and hence facilitative. In addition, the importance of including female participants is related to their position within the family and their community. Women in the Indian Muslim culture generally tend to be the care-takers and have different roles within their families: that of grandmother and wife. Thus, interviewing women can provide rich understandings of the particular constructions of depression that the individual woman has been exposed to as a result of her various familial and cultural roles. Seedat-Khan (2013) describes the multi-tiered construct of citizenship that Indian women possess, which can be applied to their membership across a variety of settings. These include the family, home, community, workplace, political and economic sectors. Furthermore, this research may offer understandings of the unique constructions of depression which she may then pass on to her children, for future generations. As mothers, spouses, friends and daughters they may provide us with a unique view of the discourses and meanings of depression in their culture.

1.6 Overview of remaining chapters

This study consists of five chapters, including this introductory chapter. Chapter two reviews relevant literature pertaining to depression and its definition, as well as culture, gender and stigma. Chapter three concerns methodology and includes the assumptions of the research, process of recruitment, data collection, method of analysis and ethical considerations. Chapter four includes the results and discussion of my findings. This chapter presents and discusses the findings of the study in the organised and identified themes. This is categorised using major themes and sub-

themes, and includes a discussion on how these findings substantiate, differ from, and contribute to the literature reviewed in chapter two. I conclude the study in chapter five. In this chapter, I reflect on the research process, literature review, methodology, and the findings. A reflexive evaluation of the study is then investigated, focusing on both self and methodological reflexivity. Thereafter, I conclude with an evaluation of the strengths and limitations of the study and provide recommendations for future research.

1.7 Conclusion

This chapter provided an introduction to my research study on South African Indian Muslim women's constructions of depression. The study was contextualised using background information and the motivation for the study. Other pertinent information regarding the study like its aim, purpose, research question, methodology used, and the necessity and value of the study were also addressed in this chapter. Lastly, an overview of the chapters that follow had also been laid out.

CHAPTER 2

LITERATURE REVIEW

2.1 Introduction

The literature review attempts to understand, more critically, the clinical definition of depression. It will consider the frameworks from which mental illness, and depression specifically, are conceptualised and operationalised. Alternative understandings and frameworks are considered to better account for cross-cultural diversity. Thereafter, the importance of culture in the understanding and construction of depression is argued. The South African Indian Muslim population is further explored, and the unique influences within this culture, are considered. Both the Islamic and the Indian influences on the constructions, aetiology and treatment of mental illness examined- with a focus on depression. Stigma, within the culture and with respect to gender dynamics, are explored. Finally, the issue of gender within the Indian culture is explored. More broadly, the gender gap in depression is considered. International research and development on these topics are referred to, with a particular interest in its applicability to South African Indian Muslim women.

2.2 Depression

Depression is a serious mental health condition that affects more than 264 million people worldwide, with more women affected than men (WHO, 2020). At its worst, depression can lead to suicide which is the second leading cause of death in 15-29 year olds (WHO, 2020).

It is important to recognize that depression is considered a mental illness by diagnostic nosologies such as the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the WHO's International Classification of Disease (ICD-11). On the other hand, lay understandings of its meaning and constructions may differ from this. To begin, let us the consider the clinical definition of depression, as put forth by the DSM-5.

The DSM-5 defines mental illness, including clinical depression, in terms of the existence of a clinically recognizable set of symptoms or behaviours associated with

interference with personal functioning (AP, 2013). This classification system identifies the following set of diagnostic symptoms for Major Depressive Disorder (MDD): the persistence of a depressed mood for at least two weeks, accompanied by sadness, irritability, anhedonia, difficulty concentrating, memory disturbance, lack of energy, changes in appetite and excessive sleep (APA, 2013). Five of the 9 symptoms must be present in the same two-week period, and must include at least one of depressed mood and loss of interest or pleasure, for the diagnosis of MDD to be met.

The DSM provides health care practitioners and other professionals with a shorthand way of communicating. In this way, professional jargon means that "depression" or "MDD" is understood as approximately the same thing. Hence it has allowed mental health care practitioners to easily and openly communicate about treatment plans and guidelines, research efforts and patient care (Thakker & Ward, 1998). However, this may also create the assumption that depression, and other mental disorders alike, are experienced and understood homogenously across varying cultures and people. Kress, Eriksen, Rayle and Ford (2005) offer critique about the cross-cultural applicability of the DSM, suggesting that it is modelled on the experiences of middle-class, white Americans. Despite this, it is used as a diagnostic tool cross culturally. Such a critique not only points to the importance of culture in understandings and treatment of mental illness, but it also highlights the importance of a critical understanding in the use and applicability of the DSM 5.[1]

2.2.1 Psychiatry and frameworks

Let us consider the framework from which we classify psychiatric conditions in the DSM-5. In addition to facilitating communication as discussed above, psychiatric classifications provide us with a means of conceiving of mental disorders and essentially assist in making diagnoses. If we were to look further into the best ways to conceive of mental disorders, we would find varying opinions and perspectives.

[1] The DSM (published by the American Psychiatric Association) and the ICD (International Classification of Diseases published by WHO) diagnostic systems are the most widely used. The criteria of MDD in both classification systems is very similar.

The conceptual approach used in the DSM and psychopathology employs the use of ideal types to conceive of various mental disorders. Ideal types are understood to be idealized descriptions of those aspects of concrete reality that interest us (Ratcliffe, 2015). They are descriptions that intend to draw clear boundaries in an attempt to define the ambiguous. Thus, in the case of the current edition of the DSM, these descriptions are listed as a set of clinically recognizable symptoms or behaviours. In the instance of clinical depression, the ideal type that is used in the DSM, is then understood as an attempt to best define an otherwise ambiguous experience of another. However, some have argued that a conceptual error exists within the approach of the DSM, founded by US Psychiatry (Kendler, 2016). That is, the ideal type that is used in the DSM to describe depression is taken for a natural type instead. A natural type is understood to have a single accurate description of what it is, regardless of the way in which one conceptualizes it (Zachar, 2000). It is thus argued by some scholars (Kendler, 2016; Jablensky, 2005) that US Psychiatry tends to reify mental disorders and DSM criteria. The DSM criteria is thus assumed not to be the index of depression, but depression itself. There is an assumption, through the use of such ideal types in the DSM, that the presentation and experience of depression is a global, and a largely homogenous concept which can be used to diagnose the disorder cross culturally.

There are undoubtedly alternative ways of conceiving of human realties (O'Reilly & Lester, 2017). A relativist position would suggest that there are as many categories to mental health as there are languages and cultures in which they are expressed (Draguns & Tanaka-Matsumi, 2003). When we apply an extreme relativist perspective to depression, for instance, it may imply that because of the variation in experience, influence of culture and language, we cannot talk of depression as a shared and similar reality. On the other hand, intermediate arguments explain that there exist common elements in the definition and understanding of mental illness, but that the cultural expression of syndromes may differ significantly, or that symptoms may group together in varying ways across different cultures (Draguns & Tanaka-Matsumi, 2003). Furthermore, the underlying assumption of the framing afforded through the classification systems is that 'disorders' are caused by biochemical or physiological concerns and thereby located within an individual (O'Reilly & Lester, 2017). Broader social and cultural factors are not considered as

relevant to an understanding of mental illness. If we consider these differing perspectives, then it stands to reason that, whilst the DSM-5 has attempted to classify depression as accurately as possible, this definition will have some variation depending on the individual who experiences it. Therefore, a continued effort to understand the complexity of such an experience ought to be pursued.

Both social constructionism and phenomenology are schools of thought which attempt to offer richer and broader understandings of psychiatric conditions than typically found in diagnostic nosologies. Social constructionism understands knowledge about the world to be a culturally shared agreement about reality (Ahmad & Harrison, 2007). This position allows for understandings of depression to be explored as a product of social, cultural, linguistic and religious world views which would also include and account for the influence of gender on this perception. Thus, there is an intersubjective and socially constructed understanding that is highlighted in this theoretical approach rather than that of a predominantly medical understanding assumed in the DSM 5. Indeed, social constructionism would consider the DSM understanding of depression as but one construct, one way of languaging about depression.

Phenomenology is another framework which offers a different perspective of mental illness, and depression more specifically. Wertz (2005) described phenomenology as allowing individuals experiencing a phenomenon to describe their experience exactly as it appears in their consciousness. Davidsen (2013, p.320) argues that, phenomenology attempts to “unite philosophy, science and lifeworld and attaches importance to rich contextualized descriptions, based on experience.” Whilst phenomenology is understood to be a dynamic philosophy with various nuanced approaches, it is said to agree on fundamental assumptions. This is defined as: a descriptive investigation of the phenomena, both objective and subjective, in their fullest breadth and depth (Davidsen, 2013). As a methodological approach, it is said to offer access to human subjective experiences from the perspective of those who experience it (Ofendu, Percy, Harris-Briitt & Bechler, 2013). Thus, if we are to approach the definition of depression using phenomenology, it would not predetermine an ideal type of depression as the DSM-5 does. Rather, it would look to understand the unique individual experience of depression (Ratcliffe, 2015). This

study does not focus on the experiences of those with depression, and thus, does not use phenomenology in its analysis. However, the value of it in broadening our understanding of how depression can be understood theoretically, is appreciated.

2.2.2 Cross-cultural variations

Across the world there is evidence of individuals experiencing patterns of behaviour which do not necessarily fit into or are explained by any of the Western diagnostic nosologies, however, are still considered "illnesses" in a specific population or cultural group (Ally & Laher, 2008). Thus, there appears a contrast between this medical model based and predominantly Western approach to understanding and categorizing mental illness and the perceptions and experiences of those from non-Western cultural backgrounds. Culture shapes the expression of psychological disorders and plays a role in the occurrence of culture-specific syndromes (Matsumoto & Juang, 2004). According to Kleinman (2004), the confrontation, management and discussion of depression varies among social worlds and what shapes this is practices and meanings embedded in culture. Culture influences the experience of symptoms, the languages used to report them, treatment decision, doctor–patient interactions, the likelihood of outcomes such as suicide, and the practices of professionals (Kleinman, 2004). As a result, some conditions are universal and some culturally distinct, "but all are meaningful within particular contexts" (Kleinman, 2004, p.951).

This emphasis on the importance of culture in understanding mental illness is echoed in the more recent editions of the DSM. The publication of the outline for cultural formulation (OCF) in the DSM-IV was considered a significant achievement for cultural psychiatry, acknowledging the relevance of culture in mainstream psychiatry (Lewis-Fernandez et al., 2014). The goal of the OCF was to assist clinicians in identifying cultural and contextual factors relevant to diagnosis and treatment. It was intended as a supplement to the multi-axial diagnostic system of the DSM-IV. After 20 years of experience with the OCF, it was revised for the DSM-5 (Lewis-Fernandez et al., 2014). This resulted in the development of semi-structured interviews in an attempt to operationalize the process of collecting information for the OCF. The revised manual is said to incorporate a greater cultural sensitivity

throughout and includes questions about culture, race, ethnicity, religion and geographic location in the cultural formulation interview guide (CFI) (APA, 2013). The CFI consists of a core of a 16-item questionnaire, a supplementary 12 modules for further assessment, as well as a means to obtain information from the caregiver. The DSM encourages the inclusion of cultural influences for the following reasons: to acquire clinical information, prevent misdiagnosis, improve clinical rapport and therapeutic efficacy and clarify cultural epidemiology (APA, 2013). Thus, the introduction of the CFI represents an acknowledgement of the broader psychosocial factors which have a significant impact on mental health care, our understanding and treatment thereof.

The above research and development indicate the increasing importance for psychology to respond to the issue of a historically predominant Western, homogenous approach (Ratele et al., 2004) to mental illness by further exploring the understandings, experiences and constructions of mental illnesses amongst different cultures. Similar research has been done amongst the South African Indian population (Ally & Laher, 2008; Bulbulia & Laher, 2013; Mohamed-Kaloo & Laher, 2014; Laher, 2014). Laher, Bemath and Subjee (2018) conducted a study to explore similar constructs within the same population group. This research intends to add to this small, but important body of work. The section above highlighted that there are different understandings of depression. Nosological systems such as the DSM and ICD offer a mostly medical-model based and Western perspective on mental illness but have included more acknowledgment of cultural considerations recently. These systems have utility in that they aid communication, diagnosis and research. Social constructionism considers mental illness itself and the different disorders as constructed in language, negotiated between people and always subject to change. On the other hand, phenomenology is interested in the subjective or personal experience of the individual and shares social constructionism's view of multiple lived realities or constructions being possible. Despite their differences, all three of these perspectives to varying degrees acknowledge the importance of culture in understanding mental illness. In the next section I thus explore the South African Indian Muslim culture.

2.3 The South African Indian Muslim culture

To further explore each aspect of an internal understanding of depression, we continue by considering how the specific South African Indian Muslim culture influences constructions of depression. The South African Indian Muslim culture is made up of both its Indian cultural aspect, as well as the Islamic religious aspect. Utz (2013) explains the diversity of the worldwide Muslim population who follow the Islamic faith, stating that there is a substantial amount of cultural variation within the Muslim population which is also expressed in treatment approaches and explanations of mental illness. Therefore, it is important to appreciate the specific dominant Indian Muslim culture within South Africa, in order to understand its unique cultural influence on understandings of depression.

Let us revisit the history of the South African Indian Muslim culture presented in chapter one. In India, the assimilation of cultural practices and beliefs of the Islamic and Hindu faiths resulted in a common Indian identity. Since South African Indian Muslims originated in India, this new common Indian identity and beliefs were inevitably passed down to this group (Ally, 2008). As a result, presently, there are many similarities between Hindu and Muslim beliefs and practices in South Africa. Hence the beliefs and ideas that are portrayed by the South African Indian Muslim population do not necessarily represent a solely Muslim perspective, rather, it is the culmination of both the Hindu and Islamic beliefs and practices that have been enmeshed over decades. This results in a unique South African Indian Muslim culture. Laher (2014) concurs with this understanding and concludes that there exist commonalities between the Hindu and Islamic understandings of health and illness, in South Africa. Going forward, the influence of both the Islamic religion as well as the Indian culture, will be explored.

2.3.1 Mental Illness in Islam

Mawdudi (1985) explains that Islam is the last of the great Semitic religions, with the laws of which were revealed to the Prophet Mohammed (Peace be upon him) over a period of 23 years. The major influences on a Muslim's life are the holy book of Islam, the Qu'ran, and the teachings and way of life of the Prophet Mohammed

(PBUH). Thus, the lives of Muslims are predominantly prescribed by these two sources of religious guidance.

Islamic medicine conceptualizes health as the maintenance of physical and spiritual health (Catherine et al., 2013). In the Islamic faith, understandings of illness can be traced back to the Qur'an itself. Four components are understood to work together to form the balanced self. According to Bulbulia and Laher (2013) these four interrelated components are; *ruh* (soul), *qalb* (connection between soul and body), the *aql* (mind/intellect) and the *nafs* (drives or desires) – all merging through the *dahmeer* (consciousness). Any imbalance between these four components results in physical, mental and/or spiritual illness. It is also believed that any illness endured is either a test from God or a blessing that results in being granted entry into paradise (Koening, 2005).

2.3.2 Aetiology of mental illness in Islam

According to Utz (2011) Islam recognizes the influence of biological, social and cognitive causes of depression, as cited by modern scientific theories of mental illness. However, the Islamic theory of mental illness emphasizes the concept of spiritual disease or death. This does not necessarily mean that those suffering from mental illnesses are morally deficient, but Utz (2011) explains that distance from God may increase the likelihood of such disorders. For example, it is understood that those struggling with their faith may find difficulty in finding explanations and meaning for their stressful life events and may be more easily affected by supernatural forces.

Supernatural forces are cited as possible causes for both mental and physical illness in Islam. This is divided into two components; *sihr* (witchcraft) and *nazr* (evil eye) (Ally & Laher, 2008). The Muslim belief in the existence of such forces is not only supported by cultural affiliations, but also by direct reference to its existence in the Qur'an (Abdussalam-Bali, 2004). Thus, this substantiation would likely influence Muslim's beliefs and perceptions about health and illness. Even within the life of the Prophet Mohammed (PBUH), it is narrated that he was a victim of witchcraft. Thus, the inference drawn from this is that if the Prophet could be affected, then so can any

individual (Ally & Laher, 2008). *Sihr*, as defined by Abdussalam-Bali (2004), is an act that brings one closer to the devil, by using the devil. It involves some type of incantation, either spoken or written, or some action that will affect the body, heart or mind of the bewitched without coming into contact with the individual affected (Utz, 2011). *Nazr* is understood as the process whereby the glance of another person is capable of causing harm to another, primarily due to envy (Utz, 2011). Symptoms of the evil eye include drowsiness, listlessness, lack of concentration, restlessness, discomfort, headaches and incessant crying and fretting among babies and young children (Abu-Rabia, 2005). The evil eye has also been understood to cause misfortune to business and other sources of income as well as other misfortunes such as car accidents.

Another commonly belief held by Muslims, is that spirit possession can be the cause of mental illness (Ally & Laher, 2008). In Islam, spirit possession is attributed to *jinn.* The word 'jinn' has Arabic roots and means hidden from sight (Ashour, 1993). *Jinn* are understood to be created from smokeless fire and exist in a realm parallel to our own (Ashour, 1993). Although not visible to the naked eye, *jinn* are understood to be able to have an influence on the lives of Muslims. The Qur'an refers to the evil *jinn* as the soldiers of the devil. A Muslim faith healer has described *jinn* as "the whisperers" of evil (Ally & Laher, 2008). Thus, they have the intent and ability to direct people towards evil. *Jinn* also have the ability to enter the human body, thus possessing the individual affected. However, jinn possession is understood as more often associated with epilepsy (Utz, 2011). Those who are considered as being possessed by *jinn* are largely diagnosed with schizophrenia or mania, amongst mental health care professionals. Delusions and hallucinations are often described as symptoms of possession (Ally & Laher, 2008). However, according to Utz (2011), depression has also been cited as a symptom of those possessed by *jinns*, amongst Muslim exorcists.

2.3.3 Treatment of mental illness in Islam

Islamic healers (Moulanas, Sheikhs and Qaris) are often instrumental in helping heal those with such spiritual illnesses. These religious healers often utilize natural

substances such as water, honey and salt to remove symptoms presented by the individual affected (Ally & Laher, 2008).

Ruqyah refers to Islamic methods of treatment in which various Qur'anic verses or supplications are recited in order to bring about a cure for the afflicted person (Utz, 2011). Treatment by these religious healers may include the use of *t'aaweez* (amulets with Qur'anic verses), water over which Qur'anic verses are read, or special prayers known as *dhikr* or *du'aa* are recited for the affected person (Bulbulia & Laher, 2013). For *ruqyah* to be most effective, it is important to first have an accurate diagnosis since the choice of verses/supplications read, depend upon the particular cause of the disease (Utz, 2011). For example, the cure for *sihr* (witchcraft) is different from that of *nazr* (evil eye). *Ruqyah* is thought to be used both as the exclusive choice of treatment for illness, or can be used in conjunction with medical treatments for biological causes (Utz, 2011). Patients of faith healers are also encouraged to engage in daily prayer and regular remembrance of God as a means of treatment (Ally & Laher, 2008). Utz (2011) further supports this idea, stating that the specific Islamic method of enhancing mental health includes prayer, supplication, reading Qur'aan, fasting, giving charity, pilgrimage and repentance. These acts of worship are considered the foundational pillars of Islam. The rejuvenation of one's connection to God through these acts of worship, is the goal of Islamic treatment for mental illness. Nearness to God is understood as the basis for the attainment of peace and serenity, and therefore, relief from the symptoms of mental illness (Utz, 2011). Prayer, in the Islamic faith, is thus considered the means to overcome illness and promote mental health and well-being.

International research highlights the importance of traditional and religious healers in individuals' health seeking behaviours (Ciftci et al., 2013). A study by Lee (2012) conducted in the Scotland, UK, highlighted the health seeking barriers within the black ethnic minority communities (BME) which included issues of religious beliefs around causes and treatment of mental illness. The BME community was made up of Pakistani, Indian and Chinese heritage communities living in Scotland. The study aimed to examine beliefs, stigma and the effectiveness of existing national mental health campaigns within the BME community. This study also found that participants from Muslim, Hindu and Sikh religious backgrounds understood mental illness

differently from Western conceptions of it being an illness. Rather, fate, black magic or “spirits” were understood as the cause of mental illness (Lee, 2012, p.293). Consequently, medication was not seen as a form of help for these individuals. Traditional treatments were reported as a common alternative to medical help seeking amongst this community. In South Africa, Ally and Laher (2008) found similar findings within the South African Muslim community. Beliefs about supernatural forces causing mental illness, resulted in individuals primarily consulting with Muslim traditional healers for help and healing.

2.4 Stigma

Across the vast literature on depression, related to culture and gender more specifically, is the significant impact of stigma. The impact of stigma is profound (Lee, 2012). Stigma negatively affects individuals with mental illness and their communities, creating injustices and sometimes devastating consequences (Ciftci, Jones & Corrigan, 2013). This impact can be seen from individuals living in constant fear and increased stress, to possible harassment and prejudice within the community, negatively impacting help-seeking behaviours, and even as far reaching as affecting job opportunities (Patel et al., 2010). According to Lee (2012) stigma can exist at several levels in society. Internalised/self-stigma relates to the person affected, public stigma which is experienced in everyday interactions with friends, family and the broader community, and lastly structural stigma (or institutional discrimination) whereby prejudice is adopted into broader legal systems, the media, cultural and business institutions.

Since this study focuses on the individual women within their cultural context, self-stigma and public stigma are of importance. Public stigma refers to the negative attitudes and discrimination that is held by members of the public towards those in society with devalued characteristics (Corrigan & Rao, 2012). Self-stigma occurs when people internalise these public attitudes and suffer numerous negative consequences as a result (Corrigan & Rao, 2012). In relation to this study, the public stigma refers to the prejudice and discrimination held by the broader Indian Muslim community, towards those with depression. Self-stigma is understood as the prejudice and discrimination that those affected by depression have internalised and

believe about themselves. According to Corrigan and Rao (2012), once a person internalizes negative stereotypes, this can result in negative emotional reactions. Low self- esteem and poor self-efficacy are key examples of these negative emotional reactions. Self-discrimination, particularly in the form of self-isolation, has many destructive effects leading to decreased health care service use, poor health outcomes, and poor quality of life (Corrigan & Rao, 2012). It is therefore imperative that the effects of stigma be considered and understood, to inform better understanding and treatment methods.

Though mental illness is stigmatized across societies, cultural variations in this stigma also exist (Abdullah & Brown, 2011). More specifically, members of Asian cultures typically express greater stigma as compared to those of Western cultural backgrounds (Cheon & Chiao, 2012). What follows, is a further discussion on these cultural influences and more specifically, family structures and gender roles within the Indian culture.

2.4.1 Cultural influences

In the South African Indian Muslim community, mental illness has been shown to be shameful for both the individual affected and the family of the individual. Mohamed-Kaloo and Laher (2014) conducted a study with 10 general medical doctors in the Lenasia area, which is situated in the South of Johannesburg and is a predominantly Indian area. The study revealed that patients suffering from mental illness tended to keep their illness a secret both from their families and the broader community. Similarly, a study conducted to understand perceptions of depression amongst South African Indian Muslim women, found that hiding depression was a common practice due to shame linked to depression, in the Indian culture (Laher et al., 2018). This finding is also prevalent in Indian communities abroad. Marrow and Luhrmann (2012) compared participants from India and the United States and found that Indian families with family members who displayed severe psychotic disorders were kept and hidden at home. This was due to Indian individuals' feelings of needing to honour family, issues of shame and moral responsibility and other cultural factors (Marrow & Luhrmann, 2012). Ciftci and colleagues (2013) conducted a review of existing literature across various Muslim populations globally, to assess mental

health stigma in the Muslim community. Similar results regarding shame were found. In addition, mental health was kept hidden from the community out of fear that community members would not be willing to marry into a family with mental illness. Furthermore, shame has been found to be a barrier to health seeking behaviours, in international research. Lee (2012) found that shame arose as a reason for avoiding health services amongst the BME (black and minority ethnic) community in Scotland, UK. Ciftci and colleagues (2013) note that even when individuals have positive attitudes to mental healing, social stigma remains a barrier. In addition, a recovery pessimism was also noted by researchers as a reason for individuals not to seek health services, whilst experiencing mental illness (Lee, 2012). This pessimism was more prevalent amongst older and first-generation immigrants of the BME population. This is useful to keep in mind regarding the South African Indian population and the effect of the individual's particular generation, on his/her constructions of depression and treatment thereof.

Kleinman (2004) highlights the issue of somatization found amongst depressed groups of various ethnic backgrounds. In many parts of Chinese society, the experience of depressive symptoms is physical rather than psychological (Kleinman, 2004). Many Chinese who are depressed report feelings of dizziness, fatigue, boredom, pain and inner pressure rather than feelings of sadness. Kleinman (2004, p.951) states that this may be due to the belief that the diagnosis of depression is morally unacceptable and "experientially meaningless". Although this concerns the Chinese rather than the Indian culture, Thakker and Ward (1998) found similar issues of expression of emotion considered undesirable in both Arab and Indian countries. Local studies have shown comparable findings regarding issues of somatization, reported by general medical practitioners about their Indian patients with mental health conditions (Mohamed-Kaloo & Laher, 2014). According to Laher and colleagues (2018), stigmatization and somaticisation are often linked in the Indian culture. This is attributed to the fact that physical illness is less stigmatized in the Indian community, and therefore, it is more acceptable for individuals to report somatic complaints rather than emotional ones (Roberts, Mann & Montgomery, 2016).

2.5 Family structures and gender roles in Indian culture

Existing literature suggests that family life plays a central role in the Indian culture, and is therefore important to consider in understandings of mental illness. A study was conducted in the United States concerning the gender, family and community correlates of mental health amongst South Asian Americans (Masood, Okazaki& Takeuchi, 2009). The large majority of the South Asian sample referred to was of Indian origin. South Asians are viewed as socialized to identify primarily with the needs of the family above those of the individual. This can have adverse effects for individuals when personal goals are discrepant with that of the familial ones (Masood et al., 2009). However, such strong family structures can also prove useful for an individual as the sense of closeness and support could contribute to positive mental health as part of a "collectivistic coping" strategy (Masood et al., 2009, p. 266). This "collectivist coping" can be of value both as a restorative and a preventative factor for those with or without a mental illness. Furthermore, Rao (2009) studied possible links between depression and feelings of guilt, amongst 42 people who were diagnosed as depressed in a general hospital in India. It was found that the average Indian felt strongly about his/her duties towards his/her children and obligations towards taking care of his/her parents. A lapse in the fulfilment of these obligations may lead to a mild degree of guilt, which was found to have some influence on one's mental state, although not significant. Nonetheless, this adds to the understanding of the importance that family life has in Indian culture, and its possible contributions to mental health as a result.

The issue of gender within these family structures is of great importance. In the Indian culture, the family structure is defined by gender roles and age. Conrad and Pacquai (2005) state that males and the elderly are considered of greater importance than women. The traditionally patriarchal Indian family structure results in women taking on a more submissive role that revolves around domestic tasks (Wassenaar, van de Veen & Pillay, 1998). More recently, some families have diverged from these traditional roles. However, Masood et al. (2009) found that mothers and daughters of South Asian origin, showed greater anxiety levels due to the lack of support of non-traditional values such as dating and female autonomy. Furthermore, this can lead to stress and conflict when negotiating between traditional

and modern beliefs and practices, which has been linked to depression in women from Indian and South Asian communities (Ekanayake, Ahmad, & McKenzie, 2012; Roberts et al., 2016). Similarly, in the United Kingdom, it is argued that rigidly defined roles in the Indian culture contribute to higher suicide rates in South Asian women living in the UK (Raleigh & Balarajan, 1992). Wassenaar et al. (1998) found that in South Africa, 66% of Indian female participants demonstrated suicidal behaviour. Suicide is associated with more serious levels of depression (WHO, 2015). Wassenaar et al. (1998) explored the relationship between suicidal behaviour, gender and culture and cultural transition between Indian culture and Westernisation. Participants suggested that the patriarchal nature of marriages lead to feelings of helplessness and lack of power. More recently, Haque (2010) found that women in traditional Indian families (which tend to be patriarchal in nature) may depend on male relatives for economic stability and may thus be more psychologically vulnerable to stressful life events that lead to the loss of such support.

In addition, Meer and Mir (2014) argue that biased interpretations of certain Islamic teachings may contribute to Muslim women experiencing mental health problems such as depression. Certain teachings regarding the position of women may be used to prevent women from obtaining an education and from seeking employment (Douki, Nacef & Halbreich., 2007). Thereby promoting dependence and vulnerability in women. Interpretations of Islamic teachings that reinforce male authoritative roles are emphasised, and little to no consideration is given to teachings that oppose and denounce mistreatment and oppression (Walpole et al., 2013). Cifcti and colleagues (2013) note that Muslim women may avoid sharing personal distress and seeking help from counsellors due to fear of negative consequences with respect to marital prospects or their current marriages. It is evident from these findings that public stigma has a nuanced impact on Indian Muslim women, when considering culture and gender as well.

From the above research, it is evident that both family structures as well as gender roles, have an important role to play in the understanding of mental illness in the South African Indian Muslim culture. The role of women in the Indian Muslim community can be argued to be traditionally, more subservient and less heard. Despite this positioning, women remain central to the functioning of households and

intimately linked to family and community structures and dynamics. As such, they occupy an insider position in their culture.

2.6 Gender and depression

One of the most consistent findings in the social epidemiology of mental health is the gender gap in depression (Van de Velde, Bracke & Levecque, 2010). Depression is approximately twice as prevalent amongst women compared to men (Essau, Lewinsohn, Seeley, & Sasagawa, 2010; Kessler, 2003; Van de Velde et al., 2010). This difference has been found throughout the world using a variety of diagnostic schemes and interview methods. According to Kessler (2003) the prevalence of major depression among women in these worldwide studies has typically ranged between one and a half to three times that of men. Generally, this gender gap has been attributed to more universal genetic, neurohormonal or psychobiological gender-linked antecedents of depression. However cross-national variation in the gender ratio of depression suggests that social conditions also have a strong association with depression (Van de Velde et al., 2010). Therefore, current research accepts that gender differences in depression are as a result of an interplay between biological, psychological and social factors (Hopcroft & Bradley, 2007).

2.6.1 Exploring the gender gap in depression

Different models have been developed to try and understand why depression is approximately twice as prevalent amongst women compared to men. The stress and vulnerability model is often used to predict the causes of depression. This describes the relationship between stressors the person is exposed to and the person's reaction to these stressors (Van de Velde et al., 2010). Gender-specific social risk factors are identified as one of the contributors to the gender gap in depression. Social roles have been identified as social risk factors. Theories on depression have addressed the gender pattern of social roles and social positions within varying areas of private and social life. Female roles seem more prone to role limitations associated with a lack of choice, role overload, competing social roles and a tendency for females to be undervalued (Piccinelli & Wilkinson, 2000). Therefore, female social positions are considered as characterized by powerlessness and lower

status levels. When studying these social roles, researchers tend to focus on the gender-specific demands that marriage, childcare and employment often make. These demands and role expectations show increasing variation because of structural and cultural changes that have taken place, especially in the last two decades (Van de Velde, 2010). For example, mothers who stay at home and are unemployed are increasingly less valued. Women continue to join the workforce in larger numbers and become economically independent, whilst sharing child care responsibilities with men. However, filling the role of homemaker and childcare provider continues to decrease the likelihood of paid employment for women, as well as additional responsibilities for those women who fulfil those roles and are employed (Piccinelli & Wilkinson, 2000). Piccinelli and Wilkinson (2000) make further mention of the higher risk of economic discrimination and job inequality that women who enter the job market face. Furthermore, when employed, women may face an increased risk of depression due to role overload and role conflict because of the combination of responsibilities associated with employment and household and care giving responsibilities. Stoppard (2000) includes the 'double-day' for women, in understanding structural factors that explain the gender gap in depression. Gender inequities in paid employment, emotional and physical abuse in relationships with men and other sources of adversity in women's lives (e.g. childhood sexual abuse, poverty associated with being a single parent) are all identified as further structural factors contributing to higher rates of depression in women (Stoppard, 2010). It is two decades after Piccinelli and Wilkinson's (2000) review and a decade after Stoppard's (2010) article was published, and one could argue that the sociocultural milieu has changed even more. Therefore, further research is required to investigate the current sociocultural factors which exist. This study aims to explore the socio-cultural factors which influence the construction of depression, amongst Indian Muslim women in South Africa.

Related research contributing to the social factors at play in the gender gap in depression focuses on stressful life events. Some theories show that the gender gap is due to a higher exposure of women to such events whilst others point to the gender differences in vulnerability as well (Van de Velde, 2010). Empirical findings regarding gendered patterns in depressive reactions to both marital disruption and employment problems has been mixed. However, a recurrent finding is that females

are more dependent on emotional support and on personal relationships in which emotional intimacy, trust and solidarity are exchanged, than men are (Rosenfield, Vertefuille, & McAlpine, 2000). In trying to make sense of this, Stoppard's (2010) conversation around symbolic gender is relevant. Stoppard (2010) stresses the importance of symbolic gender in a socio-cultural context. Symbolic gender is defined as the widely shared, but often implicit, set of beliefs about the nature of femininity and masculinity and what it means to be a woman or man. Cultural discourses of femininity, moreover, portray the 'good' woman as someone whose activities ideally are oriented around relationships and caring for others (especially family members) (Stoppard, 2000, 2010). If this is considered, then women are seen to be 'good' if they rely on and invest in their relationships, and thus, become more dependent on these relationships.

Other findings also show that women have been found to be the most important source of care responsibilities in their families. Bracke, Christiaens and Wauterickx (2008) explain this phenomenon using the socialization or internalization of personality differences theory. This suggests that women are socialized not only to take more care responsibilities, but also to expect less involvement in these responsibilities from male family members. Thus, women are more prone to bearing the "cost of caring" (Van de Velde et al., 2010, p.306). This means that they are more exposed to and more sensitive to interpersonal events, leading to increased levels of depression when interpersonal stress or loss occur. Although these explanations for the gender gap are useful, research has shown conflicting findings in the association of the risk ratio of depression with negative life events (Van de Veld et al., 2010). Thus, indicating further consideration is needed in explaining the gender gap in depression. Perhaps what is required to further explore this complexity is the complex interplay between culture and gender, and its effect on mental health and constructions thereof.

2.6.2 The gender-gap explained cross-nationally

In developed countries, the gender gap in depression and symptoms thereof, has been well documented (Hopcroft & Bradley, 2007). Comparatively, little research has investigated the gender gap in depression cross-culturally. Although this study

concerns the South African Indian Muslim female population, it is useful to consider related findings globally. Related global findings provide context for this study, as the participants in this study are from a minority group in a developing country. In the United States women are more likely to report depressive symptoms than men across age groups, with a peak in the difference noted in late middle age (Hopcroft & Bradley, 2007). Sociologists have suggested that this gender difference in depression in the U.S.A is largely due to unequal social and economic roles. Furthermore, they cite the gender difference in employment status, economic difficulties and child care problems as contributing to this phenomenon. Simon and Nath (2004) as well as an earlier study by Mirowsky (1996) found that male/female differentials in household income as well as social discrepancies significantly contribute to the depression gender gap. Hopcroft and Bradley (2007) deduce from this that the gender gap will therefore be most distinct in countries where social and economic discrepancies are most pronounced. In South Africa, social and economic discrepancies are pronounced. Considering Hopcroft and Bradley's findings (2007), the gender gap in depression would thus likely be more distinct in South Africa, Therefore, the need for further understanding of the gender gap in depression in South Africa becomes apparent. Furthermore, the social discrepancies noted in the South African Indian Muslim community mentioned above, may highlight a more distinct gender gap within *this* community specifically.

Another possible explanation for the gender discrepancy is explained using the theory of emotion cultures. Simon and Nath (2004) write about emotion cultures, which contain beliefs about gender and emotion. For example, U.S. emotion culture includes beliefs that women are more emotional and emotionally expressive than men are. In addition, emotion cultures contain beliefs around the frequency and distribution of affective experiences and behaviour for each gender (Simon & Nath, 2004). In the U.S. this is understood to be beliefs that women feel and express sadness more frequently than men. Conversely, men are thought to express and feel anger more frequently than women. This can be seen in everyday social life as well as in popular culture such as magazines, music, television and film. These avenues often portray and perpetuate gender stereotypical emotional expressions. Although this study concerns the American population, it can be argued that such an emotion

culture may be global, or at least in part observed in other cultures, including the South African Indian Muslim community.

To further understand the concept of emotion culture, two sociological theories about gender and emotion will be explored. First, Hochschild's normative theory and thereafter, Kemper's structural theory.

Hochschild's normative theory about emotion (1979, 2012) argues that cultural beliefs about emotion influence a person's feelings and expressions, based on culturally defined feeling and expression norms that dictate how one should feel and express these feelings, in specific instances. Feeling rules are cultural norms that dictate the nature, intensity, duration and target of subjective, internal experiences. Expression rules are cultural norms that regulate the nature, intensity, duration and target of affective displays (Simon & Nath, 2004). These feeling and expression rules then become the benchmark form which individuals judge their own and others' experiences and expression of emotions. Furthermore, Hochschild (2012) argues that when individuals differ from these feeling and expression rules, expression and/ or emotion management is employed in order to create a more socially acceptable and appropriate emotional response.

Considering this theory, it can be deduced that these cultural norms allow women to experience and report feeling sad more than men. Conversely, men are allowed to report and overtly experience anger more than women can. Thus, the gender gap in depression can be further understood as influenced by cultural norms around men and women's experience and expression of certain emotions, more specifically, sadness. If sadness is understood as a 'woman's emotion', then the likelihood of men being transparent about their own experience of this emotion, is significantly impacted. Rather, men are more likely to try and manage this 'woman's emotion' so that it can fit within the confines of cultural norms around gender and emotion. This highlights the need to take into consideration culture and gender when trying to understand the construction of mental illness within a people and the expression thereof.

Kemper's (1990) structural theory differs from Hochschild's (1979) in that it understands and predicts subjective feelings for men and women based on structural factors rather than cultural beliefs (Simon & Nath, 2004). According to Kemper (1990), structural factors such as a person's social position compared to others in society, influence his/her emotional responses to social situations. Status and power are argued to be the two fundamental structural dimensions of social relationships that significantly influence specific emotions during social interaction- when relational power and status are maintained or changed. He claims that the individual who holds the power and higher status in the relationship will experience positive emotions such as happiness and security. Whereas those with less power and status experience negative emotions such as fear, sadness and anger. If we are to link discussions previously mentioned around Muslim Indian women's positions within more patriarchal homes, we see the impact of this submissive, and likely, less powerful position they hold. In addition, the negative impact of such a status on these Indian women's subjective emotional experience, can be argued. Some developmental psychologists argue that the expression of emotion is more heavily socialized than the experience of emotion (Brody 1993; Kring and Gordon 1998). Thus, it may be that we all experience emotions similarly regardless of gender, however, our expression of these emotions differs.

2.7 Conclusion

The literature review discusses the ways in which depression, and mental illness, have been defined clinically. Through reviewing the DSM approach it becomes apparent that there is an error in the assumption that depression is an ideal type which can be summarized for all people, in one clear definition. Whilst this is useful for communication amongst clinical practitioners, there is definite variation in its presentation cross-culturally. This understanding has growing support in research. Phenomenology and social constructionism are two approaches which attempt to account for this variation and complexity. The South African Indian Muslim culture has a unique nature, with both Indian and Islamic influences. The Islamic perspective of mental illness was found to have differing understandings for the cause and treatment of mental illness, and depression specifically. Stigma was an important consideration in making sense of how culture influences understandings of mental

illness. Family and gender, were explored in depth in relation to the Indian Muslim culture. It is clear from the research, that socio-cultural context plays a significant role in understanding how individuals construct mental illness. Finally, the gender gap in depression was unpacked, using different theories to make sense of it. Social and economic factors as well as symbolic gender in society, and its structural implications, have all been found to be significant contributors to making sense of the gender gap. Both international and local research have been considered, and related to the South African Indian Muslim female population.

CHAPTER 3

PLAN OF INQUIRY

3.1 Introduction

Qualitative research is concerned with looking beyond the everyday, conventional ways of seeing social life, and finding novel ways to think about it (Esterberg, 2001). In adopting a qualitative approach, this research aimed to achieve these outcomes. This study aimed to explore the constructions of depression, amongst South African Indian women. The research is epistemologically positioned in the social constructionist paradigm. This Chapter is titled 'Plan of inquiry' as it explores these paradigmatic assumptions, recruitment and sampling of participants, data collection strategies as well as the process of data analysis, ensuring of quality within the research and finally, ethical considerations.

3.2 Paradigmatic Assumptions

Given the research topic and the need to explore personal and subjective perceptions of depression amongst Muslim Indian women, as well as the unique cultural influence on these perceptions, a qualitative research design is most suited to this study. Qualitative research, rather than quantitative research, is focused on understanding mental experiences and processes in more illustrative forms (Haslam & McGarty, 2007). It enables the researcher to interpret phenomena in terms of the meaning people bring to them (Greenhalgh & Taylor, 1997). Qualitative methods involve an exploration of the way in which different realities are constructed, accounting for the context of the participants, and acknowledging that there is value in varying perspectives (Haslam & McGarty, 2007). Thus, there is a rejection of the idea that a homogenous understanding of reality exists. Instead, it is understood that there are multiple, unique perceptions of reality created and used by individuals and communities. Qualitative research generally uses inductive reasoning. This means that instead of beginning with a particular theory and looking into the world for facts that support that theory, the researcher examines the social world, and in the process, develops a theory from what they are seeing and receiving (Esterberg,

2002). Qualitative research is thought to be especially suited to studying individuals within their cultural framework (Morrow, 2005).

Within qualitative research, there are different paradigms. Paradigms represent beliefs about the nature of reality and ways in which knowledge is created (Esterberg, 2002). These paradigms shape the methodological choices as well as the kind of relationship the researcher sees between the theory and the data. Three dominant paradigms are identified by Blanche and colleagues (2006). These paradigms are: positivism, interpretivism and social constructionism. The research aims will impact the paradigm used within the research. For example, research that is intended to examine objective facts will adopt a positivist paradigm, research that is focused on the meaning that individuals attach to facts will be located in the interpretative paradigm, and finally, research intended to understand reality as the product of one's social reality will be located in the social constructionist paradigm (Khotu, 2015).

The paradigm the research was situated in was social constructionism. As such it was epistemologically positioned in the social constructionist paradigm. Social constructionist inquiry is focused on explaining the processes by which individuals come to explain/describe or otherwise interpret the world in which they live (Gergen,1985). Social constructionism refers to the idea that the meaning of events and phenomena is created by people working together (McLeod, 2009). More specifically, that the history of understanding greatly influences understanding presently - and how, what McLeod (2009) refers to as, this "archaeology" of understanding is conveyed in the meaning of words. Social constructionism is particularly concerned with conversation and dialogue, because it is understood that in this interaction of speech and speakers that only certain constructions of reality are adopted. Social constructionists are said to focus on types of conversations that individuals hold with those in their lives, and the way in which the individual positions him/herself in relation to cultural discourses (McLeod, 2009). According to Burr (2004), social constructionism accepts one or more of the following assumptions:

1) an insistence on taking a *critical stance* toward taken-for-granted knowledge about ourselves and the world,

2) that there is no universal, all-encompassing way in which we understand the world, its categories and concepts, rather it is *culturally and historically specific*,
3) it is through *social interaction* that these subjective and varying understandings of the world are formed, and finally
4) these social interactions result in an *array of possible social constructions* of events, however in addition, each construction is then paired with a different kind of action from each individual.

In relation to this study specifically, social constructionism accounts for the assumption that the understanding and perception of depression amongst South African Indian Muslim females is specifically related to the cultural background of the individuals. Assumptions two and three can be related to this study as: the understanding that it is not merely the individual's isolated knowledge of depression that produces her perceptions, rather, it is her interactions with her social world and its history that shapes that knowledge and perception. Therefore, the emphasis of the unique South African Indian Muslim culture is paramount to understanding the individual's perceptions of depression. Choosing a qualitative approach specifically with explorative aims that enhances the appreciation of multiple culturally informed discourses and constructions are linked to assumption four, as well as assumption two. The aim to further understand experiences and understandings of mental illness from a non-Western perspective is specifically relevant to assumption one. In light of this theoretical positioning, specific attention was paid to language and those discourses that are available to and used by the participants.

In regard to these assumptions it is evident that social constructionism makes certain ontological assumptions. Ontologically, it subscribes to a relativist view of reality and truth. That is that there are multiple realities and truths rather a singular one. In terms of epistemology or its view of knowledge, it assumes that what we know or how we come to know it, is co-constructed by people and not discovered as objective facts (Burr, 2015). In accordance with the epistemological and ontological assumptions of social constructionism, this study makes no claim to present the findings of the research as a singular or objective reality and truth. Rather, the findings are understood as a result of a co-constructed reality, amongst many

realities. Myself, as researcher, joined the participants in conversation, that together co-constructed a reality. It is within this framework, that the findings of the research were explored. For this reason, reflexivity as a measure to ensure quality of the research, was of particular importance.

Considering that this is a very under-researched area, I chose not to use a phenomenological or narrative approach. Phenomenology is often considered to be central to the interpretive paradigm (Wojnar & Swanson, 2007). Phenomenology is principally concerned with how the everyday, intersubjective world of individuals is constituted (Schwandt, 2000). This approach would have focused on the exploration of participants' shared *experience* of a phenomenon. This would have been more appropriate if the research intended to explore Indian Muslim women's personal experiences of depression. Social constructionism sees the constitution of meaning as intrinsically linked to the social world, that the individual exists within. Thus, all individual constructions are inevitably influenced by a historical and socio-cultural dimension (Schwandt, 2000). This allows for this research to focus on the influence of culture, and gender within that. A narrative approach was not appropriate as the aim of a narrative approach would have been to explore the stories of an individual or a group of Indian Muslim women who are depressed, over a course of time. Narrative inquiry is found in people's stories of their experience (Webster & Mertova, 2007). However, since this is explorative research, asking lay people within the community allowed this study to contribute to knowledge about those discourses and constructions that are available, used, maintained and challenged, concerning a serious mental health concern within this specific population. This study can then inform studies that are concerned about the lived experiences, such as phenomenology and narrative studies.

3.3 Recruitment and sampling

A non-probability, convenience sample strategy was used and the aim was to have a sample size of approximately four Muslim women living in the greater Johannesburg area. Morrow (2005) argues that a sample size of three to five participants is sufficient for a rich set of data to work from. A smaller number of participants would also allow the researcher to interpret the data in more detail without being

overwhelmed by the quantity of data gathered (Pietkiewicz & Smith, 2012). A non-probability convenience sample means that the study includes participants that are readily available to one, as opposed to attempting to make the sample representative of the population (Stangor, 2011). The decision to recruit women from the greater Johannesburg area was thus based on convenience because I am familiar with this setting, and because a representative sample was not sought. Leaflets about the study were placed at a local Muslim Indian female doctor and at the local grocery store that is run by an Indian Muslim family. Both of these locations have a large Muslim Indian female clientele. After the first two participants had contacted me from the adverts, snow-ball sampling was then utilised in order to reach a greater number of potential participants (see section 3.4 below for detail). Snow-ball sampling refers to a sampling method whereby one or more participants are obtained, and this/these participants are used to lead the researcher to other population members (Stangor, 2011). This study sought to explore the constructions of depression from adult participants. Thus, broadly speaking, any woman from age 18-60 were considered for inclusion. In addition, all participants were English-speaking and self-identified as a woman from the Indian Muslim culture. The importance of language and discourse in this study, has been mentioned. Therefore, it was important that both participants and researcher conversed easily in English, in order to ensure that the subtleties of language were adequately understood and captured. All participants did not have any personal relationship with the researcher. Ultimately, five women were interviewed for this study between the ages of 22 and 50 years old.

3.4 Data collection strategies and process

Once ethics clearance was obtained from the Faculty of Humanities Ethics Committee (Appendix A), information leaflets (Appendix B) about the study were distributed at the local doctor and grocery store. One woman from the grocery store and one woman from the doctor, contacted me and were interested in participating in the study. I then again explained the purpose of the study and clarified any questions. I made arrangements with the two participants, to meet at a convenient time and place to conduct the interviews. A private facility within the recruitment area was available for use to conduct the interviews. On the day of the individual's

interview, the process was then explained fully again, and once consent was given, the interviews commenced. After these first two interviews were conducted, the participants were asked if they knew of any potential further participants (snowball sampling). The initial participants contacted the potential participants, and those women who agreed, were then put into contact with the researcher. I followed the same procedure (explaining purpose of the study, clarifying questions, obtaining consent) with the participants from the snowball sampling strategy, once they were contacted telephonically. All three of the potential participants identified through snowball sampling, agreed to being interviewed.

An interview guide was used to conduct the interview process (Appendix D). This guide was formulated based on the research question, the literature review and social constructionist theory. Areas that were investigated included culture, gender, and personal perceptions on depression. The semi-structured interview approach allowed me to explore the topic more openly and allowed the participants to use their own language to express their opinions. This style of interviewing participants is understood to be complementary to a constructionist paradigm and a useful way to study women and other marginalized groups (Esterberg, 2002). It is understood that the more in-depth interview style allows previously silenced groups, such as women, to finally tell their stories as they wish to (Esterberg, 2002; Reinharz & Dabidman, 1992). Interviews were audio recorded with a digital device and transcribed verbatim by me as soon as possible after the meeting with participants. Written and verbal consent was obtained for this as well, prior to the start of the interview. I made notes during the interviews, about the process of the interview as well as my personal reflections. These notes were referred to for reflexivity purposes, which is explored in further detail in chapter five.

3.5 Data Analysis

Thematic analysis is considered a foundational method for qualitative analysis (Braun & Clarke, 2006). It is defined as a method for identifying, analyzing and reporting patterns/themes within data. Willig and Rogers (2017) stress the need for thematic analysis to be paired with a theoretical approach, Braun and Clarke (2006) make mention of the use of thematic discourse analysis within a social

constructionist epistemology, which identifies patterns/themes within data and theorises language as constitutive of meaning and meaning as social. They emphasise that thematic analysis can be a "constructionist method which examines the way in which events, realities, meanings, experiences and so on are the effects of a range of discourses operating within society" (Braun & Clarke, 2006, p.81). This focus on language and discourse and its meaning within a broader social world, also holds for this study. Thus the use of thematic analysis as analytic method in conjunction with social constructionism as paradigm is complementary to the focus of this study. Furthermore, Braun and Clarke (2006) explain that thematic analysis employed within a constructionist framework, is not concerned with motivation or individual psychologies.

As recommended by Braun and Clarke (2006), transcribed interviews were then further analysed by identifying specific codes (smaller meaning units) which were combined into potential themes (larger meaning units). A coding framework was created to better structure the process of analysis. It included individual codes/smaller meaning units, grouped together under the relevant themes/larger meaning units (see appendix E), This allowed me to combine individual codes into themes, in a more visual and coherent manner. The coding framework also aided in ensuring that the analysis of the data was thorough and consistent. Codes could be tracked and added to, as I became more familiar with the data. I began with analyzing the first interview, but did not continue, and moved on to analyzing the interview with the richest data. This allowed me to grapple with the coding process better, and understand how the codes were combined into themes. Further definition of each theme was then explored and reported on. Additional reflections of my experience with each interview is explored in chapter five.

Willig and Rogers (2017) differentiate between inductive and deductively derived codes and themes. This research adopted an inductive approach. This means that there was no pre-existing coding framework or analytic preconceptions decided upon in advance (Braun and Clarke, 2006). The thematic analysis process was thus driven by the data. The six steps set out by Braun and Clarke (2006, p.87) were followed, in the process of analyzing the data. The steps are as follows:

1. I as researcher transcribed, read and re-read the data in order to become familiar with the data.
2. Generating initial codes: systematically coding initial features of interest across the entire data set.
3. Searching for themes: matching codes to potential themes and gathering all relevant data that relate to these themes.
4. Reviewing themes: Checking if the themes relate to specific coded extracts, and then within the data set in its entirety, in order to generate a "thematic map" of the analysis.
5. Defining and naming themes: generating clear names and definitions for each theme through ongoing analysis and refining of the specifics of each theme.
6. Producing the report: producing a scholarly report (i.e., this dissertation) of the analysis and including selected extracts that are vivid and compelling and enrich the analysis.

Alongside the steps for analysis, Braun and Clarke (2006) highlight the importance of the researcher as *active* in the research process. Themes are not assumed to simply emerge, but are reflective of the specific dynamic between the researcher and the data (Willig & Rogers, 2017). The inevitable role of the researcher in the research process is also highlighted by Esterberg (2001). Since researchers too are human, the research process itself can be seen as a social production. This means that the meaning of the research is negotiated between the researcher and the participants of the research. If we consider the social constructionist paradigm, then the process of interviewing the participants is a meaning-making process whereby the interaction of both researcher and participant influence the creation of knowledge. Knowledge is thus seen as dependent on and a product of the interaction between, the co-constructive dialogue between me and the participants. Thus, the researcher cannot be removed from the meaning making process because knowledge is not understood to be objective (Willig & Rogers, 2017; Yardley, 2000). This requires the researcher to be aware of his/her the role in the research. Esterberg (2001) comments on the impossibility of the researcher to truly capture the viewpoint of the participant. Instead, the researcher's findings are interpretations of what the

participant says. For this reason, a reflexivity journal was kept during the research process (see 5.3 for detail).

3.6 Quality

With the rise in qualitative methods in research, there has been a corresponding debate about the issue of quality in qualitative research and how to assess it (Mays & Pope, 2000). Yardley (2000) argues that the very pluralistic ethos and nature of qualitative research recognizes that our knowledge and experience of the world is uniquely shaped by our subjective and cultural perspective. This assumption simultaneously can be applied to the criteria by which its quality is assessed. For this reason, the criteria cannot be fixed. If it were, it would suggest that there is only one way to know and understand, rather than the broad framework which qualitative research assumes (Yardley, 2000).

Yardley (2000) offers some characteristics of good qualitative research. These criteria are thought to be flexible in their application, as opposed to more rigid, traditional criteria used to assess quantitative research. The criteria are as follows: sensitivity to context, commitment and rigour, transparency and coherence and impact and importance. Each criterion will be further explained as well as the manner in which this research incorporated the application of each.

The *sensitivity to context* criterion is made up of the three elements, namely: *context of theory, the socio-cultural context* and the *social context* between the researcher and the participant (Yardley, 2000). The *context of theory* refers to an awareness of the relevant research and empirical work which has been carried out prior. In this regard, I have discussed research studies and literature in chapter two. As such, it is a theoretical backdrop and understanding of what has been found and areas of interest and debate to be further explored. Various constructions and definitions of depression were explored, as well as the influence of religion, culture and gender upon these constructions. These explorations highlighted the influence of *socio-cultural* factors on an individual's construction of depression, and the need to further explore the nuances of such influences. This has the potential to expand our understanding of the construction of depression amongst varied groups and enhance

treatment strategies. The socio-cultural context is thus central to the topic of this study.

In considering the *social context* criteria between researcher and participant, Yardley (2000) highlights the importance of adequate grounding in the philosophy of the approach adopted. This grounding is understood to have a profound impact on the interpretation of the data. In the section 3.2 (p. 39) I have explored the social constructionist framework. This indicated that the role of the researcher could not be objective in the research process (Esterberg, 2001). Thus, I made use of a reflexivity journal. This journal was aimed to ensure increased transparency for the researcher and reader. Whilst I acknowledge that complete objectivity is not possible (Willig & Rogers, 2017) social constructionism emphasizes that the purpose of reflexivity is to be conscious of how my constructions as researcher, interplay with those of the participants'. In doing so, the aim was to honour the voice of the participant whilst acknowledging that I, as researcher, was not a neutral bystander in the interview process.

A reflexivity journal has also been shown to enhance the dependability of qualitative research (Houghton, Casey, Shaw & Murphy, 2013; Willig & Rogers, 2017). Reflexivity includes my experience of the research process as well as my influence on the process. My supervisor and I discussed themes and topics that arose from this journal and its impact on the research process. Particular discussion about this is explored in chapter five. The interview process was considered a social engagement within itself. Social constructionism emphasizes the importance of social experiences in meaning-making and linguistic significance. Morrow (2005) explains that the participant's constructions of meaning depends on many factors, including context, culture and rapport. Contextual grounding is understood to be of great significance to understanding the participants' meaning-making of their experiences. Thus, the social context of the interview was of significance to the data analysis. The identity of both researcher as well as participants was constantly kept in mind, in understanding the language and meaning that was conveyed in the interview process and the significance of the dynamic thereof. In the reflexivity journal, I kept in mind the different elements of the participants' identity, and the

unique dynamic that I experienced in the interview with each participant. This is further explored in chapter five.

Commitment is the next criterion used by Yardley (2000). Commitment is understood as prolonged engagement with the topic, the development of competence and skill as well as immersing oneself in the relevant data. Morrow (2005) describes immersion of the relevant data as relating to both the theory and literature as well as the data and analysis process. In accordance with these guidelines, I chose to transcribe the interviews myself in order to ensure that I was familiar with the data. This also allowed me the opportunity to add additional impressions. The process of analysis required multiple re-readings of the data. Morrow (2005) refers to the immersion of the researcher in the data, as an essential component of trustworthiness as a criteria for validity in qualitative research. Various theoretical sources were consulted to enhance my understanding and knowledge of the topic and literature. Constant consultation with my supervisor ensured that the level of analysis and reporting was of an adequate standard.

Rigour refers to the completeness of the data collection and analysis (Yardley, 2000). An adequate sample size is assumed here, to ensure that the relevant information can be obtained. A total of five participants were interviewed in this study. A sample size of four participants is considered adequate for a rich set of data used for qualitative research (Romney, Weller & Batchelder, 1986). Morrow (2005) mentions three to five interviews as understood to be a sufficient sample size. However, she adds that sample size in an interview-based study means little. Rather, the richness of the information from the individual interviews as well as the observational and analytical skills of the researcher, have greater significance (Morrow, 2005). In accordance with this, I was sensitive to new topics arising during the interviews, outside of the interview schedule, and explored these with the participants. *Rigour* was further ensured by employing effective analysis of the data. Thematic analysis was adopted for the analysis of the data, after consideration of its compatibility with the theoretical framework adopted for this study. The reporting of the analysis is intended to fully convey the richness and diversity it offered- including contradictions that inevitably arise. Any observations that were of significance were

included where relevant: either to the analysis of the themes or to the reflective analysis of the study.

Coherence is understood to describe the fit between the research question and the methodology adopted. The research questions and objectives were carefully phrased so as to ensure a logical connection between what the study intended to explore and how it proposed to go about doing so.

Achieving *transparency* is suggested by detailing every aspect of the process of data collection and the guidelines and rules adopted in the coding of the data (Yardley, 2000). This study consistently ensured methodological compatibility and a detailed account of the process of data collection and analysis. The use of a reflexivity journal in this study, further supports the notion of transparency. Yardley (2000) highlights the influence of one's own assumptions, intentions and actions upon the product of research- and the importance of reflecting upon and accounting for this influence in the reporting. Whilst complete transparency is impossible, I aimed to be open about. and report on, how the research was conducted and that there are limits to reporting on all decisions and interpretations.

Lastly the criterion of *impact and importance* is noted by Yardley (2000) in assessing the quality of qualitative research. This criterion refers to the influence and impact the research has on others- both in academia as well as for the community for whom the findings were considered significant. This study intended to contribute towards an establishment of literature on the understandings of depression amongst the diverse people of South Africa. Globally, it intended to contribute to growing literature on the role of culture and gender on constructions of mental illness, such as depression, and the importance thereof. Practically, this was intended to add nuance and depth to clinicians' understandings and treatment of depression, and therefore, potentially improve efficacy of treatment methods for depression amongst South African Indian Muslim women.

3.7 Ethical Considerations

Ethics clearance was obtained by the Faculty Ethics Committee at the University of Pretoria (Appendix A). In keeping with the provisions of the Health Professions Act (1974), the following criteria were met in order to ensure ethically-sound research practice:

- Participants first gave both written and verbal consent for their participation.
- It was made clear to all participants, both verbally and in the informed consent letter, that participation is completely on a voluntary basis and that they may withdraw at any stage without consequence.
- The researcher used understandable language both in the letter and verbal communication with the participants.
- Participants were given an opportunity to ask questions about the research process.
- Confidentiality was assured as well as anonymity in reporting of the data received.
- Pseudo names were allocated to all participants to ensure anonymity.

Contact details for free counselling and support services were issued to participants, should they have felt vulnerable after completion of the interview. Orb, Eisenhauer and Wynaden (2000) stress that it is not only important to inform participants of their rights, but also to protect them from adversity. However, no evidence of adversity was present during or after the interview process.

3.8 Conclusion

This chapter explored the plan of inquiry of this study: the process of data gathering and the method of analysis whilst maintaining consistency with the theoretical framework of the study throughout. Finally, ethical considerations and quality criteria for the research, were investigated. This chapter allowed me to logically describe the steps that needed to be carried out in order to ensure effective and theoretically sound research practices. A continued process of reflexivity was adopted both within this chapter, as well as throughout the duration of the study. This contributed to my continued awareness of my role in the research process.

CHAPTER 4

ANALYSIS AND DISCUSSION

4.1 Introduction

In this chapter, the results of the study are discussed. The interpretation of these results is accompanied by a discussion. The results are presented in this chapter by discussing the study's themes. Each theme represents the varying facets of influence that culminate to form each woman's construction of depression. The participant's current construction of depression may be understood to be derived from constant dialogue between various social spaces. This includes cultural, personal and medical understandings. Thus, the term depression may be understood to derive from various meaning-making spaces and social systems. In this chapter, a brief overview of the participants will be discussed. Each woman was assigned a pseudonym to protect her identity (Jay, Ayesha, Laila, Naseema and Fatima). Thereafter, four main themes will be explored to reveal the varied constructions of depression amongst the women. Furthermore, significant sub-themes will be explored which relate to each main theme.

4.2 Introducing the participants

Five women who self-identified as South African Indian Muslim women and who are currently residing in the greater Johannesburg area, participated in this study.
The first participant, Jay, was 21 years old at the time of the interview, single and a dentistry student. She presented with great enthusiasm about the topic and sharing her thoughts. She spoke with ease, and at times offered increasing detail, requiring me to bring the conversation back to the intended topic. Rapport was easily established. Ayesha was a stay-at-home mother and wife, aged 37. She appeared anxious to engage from the onset of the interview, and offered shorter answers, requiring more prompting from me. There was some difficulty in establishing rapport, which translated in a break in the flow of the interview and engagement. Laila was 50 years old, a practicing pharmacist and a mother of two, who is married. Rapport was

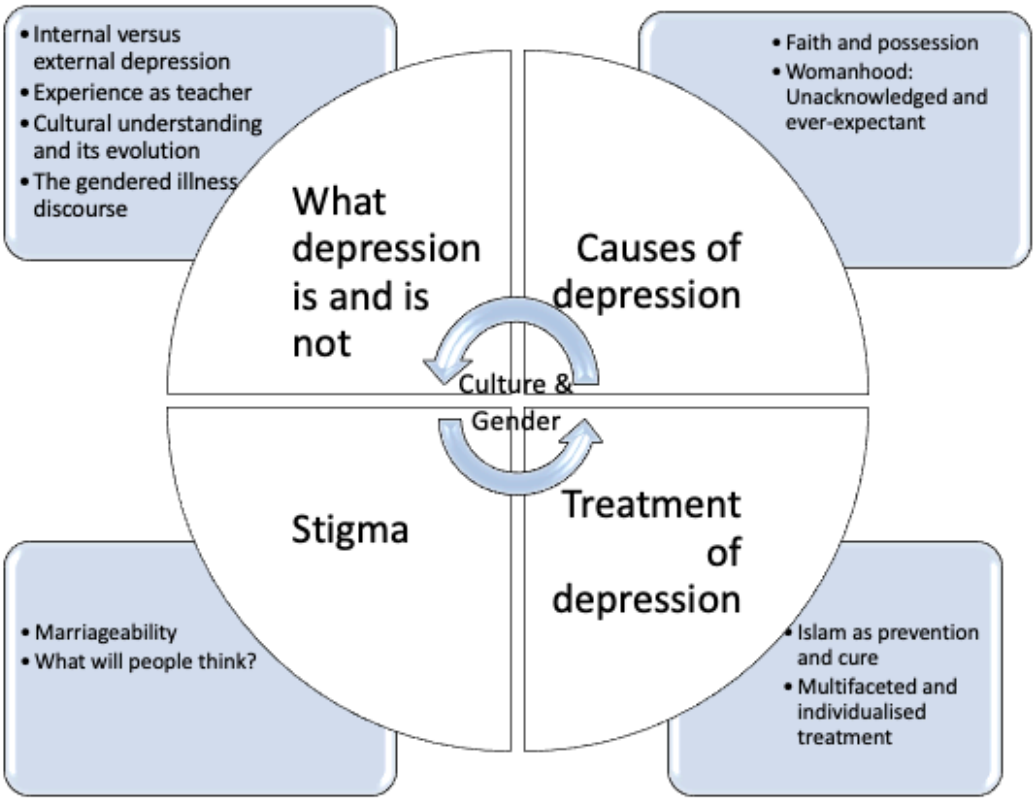
readily established with this participant, and she engaged with ease from the outset. She offered personal experiences where appropriate, to elaborate on her understanding of the topic and hence minimal probing was required. Naseema was 27 years old. She was a stay-at-home mother and divorced, at the time of the interview. She was very pleasant on contact and appeared eager to share her experiences and insights on the topic. She engaged well and spoke with ease, often elaborating without prompting. Finally, Fatima was a 34-year-old wife and stay-at-home mother of three. She was pleasant when we met and rapport was establishing easily. She engaged with ease and at times, paused to contemplate about her thoughts before answering. She elaborated and shared personal experiences where appropriate.

4.3 Introducing the themes

Once the coding of the interviews was completed, a summary of themes was grouped together. Depicted below is a summary of the four main themes and relevant sub-themes extracted from the data. The main themes included what depression is and is not, causes of depression, treatment thereof, and stigma. Each main theme included various sub-themes. The depiction also includes culture and gender as influential constructs across these themes. The analysis that follows, further explores these themes as well as sub-themes that emerged.

Figure 1

Summary of the four main themes, the related sub-themes and the influence of culture and gender across these themes



4.4 What depression is and is not

Whilst the interview did not specifically seek to look for a definition of depression, it did intend to elicit the multifaceted nature of what these women understand depression to be. In relation to this, four sub-themes emerged. The internal versus external understanding, the importance of experience in understanding and both culture and gender were significant themes in how the participants constructed what depression is.

4.4.1 The internal vs external depression

The initial question of the interview asked the participants to share their understanding of depression and was intentionally framed rather broadly. The descriptions encompassed various elements of their understanding. Overall, the women's answers reflected an attempt to understand depression with an initial focus on the internal, emotional experience of the individual and its subsequent outward expression. In their construction of depression, they differentiate between the internal lived experience and the external expression thereof. This can be said to be in contrast with the DSM 5 description of depression. The DSM 5 offers a list of largely observable, behavioural symptoms, which together are utilised to diagnose and indicate the internal experience of a major depressive disorder (APA, 2013). The DSM 5 criteria also includes some non-observable symptoms such as depressed mood, feeling hopeless and diminished interest or pleasure.
In essence, the construction of depression amongst these women focused rather, on an understanding that develops from the inside out.

> Jay: *I think generally we think about it as like being sad all the time… it's just an imbalance in the way you feel.*
>
> Naseema: *I think it starts off with a sadness, people don't speak about what is on their mind and it's something that eats at you and over a period of time it just builds and builds and builds on that and then eventually it actually becomes an illness that starts consuming you and causing a lot of other issues, causes people to have thoughts and feelings that a normal person would not have.*

These two quotes indicate that sadness is the internal, felt experience that is significant in depression. It also indicates that depression is constructed as *starting* from the inside and is like feeling sad. It is clearly defined as internal thoughts and feelings which are not normal. Fatima adds to this, explaining that depression for Indian Muslim women is the absence of spiritual connection and generally, it is the lack of an internal drive or motivation.

> Fatima: *I mean it's just a lack of a goal for any woman not only an Indian Muslim…Generally everything seems to be falling down. Around them, within them…but as a Muslim woman also sometimes I feel like it's the connection lost between creator and creation.*

Fatima indicates the destructive nature of depression, both internally and externally. Her description does not identify where the destruction begins (internal or external) but includes both in the understanding of what depression is.

Other participants' answers also showed some similarities to those indicated in the DSM 5. One participant described depression with similar symptoms to that of the DSM 5 description. She focused on the behavioural aspects, manifesting as a result of a mind state. She made particular reference to the negative impact of functionality across various aspects of the individual's life. Her description is similar to the DSM 5 (2013) criteria of Major Depressive Disorder (MDD) which includes the requirement that the observed symptoms must cause clinically significant impairment to at least one aspect of the person's life.

> Laila: *I diagnose them to be depressed in our interaction, so it is behaviour... It speaks to the way they behave, it's about how they're operating whether they're functional in their work as people as colleagues, as partners, as parents, as wives, as spouses. Are they functional? So it manifests as behaviour*.

It is interesting to note that Laila is an employed pharmacist, which is an occupation that focuses on the scientific and observable. She uses scientific/medical discourse, which is inherent to her occupation, to construct an understanding of depression that is similar to the scientific discourse of the DSM. Thus, she uses her work-culture discourse in constructing depression.

In another interview, societal shame was used to define depression. Depression was described as follows:

> Naseema: *Well depression is something that is hidden a lot amongst our Muslims, amongst Indians, I feel we're very shamed to come out with it...it is something we suffer from, but nobody is brave enough to come out and speak about it.*

Interestingly, this construction of depression highlights the broader cultural factors and issues of stigma (discussed further in section 4.7) and the possible internalisation of this, that inform how depression is constructed. So much so, that the very definition of depression is synonymous with shame. Whilst literature acknowledges the difference between self-stigma and public-stigma (Corrigan & Rao, 2012), this participant could possibly be speaking to both. The public/cultural stigma can result in the experience of internalising these attitudes and experiencing shame for the individual affected and those associated with the affected individual (Corrigan & Rao, 2012). This shame is then sheltered by not revealing the truth about one's mental health. Naseema highlights the experience of this phenomenon within the Indian Muslim community of South Africa. Both the public and self-stigma of depression becomes synonymous with its definition and the construction thereof. Naseema highlights the central role of shame in people needing to hide depression. Depression is synonymous with such negativity, so much so, that it requires bravery to even speak about it.

4.4.2 Experience as teacher

The experience of depression, directly or indirectly, altered participants' constructions thereof. Experience of depression was found to teach participants something different to the constructions they had held before. Depression is powerful in its ability to change understanding and alter stigma, when understood in interactional spaces rather than through books. When participants spoke about a change in their understanding of depression, it was largely influenced by personal experience. The influence of either having experienced depression, or having witnessed a loved one experience it, was the most influential factor in causing change in the construction of depression for these women. Depression is therefore not an inactive bystander, but joins the conversation through its participation in

people's relationships. Four of the five women cited a personal experience of depression, or of a loved one, as the reason for their change in understanding. In explaining the significance of having a mother with depressive episodes, Laila said,

> Laila: *So that was my university about depression and what mental illness could lead to.*

In response to being asked if her understanding of depression has changed, Fatima said,

> Fatima: *Oh yes definitely, because of experience and me having personal experience because of my sister-in-law…so we have been through a series of different types of treatment.*

This theme is closely linked to the social constructionist viewpoint. The exposure to and social interaction with friends and family who have experienced depression, results in the individual adjusting his/her construction of what depression is. The meaning making process of depression is no longer solely based on each woman's individual understanding- nor is it static. It becomes an ever-evolving construction, shaped by such everyday social interactions and the engagement thereof. The social nature of the construction highlights the importance of shame in relation to depression, for these women. Thus, the importance of culture and such shared meaning-making processes, becomes clear in the construction of depression.

Furthermore, participants attributed these personal experiences with depression to a greater realisation of the stigma attached to depression. Personal experiences of depression were understood by participants to have helped them recognise their own stigma about depression and aided them in challenging such negative stereotypes and misrepresentation. Thus, indicating the power of experience in its ability to alter previously held constructions.

This phenomenon has been researched previously. Wolkenstein and Meyer (2009) identify familiarity with mental illness as a key factor in the influencing of attitudes towards mental illness. Familiarity encompasses aspects such as learning or personal experience, for example, having close friends and family affected by mental

illness. This study found that people who are familiar with mental illness are less likely to exhibit prejudice or discrimination against affected individuals, and show less negative emotions when confronted with the topic (Wolkenstein & Meyer, 2009). Whilst this study includes both textbook learning and personal experience as having equal influence in changing people's constructions, there may be further nuances that exist. Laila emphasises the difference in value between learning about depression theoretically and the experience of its manifestation in life.

> Laila: *You know we may read, you may read it. I think you can read it all you want but until you don't have the actual hands on interaction and experience with depressed people, then you don't understand the full mammoth of what it could be.*

While Laila does acknowledge that one can be taught about depression by reading, this will only result in partial knowledge. Rather, depression's meaning is understood to be created between people; in the interaction with others. The enormity of such interactive personal experience for her, is realised.This subtle difference in the concept of familiarity with depression, may be valuable to explore for further research. The component of familiarity and experience is significantly linked to the construction of depression amongst these women. It is as if these women are saying that depression demands its space *between* people, rather than in books, to be truly known. It is not a fact to be read, but needs to be part of the interactional domain to truly be appreciated.

4.4.3 Cultural understanding and its evolution

It is important to note that the concept of culture within this study incorporated both the Indian culture and well as the Islamic perspective. Participants spoke to both in their descriptions of the influence of culture on their constructions of depression. All five participants spoke to the limiting nature of cultural understandings of depression and the need for a greater focus on the individual in understanding. The cultural understandings of depression are thought not to account for the complex and varied manifestation of the existence of depression, as well as the notion that it exists on a spectrum. The more limiting cultural understanding then impacts the understanding

of the cause and treatment of depression. Issues of cause and treatment will be explored in detail further on in this chapter (section 4.5 and 4.6 respectively).

Another point worth noting is that participants differentiated between their own and typical cultural understandings of depression. Here they noted similarities as well as differences. The social constructionist approach emphasises the way in which an individual situates him/herself in relation to cultural discourses (McLeod, 2009). This was evident for the participants too. On the one hand they spoke from their embeddedness within culture and used culture to understand depression. On the other hand, they also offered understandings that honour individual differences, downplaying culture. In this regard, every participant in her own way mentioned the need for a sensitivity to the unique nature of the experience of depression for each person.

> Naseema: *Culturally we have prescriptions of how to deal with it, but depression itself is not a cultural thing it's a…it's a people thing basically.*
>
> Ayesha: *I would just say that everyone is different you know, they deal with things differently.*
>
> Laila*: Cultural understanding maybe is, I think they think it is very simplistic… there is maybe a lack of understanding or a misunderstanding about it…you know the simplified version sometimes, it tends to make one overlook the enormity of what it could be.*

The above quotes offer insight into the importance these women place on the focus of the individual. There is a clear differentiation and disapproval of the mass perception, which is labelled as "simplistic" and lacking in understanding (participant 3, p. 3). From these descriptions one becomes aware that the women are insistent in bringing forth the unique experience of the person, rather than allowing it to become lost in the experience of the collective. This is not only noted by the women, but its significance is considered profound for them. The participants are speaking to an individualist/collectivist distinction here. Theoretically, this is in contrast to a social constructionist understanding. Social constructionism assumes that without the broader social meaning-making, there is no distinction between depressed and not depressed. Thus without the collective understanding, there is no individual

distinction. Therefore, the 'individualist' interpretation lies in the construction of the participants.

There appeared varying opinions on whether culture acknowledged the existence of depression. Whilst some participants felt it was acknowledged, others felt the understanding was "warped" (participant 5, p.7) and finally some expressed that culture denied the existence of depression entirely. Naseema sees this denial as problematic.

> Naseema: *That is the thing they silence it they don't, they're not willing to face it, they're not willing to speak about it… Indian women actually drown in their depression because nobody believes in it. If you speak to the parents about it they tell you straight "there is nothing wrong with her we went through it all, there is nothing it is not an issue". So I think us Indians have that problem- nobody wants to face nobody wants to help sort it out basically.*
>
> Laila: *I think the older people will tell you that don't talk about that you know, that we don't talk about that.*

In contrast to the previous theme (experience as teacher) where depression demanded a conversational space, here the discourse is about how absent and unspeakable depression is. Where absent, depression is prevented from entering social discourse because of the difficulty in voicing, verbalising and expressing its presence and meaning. Although absent in the verbal discourse, this does not mean that it is entirely silenced. Rather, it speaks powerfully in its absence. Even in being the "unspeakable" discourse, depression paradoxically, speaks volumes. Where Laila and Naseema, as quoted above, see the culture and Indian Muslim community as in denial of the existence of depression, other participants spoke about the stigma as the cause of its outward denial. Naseema also makes a connection between denial and stigma, later in the interview. Thus, for these women, depression is thought to be internally and perhaps more privately acknowledged, but due to the societal shame and stigma attached to it, it is outwardly denied. There is thus internal awareness and an inner conversation, but due to the cultural construction of depression as a shameful or silenced discourse, it cannot claim a voice in the outside world. This stigma and shame results in it becoming an unspeakable discourse. In this instance, depression is not absent, but there is a denial about its

existence in the social discourse, whilst only subjectively recognised and acknowledged.

Although mental illness stigma is evident across various societies and cultures, cultural variations in this stigma also exist (Abdullah & Brown, 2011). More specifically, people of Asian cultures typically express and experience greater levels of stigma relative to their Western cultural counterparts (Cheon & Chiao, 2012). Participants all emphasised the changes in cultural understandings and stigma, evident in the older generations' ideas compared to the new generation's.

> Laila: *I think the older people will tell you that don't talk about that you know…you be quiet and just be seen not heard, those kind of things or they will hide you, you know he is just sick he is not so well.*

The newer generation is thought to be more open-minded about depression. This is attributed to the increasing exposure to alternative discourses, outside of their own culture and community. For example, developments in technology such as social media present people with greater access to other alternative discourses. Technology, such as social media, was spoken about both as a means of connection and a useful tool in this regard, as well as a possible cause of depressive symptoms.

> Fatima: *I think with the new generations it's definitely changing because you must know, lots of the cultural like barriers that were there has been broken down over the years and so what was not accepted before is now accepted.*

This quote by Fatima, indicates a more neutral position on the changes in cultural understandings. The viewpoints of the participants of different generations, paralleled the notion that the culture of depression and its construction has evolved. Participants of different ages appeared to have different perspectives on whether these changes in acknowledgment are neutral, positive or negative. Fatima, quoted above, is in her late 30's and can be situated somewhere between the newer and older generations. However, Laila, who is 50 years of age and the eldest participant, was disapproving of the openness surrounding depression.

> Laila: *Yes I think the younger generation is more vocal about it, they speak up sometimes they need to be quiet they speak too much…It is difficult because*

> *what we perceive as depression may not be perceived the same way as the younger people today and the older people sometimes don't understand the younger ones too, so it is way different and it's almost like it's evolving from in the closet to just be out there.*

She is aware of the difference in discourses of depression employed by different generations. She indicates a difference in understanding of what this shift means, to the different generations. Laila indicates her disapproval of the shift from "in the closet" to being "out there". Thus, indicating a disapproval of making the unseen and unacknowledged now a part of the conversation. Jay on the other hand, who is 21 years old and the youngest participant, felt that this new-found openness is entirely positive.

> Jay: *I think that's changed somewhat especially like, with us, the younger people being more exposed to other view points and ideas. Like, I'm on tumblr. And tumblr is so chilled with depression it's just like there's all this love and help and unicorns… It's brilliant! I feel like it's so great to get people talking about it and stuff…But culturally I don't think it's something that, I think culturally it's something we're expected to not talk about these things. And it goes across the board. I think the Indian community especially, if something bad happens, you have to be ashamed about it. And you have to hide it and cover it up and be all secretive about it. But it's… it's really stupid.*

Both of these quotes, by Jay and Laila, highlight the spoken and unspoken in the conversations about depression utilised by the different generations. The older generation's conversations are typified by shame and attempting to hide depression. The newer generations conversations are characterised by more support and an acknowledgement of depression. These differing opinions on the same phenomenon, emphasise not only the cultural importance of the construction of depression, but also, the individual within that culture. This includes the consideration of the generation of the individual, in relation to his/her cultural background. This emphasises once again, the social constructionist focus on where the individual positions him/herself within the cultural understanding and discourse (McLeod, 2009).

4.4.4 The gendered illness discourse

All five participants of this study acknowledged with confidence that Indian Muslim women acknowledge and experience depression more than Indian Muslim men do. This is consistent with previous literature. The gender gap has been well researched in the literature, indicating a ratio of as much as twice the number of women affected by depression than men (Essau, Lewinsohn, Seeley, & Sasagawa, 2010; Kessler, 2003; Van de Velde et al., 2010). There is little evidence that there is any cultural variation on this finding.

Whilst the participants indicated some ambivalence surrounding whether or not men in fact experience it less, there was a clear and consistent argument that women acknowledge depression far more readily than men do. In fact, the participants were of the opinion that Indian Muslim men do not acknowledge depression at all. Fatima makes this clear:

> Fatima: *And men go through it as well, depression, but Indian Muslim men do not acknowledge depression I can tell you that hands down, they don't.*

Men and women are described by participants as having innate differences in the way in which they manage and experience life events. Furthermore, depressive symptoms are understood as innately female. Literature suggests that it is not an innate, biological difference that exists- rather, that gender differences in depression are as a result of an interplay between biological, psychological and social factors (Hopcroft & Bradley, 2007). Naseema goes on to explain the role of gender in the acknowledgment of depression, and management thereof.

> Naseema: *I think guys don't face the challenges a woman faces or maybe they just don't acknowledge these challenges. I think they have a different way of dealing with it a more outgoing way of dealing with it. So I guess that is why they don't acknowledge it as much as a women would in like a Indian community I would feel.*

Literature supports the view Naseema makes, from other cultural perspectives as well (Simon & Nath, 2004). She is therefore endorsing a discourse that is not unique to her culture, but is accepted across cultures. Simon and Nath (2004) argue that emotion cultures contain beliefs about gender and emotion. For example, U.S. emotion culture includes beliefs that women are more emotional and emotionally expressive than men are. In addition, emotion cultures contain beliefs around the frequency and distribution of affective experiences and behaviour for each gender. This is similar to what Naseema is expressing, indicating a cross cultural discourse surrounding the gender differences in depression.

Furthermore, this male difference is understood to result in being less emotionally attuned to women and their experiences. Laila spoke at length about the men in the South African Indian Muslim community having great difficulty empathising with the experiences of a woman. Such a phenomenon would indicate that not only does the innate gender differences render men less likely to become depressed, but also creates a more dismissive and isolated experience for the women in their lives. The following excerpt speaks to this phenomenon:

> Laila: *Sometimes men don't realise what women go through and they're like 'get on with it, take it like a man' and you can never take it like a man because we are different, we were meant to be different so we manage it differently and sometimes what is petty for him may be the world for you… I don't think Indian men, I will say most of them, have much E.Q., ponder a lot or reflect a lot on how they interact with their spouses emotionally.*

Laila is saying that not only do Indian Muslim men not suffer from depression, but they do not acknowledge it. They do not face the same reality of challenges women do and cannot empathise with them. This indicates a discourse of difference in terms of challenges and acknowledgement.

Finally, Jay acknowledged the gendered nature of depression within the Indian Muslim culture, but understood it to have negative implications for men's capacity to acknowledge their vulnerability.

> Jay: *But I think our men go through a lot of, they are also expected to live up to a lot of expectations. We think about the women a lot because it's what we experience …but they are expected, especially emotionally and*

> *psychologically, to live up to certain ideals. And depression isn't one of them. Like you still are like 'oh it's a woman, they tend to be the weaker sex'. But if a boy has depression the picture changes somewhat- he's a weak man. And that's not as ok as being a weak woman in our society.*

Jay's understanding is consistent with literature. Dominant cultural notions of masculinity dictate that men should be stoic, controlled and self-sufficient, evident in phrases like 'boys don't cry" (Vogel et al., 2011, p. 369). This is at odds with behaviours that are associated with vulnerability and weakness, and therefore, decrease the likelihood of males showing mental health symptoms or seeking help (Vogel et al., 2011). Furthermore, Jay's understanding is consistent with literature, which argues that the expression of emotion is more heavily socialised than the experience of it (Brody 1993; De Coster & Zito, 2010; Kring and Gordon 1998; Simon & Nath, 2004). Thus, gender norms and expectations play a significant role in individuals' capacity to acknowledge their own experience of certain 'gendered' emotions. Furthermore, culture is understood to have a significant role in defining these gender norms and affective displays (Simon & Nath, 2004). Gender norms and roles within this culture are such that it allows and disallows ways of being. It draws boundaries around what a man can and cannot be and women can and cannot be. This may indicate why participants were ambivalent about men's internal experiences of depression, but certain about their outward denial of its existence. Whilst Indian Muslim culture dictates that men cannot be depressed in their social world, internally, the conversation may vary.

4.5 Causes of depression

This study included an exploration of South African Indian Muslim women's constructions of the causes of depression. The answers from the five participants included various different factors which could account for their understanding of the manifestation of depression. These were for instance external factors such as coping ability, losses and disappointments, challenging life events, lack of support and the rise in materialism. These women also spoke of internal factors causing depression such as self-esteem difficulties, discontentment, and the inability to accept life challenges. Some participants emphasised that although these factors play a role, it is difficult to point to a definite trigger for the onset of depression. Jay describes this:

Jay: *I don't think it's always necessarily something that's a definite cause that you can say 'that's what made her that way' or 'that's what caused it'*.

In the exploration of participants' constructions of the causes of depression, themes surrounding faith and gender were prominent. These will be discussed in greater detail below.

4.5.1 Issues of faith and possession

Participants were asked what the cultural ideas are about the causes of depression. Some answers reflected general causes such as challenging life events and major losses and disappointments. Lack of faith was cited as a significant cause, both culturally and personally for participants.

Fatima: *I think culturally it just boils down to a lack of imaan* (faith)

Jay: *If you're spiritual you shouldn't be upset.*

These excerpts highlight the link between faith and depression. The participants' answers indicate their understanding that if you have faith, then you would not become depressed. Faith is therefore a protection against depression and the lack thereof renders people vulnerable to depression. Thus, faith is constructed as more powerful than depression and protective against becoming depressed, whilst a lack of it is thought to cause depression. Beyond the cultural importance of faith and spiritual connection, participants identified its significance for them personally. They described faith as influential in one's emotional well-being. Fatima included the breakdown of spirituality as part of the cause of depression:

Fatima: *As a Muslim woman also sometimes I feel like it's the connection lost between creator and creation*

This quote further emphasises the link between her identity as a Muslim woman and how she constructs depression as resulting from the disconnect from one's faith. These findings correlate with some international and local research, conducted

within the same population group. In the UK, a systematic review of interventions for treatment of depression amongst Muslim patients, also found that a lack of faith was understood as a cause of depression (Walpole, McMillan, House, Cottrell & Mir, 2013). A study conducted in the South African Indian Muslim female community also found that a lack of faith was understood as a cause of depression within the Muslim and Indian culture. However, the women who participated in this study did not agree with this statement. They felt that lack of faith was a commonly held belief in the Indian Muslim culture, which is part of the misconceptions held in the community about MDD. The study found that some participants attributed the cause of depression to God's punishment and a test from God (Laher et al., 2018). However, stress-related and biological aetiologies were more strongly supported amongst the participants (Laher et al., 2018).

Broadly speaking, Fatima's statement above reminds the researcher that the participant's construction of depression is inherently linked to her being a Muslim woman. This reiterates the social constructionist idea that the way in which we make sense of our world is inherently linked to the social nature of meaning-making. In this instance, Fatima is referring to the inherent impact of her identity on her construction of depression. She explicitly links her identity, which is social in nature, to her discourse and construction of the aetiology of depression.

Whilst faith and spirituality were largely acknowledged by participants as a cultural understanding for the cause of depression, all the participants felt that it was but part of their personal understanding. They emphasised once again, the need to assess each affected person, individually.

4.5.2 Womanhood: Unacknowledged and ever-expectant

A discussion on gender is largely linked to culture. In the exploration that follows, it becomes apparent that gender roles for Indian Muslim women are intrinsically linked to their culture. Participants spoke about the pressures of being an Indian Muslim woman and the changing roles that they are expected to master. This included the biological changes experienced by women at different stages in her life, as well as the roles she is expected to assume. Some women spoke of the pressure that

evolving and demanding nature of female roles place on women, while other women also saw this as the reason why women become depressed.

> Jay: *The pressures have increased because all of a sudden you don't just have to be at home cooking and having children, you also have to have a degree.*
>
> Fatima: *You know in general you can't be on top of your game all the time and there is so much for women. I sometimes feel like culturally you're supposed to be at home raising your kids and this, sometimes women I mean you have careers and you have this, so then there is that void when you have to like step into your home and just be a mummy or just be a wife. So lots of that giving up, like it was all my life. Lots of women I know now in this position that I am in, like being a mum of three kids and I mean having worked and studied and then suddenly all falls flat, so you start questioning. I think that's monetary as well, not having that independence and freedom, you know.*

From the above quotes two points become apparent. Firstly, that whilst there are additional opportunities such as career choices that can now be occupied by women, culturally, this is then added to more traditional roles which are already demanding. Secondly, that if women are to sacrifice their professional roles for that of a more traditional, homemaker role, it can result in a loss of the sense of self and independence. These factors are understood to put women at greater risk for becoming depressed. As a result, the demands do not allow space for women to focus on their own difficulties or to be vulnerable and imperfect. This is apparent in the following quotes:

> Naseema: *At the end of the day if a father ups and leaves he ups and leaves. I mean it's hard for the child but he has his mother. At the end of the day they always say a mother can be a mother and a father in one. So I guess yes a woman does have a lot more responsibilities ..I think that is the problem that we also have. You can't deal with it in your way you still have to carry on with life.*
>
> Fatima: *As Indian women you have to be that strong person.*

Furthermore, the lack of acknowledgement of women's roles as well as the minimising of their experience, is understood to be of significance to the increased incidence of depression amongst women in this community. Laila explored how even if women are to assume a traditional role, it is not given great significance or status.

After the interviewer asked Laila about her understanding that women's roles are minimised, this was her response:

> Laila: *Yes and menial, but that's the fibre that keeps the relationship together. If only they (men) perceive it that way it is such a mundane thing, but I mean you keep a home together, it takes work too.*
>
> Fatima: *Women know how much women go through, physically, emotionally I mean the changes in your life whether its giving birth, getting married the changes are big and they are drastic and sometimes they are just not acknowledged…So I think women, well I am sympathetic to somebody that would be in depression. You know in general you can't be on top of your game all the time and there is so much for women.*

Fatima's response reiterates the demanding nature that being an Indian Muslim woman, both physically and socially, requires. She speaks to the unacknowledged nature of the experience and that being a woman, affords you empathy for other women. In this sense, gender and its expectations become causal, in the construction of depression for these women. These findings correspond with prior research. Stoppard (2000) explains that female *socialisation* has been identified as a possible cause for women's increased susceptibility to depression. Female roles have been found to be limiting and are associated with a lack of choice, role overload, competing social roles and a tendency for females to be undervalued (Piccinelli & Wilkinson, 2000). Female social positions are therefore characterized by powerlessness and lower status levels. Women who stay home and are unemployed are found to be increasingly less valued (Van de Velde, 2010). Employed women however, face higher risks of depression due to role overload and role conflict as a result of increased responsibilities with employment and household and care giving responsibilities (Piccinelli & Wilkinson, 2000). These studies were conducted in Western countries and relate to women from Western backgrounds. However, if these findings are true for other women, it may be that they hold some truth for South African Indian Muslim women as well. Furthermore, a study conducted amongst South Asian women in Canada found that the stress and conflict resulting from women negotiating between traditional and more modern roles, placed them at higher risk of developing depression (Ekanayake, Ahmad, & McKenzie, 2012). This indicates that there is a cross-cultural impact of gender and gender roles on the mental health of women.

4.6 Treatment

Various different forms of treatment were described by the participants. More broadly, these were categorised under cultural and professional forms of treatment. However, other categories were explored. Women spoke to the importance of support as part of treatment. This included more personal support structures as well as community-based support. Agency was also mentioned as a means for women to feel empowered and begin to heal from depression. Faith arose as an important theme, which will be investigated further. And finally, the need for multi-faceted and individualised treatment is explored below.

Similar to the causes of depression, the participants identified multiple ways in which people who are depressed from the Muslim Indian culture consider viable treatment options. Overall these options fall within the cultural or professional domain.

4.6.1 Islam as prevention and cure

The participants were asked what the cultural ideas are surrounding acceptable forms of treatment for depression. A mixture of answers was given, which included both professional and cultural forms of treatment. The cultural forms of treatment mentioned were praying, faith and consulting with Moulanas (Islamic scholars). This is in keeping with prior research, which found that in South Africa, beliefs about supernatural forces causing mental illness, resulted in individuals primarily consulting with Muslim traditional healers for help and healing (Ally & Laher, 2008).

> Jay: *Go to a Moulana. They'll probably say you need to find spiritual help. Which helps to an extent… Umm yeah it's like if you're spiritual you shouldn't be upset, 'cause God is going to help you out of it.*
>
> Ayesha : *Well the first treatment would be our culture, you know what it teaches is that we should put our trust in Him and that everything is from Him and that we accept everything from Him.*

Jay identifies the cultural form of treatment as consulting with a Moulana to rectify spiritual deficits. She sees this form of treatment as valuable, but not a comprehensive cure. Ayesha however, states that cultural forms of treatment are

first. Thus, faith is constructed as superior in the hierarchy of treatment options. She constructs cause and cure as external from the self, emanating from a higher external source. Whilst faith is understood as the culturally acceptable treatment, Ayesha also recognises it as a personal understanding for both prevention and a part of the treatment for depression.

Participants shared the value of faith for them. This included the understanding that faith gives people a sense of comfort and an ability to accept life's challenges. As discussed under 'Causes of depression' (section 4.5), an inability to overcome challenging life's events was understood as a cause of depression amongst participants. Here we see that this theme continues, and faith is constructed as a cure and prevention for this cause of depression.

> Jay: *Finding yourself spiritually is never a bad thing and praying is never a bad thing and believing in God and understanding that there's a reason for everything and understanding that he's putting you through this and that there will be relief after every difficulty. And also, understanding that there's someone watching over you, it's very comforting for me.*

Jay is describing the value of faith for *her*, after mentioning that it is the culturally acceptable form of treatment. She explains how faith and connection with God allows her to make meaning of her world and gives her hope and a feeling of protection. This is in keeping with research. Utz (2011) explains that in Islamic theory, those struggling with their faith may find difficulty in finding explanations and meaning. Nearness to God is understood as the basis for the attainment of peace and serenity, and therefore, relief from the symptoms of mental illness for their stressful life events and may be less easily affected by mental illness. Ayesha describes her understanding of this:

> Ayesah : *I feel uhmmm as a Muslim it is easier for us to accept things that happened to us because we believe that everything is from Him.*

Although she does not qualify "easier than whom …" she does construct her particular faith as a benefit. As discussed in the causes of depression (p. 57), here too we see that protection from depression is attributed to a higher external source. Faith is described as giving people a sense of fulfilment and acceptance in their

lives, which is understood to prevent depression. Ayesha explains how faith prevented her from becoming depressed, after facing a miscarriage:

> *Ayesha: Yeah I am not saying it didn't affect me. You know it's like not that it didn't even move me, 'oh it's from my creator' I just accept it and finish. No I had bad days I had good days but whenever I had my bad days I would say 'you know why and you know the reason'.*

Ayesha's reflection indicates that her faith affords her a means to make sense of a traumatic experience. She constructs her faith as a means of protection against the uncertainty, and against become depressed. Whilst challenging life events are acknowledged, she constructs her faith as having more power over her internal experience than these events. These descriptions give us an understanding of the how culture is constructed in the prescription of treatment for depression, but also, how the individual situates herself within this collective construction. Culture, and faith within that, is constructed as being both a cure and a treatment for depression. For some of the participants, faith as a cure is constructed as the superior means of treatment, whereas for others, faith is constructed as an equal part of a multidimensional treatment.

4.6.2 Multifaceted and individualised treatment

In addition to the importance of faith, multidimensional and individualised treatment was emphasised by all the women. All the participants described treatment as a combination of culturally-acceptable treatment, professional forms of treatment and the involvement of support structures. These findings are consistent with previous literature (Laher et al., 2018). The support structure mentioned by the women included family, friends and more broader community-based groups who offer support. Professional forms of treatment included medication, psychiatry, psychology or any other medical consultations. The culturally acceptable treatment identified by the women were praying, faith and consulting with Moulanas (scholars). Every participant explained that the combination of these various factors and no single one would be the most effective form of treatment.

> *Jay: I think a lot of it has to come together. It's not just one thing that's going to help you.*

Laila: We as family also don't know what the condition is until it is diagnosed by a professional to know what is the range or where they're sitting at, what they're doing, what medication they may need together with some family support and then some counselling and some therapy and some group sessions maybe…so it is a collective.

Jay speaks to the need for this combining of understandings. Help is constructed as not located in one place or person. She constructs treatment as being from multiple sources. Laila describes professional treatment as the beginning of the treatment process, and other forms of treatment to be informed from this. Like the previous participant, she is very explicit about help not coming from one source and she identifies these and describes these according to their importance: first is the professional person who makes the diagnosis and prescribes the correct medicine as leading the way, as the most important. Following is the family and then maybe some psychological intervention. This construction of treatment as multifaceted links back to the discussion on the causes of depression (section 4.5) where participants explained that the cause of depression is constructed as multifaceted as well.

Fatima: But also when it comes to treatment I think it is what you are comfy with and is acceptable.

Ayesha: Some people need the medication or they need to speak to that someone just reading something doesn't help, everyone is not the same, and it doesn't help them.

Naseema: So it just depends on you, but there are people out there that are willing to help, you just need to find the right sought of people that can help you.

In constructing treatment, these participants identify a connection with an outside source of help. This is described as taking different forms by the different women: speaking to someone and finding people who can help as well as taking medication. This indicates that these women's construction of treatment includes seeking and accepting help from others. Consistent with previous discussions on the importance of the individual (see section 4.4.3), the women are emphasising matching the treatment to the person and his/her needs. The emphasis on understanding the unique experience and needs of the specific person affected, has been carried throughout the various broader themes. From the point of deconstructing what

depression is, to causes and now to treatment, the importance of appreciating the individual's unique experience has been significant. Participants have offered more general constructions of their understandings, but have always highlighted that the individual's needs and experience is constructed as being the most important element in constructing depression. The unique nature of each person is thus constructed as the most influential and significant element in the construction of depression.

4.7 Stigma

As we have explored previously (see section 2.4), the issue of stigma is strongly linked to depression within the Indian Muslim community (Ciftci et al., 2013; Laher et al., 2018; Mohamed-Kaloo & Laher, 2014; Roberts, Mann & Montgomery, 2016; Marrow & Luhrmann, 2012) . The topic of stigma in literature is broad. It is disease specific and it is also informed by gender (Stoppard, 2010; Van de Veld et al., 2010). In this study the two most prominent sub-themes that describe how women constructed the issue of stigma is marriageability and the idea of what people might think.

4.7.1 Marriageability

In the interview, participants were asked if they felt there was a stigma surrounding depression amongst the Indian Muslim community. The topic of marriageability and stigma was not raised by myself, however it was spontaneously elicited by the participants. Through the participants' constructions, marriageability is understood as the marriage potential a young woman or man within the community possesses. It appears to be a central theme in the Muslim Indian community and much worth and significance is placed on a person's success within and capacity to, be in a marriage. Globally, there is evidence of the importance of marriageability across cultures, within the Muslim community. In America, a cross-cultural review written on the mental health stigma in the Muslim community highlighted that Muslim women avoided sharing personal distress and seeking help from counsellors due to fear of it negatively impacting their marital prospects or their current marriages (Ciftci, Jones & Corrigan, 2013). Furthermore, 36.5% of Ethiopian Muslims reported that

community members would be unwilling to marry into their family because of mental illness (Shibre et al., 2001). In the literature review (section 2.5), the importance of family and marriage is consistently mentioned in relation to the Indian Muslim community (Ciftci et al., 2013; Masood et al., 2009). Since family is central to the Indian culture and Muslim faith, the role of marriage in creating a family, is central to creating a culturally acceptable way of life. As an Indian Muslim woman, I have always heard and been told how important getting married is for me. It was always spoken of as an inevitability, so much so that a life of not being married was not part of the discourse. In addition, favourable characteristics that would help me to be a desirable enough wife, were always reinforced. These traits included being agreeable, family-oriented, having good culinary skills and observing some subservience to male authority. Although mental health was not an explicit conversation with regard to marriageability, mental illness was always constructed as unfavourable and a less desirable quality as a wife.

Similarly, in the interviews, depression was constructed as having a negative impact on one's marriageability. Laila related a story of the negative impact of a young man not disclosing that he was depressed to his prospective wife. She was then asked if she thought depression had an impact on one's potential to be married. Her response was as follows:

> *Laila: Yes, you get labelled. I mean marriage itself is hard work, then to get someone who could be affected maybe in some or perceived to be affected or does have the diagnoses there are concerns around that. Because are they functional to be on point to deliver in the marriage as what is necessary as partners as keeping a home, working and that work / life balance or even maintaining relations with the family, can they do that? Do they want to be isolated are they recluses?*

Laila speaks to the stigma of being depressed, in the Indian Muslim community, when she says that one is labelled. She constructs marriage here as something one has to "deliver in," that there are expectations about being a partner, the ability to deal with the expectations of family, the stress of work-life balance and there is a sense of worry that a person with depression may want to retreat/isolate (thus not taking part in the partnership and fulfiling expectations). This quote relates to various elements of stigma surrounding what it means to be depressed within the Indian

Muslim community. It specifically describes the negative impact being depressed can have on the individual's perceived capacity to be an optimal spouse. Whereas Laila did not speak about any gender specifically, Jay further explains how this stigma affects women in particular.

> *Jay: But there is, there's a thousand expectations of how and who you are. …Depression does not fit in with that. And especially in younger people, younger girls as well, in terms of 'oh no she's got to keep this image because what happens when it's time for her to get married?'*

Jay is highlighting the importance of the image one is required to maintain, within this community and culture. She states clearly that depression is not an acceptable part of that image. Depression is constructed as a threat to marriageability. In this instance, both gender and culture are significant. She is saying that not only does the South African Indian Muslim culture view being depressed as negatively impacting one's marriage potential, but in addition, it is particularly *women* who are susceptible to the community's judgement thereof. These women both in some way describe what a marriageable person would look like, that is: without depression, fulfiling partnership obligations, managing stress and adhering to cultural expectations.

This can be linked to research that shows that Indian communities uphold more traditional gender roles and more patriarchal ideas surrounding family structures (Wassenaar et al., 1998). Gender however was not indicated in Laila's explanation of marriageability. Rather, it was considered of importance within the culture, regardless of gender.

The importance of maintaining a social image within the community is constructed as central to the issue of stigma, for these women. This is further explored more broadly, below.

4.7.2 What will people think?

The phrase "what will people think?" was used by several participants and conveys a cultural norm amongst South African Indian Muslims of being preoccupied with one's social image. Furthermore, it indicated the shame associated with being viewed as

depressed by others, and one's image becoming tainted in some way. Not only is one's individual image tainted, but so is the family's.

> *Jay: I think culturally…we're expected to not talk about these things. And it goes across the board. I think the Indian community especially, if something bad happens, you have to be ashamed about it. And you have to hide it and cover it up and be all secretive about it…And you're just like 'it's shame, honour on our name'… Outdated ideologies about where we come from and 'oh no, think about what people will say'…you don't want to show weakness and you don't want to show that you, your family and your people are capable of anything less than the best.*
>
> *Naseema: I think people feel very ashamed to go through it, people feel like someone will look down on you or they will think that, they will look down upon my family because I am going through that. I think that is one of the reasons people keep quiet about it or don't make an effort to treat it. They worry more about what people will say than about how is it going to help me or my family in the future.*

Laila speaks directly to the shame and need to hide any perceived difficulties, in order to maintain a perfect image within the community. She refers to depression as something "bad" and this is constructed as shameful within the community. The shame associated with depression permeates beyond the individual: it taints the family and whoever "your people" may be. This can be understood as the broader society one is associated with as well the culture. Both Laila and Naseema speak about the shame brought to the family name, should an individual be thought to be depressed. Naseema specifically links the shame attributed to the family via the individual who is depressed. She goes onto explain how this stigma negatively impacts health-seeking behaviours amongst South African Indian Muslims. Naseema says the shame and the preoccupation with social image, causes people to delay/not access treatment. Furthermore, she highlights the hierarchical construction of image in the public domain being more important in the present, than help-seeking in the future.

> *Laila: We as a society… sometimes do not want to face the truth because of the shame and the guilt and the reputation and the stigma and what would people say… The 'I will get through this' and then they dabble in whatever they think is going to help them and it doesn't really help them but the overarching thing is what are people going to think and this is not supposed to happen.*

From the above quotation is a clear that the reality of depression is denied and kept secret, in an attempt to preserve the ideal family image. This inhibits acknowledgment of depression and health-seeking behaviours as a result. Whilst Naseema commented on the community providing supportive spaces such as support groups for those with depression, it appears to also provide pressure and public stigma. Thus, the community is constructed as both cause and cure: providing treatment for depression, as well as preventing it by adding to the public stigma.

These findings are consistent with prior research. Corrigan and Rao (2012) elaborate on the effects of public stigma, as well as the internalising of such prejudice, resulting in self-stigma. In the South African Indian Muslim community, mental illness has been shown to be shameful for both the individual affected and the family of the individual (Laher at al., 2018; Mohamed-Kaloo & Laher 2014). Abroad, similar concerns found that Indian families with family members who displayed severe mental illness were kept and hidden at home. This was due to Indian individuals' feelings of needing to honour family, issues of shame and moral responsibility and other cultural factors (Marrow & Luhrmann, 2012). Furthermore, shame has been found to be a barrier to health seeking behaviours, in international research. Lee (2012) found that shame arose as a reason for avoiding health services amongst the BME (black and minority ethnic) community in Scotland, UK.

4.8 Conclusion

The analysis and discussion chapter began by introducing the participants and the process of each interview. Thereafter an overview of the main themes, and relevant sub-themes were outlined. What depression is and is not, the causes and treatment as well as stigma were identified as the four main themes. Culture and gender were identified as important themes that influenced all areas of discussion. From the discussion, it becomes apparent that social conversations about depression are absolutely crucial in understanding constructions of depression. These women allude to various conversations amongst their family and friends who have offered them a clear sense of what is and is not acceptable within the community and culture. Depression is clearly understood as shameful, within that. Whilst their individual

constructions may vary, one is able to appreciate the significance of the social discourse that exist.

Depression is constructed in similar and different ways to that of the DSM and is heavily influenced by experience, culture and gender. It is constructed as a female illness, with an evolving discourse attributed to exposure to other global discourses. The participants constructed the cause of depression to multiple factors include faith, and a lack thereof. The experience and expectations of being an Indian Muslim woman was constructed as a possible cause to become depressed. Faith was described as both a cure and prevention for depression, with a multi-faceted approach as the preferred treatment method amongst participants. Finally, stigma, especially public stigma was seen as an impediment for help-seeking behaviours amongst Indian Muslim women. Marriageabililty was particularly negatively impacted for Indian Muslim women who were either depressed, or associated with a depressed family member.

CHAPTER 5

CONCLUSION AND EVALUATION OF THE STUDY

5.1 Introduction

The purpose of this chapter is to conclude the findings of this research. I will begin by reviewing and summarising the chapters preceding. I will then present a reflexive evaluation of this study, which is made up of self-reflexivity and methodological reflexivity. Finally, the chapter concludes with an evaluation of the contributions and limitations of this study to current literature, and recommendations for further research and practice.

5.2 Conclusions of the study

Chapter one provided an introduction to the research study on South African Indian Muslim women's constructions of depression. The study was contextualised using background information and the motivation for the study. Depression, culture and the need for indigenising knowledge to respond to local realities, was examined. The unique South African Indian Muslim culture was introduced, as well as the lack of research amongst South African Indian Muslim women. In response to this, the research topic was presented.

The literature review then explored prior research relating to this study. It began by exploring the definition of depression, according to the DSM. The medical framework used in psychiatry, to define depression, was explored and critiqued. An argument was made for the need to consider the limiting ways in which depression is currently understood, and the varying frameworks from which it could be viewed. In particular, it was argued that culture and gender should be significant factors to consider when understanding mental illness. Social constructionism was chosen as a theory which accounted for factors such as culture, gender, religion, language and the social nature of meaning-making in the understanding of depression. Cultural factors were then considered, and the impact of culture on the expression and understanding of depression was highlighted. Furthermore, it was found that such an understanding has significant value in understanding health-seeking behaviours amongst different

cultural groups. It has also been found to aid in the enriching of psychological practice in South Africa. The specific Indian Muslim culture was further investigated. Both causes and treatment of depression within the culture and the Islamic religion, was explored. Stigma within the context of culture, was then incorporated. Both self and public stigma was investigated in greater depth. The gender gap in depression was also considered, with a particular focus on several theories that attempt to make sense of this gap. Furthermore, gender in the context of the Indian Muslim culture was examined. Ultimately, the literature review conveyed the importance of enriching our understanding of depression, with a particular focus on culture and gender. More specifically, in relation to this study, it highlighted the unique nature of the Indian Muslim community in South Africa and the significance of gender within this community. Both in theory and in practice, the literature highlighted the value and need for such research.

Chapter three began by evaluating the paradigmatic assumptions of this study. It was argued that the study uses qualitative research, with inductive reasoning, to best explore the research topic. Within qualitative research, this research is epistemologically situated in the social constructionist paradigm, which understands reality as the product of one's social reality. Social constructionism focuses on types of conversations that individuals hold with those in their lives, and the way in which the individual positions him/herself in relation to cultural discourses. The various assumptions held within this paradigm were explored, and shown to be suitable for the focus of this research. The recruitment and sampling process was then described in detail. Ultimately, five self-identifying Indian Muslim women were interviewed for this study between the ages of 22 and 50 years old. A semi-structured interview style was adopted. An interview guide was used for all five interviews, with questions relating to culture, gender and personal constructions of depressions. Thematic analysis was used to analyse the data. The various steps in analysis were described further. Various criteria for quality of the research were discussed in detail, and shown to be met by the research study. Consent, confidentiality and anonymity were all ensured in the process.

The results of the study were then presented in chapter four, including the analysis and discussion. The analysis of the research was presented through four main

themes and related sub-themes. The four main themes were as follows: what depression is and is not, the causes of depression, treatment of depression and stigma. Under the first main theme titled ‘what depression is and is not’, four further sub-themes were identified. Firstly, participants spoke to the internal versus the external presentation of depression. Overall, the women’s answers reflected an attempt to understand depression with an initial focus on the internal, emotional experience of the individual and its subsequent outward expression. In their construction of depression, they differentiate between the internal lived experience and the external expression thereof. Experience as teacher was identified as the second sub-theme of what depression is and is not. The experience of either having been depressed, or knowing someone personally who had been depressed, was identified as a significant catalyst for a change in the women’s constructions of depression. Cultural understanding and its evolution is the third sub-theme. The cultural understandings of depression were thought not to account for the complex and varied manifestation of the existence of depression, as well as the notion that it exists on a spectrum. On the one hand participants spoke from their embeddedness within culture and used culture to understand depression. On the other hand, they also offered understandings that honour individual differences, downplaying culture. In addition, participants explained how the influence of culture on the construction of depression has evolved over generations. And finally, gender was explored as a sub-theme related to what depression is and is not. The participants stated that not only is depression experienced by more women than men, but men were also understood to acknowledge depression less than women.

The influence of culture and gender was evident across the themes. Under the second theme titled ‘causes of depression’, culture and gender were significant sub-themes once again. Cultural understandings of the causes of depression included having a lack of faith. Thus, faith was constructed as more powerful than depression and protective against becoming depressed, whilst a lack of it was thought to cause depression. Beyond the cultural importance of faith and spiritual connection, participants identified its significance for them personally. However, faith was but part of the participants’ understanding of the causes of depression. They highlighted the unique nature of the individual and the importance of considering multiple factors when assessing cause.

Gender was also identified as cause of depression. Participants explained the role of being an Indian Muslim women and its pressures. The demanding, and often unacknowledged, nature of being an Indian Muslim women was directly linked to causing depression. The impact of traditional gender roles, even when adopting more modern roles, was constructed as burdening to women in a unique way.

Culture continued to play a role in the participants' constructions of the treatment of depression. Generally, the participants identified multiple ways in which people who are depressed from the Muslim Indian culture consider viable treatment options. Overall these options fall within the cultural or professional domain. Within culture, Islam and faith was constructed as both a prevention and cure for depression. Once again, participants identified faith as a culturally acceptable form of treatment as well as personally significant. For some of the participants, faith as a cure was constructed as the superior means of treatment, whereas for others, faith was constructed as an equal part of a multidimensional treatment. Furthermore, the importance of faith, multidimensional and individualised treatment was emphasised by all the women. All the participants described treatment as a combination of culturally-acceptable treatment, professional forms of treatment and the involvement of support structures. The support structures included personal relationships like friends and family, as well as community-based support groups. Professional forms of treatment included medication, psychiatry, psychology or any other medical consultations. The culturally acceptable treatment identified by the women were praying, faith and consulting with Moulanas (scholars).

Stigma, within the Indian Muslim community, was identified by all the participants as significant. In the analysis, two further sub-themes were explored. Namely; marriageability and 'what will people think?'. Through the participants' constructions, marriageability is understood as the marriage potential a young woman or man within the community possesses. It appears to be a central theme in the Muslim Indian community and much worth and significance is placed on a person's success within and capacity to, be in a marriage. Depression was constructed as having a negative impact on one's marriageability. Furthermore, some participants felt that women in particular are more susceptible to the judgement thereof. This is further

exacerbated by the importance of a social image within the Indian Muslim community. The importance of maintaining a social image within the community is constructed as central to the issue of stigma. The phrase 'what will people think?' was used many times by participants to describe the significant role social image has in the Muslim Indian community, and how the stigma and shame attached to depression taints the social status of the affected person and his/her family. This shame results in individuals and families hiding the reality of depression, and thus preventing those affected, from seeking help. The public stigma associated with depression is understood to be internalised and results in self-stigma.

Following from this overview, I will now explore the reflexive evaluation of the research. Both self-reflexivity and methodological reflexivity will be examined.

5.3 Reflexive evaluation of the study

One of the most celebrated practices of qualitative research is reflexivity (Tracy, 2010). It is understood to promote honesty and authenticity between the research, the researcher and the audience. In chapter three, reflexivity was found to enhance the quality of the research (section 3.6). More specifically, reflexivity was found to enhance the dependability and transparency of the research (Houghton, Casey, Shaw & Murphy, 2013; Yardley, 2000). In accordance with this, a reflexivity journal was kept throughout the process. What follows, is a summary of the reflexivity journal. Two areas of reflexivity will be explored. Self-reflexivity will explore personal bias and experiences that may have influenced the research process and methodological reflexivity will investigate the process of analysing and interpreting the data.

5.3.1 Self-reflexivity

As a self-identifying South African Indian Muslim woman, I can appreciate the value of religion and culture in the everyday lives of those within my community. Biologically, I am mixed- race. My father is an Indian Muslim man and my mother is a mixed race Muslim woman, who comes from a varied religious and cultural background. I was, however, raised predominantly in the Indian Muslim community.

This means that I have always been a part of the culture and community, but simultaneously feel somewhat outside of it. I have always wrestled with my own identity and what it means to be of both mixed race and a mixed religious background. This research involves the complexity of identity and the individual and its very nuanced relationship in shaping our thoughts about the world. As a self-identifying Indian Muslim woman, it has incited curiosity in me- how these various aspects of identity come together to inform our way of life. This includes what it means to be an Indian Muslim *woman*. I have become more and more aware of the central role of gender within the Indian Muslim culture. Over the years, I have felt frustrated with the restrictive and often over-loaded role women play in the community. However it is clear that women also play a central role within their families. During interview three, I was particularly moved by the woman's expression of this difficulty. There was a clear sense of the burdened and silenced role that women are often expected to assume within the community. My pre-existing sensitivity to this meant that in the interview, I was especially sympathetic to this phenomenon. On the one hand this facilitated rapport. On the other hand, it could be viewed as an inhibiting element. When sympathising with the participants who I viewed as victims or disempowered, I may also have been colluding with that specific discourse and not exploring alternative discourses of empowerment and agency.

The influence of the various aspects of identity could not be ignored in the interview process. During the interview process, it became clear that self-identifying as a South African Indian Muslim woman allowed participants to engage more easily with me. Unluer (2012) identifies the advantage of having an established intimacy and a greater understanding of the culture being studied, when the researcher is an insider. In being an Indian Muslim and being a woman, and the combination of these two, meant that the women spoke to me as if I am one of them. Certain cultural and religious norms were familiar to me and participants relied on this in their engagement. Similarly, participants spoke to me openly about gender, assuming that I could understand their experience, being a woman myself. Coming from a psychological perspective, it appeared the women were willing to speak about their criticisms of cultural ideas and norms. I imagine that I was representative of a more medical perspective, with an appreciation for the cultural elements of our shared

background. Finally, my generic role as researcher and theirs, as participant, involved a particular dynamic. Whilst I, as researcher, may have been perceived as having power in being the researcher and psychologist, the participants also held power in that they held discourses that I was interested in.

Growing up in the South African Indian Muslim community, I have heard many conversations about mental illness. I became aware of the stigma attached to it, as well as the cultural understandings which were often accepted. Conversations about the importance of faith were always attached to the way people spoke about preventing depression. This has been frustrating for me. As a health care professional, this opinion felt simplistic and a barrier for people getting the appropriate help needed. In my professional capacity, I attempt to hold and be respectful of the participant's cultural beliefs. In this research process however, I became aware of this bias.

After the interview process I recognised how this bias impacted the interviews and rapport with individual participants. When participants offered ideas about depression that were more culturally-aligned, I struggled to engage with the participant more openly. My interview with Ayesha is a reflection of this. Because I have believed cultural understandings of depression to be simplistic, I was less motivated to engage with such a perspective. This had a negative impact on rapport. However, with participants who were more critical of cultural ideas of depression, and more inclusive of professional treatment and understandings, rapport was established more easily. During these interviews, the conversation developed easily and the engagement with the topic was richer and had greater depth. I did not anticipate that the women would have a personal appreciation for both cultural understandings as well as professional ones. I found this insightful in that the women offered more personal interpretations of cultural understandings of depression, and had incorporated these beliefs into a more complex overall understanding of depression. My bias meant that I assumed that cultural understandings were imposed on people rather than willingly adopted and explored by the individual. On the one hand being an insider researcher established rapport easier, facilitated by the shared meaning and familiarity with the cultural norms and the language used.

On the other hand, being an insider was inhibiting in that it favoured some discourses and negated/stifled others.

5.3.2 Methodological reflexivity

The processing of analysing and interpreting the data proved more complex in reality, compared to the steps that were set out in theory. I required guidance from my supervisor to assist me in finding a structured way in which to make sense of the data. The use of developing a coding framework offered much needed structure in the process of analysis. The reading and re-reading of the data, whilst doing this, gave me the opportunity to become increasingly familiar with the data. In addition, the grouping of themes and organisation of major and sub-themes was challenging for me. Once again, supervision was necessary to work through these challenges. I found myself questioning whether the themes I identified were 'correct' or not. It was important for me to recognise that there was no perfect or right way to organise the themes. I needed to remind myself that my interaction with the data was unique, between myself and the participants, and that the inter-subjective, co-constructionist nature of the analysis was part of the process. Whilst there was no perfect analysis, I needed to balance my appreciation of my role as researcher in the co-construction of the interview process, as well as attempt to be fair in my presentation of what participants' intended to convey.

Furthermore, the concept of co-construction was challenging to fully comprehend in the analysis. I found that it was easier for me to describe the themes that emerged, but not necessarily understand *how* the socio-cultural context and discourses had influenced the emergence of such themes. In particular, I found it challenging to frame my finding in terms of discourses. My training as a clinical psychologist largely focused on the individual's experience of his/her world. Shifting my focus towards viewing the individual's constructions as part of a broader socio-cultural reality, required constant revision.

Morrow (2005) explains that participants' constructions of meaning depends on various factors. She includes the importance of rapport, amongst these factors. This links the importance of rapport with the eventual aim of analysis, of the data. In the

data collection process, discussing the research with participants as well as the process of requesting informed consent prior to commencing, helped build rapport with participants. Participants were prepared prior to the interview and engaged in a manner that recognised their agency. This was valuable to the interview process and eventually, the process of analysis and interpretation of the data. In facilitating rapport, this process enhanced the richness and authenticity of the interviews.

5.4 Limitations, strengths and contributions

In this section, the limitations and strengths/contributions pertaining to this research study will be addressed.

5.4.1 Limitations

The first limitation of this study is with regards to the sample used. The sample included five self-identifying Indian Muslim women from the broader Johannesburg area. As such Indian Muslim women from other parts of South Africa may have varying experiences compared to those in this study, that are particular to the Indian Muslim community within that area of South Africa. Therefore it would be inadvisable to generalise findings to all Indian Muslim women in South Africa. Whilst similarities may exist, generalisability is limited. In addition, the sample of participants are from the South African Indian Muslim community who have multiple generations who have been born in South Africa. Thus, this study is also limited to the more established Indian Muslim community in South Africa, as opposed to the newer immigrant population of Indian Muslims.

Secondly, my inexperience as a novice researcher and anxiety conducting my first qualitative research, could have negatively impacted the interview process. Looking back, I am aware that I struggled to elicit richness in the interviews when participants were less open and descriptive in their answers.

Thirdly, the thematic analysis method adopted, required me to use my own interpretation of the data to analyse and extract themes from the data. Thus, the findings of this study cannot be considered absolute truths. Rather, the results and

interpretations reflect my individual co-construction of the interview process and analysis. I did, however, discuss the measures and criteria I had taken and considered to ensure the quality of the research (Chapter three).

5.4.2 Strengths and contributions

This study highlighted and deepened the understanding of Indian Muslim women's constructions of depression. It adds to a very limited body of research within this population group. Moreover, it brings to light, the social nature of meaning-making and therefore, of understanding depression. Thus, it adds to the growing body of research which seeks to emphasise cultural factors in understanding mental health, and the treatment thereof. This study highlighted the need to consider gender, within culture, when seeking to understand constructions of mental health and mental illness. Not only does this enrich an awareness for cultural sensitivity in mental health, but seeks to challenge prescriptive notions of mental illness. And in so doing, appreciate the multi-faceted and nuanced approach that is needed to understand constructions of depression, and mental health, in general. These factors all contribute to deepening understandings of depression and localised constructions of mental health in South Africa, to ensure better treatment and clinical practice.

5.5 Recommendations

This section proposes a set of recommendations based on the findings of the study. These recommendations will assist in the treatment of depression. Furthermore, recommendations about possible future studies will also be discussed.

5.5.1 Recommendations for practice/treatment

This research highlights the need for a broadening and bridging of mental health understandings and treatment between the individual and their social world. It is apparent from the research, that the Indian Muslim community have a unique composition and have a strong collectivist identity which impacts individual constructions of depression and treatment. Community-based programmes may be useful to educate and help de-stigmatise depression. Furthermore, community

support was identified as valuable in the treatment of depression, and may thus be especially valuable to those in the Indian Muslim community.

In individual treatment, the experience of women in this community must be explored. It is apparent that culture and gender have a significant impact on the construction of depression and thus are key components in effective clinical practice. The themes explored in this study indicate that culture and gender influence how individuals understand what depression is, what it is not, the causes and treatment thereof as well as the stigma attached to it. Thus, even in individual work, the broader social reality must be appreciated and brought in to deepen an understanding of the individual. The participants highlight the need for the female experience, within the Indian Muslim community, to be seen and appreciated in treatment. Whilst the focus of the study is women, other genders' experiences are equally important to be considered in treatment.

5.5.2 Recommendations for future research

Women in this study speak to the significant role of women in all areas of life. In addition, they are understood to have greater risk factors in relation to depression, and are therefore considered more vulnerable. Furthermore, women in the Indian Muslim community expressed their unseen experience, and its relation to depression. Thus, further research for women in the Indian Muslim community would be valuable to address this. Similar research could be conducted with men in the Indian Muslim community. The results of this study allude to the often repressed emotional experience of men within this community, thus further research may be valuable in bringing Indian Muslim men's constructions of depression to light. In addition, further research in other Indian Muslim communities in South Africa would be valuable. Participants mentioned the nuances of different South African Indian Muslim communities within South Africa. These varying experiences would be valuable to enrich understanding.

The role of first and second generation immigration groups within the Indian Muslim population, may be another avenue to be researched. Whilst this research included South African Indian Muslim women who have had more than two generations of

family who were born here, further researcher may explore how first and second generation immigrants construct depression. Previous research indicates that this has an impact on health-seeking behaviour (discussed in chapter two). This study also found that cultural influence on constructions of depression were influenced by generation and has evolved over time. This further supports the need for research of those in first and second generation immigration populations, within the South African Indian Muslim population

5.6 Conclusion

This research study sought to explore South African Indian Muslim women's constructions of depression, with a focus on the influence of culture and gender on these constructions. This chapter summarised the study and the findings obtained by means of thematic analysis and highlighted the complexity of these participants' constructions. A reflexive evaluation of the study was then explored, focusing on both self-reflexivity and methodological reflexivity. And finally, the limitations, strengths/contributions, and recommendations for future research were addressed to conclude the chapter.

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APPENDIX A
ETHICAL APPROVAL FROM FACULTY

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Research Ethics Committee

1 March 2017

Dear Prof Maree

Project:	**An exploration of Indian Muslim women's construction of depression**
Researcher:	**S Dockrat**
Supervisor:	**Ms A Prinsloo**
Department:	**Psychology**
Reference number:	**16305770 (GW20161116HS)**

Thank you for the response to the Committee's correspondence of 7 December 2016.

I have pleasure in informing you that the Research Ethics Committee formally **approved** the above study at an *ad hoc* meeting held on 1 March 2017. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should your actual research depart significantly from the proposed research, it will be necessary to apply for a new research approval and ethical clearance.

The Committee requests you to convey this approval to the researcher.

We wish you success with the project.

Sincerely

Prof Maxi Schoeman
Deputy Dean: Postgraduate and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

APPENDIX B

INFORMATION LEAFLET

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

Title of study

An exploration of Indian Muslim women's constructions of depression.

Invitation

We invite you to participate in a research study. This leaflet is meant to help you decide if you would like to participate and help inform you about the procedure and what is involved. If there is anything further you would like to know, please do no hesitate to ask the researcher, Safia Dockrat.

Purpose of study

This study seeks to understand how South African Indian Muslim women understand depression, and how culture and gender have influenced this understanding. Approximately 4-8 women from the South African Indian Muslim community who self-identify as such, will participate in the study. Your contribution will be greatly appreciated.

Procedures

The study involves conducting interviews, each approximately an hour long. The researcher, Safia Dockrat, will ask you questions during the interview about your understandings of depression, cultural influences concerning this understanding and the role of gender as a possible consideration. There will also be questions regarding your perceptions about treatment and the causes of depression. Because the study is interested in your unique understanding, there are no right and wrong answers. This study is not about how you have experienced depression, rather, it is about thoughts of depression in your culture in general.

Risk and discomfort involved

There are no immediate risks in participating in this study. If there are any questions that make you uncomfortable, you do not need to answer them. If you feel that after the interview, you require further support regarding any uncomfortable content that the interview may have brought up, a toll-free counselling service contact number is provided below.

Lifeline counselling line: 0861 322 322

Possible benefits of the study

There are no incentives or direct benefits to you, for your participation in this study. Your participation in this study will help inform mental health professionals and researchers better understand the influence of culture and gender in the understandings of depression. This may in turn help us to develop more effective treatment strategies cross-culturally.

What are your rights as participants?

Your participation in this study is entirely voluntary. You can refuse to participate and withdraw participation during the interview at any point, without giving any reason. Your withdrawal will not negatively affect you in any way.

Ethics approval

This study has received written approval from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria. Copies of the approval letter is available you, should you request one.

Information and contact person

The contact person for this study is Safia Dockrat. If you have any queries about the study, please contact her at 073 388 3021. Alternatively, you may contact the supervisor, Adri Prinsloo, at 012 420 2918.

Compensation

Your participation in this study is done so on a voluntary basis. There will be no compensation for your participation.

Confidentiality

All information that you provide will be kept strictly confidential. Once we have analysed the information, no one will be able to identify you. The information will then be archived for future research and stored in the Humanities building at the University of Pretoria, in HSB 11-24. Research reports and articles in psychology journals will not include any information that may identify you. Pseudonyms will be used when reporting on the results and findings in the journal article in which the results are to be published.

APPENDIX C

CONSENT TO PARTICIPATE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Department of Psychology

CONSENT TO PATICIPATE IN THIS STUDY

I confirm that the researcher conducting this study has told me about the nature, process, risks, discomforts and benefits of the study. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not have any negative consequences for me.

I have received a signed copy of this informed consent agreement.

Participant's name _____

Date _____ Place

_____

Participant's signature _____

APPENDIX D

SEMI-STRUCTURED INTERVIEW GUIDE

1. As an Indian Muslim woman, what do you understand depression to be?
2. Has this understanding changed over time? If so, how and why?
3. Do you feel your understanding of depression differs to the cultural understanding in any way? How so?
4. What role do you think culture plays in how you understand depression?
5. From your point of view, do Indian Muslim women and men perceive depression in the same way?
6. What are the cultural ideas around the cause/s of depression?
7. How do your understandings about the causes of depression differ from these cultural ones?
8. What are the cultural ideas around acceptable treatment for depression?
9. How do your understandings about acceptable treatment of depression differ from these cultural ones?
10. How do you think people from different generations agree or differ in their beliefs about depression?
11. Do you think there is a stigma around speaking about depression or being diagnosed with depression? If so, please explain further.

APPENDIX E

CODING FRAMEWORK

Definition

- D- what it is not
- D- by stigma
- D- voluntary
- D-illness
- D- disconnection
- D- functionality
- D- mind-state
- D-behavioural change
- D- biological
- D- imbalance
- D- hopeless
- D- change/constant experience↵

(I added experience as a significant link to a change in the understanding/definition of depression)

- D- cultural denial (Cd)
- D-cultural affirmation (Ca)
- Cultural D- simplistic
- D- men
    - deny/suffer too
    - under recognising/ minimising
- D- women
    - acknowledge/deny
    - supportive
    - increased incidence
    - roles vs individual (this may need to be broadened as relating not only to depression, but also as a cause)
    - “So I can find support in the collective but I don’t exist”
- D- gender differences
- D- aligns with culture (ac)

- D- separate from culture (sc)
- D- generational differences
    - du2 (reasons for generational differences in understanding
        - (values, context, varied sources of knowledge)
- D- OldGen
    - Denies/ acknowledges
- D- YGen
    - Denies/acknowledges

Treatment

- T- C (Islamic Practices)
- P- C (Islamic practices) – here I felt the participant spoke to both it as a treatment and preventative measure- requiring different codes.
- T- Professional (meds, psychiatry, psychology)
- T- C & P
- T- personal support
- T- agency/action
- T- multiple factors

Du 2 (Causes)

- Du2- coping ability
- Du2- losses/disappointments
- Du2- challenging life events
- Du2- non-acceptance
- Du2- decreased support/isolation
- Du2- gender differences
- Du2- gendered coping (rumination, loss of self, demand of roles)
  (I'm not sure if the specifics are needed but I felt the specific combination of gender and the way it informs coping, was significant)
- Du 2- changes & demands (for women)/ gender roles
- Du2 lack of faith
- Du- becoming possessed
- Du2- materialism/discontent
- Du2- changes in lifestyle

- Du2- self-esteem difficulties
- Du2 technology

Stigma

- S- Reporting
- S- About the afflicted
- S- marriageability
- S-helping
- S-seeking treatment
- S- collectivist identity

  (what I was trying to capture here was the influence of not wanting to bring dishonour to family and how the community perceives one)
- Anti-stigma- technology

Individual

(This is its own code. We had flagged the participant stressing the unique individual experience and situation as opposed to cultural norms, which came up again and again in the next interview. To me this permeates the specific categories and therefore needed its own category/coding. It appears to influence various bigger codes eg. Definition, treatment, cause).

- Cultural relativism – the idea that within one culture there are differences- so even within this community, there's commonality but not the same.