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An Afrocentric exploration of South African cultural-religious narratives of depression

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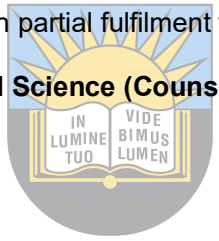

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DECLARATION

I Matthew Conway-Cleaves, student number 202100340 declare that this Dissertation titled "An Afrocentric exploration of South African cultural-religious narratives of depression", submitted for the award of Master of Social Science (Counselling Psychology) in the Faculty of Social Sciences and Humanities at the University of Fort Hare, is my own work and has never been submitted for any other degree at this university or any other university.

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AUTHORS' NOTE

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ABSTRACT

The perceptions of causes of depression are diverse, formulated from many different factors such as personal experiences, education, generational and cultural influences, and religious beliefs. While there is a large body of literature on both depression and religion and culture, there is a limited amount available that synthesizes the findings of multiple different studies, finding key common themes. Therefore, this review aimed to develop a comprehensive understanding of how religious and cultural narratives describe and influence depression. As a result, a meta-ethnography was carried out to synthesise existing literature on cultural-religious narratives of depression within a South African context. Five published journal articles were sampled for translation and synthesis. From this process, three key themes were developed, namely Conflictual Coexistence, Observation-Based Discernment, and Status or Stigma. The result is a lens that is formed through a mixture of traditional cultural religious traditions and beliefs interconnected with contemporary ways of understanding and being. This framework for diagnosing and treating a mental illness is heavily reliant on observable symptoms. As a result, status or stigma can be attached to multiple aspects of the situation surrounding an individual with or suspected of having a mental illness. Stigmatisation can be noted to form a cycle that becomes inclusive of prognosis, finance/employment and not being able to fulfil culturally held expectations. As a result, future research, and therapeutic intervention of this mental disorder within this demographic will be better informed.

Keywords: depression, beliefs, culture, religion, South Africa, narratives, qualitative, meta-ethnography, conceptualisation, treatment seeking, outcomes

Table Of Contents

Chapter 1: Introduction

1.1 Introduction and Background

Depression is a severe mood disorder that affects both thought and behavioural patterns (Depression, 2021). The perceptions of causes of depression are diverse, formulated from many different factors such as personal experiences, education, generational and cultural influences, and religious beliefs (Murphy & Hankerson, 2017).

Religious belief and spirituality are interconnected with culture in the formation of systems of meaning and values (Eckersley, 2007). Culture can be understood as a constructed system as a result of ongoing processes of interaction between humans. Therefore, it is a general yet complex system within a society that can negatively or positively influence the behaviours, perspectives, and thoughts of humans within said system (Bhugra & Becker, 2005). This complex system in conjunction with a bio-medical condition results in a complex experience and comprehension of the biological issue for both the individual and the community.

While there is a large body of literature on both depression and religion and culture, there is a limited amount available that synthesizes the findings of multiple different studies, finding key common themes. To position the review, the following sections provide a brief contextual overview on international and South African literature relating to culture, religion, spirituality, and mental health. The delineation of these constructs is presented in the literature review in chapter 2.

1.1.1 International Context

Within an international context, studies focusing on populations within the United States, the United Kingdom, Norway, Germany, and the Asian continent were selected for review. Several themes were identified including the influence of acculturation, multi-cultural comparisons and variations within a single geographical location, and the influence of religion.

Within the United States, religious and spiritual practices were noted to increase life satisfaction, and serve as a protective buffer against depression (Desmond et al., 2018).

These positive effects however tend to be mitigated by negative experiences within the religious system, and insecure developmental attachment styles that are exacerbated through social isolation (Klausli & Caudill, 2018).

Within minority groups, a western framed psychosocial/biological attribution of depression was held by the majority of participants, however, a significant minority still attributed causal beliefs to the supernatural and cultural beliefs (Murphy & Hankerson, 2017). While depression prevalence is noted as being the lowest amongst African Americans, the consequences that discrimination has on the prognosis are far more severe than in non-minority groups (Mereish et al., 2016).

Cases of acculturation identified included Japanese, Nigerian, Hispanic and Turkish immigrant populations. Identity formation and stability in youth before immigration was noted to be a protective buffer against depressive symptoms brought on through cultural adaptation (Meca et al., 2019). In agreement, immigrants in a German study were more likely to develop depressive symptoms when replacing or integrating the new host culture with their own (Behrens et al., 2015). Dominant cultural conceptualizations of phenomena can often be rejected by immigrants to either reduce depressive symptoms or out of obligation when the native culture prohibits or has no conceptual framework for understanding the phenomena (Meca et al., 2019). Cultural participation is noted as a protective buffer against depression (Cuypers et al., 2011). Within Asian communities, greater stigma is attached to depression and the resulting symptoms, however, Chinese narratives positively framing adversaries have been shown to increase resilience which acts as a protective buffer (Li et al., 2021).

Through globalization, the interconnection between cultures has become more prevalent resulting in an amalgamation of cultures in singular geographic locations. Comparative studies by Chang et al. (2011), McClelland et al. (2013) and Jobson et al. (2018) identified common distinguishing features between each study's cultural comparatives. The aspects investigated within these studies could fall within the constructs of either individualism or collectivism. Both constructs can be noted to influence the reporting

of depression, treatment-seeking behaviours and prognosis both positively and negatively. Neither of the two constructs was identified to hold exclusivity to a predominantly positive or negative influence.

1.1.2 South African Context

Several themes were identified in studies focusing on mental health and culture within a South African context: the influence of religious/cultural beliefs, the influence of stigma and perspectives on mental health from traditional spiritual healers.

Religious association in the form of belief or practice was noted as a protective buffer against depressive symptomology (Tomita & Ramlall, 2018). These cultural influences have also been noted to mitigate depressive symptoms stemming from socio-economic factors such as unemployment, discrimination, and stigma (Sorsdahl & Stein, 2010). In certain contexts where mental health literacy is low, cultural/religious stigmatization can result in the worsening of depressive symptoms and or the somatization of symptoms (Laher et al., 2018). Furthermore, low levels of mental health literacy in conjunction with high levels of stigma resulted in greater levels of ignorance in terms of treatment options (Sorsdahl et al., 2010).

When spiritual or cultural causal explanations were provided to explain depressive symptoms, subsequent treatment-seeking behaviours would align with culturally related forms of healing (Burns et al., 2010). For traditional healers, Western biomedical forms of treatment are seen as subservient to traditional forms of treatment that only serve the patient to be strong enough to receive traditional treatments (Sorsdahl et al., 2010).

While concerns are raised by medical professionals around the lack of mental health literacy among traditional healers, a collaborative effort with them has revealed positive results in preventative measures and adherence to treatment plans for patients (Sorsdahl et al., 2010).

1.2 Research Problem

Culture shapes the explanatory descriptors and experiences, the types of treatment pursued, the perceptions of medical professionals and the prognosis of mental illnesses

(Laher et al., 2018). Furthermore, communication between the psychologist and client is highly influenced by the language that is constructed from spiritual and cultural beliefs formed within both individuals' contexts (Mayer & Viviers, 2014).

Based on medical, epidemiological data, surveys, and meta-regression modelling within the time frame 1990 to 2017, the global prevalence of depression is significantly rising (Global Burden of Disease (GBD 2019), 2020). According to the World Health Organization, over 264 million people globally are affected by depression and close to 800 000 people die each year due to suicide which is noted as one of the severe consequences of depression (Depression, 2020).

Literature indicates influential associations between depression and the societal context it is experienced within. If the systems of meaning formed by cultural and religious beliefs are neglected by mental health practitioners, the development of effective interventions, treatment and trust in healthcare intuitions will be hindered. A study that increases the knowledge and understanding of these systems of meaning, can increase the effectiveness of interventions and treatment, establish greater trust between communities and mental health practitioners and therefore be of great benefit to the mental health of society.

Therefore, based on the rising prevalence of depression and the association of depression and the sociocultural setting in which it is experienced in, a need has been identified to explore cultural and religious systems of meaning in relation to depression so that theory or new conceptualisations may be produced.

1.3 Research Question

1.3.1 Main Research Question

Within a South African context, what influence do Cultural and Religious Narratives of mental health have on depression?

1.3.2 Sub Research Questions

1. How is depression understood within the religious/cultural context?

2. What are the various treatment-seeking behaviours or responses to the symptoms of depression?
3. How do the cultural/religious beliefs/practices influence the course and prognosis of mental depression itself?

1.4 Aims and Objectives

This review aims to develop a comprehensive understanding of how religious and cultural narratives describe and influence depression.

The first objective of the study is to explore how depression is understood within an Afrocentric religious and cultural context.

The second objective of the study is to describe treatment-seeking behaviours and responses to depressive symptoms.

The third objective of the study is to explore how cultural beliefs and practices influence the prognosis of depression.

1.5 Theoretical Framework

The theoretical underpinnings of the study are grounded in a social constructionism framework. The constructionist approach is based on the philosophical framework of understanding and addressing the dynamic changes in post-modern societies (Gergen, 1994). The social constructionist approach has been selected as a theoretical framework as its purpose is not to affirm universal elements or evaluate which perception is ‘better’, but rather to offer specific guidance concerning the techniques suited to obtaining an understanding of the influence of social perceptions (Harré, 2002). The emphasis is placed on the exploration of how perceptions of self are developed as a result of social environmental interaction. Perception is a result of awareness, and it allows individuals to process objects and ideas in their world. Therefore, individuals make subjective judgements about objects and facts in a variety of ways. It is also important to note that how individuals think about the self and other subjects usually is through the concepts themselves, concepts which are products of the societies (Tyler & Slater, 2018). However, it is important to note that the existence of certain objects and facts is not dependent on human perception.

While the biological aspects of depression can be understood as one of these independent factors, it remains a considerably noteworthy research issue as to how social and cultural factors influence the development and outcomes of a diagnosis.

Possibilities of engagement are limited in advance by the structures that reinforce the social narrative of depression (Ritzer & Stepnisky, 2013). This informs and shapes the language, understanding and terms of engagement with the presentation of depression. Language makes the world concrete, comprehensible, and tangible in a pragmatic way. Speakers can convey reality and make meaning of facts and occurrences through the use of language (Tyler & Slater, 2018). Within these interactions, language is emphasized as a form of reality creation and reinforcement (Camargo-Borges & Rasera, 2013).

Socially constructed narratives have an explicit role in the forming and retaining of social realities of how depression is defined and understood (Hayward & Bright, 1997). These shifting dynamics within societies are noted as the result of meanings that are socially constructed through the various interactions of people within societal contexts (Gergen, 1994). These conceptualisations can result in a stigma that can be held by both the community and the individuals with depression (Sayce, 1998). Stigmatisation occurs when the norms of a society identify certain constructs as deviant and in violation of the community's values (Goffman, 1963; Pitchford, 2001).

Social constructionism has evolved into an overarching label for a collection of methods of understanding the activities within psychology and sociology. In terms of research, it is an approach dealing with the structure and formation of knowledge. As a result, social constructionism is particularly concerned with the perceptions held of the world as representations of reality. This approach provides a theoretical framework of assumptions that are foundational to the understanding of the qualitative data that will be extracted.

The research activity itself is also understood within this theoretical framework. The research process is understood as a sense-making action and tool used to assist a knowledge production process (McNamee & Gergen, 1998). It describes and guides the process of analyzing and synthesizing the data collected from previous qualitative research.

1.6 Rationale for Using a Meta-Ethnography

Determining whether a study aims to aggregate data or interpret data to construct conceptual understandings of a phenomenon, will inform the researcher what form of qualitative synthesis will be selected. As the aim of this study is in line with the latter, a meta-ethnography was utilized.

The method, proposed by Noblit and Hare (1988), goes beyond just aggregating study findings. Their approach was utilized to combine the topics of many studies to create something new. This research design allows for a broader and more in-depth knowledge of depression experiences and/or perceptions to be obtained. In turn, allowing for the generation of unique conceptual insights.

Additionally, this research design is commonly used within healthcare settings, particularly for questions relevant to patient experiences to inform policy and practice (Atkins et al., 2008).

1.7 Structure of Mini-Dissertation

This mini dissertation is divided into five chapters. Chapter two addresses the relevant literature about culture, religion/spirituality, depression and more specifically how these concepts relate to experience, treatment-seeking behaviours and prognosis. Chapter three outlines the study's research design and methodology. Additionally, the chapter provides the phases employed in the carrying out of the study. Lastly, the ethical considerations are contextualized. Chapter four documents the characteristics as well as the results of the translation and synthesis of the selected studies. The fifth and final chapter integrates and discusses the data from the previous three chapters. The chapter is then concluded with the strengths and limitations of the study and recommendations for further research.

Table 1

Structure of Mini Dissertation (The seven steps by Noblit and Hare)

Chapter 1	**Introduction**		
	Phase 1 - Selecting meta-ethnography and getting started	Rationale	Introduction & Background
		Aim of Study	Research Question
		Focus	Aim and Objectives
		Rationale for use of meta-ethnography	Theoretical Framework
			Rationale for use of meta-ethnography
			Structure of mini dissertation
			Conclusion
Chapter 2	**Literature Review**		
			Introduction
			Literature Review
			Conclusion
Chapter 3	**Research Methodology**		
	Phase 2 - Deciding what is relevant	Search strategy	Introduction
		Search Process	Research Paradigm
		Selecting Primary Studies	Research Approach
	Phase 3 - Reading included studies	Reading and data extraction approach	Research Design
	Phase 4 - Determining how studies are related	Process for determining how studies are related	
	Phase 5 - Translating studies into one another	Process of translating studies	
		Synthesis process	
			Ethical Considerations
			Conclusion
Chapter 4	**Results**		
	Phase 2 - Deciding what is relevant	Outcome of study selection	Introduction
	Phase 3 - Reading included studies	Presenting characteristics of included studies	Outcome and Characteristics
	Phase 4 - Determining how studies are related	Outcome of relating studies	Relation and Translation
	Phase 5 - Translating studies into one another	Outcome of translation	Data Synthesis
	Phase 6 - Synthesizing translations	Outcome of synthesis process	Discussion
			Conclusion
Chapter 5	**Summary and Conclusion**		
	Phase 7 - Expressing the Synthesis	Summary of findings	Introduction
		Strengths, limitations, and reflexivity	Summary of Findings
		Recommendations and conclusion	Strengths, limitations, and reflexivity
			Conclusion

Note. The greyed content indicates what phase items of the eMERGe Meta-ethnography reporting guidance are incorporated into the chapters of this report.

1.8 Conclusion

This chapter outlined the background of the research by providing a brief national and international contextualization of the topic. It then rationalized the need for a synthesis of available data about experiences influenced by various cultures and beliefs.

While biological attributions undeniably account for various aspects of depression, no less focus should be given to the influences of culture and belief on how it is understood and how it influences the response. No studies were discovered that synthesize these concepts. The study will therefore attempt to fill this gap for the development of a guiding framework. The following chapter takes an in-depth look at the scope of relevant literature on the topic.

Chapter 2: Literature review

2.1 Introduction

Lived experience and behavioural theories can often be thought of as unscientific and less adaptable. As a consequence, subjective ideas like spirituality and culture based on human experiences tend to be overlooked, denying access to the holistic perspective based on traditional wisdom (Booth, 2012; Eliason & Amodia, 2007). A holistic approach to healthcare cannot overlook a person's spiritual, religious, and cultural components (AHNA & ANA, 2019; Sawatzky & Pesut, 2005).

The term "religion" "is not a neutral signifier, rather it has significant implications of a partisan and philosophical nature (Ramsey and Ledbetter, 2001). Due to this lack of neutrality, the term is further explored and delineated to provide a framework for the following chapters. Following the exploration of these terms as well as culture and depression, this chapter will explore relevant literature relating to how culture and religion influence comprehension of depression, influence treatment-seeking behaviours and prognosis.

2.2 Religion and Spirituality

The word religion originates from the Latin root *religio*, which denotes a relationship between humans and some greater-than-human power (Hill et al., 2000). Religion is often linked to specific acts or rituals used to demonstrate devotion towards a Deity or deities (Hill et al., 2000). It is often articulated through denominational systems and the doctrine of these systems can be linked to traditional ideals and activities associated with various subgroups of people or faiths. Within a religious system, the individual is related to a particular set of beliefs, Deities, sacred texts, morals, and ethics (Yeşilçınar et al., 2018). On the subject of psychological well-being and religion, there has been a significant volume of studies (Hafeez & Rafique, 2013).

Spirituality has generally been associated with religion, although it has gained popularity beyond the association with religion since the 1960s (Hill et al., 2000). Tradition,

norms, culture, and conscious aims are noted as the more prominent aspects of religion, as opposed to spirituality (Taliaferro, 2008; Yeşilçnar et al., 2018).

Spirituality is a subjective and metaphysical concept with a multitude of preconceptions. Spirituality is a linking of something beyond oneself and something within themself (Florczak, 2010; Lavorato Neto et al., 2018), and people interpret and experience it in various ways, whether through the discipline of a specific religion (Yeşilçnar et al., 2018), outside of an organized religious system or through an amalgamation of different philosophical and religious customs (Lavorato Neto et al., 2018). Spirituality can be religious or secular. It is a human attempt to connect with God, self, or nature, as a process of finding purpose and meaning (Burkhart & Hogan, 2008).

Individuals who may not consider themselves religious can have spiritual experiences. For instance, a person could have a spiritual encounter with nature and so be greatly impacted by it (de Jager Meezenbroek et al., 2010). In everyday language, the phrase spiritual, for example, is used to indicate something gratifying, moving, profound, or significant (Hill & Pargament, 2003). Hill and colleagues believe that without a feeling of sanctity, activities and lifestyles can be gratifying, touching, significant, and important, however, they are not spiritual. In this usage, sacred refers to a person, philosophy, or concept that is greater than oneself (Hill & Pargament, 2003).

God-centred spirituality has a theological foundation and intersects with religion. Spirituality that is world centred and humanistic is concerned with a connection to nature and human advancement and potential, respectively (Hill et al., 2000). In the present era, spirituality is an extensive word that encompasses beliefs that aren't necessarily related to God or gods. Spirituality is seen as a fundamental phenomenon, with spiritual structures embodying psychological and emotional traits that are inherited from one's parents and influence one's behaviour throughout life (Piedmont, 2005).

Alternatively, Pargament et al. (2005) provide a definition of religion that includes both concepts of a desire for meaning in ways connected to the “what” that is sacred. This concept is not restricted by a specific religion, denomination, or doctrine, and allows for

personal choice of what merits importance. By the aforementioned definition, the terms religion and spirituality will be used interchangeably in this text.

Religion and spirituality are complicated internal and social factors that have received little attention in formal health provision discourse. As studies have yet to achieve a singular consensus on how to define these multi-dimensional words, there are numerous conflicting definitions of religiosity and spirituality. Approaches for research however have been established. An example of such is the application of Hill's criterion to establish a baseline for the two phrases. According to Hill et al. (2000), although the terms religiosity and spirituality have different meanings, spirituality may be a valuable complement to religious practice, and religious practice can give depth to spirituality. As a result, the two words are related but not interchangeable (Adams et al., 2000). When scholars and health professionals unknowingly use the terms interchangeably, Hill and colleagues claim that it diminishes certain crucial aspects of religion and spirituality (Hill et al., 2000). However, separating religion and spirituality within the praxis of research may result in redundant ideas and indicators (Hill & Pargament, 2003).

Therefore, in the literature with a narrow scope, spirituality, religion, and faith can interchangeably be employed (Yeşilçınar et al., 2018). However, it remains crucial that there is an awareness of how these terms are distinct and delineated where necessary to ensure that redundancies are reduced and that crucial distinguishment where appropriate, is noted.

Keyes (2011) discusses how finding a sense of meaning in life is more about the specific solutions we discover to our inquiries about purpose than an inevitable guarantee of pleasure and morality. As a result, religion and spirituality are extremely personal expressions, and the specific implications of adhering to a specific faith cannot be predicted. Knowing the distinction between spirituality and religion is crucial in health care provision as these terms can elicit various meanings for different people as spiritual elements are often personal (Yeşilçınar et al., 2018). Therefore, in practice, practitioners need to understand what the terms religion and spirituality imply, how they are related and dissimilar, and where they deviate and converge.

An Afrocentric approach asserts that there are two main levels of reality—the observable and invisible, or the physical and spiritual realms. These levels are interconnected with a theoretical emphasis on the reciprocity that take place between the commonplace and the supernatural (Nwoye, 2022). This perspective holds that nature, humankind, and the spiritual all coexist in unison and make up a single, well-ordered totality (van der Merwe et al., 2016). Within this totality, the implication of the spiritual realm is noted as crucial to how Africans behave socially and morally. Many spiritual entities and energies, both good and bad, have an impact on people's and groups' day-to-day existences (van der Merwe et al., 2016).

The factors that are bi-directional in influence concerning spirituality and religion include cognitive, emotional, social, interpersonal, and physiological aspects that in turn influence health (Hill & Pargament, 2003). Religion and spirituality may have a significant impact on one's quality of life and subjective well-being (Abdel-Khalek, 2010). Religious and spiritual challenges have been linked to both favourable and poor health outcomes in individuals, according to various empirical studies (Williams & Sternthal, 2007; Koenig, 2012; Schlundt, 2008). Living a religious and spiritual life, however, does not ensure a trouble-free existence. Even the most well-known founders of the world's prominent faiths, such as Buddha, Moses, Mohammed, and Jesus Christ, struggled. Paradoxically, religious, and spiritual difficulties and tribulations can be beneficial as they might lead a person on or off the path of spiritual significance and progress (Hill & Pargament, 2003). Interpersonal, intraindividual, and God-related religious and spiritual conflicts have been classified by psychologists as interpersonal, intraindividual, and God-related struggles. The conflict between the individual and others in his or her social life, such as a spouse, family member, or religious group, is common in interpersonal problems (Hill & Pargament, 2003). Intraindividual battles are characterized by tensions arising from an individual's sentiments or actions, as well as qualities that the person values (Hill & Pargament, 2003). Struggles with God might involve questions about the divine, as well as questions about God's mercy,

sovereignty, or design for the individual (Davies & Thate, 2017). These theological and spiritual conflicts are significant since they affect one's health and well-being.

The impact of faith and spirituality in dealing with stressful circumstances, disease, health, and welfare is extensively documented in literature. During such circumstances, spirituality may assist in coping and making sense of the circumstances in a beneficial manner (Greenstreet, 2006). Faith is noted as a powerful resource for fostering hope (Nedderman et al., 2010). Religiousness and spirituality can be significantly connected with individual psychological health. In this regard, religiousness and spirituality have a positive impact on physical and psychological wellbeing (Burris et al., 2009).

In the three years following the terror attacks of September 11th, 2001, in the United States, religion was associated with fewer cases of mental illness, more optimistic attitudes, and fewer occurrences of cognitive deficits (Silver, 2002). Reduced accounts of physician-diagnosed mental health issues, such as anxiety and depression, have also been associated with religiosity (Silver, 2002). Providing purpose to life and hope towards the end of life and decreasing rates of substance abuse and suicide are additional benefits that have been reported (Hill et al., 2000; Koenig & Larson, 2001).

While religion and spirituality may be beneficial to people, they can also be harmful (Hill et al., 2000). Some of these adverse implications on people include increased rates of discrimination, anxiety, and feelings of guilt and shame when not adhering to social standards and traditions (Koening & Larson, 2001). Furthermore, perceiving pressures as a divine punishment or passively expecting a higher power to fix issues, or believing problems are beyond a Deity's power to solve have all been connected to depression and poor cognitive functioning. African psychology, in contrast to humanistic approaches, acknowledges that while people contribute to the environment, they do not fully control it. In this sense, they are not exclusively culpable for the outcomes of their drive for self-actualization (Nwoye, 2022). Moreover, Nwoye, (2022) there is a propensity to ascribe various tragedies, illnesses, deaths, and failures on omnipresent bad spirits, vengeful ancestors, and forces of fate working through nature as well as some evil individuals.

A large portion of research however has revealed that those who identify as religious or spiritual have greater levels of wellbeing (Bożek et al., 2020; Villani et al., 2019; Jackson & Bergeman, 2011; Unterrainer et al., 2012). Some hypotheses for this influence emphasize how religion, in particular, may serve as a source of identity and social support, as well as a framework for approaching existential unknowns (Ivtzan et al., 2011). Religion/spirituality also extends psychological resources, fosters healthy behaviours, and contributes to a feeling of coherence, according to George et al. (2002). Additional research has found that positive well-being associated with greater degrees of religiosity outweighs the advantages of other resources such as social support, marital status, and money on their own (Koenig & Larson, 2001). Such positive effects are thought to be caused by religious ideas and behaviours that are grounded in optimism, which in turn generates hope. There is also an emphasis on compassion for others, emphasizing forgiveness, kindness, and charity, which may also serve as a respite from one's troubles. Religion also improves social support that goes beyond familial bonds, acting as a buffer in times of stress and adversity (Chokkanathan, 2013).

2.3 Culture

It's essential to define what "culture" implies before considering the influence of cultural influences on the interpretation and experiences of depression. There has been a trend moving away from focusing on race and more towards thinking about culture. Race was formerly related to ancestry but has now evolved into a term that relates to biological origin as well as physical qualities such as skin colour and physical features (Fernando, 2002). It is typically regarded as permanent and static. Culture, on the other hand, has evolved over time and now has various meanings. Culture was initially defined by Tylor (2018) as a complicated system which contains knowledge, beliefs, art, morals, law, tradition, and any other capacities and habits acquired by man as a member of society. Anthropologists, sociologists, economists, psychologists, academics, and laypeople have all come up with their classifications since then. Despite minor changes, all interpretations

appear to involve some form of recognizing how humans behave, what they know and what is produced and used as a result (Westby & Ford, 1993).

According to Fiske et al. (1998) culture is a composition of the accumulation of values, standards of conduct, modes of expression, norms, values, religious beliefs, vocational choices, and other human-made aspects for a collective of individuals who share a common language and location over a period of time. Bodley (2000) further refines the conceptualisation of culture through representation in behavioural, normative, cognitive, symbolic and historical semantics. From a behavioural perspective, culture is embodied in a way of living that is shared and can be acquired (Csordas, 1990). These behaviours are guided by a culturally established set of principles, values, or living norms. These norms, from a cognitive perspective, depict culture as a collection of ideas or acquired behaviours that suppress urges and separate humans from animals, and therefore present culture as a composition of structured and interconnected ideas, symbols, and behaviours (Bodley, 2000).

Culture as understood through symbols is formed through society's shared understanding of arbitrarily assigned meanings (Ritzer & Murphy, 2019). The historical and behavioural aspects of culture, the fact that values and behaviour are passed down from generation to generation, and the fact that they are shared all highlight the fact that culture is unique to a group of people (Salzman, 2001). Individuals who share a shared culture, including common values and ideas, are characterized as a cultural group (Westby & Ford, 1993). According to Westby and Ford (1993), these aspects of culture provide individuals with a framework to contextualize their responsibilities and experiences. Beliefs, attitudes, values, myths, ideologies, habits, and other behaviours as previously mentioned, can characterize a people group and their connections with others. A culture, therefore, links together individuals who share common experiences, ideas, and values (Sillars & Gronbeck, 2001).

Geert Hofstede, a Dutch social psychologist, developed innovative and comprehensive frameworks for assessing how different nationalities and cultures predispose

members to think and behave to a certain extent (2003). One of Hofstede's most important discoveries demonstrates that culture may be utilized as a cause and predictive factor in behaviour (Hofstede, 1991). The implication of this would be that a group's behaviour might vary depending on their cultural differences. The term mental programming is used by Hofstede (2001) to describe a predisposition to ways of thinking and behaving that develop from either a universal, collective, or individual influence, that is, biology, cultural or personality influences respectively. This premise is similar to how computers are coded to respond and how humans react in a long-term learning process when confronted with a wide range of events. The human being possesses predetermined behaviours when confronted with specific situations by using patterns of reasoning, feeling, and acting acquired throughout his or her life, particularly during childhood, in the same way that a computer processes an input in a specific manner to achieve a specific outcome (McSweeney, 2002). From this perspective, the culture notion illustrates that a particular group shares collective mental programming patterns that can be distinguished from those of other groups. Furthermore Hofstede (2001), illustrated that culture can therefore be conceptualised as this collective mental programming that presents as constructs, he labelled as values, rituals, heroes, and symbols.

In terms of the conceptualisation of these constructs, Hofstede used the layers of an onion as a metaphor to represent how cultural manifests in human practices (2001). Values, like the centre of an onion, constitute the basis of culture, however, they are implicit, and can only be deduced from the way individuals respond in different situations (Hofstede, 1991). Values are the deepest expressions of culture whilst behaviour – as the onion's upper layers – is more visible and is a result of the values. Linking to the previous conceptualisations of Fiske et al. (1998), symbols, heroes, rituals, and values are used to recognize the norms and distinctions that enable us to characterize cultural expressions. The symbols, which occupy the more superficial layers, reflect the most apparent characteristics of the culture and are expressed in physical appearances, by words, gestures, drawings, and items that carry a distinct meaning that can only be recognized as significant by people who share a common

culture (Hofstede, 2001 1991). The heroes are role models for a particular style of thinking, feeling, and acting. These figures might be living or dead, real or imagined, but they all represent a group's core principles (Hofstede, 2001). Rituals are group actions that are conducted to achieve certain goals and are considered fundamental to a group. Any external observer can see symbols, heroes, and rituals, however, may not fully grasp the significance to the cultural group because of the difference in values. Because values reflect the fundamental representations of culture, they are located at the centre of the onion diagram (Hofstede, 1991). Because our values are instilled in us early in life, they are typically unconscious and imperceptible to other observers. They can only be discovered by observation and analysis, taking into account how individuals respond in different situations. Under Hofstede's cultural paradigm, the function of behaviour as a result of culture, is identified as a stabilising force that reproduces value-based practices (1991). Cronk (2017) categorizes behaviour as a result of culture and, as a result, precludes behaviour from being a component of culture. Behaviour is not part of a culture, but rather is a result of cultural values, as Hofstede (1991) asserted. Measuring behaviours, therefore, reveals the underpinning cultural values and, as a result, the essence of each culture (Roccas & Sagiv, 2009). Aligning with Hofstede's conception of cultural behaviour, Nwoye (2022) proposes culture as the process by which a typical person acquires the customs and practices of their community and, in this manner, is assisted in working toward fulfilling the wholeness and wellbeing. Therefore, a new-born is subjected to the body of localized knowledge that has been developed within his or her community that allows them to develop from a state of a contextual immaturity into a mature way of being, as understood in the community of which they a part of (Nwoye, 2022).

While African perspectives hold that culture is understood as the perspectives that people have about the world, themselves, and their ideas, values, social conventions, folklore, and spiritual concepts, a growing globalization and merging of meaning making systems adds complexity to conceptualisations and inferences made by professionals and the layperson (Mpofu, 2011).

Some major findings have emerged from research concentrating on health care professionals' experiences of dealing with clients from various cultural origins. Several studies identified health professionals' fears of upsetting others and that these fears prohibited them from asking essential questions or having important dialogues, ultimately limiting their capacity to provide adequate health care services (Kai et al., 2007; Omeri & Malcolm, 2004; Jirwe et al., 2010). Additionally, studies have shown the difficulties in communicating with clients from various backgrounds, as well as the influence this has on their capacity to establish trust and rapport (Brooks et al., 2019; Jirwe, Gerrish & Emami, 2010). Practitioners may have issues in accommodating religious and cultural needs, such as creating a prayer space and being conscious that some behaviours, such as how individuals respond to and handle sorrow and death, may differ between cultures (National Research Council, 2009).

Culture is present in every community for every group and individual (Fernando, 2010). Western notions about health and sickness are impacted by the same historical and cultural forces that have shaped Western society. However, there is a tendency to regard Western conceptualisations as empirical and scientific, and thus the accurate way of doing things, ignoring the concept that western values and ideas influence healthcare in the same way that other people's cultural values and ideas influence their views on health and pain (Mazzocchi, 2006; Kirmayer, 2012; Fernando, 2010).

The fundamental role of culture in many psychological processes has been highlighted through various research conducted over the last two decades, which has found significant cultural diversity in cognitive, affective, and specific abilities (Heine & Ruby, 2010). Cultural influences have been identified to play a significant role in the development, presentation, characterization, diagnosis, and intervention of psychopathology (Marsella & Yamada, 2010). A collection of studies has shown significant cultural differences in the modalities of expression, interpretation, and social and personal reaction to psychological discomfort and dysfunction during the previous two decades (Hareli et al., 2015; Kirmayer & Ryder, 2016; Marsella & Yamada, 2010; Tanaka-Matsumi & Draguns, 2003). Questions

have been raised, however, whether the discrepancies in depression prevalence represent true variations in depression prevalence or are the product of cultural variations in the somatic and clinically observable presentation of depression (Parker et al., 2001; Ryder et al., 2002).

2.4 Depression

Depression is a significant mental condition that has serious health, financial, and socio-emotional effects. Sadness, lack of interest or pleasure, feelings of worthlessness, guilt, disturbed sleep or appetite, diminished energy, and impaired concentration are all symptoms of depression, according to the World Health Organization (*Depression*, 2019).

Describing painful experiences that mirror our modern concept of depression may be documented as far back as ancient Greece (Fornaro et al., 2009). The fifth-century BC Greek physician, Hippocrates, referred to a lady who had a lack of sleep, diminished appetite, increased thirst, and nausea and described this presentation of symptoms as melancholia (Telles-Correia & Marques, 2015). Melancholia is derived from the Greek word melaina chole, which translates to "black bile" (Solomon, 2002). It is important to note however that melancholia was not originally seen as a distinct sickness, but rather as a symptom of a larger illness (Sadeghfard et al., 2016). During the Middle Ages, the terms melancholia and mania would be used interchangeably. Anxiety, sorrow, disillusionment, a proclivity for isolation, suicidal risk, or even lovesickness were all grouped under this umbrella term (Tekiner, 2014). Furthermore, melancholia was linked to several vegetative symptoms, including decreased mobility and loss of coordination (Davidson & Turnbull, 1986). Melancholy was romanticized by Renaissance philosophers (Sullivan, 2008). It began to be attributed to a great deal of depth, artfulness, sophistication, and even brilliance. Dejection was connected with wisdom, and vulnerability was seen as the cost of being creative and nuanced (Sullivan, 2008).

Emil Kraepelin developed a psychobiological approach and classification of depression near the end of the nineteenth century (Bar & Ebert, 2010). Manic-depressive insanity was his classification for mood disorders. Depressive symptoms comprised a sad

mood, restriction of thoughts, and weakening of motivation, whereas manic symptoms were bursts of ideas, excitement, and exhilaration. Karl Leonhard expanded on Kraepelin's efforts in the 1950s. Unipolar and bipolar depression became two separate entities, according to Leonhard (Angst & Sellaro, 2000). At the start of the 20th century, two key movements arose that had a significant influence on the evolution of mental health. Freud pioneered the psychological conceptualization of mental diseases, which led to the development of a plethora of psychoanalytical ideas in the social sciences and Kraepelin's psychobiological theory, on the other hand, ushered in a more absolute knowledge of depression based on molecular causes (Solomon, 2002). The knowledge of mental illness has evolved over the previous two and a half millennia, becoming more refined and diverse.

A variety of conceptualisations of depression have developed over time. The most prominent theories of depression include a biomedical approach, cognitive theories and biopsychosocial theories of depression (Deacon, 2013; Garcia-Toro & Aguirre, 2007; Gotlib & Joormann, 2010).

For decades, the biomedical approach has driven the conceptualization of disease (Deacon, 2013). The biomedical approach is founded on the notion that sickness may be quantified using biomedical variables (Hahn & Kleinman, 1983). Therefore, biomedical conceptions emphasize disease's physical mechanisms. Several biological mechanisms have been implicated in the aetiology of depression. The vascular depression hypothesis, for example, proposes that cerebrovascular illness is linked to depressive symptoms (Taylor et al., 2013). Another biological rationale for depression is that hormonal variances underlie depressive symptoms (Shadrina et al., 2018). Mental disorders, depression, in particular, are primarily conceptualized and operationalized via a biological lens (Deacon, 2013). In the context of depression, the biomedical approach has been criticised for solely relying on medical treatment through pharmaceuticals, despite the possibility of mental health issues being entrenched in social circumstances that are untreatable by drugs (Rocca & Anjum, 2020). Kokanovic et al. (2012) discovered a discrepancy between an individual's diagnosis of depression and the manner in whereby they evaded depending on biomedical

explanations of depression. Participants resisted medicalization by focusing on the social, everyday surroundings of their suffering.

From a cognitive theories approach, the significance of thought patterns in the aetiology of depression is highlighted (Disner et al., 2011). A cognitive perspective, for example, would propose that a pessimistic way of thinking and making sense of the world leads to depressive symptoms (Gotlib & Joormann, 2010). As per this viewpoint, depression is caused by a negative interpretation of circumstances or a difficulty to detach from negative beliefs, rather than by the situations or thoughts directly (Disner et al., 2011). Therefore, the cognitive model of depression focuses on an individual's perspective of the situation rather than the situation itself. Developed conceptions of aetiology claim that certain persons have cognitive susceptibility, which then interplays with stressors to cause depression (Beevers, 2005). Cognitive approaches to depression have been critiqued for implying that depression is caused by negative thought patterns without explaining the aetiology of the thought patterns (Power & Champion, 1986). As a result, it is possible that the manifestations and aetiology of depression can become interlinked.

While biomedical and cognitive conceptions of depression are primarily concerned with the biological underpinnings of depressive problems, biopsychosocial explanations of depression include the social circumstances in its conceptualisation of depression (Garcia-Toro & Aguirre, 2007). A biopsychosocial paradigm emphasizes the necessity of looking at all significant biological, cognitive, and social aspects that could lead to depression. All of these variables appear to be interconnected (Schotte et al., 2006). According to this paradigm, depression is caused by a combination of biological, social, and psychological elements that appear to be unrelated yet interact in ways that can lead to the development of depression (Garcia-Toro & Aguirre, 2007; Schotte et al., 2006).

The American Psychiatric Association produced and published the DSM, and its most recent version, the DSM- 5-TR, in March 2022. (American Psychiatric Association, 2022). The Diagnostic and Statistical Manual and the ICD-10 International Classification of Mental and Behavioural Disorders are two prominent and current methods for diagnosing

depression (Clark et al., 2017). The ICD-10 is more commonly utilized in European contexts, whereas the DSM-5 is more commonly used in the United States and non-European nations (Sadock et al., 2014). The developers of both frameworks, however, are continuing to collaborate to make them harmonious with each other (Kupfer et al., 2008). Based on the existence of combinations of clinical symptoms and the levels of impairment, such frameworks provide diagnostic criteria. Depression impairs a person's mental, bodily, and emotional well-being, affecting every aspect of their life. The Diagnostic and Statistical Manual of Mental Disorders defines major depressive disorder as having nine potential symptoms: depressed mood, decreased interest or pleasure (anhedonia), changes in weight or appetite, sleep problems, psychomotor agitation or retardation, fatigue/loss of energy, worthlessness/guilt, concentration problems, and thoughts of death (American Psychiatric Association, 2022). Many people suffering from the disorder find it difficult to do everyday activities and maintain relationships as a result. Comorbidities, or the existence of additional chronic illnesses or disorders, have also been discovered to be frequent among those who suffer from depression. Anxiousness and addictions are common comorbidities (Sadock et al., 2014). However, it is not restricted to the aforementioned comorbidities; depression has been linked to a variety of medical ailments (Goodwin, 2006).

Depression is diagnosed via organized or semi-structured interviews, and at least five of the nine depressive symptoms indicated in DSM-5 need to be evident for a diagnosis, with low mood and/or reduced interest/pleasure being required in at least one of them (American Psychiatric Association, 2022). Because Depression is defined by a certain set of symptoms rather than a precise pattern, symptom presentation might vary greatly across people with the same diagnosis (Sadock et al., 2014).

With regards to treatment and treatment-seeking behaviours, Lecrubier (2008) indicated that depression is a primary cause of impairment and diminished quality of life and concluded that a lack of adjustment resulted in inadequate progression in the therapy phase of treatment. Schneiderman et al. (2005) added to this by indicating that stressful life experiences appear to be a dominant triggering factor of major depressive disorders.

Several studies have discovered that biological factors such as genes have a role in the aetiology of mental conditions (Lebowitz & Ahn, 2014; Sullivan et al., 2000; Arango, 2001). A common understanding is that depression is produced by a deficiency of signalling chemicals in the brain, and that gender variation exists in this regard (Jovanovic et al., 2008). Epigenetic explanatory models have also been identified in research (Caspi et al., 2005). Even in primarily hereditary conditions, environmental influences can have a significant effect (Kim-Cohen et al., 2006). Caspi et al. (2005), for example, found that a short gene version for serotonin transporter had an influence on the formation of depression, yet the risks were greater if the children experienced a turbulent upbringing. Depression is thus a result of a complex interaction between genetic predisposition and depression-related environmental stressors. Many diverse social and psychological variables have a role in the development of psychological conditions (Schneiderman et al., 2005).

Spirituality and religion, on the other hand, have been linked to a reduction in symptoms of depression with a high degree of social support (Pérez et al., 2009). According to Lecrubier (2008), several studies have indicated that proper identification of depressed patients is only slightly effective, based on basic care data. Another aspect of seeking to define, recognize, and treat depression and its relationship to behaviour is to include the wide range of social perspectives on the mood disease, including its prevalence and treatment across cultural and ethnic borders. Jimenez et al. (2010) investigated racial disparities in mental disease among older persons. Given the different ethnic and cultural demography, these disparities should not be neglected in the exploration of depression.

African viewpoints, in contrast to Eurocentric perspectives, acknowledge the notion that depression may not solely have its development in physical, mental, or social disruptions but can also, on occasion, be rooted in the spiritual context of the person exhibiting depressive symptoms (Nwoye, 2022). Mpofu (2011) differentiates the development of depressive symptomology either stemming from a spiritual, communal, or physiological domain. Nwoye (2022) asserts that the development due to the spiritual domain can be distinguished by an individual's abnormal presentation of symptoms. He

further explores how the depression could therefore be understood as a symbolic illness, requiring spiritual entities to be contacted through mediators or hermeneuts in order to find a solution (Nwoye, 2022).

2.5 Comprehension of Depression formed through Religious and Cultural Narratives

Religious and spiritual leaders hold the belief that they play an important role in the mental health of their members by providing explanations of purpose and belonging to make sense of mental illnesses (Freire et al., 2020). Freire et al. (2020) further noted that religious leaders having limited training and little experience in de-escalating and managing congregational member's mental health issues, generally held the belief that medical professionals are competent to treat congregational members, however, identified their lack of contextual knowledge of cultural/religious beliefs as problematic.

Differences in ethnicities and ages correlated to differences in causal beliefs and explanations for depression and depressive symptoms (Khalsa et al., 2011; Hansson et al., 2010). The article by Freire et al. (2018) reviewed literature related to depression as a secular illness as well as depression through the lenses of five different religious/spiritual narratives: Judaism, Christianity, Islam, Buddhism and Hinduism. Freire et al. (2018) reported on how different understandings of mental health/illnesses emerge from each religion's narrative as well as how they reinforce or conflict with the understandings of medical practitioners.

The treatment preference for medication revealed a significant correlation with causal attributions of an external nature such as relational and financial stresses, social isolation, and childhood abuse/neglect (Read & Bentall, 2012). Khalsa et al. (2011) in agreement, noted external factors as causal attributions of depression, however, only found that childhood abuse/neglect was predominantly used to explain depression when psychotherapy was the treatment preference. This causal attribution of an external nature has been found to significantly correlate with higher levels of depression severity (Rubenstein et al., 2016). The study of Reed and Neville (2013) asserts that the use of medication is associated with a preoccupation with an externally defined cause, whereas participation in religious practices

is associated with internally oriented reasons for depression, which are more personally defining. Particularly, under this framework, "spiritual growth" is seen as developing self-understanding through introspection and insight (Townsend et al., 2002). Qualitative research allows for in-depth examination through the lens of religion and culture coupled with quantitative research is essential to understanding the importance of religion and culture within mental health treatment (Cuypers et al., 2011).

Despite Western bio-medical explanations of depression spreading through globalization, cultural/religious variations of understanding and expression persist (Brijnath & Antoniades, 2018). Therefore, culturally formed expressions and idioms of understanding and framing depressive symptoms remain significant and relevant (Ng'oma et al., 2019). In circumstances whereby immigrants experience acculturation, cultural/spiritual beliefs often remain functional as explanatory models for the causation of depressive symptoms (Caplan et al., 2012). While explanatory models remain fairly stable, cultural variations in psychological processing and coping appear to decrease as pathology becomes more severe (Balkir et al., 2013). The European/Western emphasis on individuality has resulted in the socially acceptable practice of giving detailed and elaborate personal histories and causal explorations which are noted to be positively related to better mental health outcomes (Jobson et al., 2018). European samples, however, typically attribute causal explanations to external factors such as socio-economic, socio-cultural and relational stressors as opposed to biological causes (Midgley et al., 2016; Hansson et al., 2010).

2.6 Treatment Seeking Behaviours

Forms of coping with depressive symptoms through communal engagement and support are common in various religious and cultural communities (Balkir et al., 2013; Edwards et al., 2020). Religious leaders are often the first and potentially, only persons contacted by distressed members seeking counsel (Freire et al., 2018). Distressed individuals who seek a form of treatment, typically choose a form that they believe will be effective (Khalsa et al., 2011). However, in mild to severe presenting cases of psychopathology, religious leaders were noted as not feeling competent enough to

adequately address the presenting matter (Freire et al., 2018). Despite this, Freire et al. (2018) note that religious leaders may feel conflicted about referring members to medical professionals out of fear that the explanations and forms of treatment may conflict with religious morals. In line with this, treatment-seeking behaviours of members of various religious and cultural groups are often hindered due to moral obligations to their belief or out of fear of the stigmatization that would ensue (Ng'oma et al., 2019).

The influence of globalization has led to the syncretism between traditional cultures, beliefs, and Western-biomedical theory (Caplan et al., 2012). This has resulted in coping strategies that have been formed through the combination of cultural practices and understandings presented by western medicine (Rodríguez-Galán & Falcón, 2017). However, in contexts with current or historical discrimination, discriminated members' treatment-seeking behaviours are often hindered due to cultural mistrust (Dean et al., 2018).

2.7 Cultural/Religious Influence on Prognosis

Culture and religious/spiritual beliefs are noted to moderate the expression and course of prognosis (Jobson et al., 2018). Both acculturation and the related stressors influence the prognosis of depression and depressive symptoms (Balkir et al., 2012).

Religious/spiritual leaders play an important role in maintaining and aiding the mental health of their members (Freire et al., 2018). Cultural/spiritual practices or roles that promote isolation due to belief or position, however, increase the risk and severity of depression (Edwards et al., 2020). Such practices include the imposition of social isolation, such as through physical separation from others, and/or through negative sanctions for association with non-group members. For example, separation from one's religious community due to conflict (e.g., with one's family) is associated with elevated depression and suicidality (Joseph & Linley, 2004). Furthermore, doubts about faith or conflicts within belief systems can form identity-related tensions and result in disengagement which can also increase the risk and severity of depression (Hansson et al., 2010; Rodríguez-Galán & Falcón, 2017).

Spiritual causal attributions are noted to reduce hopelessness associated with depression in the short-term, however, if the absence of improvement continues, the long-

term effects result in the worsening of depressive symptoms (Brijnath & Antoniades, 2018). Spiritual causal attributions are the perception of an illness as being caused by spiritual forces. The attribution of depression to divine intervention can either be beneficial or detrimental depending on the person's spiritual orientation. Individuals with a spiritual orientation that is negative and contradicts a depressive disorder, such as experiencing loss or rejection from God, will result in a negative feeling of hopelessness. If individuals do not follow whatever causes the depression, they will experience hopelessness and a depressed mood (Brijnath & Antoniades, 2018). Faith is noted as having both the ability to impede or drive the recovery process (Breland-Noble et al., 2015).

2.8 Conclusion

This chapter has provided a concise review of published academic literature relating to the study's topic of interest. Following the literature review on depression, culture, and religious beliefs, it is evident that there are many different factors in play when trying to conceptualize an individual's depression within their cultural-religious context. The following chapter outlines the methodology which entails a detailing of the research paradigm, approach and design selected for the mini dissertation. Lastly, the chapter concludes with a reflection on relevant ethical considerations.

Chapter 3: Methodology

3.1 Introduction

This chapter explains the methodology and the paradigm encapsulating it used by the researcher to address the study's research question: “Within a South African context, what influence do Cultural and Religious Narratives of mental health have on depression?”

A qualitative research technique within an interpretative paradigm was used to explore the experiences of these potential influences. The data from a variety of published studies were combined using a meta-synthesis process. More specifically, the meta-ethnography design of Noblit and Hare (1988) was used in this study. A meta-ethnography was deemed as a suitable research design as the study’s research question presented as an emergent question that required an investigative approach. The aim of a meta-ethnographic design is to investigate perceptions, experiences, and behaviours to develop new theories or conceptualizations about them (Noblit & Hare, 1988). As the major source of data, this design relies on already published findings from other research investigations. As a result, the data for this study was derived from the findings of studies undertaken by other researchers based on their raw data.

The research paradigm, approach, and design are all described in the first section of this chapter. The research design is presented in the format of the seven steps established by Noblit and Hare (1988). Special focus is placed on step two which presents the sampling procedure, step five which addresses the process of translations, and step six which elaborates on the synthesis process. Additionally, the process of how these seven steps were converted into the format of this research paper is described. Lastly, the ethical and quality factors that have to be taken into account will be discussed and the chapter will be concluded.

3.2 Research Paradigm

The research process, according to Blanche et al. (1999), comprises three primary dimensions: ontology, epistemology, and methodology. A research paradigm is therefore an all-encompassing system of interconnected action and thought that defines the essence of

inquiry along these three dimensions. Additionally, a paradigm can be understood as a pattern used to describe a conceptual framework held by a group of researchers that serves as a useful model for analysing issues and finding answers (Kuhn, 1986). Kuhn further elaborates on paradigm referring to a research culture exemplified through a cluster of shared views, attitudes, and assumptions about the nature and conduct of research (Kuhn, 1986). From this, we can assert that a paradigm implies a structured pattern, or a framework of research ideologies (Olsen et al., 1991).

Lather (1986) indicates that research paradigms reflect one's view of the world both as it is and how one desires it to be. Wang and Zhu (2016) further expounded on this understanding of paradigms by characterizing them as a conceptual framework that can be used to guide a researcher's thinking throughout the course of a study. These frameworks are composed of sets of assumptions, concepts, and values that are at the same time reflected in and reinforced by particular ideologies, epistemologies, ontologies, methodological strategies, and styles or forms of writing or talking about findings (Wang & Zhu, 2016).

Positivism, interpretivism, and critical postmodernism are three conceptually separate research orientations, according to Gephart and Corvellac (1999). The essential elements within each of these three paradigms are the worldview, the kind of information sought, and the various methods by which knowledge is constructed and appraised.

Within an Interpretive paradigm, researchers assert that reality is made up of people's subjective perceptions of their environments; therefore, interpretivists subscribe to a subjective epistemology and that ontologically, knowledge and truth are socially constructed (Levers, 2013). Interpretive researchers argue that there is no singular approach to knowing (Lopez & Willis, 2004).

It is important to note that the interpretive research paradigm is empirical as it provides a framework that regulates discernment of how people's subjective experiences are formed through their actions in situations that they view as important (Bonache & Festing, 2020). This paradigm is a way to understand the socially constructed nature of reality, which

is located in the society under research (Lopez & Willis, 2004). It relies on observations of objective reality but aims to observe from 'the point of view' or perspective of the people under study. In this way, it stresses that objectivity refers to a particular shared epistemology (or understanding) and not exclusively to an attitude towards the external world (Carson et al., 2001). Even though there is no single correct or incorrect way of understanding within this paradigm, concepts that are put forward need to be relevant to the concrete situation they describe, in other words, theories must fit in with the qualitative data which gives rise to them, as well as other data relating to other situations (Lopez & Willis, 2004). It cannot be based purely on generalisations and abstractions; it needs to take into account the context so that any new theory is relevant to that situation in a particular way (Levers, 2013). Interpretation is about finding codes and practices that are shared by all participants within a range of traditions (Putnam & Banghart, 2017).

Aspects of interpretivism as applied in this study, are conceptualised and applied to four categories. The first is the research objectives, which are to explore how depression is understood within various religious and cultural contexts, describe treatment-seeking behaviours and responses to depressive symptoms, and explore how cultural beliefs and practices influence the prognosis of depression. Secondly, from an ontological perspective, these objectives are underpinned by the ontology of multiple realities that are and can be constructed and explored through interaction. Thirdly, from an epistemological understanding, the experience of and reaction to depression can form as a result of people's differing information, perspectives, interpretations, and experiences informed by their social environment. Lastly, the methodology within the interpretivist paradigm consists of the process of the researcher synthesising meanings relative to context, culture and values. (Cantrell, 2003).

This paradigm expands the scope of the research to include aspects of influence and effect, as well as treatment-seeking behaviours influenced by cultural and religious narratives. The interpretative paradigm in research according to Walsham (1995), is intended to develop a knowledge of the context and the process by which information

science impacts and is impacted by the context. This notion supports the researcher's selection of the interpretive paradigm as the study's philosophical framework.

3.3 Research Approach

The research approach is a method of investigation that progresses from fundamental principles to the study's design and data-collecting techniques (Myers, 2019). Even though there are additional variances in research approaches, qualitative and quantitative research approaches have been the most prominent classifications.

Qualitative research is naturalistic and therefore it aims to investigate the daily lives of various groups of individuals and communities in their local environments (Salkind, 2010). The qualitative approach to its subject matter is an attempt to make sense of or interpret occurrences in relation to the meanings individuals assign to them (Denzin & Lincoln, 2003). Later developments in qualitative research include ethnographic approaches, participant observation, and the case study approach (Creswell & Poth, 2017). The quantitative approach to research is a systematic scientific procedure used in studies to gather and analyse data based on experimental designs and statistical procedures (Salkind, 2010). In a general sense, quantitative research rejects the qualitative approach's emphasis on interpreting occurrences concerning the meanings assigned by personal experience and applies the scientific method (Creswell & Poth, 2017).

Regardless of the approach chosen, researchers must understand their subject matter's purpose and what makes it unique (Aspers & Corte, 2019). The researcher must be able to identify and understand the theoretical perspectives that have been used by others who have investigated similar or related phenomena. The researcher should also consider what potential biases are likely to influence their findings (Aspers & Corte, 2019).

Because there is a gap in knowledge about the subject, qualitative research tries to study and identify concerns regarding it (Domegan & Fleming, 1999). Qualitative research, according to Myers (2019), is provided to enable researchers better understand individuals and the social and cultural environments in which they live. Such research allows for the exploration and representation of the intricacies and contrasts of the worlds under

investigation (Creswell & Poth, 2017). Various knowledge assertions and inquiry methodologies are used in qualitative research.

Observation and participant observation (fieldwork), interviews and surveys, records and writings, and the researcher's perceptions and values are all examples of qualitative data sources (Myers, 2019). Individuals, experiences, views, sentiments, and settings, as well as combinations of these, may all be used as data sources.

The researcher is the primary tool for data gathering and processing in qualitative research (Denzin & Lincoln, 2003). Both researcher and participant have developed and continue to construct their respective realities. These realities merge when the researcher seeks to collect data unobtrusively, seeking to investigate real-world events as they evolve organically without the use of preconceived limits or circumstances that govern the research or its findings (Cohen et al., 2017). The qualitative researcher, therefore, aims to make sense of the numerous interpretations.

Guba (1981) advises that when determining a research approach, it is essential to adopt an approach whose principles are best matched by the phenomena being researched. Qualitative approaches are more suitable than quantitative strategies when the phenomena being studied are concerning the participants' interactions and perceptions, as well as the description of the processes that characterize the phenomena (Aspers & Corte, 2019). Qualitative research methods can better account for the complexity of group behaviours and influences and uncover new data and themes among the numerous elements of primary data collected (Hammarberg et al., 2016). As analysis techniques develop, qualitative research methodologies are becoming more extensively employed (Price, 2002).

Qualitative research focuses on the interpretations and understanding of social occurrences and is characterized as an exploration of components of social life (Jupp, 2006). When researchers want to learn more about the human side of a phenomenon, they can make use of qualitative research methods (Given, 2008). Over time, the line between qualitative and quantitative research has grown less obvious, since many studies are using mixed-method techniques (Given, 2008). However, the singular selection of a qualitative

approach is still appropriate when the researcher aims to understand how individuals construct their realities (Jupp, 2006). This research approach is concerned with generating and/or improving understanding of perceptions of experiences and responses and therefore has been selected for this mini dissertation (Harper & Thompson, 2011). Furthermore, this is an effective strategy for approaching mental health topics of interest that affect people's health. To answer the research questions, a qualitative approach was selected.

3.4 Research Design

A research design is akin to a blueprint for a building, a master plan or a blueprint for how the investigation will be carried out. It demonstrates how the primary components of the research project are selected, pursued, and integrated to answer the research questions (Given, 2008). Therefore, the research design may be thought of as the implementation of rationale in a collection of procedures that maximizes the integrity and validity of the data (Guba, 1981). The research design, according to Neuman (2011), provides rigour from establishing the philosophical assumptions that underpin the approach through to the search strategy and data-collecting methods. In its essence, a research design is a plan of action for moving from a set of questions to be answered to a collection of potential conclusions (Yin, 2017).

There are multiple ways a qualitative synthesis may be undertaken. Determining if the goal is to compile results or interpret findings to acquire a conceptual understanding of a phenomenon is one of the most critical factors when choosing a research design (Toye et al., 2014). The latter was consistent with the objectives of this study; hence a meta-ethnography was selected. A Meta-ethnography, according to Harper and Thompson (2011), is the most prominent research design for synthesising qualitative data. The meta-ethnography approach of Noblit and Hare (1988) was selected for this study. Meta-ethnography is a qualitative research approach that is used to synthesise studies that are connected by thematic elements (Given, 2008). A meta-ethnography is an effective and appropriate research design for interpreting qualitative data (Atkins et al, 2008). It permits a corpus of qualitative data to be compiled methodically, and it can yield new and essential

insights, even in topics that appear to be well-studied (Campbell et al., 2011). It is worth noting that failure to generate new insights does not always imply that the synthesis has been unsuccessful. Rather, it might indicate that the subject of inquiry has already produced a wealth of information in primary research.

Since its inception in the year 1880, meta-ethnography has seen several changes (Atkins et al, 2011). One example is that search strategies are more recently documented, such as in Malpass et al. (2009). Furthermore, meta-ethnography is not restricted to the combination of ethnographies. Instead, a variety of qualitative investigations can be synthesised (Britten et al., 2002). The most important criterion is that the research to be synthesised be connected to the same issue. When investigations 1) pertain to comparable issues, 2) attempt to dispute each other or 3) strive to create subsequent lines of argument, a meta-ethnography would be a suitable research design (Noblit & Hare, 1988). Noblit and Hare (1988) further suggest an approach that goes beyond just aggregating study data. Their strategy was utilized to combine the concepts of many studies to create something new. Although this approach was created in 1988, it has grown in popularity as a means of synthesizing qualitative research data over the last decade (Atkins et al, 2011). An interpretive epistemological framework underpins meta-ethnographies (Noblit & Hare, 1988).

The translation approach of synthesizing that a meta-ethnography employs is the major difference between it and other research designs that synthesise data (Noblit & Hare, 1999). This contrasts with procedures like integrative research reviews and meta-analyses, which utilize a more aggregative theory (Xiao & Watson, 2017). This translation approach, according to Noblit and Hare (1988), suggests employing reciprocal translations of the studies' ideas and analogies. The formulation of broad metaphors that capture the ideologies and concepts of the many investigations was an important aspect of this method. This concept illustrates that the formulation and subsequent synthesis, does not require predetermined themes for sample selection but rather that the sample are connected to the same root issue (Noblit & Hare, 1988).

Noblit and Hare outlined the following seven steps in carrying out a meta-ethnography: 1) getting started, 2) deciding what is relevant, 3) reading the studies, 4) determining how studies are related to each other, 5) translating studies into each other, 6) synthesizing translations and 7) expressing the synthesis (Seers, 2014). Section 3.4.1 to 3.4.7 explores the theoretical basis of each phase as well as documents how the research process was carried out in relation to the seven phases as outlined by Noblit and Hare (1988).

3.4.1 Phase 1: Getting Started

The first phase is getting started. This entails finding a topic of academic interest about which qualitative research could provide insights. Qualitative techniques are the preferable option when the researcher has limited influence over occurrences, and when the attention is on a specific phenomenon inside some real-life context, as Yin (2017) indicates. During this stage, the researcher is considering how analysing a series of articles might help enlighten his or her academic interest in a specific phenomenon. This step entails part of the search for anything noteworthy of synthesizing (Toye et al., 2014). This identified issue persists as the synthesis progresses, as intellectual curiosity grows, and as texts are read. But, in most cases, what makes a synthesis attempt worthwhile will vary. A synthesis that isn't worth performing isn't worth doing well, according to Patton (2014). A synthesis that is irrelevant to the author has no value.

This meta-ethnography began with a specific topic of interest to the researcher. The researcher had an initial interest in how religious and culture-formed perceptions influence ways of being. Following this academic interest, the researcher began reading up on the topic and related contexts, viewpoints, concerns, and conflicts. This resulted in the exploration of possible themes for additional research (Noblit & Hare, 1988).

3.4.2 Phase 2: Determining what is relevant to the initial interest

The second phase consists of determining what is pertinent with regard to the phenomena of interest identified during phase 1. A lot of time and effort goes into compiling a comprehensive list of papers that might be included in a meta-ethnography. The

interpretations and analyses can be aggregated in a meta-ethnography, but the sheer aggregation of similarities and dissimilarities between cultural environments is unproductive (Toye et al., 2014). Identifying who the target for the synthesis is, and what is trustworthy and relevant to the research question are all important factors in deciding what texts are significant (Noblit & Hare, 1988). Finally, a meta-ethnography is motivated by a meaningful curiosity gained from the analysis of various papers. Studies in specific contexts should always be treated as such. Making generalisations across all research findings of a particular context will produce meaningless conclusions unless there is a compelling reason for doing so (Britten et al., 2002).

It was vital to accumulate an extensive list of academic papers that could have been included in the synthesis (Noblit & Hare, 1988). This was undertaken in line with the current ethos of what is considered high-quality inquiry (Toye et al, 2014). A research question was only formulated when the overall subject of interest was determined. Informed by the research question, an initial search was undertaken in April 2021 to locate primary texts related to the topic of interest to determine the viability of this investigation. At this point, the research topic was used as a starting point for finding and retrieving papers that could be relevant. The research topic, being broad, was then narrowed down to a more specific context. Additional texts were collected and screened with new research being sought until December 2021.

In terms of the search strategy and process, each selected database was searched by the research student, based on the following strategy. Each column in “Table 3 SPIDER Elements”, contains a set of synonyms for the key search terms. Each term in the column was entered into the various databases and was truncated where deemed appropriate. All individual searches for that column were combined using the “OR” Boolean operator into a single group. Each overall group was then combined using the “AND” function to produce a final list of citations, which was saved into Zotero and screened for duplicates. Selective sampling was utilized for the most effective use of limited resources (Patton, 2014). The mnemonic STARLITE was utilised as a strategy for framing the foreground (Booth, 2006).

Table 2

STARLITE

S: Sampling strategy
• Selective: Sample three databases and select relevant studies based on the judgement of the researcher.
T: Type of studies
• Any form of qualitative study (including ethnographic, grounded theory etc.)
A: Approaches
• Online journal searching and citation snowballing
R: Range of years (start date–end date)
• 2010-2021
L: Limits
• Human, English
I: Inclusion and exclusions
• Inclusion and exclusions Inclusion: qualitative methods, original qualitative data, conducted within South Africa; exclusion: quantitative methods
T: Terms used
• Terms used and complete search strategies available in table 2
E: Electronic sources
• Electronics sources: Ebscohost: APApsychinfo and Taylor & Francis

Table 3

SPIDER Elements

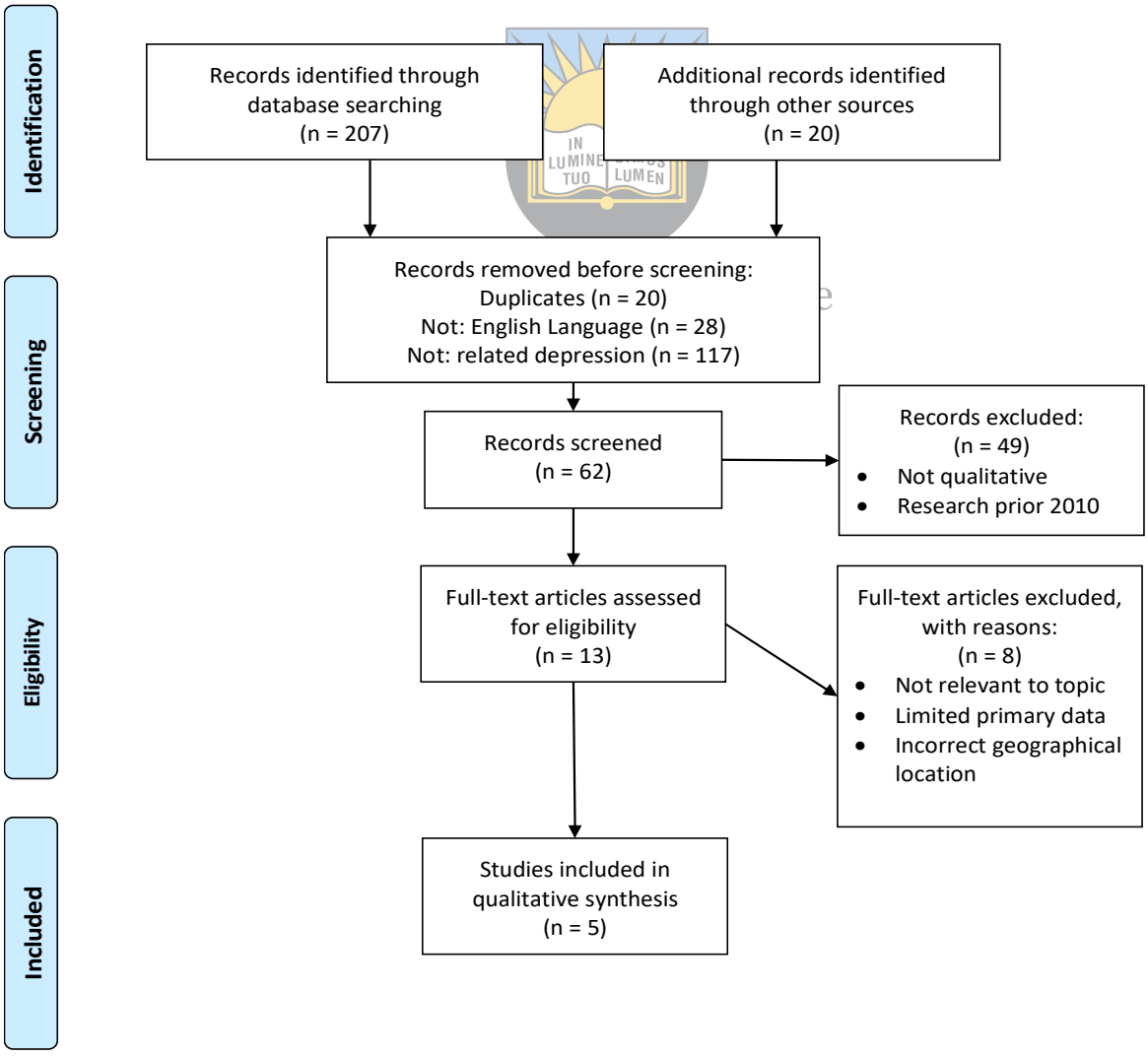
SPIDER Elements	Keywords
S-Sample	depression OR depressive disorder OR depressive symptoms OR major depressive disorder OR mental illness
PI- Phenomenon of interest	Religion OR Religious OR Spirituality OR spiritual OR faith OR belief OR Culture OR Cultural identity OR Cultural values
D- Design	Lived experience OR life experience OR Narrative OR ethnograph OR interview OR discourse analysis
E- Evaluation	Understand OR understanding OR belief OR Narrative OR experience OR treatment seeking
R- Research type	Qualitative

Five key academic journal articles published between 2010 and 2021 were included in the sample. An appropriate number of articles for a meta-ethnography design is determined by the quality of the articles (Sandelowski & Boshamer, 2006). The articles' status as published in a peer-reviewed journal was used as the initial screening to confirm a baseline level of validity and quality. To further evaluate the quality and relevance of the studies that were included, the researcher employed the Critical Appraisal Skills Programme

(CASP) criteria checklist. The CASP was selected as the appropriate instrument as it fosters a methodical procedure for assessing a research article's advantages and limitations. After being critically reviewed, each article is allocated a numerical rating out of 10 with a higher rating correlating to a better quality article. Of the five appraised papers, the scores ranged from 6 to 9. The three articles that obtained the highest rating were considered the base articles. These three base articles served as the starting point for the relation and translation phase of the research process. Taking into account the time restrictions, five articles were deemed suitable while remaining within the boundaries of a mini dissertation.

Figure 1

PRISMA flow diagram (2009)



3.4.3 Phase 3: Reading the Studies

Reviewing the studies is the third phase. The majority of recommended research synthesis methods go directly to assessing the study's qualities that are relevant to the issue of interest (Patton, 2014). The synthesis methods in qualitative research are more dynamic and progress during the synthesis process (Neuman, 2011). As a result, in a meta-ethnography, this stage is less defined. Rather, the phase can be understood as the extensive reading of the narratives and the recording of interpretative metaphors (Noblit & Hare, 1988). The synthesis of texts within a meta-ethnography entails paying close attention to the specifics within the narratives and what they reveal about the researcher's substantive interests.

Other forms of research synthesis proceed rapidly to analysing the key characteristics of the study relevant to the subject of focus (Noblit & Hare, 1988). However, in a meta-ethnography, the third phase is more fluid and less explicit in terms of process. Noblit and Hare (1988) further elaborated that a meta-ethnography demands attentive attention to the text's intricacies, which can be achieved through numerous re-readings. The synthesis formed during this phase of this research project. Commonalities, parallels, and links began to emerge from initial readings of the articles.

Several readings of the articles were required for the themes to be identified. These themes are elaborated on in the following chapter. Upon the first examination, the emphasis was on finding potential primary research articles relevant to this mini dissertation's topic. The articles were reviewed again to make sense of the research investigation's context, including sample details, author details, and methodology used. More re-reading was completed to identify key topics from each article and contrasts in the articles to synthesize them.

3.4.4 Phase 4: Determining how the Studies are Connected

The fourth phase is characterised by establishing how the texts are related to one another. The selected texts must be brought together which necessitates figuring out how these texts are related (Atkins, 2008). Noblit and Hare (1988) assert that juxtaposing the

important metaphors, words, concepts, and perceptions, including their interconnections, utilized in each narrative is a crucial approach for this stage. The goal is to establish a preliminary hypothesis on the link between texts by the end of phase four (Noblit & Hare, 1988).

It is critical to determine how the numerous texts are related. This can be achieved, according to Noblit and Hare (1988), by compiling inventories of central topics, themes, expressions, and metaphors for all of the primary data and juxtaposing them. Toward the completion of this phase, the researcher should be able to generate an informed assumption regarding the link between the texts. Noblit and Hare (1988) outlined three methods by which texts may be related. 1) The texts cover approximately the same issues, 2) the texts dissolute each other, and 3) the texts elaborate on each other's arguments. The goal of a meta-ethnography that addresses research with comparable subject topics, as this research paper did, is to generate reciprocal translations of the texts. Each text was translated into the metaphors or themes of the others, and vice versa. This was accomplished by the use of phrases that emanated from one article that were combined with those from another, as well as the creation of new phrases that encapsulated themes from other studies.

The primary journal articles included in this meta-ethnography are interrelated to one another by a similar broad area of interest. The subjects were all South African individuals who have an understanding of depression or mental illness that is informed through a cultural narrative.

To discover the relationship between the primary data of the texts, Noblit and Hare (1988) proposed compiling a list of concepts or metaphors. Such lists could then be used to compare and contrast the findings to determine their relationship. Additionally, studies have compared themes using grids or tables (Atkins et al., 2008). To begin, lists were made for each of the texts to identify the major themes that emerged. From there, a grid framework was used to lay out the expanded patterns to make comparing them easier. A final structure of three themes was drawn out after several readings of the studies.

3.4.5 Phase 5: Translating the Studies into one another

Phase five is translating the studies into one another. Translation can simply be understood as treating the narratives as comparisons (Noblit & Hare, 1988). It is important to note however that translation is more complicated and in-depth than just a mere comparison. This is because the key is to preserve the distinctive nature of each text and respect holism which enables an appropriate comparison (Toye et al., 2014). A good translation keeps each account's fundamental metaphors and concepts in context with other significant metaphors and concepts and potentially also contrasts the metaphors or concepts in other narratives texts (Britten et al., 2002).

Establishing how the data from the texts are similar to one another is one of the first components of translating the studies into one another (Noblit & Hare, 1988). It is critical to maintain the nuances of each text and preserve the full meaning captured in each text while at the same time, allowing for comparisons. Each text's fundamental ideas and metaphors, as well as their relationships with other studies' important data, have to be retained (Noblit & Hare, 1988). These themes, metaphors, and interconnections were then compared to the other texts. During this stage of the research, it was critical to grasp what the conclusions of the selected texts contain since this data serves as the foundation for a meta-ethnography (Sandelowski & Barroso, 2002). Malpass et al. (2009) defined three layers of possible data based on three tiers of analysis: The first order constructs are defined as people's rationalisations of their own lived experiences. The second order constructs pertain to a researcher's understanding and explanation of first order constructs. This can be understood as interpretations of interpretations. The third order constructs form as a result of the aggregation and interpretation of first order and second order constructs. This can simply be understood as interpretations of interpretations of interpretations. The five texts selected constitute the source of data for the meta-ethnography. These texts correspond with second order structures (Sandelowski & Barroso, 2002).

3.4.6 Phase 6: Synthesizing Translations

Synthesizing translations is the sixth phase. Synthesis is the process of transforming an entire collection of texts into something more than just the aggregation of multiple parts (Noblit & Hare, 1988). Concerning stage five, the synthesis can be simply understood as the organised and curated collection of translations (Noblit & Hare, 1999).

This step aims to construct a distinct totality from the translations generated in the previous phase. It is critical to note that this phase is to be differentiated from just a mere collection of the several texts' findings (Noblit & Hare, 1988). The translations were examined to see whether certain themes and or metaphors from one text's data could be applied to the corresponding themes and metaphors from the others. This phase entailed analysing and translating the various interpretations into one another. This was accomplished by first identifying the concepts in a single text. This single text was then compared to a second text to find discrepancies or commonalities. This was then repeated with the remaining texts until all were thoroughly examined. In several cases, new overarching themes were created to bring together many themes observed in the various research.

3.4.7 Phase 7: Expressing the Synthesis

Phase seven is putting the synthesis into words. Although it is evident that the majority of syntheses are written for an academic readership, it is merely one of several conceivable formats. Other techniques of synthesis may be preferred when the synthesis is motivated by a desire to enlighten clinicians. The audience itself might be used to translate and develop symbolic forms that are suited for specific uses. Based on the target population and the medium they value, recordings, performances, artworks, and music all appear to be suitable forms (Patton, 2014).

The standard method for disseminating the findings of a meta-ethnography is via a written format. It was critical to be mindful of the target readership and goal of the research before deciding on how to disseminate the findings. Writing with a specific audience in mind did not imply a diminution in the study's findings. Rather, it ensured that the vocabulary

chosen allowed the audience to comprehend the phenomena in light of other people's perceptions and conceptualisations. To do so, one must have a comparable understanding of the audience as they do of the studies that are to be analysed, as each will be portrayed to another premised on both their commonality and distinctiveness (Noblit & Hare, 1988). The University of Fort Hare has required this research study as part of the prerequisites for a Master of Social Sciences in Counselling Psychology degree. Cognisant of this, the research was prepared in a way that could be reviewed using these criteria.

3.5 Ethical Considerations

The journal articles used to produce the data for this research study came from the academic context, which was accessible to the public. As a result, no ethical approval was required to utilize the data. However, as per the requirements set out by the University of Fort Hare, a proposal was submitted and cleared by the university ethics committee. The researcher undertook this project under the supervision of a knowledgeable expert in the field who has expertise in cultural psychology. The ethical standards of a high-quality research paper were followed. Auditability and disclosure were given specific attention to generate research that is transparent, responsible, and reproducible (Thorne et al., 2004). These conditions allow for the replicability of the study (O'Leary, 2004). A full explanation of the study's approach and design was supplied for transparency. This provided a basis for greater clarity, allowing others to retrace or verify the research process which enhances the study's repeatability (O'Leary, 2004). Using a well-known synthesis design, this research study aimed to produce a high-quality output. Meta-ethnography is a well-known and extensively utilized approach among reputable academics and across several academic disciplines (Harper & Thompson, 2011).

3.6 Conclusion

This chapter contained an outline of the study's methodology which guided and informed the research process to address the research question. Noblit and Hare's meta-ethnography was the selected research design. A meta-ethnography is a form of a qualitative approach to data synthesis which falls within an interpretative paradigm. This

chapter has discussed how the seven stages of Noblit and Hare's meta-ethnography were applied to the research process and how the reporting guidance was integrated into the written format of this mini dissertation. Five primary journal articles were selected and synthesised from a list of prospective papers linked to the topic of interest. The chapter ended with a review of the compliance with ethical considerations that this study raised.

Chapter 4: Findings

4.1 Introduction

Based on the selection process outlined in chapter 3, 5 primary studies were selected for data synthesis. Concerning the meta-ethnography reporting guidance as outlined by France et al. (2019), the following chapter first tabulates the outcome and characteristics of the selected articles as noted in phase 3 of the seven phases. The chapter then documents the outcomes of how the studies were related, translated, and synthesized as stipulated in phases 4, 5 and 6.

4.2 Outcome and Characteristics

The selected studies frame narratives from a predominantly cultural perspective. While this may be the case, it does not reflect a lack of a religious construct influencing narratives of depression within the articles. Studies such as Booi and Edwards (2014) and Hertog et al. (2020), indicate various faiths noted in the sample demographic, yet they are almost alluded to as a sub-component of the cultural construct. This form of conceptualisation aligns with Fiske et al.'s (1998) understanding of culture as a collection of constructs, religious beliefs being one of them. With this insight, the researcher deemed it appropriate to maintain the "religious" construct within the research question despite the selected articles appearing to focus primarily on culture.

Table 4

Studies selected

Author(s)	Title	Date of Publication	Geographical Location	Participants	Qualitative Approach
K.R. Sorsdahl; A.J. Flisher; Z. Wilson; D.J. Stein	Explanatory models of mental disorders and treatment practices among traditional	2010	Mpumulanga, South Africa	Convenience sampling of 50 traditional healers	Cross-sectional exploratory design using 4 focus group

	healers in Mpumulanga, South Africa				discussion and 18 in-depth interviews
V. Campbell-Hall, I. Petersen, A. Bhana, S. Mjadu, V. Hosegood, A.J. Flisher	Collaboration Between Traditional Practitioners and Primary Health Care Staff in South Africa: Developing a Workable Partnership for Community Mental Health Services	September 2010	KwaZulu-Natal, South Africa	Purposive sampling of traditional healers, service providers in health care and service users	individual and focus group qualitative interviews
T.N. den Hertog, E. Maassen, J.T.V.M. de Jong, & R. Reis	Contextualized understanding of depression: A vignette study among the !Xun and Khwe of South Africa	2020	Platfontein, South Africa	Convenience followed by snowball then purposive sampling of 14 Khwe and 6 !Xun	Semi structured interviews
B.N. Booi, & D.J.A. Edwards	Becoming a Xhosa Healer: Nomzi's Story	2014	Queenstown, South Africa	Purposive sampling of a 67-year-old Mfengu woman	Psychological Hermeneutic case study
I. Schierenbeck, P. Johansson, L.M. Andersson, G. Krantz, & J. Ntaganira	Collaboration or renunciation? The role of traditional medicine in mental health care in Rwanda and Eastern Cape Province, South Africa	2016	Eastern Cape, South Africa & Kigali, Rwanda	Purposive sampling of 12 Eastern Cape respondents and 8 Kigali respondents	Comparative case study of semi-structured interviews

4.3 Relation and Translation

To ensure academic vigour is maintained within the process of relation and translation, it is important to indicate how the primary studies that were selected relate to

each other in the context of the study and whether this relation is reciprocal and/or refutational or exploring different aspects of the topic.

Each of the five studies selected intrinsically relates to the research question and sub-research questions. Each one of the studies focuses on the interconnection of cultural and religious identity and mental health. More specifically, how depression is affected by and affects culture. Additionally, the studies are all located within Southern Africa and focus on communities that incapsulate traditional Afrocentric cultural practices or beliefs.

Studies such as Campbell-Hall et al. (2010) and Schierenbeck et al. (2016) place an emphasis on the interaction between established biomedical approaches and cultural approaches. Whereas studies like Sorsdahl et al. (2010), Hertog et al. (2020), and Booi and Edwards (2014) give more attention to conceptualizations and responses to mental health and depression.

While the majority of the selected studies provide first and second order constructs relating to conceptualization, treatment seeking and prognosis, it is important to note that the studies by Campbell-Hall et al. (2010) and Sorsdahl et al. (2010) contained only second order interpretations relating to prognosis.

Tables 4.2, 4.3, 4.4, 4.5 and 4.6 document and differentiate between the source of the concepts obtained from the participants which are referred to as first order constructs, and those established by the authors of the primary study accounts which are referred to as second-order constructs. These sources of data are categorised according to conceptualisation, treatment, and prognosis. These three concepts are used as a lens to screen for themes and are directly derived from the three sub-research questions. The tabulations assist in ensuring that the original meanings from the participants and the second order interpretations of the researchers are read and understood accurately within their specific contexts. While maintaining their original meanings, the data can then be synthesized into key themes as a response to the research question.

Table 5

First and second order constructs within Sorsdahl et al. (2010)

Concepts	First Order Interpretations	Second Order Interpretations
Conceptualization	*"Mental illness is different to stress and heart illness 'cause mental ill person will live alone, damage property and say many useless things. They do not stay at one place are very restless and talking to themselves not making any sense. They pick up dirt from dust bins, they do not wash and they beat other people up for no reason".* *"The ancestors are trying to tell that person that they should follow the calling and become a traditional healer. The ancestors can cause a number of problems to a person if they do not listen to the calling, even a mental illness. A calling can be viewed as a blessing and a burden"* *"It is true that a person gets mentally disturbed if they don't do their family rituals, or traditions. Another person gets mad because they were abused, another because they killed someone and then you find that some people have a calling, to become traditional healer. We can help patients who have a mental illness caused by African reasons."*	Traditional Healers recognize mental illness as a distinct issue. Some Traditional healers identified consulting ancestors to aid diagnosis while all were able to identify based on the patients' disturbances. Mental illness having multiple possible causes, predominantly pointed towards witchcraft and possession by evil spirits. Additional explanations related to causal factors such as family problems, substance abuse and poverty that were left undealt with which resulted in a condition worsening. Ukuthwasa – the call for an individual from the ancestors for them to become a traditional healer, results in the spiritual infliction of a mental disorder. Additionally, "African reasons" – not doing customs practices that are required. The traditional healers were not able to identify depression in a case vignette that was presented to them. They all believed that the individual in the vignette was not suffering from any mental illness. However, all indicated that she required a traditional healer or medical doctor. They indicated that she may be bewitched, possessed by a bad spirit or has HIV or illness of the heart. At face value, the traditional healers her symptoms were the result of "thinking too much" or stress.
Treatment	*"Healing can be expensive, and families end up paying for the patient… …He would throw things at neighbours house and start fights. Other community members laugh at the sick patient too, this is very bad."* *"I have a mentally ill patient, who had gone to the Western doctor and did not get cured. His family took him to me and he stayed with me for 5 months. He took 1 teaspoon of muti 3 times a day with food. Although he does not live with me anymore, he still takes his muti. He is much better now and will soon be cured".*	Treatment both western biomedical and traditional are expensive and families have to pay both financially and socially. General consensus among respondents is that traditional healers possess the skills and knowledge to "cure a mental Illness". Treatment enforcement typically consists of frequent visitations or requiring the patient to stay with the traditional healer. This treatment duration is estimated between as little as two weeks to a year and six months. Treatment procedures are methodically and structured. When clients are violent or uncooperative, traditional healers make use of forceful methods such as tying patients down with rope and/or chains.

		Muti used in all treatment approaches and is either given for consumption orally or sniffed or for the patient to bathe in. Traditional healers are secretive about the ingredients used for their muti however some information was given about commercially available items, often toxic, that are used in mixtures. When the vignette was seen as just a result of "thinking to much", the remedy would be for that individual to be helped to deal more effectively with their life situation.
Prognosis		Without adequate treatment traditional healers made acknowledgement of extended consequences of mental illness including loss of employment, not being able to care for one's family, being ridiculed by the community resulting in isolation and loneliness A major theme of psychotic illnesses and more specifically, the severe behavioural disturbances accompanying them, as a standard of what is mental illness. Without the drastic behavioural abnormalities, Traditional healers may not be as likely to accurately detect and diagnose a mental illness.

Table 6

First and second order constructs within Campbell-Hall et al. (2010)

Concepts	First Order Interpretations	Second Order Interpretations
Conceptualization	*". . . they say oh he's like this because this person was a killer before – was a thief – so they bewitched him . . .. Or just he's jealous because you are progressing (doing well) in this family . . . what they always mention is about bewitching. . . . if people have not performed certain rituals that they were supposed to perform it does happen."* *"But I believe the illness has something to do with imimoya [forces beyond one's power]".* *"Sometimes they go and take the soil from the grave and use it to bewitch people, making them mentally ill . . ."*	Attribution of mental illness to cultural causes more frequently than biological explanations. The cultural explanation falls within in two broad categories: one being caused by witchcraft and the other by the ancestors of an individual. Witchcraft can follow as a demand for justice or spite. Ancestors are seen as causal factors when rituals and/or traditions have not been performed. Community members with low mental health literacy relate diagnosis to causal factors such as genetics, rape, accidents, death of a family member, thinking too much and spiritual influence. Traditional healers believe that the cause of mental illness is either social or cultural. The social problems are indicated as personal problems, rape, bereavement, substance abuse and thinking too much. In terms of cultural problems, these link to spiritual causal attributions such as

		bewitchment, upsetting one's ancestors or receiving an ancestral calling.
Treatment seeking	*"We rebuild them. Coming to those who have lost loved ones, we also visit them and give them words of comfort . . ."* *". . .but when I was seeing the faith healer it seemed to get worse so I stopped and continued with the doctor only, since then."* *"It was difficult to find something to do to bring in money so I had to go to [place name] and see the doctor. That was when I was told to start treatment. And they helped me with getting the grant."* *"there are Western illnesses that can be cured using Western medicines and they will stop. For . . . example, I have never encountered a traditional healer who cures TB . . .. We do not have the machine to detect TB like the X-Rays and laboratories that can test if it's really TB. It's important that we work jointly. There are also illnesses like . . . umeqo (something that has been bewitched) that Western doctors cannot treat no matter how much they examine."* *"The pills they are using are from our plants already so you see if we were to give them our methods, then we will never be able to work again . . . We cannot give away our secrets because they will take them and use them but they will never give us theirs."*	Treatment from a traditional healer would take the form of talking or referring to a social worker or the police in the instance of rape. Majority of individuals would seek health care through a biomedical facility while additionally consulting a traditional healer. Other cases reported first seeking healing from a traditional healer and then seeking biomedical treatment as a last resort. When there is a duality of traditional biomedical, there can be difficulty with treatment adherence as individuals may shift between approaches as they may feel torn between cultural beliefs and western biomedical influence. Individuals seeking financial assistance related to a disability, need to seek a biomedical assessment in order to have access to a grant. Traditional healers claim that western illnesses need to be cured using western medicines and spiritual illnesses need to be cured using spiritual treatment methods. Traditional healers have also expressed fear of working with biomedical doctors, as they fear their traditional knowledge will be exploited.
Prognosis		Tension between two approaches to the presenting problem can often result in individuals not adhering to either forms of treatment and thus increasing the chances of the mental illness remaining or becoming exacerbated.

Table 7

First and second order constructs within den Hertog et al. (2020).

Concepts	First Order Interpretations	Second Order Interpretations
Conceptualization	Depression as a "thinking problem", or as "thinking too much" or "thinking about many things", "sickness in thoughts", "bad thoughts", "stress" "pain in heart", "sadness", "loneliness", "low energy", "bad spirit". *"There are a lot of people out there struggling in their life... it is like this."* *"Some of their family don't even care about them and they have stress about these problems and it keeps them*	The onset of the conceptualized issue was explained through contextualized stories such as life struggles, physical difficulties, cognitive and spiritual aspects. Life struggles were explained as socioeconomic problems and interpersonal problems. Physical interpretations linked specific symptoms and conditions such as old age, sickness, slow speech and movement, poor eating, not sleeping properly.

	thinking about this and it hurts them inside."	Cognitive dimensions linked to worrying and thinking too much and stress.
	"the work of evil", "Just a bad spirit"	Spiritual dimension linked to both a bad spirit causing the symptoms or the intentional spiritual infliction. Additionally, the cultural influence on the spiritual dimension link witchcraft and ancestors with influence on suicidal ideation and negative emotions.
Treatment seeking	*"So that her friends can give her an idea."* *"She must make friends, and she must ...sit and she must speak with her friends."* *"I think there is a role for medication because maybe she is in stress... or maybe she had a high blood. Stress can go to high blood and... it can't take anymore. She can go to the clinic or the hospital for the medication."*	Coping and health seeking strategies are centered around reducing negative effect and rumination. Engaging in social relations as well as other sources of social support such as church groups, psychologists, social workers and health care clinics. Medication seen only as a treatment option to physical symptoms such as blood pressure, eating and sleeping difficulties. Another form of coping was through distraction. Religious and cultural practices such as prayer and reading the bible were mentioned as ways of coping with negative affect.
Prognosis	*""I'll make an example of myself: I don't have a job, the whole day there is nothing to do. So you will be feeling lazy and there will be a problem. ...The lady, if she would have a job she will be like ...she has to prepare for the job, ...she is like fresh and she wants more of these challenges in her life. She is clean and she will do things, she will eat and live healthy."*	Poverty and unemployment sustain the challenges to contribute toward depression.

Table 8

First and second order constructs within Booi and Edwards (2014).

Concepts	First Order Interpretations	Second Order Interpretations
Conceptualization	*"The water formed a cone-like shape where I was going to go in"* *"Witchcraft is here to stay."*	Consequences both physical and cognitive for not adhering to ancestral calling. Intwaso is noted as an intentional call initiated by a deceased family member to guide the individual to develop their spiritual gifting. This can often present symptoms associated with mental illness. Ritual acts known as Amasiko such as rites of passage, addressing illness, difficulties, misfortunes are followed to honour ancestors and if neglected, can bring misfortune upon family. The culturally formed understandings of where mental illness originate is dynamic yet permanent.

Treatment seeking	*"The ancestors used to talk to me through dreams, and they sent me to people who needed help."* *"She also taught me to strengthen homes, as a preventative measure against evil spirits."* *"After the ceremony, I was able to walk normally again."* *"When divining, I just look at the patients' eyes, then my left hand itches, and when I look at the hand something will be written that can only be read by myself and not anyone else. Then I tell the patient what his or her problem is, and where it emanates from."*	Traditional healers use muti as a charm to protect against malicious spiritual attacks.
Prognosis	*"I cried and asked my ancestors to bear with me, as my mother had no money to pay for all the necessary procedures."* *"…despite having missed most of the lectures and assignments due to my "sickness."* *"I worked as a teacher in Alice. I despised the other teachers, isolated myself, was very irritable and rude and did not want anything to do with them."* *"I became more hydrophobic. When crossing the bridge, I felt as if the water was covering me, and I experienced tightness of the chest. I then decided to resign from my teaching post in Alice."* *"I lost my friends because I told them when they were having harmful muti."*	Poverty's influence on the spiritual as members need to afford various physical items to complete rituals and traditions. The shifting of and adaption of Xhosa traditions are changing from older more traditional practices due to a cultural clash both in terms of infrastructure and social norms.

Table 9

First and second order constructs within Schierenbeck et al. (2016)

Concepts	First Order Interpretations	Second Order Interpretations
Conceptualization	*"They start to see things and all that stuff, and for you, you will say it's schizophrenia, visual hallucinations, and someone else will say it's my ancestors calling me."* *"This child was early on set schizophrenia and he refused to admit it, he refused to admit her psychotic behaviour. He took her to the traditional healer in - on three occasions and it was actually the traditional healer that brought that child in and to say, 'You need to admit this child - this is a psychiatric disorder.'"* *"We had a junior doctor …you could see that he had a huge problem trying to balance what he believed, in spite of*	Perception of Mental Illness (theme of tension between interpretations) Bewitchment or being called is not considered a mental illness. Diagnosis should be aided by a traditional healer and therefore collaboration is required. Biomedical diagnosis often carries confusion and stigma whereas traditional explanations such as being called or bewitched can bring grace or status and respect from the community. One common misconception is that mental illness is permanent Understanding of and behaviours regarding symptoms of mental illness is the result of a mixture of traditions, religious and

	being a doctor, he held a lot of traditional beliefs."	biomedical beliefs indicate parallel belief systems that interconnect in ways that are complimentary and contradictory. Duality of biomedical doctors with clashing cultural/religious beliefs
Treatment seeking	*"They are the first point of call, mostly for our people, the African people, because if you can't think, can't find a reason for this and explain it, let me go and hear it from a traditional healer."* "People with depression are not a bother because of limited knowledge out there, a person who's depressed might withdraw … and not bother anybody … so they don't seek help *for depression"* *"They tend to go to traditional healers first and what was amazing to me was that a person could be really quite severely ill but he would get a lag time of two to three years before the patient comes to see you."*	Factors influencing choice: Traditional medicine is noted as more accessible than Biomedical treatment. Scarcity of medical facilities/rooms and staff Lack of transportation Lack of biomedical knowledge and misconceptions regarding symptoms and treatment form another major reason why individuals do not seek biomedical treatment. Many individuals first go to a traditional as they have a desire to find a deeper meaning in their symptoms but also receive a culturally appropriate and sensitive explanation Traditional healers and medicine or religious church before biomedical. This illustrates that the biomedical discourse is seen as a complementary system when traditional treatment fails even among traditional healers.
Prognosis	*"When people come to the psychiatric clinic, people that are ignorant about mental health will tell them, 'Ah, you are mad, you are crazy, you are a nut and you are this and you are that, 'so at the end of the day patients don't feel like coming here."* *"There is one in … she will treat and then if there is no improvement she will actually bring the client to the psychiatric facility … so they work hand in hand with, they are trying to draw in the community and the traditional healers so that you still take the culture into consideration."*	Stigma discouraging biomedical care (Dual stigma) Being associated even with biomedical care can be stigmatizing for both individual and family. Double stigma firstly through a having a mental disorder, but secondly having one that is culturally inappropriate such as a "white peoples sickness". Prognosis better when referrals are engaged. Priority of treating persons related to cultural orientation. Grace or Status.

4.4 Data Synthesis

After extensive reading, relation, and translation of the selected 5 primary studies, 3 themes emerged about how cultural and religious narratives influence conceptualization, treatment seeking and prognosis of depression. The researcher initially intended for the themes to be identified, to exclusively correspond to each of the three research objectives. That is to say that a theme per research objective was initially planned. During the relation and translation phase, however, the themes that were emerging were not neatly fitting into

each objective exclusively. Rather, they emerged as multi-faceted with aspects within each relating to the different research objectives.

The themes that emerged are Conflictual Coexistence, Observation-Based Discernment, and Status or Stigma. Each theme predominantly relates to meeting the first research objective, that is how depression is understood within an Afrocentric context. The presence of conceptualisation within each theme, however, forms the foundation for meeting the second and third research objectives. The second research objective, which is to describe treatment-seeking behaviours and responses to depressive symptoms, was met within each theme through the exploration of conceptualisations of causation and treatment options. The third research objective, which is to explore how cultural beliefs and practices influence the prognosis of depression, is primarily met within the data of the third theme. Additionally, the data relating to conceptualisation and treatment-seeking behaviours provides a basis to hypothesise prognosis and is further elaborated on in the discussion.

4.4.1 Conflictual Coexistence

When assessing constructs such as how participants have conceptualized symptoms related to mental health and the subsequent treatment-seeking behaviours, all studies contained the dimension of tension between traditional beliefs and contemporary influences. While individuals may be predisposed to relying more on a particular belief system, the context in which they exist is multifaceted and therefore perception becomes more complex. The result is a lens that is formed through a mixture of traditional cultural religious traditions and beliefs interconnected with contemporary ways of understanding and being. These interconnections can be both complimentary and conflictual. They may also initially be complementary but then diverge into tension and conflict.

In instances where mental illness is acknowledged by traditional healers and community members as a distinct illness such as in Sorsdahl et al. (2010) tension between beliefs can still be identified. These communities acknowledge the multidimensional influences that can become causal factors for depression however frequently attribute causal factors to either social or cultural-related matters above biomedical explanations (Campbell-

Hall et al., 2010). Social problems are indicated as socioeconomic problems and interpersonal problems while cultural problems are linked to spiritual activities such as bewitchment, upsetting one's ancestors or receiving an ancestral calling (den Hertog et al., 2020; Campbell-Hall et al., 2010). It is important to note even within these areas of general agreement, tension regarding conceptualization still arises. While some communities believe that mental illness can be inflicted through spiritual causes, others remained determined that if spiritual causal factors are involved, then the presenting problem becomes a distinct issue (Schierenbeck et al., 2016).

While mental health literacy influences perceptions and treatment-seeking behaviours, on both sides of the spectrum, literate and low levels of literacy are prone to experience tension between various outlooks (Schierenbeck et al., 2016). When both traditional and biomedical options are pursued simultaneously, treatment adherence is reportedly negatively affected (Campbell-Hall et al., 2010). An apparent tension between frameworks used for understanding and responding to a phenomenon can leave an individual prematurely ending treatment or not fully engaging resulting in a poor prognosis.

As countries have become more connected and globalized, the integration of western systems, biomedical or other into local communities has created a tension between what may be wanted versus what must be engaged with. Examples of such invasion can be noted in how many cultural traditions have shifted and adapted due to western influence (Booi & Edwards, 2014). On the other hand, some individuals may be required to approach a differing framework such as a biomedical diagnosis for grant applications (Campbell-Hall et al., 2010). Such a case is an example of the interconnectivity experience that can be both complimentary and conflictual.

In more recent times, indigenous knowledge has been celebrated and promoted to form part of multidisciplinary teams, however, gatekeepers of such knowledge like traditional healers remain secretive and do not trust western medical establishments due to the fear of exploitation (Campbell-Hall et al., 2010; Schierenbeck et al., 2016; Sorsdahl et al. 2010).

Ultimately, despite the tension or benefit, members of groups tend to seek

culturally appropriate explanations to appropriate their experience (Schierenbeck et al., 2016).

4.4.2 Observation-Based Discernment

Across all constructs in the reviewed articles, the theme of observation-based discernment was identified. This theme encompasses the concept that a common framework for diagnosing and treating a mental illness is heavily reliant on observable symptoms.

Concerning conceptualization and treatment, participants in Campbell-Hall et al. indicated a strong belief that the treatment of a problem is determined by the cultural origination of the issue (2010). For example, a western illness is to be cured with western medicine while spiritual issues are to be cured by spiritual means. While this view tends to hold a balance, discernment can often be skewed resulting in a diagnosis that is more often founded in a cultural explanation than a biological one (Campbell-Hall et al. 2010).

One aspect influencing the type of perception that is predominantly held is the level of mental health literacy. In communities where mental health literacy levels are low, a greater focus is placed on symptoms as opposed to the condition itself (Campbell-Hall et al., 2010). Because of this, conceptualization and treatment-seeking behaviours become rooted in narrative-based life stories (den Hertog et al., 2020). Additionally, this understanding often grounds the symptom in a framework of permanence (Schierenbeck et al., 2016).

Furthermore, a reliance on exaggerated and observable abnormal behaviour is often required for traditional healers to make a mental illness diagnosis (Sorsdahl et al., 2010). This often results in misdiagnosis with no treatment plan, traditional or biomedical to be put into action. Despite this, the theme becomes prominent through the confidence held by both traditional healers and community members in the traditional healers' ability to cure mental illness (Sorsdahl et al., 2010).

Traditional healers in Campbell-Hall et al., however, indicate a disposition to refer individuals to biomedical health workers when physical symptoms are presented (2010). Additionally, when non-physical or interpersonal issues are identified, the traditional healers

in the article indicated assisting the presenting individual with ways of coping. These issues however would still carry an observable consequence that would be identified.

4.4.3 Status or Stigma

The last theme that was identified refers to the community's perception of an individual's existence in relation to their perceived issue. The status or stigma can be attached to multiple aspects of the situation surrounding an individual with or suspected of having a mental illness.

Even in instances where multiple causal factors are acknowledged, an interpretation bias may lead to the diagnosis of spiritual causation before biomedical (Booi & Edwards, 2014). In some cases, this could take the form of status in the outworking of grace if the individual is the victim of a curse or bewitchment done in spite. If the individual has not honoured their ancestors and has not completed a ritual, the resulting suffering would be viewed more from the perspective of disgrace, as the individual has not shown honour, thus resulting in stigma (Sorsdahl et al., 2010; Booi & Edwards, 2014). A severe behavioural disturbance can also be viewed in a positive light. In instances whereby an individual is receiving the calling to go into training to become a traditional healer, the situation is viewed with respect and status (Schierenbeck et al., 2016).

It is important to highlight the instances where a dual stigma or status can emerge. Firstly, the complexity of receiving adequate health care can carry a stigma as members may be against this form of framework as it clashes with their worldview (Schierenbeck et al., 2016). Additionally, this can be fuelled by the misconception that the issue is permanent and therefore, the individual receives a permanent label and therefore a perpetual stigma (Booi & Edwards, 2014). When this individual is stigmatized, the prognosis may worsen therefore creating a cycle of stigma. The difficulty arises then, that even when an individual disengages with treatment adherence, they still may continue struggling.

When it comes to the theme of status or stigma, families tend to experience the same form of response related to the individual. Families end up suffering either socially, financially or both (Sorsdahl et al., 2010). The cycle of stigma may then be sustained when

an individual is no longer able to take care of his family either due to their symptoms, lack of finance or both. A cycle of stigma then becomes inclusive of prognosis, finance/employment, and not being able to fulfil culturally held expectations (den Hertog et al., 2020; Booi & Edwards, 2014).

When looking at depression specifically, a dual stigma is attached to the diagnosis. The first aspect is a result of having a mental illness and the physical/emotional symptoms thereof. This internalized stigma becomes apparent when an individual who has been diagnosed with depression will be seen as weak and unable, the stereotypical view of someone who does not have the fortitude to handle depression. The second is having a culturally inappropriate “white people’s illness” (Schierenbeck et al., 2016).

4.5 Discussion

Within a social constructionist framework, the formation and retention of social realities regarding how depression is defined and interpreted are specifically influenced by socially produced narratives (Hayward & Bright, 1997). More specifically, the way that individuals perceive the world and construct reality is through the use of language, which is arranged into discourses, narratives, stories, and dialogues. (Camargo-Borges & Rasera, 2013). What becomes regarded as reality can then be noted as a result of a certain historical and cultural context (Gergen, 1994). This framework provides validity to both the first and second order constructs of the experiences of depression as well as the significance of the data for intervention and further exploration.

In terms of the conceptualisation of mental illness, more specifically depression, the way one’s understanding is formed can be seen as a result of a mixture of traditional, cultural and religious traditions and beliefs interconnected with contemporary ways of understanding and being. Despite this convergence of sources for understanding, matters such as symptomatic presentations of depression can often still be solely attributed to entirely cultural, or contemporary ways of conceptualization. In circumstances where cultural and religious influences are greatly tied to belonging and community identity, an inherent predisposition will likely take place in which facet the conceptualization stems from. Another

aspect of what determines the dominance of a framework lens is related to how an issue becomes identified. When symptoms or consequences of depression are presented in a way that prompts an explanation, the conceptualizations that follow are influenced by what is observable. A prominent occurrence noted in almost all synthesised literature was the conflation of biomedical and Western terminology. This conflation of medical advances strictly to a Western culture potentially not only undermines the melting pot of cultural contributions toward health sciences but also contributes to a divisive narrative that allows space for stigma to take hold. In the case of depression, what is often noticed by other members of the community is the consequences of the symptoms and not the symptoms themselves. In these instances, when the issues stemming from the symptoms are addressed, some change may be noticed, however, stigma may still apply if varied interpretations are alluded to. As a result of these implications, the conceptualisation of depression predominantly takes place within a dialogue of narrative stories. These stories can form based on context and how they will add to the search for meaning, bring status or avoid stigma.

As stigma forms as a result of certain conceptualisations, treatment beliefs and seeking-related behaviours are negatively affected. These can come from communities criticising a member's engagement with a construct that is not seen as acceptable or if the individual incorrectly engages with a culturally accepted construct. With the various social constructions of health, members of local communities have however expressed a desire for mental health care that embraces collaboration with traditional healers. This is driven by a need to receive culturally sensitive explanations as well as find deeper meaning in diagnoses. Despite this, various factors still influence treatment-seeking behaviours. A huge factor is a tension between traditional healers and established biomedical healthcare. Traditional healers are not opposed to collaboration however yet remain secretive about their practices out of a fear of being exploited or immobilised due to practices that would not be deemed acceptable. Despite higher levels of mental health literacy correlating to more favourable outcomes, little to no difference appears to be noted in terms of the tension

between frameworks of understanding with those with lower levels. One could assume that treatment-seeking behaviours would then be guided by the approach that results in the least amount of tension with individual and communal identity. The interconnectivity of cultures and beliefs furthermore has led to the integration of western systems, biomedical or other into local communities. Communities who wish not to engage in such forms of treatment may be required to do so to receive monetary or other needed benefits despite the potential stigma. As indicated within conceptualisation, observable symptoms provide strong guidance for treatment-seeking behaviours. Additionally, certain presentations of symptoms can be exclusively allocated to the cultural or biomedical cause. When this occurs, treatment is selected based on the identified cause. Lastly, a lack of integration of culturally specific treatment approaches and biomedical approaches is apparent. There are various explanations as to why, however, a prominent account relates to mistrust between traditional healers and medical professionals. As a result of such disdain or mistrust, members influenced by these figures of authority can be swayed in terms of their treatment-seeking behaviours.

Ultimately, across the studies identified, a great deal of research focus is on how depression and mental illness are conceptualised but with minimal data on how this influences prognosis. With this being noted, however, certain aspects of how conceptualisation and treatment-seeking are influenced can provide a basis to hypothesise the consequences they could have on prognosis. A perceived conflict between the frameworks used to understand and respond to a phenomenon can lead to an individual terminating treatment early or not fully engaging, resulting in a poor prognosis. Additionally, a commonly perceived permanence of mental illness can increase stigma resulting in poor treatment engagement and prognosis. The issues mentioned above can result in dual stigma. Dual stigma has been defined as the stigma that people with mental illness experience in addition to their mental illness, and the stigma attached to the medical label. It is related to the fact that people with mental illness are often blamed for their condition by society. When a member experiences depression in a way that is not acceptable within their

cultural context, the individual not only experiences the consequences of their condition but also the stigma surrounding it. Additionally, based on the theme of observation-based discernment, the potential of various role players having a skewed perspective of presenting symptoms or a lack thereof can lead to potential misdiagnosis. In such instances whereby misdiagnosis takes place, it is more likely for a poor prognosis to follow.

The most prominent theme identified was “Conflictual Coextensive”. This could be partly due to a hypothesis that members of any community may be more willing to discuss the impact of external perspectives or forces interfering with their approaches as opposed to difficulties of sensitive information within their community.

4.6 Conclusion

This chapter expounded on the selection and translation of the selected 5 articles. This was then followed by a synthesis which resulted in the emergence of three key themes, namely Conflictual Coexistence, Observation-Based Discernment, and Status or Stigma. These three key themes were derived from comparison and translation based on the first and second order constructs identified in the selected studies. Lastly, a discussion of themes relating to the research question and objectives was presented. The following chapter will summarise the findings, discuss strengths, limitations and concluding reflections. These forms of reporting align with the seventh phase of a meta-ethnography (Noblit & Hare, 1988).

Chapter 5: Summary and Conclusion

5.1 Introduction

The primary aim of this chapter is to reinforce the process and findings of this study. This is accomplished by reporting on a summary of the findings of the meta-ethnography synthesis, its strengths, limitations, and a conclusion. These items reported align with the seventh phase outlined by Noblit and Hare (1988).

5.2 Summary of Findings

Mental health literacy influences perceptions and treatment-seeking behaviours. While individuals may rely more on a particular belief system, the context they exist in is multifaceted and therefore perception becomes more complex. The result is a lens that is formed through a mixture of traditional cultural religious traditions and beliefs interconnected with contemporary ways of understanding and being. These interconnections can be both complimentary and conflictual - initially complimentary but then diverging into tension and conflict. When assessing constructs such as how participants have conceptualized symptoms related to mental health and the subsequent treatment-seeking behaviours, all studies contained the dimension of tension between traditional beliefs and contemporary influences. While individuals may be predisposed to relying more on a particular belief system, the context in which they exist is multifaceted and therefore perception becomes more complex. In instances where mental illness is acknowledged by traditional healers and community members as a distinct illness, the tension between beliefs can still be identified.

The theme of Observable Discernment was identified across all constructs in the reviewed articles. This is the concept that a common framework for diagnosing and treating a mental illness is heavily reliant on observable symptoms. In communities where mental health literacy levels are low, a greater focus is placed on symptoms as opposed to the condition itself (Campbell-Hall et al., 2010).

Status or stigma can be attached to multiple aspects of the situation surrounding an individual with or suspected of having a mental illness. In some cases, this could take the form of status in the outworking of grace if the individual is the victim of a curse or

bewitchment done in spite. It can also be important to highlight the instances where a dual stigma or status can emerge. Cycles of stigma can be sustained when an individual is no longer able to take care of his family due to their symptoms, lack of finance or both. A cycle of stigma then becomes inclusive of prognosis, finance/employment and not being able to fulfil culturally held expectations. With depression, a dual stigma arises. The first aspect is a result of having a mental illness and the second is having a culturally inappropriate "white people's illness" (Schierenbeck et al., 2016).

5.3 Strengths, Limitations and Reflexivity

As a core component in ensuring the academic vigour of the meta-synthesis, two procedures can be acknowledged. The first is related to the quality appraisal of the studies selected for data. The second encompassed documenting the nuances of each text; preserving the full meaning captured in each text while at the same time, allowing for comparisons. This was achieved through the identification and distinction between first order and second order constructs within the selected studies. These procedures in handling data can be seen as a major strength of the study.

In terms of weaknesses, the demographic criteria for the selected studies, while focused on traditional South African communities, can be seen as broad. The Afrocentric focus provides insight into covering local traditional cultural narratives, yet within these communities, various sub-culture intricacies exist. These sub-cultures may have differences in approaching various phenomena despite being grouped under a larger cultural label. This would imply that not all conclusions can be attributed to members of all traditional cultures within a South African context.

In terms of recommendations for future research and interventions, it would be beneficial if future developments could pursue to develop psychoeducation that seeks to balance biomedical approaches to mental illness while at the same time, honouring traditional conceptualizations and approaches. Terms such as “culture sensitive” have been used in mental health education and services yet can still fail to account for root issues at the base of issues such as dual stigma. In terms of policy, collaborative care models can be

developed and deployed nationally to facilitate engagement between mental health practitioners, medical professionals, social workers, and community leaders to establish multidisciplinary approaches to wellness. Additionally, increasing the funding made available for research on the intersection of culture and mental health can help inform future policies and approaches to healthcare practice. Such research prospects can include focusing on subculture intricacies in understanding how the specific community approaches mental illnesses.

5.4 Conclusion

The research aim of this study was to develop a comprehensive understanding of how religious and cultural narratives describe and influence depression. As a result, this research study used a meta-ethnography to address the research question. Based on the data and findings of five original research studies, the data analysis that followed created 3 themes. The themes were Conflictual Coexistence, Observation-Based Discernment, and Status or Stigma. Within each of these themes, aspects of the initial 3 sub-research questions were identified and answered.

The purpose of this research project was to synthesize the themes, concepts, and metaphors of five main studies under the specified overarching themes. As a result, the synthesis generated something more than just a collection and aggregation of data, which is consistent with one of the meta-ethnographies' basic tenets: to create a whole that is larger than the sum of its parts (Thorne et al., 2004). These themes serve as a framework for understanding how Afrocentric cultural/religious narratives of depression influence its conceptualisation, treatment methods and seeking as well as prognosis. Consequently, these constructs are noted to be significantly influenced by the tension identified between traditional beliefs and contemporary influences experienced by community members. As an attempt to mitigate this tension, community members tended to rely primarily on observable symptoms in order to obtain diagnosis and treatment. Prognosis was noted not only to be influenced by this reliance on observable symptoms but also a community's perception of an unwell individual, held either in a positive regard or with stigma. As a result, future research,

and therapeutic intervention of this mental disorder within this demographic group will be better informed.

References

Abdel-Khalek, A. M. (2010). Quality of life, subjective well-being, and religiosity in Muslim college students. *Quality of Life Research*, *19*(8), 1133–1143. https://doi.org/10.1007/s11136-010-9676-7

Adams, T. B., Bezner, J. R., Drabbs, M. E., Zambarano, R. J., & Steinhardt, M. A. (2000). Conceptualization and Measurement of the Spiritual and Psychological Dimensions of Wellness in a College Population. *Journal of American College Health*, *48*(4), 165–173. https://doi.org/10.1080/07448480009595692

AHNA & ANA (2019). *Holistic Nursing: Scope and Standards of Practice* (3rd ed.). American Nurses Association.

American Psychiatric Association. (2022). *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (Dsm-5-Tr(tm))* (Vols. 5-TR). American Psychiatric Association Publishing.

Angst, J., & Sellaro, R. (2000). Historical perspectives and natural history of bipolar disorder. *Biological Psychiatry*, *48*(6), 445–457. https://doi.org/10.1016/s0006-3223(00)00909-4

Arango, V. (2001). Serotonin 1A Receptors, Serotonin Transporter Binding and Serotonin Transporter mRNA Expression in the Brainstem of Depressed Suicide Victims. *Neuropsychopharmacology*, *25*(6), 892–903. https://doi.org/10.1016/s0893-133x(01)00310-4

Aspers, P., & Corte, U. (2019). What is Qualitative in Qualitative Research. *Qualitative Sociology*, *42*(2), 139–160. https://doi.org/10.1007/s11133-019-9413-7

Atkins, S., Lewin, S., Smith, H., Engel, M., Fretheim, A., & Volmink, J. (2008). Conducting a meta-ethnography of qualitative literature: Lessons learnt. *BMC Medical Research Methodology*, *8*(1). https://doi.org/10.1186/1471-2288-8-21

Balkir, N., Arens, E. A., & Barnow, S. (2012). Exploring the relevance of autonomy and relatedness for mental health in healthy and depressed women from two different

cultures: When does culture matter? *International Journal of Social Psychiatry*, *59*(5), 482–492. https://doi.org/10.1177/0020764012441428

Bar, K. J., & Ebert, A. (2010). Emil Kraepelin: A pioneer of scientific understanding of psychiatry and psychopharmacology. *Indian Journal of Psychiatry*, *52*(2), 191. https://doi.org/10.4103/0019-5545.64591

Beevers, C. (2005). Cognitive vulnerability to depression: A dual process model. *Clinical Psychology Review*, *25*(7), 975–1002. https://doi.org/10.1016/j.cpr.2005.03.003

Behrens, K., del Pozo, M. A., Großhennig, A., Sieberer, M., & Graef-Calliess, I. T. (2015). How much orientation towards the host culture is healthy? Acculturation style as risk enhancement for depressive symptoms in immigrants. *International Journal of Social Psychiatry*, *61*(5), 498–505. https://doi.org/10.1177/0020764014560356

Bhugra, D., & Becker, M. A. (2005). Migration, cultural bereavement and cultural identity. World psychiatry : official journal of the World Psychiatric Association (WPA), 4(1), 18–24.

Blanche, T. M., Durrheim, K., & Painter, D. (1999). *Research in Practice: Applied Methods for the Social Sciences*. Juta Academic.

Bodley, J. H. (2000). Global Problems and the Culture of Capitalism:Global Problems and the Culture of Capitalism. *American Anthropologist*, *102*(1), 205–206. https://doi.org/10.1525/aa.2000.102.1.205

Bonache, J., & Festing, M. (2020). Research paradigms in international human resource management: An epistemological systematisation of the field. *German Journal of Human Resource Management: Zeitschrift Für Personalforschung*, *34*(2), 99–123. https://doi.org/10.1177/2397002220909780

Booi, B. N., & Edwards, D. J. A. (2014). Becoming a Xhosa Healer: Nomzi's Story. *Indo-Pacific Journal of Phenomenology*, *14*(2), 1–12. https://doi.org/10.2989/ipjp.2014.14.2.3.1242

Booth A. (2006). "Brimful of STARLITE": toward standards for reporting literature searches. *Journal of the Medical Library Association : JMLA*, *94*(4), 421–e205.

Booth, L. (2012). *Spirituality and Recovery: A Classic Introduction to the Difference Between Spirituality and Religion in the Process of Healing* (4th Revised ed.). Health Communications Inc.

Bożek, A., Nowak, P. F., & Blukacz, M. (2020). The Relationship Between Spirituality, Health-Related Behavior, and Psychological Well-Being. *Frontiers in Psychology*, *11*. https://doi.org/10.3389/fpsyg.2020.01997

Breland-Noble, A. M., Wong, M. J., Childers, T., Hankerson, S., & Sotomayor, J. (2015). Spirituality and religious coping in African-American youth with depressive illness. *Mental Health, Religion & Culture*, *18*(5), 330–341. https://doi.org/10.1080/13674676.2015.1056120

Brijnath, B., & Antoniades, J. (2018). What is at stake? Exploring the moral experience of stigma with Indian-Australians and Anglo-Australians living with depression. *Transcultural Psychiatry*, *55*(2), 178–197. https://doi.org/10.1177/1363461518756519

Britten, N., Campbell, R., Pope, C., Donovan, J., Morgan, M., & Pill, R. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research & Policy*, *7*(4), 209–215. https://doi.org/10.1258/135581902320432732

Brooks, L. A., Manias, E., & Bloomer, M. J. (2019). Culturally sensitive communication in healthcare: A concept analysis. *Collegian*, *26*(3), 383–391. https://doi.org/10.1016/j.colegn.2018.09.007

Burkhart, L., & Hogan, N. (2008). An Experiential Theory of Spiritual Care in Nursing Practice. *Qualitative Health Research*, *18*(7), 928–938. https://doi.org/10.1177/1049732308318027

Burns, J. K., Jhazbhay, K., & Emsley, R. A. (2010). Causal attributions, pathway to care and clinical features of first-episode psychosis: A South African perspective. *International Journal of Social Psychiatry*, *57*(5), 538–545. https://doi.org/10.1177/0020764010390199

Burris, J. L., Brechting, E. H., Salsman, J., & Carlson, C. R. (2009). Factors Associated With the Psychological Well-Being and Distress of University Students. *Journal of American College Health*, *57*(5), 536–544. https://doi.org/10.3200/jach.57.5.536-544

Camargo-Borges, C., & Rasera, E. F. (2013). Social Constructionism in the Context of Organization Development. *SAGE Open*, *3*(2), 215824401348754. https://doi.org/10.1177/2158244013487540

Campbell, R., Pound, P., Morgan, M., Daker-White, G., Britten, N., Pill, R., Yardley, L., Pope, C., & Donovan, J. (2011). Evaluating meta-ethnography: systematic analysis and synthesis of qualitative research. *Health Technology Assessment*, *15*(43). https://doi.org/10.3310/hta15430

Campbell-Hall, V., Petersen, I., Bhana, A., Mjadu, S., Hosegood, V., & Flisher, A. J. (2010). Collaboration Between Traditional Practitioners and Primary Health Care Staff in South Africa: Developing a Workable Partnership for Community Mental Health Services. Transcultural Psychiatry, 47(4), 610–628. https://doi.org/10.1177/1363461510383459

Cantrell, D. C. (1993). Alternative paradigms in environmental education research: The interpretive perspective. Alternative paradigms in environmental education research, 8, 81-104.

Caplan, S., Escobar, J., Paris, M., Alvidrez, J., Dixon, J. K., Desai, M. M., Scahill, L. D., & Whittemore, R. (2012). Cultural Influences on Causal Beliefs About Depression Among Latino Immigrants. *Journal of Transcultural Nursing*, *24*(1), 68–77. https://doi.org/10.1177/1043659612453745

Carson, D. J., Gilmore, A., Perry, C., & Gronhaug, K. (2001). *Qualitative Marketing Research* (First ed.). SAGE Publications Ltd.

Caspi, A., Sugden, K., Moffitt, T. E., Taylor, A., Craig, I. W., Harrington, H., McClay, J., Mill, J., Martin, J., Braithwaite, A., & Poulton, R. (2005). Influence of Life Stress on Depression: Moderation by a Polymorphism in the 5-HTT Gene. *FOCUS*, *3*(1), 156–160. https://doi.org/10.1176/foc.3.1.156

Chang, E. C., Chang, R., & Sanna, L. J. (2011). A Test of the Usefulness of Perfectionism Theory Across Cultures: Does Perfectionism in the US and Japan Predict Depressive Symptoms Across Time? *Cognitive Therapy and Research*, *36*(1), 1–14. https://doi.org/10.1007/s10608-011-9376-9

Chokkanathan, S. (2013). Religiosity and well-being of older adults in Chennai, India. *Aging & Mental Health*, *17*(7), 880–887. https://doi.org/10.1080/13607863.2013.790924

Clark, L. A., Cuthbert, B., Lewis-Fernández, R., Narrow, W. E., & Reed, G. M. (2017). Three Approaches to Understanding and Classifying Mental Disorder: ICD-11, DSM-5, and the National Institute of Mental Health's Research Domain Criteria (RDoC). *Psychological Science in the Public Interest*, *18*(2), 72–145. https://doi.org/10.1177/1529100617727266

Cohen, L., Manion, L., & Morrison, K. (2017). *Research Methods in Education* (8th ed.). Routledge.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative Inquiry and Research Design (International Student Edition)*. SAGE Publications.

Cronk, L. (2017). Culture's influence on behavior: Steps toward a theory. *Evolutionary Behavioral Sciences*, *11*(1), 36–52. https://doi.org/10.1037/ebs0000069

Cuypers, K., Krokstad, S., Lingaas Holmen, T., Skjei Knudtsen, M., Bygren, L. O., & Holmen, J. (2011). Patterns of receptive and creative cultural activities and their association with perceived health, anxiety, depression and satisfaction with life among adults: the HUNT study, Norway. *Journal of Epidemiology and Community Health*, *66*(8), 698–703. https://doi.org/10.1136/jech.2010.113571

Davidson, J., & Turnbull, C. D. (1986). Diagnostic Significance of Vegetative Symptoms in Depression. *British Journal of Psychiatry*, *148*(4), 442–446. https://doi.org/10.1192/bjp.148.4.442

Davies, D. J., & Thate, M. J. (2017). *Religion and the Individual: Belief, Practice, and Identity*. Mdpi AG.

de Jager Meezenbroek, E., Garssen, B., van den Berg, M., van Dierendonck, D., Visser, A., & Schaufeli, W. B. (2010). Measuring Spirituality as a Universal Human Experience: A Review of Spirituality Questionnaires. *Journal of Religion and Health*, *51*(2), 336–354. https://doi.org/10.1007/s10943-010-9376-1

Deacon, B. J. (2013). The biomedical model of mental disorder: A critical analysis of its validity, utility, and effects on psychotherapy research. *Clinical Psychology Review*, *33*(7), 846–861. https://doi.org/10.1016/j.cpr.2012.09.007

Dean, K. E., Long, A. C., Matthews, R. A., & Buckner, J. D. (2018). Willingness to Seek Treatment Among Black Students With Anxiety or Depression: The Synergistic Effect of Sociocultural Factors With Symptom Severity and Intolerance of Uncertainty. *Behavior Therapy*, *49*(5), 691–701. https://doi.org/10.1016/j.beth.2017.12.008

den Hertog, T. N., Maassen, E., de Jong, J., & Reis, R. (2021). Contextualized understanding of depression: A vignette study among the !Xun and Khwe of South Africa. *Transcultural psychiatry*, *58*(4), 532–545. https://doi.org/10.1177/1363461520901888

Denzin, N. K., & Lincoln, Y. S. (2003). *The Landscape of Qualitative Research: Theories and Issues* (2nd ed.). SAGE Publications, Inc.

Depression. (2019, November 29). Word Health Organization. https://www.who.int/health-topics/depression#tab=tab_1

Depression. (2020, September 13). World Health Organization. https://www.who.int/news-room/fact-sheets/detail/depression

Desmond, S. A., Kraus, R., & Dugan, B. J. L. (2018). “Let the heavens be glad, and the earth rejoice”: religion and life satisfaction among emerging adults in the United States. *Mental Health, Religion & Culture*, *21*(3), 304–318. https://doi.org/10.1080/13674676.2018.1478397

Disner, S. G., Beevers, C. G., Haigh, E. A. P., & Beck, A. T. (2011). Neural mechanisms of the cognitive model of depression. *Nature Reviews Neuroscience*, *12*(8), 467–477. https://doi.org/10.1038/nrn3027

Domegan, C., & Fleming, D. (1999). *Marketing Research in Ireland: Theory and Practice*. Gill & Macmillan Ltd.

Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: issues and findings. *Behaviour Research and Therapy*, *41*(7), 755–776. https://doi.org/10.1016/s0005-7967(02)00190-0

Csordas, T. J. (1990). Embodiment as a Paradigm for Anthropology. Ethos, 18(1), 5–47. http://www.jstor.org/stable/640395

Eckersley, R. M. (2007). Culture, spirituality, religion and health: looking at the big picture. *Medical Journal of Australia*, *186*(S10). https://doi.org/10.5694/j.1326-5377.2007.tb01042.x

Edwards, L., Bretherton, R., Gresswell, M., & Sabin-Farrell, R. (2020). The relationship between social support, spiritual well-being, and depression in Christian clergy: a systematic literature review. *Mental Health, Religion & Culture*, *23*(10), 857–873. https://doi.org/10.1080/13674676.2020.1838459

Eliason, M. J., & Amodia, D. S. (2007). An integral approach to drug craving. *Addiction Research & Theory*, *15*(4), 343–364. https://doi.org/10.1080/16066350701500627

Fernandes Ferreira, L., de Pinho Freire, A., Luiza Cunha Silveira, A., Pereira Martins Silva, A., Corrêa De Sá, H., Soares Souza, I., Stefany Araújo Garcia, L., Silva Peralta, R., & Moreira Borges Araujo, L. (2020). The Influence of Spirituality and Religiosity in Acceptance of the Disease and Treatment of Oncologic Patients: an Integrative Literature Review. *Revista Brasileira de Cancerologia*, *66*(2). https://doi.org/10.32635/2176-9745.rbc.2020v66n2.422

Fernando, S. (2002). *Mental Health, Race and Culture* (2nd ed.). Palgrave Macmillan.

Fernando, S. (2010). *Mental Health, Race and Culture: Third Edition* (Third ed.). Red Globe Press.

Fiske, A. P., Kitayama, S., Markus, H. R., & Nisbett, R. E. (1998). The cultural matrix of social psychology. In D. T. Gilbert, S. T. Fiske, & G. Lindzey (Eds.), The handbook of social psychology (pp. 915–981). McGraw-Hill.

Florczak, K. L. (2010). Gathering Information on Spirituality. *Nursing Science Quarterly*, *23*(3), 201–205. https://doi.org/10.1177/0894318410371836

Fornaro, M., Clementi, N., & Fornaro, P. (2009). Medicine and psychiatry in Western culture: Ancient Greek myths and modern prejudices. *Annals of General Psychiatry*, *8*(1). https://doi.org/10.1186/1744-859x-8-21

France, E. F., Cunningham, M., Ring, N., Uny, I., Duncan, E. A., Jepson, R. G., Maxwell, M., Roberts, R. J., Turley, R. L., Booth, A., Britten, N., Flemming, K., Gallagher, I., Garside, R., Hannes, K., Lewin, S., Noblit, G. W., Pope, C., Thomas, J., . . . Noyes, J. (2019). Improving reporting of meta-ethnography: The eMERGe reporting guidance. *Psycho-Oncology*, *28*(3), 447–458. https://doi.org/10.1002/pon.4915

Freire, J., Moleiro, C., Rosmarin, D. H., & Freire, M. (2018). A call for collaboration: Perception of religious and spiritual leaders on mental health (A Portuguese sample). *Journal of Spirituality in Mental Health*, *21*(1), 55–75. https://doi.org/10.1080/19349637.2017.1423001

Garcia-Toro, M., & Aguirre, I. (2007). Biopsychosocial model in Depression revisited. *Medical Hypotheses*, *68*(3), 683–691. https://doi.org/10.1016/j.mehy.2006.02.049

George, L. K., Ellison, C. G., & Larson, D. B. (2002). TARGET ARTICLE: Explaining the Relationships Between Religious Involvement and Health. *Psychological Inquiry*, *13*(3), 190–200. https://doi.org/10.1207/s15327965pli1303_04

Gephart, R., & Corvellac, H. (1999). Stories of Achievements: Narrative Features of Organizational Performance. *Industrial and Labor Relations Review*, *52*(3), 486. https://doi.org/10.2307/2525150

Gergen, K. J. (1994). *Realities and Relationships: Soundings in Social Construction*. Harvard University Press.

Given, L. M. (2008). *The SAGE Encyclopedia of Qualitative Research Methods* (1st ed.). SAGE Publications, Inc.

Global Burden of Disease (GBD 2019). (2020, December 9). Institute for Health Metrics and Evaluation. https://www.healthdata.org/gbd/2019

Goffman, E. (1963). *Stigma: Notes on the Management of Spoiled Identity*. Touchstone.

Goodwin, G. M. (2006). Depression and associated physical diseases and symptoms. *Dialogues in Clinical Neuroscience*, *8*(2), 259–265. https://doi.org/10.31887/dcns.2006.8.2/mgoodwin

Gotlib, I. H., & Joormann, J. (2010). Cognition and Depression: Current Status and Future Directions. *Annual Review of Clinical Psychology*, *6*(1), 285–312. https://doi.org/10.1146/annurev.clinpsy.121208.131305

Greenstreet, W. (2006). From spirituality to coping strategy: making sense of chronic illness. *British Journal of Nursing*, *15*(17), 938–942. https://doi.org/10.12968/bjon.2006.15.17.21909

Guba, E. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development*, *29*(2). https://doi.org/10.1007/bf02766777

Hafeez, A., & Rafique, R. (2013). Spirituality and Religiosity as Predictors of Psychological Well-Being in Residents of Old Homes. Dialogue (Pakistan),8 (3), 285- 301.

Hahn, R. A., & Kleinman, A. (1983). Biomedical Practice and Anthropological Theory: Frameworks and Directions. *Annual Review of Anthropology*, *12*(1), 305–333. https://doi.org/10.1146/annurev.an.12.100183.001513

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: when to use them and how to judge them. *Human Reproduction*, *31*(3), 498–501. https://doi.org/10.1093/humrep/dev334

Hansson, M., Chotai, J., & Bodlund, O. (2010). Patients' beliefs about the cause of their depression. *Journal of Affective Disorders*, *124*(1–2), 54–59. https://doi.org/10.1016/j.jad.2009.10.032

Hareli, S., Kafetsios, K., & Hess, U. (2015). A cross-cultural study on emotion expression and the learning of social norms. *Frontiers in Psychology*, *6*. https://doi.org/10.3389/fpsyg.2015.01501

Harper, D., & Thompson, A. R. (2011). *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (1st ed.). Wiley-Blackwell.

Harré, R. (2002). Material Objects in Social Worlds. *Theory, Culture & Society*, *19*(5–6), 23–33. https://doi.org/10.1177/026327640201900502

Hayward & Jenifer A. Bright, P. (1997). Stigma and mental illness: A review and critique. *Journal of Mental Health*, *6*(4), 345–354. https://doi.org/10.1080/09638239718671

Heine, S. J., & Ruby, M. B. (2010). Cultural psychology. *WIREs Cognitive Science*, *1*(2), 254–266. https://doi.org/10.1002/wcs.7

Hill, P. C., & Pargament, K. I. (2003). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *American Psychologist*, *58*(1), 64–74. https://doi.org/10.1037/0003-066x.58.1.64

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, J. M. E., Swyers, J. P., Larson, D. B., & Zinnbauer, B. J. (2000). Conceptualizing Religion and Spirituality: Points of Commonality, Points of Departure. *Journal for the Theory of Social Behaviour*, *30*(1), 51–77. https://doi.org/10.1111/1468-5914.00119

Hofstede, G. (1991). *Cultures and Organizations: Software of the Mind* (1st ed.). McGraw-Hill.

Hofstede, G. (2001). *Culture's Consequences: Comparing Values, Behaviors, Institutions and Organizations Across Nations* (1st ed.). SAGE Publications, Inc.

Ivtzan, I., Chan, C. P. L., Gardner, H. E., & Prashar, K. (2011). Linking Religion and Spirituality with Psychological Well-being: Examining Self-actualisation, Meaning in Life, and Personal Growth Initiative. *Journal of Religion and Health*, *52*(3), 915–929. https://doi.org/10.1007/s10943-011-9540-2

Jackson, B. R., & Bergeman, C. S. (2011). How does religiosity enhance well-being? The role of perceived control. *Psychology of Religion and Spirituality*, *3*(2), 149–161. https://doi.org/10.1037/a0021597

Jimenez, D. E., Alegría, M., Chen, C. N., Chan, D., & Laderman, M. (2010). Prevalence of Psychiatric Illnesses in Older Ethnic Minority Adults. *Journal of the American Geriatrics Society*, *58*(2), 256–264. https://doi.org/10.1111/j.1532-5415.2009.02685.x

Jirwe, M., Gerrish, K., & Emami, A. (2010). Student nurses' experiences of communication in cross-cultural care encounters. *Scandinavian Journal of Caring Sciences*, *24*(3), 436–444. https://doi.org/10.1111/j.1471-6712.2009.00733.x

Jobson, L., Miskon, N., Dalgleish, T., Hitchcock, C., Hill, E., Golden, A. M., Zulkefly, N. S., & Mukhtar, F. (2018). Impact of culture on autobiographical life structure in depression. *British Journal of Clinical Psychology*, *57*(3), 382–396. https://doi.org/10.1111/bjc.12181

Joseph, S., & Linley, P. A. (2004). Positive Therapy: A Positive Psychological Theory of Therapeutic Practice. In P. A. Linley & S. Joseph (Eds.), Positive psychology in practice (pp. 354–368). John Wiley & Sons, Inc..

Jovanovic, H., Lundberg, J., Karlsson, P., Cerin, S., Saijo, T., Varrone, A., Halldin, C., & Nordström, A. L. (2008). Sex differences in the serotonin 1A receptor and serotonin transporter binding in the human brain measured by PET. *NeuroImage*, *39*(3), 1408–1419. https://doi.org/10.1016/j.neuroimage.2007.10.016

Jupp, V. (2006). *The SAGE Dictionary of Social Research Methods* (1st ed.). SAGE Publications Ltd.

Kai, J., Beavan, J., Faull, C., Dodson, L., Gill, P., & Beighton, A. (2007). Professional Uncertainty and Disempowerment Responding to Ethnic Diversity in Health Care: A Qualitative Study. *PLoS Medicine*, *4*(11), e323. https://doi.org/10.1371/journal.pmed.0040323

Keyes, C. L. (2011). Authentic purpose: the spiritual infrastructure of life. *Journal of Management, Spirituality & Religion*, *8*(4), 281–297. https://doi.org/10.1080/14766086.2011.630133

Khalsa, S. R., McCarthy, K. S., Sharpless, B. A., Barrett, M. S., & Barber, J. P. (2011). Beliefs about the causes of depression and treatment preferences. *Journal of Clinical Psychology*, *67*(6), 539–549. https://doi.org/10.1002/jclp.20785

Kim-Cohen, J., Caspi, A., Taylor, A., Williams, B., Newcombe, R., Craig, I. W., & Moffitt, T. E. (2006). MAOA, maltreatment, and gene–environment interaction predicting children's mental health: new evidence and a meta-analysis. *Molecular Psychiatry*, *11*(10), 903–913. https://doi.org/10.1038/sj.mp.4001851

Kirmayer, L. J. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, *49*(2), 149–164. https://doi.org/10.1177/1363461512444673

Kirmayer, L. J., & Ryder, A. G. (2016). Culture and psychopathology. *Current Opinion in Psychology*, *8*, 143–148. https://doi.org/10.1016/j.copsyc.2015.10.020

Klausli, J., & Caudill, C. (2018). Depression for college students in a traditional Christian culture context: the role of attachment, spirituality and social support. *Mental Health, Religion & Culture*, *21*(1), 105–115. https://doi.org/10.1080/13674676.2018.1458083

Koenig, H. G. (2012). Religion, Spirituality, and Health: The Research and Clinical Implications. *ISRN Psychiatry*, *2012*, 1–33. https://doi.org/10.5402/2012/278730

Koenig, H., & Larson, D. (2001). Religion and Mental Health: Evidence for an Association. International Review of Psychiatry, 13 (2), 67-78.

Kokanovic, R., Bendelow, G., & Philip, B. (2012). Depression: the ambivalence of diagnosis. *Sociology of Health & Illness*, *35*(3), 377–390. https://doi.org/10.1111/j.1467-9566.2012.01486.x

Kuhn, T. S. (1986). *The Structure of Scientific Revolutions* (2nd ed.). University of Chicago Press.

Kupfer, D. J., Regier, D. A., & Kuhl, E. A. (2008). On the road to DSM-V and ICD-11. *European Archives of Psychiatry and Clinical Neuroscience*, *258*(S5), 2–6. https://doi.org/10.1007/s00406-008-5002-6

Laher, S., Bemath, N., & Subjee, S. (2018). An exploration of understandings of major depressive disorder in a South African Indian Muslim female community. *Mental*

Health, Religion & Culture, *21*(6), 625–642. https://doi.org/10.1080/13674676.2018.1519783

Lather, P. (1986). Issues of validity in openly ideological research: Between a rock and a soft place. *Interchange*, *17*(4), 63–84. https://doi.org/10.1007/bf01807017

Lavorato Neto, G., Rodrigues, L., Silva, D. A. R. D., Turato, E. R., & Campos, C. J. G. (2018). Spirituality review on mental health and psychiatric nursing. *Revista Brasileira de Enfermagem*, *71*(suppl 5), 2323–2333. https://doi.org/10.1590/0034-7167-2016-0429

Lebowitz, M. S., & Ahn, W. K. (2014). Effects of biological explanations for mental disorders on clinicians' empathy. *Proceedings of the National Academy of Sciences*, *111*(50), 17786–17790. https://doi.org/10.1073/pnas.1414058111

Lecrubier, Y. (2008). Recognizing and Effectively Treating Depression. *CNS Spectrums*, *13*(S11), 5–9. https://doi.org/10.1017/s109285290002825x

Levers, M. J. D. (2013). Philosophical Paradigms, Grounded Theory, and Perspectives on Emergence. *SAGE Open*, *3*(4), 215824401351724. https://doi.org/10.1177/2158244013517243

Li, Q., Zhang, W., & Zhao, J. (2021). The longitudinal associations among grandparent–grandchild cohesion, cultural beliefs about adversity, and depression in Chinese rural left-behind children. *Journal of Health Psychology*, *26*(1), 140–155. https://doi.org/10.1177/1359105318803708

Lopez, K. A., & Willis, D. G. (2004). Descriptive Versus Interpretive Phenomenology: Their Contributions to Nursing Knowledge. *Qualitative Health Research*, *14*(5), 726–735. https://doi.org/10.1177/1049732304263638

Malpass, A., Shaw, A., Sharp, D., Walter, F., Feder, G., Ridd, M., & Kessler, D. (2009). "Medication career" or "Moral career"? The two sides of managing antidepressants: A meta-ethnography of patients' experience of antidepressants. *Social Science & Medicine*, *68*(1), 154–168. https://doi.org/10.1016/j.socscimed.2008.09.068

Marsella, A. J., & Yamada, A. M. (2010). Culture and Psychopathology: Foundations, Issues, Directions. *Journal of Pacific Rim Psychology*, *4*(2), 103–115. https://doi.org/10.1375/prp.4.2.103

Mayer, C. H., & Viviers, R. (2014). 'Following the word of God': Empirical insights into managerial perceptions on spirituality, culture and health. *International Review of Psychiatry*, *26*(3), 302–314. https://doi.org/10.3109/09540261.2014.914473

Mazzocchi, F. (2006). Western science and traditional knowledge. *EMBO Reports*, *7*(5), 463–466. https://doi.org/10.1038/sj.embor.7400693

McClelland, A., Khanam, S., & Furnham, A. (2013). Cultural and age differences in beliefs about depression: British Bangladeshis vs. British Whites. *Mental Health, Religion & Culture*, *17*(3), 225–238. https://doi.org/10.1080/13674676.2013.785710

McNamee, S., & Gergen, K. J. (1998). *Relational Responsibility: Resources for Sustainable Dialogue* (1st ed.). SAGE Publications, Inc.

McSweeney, B. (2002). The essentials of scholarship: A reply to Geert Hofstede. Human Relations, 55(11), 1363-1372.

Meca, A., Rodil, J. C., Paulson, J. F., Kelley, M., Schwartz, S. J., Unger, J. B., Lorenzo-Blanco, E. I., des Rosiers, S. E., Gonzales-Backen, M., Baezconde-Garbanati, L., & Zamboanga, B. L. (2019). Examining the Directionality Between Identity Development and Depressive Symptoms Among Recently Immigrated Hispanic Adolescents. *Journal of Youth and Adolescence*, *48*(11), 2114–2124. https://doi.org/10.1007/s10964-019-01086-z

Mereish, E. H., N'cho, H. S., Green, C. E., Jernigan, M. M., & Helms, J. E. (2016). Discrimination and Depressive Symptoms Among Black American Men: Moderated-Mediation Effects of Ethnicity and Self-Esteem. *Behavioral Medicine*, *42*(3), 190–196. https://doi.org/10.1080/08964289.2016.1150804

Midgley, N., Parkinson, S., Holmes, J., Stapley, E., Eatough, V., & Target, M. (2016). "Did I bring it on myself?" An exploratory study of the beliefs that adolescents referred to

mental health services have about the causes of their depression. *European Child & Adolescent Psychiatry*, *26*(1), 25–34. https://doi.org/10.1007/s00787-016-0868-8

Mpofu, E. (Ed.). (2011). Counseling People of African Ancestry (1st ed.). Cambridge University Press. https://doi.org/10.1017/CBO9780511977350

Murphy, E., & Hankerson, S. (2017). Beliefs about causes of major depression: Clinical and treatment correlates among African Americans in an urban community. *Journal of Clinical Psychology*, *74*(4), 594–607. https://doi.org/10.1002/jclp.22523

Myers, M. D. (2019). *Qualitative Research in Business and Management* (3rd ed.). SAGE Publications Ltd.

National Research Council. (2009). *Bereavement: Reactions, Consequences, and Care*. National Academies Press.

Nedderman, A. B., Underwood, L. A., & Hardy, V. L. (2010). Spirituality Group With Female Prisoners: Impacting Hope. *Journal of Correctional Health Care*, *16*(2), 117–132. https://doi.org/10.1177/1078345809356526

Neuman, L. W. (2011). *Basics of Social Research: Qualitative and Quantitative Approaches (3rd Edition)* (3rd ed.). Pearson.

Ng'oma, M., Meltzer-Brody, S., Chirwa, E., & Stewart, R. C. (2019). "Passing through difficult times": Perceptions of perinatal depression and treatment needs in Malawi - A qualitative study to inform the development of a culturally sensitive intervention. *PLOS ONE*, *14*(6), e0217102. https://doi.org/10.1371/journal.pone.0217102

Noblit, G. W., & Hare, D. R. (1988). *Meta-Ethnography: Synthesizing Qualitative Studies (Qualitative Research Methods)* (1st ed.). SAGE Publications, Inc.

Noblit, G. W., & Hare, R. D. (1999). Chapter 5: Meta-Ethnography: Synthesizing Qualitative Studies. Counterpoints, 44, 93–123. http://www.jstor.org/stable/42975557

Nwoye, A. (2022). African Psychology: The Emergence of a Tradition (1st ed.). Oxford University Press. https://doi.org/10.1093/oso/9780190932497.001.0001

O'Leary, Z. (2004). *The Essential Guide to Doing Research* (First ed.). SAGE Publications Ltd.

Olsen, M. E., Lodwick, D. G., Dunlap, R. E., & Fonseca, V. (1991). *Viewing The World Ecologically* (1st ed.). Westview Press.

Omeri, A., & Malcolm, P. (2004). Cultural diversity: A challenge for community nurses. *Contemporary Nurse*, *17*(3), 183–191. https://doi.org/10.5172/conu.17.3.183

Pargament, K. I., Magyar-Russell, G. M., & Murray-Swank, N. A. (2005). The Sacred and the Search for Significance: Religion as a Unique Process. *Journal of Social Issues*, *61*(4), 665–687. https://doi.org/10.1111/j.1540-4560.2005.00426.x

Parker, G., Cheah, Y. C., & Roy, K. (2001). Do the Chinese somatize depression? A cross-cultural study. *Social Psychiatry and Psychiatric Epidemiology*, *36*(6), 287–293. https://doi.org/10.1007/s001270170046

Patton, M. Q. (2014). *Qualitative Research & Evaluation Methods: Integrating Theory and Practice* (4th ed.). SAGE Publications, Inc.

Pérez, J. E., Little, T. D., & Henrich, C. C. (2009). Spirituality and Depressive Symptoms in a School-Based Sample of Adolescents: A Longitudinal Examination of Mediated and Moderated Effects. *Journal of Adolescent Health*, *44*(4), 380–386. https://doi.org/10.1016/j.jadohealth.2008.08.022

Piedmont, R.L. (2005). The role of personality in understanding religious and spiritual constructs. In R.F. Paloutzian and C.L. Park (Eds.), Handbook of the psychology of religion and spirituality, (pp. 253-273) New York: Guilford Press.

Pitchford, S. R. (2001). Image-Making Movements: Welsh Nationalism and Stereotype Transformation. *Sociological Perspectives*, *44*(1), 45–65. https://doi.org/10.2307/1389808

Power, M. J., & Champion, L. A. (1986). Cognitive approaches to depression: A theoretical critique. *British Journal of Clinical Psychology*, *25*(3), 201–212. https://doi.org/10.1111/j.2044-8260.1986.tb00696.x

Price, B. (2002). Laddered questions and qualitative data research interviews. *Journal of Advanced Nursing*, *37*(3), 273–281. https://doi.org/10.1046/j.1365-2648.2002.02086.x

Putnam, L. L., & Banghart, S. (2017). Interpretive Approaches. *The International Encyclopedia of Organizational Communication*, 1–17. https://doi.org/10.1002/9781118955567.wbieoc118

Ramsey, E. & Ledbetter, S., 2001, 'Studying religion: Issues in definition and method', in I.S. Markam & T. Ruparell (eds.), Encountering religion: An introduction to the religions of the world, pp. 1-14, Blackwell Publishers, Oxford, UK

Read, J., & Bentall, R. P. (2012). Negative childhood experiences and mental health: theoretical, clinical and primary prevention implications. *British Journal of Psychiatry*, *200*(2), 89–91. https://doi.org/10.1192/bjp.bp.111.096727

Reed, T. D., & Neville, H. A. (2013). The Influence of Religiosity and Spirituality on Psychological Well-Being Among Black Women. *Journal of Black Psychology*, *40*(4), 384–401. https://doi.org/10.1177/0095798413490956

Ritzer, G., & Murphy, W. W. (2019). *Introduction to Sociology* (5th ed.). SAGE Publications, Inc.

Ritzer, G., & Stepnisky, J. (2013). *Sociological Theory*. McGraw-Hill Education.

Rocca, E., & Anjum, R. L. (2020). Complexity, Reductionism and the Biomedical Model. *Rethinking Causality, Complexity and Evidence for the Unique Patient*, 75–94. https://doi.org/10.1007/978-3-030-41239-5_5

Roccas, S., & Sagiv, L. (2009). Personal Values and Behavior: Taking the Cultural Context into Account. *Social and Personality Psychology Compass*, *4*(1), 30–41. https://doi.org/10.1111/j.1751-9004.2009.00234.x

Rodríguez-Galán, M. B., & Falcón, L. M. (2017). Religion as a coping mechanism for health problems and depression among aging Puerto Ricans on the Mainland. *Journal of Religion, Spirituality & Aging*, *30*(2), 130–153. https://doi.org/10.1080/15528030.2017.1413031

Rubenstein, L. M., Freed, R. D., Shapero, B. G., Fauber, R. L., & Alloy, L. B. (2016). Cognitive attributions in depression: Bridging the gap between research and clinical

practice. *Journal of Psychotherapy Integration*, *26*(2), 103–115. https://doi.org/10.1037/int0000030

Ryder, A. G., Yang, J., & Heine, S. J. (2002). Somatization vs. Psychologization of Emotional Distress: A Paradigmatic Example for Cultural Psychopathology. *Online Readings in Psychology and Culture*, *10*(2). https://doi.org/10.9707/2307-0919.1080

Sadeghfard, A., Bozorgi, A. R., Ahmadi, S., & Shojaei, M. (2016). The History of Melancholia Disease. Iranian journal of medical sciences, 41(3 Suppl), S75.

Sadock, B. J., Sadock, V. A., & Md, R. P. (2014). *Kaplan and Sadock's Synopsis of Psychiatry: Behavioral Sciences/Clinical Psychiatry* (Eleventh ed.). LWW.

Salkind, N. J. (2010). *Encyclopedia of research design* (Vols. 1-0). Thousand Oaks, CA: SAGE Publications, Inc. doi: 10.4135/9781412961288

Salzman, P. C. (2001). *Understanding Culture : An Introduction to Anthropological Theory* (1st ed.). Waveland Press.

Sandelowski, M., & Barroso, J. (2002). Reading Qualitative Studies. *International Journal of Qualitative Methods*, *1*(1), 74–108. https://doi.org/10.1177/160940690200100107

Sandelowski, M., & Boshamer, C. C. (2006). Divide and conquer: Avoiding duplication in the reporting of qualitative research. *Research in Nursing & Health*, *29*(5), 371–373. https://doi.org/10.1002/nur.20153

Sawatzky, R., & Pesut, B. (2005). Attributes of Spiritual Care in Nursing Practice. *Journal of Holistic Nursing*, *23*(1), 19–33. https://doi.org/10.1177/0898010104272010

Sayce, L. (1998). Stigma, discrimination and social exclusion: What's in a word? *Journal of Mental Health*, *7*(4), 331–343. https://doi.org/10.1080/09638239817932

Schierenbeck, I., Johansson, P., Andersson, L. M., Krantz, G., & Ntaganira, J. (2016). Collaboration or renunciation? The role of traditional medicine in mental health care in Rwanda and Eastern Cape Province, South Africa. *Global Public Health*, *13*(2), 159–172. https://doi.org/10.1080/17441692.2016.1239269

Schlundt, D. (2008). Religious Affiliation, Health Behaviors and Outcomes: Nashville REACH 2010. *American Journal of Health Behavior*, *32*(6). https://doi.org/10.5993/ajhb.32.6.15

Schneiderman, N., Ironson, G., & Siegel, S. D. (2005). Stress and Health: Psychological, Behavioral, and Biological Determinants. *Annual Review of Clinical Psychology*, *1*(1), 607–628. https://doi.org/10.1146/annurev.clinpsy.1.102803.144141

Schotte, C. K., van den Bossche, B., de Doncker, D., Claes, S., & Cosyns, P. (2006). A biopsychosocial model as a guide for psychoeducation and treatment of depression. *Depression and Anxiety*, *23*(5), 312–324. https://doi.org/10.1002/da.20177

Seers, K. (2014). Qualitative systematic reviews: their importance for our understanding of research relevant to pain. *British Journal of Pain*, *9*(1), 36–40. https://doi.org/10.1177/2049463714549777

Shadrina, M., Bondarenko, E. A., & Slominsky, P. A. (2018). Genetics Factors in Major Depression Disease. *Frontiers in Psychiatry*, *9*. https://doi.org/10.3389/fpsyt.2018.00334

Sillars, M. O., & Gronbeck, B. E. (2001). Communication criticism: Rhetoric, social codes, cultural studies. Prospect Heights, Ill: Waveland Press.

Silver, R. C. (2002). Nationwide Longitudinal Study of Psychological Responses to September 11. *JAMA*, *288*(10), 1235. https://doi.org/10.1001/jama.288.10.1235

Solomon, A. (2002). *The Noonday Demon: An Atlas of Depression*. ScribnerPaperback.

Sorsdahl, K. R., & Stein, D. J. (2010). Knowledge of and Stigma Associated With Mental Disorders in a South African Community Sample. *Journal of Nervous & Mental Disease*, *198*(10), 742–747. https://doi.org/10.1097/nmd.0b013e3181f4b2d7

Sorsdahl, K., Flisher, A., Wilson, Z., & Stein, D. (2010). Explanatory models of mental disorders and treatment practices among traditional healers in Mpumulanga, South Africa. *African Journal of Psychiatry*, *13*(4). https://doi.org/10.4314/ajpsy.v13i4.61878

Sullivan, E. (2008). Melancholy, medicine, and the arts. *The Lancet*, *372*(9642), 884–885. https://doi.org/10.1016/s0140-6736(08)61385-9

Sullivan, P. F., Neale, M. C., & Kendler, K. S. (2000). Genetic Epidemiology of Major Depression: Review and Meta-Analysis. *American Journal of Psychiatry*, *157*(10), 1552–1562. https://doi.org/10.1176/appi.ajp.157.10.1552

Taliaferro, D. H. (2008). Commentary on “Religious Activities of Inpatients and Their Family Visitors in Taiwan.” *Journal of Holistic Nursing*, *26*(2), 107–108. https://doi.org/10.1177/0898010108319903

Taylor, W. D., Aizenstein, H. J., & Alexopoulos, G. S. (2013). The vascular depression hypothesis: mechanisms linking vascular disease with depression. *Molecular Psychiatry*, *18*(9), 963–974. https://doi.org/10.1038/mp.2013.20

Tekiner, H. (2014). Aretaeus of cappadocia and his treatises on diseases. *Turkish Neurosurgery*. https://doi.org/10.5137/1019-5149.jtn.12347-14.0

Telles-Correia, D., & Marques, J. G. (2015). Melancholia before the twentieth century: fear and sorrow or partial insanity? *Frontiers in Psychology*, *6*. https://doi.org/10.3389/fpsyg.2015.00081

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative metasynthesis: reflections on methodological orientation and ideological agenda. Qualitative health research, 14(10), 1342–1365. https://doi.org/10.1177/1049732304269888

Tomita, A., & Ramlall, S. (2018). A Nationwide Panel Study on Religious Involvement and Depression in South Africa: Evidence from the South African National Income Dynamics Study. *Journal of Religion and Health*, *57*(6), 2279–2289. https://doi.org/10.1007/s10943-017-0551-5

Townsend, M., Kladder, V., Ayele, H., & Mulligan, T. (2002). Systematic Review of Clinical Trials Examining the Effects of Religion on Health. *Southern Medical Journal*, *95*(12), 1429–1434. https://doi.org/10.1097/00007611-200212000-00015

Toye, F., Seers, K., Allcock, N., Briggs, M., Carr, E., & Barker, K. (2014). Meta-ethnography 25 years on: challenges and insights for synthesising a large number of qualitative

studies. *BMC Medical Research Methodology*, *14*(1). https://doi.org/10.1186/1471-2288-14-80

Tyler, I., & Slater, T. (2018). Rethinking the sociology of stigma. *The Sociological Review*, *66*(4), 721–743. https://doi.org/10.1177/0038026118777425

Tylor, E. B. (2018). *Primitive Culture: Researches Into the Development of Mythology, Philosophy, Religion, Language, Art, and Custom Volume 1*. HardPress.

Unterrainer, H. F., Lewis, A. J., & Fink, A. (2012). Religious/Spiritual Well-Being, Personality and Mental Health: A Review of Results and Conceptual Issues. *Journal of Religion and Health*, *53*(2), 382–392. https://doi.org/10.1007/s10943-012-9642-5

van der Merwe, K., Ntinda, K., & Mpofu, E. (2016). African perspectives of personality psychology. In Personality Psychology (1st ed., pp. 53–71). Oxford University Press Southern Africa.

Villani, D., Sorgente, A., Iannello, P., & Antonietti, A. (2019). The Role of Spirituality and Religiosity in Subjective Well-Being of Individuals With Different Religious Status. *Frontiers in Psychology*, *10*. https://doi.org/10.3389/fpsyg.2019.01525

Walsham, G. (1995). Interpretive case studies in IS research: nature and method. *European Journal of Information Systems*, *4*(2), 74–81. https://doi.org/10.1057/ejis.1995.9

Wang, S., & Zhu, P. (2016). Thinking about research paradigms in educational research. *Advances in Social Sciences Research Journal*, *3*(1). https://doi.org/10.14738/assrj.31.1708

Westby, C. E., & Ford, V. (1993). The Role of Team Culture in Assessment and Intervention. *Journal of Educational and Psychological Consultation*, *4*(4), 319–341. https://doi.org/10.1207/s1532768xjepc0404_3

Williams, D. R., & Sternthal, M. J. (2007). Spirituality, religion and health: evidence and research directions. *Medical Journal of Australia*, *186*(S10). https://doi.org/10.5694/j.1326-5377.2007.tb01040.x

Xiao, Y., & Watson, M. (2017). Guidance on Conducting a Systematic Literature Review. *Journal of Planning Education and Research*, *39*(1), 93–112. https://doi.org/10.1177/0739456x17723971

Yeşilçınar, L., Acavut, G., İYigün, E., & Taştan, S. (2018). Eight-Step Concept Analysis: Spirituality in Nursing. *International Journal for Human Caring*, *22*(2), 34–42. https://doi.org/10.20467/1091-5710.22.2.34

Yin, R. K. (2017). *Case Study Research and Applications: Design and Methods*. Sage Publications, Inc.

Appendix

Letter of Ethical Clearance

University of Fort Hare
Together in Excellence

ETHICS CLEARANCE
REC-270710-028-RA Level 01

Project Number:	MAK111SCON01
Project title:	**An Afrocentric exploration of South African cultural-religious narratives of depression.**
Qualification:	Master of Social Science: Counselling Psychology
Student name:	Matthew Conway-Cleaves
Registration number	202100340
Supervisor:	Dr M Makupula
Department:	Psychology
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby grant ethics approval for MAK111SCON01. This approval is valid for 12 months from the date of approval. Renewal of approval must be applied for BEFORE termination of this approval period. Renewal is subject to receipt of a satisfactory progress report. The approval covers the undertakings contained in the above-mentioned project and research instrument(s). The research may commence as from the 23/11/21, using the reference number indicated above.

Note that should any other instruments be required or amendments become necessary, these require separate authorisation.
Please note that UREC must be informed immediately of

- Any material changes in the conditions or undertakings mentioned in the document;
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The student must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

UREC retains the right to

- Withdraw or amend this approval if
    - Any unethical principal or practices are revealed or suspected;
    - Relevant information has been withheld or misrepresented;
    - Regulatory changes of whatsoever nature so require;
    - The conditions contained in the Certificate have not been adhered to.

- Request access to any information or data at any time during the course or after completion of the project.

Your compliance with Department of Health 2015 guidelines and any other applicable regulatory instruments and with UREC ethics requirements as contained in UREC policies and standard operating procedures, is implied.

UREC wishes you well in your research.

Yours sincerely

Taole-Mjimba, Nthabi

Digitally signed by Taole-Mjimba, Nthabi
Date: 2023.02.26 22:35:39 +02'00'

Dr N Taole-Mjimba
Chairperson: University Research Ethics Committee
17 February 2023