Students' Constructions of Mental Illness: Using Discourse Analysis to Develop Critical Language Awareness

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Supervisor: Dr. Wahbie Long
Word Count:
Abstract: 234
Main Body: 9 934

The financial assistance of the National Research Foundation (NRF) towards this research is hereby acknowledged. Opinions expressed and conclusions arrived at, are those of the author and are not necessarily to be attributed to the NRF.

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Acknowledgements

I would like to express my sincere appreciation to the following people for their help with this research dissertation:

To my supervisor, Dr Wahbie Long, for his patience and guidance throughout this project and for sharing his knowledge and insight with me.

To the students who participated in my study, for their enthusiasm about the topic and for speaking so openly about mental illness.

To the National Research Foundation (NRF), for their financial assistance towards this research. However, the opinions expressed and conclusions arrived at are mine and are not attributed to the NRF.

To my parents and Matthew, for their emotional support.

Abstract

Discourses actively construct the objects of which they speak and these constructions have implications for subjectivity and power dynamics. Research has shown that hegemonic discourses of mental illness are problematic because they are implicated in the legitimization of unequal power relations and the perpetuation of stereotypes. In light of this, the need for the critical appraisal of the discursive practices within psychology in South Africa has been identified. This study, therefore, sought to facilitate the development of critical language awareness by identifying the discourses that psychology students draw on when talking about mental illness. Three semi-structured focus group discussions were conducted on the topic. These groups consisted of between five and seven undergraduate psychology students from the University of Cape Town. A Foucauldian discourse analysis approach was used to analyse the data because of its focus on power relations. The findings of the study show that students drew predominantly on a biomedical discourse and a romantic discourse when talking about mental illness. Both discourses, although via different discursive practices, construct mental illness as a Western, biomedical phenomenon. Thus, the intersection of these two discourses serves to disempower non-Western groups twice over. The use of these discourses in South African psychology is problematic as they locate the majority of the population in a position of powerlessness. This study therefore highlights the need for the development of new discursive practices within psychology in South Africa.

Keywords: critical language awareness; focus groups; Foucauldian discourse analysis; mental illness; power relations; psychology in South Africa; university students

Introduction

Although many believe the contrary, language is not a neutral means of communication. Rather, it is actively used to construct meaning and to achieve things in the world (Durrheim, 1997). The ways in which phenomena are constructed serve a certain purpose, which is often to uphold and legitimate unequal power relations (Willig, 2001). A naïve acceptance of dominant discourses is therefore problematic as they are implicated in the continuation of social inequality. This is especially true for discourses around mental illness and psychology as these are phenomena that have great influence over people's lives in today's "psychological society" (Jansz, 2004, p. 35). The present study, therefore, aims to develop a critical awareness of discourses around mental illness within South African psychology. In particular, it aims to highlight the implications that they have for the treatment of mental illness, subjectivity, and power relations, and how these may perpetuate inequity. It is hoped that this process of conscientization will create a starting point for the development of alternative discourses of mental illness – discourses that aid empowerment and equality.

Discourses of Mental Illness

The biomedical discourse

The biomedical discourse is one of the most dominant discourses of mental illness. Within this discourse mental illness is constructed as a naturally existing phenomenon that has an organic basis (Schneider, 2010). It is thus seen as having an identifiable aetiology that can be objectively diagnosed and treated (Wilson & McLuckie, 2002; Young, 2009). Inherent in the idea of treatment is the notion of disease which frames mental illness as a medical problem that can be remedied by psychiatrists (Wilson & McLuckie, 2002).

Research has shown how panic disorder, for example, is constructed as an internal, treatable condition, thereby positioning it within the biomedical discourse (Wilson & McLuckie, 2002). Similarly, through talking about diagnosis and by comparing depression with physical illnesses women drew on a biomedical discourse when speaking about their experiences of depression (Lafrance, 2007).

Constructing mental illness in this way has implications for subjectivity and power relations. The biomedical discourse locates mental illness within the person and ignores external causal factors (Wilson & McLuckie, 2002). As a result, individuals might come to believe that there is something inherently wrong with them (Young, 2009). People living with

panic disorder commented that by attributing the disorder to biological factors, they saw themselves as being permanently compromised (Wilson & McLuckie, 2002). The benefit of the biomedical discourse, however, is that it can absolve individuals of any responsibility they might feel for their condition, as one cannot control one's own biochemistry or genes (Speed, 2006).

There is also an inherent power imbalance within this discourse because individuals with mental illnesses are constructed as patients (Speed, 2006). This position assumes a passive acceptance of a medical diagnosis as well as adherence to a set treatment regimen. Conversely, psychiatrists are constructed in a position of power (Fee, 2000). This construction in turn interacts with the dominant ideology around mental illness, which proposes that those who are different from the norm should be disciplined and restrained (Fee, 2000).

The psychodynamic discourse

The psychodynamic discourse of mental illness is another prominent discourse. Emerging predominantly from the writings of Freud, it constructs mental illness as resulting from psychological processes such as unconscious conflicts (Farrell, 1961). Although the biomedical and psychodynamic discourses construct mental illness in different ways, there are similarities in their implications. The psychodynamic discourse also constructs mental illness as an abnormality (Wilson & McLuckie, 2002), albeit, an emotional or psychic one. In this way, individuals with mental illnesses are located in an isolated space outside the range of 'normal' human experience (Wilson & McLuckie, 2002). The psychodynamic discourse also sees mental illness as resulting from internal problems and thus it is seen as largely acontextual (Wilson & McLuckie, 2002). This is problematic as contributory external factors are not considered, and can lead to individuals feeling responsible for their condition. Furthermore, the psychodynamic discourse implies a power hierarchy between the client and therapist (Kanefield, 1981). Within the psychodynamic discursive order, power is attributed to the therapist because of their knowledge, position, and verbal and interpersonal abilities (Douglas, 1985). Clients are thus located in a position of diminished power, as they do not have access to psychoanalytic expertise. The help-seeking position which clients occupy is also an inherently disempowered one.

The discourse of dangerousness

It has been found that a discourse of dangerousness is frequently drawn on when representing mental illness in the media. Studies on the depictions of mental illness in print media have found that it is often associated with criminality (Olstead, 2002) and

unpredictable behaviour (Coverdale, Nairn, & Claasen, 2002). Such constructions have also been found in children's media. Lawson and Fouts (2004) showed how words such as 'crazy' and 'mad' were used to reference mental illness in Disney movies. The terms imply a loss of control and construct characters with mental illness as objects of fear (Wilson, Nairn, Coverdale, & Panapa, 2000). In television dramas, characters with mental illness were predominantly shown to be violent, aggressive, and emotionally volatile (Wilson, Nairn, Coverdale, & Panapa, 1999). By associating mental illness with violence, criminality, and losing control, the media draws on a discourse of dangerousness. This constructs mental illness as something to be feared and thereby perpetuates stigma (Coverdale et al., 2002). This has implications for subjectivity as such negative views can lead to feelings of anxiety, anguish, and loneliness within individuals living with mental illness (Dinos, Stevens, Serfaty, Weich, & King, 2004). The discourse of dangerousness also implies certain power relations by framing mental illness as making people dangerous and out of control, and inferring that they should be kept away from society. Such constructions serve to alienate those with mental illness (Lawson & Fouts, 2004).

The romantic discourse

The word 'romantic' in this context refers to an idealistic view of reality. The romantic discourse of mental illness is most commonly drawn on when speaking about non-Western cultures in texts about cross-cultural psychology. Within this discourse mental illness is seen as being non-existent in non-Western cultures (Swartz, 1998). Conversely, if it is seen to exist then it is constructed as being unproblematic, unstigmatized, and cured exclusively by traditional healers (Swartz, 1998). Constructing mental illness in this way does two things. Firstly, it assumes that the world can be divided in two: the rational, scientific, Western world that makes use of biomedicine; and the irrational, spiritual non-Western world that uses traditional healers (Spiegel & Boonzaier, 1988). This assumption implies that rationality is fundamentally a Western characteristic. Secondly, constructing the psychological needs of non-Western cultures as inherently different to those of the West implies the need for an 'indigenous' psychology (Nell, 1990). This idea echoes early anthropological writings which argued that "the psyche of non-Western peoples differed in its modalities of reasoning and its cognitive structures from the Western norms" (Nell, 1990, p. 132). These two implications are problematic as they speak to broader racialized discourses of difference and inferiority; discourses that have historically been used to legitimate the oppression of non-Western groups.

Challenges to hegemonic discourses

Four leading discourses of mental illness have been outlined above. However, the biomedical and psychodynamic discourses are the most dominant, which has resulted in them being challenged in various ways.

Foucault (1967) argues that mental illness, rather than being an underlying biological condition, is a concept that is constructed within a particular social system of meaning. It is thus important to acknowledge that psychiatry and psychology are themselves social constructions which have arisen as a result of complex interactions between medicine, politics, law, administration, and public control (Nesseler, 2011).

A discourse which is critical of biomedical constructions of mental illness is the survivor discourse (Speed, 2006). Within this discourse, people with mental illnesses are portrayed as survivors who reject a psychiatric diagnosis. Survivors resist the passive sick-role prescribed by the biomedical discourse and instead portray themselves as active agents. Medical aetiologies are replaced with non-medical aetiologies, such as spiritual crises, holistic issues, and familial problems. Survivors question the legitimacy of psychiatric knowledge and medical hegemony and call for social change.

The psychodynamic discourse has also been challenged. Prilleltensky (1997) questions the ethics of framing mental health problems as apolitical, internal diagnoses and thereby ignoring the social contexts in which they emerge. Constructing mental illness in this way informs interventions that are aimed at the individual, rather than the unhealthy systems in which they live. Similarly, Hillman and Ventura (1993) critique the ‘psy-complex’. A preoccupation with internal problems is unhelpful when “the sickness is out *there*” (p. 4). By failing to acknowledge the role that society plays in mental distress, the psychodynamic discourse perpetuates victim blaming and encourages personal solutions to societal problems (Prilleltensky, 1997).

The significance of analysing discursive practices in psychology

The leading ways in which mental illness is spoken about have been outlined and it has been shown how certain discourses retain power imbalances, perpetuate stigma, and make available disempowered subject positions. There is thus a need for new discursive practices within psychology and many have highlighted this need in South Africa. Pretorius (2012) shows how the biomedical discourse limits the relevance of the discipline, as by locating the cause of mental illness within the person, it fails to consider the social realities of

people in South Africa. He argues that relevant psychology will be a discipline that has a discourse which mirrors what happens in society (Pretorius, 2012). Furthermore, Dawes (1986) states that 'relevant' psychology in South Africa involves rethinking the subject matter of psychology by taking into account the ways that social and ideological discourses construct the individual, psychologist, researcher and the knowledge they produce. Critical discourses in the training and teaching of psychology should also be promoted. Ahmed and Pillay (2004) contend that teaching and training institutions need to ensure they are not recycling ideas that perpetuate the unequal power relations of the past. A critical examination of the discourses currently in use is thus needed. For, before these discourses can be changed, a point from which to work must be defined. This can be done through the development of what Fairclough (1992) calls critical language awareness. Critical language awareness is "an orientation towards language…[that] highlights how language conventions and language practices are invested with power relations and ideological processes" (Fairclough, 1992, p. 7). Fairclough argues that consciousness is necessary for the development of new practices and ways of speaking that can contribute to social equality and emancipatory discourses. In order for such awareness to be developed within South African psychology, more research with a critical language awareness orientation needs to be conducted into the discourses around mental illness. Such research should be done with psychology students as they are the current recipients of psychological knowledge and are therefore likely to draw on current discourses being circulated within psychological institutions when discussing mental illness.

Research Aims and Questions

This study has two central aims. Firstly, it aims to explore and understand the discourses that undergraduate psychology students draw on when talking about mental illness. Secondly, by exploring these discourses, the study aims to offer a critique of dominant discourses of mental illness, thereby contributing to the development of critical language awareness within South African psychology. These aims shall be accomplished by answering four questions:

1. What discourses do students use when talking about mental illness?
2. How do these discourses interact to construct mental illness?
3. What are the implications of these discourses in terms of subjectivity and power relations?
4. What are the implications of these discourses with respect to the treatment of mental illness in South Africa?

Methodology

Research Design

Qualitative research

A qualitative research approach was used for this study. Broadly speaking, qualitative research is concerned with describing and understanding, rather than explaining, human behaviour (Babbie & Mouton, 2001). Accordingly, qualitative research generally explores how people experience and make sense of their world (Willig, 2001). This stance allows the current study to explore the meanings that students attach to mental illness. Furthermore, the qualitative approach acknowledges that research takes place within a certain historical and cultural context (Marecek, 2003). Thus, the way people speak and act is viewed as contingent on the time and place that they occupy. Such an approach is fitting for the present research because it allows an examination of how social, historical and cultural processes influence the ways in which mental illness is spoken about.

Two important aspects of qualitative research are reflexivity and language. Reflexivity enables one to acknowledge that no research is completely objective as it will always be influenced to some extent by the researcher's values, ideas, and biases (Marecek, 2003). This is significant for the present study as it allows me to identify the ways in which my person has shaped the research process.

Subjective experiences are interpreted through language and consequently language is emphasised within qualitative research (Wilson & Maclean, 2011). A focus on language is central to the present study, as it is through language that the concept of mental illness is constructed.

Theoretical Framework

Social constructionism

The social constructionist perspective assumes a critical stance towards positivist and empirical knowledge (Burr, 2003). It critiques the idea that observations of the world result in an unproblematic, unbiased description of reality. Hence, social constructionism is often used to critique mainstream psychology and to produce different accounts of psychological phenomena (Burr, 2003). As noted previously, this is one of the aims of this research project. Social constructionism also highlights how human experience and knowledge are historically and culturally mediated (Durrheim, 1997). Accounts of human experience are never direct

reflections of environmental conditions; instead they are interpretations which are influenced by social factors (Willig, 2001).

The role of language is of great importance in social constructionism. From this perspective, words do not objectively describe reality, but rather, actively construct it (Durrheim, 1997). The emphasis is placed on what language *does*. It is not seen as a neutral means of communication, but as a medium through which things are accomplished, performed, and constructed (Durrheim, 1997).

Lastly, the social constructionist perspective acknowledges that different constructions of the world have different implications. Constructions of phenomena have implications for power relations and subjectivity because they define what is permissible for certain people to do, and how they relate to others (Burr, 2003).

This study is interested in the discourses that psychology students use to construct mental illness. A social constructionist framework is therefore fitting as it posits that phenomena are constructed *through* language. Because of this it is often assumed that social constructionism does not ascribe to a bottom-line reality. While some social constructionists do have a relativist conception of reality most are deeply interested in the 'real' world. Discourse analysts agree that discursive practices have 'real' effects because the ways that things are constructed have implications for the ways in which the world is experienced (Willig, 2001). Therefore, using a social constructionist framework allows for the consideration of how constructions are linked to power relations, and how these are manifested in the 'real' world. Since this is a central aim of the current study, a social constructionist framework is appropriate.

Data Collection

Participants and sampling procedure

The participants for this study were undergraduate psychology students from the University of Cape Town (UCT) and were sampled using convenience sampling. UCT's Student Research Participation Point (SRPP) program was utilised to recruit participants. This program requires undergraduate psychology students to obtain a certain number of points for participating in research projects. Participants were signed up on a 'first-come-first-served' basis and offered three SRPP points for participation. This sampling procedure does not emphasise representativeness and is therefore in keeping with the qualitative research approach, which is not overly concerned with reliability and generalizability, aiming rather to gain an in-depth understanding of a particular phenomenon (Willig, 2001). In total,

17 participants took part in the study. The sample consisted of 11 females and 6 males, ranging in age from 18 to 37 years. In terms of self-identified racial demographics, one was ‘black’, one was ‘Indian’, five were ‘white’, and ten chose not to define themselves in racial terms.

Focus groups

The data was collected using focus groups. A focus group can be defined as an informal group discussion that focuses on a particular topic of interest to the researcher (Wilkinson, 2008). This method has three main strengths. Firstly, focus groups generate detailed data through participant discussion and debate (Willig, 2001). Secondly, focus group interactions mimic everyday conversations, and they are therefore less artificial and have higher ecological validity (Willig, 2001). Thirdly, focus groups are suited to discussing sensitive issues as the group context can facilitate personal disclosure (Farquhar, 1999).

Since mental illness can be a sensitive topic for some people, using a focus group was a suitable method of data collection.

Focus groups are consistent with the social constructionist framework because they allow the researcher to investigate how participants collectively construct meaning (Willig, 2001). A focus group discussion can show how participants justify their views, as well as how they are persuaded by others to change their opinions. Using focus groups to collect data for this project therefore allowed for the exploration of how students jointly construct meaning around mental illness.

This project made use of three focus groups which consisted of between five and seven participants. Each group met once for a period of between 60 and 90 minutes. The focus groups were facilitated by myself and were conducted in a semi-structured format. This structure was used because it encourages participants to speak freely and to communicate their own understanding of the research topic (Willig, 2001). The discussion was guided by a series of broad questions (see Appendix A). Since there is limited research in this area these questions were created specifically for this study. The questions were chosen in order to facilitate a general discussion around the topic of mental illness, while allowing space for exploring specific issues that arose. The discussions were recorded and transcribed (see Appendix B for transcription details).

Data Analysis

Foucauldian discourse analysis

The data were analysed utilising Foucauldian discourse analysis (FDA). A discourse can be defined as "a system of statements which constructs an object" (Parker, 1992, p. 4). From a Foucauldian perspective, the discourses available within a culture "facilitate and limit, enable and constrain what can be said, by whom, where and when" (Parker, 1992, p. 15). Therefore, discourses construct objects as well as subject positions (Parker, 1992). Subject positions make available certain ways of seeing and being in the world and, when these positions are adopted, have implications for subjectivity and experience (Willig, 2008). FDA is in keeping with the social constructionist framework, as it sees language as constructing experience rather than objectively reflecting it (Willig, 1999).

FDA also looks at the role that discourses play in legitimating power imbalances (Willig, 2008). Dominant discourses make available ways of seeing and being that are implicated in the exercise of power (Willig, 2008). These discourses favour constructions of reality which validate existing power relations and social structures. Furthermore, FDA examines how discourses are linked to institutional practices (Willig, 2008). In this way, discourses are not just ways of speaking, but ways of organizing, regulating and administering social life. While discourses support and reinforce existing social and institutional organizations, these structures, in turn, also give validation to the discourses (Willig, 2008). Accordingly, FDA has been chosen as the analytic method in this study because it allows one to investigate how phenomena are constructed within language, the implications that these constructions have, and how these implications are linked to wider institutional practices, all of which are key concerns in this study.

Ethical Considerations

Potential harm

The research presented no physical risks to participants; however, since mental illness can be a sensitive topic, there was the potential for psychological distress. Therefore, at the beginning of each focus group the participants were made aware of available counselling facilities should they have felt upset as a result of the discussion (see Appendix C).

Informed consent

Before the start of each focus group every participant received an informed consent form and an audio recording and transcription consent form (see Appendix D and E). This was to ensure that they had enough information to make an informed decision about participating (Wilson & Maclean, 2011). The details of the study were also outlined verbally and participants were given an opportunity to ask questions.

Right to withdraw

It was made clear to the participants that they could withdraw from the study at any point without being penalised (Willig, 2001).

Privacy and confidentiality

All the data that was collected about the participants was kept private in order to ensure their confidentiality (Wilson & Maclean, 2011). I was the only person who had access to the participants' details, the recordings of the focus groups and the notes made about the focus groups. At no point in the report write-up were participants referred to by their real names.

Debriefing

At the end of each focus group the participants were informed about the purpose and the full aims of the research study (Wilson & Maclean, 2011).

Reflexivity

In keeping with the qualitative approach, it is important for me as the researcher to acknowledge how my person has influenced the research process (Willig, 2001). By doing this I recognise that it is impossible to eliminate the role of the researcher while conducting research (Willig, 2001).

Firstly, my own beliefs about psychology in South Africa have informed the shaping of this study. I believe that psychology has a lot to offer South Africa; however, if we do not reflect critically on our discourses and practises I believe that it can easily become an irrelevant and unhelpful discipline. It was from this critical position that my research question emerged.

In order to give voice to the participants' understandings of mental illness I endeavoured to remove my critical stance from the focus group discussions. However, in hindsight, I feel that it was evident in questions such as "do you think 'mental illness' is the best term to describe such problems?" In this way, my beliefs about psychology and mental illness have shaped the focus group discussions.

Secondly, race also played a role in the focus group discussions. Most of the focus group participants were white and this majority position could have encouraged the use of the romantic discourse. It is possible that the romantic discourse would not have been so prominent had there been more black participants in the groups. This is because issues around 'culture' are politically loaded due to South Africa's apartheid history. Therefore, white students often remain silent on the topic of culture in the presence of black students as they

do not want to be seen as speaking 'for' them. The fact that I am white could also have influenced the dominance of the romantic discourse as the participants could have felt that it was acceptable to speak in such ways in my presence.

Results and Discussion

Two discourses were identified within the data, namely, the biomedical discourse and the romantic discourse. The ways in which these discourses emerged and the implications that they have for the treatment of mental illness, subjectivity, and power relations are discussed below.

The Biomedical Discourse

The biomedical discourse of mental illness was the most dominant discourse that emerged with all the participants except one making use of it. Within the text analysed three main ideas contributed to the construction of the biomedical discourse. These were: the biological basis of mental illness, mental illness as a medical phenomenon, and Cartesian dualism.

The biological basis of mental illness

The participants emphasised the organic basis of mental illness and thus constructed mental illness as a real and distinct entity that exists naturally in the world (Haslam, 2000):

> *Melissa*: Ya 'cause like mental illness, it makes it sound like there's <u>physically</u> something wrong with the brain, like an illness, so like when maybe there's a chemical imbalance or something then that could be an illness because it's not necessarily your fault or, like your past experiences have caused it, it's just your brain not functioning properly, or at it's like optimal level.
> *Lebogang*: But I feel like most mental illnesses or disorders have some form of biological basis, it'll bring us to the argument of nature versus nurture because I mean some say depression can be genetic or it can be a chemical imbalance in somebody's brain… (FG1)

> *Farai*: I think mental illness is like if you have some sort of dysfunction in some area of your brain or your nervous system or something then that causes you to not be able to act the way that a normal person at that stage of life should be acting (FG3)

In these extracts mental illness is constructed as a physical problem that has a "biological basis" such as a chemical imbalance in the brain, neurological dysfunction, or genetic

vulnerability. Abnormal brain functioning was particularly highlighted within the focus groups. This is apparent in the above extracts as all the participants make reference to the brain in some way. The brain is therefore constructed as central to the development of mental illness. In Young's (2009) analysis of memoirs of mental illness the brain also played a significant role in the authors' descriptions of their symptoms and treatment. For example, "I feared that my brain was actually heating up and might explode," (Saks, 2007 as quoted in Young, 2009, p. 57). By speaking of the brain as fundamental to their experience of mental illness, the authors drew on a biomedical discourse.

Mental illness as a medical phenomenon

The use of medical terminology was another way in which the participants drew on the biomedical discourse:

> *Brandon*: …If similar symptoms present themselves and we can associate those particular symptoms with a particular label, it does make treating those symptoms a little bit easier and researching treatments for those particular symptoms
> *Sharon*: Mmmm
> *Melissa*: Ya
> *Brandon*: I think it's more true of the psychiatric community because they're looking for a chemical or a tablet to
> *Lebogang*: To fix that (FG1)

> *Hannah*: I mean a friend of mine, she has been given an anti-anxiety, anti-depressant, anti-psychotic and tranquilizers
> *Sorrel*: Wow!
> *Hannah*: And she's…exactly and it's crazy, she really doesn't like it, but you know it's something a psychiatrist, a <u>doctor</u> does 'cause she's mentally <u>ill</u> (FG2)

The medical terminology used in these extracts constructs mental illness as a medical concern that can be diagnosed and then treated by doctors with medication (Wilson & McLuckie, 2002). By stating that mental illness presents with certain "symptoms" and that these can be treated, Brandon locates mental illness within the medical realm. Furthermore, mental illness is seen as the preoccupation of the "psychiatric community" who aim to "fix" it with a "chemical" or "tablet". This construction is also evident in the second extract. Mental illness is framed as being treated by a variety of psychotropic medications that are prescribed by medical professionals. Unequal power relations are also apparent in this quote.

Hannah's friend does not like the amount of medication she has been prescribed, yet this action is legitimized because it was done by a "doctor" who holds a position of power within the biomedical discourse over people who are "mentally ill" (Fee, 2000).

Similar constructions of mental illness have been found in other discursive research. Wilson and McLuckie (2002) showed that talk about panic disorder drew on a biomedical discourse when panic was constructed as a "treatable condition" (p. 33). The notion of treatment is implicitly related to the concept of illness (Radley, 1994) and therefore talking of treatment draws on the biomedical discourse.

Cartesian dualism

Cartesian dualism refers to the idea that the mind and body are separate and it is a central principle of Western biomedicine (Gordon, 1988). Participants made use of this idea when they contrasted mental illnesses with physical illnesses:

> *Sharon*: …so it's a really tough thing because you're dealing with people's head spaces you know, you're not dealing with something that's like a oh you've got an infection in your thumb, deal with the thumb, you're dealing with thought, and that's where it becomes so grey and difficult
> *Melissa*: Ya because everybody's thoughts are different, our bodies are the same so we treat illnesses as a body illness but then there's this whole other world, that we've spoken for the last hour, about how it's different purely based on thought. Like our bodies may be the same, if you get a cut it heals, you treat it with whatever, but thought just influences it, just makes it all go crazy… (FG1)

In this passage a distinction is made between physical ailments, such as "infection[s]" and mental illnesses that involve "people's head spaces". Physical illnesses are constructed as having a straightforward treatment process – "if you get a cut it heals, you treat it with whatever" – whereas treatment for mental illnesses is seen "grey and difficult." Contrasting mental and physical illnesses in this way, constructs them as two separate entities that are fundamentally different from each other and that require different forms of treatment. Therefore, a clear distinction is made between the mind and the body. The body is constructed as known and as being the same for all people while the mind is constructed as unknown and different for each person. Other discursive research has found that women with anorexia draw on the notion of Cartesian dualism when talking about their anorexia and femininity (Lester, 1997; Malson & Ussher, 1996). In this context, however, Cartesian

dualism is used to justify the mind's control over the body (Malson & Ussher, 1996).

Although the concept of Cartesian dualism forms part of a broader biomedical discourse, the way the participants used it contradicts their biomedical constructions of mental illness. Within the biomedical discourse mental illnesses are constructed as being the same as physical illnesses in that they result from underlying biological causes. However, Cartesian dualism posits that mental illnesses are inherently different from physical illnesses. The meaning of this shall be discussed later in the paper.

Implications of using a biomedical discourse

Discourses construct objects and subjects (Parker, 2002) and they therefore have implications for practises, subjectivity, and power relations (Willig, 2001). The following discussion will show how the biomedical discourse has implications for the practice of treating mental illness, people's subjective experience of mental illness and power relations.

Treatment

The biomedical discourse locates the cause of mental illness within the individual's biological functioning (Young, 2009). This suggests that treatment for mental illness should target the individual's biochemistry or brain functioning rather than environmental or social factors. However, in a country like South Africa where poverty and violence are prevalent, the biomedical discourse is unhelpful as it disregards some of the primary risk factors for mental illness (Pretorius, 2012). Thus, what the biomedical discourse constructs as pathology might be better understood as a natural response to extremely stressful circumstances (Pretorius, 2012). Talking about mental illness in this way can therefore disguise and preserve social inequalities.

In light of these treatment implications it is interesting to note that the participants expressed resistance towards psychiatric medication because they saw it as addictive:

> *Simon*: …With the pharmaceutical companies just peddling all these drugs, is that even if you were a healthy person who was just sad, once you get on these drugs you're obviously not going to want to stop taking them because even though you may feel happy, you may feel happier on the drugs, so why would you ever wanna go back to the normal?
> *Hannah*: But also there's very hectic withdrawal effects
> *Simon*: Exactly, ya (FG2)

In this passage the pharmaceutical companies are seen as "peddling" psychiatric medication thereby positioning them as drug dealers and placing the use of psychiatric medication within

the realm of substance abuse. Psychotropic medication is also constructed as something that is addictive because once you start taking the medication "you're obviously not going to want to stop taking [it]." The negativity evident in these constructions directly contradicts the participants' use of the biomedical discourse which implies a treatment such as medication. Contradictions were also noted previously between the biomedical discourse and the idea of Cartesian dualism.

These contradictions are important as they suggest that there is a competing discourse at work that is causing the biomedical discourse to unravel (Parker, 2002). Within these focus groups the competing discourse took the form of the psychodynamic discourse. Although on a broader scale it is prominent, the biomedical discourse was so dominant within these focus groups, that the psychodynamic discourse became marginalized. The following quote shows how the psychodynamic discourse competes with the biomedical discourse because it highlights aspects of mental illness that cannot be contained within the biomedical order:

> *Dean*: …things like OCD and schizoid and all the anxiety disorders, you couldn't really classify them as illnesses because they don't present any sort of physical symptoms. People aren't coughing and, it just sort of, it manifests in a specific environment or on a specific cue. So it's not so much an illness as it's sort of a reaction to something. Or whether it's something in the present or something in the past, buried in the subconscious. (FG1)

By reflecting on the use of the word 'illness' Dean demonstrates how this word does not capture the lived experience of many mental illnesses and that there are therefore other ways of constructing it, such as a "reaction" to something "buried in the subconscious". Framing mental illness in this way draws on the psychodynamic discourse. The use of competing discourses of mental illness also implies competing constructions of treatment:

> *Simon*: …I've still got the techniques that the psychologist gave me now that I can use as opposed to just running backwards for some drugs
> *Hannah*: The thing again keeps coming back to drugs but with a lot of people who are just prescribed normal antidepressants they have a period of about five years where they're very good and then they relapse. Whereas with psychotherapy or just general therapy it's an on-going process firstly, but secondly, it also teaches you to alter your way of behaving and functioning and thinking (FG2)

In this extract, the participants draw on a biomedical and a psychodynamic discourse when talking about treatment. This can be seen in references to "antidepressants" and "psychotherapy" respectively. Medication is constructed as having a short term effect, while psychotherapy is seen as having long-term efficacy because it changes one's thinking and behaviour.

Subjectivity

The biomedical discourse also has implications for subjectivity. By constructing mental illness as resulting from organic dysfunction the blame is removed from the individual as one cannot control one's genes or bio-chemistry (Speed, 2006). Mental illness is thus framed as something that is separate from an individual's personhood and life history (Luhrmann, 2000). This liberates the individual from the feeling that they are responsible for their condition. Interviews with women living with depression found that the women adopted a biomedical discourse in order to manage the stigma around depression (Schreiber & Hatrick, 2002). The women stated that they felt a great sense of relief when they were told their depression had a biological explanation as it meant that it was not their fault. Many anti-stigma campaigns have also made use of the biomedical discourse in order to remove attributions of responsibility from those living with mental illness (Haslam, 2000). However, situating the cause of mental illness within an individual's genes or brain chemistry can also make them feel as if there is something fundamentally wrong with them as the cause is seen as a part of their biological make-up (Young, 2009). This can make one feel as if the mental illness will be with one forever.

Power relations

A certain power hierarchy is implied within the biomedical discourse. In this discourse people with mental illness are constructed as patients who occupy a disempowered position in relation to psychiatrists (Crawford, 1999). Psychiatrists have access to a large body of knowledge which is mostly inaccessible to patients and which gives them the authority to examine patients (Crawford, 1999). Due to this patients are constructed as passive bodies that are subject to analysis but whose own version of illness is not considered important. This power relation highlights the close link between power and knowledge (Parker, 2002). Indeed Foucault (1980) argued that the production of knowledge is almost inseparable from power relations. In a critical discourse analysis of the construction of mental illness in Serbian newspapers, journalists frequently used statements from psychiatrists in their reports (Bilić & Georgaca, 2007). By doing this, psychiatrists were positioned as experts on mental illness and other accounts of mental illness were delegitimized. Consequently, the

dominance of the biomedical model was maintained.

However, wherever there is power there is also resistance (Foucault, 1980) and resistance to the biomedical discourse was evident in these focus groups. Firstly, resistance to the biomedical discourse was shown through the use of the counter-hegemonic psychodynamic discourse. Secondly, resistance was displayed through comments about how the biomedical model does not always match subjective experience:

> *Johan*: …I think it very rarely exists in the world in the way that we conceptualise it if you know what I mean. I don't think even schizophrenia is just a collection of symptoms like flu is. (FG2)

> *Sharon*: And it's so complex because each and every individual lives and operates, functions differently, has a different view of the world, so it makes it so hard to sit in front of somebody and say 'ok, this is perfect, this is your diagnosis and this is the perfect cure for your problem', you know, 'a bit of this, a bit of that, a bit of this and medication and we'll sort you out.' (FG1)

In the first quote Johan is arguing that mental illnesses do not always present in the ways in which they are theorized. They are not always "just a collection of symptoms" that fit neatly into a biomedical diagnosis. In the second quote, Sharon is similarly stating that due to the complexity of people's lives it is often difficult to find a distinct diagnosis and a "perfect cure". Young (2009) shows how individuals resist dominant discourses of mental illness by constructing their own narratives of mental illness. Through writing their stories, the individuals showed how their lived experiences differ from hegemonic constructions of mental illness. Young argues that these narratives are an "incremental but essential shift in the social construction of mental illness" (2009, p. 67).

The Romantic Discourse

The romantic discourse was also prominent as twelve out of the seventeen participants drew on it in during the focus groups. This discourse was specifically drawn on when the participants spoke about mental illness in non-Western cultures. According to Swartz (1998) the romantic discourse is made up of four central contentions. Firstly, that mental illness does not exist in non-Western cultures. Secondly, in such cultures mental illness is not viewed as problematic. Thirdly, where it does exist it is not stigmatized and fourthly, all mental

illnesses are cured by indigenous healers. The following discussion will show how these ideas constituted the romantic discourse and the implications that this discourse has for the treatment of mental illness, subjectivity and power relations.

Mental illness does not exist in non-Western cultures

The extract below was an answer to the question "How do you think mental illness is experienced in South Africa?"

> *Hannah*: I think we're still influenced to a great extent by Western culture, but also to a great extent by traditional cultures. And more traditional cultures all over the world are less…it's quite a new idea, mental illness, and so anything new is still you know, it's kind of looked at 'Ok do we wanna look at this? Do we wanna explore it more?' (FG2)

In this quote, mental illness in the context of "traditional cultures" is constructed as "quite a new idea". This suggests that before "traditional cultures" were "influenced" by "Western culture" the concept of mental illness did not exist in that setting. Furthermore, contrasting "traditional cultures" with "Western culture" suggests that they are two separate entities. A similar idea is evident in the following quote:

> *Sunita*: …Well in specific cultures, yes, because obviously in the cities it's taken more seriously, but I don't know if people yet perceive disorders as an entity or as anything, or if it is just a reaction or an emotion?
> *Sharon*: Just from my perspective, from my sort of age group, we're all educated, varsity degrees, probably professionals for 10 to 15 years, entrepreneurs, lawyers or accountants or whatever, and I think in that spaces, it's a lot more, people are a lot more compassionate and understanding, I don't know from other perspectives, it is a cultural thing you know it's a white, educated etc. (FG1)

In this extract, the concept of mental illness is constructed as only existing in certain contexts. Sunita states that in "specific cultures" "disorders" are not perceived as an "entity" but rather as "a reaction or an emotion." In this way, mental disorders within a cultural context are seen as being no different to everyday emotional reactions, thereby implying that they do not exist as clinically significant entities. Sunita also makes the distinction between "specific cultures" and "cities" suggesting that 'culture' is located outside of the city. "Cities" are also constructed as places where mental illness is "taken more seriously". Similarly, Sharon constructs mental illness as being a "cultural thing". However, this time 'culture' refers to a

"white, educated" culture. Sharon therefore implies that mental illness is not a phenomenon in cultures that are not "white" and "educated".

Implicit within these quotes are ideas about development. Spiegel and Boonzaier (1988) argue that the use of the word 'traditional' within the South African context is not merely descriptive, but is rather is used to portray a group of people in a negative light. Groups labelled as 'traditional' are seen as being "backward" and "pre-rational" and unable to compete with "modern", "progressive", and "developed" groups (Spiegel and Boonzaier, 1988, p. 43). Although the second quote does not use the word 'traditional', by contrasting "cultures" with "cities", ideas about development are also implied. Within such constructions a Western, psychological understanding of emotional distress is placed at the top of the developmental hierarchy, while 'traditional', non-Western understandings are placed at the bottom (Swartz, 1998). In this way, it is assumed that 'traditional' people will become more emotionally sophisticated once they come into contact with Western psychological practices (Swartz, 1998). Such constructions suggest that 'traditional' people cannot experience mental illness because they are at a lower evolutionary level (Nell, 1990). These ways of speaking are compatible with discriminatory discourses of racial difference and inferiority (Spiegel and Boonzaier, 1988) as is evident in the following quote by Bevis (1921): "Naturally most of the [negro] race are care-free, live in the 'here and now' with a limited capacity to recall or profit by experiences of the past. Sadness and depression have little part in his psychological makeup" (p. 11). Such beliefs have been used to legitimate harmful practices, because if depression is not part of black people's psychological make-up, then there is no need to worry about damaging them emotionally (Swartz, 1998). In fact, during apartheid the emotional distress of migrant mineworkers was attributed to difficulties in adjusting to a 'Westernized' way of life, which allowed people to ignore the terrible conditions they were living and working in (Swartz, 1985). Thus, constructing black people as psychologically 'other' justified their economic exploitation.

Mental illness is not seen as problematic

In the focus group discussions mental illness in a non-Western context was framed as being unproblematic:

> *Lebogang*: I think I like medical anthropology because it brings about, it stops us from thinking from a Western perspective, especially because we live in Africa, we have so many different cultures that perceive things in so many different ways. It takes us outside our medical models and makes us look at mental illness or illness in general from a more cultural

perspective. Like what this village thinks about let's say schizophrenia, so to them it could either be a blessing from God and they become the village witch doctor
Melissa: Shaman
Lebogang: Exactly! And they're praised. So it's interesting.
Brandon: But you know in that situation, if the person's behaviour isn't maladaptive, I mean I'd be reluctant to even call it a disorder (FG1)

In this extract, mental illness within African cultures is constructed as being a "blessing from God" which allows one to "become the village witch doctor." As a result of this, Brandon is "reluctant" to call such behaviour a "disorder." Thus, not only is mental illness seen as unproblematic, but it is also seen as a positive thing. Similarly:

Lydia: Actually I think in a lot of traditional cultures, symptoms that we now associate with mental illness were actually with stuff like being a prophet or something.
Brett: Ya
Lydia: Having access to like subtle realms or something (FG3)

In this quote, the positive and supernatural aspects of mental illness in non-Western cultures are again emphasised. Constructing mental illness in this way relates to notions about rationality. Anthropological writings have frequently stated that within an African 'world-view' all forms of illness are caused by the supernatural (Spiegel & Boonzaier, 1988). This "primarily intuitive, non-rational" world-view is then contrasted with the "primarily scientific, rational" Western world (Bührmann, 1984, p. 15). Such constructions tie into ideas around a Western monopoly on rationality and science (Spiegel & Boonzaier, 1988), which further relate to the racist discourses around development discussed previously.

Mental illness is unstigmatized

Conversely, participants suggested that, if mental illness does exist in non-Western cultures, then it is unstigmatized:

Lebogang: But my point was not about leaving or treating him, it was about perspective. In that cultural setting he is ok but once he leaves that setting into another, then it is perceived as a problem
Brandon: I see what you're saying

> *Melissa*: I was more sort of like on the fact about how different cultures perceive something…And the fact that we, well the Western society, impose such a negative thing upon it when you know the minority is actually like ‘it’s actually ok’… (FG1)

This extract is from a discussion about schizophrenia in ‘cultural contexts’. Lebogang and Melissa contrast the way “Western society” views mental illness with the way the “minority” in a “cultural setting” sees it. Mental illness in Western cultures is constructed as a “problem” whereas, in non-Western cultures, it is constructed as not being stigmatized: “it’s actually ok”. Likewise,

> *Brett*: …What they found was the people didn’t see the mental illnesses that we define as schizophrenia and that sort of thing as a bad thing there, well they just didn’t see it as an issue, that you should be like put in a different place. So they didn’t record it, they just lived with the families, these huge family networks… (FG3)

This quote is taken from a discussion about mental illness in India. Brett constructs mental illness as unstigmatized in that context because it is not seen as “a bad thing”. Furthermore, India is constructed as a place where people with mental illness are not isolated from the rest of society, but rather are incorporated into “huge family networks.” Constructing mental illness as being perceived in different ways in Western and non-Western cultures assumes that the world can be neatly divided into these two blocs (Swartz, 1985). Also, talking about how people with mental illness are accepted and cared for in non-Western cultures implies that such contexts have “both a unique reality and a unique fund of wisdom” (Nell, 1990, p. 131). This furthers the othering of non-Western cultures, which become characterised as inherently different from Western ways of being.

Mental illness is cured by indigenous healers

The extracts below show how mental illness in non-Western cultures is seen as being treated exclusively by traditional healers.

> *Lebogang*: … In certain parts of the world someone will have schizophrenia but in that society and that culture it could be a demon possession and that’s what they would believe so they would go to what they would call a witch doctor and they would get the demon removed and
>
> *Melissa*: They would be fine.
>
> *Lebogang*: Ya, a couple of processes and they’d be ok after that (FG1)

In this quote, schizophrenia in a cultural context is constructed as something that can be cured by a "witch doctor". All that is needed is a "couple of processes" and then the individual is "fine." Similarly, Mandisa states that people in Khayelitsha and Gugulethu would prefer help from traditional healers:

> *Mandisa*: Like last year when we went out for clinics we'd go out to communities like Khayelitsha and Gugulethu and then, we had to, in each household that we went into, we had to ask them what's their first point of help or whatever and then most of them said traditional help so they would go for traditional help (FG3)

Spiegel and Boonzaier (1988) argue that, historically, the emphasis on different systems of healing has been used to explain how African people "are really different" (p. 44) because they continue to consult traditional healers despite the existence of Western, medical health care. This has political connotations in South Africa as, during apartheid, discourses of racial difference were used to argue that black South Africans 'naturally' preferred this system of healing (Swartz, 1995). Such ways of speaking imply that black South Africans had a choice of healing systems; however, during apartheid public mental health services were not widely available (Freeman, 1989). Furthermore, stating that black people would rather seek mental health care from indigenous healers justifies the provision of inadequate mental health care services to black populations.

Implications

The romantic construction of mental illness in non-Western cultures implies three main ideas. Firstly, that Western and non-Western cultures are fundamentally different, which ties into discourses of othering. Secondly, that this difference arises from the fact that Western cultures are predominantly scientific and rational, whereas non-Western cultures are mainly superstitious and irrational. Thirdly, these concepts relate to ideas around development and suggest that non-Western groups occupy 'a lower evolutionary level than the glittering first world of psychologists' (Nell, 1990, p. 129). In these ways, romantic constructions of mental illness tie into broader racialized discourses of difference. Such constructions are particularly problematic within the South African context as they echo racist arguments which were used to justify apartheid ideology. Framing mental illness in non-Western cultures in this way has implications for the treatment of mental illness, subjectivity, and power relations.

Treatment

By constructing Western and non-Western cultures as essentially different, the romantic discourse allows psychologists and psychiatrists to attribute failed treatment to 'cultural differences' rather than their own inadequacies (Nell, 1990). This can create a space for professional laziness whereby mental health professionals fail to engage with their clients on the assumption that the treatment will not work anyway. This discourse can also mean that mental health problems of non-Western clients are translated into 'cultural' issues, thereby leading to the relinquishment of clinical responsibility (Swartz, 1991). It has been shown how the psychiatric problems of black patients in a psychiatric ward were often changed into issues relating to African culture and rituals (Swartz, 1991). Consequently, patients were advised to leave the hospital and seek help from a traditional healer. This phenomenon has been called a sophisticated way of "getting rid of patients" (Mizrahi, 1986, p. 14). As well as denying clients mental health care, this approach can also lead to cultural stereotyping (Gobodo, 1990). Assuming that all black clients embody a particular cultural essence (Swartz, 1991) and over-emphasizing the role of culture (Gobodo, 1990) is to engage in cultural essentialist thinking, which permeates racist discourses of difference. The romantic discourse can thus result in people not receiving the help that they need and mental health professionals not acting in the best interests of their clients.

Subjectivity

The romantic discourse of mental illness has particular implications for the subjectivity of black South Africans. Subjectification refers to the way in which people make themselves into subjects (Foucault, 1983). Therefore, within this discourse black South Africans may subjectify themselves as psychologically different to white South Africans. This is evident in the growing calls from black African psychologists for an indigenous African psychology. For example, Mkhize (2004) argues that modern psychology is based on Western ideas which have side-lined indigenous theoretical frameworks. There is thus a need for the development of psychologies that consider indigenous people's worldviews. Mkhize states that African psychology should be based on African metaphysics, which focuses on both the past and the present, promotes harmonious living, and emphasizes the relational nature of personhood. Inherent in this argument is the idea that African people have an essentially different way of being and seeing to Western people. What is interesting is that such ideas are being promoted by black African psychologists, which indicates that they have subjectified themselves in terms of the constructs within the romantic discourse. However, in making such an argument about subjectivity and the romantic discourse, one runs the risk of

denying black intellectual agency and implying that they do not understand themselves. The situation is thus inherently paradoxical.

Power relations

The romantic discourse also infers unequal power relations. Constructing non-Western groups as 'undeveloped', and therefore unable to experience mental illness, places them in an inferior position to 'developed', Western groups who are 'psychologically minded' (Swartz, 1998). In this way, culture becomes a source of power in mental health care settings (Swartz, 1991). Focusing on the cultural context of mental health problems opens up the possibility of fixating on cultural difference. Such a way of thinking runs the risk of legitimating discourses of separate development that were used to uphold the apartheid regime (Swartz, 1991). In this way the romantic discourse allows for the grouping of people along cultural and possibly racial lines and thus the perpetuation of a harmful social hierarchy. These power imbalances have been cited by black South Africans as barriers to receiving adequate mental health care, as they felt that their therapists were still influenced by racial stereotypes (Ruane, 2010). The romantic discourse thus perpetuates elements of South African psychology's racist past.

This discourse also legitimates the on-going marginalisation of traditional healers. Indigenous healing practises have been denigrated through decades of colonialism, cultural imperialism and the power of the pharmaceutical industry (Richter, 2003). The romantic discourse perpetuates this by locating traditional healing within the realm of the irrational and undeveloped. Traditional healers are therefore seen to have no place in the rational, scientific world of Western medicine. Thus, the power of biomedicine is maintained while alternative understandings are side-lined.

Summary and Conclusion

The biomedical discourse and the romantic discourse come together to construct mental illness in South Africa. The biomedical discourse constructs mental illness as a biologically-based phenomenon that can be diagnosed and treated by health professionals. Such ways of speaking have emerged out of the institutionalised practices of Western biomedicine. The romantic discourse locates mental illness in the realm of the supernatural and, consequently, within the ambit of traditional healing. Thus mental illness in non-Western cultures is located in the sphere of the irrational, thereby constructing it as fundamentally different to 'rational', Western, medical interpretations. In this way mental

illness is framed as something that is irrelevant to non-Western cultures. Therefore, both discourses, although via different discursive practices, construct mental illness as a Western, biomedical phenomenon.

The power relations implicit in each discourse are consequently compounded. Ideas about development inherent in these discourses construct Western practices as further along a developmental scale than 'traditional', non-Western practises (Swartz, 1998). Therefore, when the discourses dovetail to construct mental illness, psychiatrists are positioned at the top of a much larger hierarchy; in a position of power over patients as well as non-Western people (see Appendix F). In contrast, non-Western people are placed at the bottom of a much larger hierarchy. In this way, the intersection of the two discourses serves to disempower non-Western groups twice over. The use of these discourses in South African psychology is therefore problematic as they locate the majority of the population in a position of powerlessness.

The fact that these discourses were used by undergraduate psychology students is significant for two reasons. Firstly, these students' primary source of knowledge about mental illness is university teachings. This therefore suggests that these problematic discourses are being drawn on in the teaching of psychopathology at a university level. Secondly, these students are possibly the next generation of psychologists and researchers. Since discourses inform ways of seeing and being in the world (Willig, 2008), it is concerning to think that such discourses could be perpetuated in future research and clinical practice.

This study therefore highlights the need for the development of new discursive practices within South African psychology. Alternative discourses need to be established that: do not tie into broader racist discourses; do not perpetuate power imbalances, and do not enable othering. By creating a critical awareness of some of the current discourses being used within psychology in South Africa, this study hopes to be the starting point for the development of new discourses. It is hoped that through the continuation of research of this nature discourses will be developed that empower people and facilitate the provision of mental health care to all.

In terms of the limitations of this study, it is necessary to highlight that the small group used might not be representative of all psychology undergraduate students in South Africa. Therefore, the discourses of mental illness that UCT students use might differ from those of other universities. However, representative samples and objectivity are not the central aims of qualitative research. Rather, qualitative research focuses on exploring a particular phenomenon or experience in great detail (Willig, 2001).

Using the term ‘mental illness’ in the title of the project and the discussion questions might have influenced the way that the participants spoke about it. This is because the word ‘illness’ automatically locates the topic within the biomedical realm. However, it is hard to avoid this problem as “it is difficult, if not impossible, to think and express oneself outside [of] discursive constraints,” (Mills, 2003, p. 57). Therefore, any other term that could have been used would have similarly located mental health problems in other discursive orders.

Future research in this area should, firstly, explore the discourses that are being used to talk about other significant aspects of psychology in South Africa. For example, issues around culture and treatment emerged as important themes in the focus groups, yet the research question prevented these from being explored in-depth. It would therefore be worthwhile to investigate specifically how ‘culture’ is constructed in relation to psychology. Furthermore, discourses around treatment should be examined, as the implications of such discourses directly affect people’s lived experience of mental illness. Secondly, alternative discourses of mental illness need to be developed. These discourses should focus on the empowerment of people and enable access to mental health care for all. One such alternative could be the comprehensive discourse that sees mental illness as resulting from an interaction of biological, cultural, psychological and social factors (Hahn, 1995).

This study has furthered the development of critical language awareness within South African psychology. By analysing existing discourses of mental illness, commonly accepted understandings of mental illness have been critiqued and have been found to be problematic. Thus, a space has been created for the development of alternative discourses of mental illness. In this way, the present study has contributed to the on-going effort to make psychology in South Africa a more relevant and helpful discipline.

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Appendix A

Focus Group Schedule: Broad Questions to Facilitate Discussion

- How would you define mental illness?
  - What do you think causes mental illness?
  - What do you think is the best way to treat mental illness? Is there a best way?
  - Do you think ‘mental illness’ is the best term to describe such problems?
- How would you react if you were diagnosed with a mental illness?
  - If a friend or a family member was?
- Do you think mental illness is perceived the same all over the world?
  - How do you think mental illness is perceived in South Africa?
  - What do you think it is like to live with a mental illness in South Africa?
- Closing comment: Is there anything else you would like to add?

Appendix B

Transcription Details

All the names used in the paper are pseudonyms, except for the researcher's name which has remained 'Sorrel'.

FG1, FG2, and FG3 denote focus group 1, focus group 2 and focus group 3 respectively.

Words that are underlined indicate emphasis. For example:
For this research project I conducted <u>three</u> focus groups.

Ellipses:

- Ellipsis at the beginning or the end of a quote indicates that it is taken from a longer extract. For example:
  …For this research project I conducted three focus groups.
  For this research project I conducted three focus groups…
- Ellipsis in the middle of a quote indicates a pause. For example:
  For this research project…I conducted three focus groups.

Appendix C

Referral List

Given below are two services that can offer help should you feel that you require any form of counselling or support.

UCT Student Wellness Service

Services. The UCT Wellness Service offers counselling for any personal, emotional, social or psychological problem.

Payment. The counselling service costs R100 per session, however, this is negotiable and students who are able to prove that they receive financial aid from UCT are not charged.

Student Wellness is located at 28 Rhodes Ave, Mowbray which is very close to campus.

Contact: 021 650 1017 / 1020 for an appointment.

LifeLine

Services. 24 hour telephone counselling service. Specifically: rape counselling, trauma counselling, face to face counselling, and HIV/AIDS counselling.

Payment. Services are free of charge.

Office: 021 461-1113

Crisis: 021 461-111

Email: info@lifelinewc.org.za

Appendix D

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF PSYCHOLOGY

Informed Consent Form
Students' Perceptions of Mental Illness

1. **Invitation and Purpose**

   You are invited to participate in this study which will explore the ways that students talk about mental illness. This study is a Psychology Honours research project.

2. **Procedures**

   - If you decide to participate in this study then you will take part in a group discussion about mental illness.
   - In order to participate in this discussion you do not have to have first-hand experience of mental illness. However, if you do, you are not obliged to share any personal information that makes you feel uncomfortable.
   - The group discussion itself will take approximately 60 minutes.
   - Participating in this study is voluntary. You are free to withdraw at any time without any penalties and without giving a reason why.

3. **Risks, Discomforts & Inconveniences**

   - This study poses very little risk to you.
   - Talking about mental illness might bring up sensitive issues which could potentially be emotionally distressing. However, you will decide what you would like to discuss and/or share and you are in no way obligated to talk about anything that makes you feel uneasy or upset.
   - If you would like to contact a counsellor after the discussion, you can contact the organizations listed on the referral list.
   - You might be inconvenienced by having to give up 90 minutes of your time.

4. **Benefits**

   - For participating in this study you will be compensated with 3 SRPP points.
   - You may also benefit from the study in that you may gain insights about mental illness that you did not previously have.

5. **Privacy and Confidentiality**

- Any information that you share is strictly confidential. You will remain anonymous throughout the research process. You have the right to request that any information you have shared be removed from the study.
- Throughout the research process I, as the researcher, will ensure that you remain anonymous and that the information you share is kept confidential. However, I cannot guarantee that others in the group will maintain confidentiality.
- Digital voice recorders will be used to record the discussion. If you would like these to be switched off at any time, you may request this.
- The recordings will only be listened to and accessed by myself and my supervisor.

6. **Contact details**

If you have questions, concerns, or complaints about the study please contact Sorrel Pitcher (primary researcher) at sorrel.p@gmail.com or Dr Wahbie Long (supervisor) at wahbie.long@uct.ac.za. If you have any questions regarding the ethics of this study please contact Rosalind Adams (Psychology Honours course secretary) at Rosalind.Adams@uct.ac.za who will put you in contact with a member of the Psychology ethics committee.

7. **Signatures**

[Participant's name] ____ has been informed of the nature and purpose of the study described above, including any risks involved in the procedure. He/she has been given time to ask any questions and these questions have been answered to the best of the researcher's ability. A signed copy of this consent form will be made available to the participant.

____

Researcher's signature Date

I have been informed about this research study and understand its purpose, possible benefits, risks, and discomforts. I agree to take part in this research as a participant. I know that I am free to withdraw this consent and quit this project at any time, and that doing so will not cause me any penalty or loss of benefits that I would otherwise be entitled to. I understand that any information I share in this study will be kept confidential and that I will remain anonymous throughout the research process.

____

Participant's signature Date

Appendix E

UNIVERSITY OF CAPE TOWN
DEPARTMENT OF PSYCHOLOGY

Consent to Audio Recording and Transcription
Students' Perceptions of Mental Illness

Researcher: Sorrel Pitcher

This study involves the audio recording of the group discussion. Neither your name nor any other identifying information will be associated with the audio recording or the transcript. Only my supervisor and I will be able to listen to the recordings.
The tapes will be transcribed by me and erased once the transcriptions are checked for accuracy. Transcripts of the group discussion may be reproduced in whole or in part for use in presentations or written products that result from this study. Neither your name nor any other identifying information will be used in presentations or in written products resulting from the study.

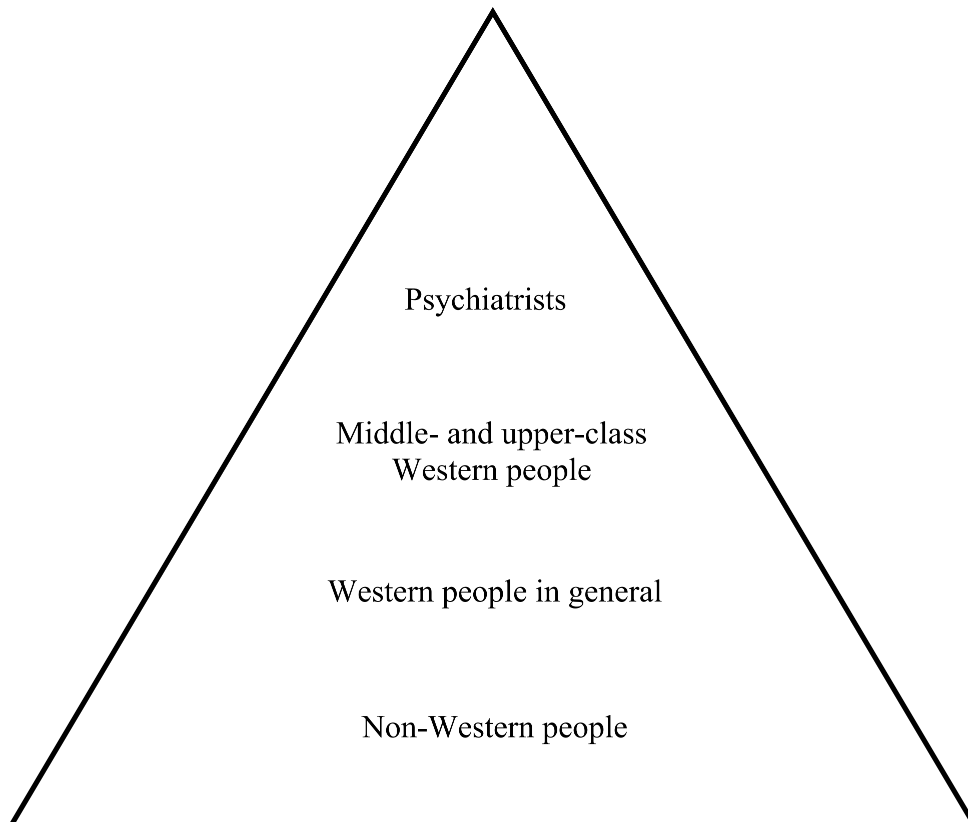
By signing this form, I am allowing the researcher to record my voice and transcribe my comments as part of this research.

____ ____________________

Participant’s signature **Date**

Appendix F

The hierarchy implied when the biomedical discourse and the romantic discourse jointly construct mental illness



Adapted from a figure in Swartz (1998, p. 107).