HOW TO CITE THIS ARTICLE
Kiingati, J.B. (2023). UNEARTHING DEPRESSION
https://afroheritageconsult.org/wp-content/uploads/2023/09/Unearthing-Depression.pdf
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UNEARTHING DEPRESSION

Abstract

Depressive Disorders, together with anxiety disorders, are part of the common mental disorders described by the Joint Commissioning Panel for Mental Health (2013). The commission separates common mental disorders from the severe mental illnesses which include Schizophrenia - a mental disorder characterised by distortions in thinking, perceptions and emotions, language, sense of self and behaviour, and having experiences that include hallucinations (hearing of voices or seeing things that are not there), delusions (fixed, false beliefs) (WHO, 2019), and Bipolar Disorders- severe fluctuations in a person's moods in a way that far surpasses normal mood changes. These fluctuations affect an individual's entire life (work, relationships, school) and may be coupled with substance abuse and suicidal attempts (International Bipolar Foundation, 2009). This paper starts with a presentation of a depressive disorder case followed by definitions, prevalence and distribution of the disorders. It then presents the types of depressive disorders, as well as factors contributing to the disorders. Later, it gives the effects, interventions as well as barriers to the interventions. In the end, it sheds light on the relationship between depressive disorders and stress, as well as that between the disorders and suicide. The findings are that a lot has been researched on depression. In these studies, the Developed world sees a concern linking depressive disorders to chronic illnesses and disability. In the developing world however, health policies are still in their pristine stages focussing on communicable and non-communicable diseases, substance abuse, need to improve on policy, and strengthen efforts to provide affordable universal health care. In all, depressive disorders continue to be a major concern in these developing countries due to illiteracy levels, poverty, chronic illnesses, communicable and non-communicable infections, ageing, as well as stigma, linking mental challenges to witchcraft and to the spiritual domain. It is therefore highly recommended that studies continue to be carried out in the area of mental health and its link to social transformation.

Inclusion/Exclusion Criteria

The paper is informed by a literature systematically selected. This literature, was sought discretely from online scholarly material: Google Scholar, Academia, and ResearchGate. Material from EbscoHost and Elsiever was also included. In addition, formal reports from World Health bodies were included. Terms used in the search included depression: definition, factors influencing, causes, effects, interventions. Inclusion of Africa, was inserted only when specificity on the region was needed. Additional specific terms emanating from the first search were included for clarification. Articles that emerged on the first search pages were selected as per their relevance to the study.

While it is best practice for consulted literature to be recent (not more than 10 years old), this study has allowed older literature. This is based on the need for the developing world to borrow and learn from the steps taken in the developed world in relation to health care development. This is especially needed in the area of mental health, within which, Africa still struggles with beliefs of witchcraft and the spiritualizing of mental issues, amidst challenges of poverty and ignorance.

Aim/Goal

The aim of the paper is to contribute towards mental wellness, here in described as "a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2013). This paper seeks to contribute towards improved mental health through a better understanding of depressive disorders that account for 5-20% of illnesses among adults (WHO 2012; Ishtiaq et, al. 2018; Scholten, et al., 2016), and affect about 4.4% of the world's population (WHO, 2017, p. 5).

Introduction: Hen's Case

Tim came home in the evening after visiting a neighbour and friend.

"Oh, you have come back?" The father asked.

"Yes, I have," Tim replied.

"Then go on and execute the plan?"

He was such a joker in word and deed, and Tim took this to be one of his father's jokes. He laughed it away and remained around his father who was in his early seventies.

"Is part of the plan not to give me food?" Another unsuspecting comment broke the silence between the two men.

Tim decided not to respond to this, but rather dash into the kitchen where the mother was, and find out why the father had not been fed. Promptly, the mother pointed at a plate that the husband had just used; it had not yet been washed.

At this Tim got a little confused. He did not understand why this second comment. He however, chose to let the evening end as he retired to bed.

The following morning came in with some strangeness. Hen, Tim's father got into some incomprehensible talk. It was not clear what he was talking about but certainly there was incoherency. The look from his eyes also appeared a little out of the normal; it was quite sharp and intrusive. Tim and the mother decided to seek some advice. They reached out to some close relatives, who advised that Hen be taken to hospital. From a neighbour, they borrowed a car, with which to transport Hen to hospital. These preparations took the better part of the morning.

When requested to get out of the house to go to hospital, Hen, contrary to earlier actions, refused. He even threatened to be violent. Tim attempted to get some men to lure him into the vehicle, but failed. In the end, there was a consensus that Tim goes to the nearby police post to seek some help. While on his way, he heard screams. He turned back to the direction of their house, only to see smoke rising from the parent's house. Hen had set the house ablaze in an attempt to commit suicide.

Thanks to the speedy and prompt response from neighbours. A chain of rescuers was in place welling each spot that showed signs of fire. At the time, Hen, holding an attack hand-axe was trying to stop the crowds from putting off the fire. He wanted to die, rather than be exiled by his family. The thoughts of what was going on in his mind were shared later after he had been overpowered. He even revealed how he had turned on the gas cylinder, but unfortunately it was empty. He had even tried to pour kerosene on to himself to allow speedy flaming, but that had not worked well. The rescuers who had gained entry into the house through the roof had drenched his body with water. In the squabble, Hen's had got broken. It is only then that men jumped on to him and overpowered his attacks. He was dragged outside and was allowed to rest on the yard.

Later, Hen was taken to hospital. After a day of diagnosis, it was stated that he had cerebral Malaria and was treated. After a few days of stay, the family took him back home. The following day was a Sunday. At about midday, a group of women who belonged to the church where Hen ministered, came to visit him. He spent time informing them how the wife was starving him. He even narrated how the family was plotting to exile him from this country into another land where his ancestors came from. This became a long day of accusations. He later in the evening decided to escape.

One of his sons followed him at close range. Unsuspecting, this middle-aged man spotted a sharp dagger flashed out of Hen's waist. He intended to drive into him. Speedily, in an attempt to rescue his life, he side-stepped before disappearing. Hen had been in the military and so knew well how to attack and hide from any pursuant. That was the last the family saw of Hen that night.

It was during the El Nino rains that were thundering angrily times without end. The family young ones attempted to go round the fields all night in search of Hen but in vain. Amidst the cold, the hunger, darkness and heavy rain, the searchers gave up their quest and came back home. It was around 3. a.m. They tried to warm themselves and change into some dry clothes. In the early hours of the morning, at around 5.30, they were all ready to re-start the search.

Just then, a stranger entered into the compound accompanied by a neighbour. Behind them, was Hen, water dripping from all over his body. It was later revealed that he had spent a night in water, in a large swamp from which building stones had been excavated. He had gone in, in an attempt to commit suicide, but due to his swimming prowess, remained afloat. The stranger was a police officer. He was coming to stage an arrest since the family was planning to exile their father. The neighbour knew the family well and stood to their defence.

All was strange. No one in the family exactly knew what was happening. The medics that continued being involved were not giving clear information on the phenomena. Monies continued being spent in hospitals. Anxiety continued reigning over all. Any time that Hen was not hospitalised, he had to be under 24-hour surveillance.

Again, evening was setting and it was a little dark. Alerts from the house signalled that Hen had again disappeared. Another search was instigated. All went into the nearby open field as directed by a passer-by who had spotted him. After about 30 minutes of rounds, despair was beginning to sink in. Just then there was a dog-bark. At that very time, Tim looked behind and saw something dangling from a tree. The dog had heard some leaf shuffles. Later, it was understood that throughout the search, Hen was already on top of a tree. He was waiting for the crowds to give up before he could execute his plan. He already had a loop round his neck. The other end of the rope was tightly fitted on to a tree branch. As soon as the crowds had passed, he had let himself down to allow the loop to grasp his neck putting an end to his life of struggle.

The dog, had interrupted the execution of the plan. It had alerted Tim who speedily turned back. Spotting the new spectacle, he rushed back and raised this heavy body. At that time Hen requested the son to help him have the loop grasp well at the neck so that he could be off. Tim shouted for help and soon the rest of the crowds arrived. Together they helped lower Hen's body that still had life. On arrival at the scene, the wife (aged 68) knelt at the spot, and prayed in tears. The family took Hen to hospital, this time changing the doctor. A mysterious recovery journey began and in three years, Hen fully recovered. He passed on ten years after recovery, aged 86. The cause of the death was pneumonia.
Such is the journey with depression. Some end up dead, others end up permanently incarcerated, while others recover. Family members struggle to understand what is happening as spiritualists speedily relate the occurrences to spirits. This paper seeks to shed light on the discourse on depression with reference to this case that took place in Kenya in 1994-2007. Pseudonyms have been used for confidentiality.

Definitions, Prevalence and Distribution of Depressive Disorders (DD)

Definition of depression and depressive disorders

"Depression comes from the Latin "*depressio*" which means sinking. The person feels sunk with a weight on their existence. It is a mood disorder that varies from: normal transient low mood in daily life itself, to clinical syndrome, with severe and significant duration and associated signs and symptoms, markedly different from normality (Bernard, 2018, p.6)". Addressing the co-relation between Depression and heart failure as well as stress, Pasic, Levy, and Sullivan, (2003) define Major Depression as "a disorder that involves abnormalities in the central monoaminergic neurotransmitter system and gives rise to behavioural changes and alterations in neurohormonal pathways" (p. 184). The "Monoamine neurotransmitters include serotonin and the catecholamines dopamine, adrenaline, and noradrenaline... [which] have multiple functions including modulation of psychomotor function, cardiovascular, respiratory and gastrointestinal control, sleep mechanisms, hormone secretion, body temperature, and pain" (Pons, 2010, p. 64). They thus also regulate emotions, arousal as well as certain types of memory (Mele, Čarman-Kržan, Jurič, 2010). Though linked to melancholy, Depression differs from melancholy in that it describes experiences that are associated with "high levels of sadness, discomfort, loss of interest, mental confusion and alterations in the execution of daily activities" (p.6). Melancholy on its part however, relates to "longing or memories of the past, more accurately related to sadness of past time(s) 'that will not return' (p.6)" For a further understanding of the definition, refer also to Jiménez (2002). In this paper, depression is defined as a mental condition characterized by severe feelings of hopelessness and inadequacy, typically accompanied by a lack of energy and interest in life (TOED, 2008). Critical is that depression hinders one from operating normally.

Depressive disorder explains "persistent feeling of sadness and worthlessness, and a lack of desire to engage in formerly pleasurable activities" (Psychology Today, 2019). Other terms used for the depressive disorders include major depressive disorders (MDD), clinical depression (CD), major depression (MD), and unipolar depression (UD).

In relation to Hen's case, lack of knowledge on what is depression and its symptoms, led Tim and the mother, into deep lengthy moments of anguish. The close family members also joined in the suffering. There were moments when some spiritualized: what sins has the family committed that God is punishing you? For others, it was drenching in pity and uncertainty. Tim had to stop working to keep 24-hour watch over his father. Diagnosis from a general practitioner in one of the hospitals that the family visited was also wanting as he was diagnosed of cerebral malaria. Certainly, continued information on the part of health practitioners, and on the general public is needed. This would shed light on depressive disorders and other related ailments. This would also go a long way in avoiding the current quick labelling that individuals carry out on themselves and on their close colleagues, following some shallow contact with the internet.

Prevalence of Depressive Disorders

The World Mental Health Survey conducted in 17 countries found that on average of about 1 in 20 people reported having an episode of a depressive disorder in the previous year (2011) (WHO 2012, p. 6). Ishtiaq et, al., (2018) and Scholten, et al., (2016), rate depressive disorders among adults at between 5-20%. Globally, "over 300 million people are estimated to suffer from depressive disorders, equivalent to 4.4% of the world's population (WHO, 2017, p. 5)". Figure 1 presents the prevalence rates of depressive disorders per region.

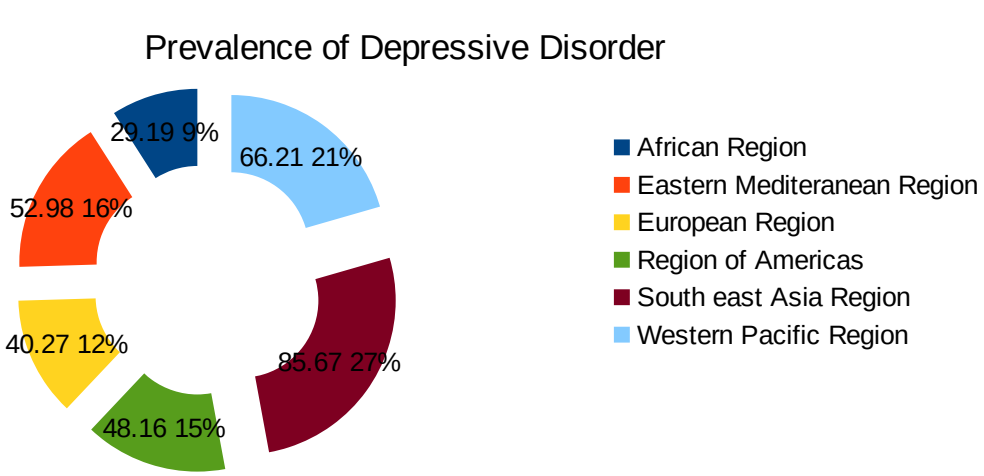


Figure 1: Prevalence of Depressive Disorders

The numbers given are both in population as well as in percentage. The first numbers represent the population of the depressive disorders in millions. The 29.19 number given for Africa, is actually 29,190,000 Africans. The percentage is in relation to the number of depressive disorder cases in the world.

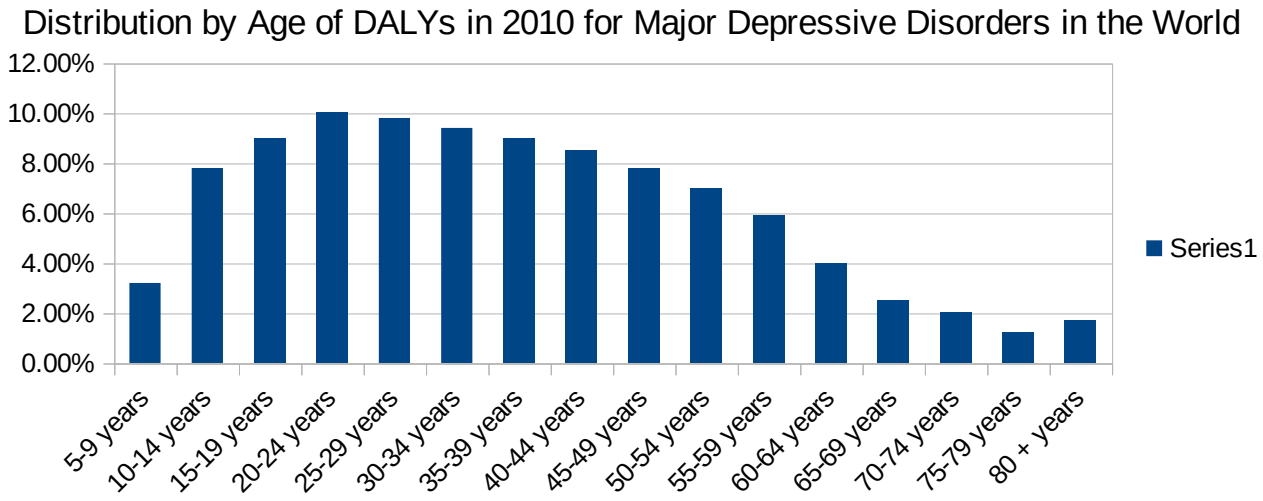
In Africa, the prevalence is at 9%, showing that it is low compared to other regions. However, it is noted that this region is heavily affected by poverty and other diseases (Elefia & Ben, 2019). Also, availability of health provisions is low compared to the developed world (Molyneux, Hotez, & Fenwick, 2005). In addition to these factors, illiteracy levels also allow low numbers of Africans seeking medical attention (Feinstein, Sabates, Anderson, Sorhaindo & Hammond, 2006). This means that cases of depression would easily go un-recorded. Therefore, despite the percentages of depressive disorders being low in Figure 1, the effect on individuals, amidst poverty, is burdensome in the region. Also, according to Outhoff (2019), studies on depression prevalence generate discrepancies indicating difficulties in accurate assessments. In addition, self-rated depression scales tend to give higher point prevalence than the clinical-rated. It is with this that increased awareness on the disorders play a significant role in improving mental health in Africa.

This information on the prevalence of Depressive disorders is significant. One in twenty people struggles with depression (WHO 2012). The statistics of these prevalence state that if a village has 400 people, 20 are struggling with depression, and if the number is 4000, then 200 are patients of depressive disorders. In relation to prevalence, between 10 and 49 years, the prevalence is at above 6%. Going by the 200 patients in a village of 4000 inhabitants, means that 12 X 8 = 96 of these will be between 10 and 49 years, the prime years of one's productivity. In all the ages, female is more prone to depressive disorders. Again, given the significant role played by mothers, renders depressive disorders a major contributor to the malfunctionality of families. This information is intended to oblige each one to pay more attention to the disorder. This means that at the individual and at the nuclear family level, preventive measures suggested in under interventions later in the study, need to be taken seriously. With the African state of health struggling at the levels of availability and affordability, preventive measures need to be highly embraced. These include among others relaxation and day to day social skills. For a comprehensive look at these measures look at the intervention section.

Distribution of Depressive Disorders by age

Depressive disorders generally affect persons of all ages. Important from researches conducted on the ailment, is the effect that depression has on the productive age

Figure 2: Depressive Disorders by Age

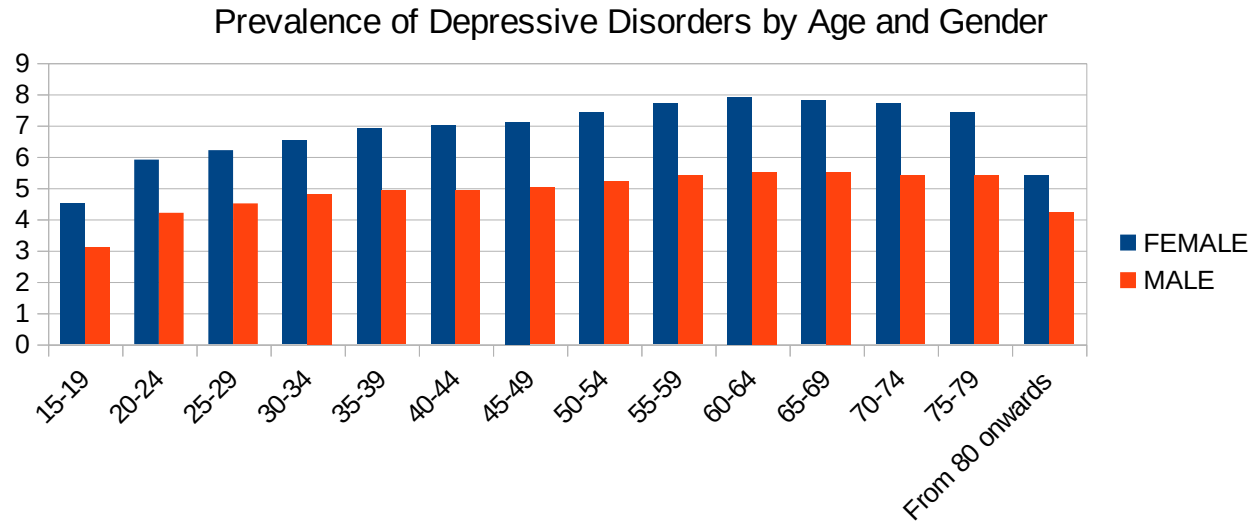


Source: Global Burden of Disease Study 2010 (GBD 2010) Results by Cause 1990-2010. Data downloaded from Institute for Health Metrics and Evaluation (IHME, 2013).

Distribution of Depressive Disorders by Age and Gender

The Global Burden of Diseases study (2015), gives data on prevalence, this time including age and gender.

Figure 3: Depressive Disorders by Gender and Age



Source: Global Burden of Disease Study 2015 (http://ghdx.healthdata.org/gbd-results-tool)
Regional data shown are age-standardized estimates.

Both Figures 2 and 3 present data on depressive disorders. However, Figure 2 shows that the peak is at 20-24 with 10%. Figure 3 shows that the peak is at 60-64 with females being at 7.9% while male is at 5.5%. Figure 2 also points to the young ages 10-49 as when depressive disorders are at their high. Figure 3 on the contrary presents ages 50-79 as when depressive disorders are high. From both reports, one can infer that, depressive disorders are generally high at almost all ages in youth and adulthood. Figure 3 gives additional information. Women are more prone to depressive disorders than men, as also supported by (Hammen, Henry & Daley, 2000). This is so at all ages.

Types of Depressive Disorders and Symptoms

According to the classification systems in ICD-10 (International Classification of Diseases, 10th ed.) (WHO, 2010) and the DSM-IV (Diagnostic and Statistical Manual of Mental Disorders, 4th ed.) (APA, 2000), there are two types of depressions.

(i) Depressive episode or otherwise referred to as single major depressive disorder involves symptoms such as depressed mood, loss of interest and enjoyment, and increased fatigability. It may be classified as a mild, moderate, or severe depressive episode, depending on the number of symptoms, the length of time the symptoms take, and the severity. The following are the notable symptoms related to depression:

Loss of	**Reduced**	**Feelings of**	**Others**
(i) weight	(i) energy/activity	(i) guilt	(i) marked tiredness
(ii) libido	(ii) capacity to enjoy	(ii) worthlessness	(ii) agitation
(iii) appetite	(iii) interest		(iii) disturbed sleep
(iv) interest in pleasurable things & feelings	(iv) concentration		(iv) unresponsive to circumstances
	(v) self-esteem		(v) low mood
	(vi) self-confidence		

Table 1: Symptoms of Depressive Episode
Adopted from Cesar and Chavoushi, 2013, p. 6.15-6.

These symptoms are divided into somatic and psychological

Somatic (affect the body) symptoms	**Psychological (affect the mind) symptoms**
Tired/fatigue	Feeling: depressed, sad, irritable, emotional /want to cry, worthless, anxious, nervous, fearful
No energy/listless (no enthusiasm)	Having poor memory, poor concentration, apathy, non-motivation, constant worry
Broken/decreased sleep	Having decreased interest in hobbies/friends
Changed appetite	Having unwelcome thoughts
Palpitations/feeling of increased heart beat	
Concomitant organic medical condition (e.g., backache, arthritis)	

Table 2: Somatic and Psychological Symptoms of Depressive Episode
Adopted from Tylee, et al., (1999). Refer also to Cesar and Chavoushi (2013, p. 6.15-6).

Added symptoms from Karl, (2002, pp. 6 & 7), include hopelessness, or emptiness, sleep problems (including sleeping too much, having trouble falling or staying asleep, or waking very early in the morning), weight loss or weight gain (due to changed appetite), restlessness/frustration, decision making, or mental slowing, feelings of excessive guilt, helplessness, decreased interest in interacting with others, recurring thoughts of death or dying, and thoughts of suicide or suicide attempts

Patients suffering from depressive disorders may find themselves waking up earlier than normal times, waking up in the morning several hours before the usual time. With this therefore, depression is noted as being at its worst in the mornings. In addition to these, Bruce (2021) has additional symptoms which include feeling sleepy during the day, weight gain, trouble making decisions and feelings of suicide.

At this juncture, it is important to pay attention to symptoms of depressive disorders. Had Tim and the mother been aware of the symptoms, and had the family been in discussion on health matters, the suicide attempts that Hen went through would have been avoided. The losses as a result of fire to their house would have been averted. Also, the threat to life, when Hen almost stabbed his son, would also have been prevented. At the individual level, it is important that one is aware of the symptoms. This will allow one to share on matters that may be going on in the individual and so seek early interventions.

(ii) ***Recurrent depressive disorder****:* This disorder is characterised by depressive episodes as described in (i). However, there is no history of independent episodes of mood elevation and increased energy (mania) (Cesar & Chavoushi, 2013). However, "brief episodes of mild mood elevation and over-activity (hypomania) may follow depressive episodes. Severe forms of recurrent depressive disorder are associated with manic-depressive depression, melancholia, vital depression and endogenous depression (p. 6.15-6)". Also, as per WHO (2017), this depressive disorder also called dysthymia tends to be less intense and lasts longer.

WHO also adds on another category, which they do not place under the two discussed depressive disorders. This is called anxiety disorders (AD). These are characterised by feelings of anxiety and fear, including generalised anxiety disorder (GAD), panic disorder (PD), phobias, social anxiety disorder (SAD), obsessive-compulsive disorder (OCD) and post-traumatic stress disorder (PTSD) (2017, p. 7).

With both depressive disorders and anxiety disorders, the effects can range from mild to severe. The duration of symptoms, as well as the severity or the intensity typically experienced by patients determine the level of the disorder.

Another classification of depressive disorders is given by Bruce (2021)

Type	***Explanation***
Anxious Distress	Feelings of tension and restlessness; Trouble concentrating due to thoughts of something awful may happen, or a feeling that you might lose control of self.
Melancholy	Feel sad and lose of interest in activities that one previously enjoyed; Feeling bad even when good things happen; Feeling particularly down in the mornings; Weight loss; Poor sleep; Suicidal thoughts; Lack of appetite.
Agitated	Feel constantly uneasy; Talk a lot; Fidgeting and pacing around; Act impulsively
Persistent Depressive Disorder (Dysthymia)	This entails a depression that lasts for 2 years or longer; Also describes dysthymia (hat lasts for 2 years or longer, it's called persistent depressive disorder. This term is used to describe dysthymia (low-grade persistent depression) and chronic major depression. Symptoms

	include: change in appetite (eating too much or too little), sleeping too much or too little, lack of energy/ fatigue, low self-esteem, trouble making decisions, feeling hopeless.
Bipolar Disorder/ Manic Depression	Having mood episodes that range from high energy (up mood) to low energy (depressive periods). When in low energy, symptoms are of major depression.
Seasonal Affective Disorder (SAD)	A period of major depression. In Europe it happens during the winter months. In Africa it may be when there is less sunlight.
Psychotic Depression	Exhibit symptoms of major depression along with "psychotic" symptoms, such as: Hallucinations (seeing or hearing things that are not there), delusions (false beliefs), and paranoia (wrongly believing that others are trying to harm you).
Peripartum Depression	Among women who experience major depression in the weeks and months immediately after childbirth. Approximately 1 in 10 men also experience depression in the peripartum period.
Premenstrual Dysphoric Disorder (PMDD)	Among women at the start of their period where they experience: mood swings, irritability, anxiety, trouble concentrating, fatigue, change in appetite, change in sleep patterns, and feelings of being overwhelmed.
Situational Depression	This is a depressed mood when having trouble managing a stressful life event such as death in the family, a divorce, or losing a job. Doctors also call it "stress response syndrome."
Atypical Depression	Contrary to the persistent sadness of typical depression. It is a "specifier" that describes a pattern of depressive symptoms. Positive event can temporarily improve your mood. Symptoms of atypical depression include: increased appetite, sleeping more than usual, feeling of heaviness in one's arms and legs, and oversensitivity to criticism.
Treatment Resistant Depression	It related to about 1/3 of people who fail to respond to depression treatment. The failure may be due to other conditions.

Table 3: Bruce's Classification of Depressive Disorders (Bruce, 2021).

Complementing the list from Bruce (2021), Cesar and Chavoushi (2013, p.6.15-6), state that depressive disorders are part of mood disorders that are further part of mental disorders. They classify the depressive disorders into three namely: "single major depressive disorder, recurrent major depressive disorder, dysthymia or as a depressive disorder not otherwise specified". The DSM V adds disruptive mood; dysregulation disorder, single and recurrent episodes; substance/medication-induced depressive disorder; depressive disorder due to another condition; other specified depressive disorder; and unspecified depressive disorder (APA, 2013). In this paper, the term depressive disorders shall be used to stand for any in the given list.

Not all feelings of low, qualify to be a depression. In general, major depression is when such low situations last for more than two weeks and interfere with regular daily activities (ADAA. 2016). When the condition lasts for at least two years, then it is called persistent depressive disorder (PDD). When the situation is characterised by shifts from severe highs (mania) or mild highs (hypomania) to severe lows (depression), then it is referred to as bipolar disorder (BD). Mania is often characterised by three or more of "abnormal or excessive elation, irritability, a decreased need for sleep, grandiose notions, increased talkativeness, racing thoughts, increased sexual desire, markedly increased energy,

poor judgment, and inappropriate social behaviour (ADAA, 2016)", as well as unrealistic belief in one's powers and abilities. On the contrary, depression would also be characterised experiences of five or more of the symptoms, lasting for most of the day, nearly every day, for a period of two weeks or longer (ADAA, 2016). The following insertion sheds more light:

> Five of the following features should be present most of the day, or nearly every day, for two weeks, representing a change of functioning (must include 1 or 2) [for one to be diagnosed as being clinically depressed]:
> 1. Depressed mood (feeling sad, empty, hopeless, tearful) nearly every day, for most of the day;
> 2. Marked loss of interest or pleasure in all or almost all activities;
> 3. Significant weight loss or gain (more than 5% change in 1 month) or an increase or decrease in appetite nearly every day;
> 4. Insomnia or hypersomnia nearly every day;
> 5. Observable psychomotor agitation or retardation;
> 6. Fatigue or loss of energy nearly every day;
> 7. Feelings of worthlessness or inappropriate or excessive guilt (not merely self-reproach about being sick);
> 8. Diminished ability to think or concentrate, or indecisiveness, either by subjective account or observed by others;
> 9. Recurrent thoughts of death (not just fear of dying), suicidal ideation, a suicide attempt, or a specific plan for committing suicide (Outhoff, 2019, p. 15, adapted from American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders, 5th Ed, May 2013); Cleare et al., 2015).

This section is not aimed at increasing easy quick diagnosis or labelling individuals on matters of depressive disorders. Rather, the individual as well as those living with him/her, need to be aware of the probable conditions that one may be going through. This should inform each on the steps to take as they seek professional interventions. It is worth noting that, it is the psychiatrist who is mandated with giving the appropriate official diagnosis in relation to mental illnesses and more so depressive disorders. However, this information should allow the persons around a patient, to have some information regarding their supposed patient.

Factors Contributing to Depressive Disorders

> In response to the question on the causes of depression, Karla (2002, pp. 12 & 3) states:
> Depression isn't "all in your head." It is not a sign of personal weakness, and it is not caused by laziness or a lack of willpower. It is a real illness with real causes. Some of these causes include biology, heredity, personality, and/or life experiences. Depressive disorders involve chemical changes in the brain. People with depression typically have too much or too little of certain brain chemicals, called "neurotransmitters." Whether these chemical changes are always the primary cause of depression or occur after someone becomes depressed is a question that has yet to be answered.

With this understanding, this section of the paper focuses on pscho-social factors that contribute to depressive disorders. According to NIHCE (2009) and Sabaté (2004), adverse life events, such as losses of a significant person, object, relationship or health, are seen as contributory factors to depression. However, they also note that depression can happen with no apparent cause. This section delves on factors contributing to depressive disorders.

(i) Personality

Among the factors that contribute to depressive disorders is personality. Personality is "the state of being a person; the characteristics and qualities that form a person's distinctive character; and the sum total of all the physical, mental, emotional, and social characteristics of a person... it's everything about you [a person] that make(s) you [the person] what [they] you are- a unique individual (Schultz & Schultz, 2017, p. 1)". Studies on personality are pegged on five parameters, also called the Five Factor Model (FFM):

Parameter	**Components**
Extraversion	Sociable, having positive energy, gregariousness (friendliness). Associated with positive emotionality (Markon et al., 2005)
Agreeableness	Empathic and having warmth towards others
Neuroticism	Ability to experience feelings of anxiety, irritability and depression. Associated with negative emotionality (Markon et al., 2005)
Conscientiousness	Organized and self-disciplined
Openness to experience	Having an interest in cultural events, being creative and holding non-traditional beliefs

Table 4: Five Factor Model by Tackett (2006, p. 586).

Personality differs from temperament in that the latter refers to "traits or characteristics that are biological in nature and appear very early in life" (Tackett, 2006, p. 584). Temperaments are therefore, observable in infancy and toddlerhood (Frick, 2004), and becomes a subset of personality. Personality on the other hand, develops as children progress cognitively and emotionally pegged on their interactions with the environment (Tackett, 2006). It involves ways in which persons learn to respond to experiences in more complex ways (Caspi, 2000; Shiver & Caspi, 2003). It is therefore, influenced by nature, nurture (upbringing), roles played (Kopytoff, 2005), gender (Oyewumi, 2005) and even culture (Calhoun, Gerteis, Moody, Plaff, & Virk, 2009). Personality is one's identity; sameness with oneself over a time (Kiingati, 2019).

Klein, Kotov, and Bufferd, (2011) state that both personality and temperament are dynamic constructs that develop though one's lifespan, changing with maturation and life situations (Fraley & Roberts, 2005, Rothbart & Bates 2006). With increased conscientiousness Neurotic negative emotions may reduce, paving way to more extraversive emotions (Roberts et al. 2006). Different environments therefore, influence initial dispositions (Caspi & Shiner 2006), so are the stressful events (Fraley & Roberts 2005, Kandler et al., 2010), as will be discussed under factors influencing depressive disorders.

In relation to personality and depressive disorders, six models emerge. In the presentation of the models, neuroticism is not only constantly mentioned, but is closely discussed as a representation of personality. This term which has its roots in Freudian theory and in the modern times associated with Hans Eysenck, features largely in psychophysiological and lexical studies (Eysenck & Eysenck, 1985; John, Robins, & Pervin, 2008; Mathews, Fox, Yiend, & Calder, 2003; Matthews, Deary, & Whiteman, 2003). Studies on the associations between neuroticism and anxiety, depression, substance abuse and psychological disturbances have also been largely carried out. Treatment and management of these factors, reduces neuroticism (Zinbarg, Uliaszek, & Adler, 2008). Additional studies also show that lifestyles that foster high neuroticism are linked to high stressful experiences (Hankin, Stone, & Wright, 2010; Kercher, Rapee, & Schniering, 2009; Middeldorp, Cath, Beem, Willemsen, & Boomsma, 2008). Neuroticism therefore, presents a broad understanding of personality and represents its apex (Ormel et al., 2013). In this study, it is noted as a highly significant factor in understanding the

relationship between personality and depressive disorders. Table 5 gives each model, what it is, and what it says about the relationship between MDD and Personality.

Model	**What it entails**	**Relationship between MDD & personality**
Stress-Vulnerability model i.e., stressful triggers influence symptomatic episodes; neuroticism sets in motion processes that lead to common mental disorders	It states that "genetic or biological predisposition to certain mental disorders exists and psychological and social factors can increase the likelihood of symptomatic episodes. (Journeypure Clarksville, 2019)". "Biological vulnerability and stress—are influenced by … factors (alcohol & drug use, medication use, coping skills, social support, & meaningful activities), [and] people have some control over (Behavioural Health Evolution, 2008, p. 2). It is a predisposition model: having a causal/etiological role (Clark, 2005; Ormel et al., 2013).	Personality features predispose a person to MDD i.e., high levels of neuroticism (an expansive personality trait dimension showing the degree to which a person experiences the world as distressing, threatening, and unsafe (Watson & Casillas, 2003)), tend towards high levels of MDD development
Pathoplasty model (also called pathoplastic model) i.e. personality influences somatic episodes	This model influences the manifestation of a later disorder rather than having a causal role (Clark, 2005). It helps shape the environment in such a way that a disorder is sustained (Clark, Watson & Mineka, 1994). In so doing, it becomes an exacerbating model in which a personality factor worsens a manifestation (Tackett, 2006). For it to be viable, it has to be assessed before the onset of a disorder, throughout the process and at the end. This makes it complicated (Tackett, 2006).	Personality affects the onset, severity and course of the MDD, including response to treatment i.e. high levels of neuroticism result in greater level of severity, chronicity of the MDD and to the more negative response to treatment.
Complication/ Scar model i.e. multiple depressive disorders permanently influence personality (neuroticism).	This model holds the premise that the development of psychopathology (especially of Axis 1 disorders: mood, anxiety, disruptive behaviour, substance use disorders (Crawford, Cohen, First, Skodol, Johnson, Kasen, 2008)) changes an individual's premorbid (attributes preceding the occurrence of a disease or disorder) personality. A comprehensive list of the five axes and related disorders, refer to Substance Abuse & Mental Health Services Administration. DSM-IV to DSM-5 Changes: Overview. DSM-5 Changes: Implications for Child Serious Emotional Disturbance. https://www.ncbi.nlm.nih.gov/books/NBK519711/.	When multiple depressive disorders occur, an individual's neuroticism increases (Tackett, 2006). MDD has a permanent effect on personality change.
State model i.e. multiple depressive disorders temporarily influence personality (neuroticism).	Sharing its position with the Scar model, it states that neuroticism is shaped by common mental disorders. However, while in the Scar model the episode of the common disorder model has permanent effect, in the State model, the effect is temporary; is there at a time and state, then disappears (Ormel, et al., 2013)	MDD has a temporal effect on personality change.
Spectrum model i.e. personality & psychopathology are in a continuum	The model "states that personality traits and manifestations of psychopathology lie on a continuum (or, continua) such that the relationship between personality and psychopathology is dimensional. A[n]... example of this model is the "schizophrenia spectrum" of disorders: Schizophrenia, Schizotypal Personality Disorder, and Paranoid Personality Disorder, which are often described as differing manifestations of a common aetiology (Tackett, 2006, p. 588). Also refer to Nicolson et al., (2003).	There is a continuum involving pathological processes: mild-moderate-severe and this continuum is also present with personality i.e. (i) Normative personality-normal process (ii) Psychopathology-pathological process
Common cause/ Shared cause/ Liability/ Factor model i.e. personality and psychopathology (MDD) have similar	The model predicts that "depression and personality are distinct entities, but share common etiopathogenetic mechanisms. However, there are no causal influences between both entities in this specific model...[i.e.] patients frequently present with depression and personality dysfunction, because both problems have the same or similar causal influences, but	Shared etiological factors give rise to both personality and MDD... In that line, neuroticism and common mental disorders share the same genetic and environmental determinants (Ormel et al., 2013, p.

causal influences.	a patient's depression is not caused by his or her personality problems" (Bahn, Herpertz & Krause, 2018, p. 3). MDD and BPD will often present together (p. 4). Hence, "patients suffering from BPD will often present with depression, because the personality dysfunctions in functional domains underlying BPD elevates the risk for depressive symptoms (e.g., interpersonal rejection sensitivity outpatients at risk for depressive reactions to real or perceived abandonment)" (p.8).	687).

Table 5: Model of Personality

The six models show some association between personality and MDD. It is however, not unanimously agreed what is the stimulant and what is the result. The position of this present study is that for there to be a clear understanding of depressive disorders, there needs to be an involvement of personality, as well as social factors. It is with this that this study seeks to understand depressive disorders in the light of psychosocial interventions.

Still on personality, The APA (1994), speaks of personality disorders (PDs). An individual is rated as struggling with PD when 5 of the following traits are noted:

> mood [is] dominated by dejection, gloominess, cheerlessness, joylessness, and unhappiness; self-concept centres around beliefs of inadequacy, worthlessness, and low self-esteem; critical, blaming, and derogatory toward self; brooding and given to worry; negativistic, critical, and judgmental toward others; pessimistic; and prone to feeling guilty or remorseful (Bagby, Quilty & Ryder, 2008, p. 15).

Three PD categories are given under the A (paranoid, schizoid, and schizotypal), B (antisocial, borderline, histrionic, and narcissistic), and C (avoidant, dependent, obsessive, and compulsive) (Bagby, Quilty & Ryder, 2008). Individuals with MDDs show high elevation of PDs. This understanding of personality shows that it is core in understanding depression.

(ii) Life events

Scholars show an association between stressful life events and depression. Among notable life events are failed relationships, high expectations in career, education and business, financial hardships, failed marriages and even illnesses (Chania, G. quoted in Wainaina, 2021). Other factors include loss, especially that of a spouse (Kiingati, 2019b), unemployment, and even divorce. There is also a high association between stress and depressive disorders (Hammen, 2005). For an elucidation of the life events, unemployment, loss and insecurities are singled out. Professional related factors, health conditions and dependency are all discussed as separate entities.

Unemployment is a concern in the world but more so in the developing world. In Africa, "[her] youth unemployment rate is the lowest in the world" (ILO, 2020). Statistics reveal four parameters of unemployment:(i) gender; (ii) not in employment, education or in training (NEET); (iii) youth employment rate (iv) labour underutilization (LUZ) (ILO, 2020;), is looked at as a dividend awaiting tapping. For that to happen, "an appropriate and customised mix of pro-employment policies and programmes at macro, sectoral and labour market levels with a strong emphasis on the demand side support for structural transformation while paying attention to disadvantaged groups in the labour market" (p. 3) is needed.

Unemployment is significantly related to depressive disorders due to various reasons. The first is that an idle mind is the devil's workshop. When one is idle, not only do they feel undervalued, but they also feel unappreciated (Kolade, 2016). Idleness is related to unproductivity (Brodsky & Amabile, 2017) and to feelings of unworthiness, thus affecting the mental health of the unemployed (Farré, Fasani, & Hannes, 2018)). The lack of productivity leads to a summation of poverty (Vandenberg, 2004) and to the widening of the gap between the rich and the poor, as well as the increase in antisocial behaviour leading to societal conflict (Narayan Pritchett & Kapoor, 2009). These factors contribute to psychopathology.

Loss, in general influences one's psychological state. Loss of spouse is ranked among the leading life events that are highly associated with depressive disorders (Kiingati, 2019a, p.xxx). This author states that, "widows suffer a 'psycho-pathological state' representing the epitome of women's marginalization". This point is also supported by Matlin (2004). Schaal, Dusingizemungu, Nadja and Elbert (2011), discuss African women in Rwanda. They concentrate on Post Traumatic Stress Disorders of women in war torn areas. While the focus of these authors is on women, loss of spouse in general amounts to psycho-pathology. It is therefore a notable concern when addressing depression within psychosocial parameters. Other notable losses that contribute to psycho-pathology include job insecurities among them loss of occupation and income (Anderson, McDaid, Basu, & Stuckler, 2011), of spouse (divorce and widowhood) (Araújo, & Lima, 2016; Vijay, 2010), and of property (WHO 2014).

Insecurities are also linked to psychological issues (Shim & Compton, 2020). In figure one (p.27), they single out insecurities emanating from homelessness, housing instability, food and transportation insecurities, poor access to health care, discrimination, adverse early life experiences, exposure to violence, and conflict, interaction with the criminal justice system, neighbourhood disorder, pollution and climate change, as key insecurities. They also add low education, unemployment, underemployment, poverty, income, inequality, area-level poverty, adverse features of the built environment, as other insecurities. These are founded on poor public policies and social norms. In turn, they lead to reduced options (poor choices), behavioural risk factors, physiologic stress responses and finally to psychological stress. According to World health Organization (2014, p. 9), "Certain population subgroups are at higher risk of mental disorders because of greater exposure and vulnerability to unfavourable social, economic, and environmental circumstances, interrelated with gender." With this therefore, insecurities contribute towards mental challenges among them depressive disorders.

(iii) Professionalism

Professionalism refers to expectations of work performance, targeting skills and competencies, as well as attitudes geared towards ethics, autonomy, responsibility, mutual respect, experiential knowledge, altruism, the development of professional identity, and commitment to a particular body of knowledge, aimed at dealing with world problems and for the benefit of self and of others (Araugo & Beal, 2013). Professionalism therefore gives purpose, financial muscle as well as social status to the individual professional. Due to its stakes, professionalism is highly linked to mental wellness. In this sub-section, the discussion brings to play four professions namely: educators, emergency response providers and faith-based ministers, as well as medical practitioners. The first three professions have a direct role in behavioural formation and sustenance, while the last profession is the domain within which mental health falls. For these reasons they have been selected for this study.

Educators: The term educator is in this paper, synonymous to teacher. However, it goes beyond instructing, to refer to one who brings content alive through commitment and passion. On this note

then, educating becomes a calling that amplifies the voices, desires and dreams of the learners (Suckstein, 2016). Educating has been associated with value, making it a noble profession (Gorsy, Panwar & Kumar, 2015). This profession is however, endowed with the task of enhancing learners' integral well-being and mental health (House of Commons, 2017). This mandates the educators with the task to teach learners how to be well and to do well (Morris, 2015). In this task, educators need to help the learners detect challenges related to mental health, have proper diagnosis, seek the called-for, prompt professional assistance and avoid label-related stigma (Vieira et al, 2014; Catalina, 2020). It is worth noting that some learners have low levels of mental health leading them to experience problematic behaviour and have unsatisfactory outcomes (Feinstein, 2015). it is with this that teachers are tasked with the learners' integral wellness (WHO, 2018).

Educators have an almost daily interaction with learners and therefore, have a large and long-lasting impact on the growing minds (Moor et al., 2007). Nevertheless, as they nurture the learners' social skills, peer relational competencies, as well as performance abilities (Pianta and Stulhman, 2004), they also are prone to mental challenges. Kaur (2007), addressing occupational stress, mental health and coping resources concentrates on teachers. He sees the stressors as emanating from their work and interactions with learners. He reiterates the importance of assisting teachers cope with their tasks, as a way of helping them and the learners experience wellness. Others who address teachers' mental wellness, link it to burnout (Srivatsava & Khan, 2008), personality (Srivatsava, 2003), locality:urban or rural (Kumar, 2013), and to childhood experiences as well as cultural influences (Kroeger & Bauer, 2004). Overlooking teachers' mental wellness could lead to vices such as alcoholism (Rukundo, 2013), abusive relationships between educators and learners (McEachern, Kenny & Aluede, 2013), school unrests (Daniels & Strauss, 2010; Greenberg, Brown, & Abenavoli, 2016; Cipriano, 2020) and even learner and/or educator suicide (Substance Abuse and Mental Health Services Administration, 2012).

In addition to the learners and teachers, the integral staff team is also considered (Morris, 2015). Morris lays emphasis on the entire staff community at school stating that the mental health of all in the school is significant in ensuring a healthy learning atmosphere. Atkins and colleagues (2010), adding to the discourse, includes the wellness of the parents and guardians of the learners. In this integral context therefore, the learner is part of a larger community, whose integral wellness is sought. The second profession that is looked at is that of emergency response providers.

Emergency Response Providers have been on record falling prey to depressive disorders (SAMHSA, 2018). These providers include emergency medical services, firefighters and police officers. It entails all those mandated with public safety including their related personnel, agencies and authorities (Domestic Security, 2010). These responders face challenging, dangerous and draining situations as they attempt to rescue and provide physical and emotional support. They therefore, face increased risk of trauma and are prone to depression and suicide (Stanley, et al., 2016; Badge of life, 2016). They also face death and safety threats, grief, injury, pain, loss, long hours of work, frequent and longer shift hours, poor sleep, physical hardships, and other negative experiences (Botha, Gwin, & Purpora, 2015; Heavey et al., 2015; Marmar et al., 2006; Patterson et al., 2012; Quevillon, Gray, Erickson, Gonzalez, & Jacobs, 2016). Table 6 gives a summary of selected scholarly works on depression related issues among emergency response providers.

Table 6. Scholarly Works on Depression-related issues among Emergency Response Providers

	Emergency Medical Services Personnel	Fire Fighters	Police Officers
Behavioural and health issues affecting the ERPs	Bentley et al., 2013: lack of adequate time to recover after/between traumatic events	Stanley, I. H., Boffa, J. W., Hom, M. A., Kimbrel, N. A., & Joiner, T. E., 2017: stigma, cost & resources for care, time off from work.	Moad, 2011: critical incidents, environmental hazards, and traumatic events
Depression	Bentley et al., 2013; Garbern, Ebbeling, & Bartels, 2016; Pajonk, Cransac, Muller, Teichmann, & Meyer, 2012.	Stanley, I. H., Boffa, J. W., Hom, M. A., Kimbrel, N. A., & Joiner, T. E., (2017); Haddock, Poston, Jahnke, & Jitnarin, (2017).	Bowler et al., 2016
Stress and Post-Traumatic Stress Disorder & symptoms	Marmar et al., 2006; Pajonk, Cransac, Muller, Teichmann, & Meyer, 2012; Bentley et al., 2013; Botha, Gwin, & Purpora, 2015; Benedek, Fullerton, & Ursano, 2007.	Dowdall-Thomae, Gilkey, Larson, & Arend-Hicks, 2012; Marks, Bowers, DePesa, Trachik, Deavers, James, 2017; N.F.P.A., 2012; Benedek, Fullerton, & Ursano, 2007 (includes the military).	Aumiller, G. & Goldfarb, D., 2011; Solomon, 2011; McCanlies, Mnatsakanova, Andrew, Burchfiel, & Violanti, 2014; Bowler et al., 2016.
Substance Use and Abuse	Kenna, & Wood, 2005; Kenna, & Lewis, 2008.	Stanley, Boffa, Hom, Kimbrel, & Joiner, 2017; Haddock, Poston, Jahnke, & Jitnarin, 2017; Jahnke, Poston, Haddock, Jitnarin, Hyder, Horvath, 2012); Jahnke, Poston, Haddock, Jitnarin, Hyder, & Horvath, 2012).	McCanlies, Mnatsakanova, Andrew, Burchfiel, & Violanti, 2014.
Suicide & Suicide Ideation	Stanley, Hom, Hagan, & Joiner, 2015; Stanley, Hom, & Joiner, 2016; Stanley, Boffa, Hom, Kimbrel, & Joiner, 2017.	Stanley, Hom, Hagan, & Joiner, 2015; Stanley, Hom, & Joiner, 2016; Boffa, Stanley, Hom, Norr, Joiner, & Schmidt, 2017.	Fleischmann et al., 2016; Stanley, Hom, & Joiner, 2016; U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, 2016; Violanti, Robinson, & Shen, 2013; Bishopp & Boots, 2014.

With this background therefore, the following questions appear: What factors relating to emergency response responders contribute towards their vulnerability in relation to depressive disorders? How can the emergency response personnel be facilitated to protect them from falling prey to depressive disorders? What needs to be done to help the emergency response personnel deal positively with depressive disorders? What needs to be done to promote mental health among emergency response personnel?

Before dealing with significant relational issues that affect emergency responders and the training they go through, two key terms that are frequent in the day-to day works of the responders, namely disaster and hazard are given. Disaster refers to any serious disruption of societal functioning leading to widespread human, material and environmental loss. The disruption strains existing response resources thus calling for external assistance (International Federation of Red Cross and Red Crescent Societies, 2000). On its part, hazard refers to

> the potential occurrence, in a specific time period and geographic area, of a natural phenomenon that may adversely affect human life, property or activity to the extent of causing a disaster. A hazard occurrence (the earthquake, the flood, or the cyclone, for example) becomes a disaster when it results in injuries, loss of life and livelihoods, displacement and homelessness and/or destruction and damage to infrastructure and property (IFRCRCS, 2000, p. 7).

For the responders to adequately deal with disasters and hazards, training is key. This training refers to a clear understanding the types of disasters, how they occur, and the consequences they have for society (UN/ISDR & UN/OCHA, (2008). In addition, disaster preparedness focuses on assessing the effect of the disaster, recommending means to control it and ways to provide support (UN/ISDR & UN/OCHA, (2008). This is informed by the seriousness of the emergency as indicated in Table 7.

Table 7: Risk Assessment; Seriousness of Emergency = Impact X Likelihood

	Negligence	**Minor**	**Moderate**	**Severe**	**Critical**
Very Unlikely	1	2	3	4	5
Unlikely	2	4	6	8	10
Moderately Likely	3	6	9	12	15
Likely	4	8	12	16	20
Very Likely	5	10	15	20	25

Adopted from Inter-Agency Standing Committee (2015, p. 35)

Advanced Preparedness Actions (APAs) helps in enabling and ensuring high level readiness to respond to risks, which in turn lowers the levels of risk on the emergency responders. For each of the emergencies, the responders are well informed thus enhancing their preparedness. This contributes to their resilience which in turn works positively towards minimising trauma. However, this does not entirely remove the psychological risks and subsequent depression among responders, hence the need for continued information on emergency response personnel and depression.

In addition to the stipulated challenges, emergency responders especially security officers fall prey to attacks from criminals (FBI, 2011; Bierie, et al., 2013; Covington, et al., 2014; Bierie, 2015), face inter-relational challenges among other emergency responders, have critical decisions to make, face continued exposure to citizens in pain or distress, are exposed to possible deaths, and sometimes undergo boredom and inactivity (Dowler, 2005; Agolla, 2009; Shane, 2010). These factors coupled with family life challenges, contribute to depressive disorders among emergency response providers (Leino et al., 2011 (a); Leino et al., 2011(b)).

Medical practitioners are looked at as successful life models. Yet, these practitioners are also on record struggling with depressive disorders, "Recent meta-analyses of global studies estimate an overall prevalence of 27% in medical students, 29% in registrars and up to 60% in practising doctors" (Outhoff, 2019, p. 13. Also refer to Bailey, Robinson & McCorry, 2018; Gerada, 2018). By and large, medical practitioners fall into the category of emergency responders and so share the challenges discussed prior. Additional circumstances contributing to medical practitioners' proneness to stress include: "long hours (of/at work), extensive workloads, (...) growing intensity and complexity of the job, relentless contact with patient ill health and emergencies, high levels of responsibility, rapid change within healthcare, institutional constraints such as discrimination and intimidation, lack of autonomy, low levels of support, loss of job satisfaction, low morale and the inability to attend to their personal lives" (Outhoff, 2019, pp. 13/4. Also refer to Bailey et al., 2018; Naidoo, 2018). In addition,

there are reports on high alcohol use/abuse among medical practitioners, as well as self-medication (Lebares, Guvva, Ascher, O'Sullivan, Harris, Epel, 2018). Another realization informs medical practitioners that "doctors are vulnerable to depression. Yet they seek treatment less frequently and die by suicide more than the general population" (Outhoff, 2019, p. 16; Middleton, 2008). These factors have a positive co-relation with depressive disorders. There is an appeal to medical practitioners to be more aware of depression and of its early signs (Glass, 2003).

Faith based leaders are also prone to depressive disorders. Priests and pastors encounter clients with challenging psychological issues (Murambidzi, 2016). Such issues include deaths and bereavement, family-marital challenges, and drug abuse (DeRienzia, 2016) of their congregants and of their family members. They too go through intense depressive moments as they go through sickness and imminent deaths; Jesus went through it in the Garden of Gethsemane (Mk 13:34: "My soul is overwhelmed with sorrow to the point of death") For some versions, "he is deeply depressed". In addition to own depressing challenges, like with the medical practitioners, faith-based leaders, also struggle with depressive disorders due to societal expectations on who the pastor is and is meant to be (Robertson, 2011). The following are among the identified causes of depression among pastors according to DeRienzia, (2016, p. 38), loneliness, trouble getting along with one's wife or husband, demonic influence, drinking too much (alcohol), lack of religious belief, not enough will power, lack of self-control, trouble adjusting on the job, stress, excessive drug use, self-pleasure [seeking], learned habits towards depression, inherited depression, a run-down physical condition, and sex habits. Together with other helping professions such as teaching, the individuals are prone to burnout (Warner, 2009). Awareness on the part of the pastor is significant in dealing with the challenge. It is recommended that following the awareness, pastors seek continued self-care and where necessary, professional interventions that are geared towards mental health care.

This section has singled out four professions; educators, emergency responders, medical practitioners (doctors), and faith-based leaders. This is because the selected areas are noted as high risk, due to the levels of stress associated with the interventions. Certainly, individuals linked to different other professional areas may also be at high risk depending on their everyday interactions and job requirements. It is hoped that through increased awareness irrespective of areas of operations and conditions, more persons shall seek mental health care. The next part looks at health related conditions as factors that contribute to depressive disorders.

(iv) Health related conditions

In this section the study focuses on the association between depressive disorders and chronic illnesses, and disabilities.

Addressing the relation with chronic illnesses, the work of Li, Ge, Greene and Dunbar-Jacob (2019), is significant. The authors state that depression is a "common comorbidity among patients who experience chronic diseases, such as cancer, stroke, heart disease, diabetes, and chronic obstructive pulmonary disease" (p. 117). Of interest is their "integrated review of the literature on the prevalence of depression among patients with chronic diseases in China and the United States and its relationship to poorer health outcomes" (p. 117). They address six chronic illnesses namely Cancer, Stroke, Heart Disease, Diabetes and Chronic Obstructive Pulmonary Disease (COPD).

While addressing this relationship, it is worth noting that depression is ranked the largest cause of non-fatal health loss (WHO, 2017). Therefore, the presence of chronic illnesses and depression among a people, is severe. In United States of America, chronic illnesses together with accidents and

suicide account for over 74% of deaths (Xu, et al., 2015), while in Europe and China chronic illnesses account for 77% (majorly heart disease, stroke, cancer) and 86.6% mortality, respectively (Mladovsky, Allin, Masseria, Hernández-Quevedo, McDaid, & Mossialos, 2009; National Health and Family Planning Commission of the PRC. (2015).

The burden is certainly larger in Africa, which still struggles with over 69% of deaths linked to infectious diseases (Young, Critchley, Johnstone, Unwin, 2009). This means that an added burden from chronic illnesses is almost insurmountable, with little or no policies at all (Alwan, Maclean, Mandil, 2001). Nevertheless, studies such as that by BeLue, Okoror, Iwelunmor, Taylor, Degboe, Agyemang and Ogedegbe (2009) point to the need to explore such studies, as they shed light on the increasing risk of cardiovascular disease (CVD), diabetes and within the presented risk of developing active tuberculosis (de-Graft, Aikins, Unwin, Agyemang, Allotey, Campbell, & Arhinful, 2010).

Adding to the complication is poverty, amidst cryptic emotional conflict and breakdown, realised in marital and intimate relationships, as well as in family abandonment (de-Graft, 2005; 2006), as well as stigma associated with "physical chronic conditions such as diabetes, cancers and epilepsy and mental illnesses like schizophrenia and psychosis" (de-Graft, 2010, p. 3; also refer to Alwan, Maclean & Mandil, 2001; Allotey, Reidpath, 2007). Other depressive disorder related issues linked to chronic illnesses include interrupted social identities (Bury, 1982), asthma, cancer, diabetes and sickle-cell anaemia linked to depression (Green, Greenblatt, Plit, Jones, & Adam, 2001; Ohaeri, Shokunbi, Akinlade, Dare, 1995; Ohaeri, Campbell, Ilesanmil, Ohaeri, 1998), 'chronic unhappiness' [Ellis, 1996), spiritual distress (Ohaeri, Shokunbi, Akinlade, Dare, 1995), psychiatric disturbances (Ebigbo, Oli, 1985), and suicidal ideation (Ohaeri, Shokunbi, Akinlade, Dare, 1995). These realities point to the complexity brought about by a combination of the depressive disorders and chronic illnesses. While there are notable efforts in some countries in Sub-Saharan Africa (Campbell, 2000), more needs to be done on policy, fiscal planning, and community inclusivity on matters health.

The second concern of this sub-section is the association between depressive disorders and disability. In relation to disabilities and depressive disorders, Karl, (2002, p.3), notes that

> not everyone with a disability becomes depressed, and those who do become depressed may not be depressed because of their disability. However, people with disabilities face unique challenges and stresses which place them at increased risk for depression...symptoms of depression may be 2 to 10 times more common in individuals with disabilities or chronic illnesses, and depression is one of the most common 'secondary conditions' associated with disability and chronic illness.

The relationship between depression and disability is complex. This is because it is also often linked to chronic diseases as well as chronically painful conditions (Von Korff, Ormel, Katon & Lin, 1992). Also, the direction of nature and the direction of causality is unclear in relation to depressive disorders – disability – chronic illness. The same scholars also point to a theory of synchrony since there appears to be a strong co-relation involving the three.

In Africa, there is hardly any literature linking disability and depressive disorders. There appears to be a focus on communicable and non-communicable diseases (Abas, Ali, Nakimuli-Mpungu, Chibanda, 2014; Bernard, Dabis, de Rekeneire, 2017) as well as poverty and health (Duthé, Rossier, Bonnet, Soura, & Corker, 2016). Nevertheless, Pandey, Vani and Raghav (2018) focussing on South Africa, shed light on aging, depression, non-communicable diseases, and depression. Their emphasis is however, on the aged and on the disability that is brought about by age. They bring to play

psycho-social factors that are linked to depression among the aged: marriage, affluence, trust in community and familiar neighbourhoods. Their appeal is for further investment on health.

Further work is by Sankoh, Sevalie and Weston (2018). They give the following statistics, "Between 2000 and 2015 the continent's population grew by 49%, yet the number of years lost to disability as a result of mental and substance use disorders increased by 52%. In 2015, 17·9 million years were lost to disability as a consequence of mental health problems" (p. e954). Their goal is to inform policy.

Certainly, there is need to further explore this area in Africa. The essence currently is to borrow from European studies, on the realization that that disability, depressive disorders and chronic illnesses are closely linked (Von Korff, Ormel, Katon & Lin, 1992). In Africa, the challenge is also aggravated by poverty and ignorance. The poorly developed health conditions call for improved policy and further investment. The other notable factor contributing to depressive disorders is substance abuse.

(v) Substance Abuse

Contributing to the discourse, Ziedonis, Farren and George (1998) discuss alcohol, cocaine and cigarettes noting that there is poor prognosis and response to treatment on depression among takers of these substances. Their position is supported by Sharma (2013), who notes that "a person who is suffering from depression may feel hopeless, lonely and distractable and gradually plunge[s] into drug abuse and vice versa" (p. 96). Another study by Behavioral Health Evolution (2008), states that drugs increase one's pre-existing biological vulnerability to psychiatric disorders where substance use triggers psychiatric disorders.

Factors linking substance abuse to depressive disorders according to Sharma (2013, pp. 96-7) indicate that those engaged in the latter are likely to have delayed diagnosis (Albanese, Clodfelter, Pardo, Ghaemi, 2006), more severe psychopathological symptoms (Ringen et al. 2008), less compliance with treatment (Verheul, Van den, Hartgers, 1998), poorer effects of treatment (Torrens, Fonseca, Mateu, Farre, 2005), more impairment of social functioning (Mazza, Mandelli, Di, Harnic, Catalano, Tedeschi, 2009), increased admissions to emergency department (Curran, et al., 2003), higher prevalence of physical comorbidity (Rosenberg, Drake, Brunette, Wolford, Marsh, 2005) , and suicidal ideation (Cottler, Campbell, Krishna, Cunnigham-William, Abdallah, 2005). They are often unemployed (Fergusson, Horwood, Lynskey, 1997), and homeless (Caton, Shrout, Eagle, Opler, Felix, Dominguez, 1994). They are also involved in violent episodes (Elbogen, & Johnson, 2009), or criminal activities (Goldstein, & Levitt, 2008), and indulged in alcohol dependence (Pradhan, Adhikary, & Sharma, 2008). These factors render them more susceptible to depressive disorders.

Specifying on alcohol, Ziedonis, Farren and George (1998) note that its abuse and dependence in relation to depression, affects women (20% & 49%) more than the way it affects men (9% & 24%). Further on, the scholars note a link between neurotransmitters (serotonin and neropinephrine) interacting with dopamine as contributing to depression.

They note that cigarettes are highly associated with Major Depression and with other Depressive Disorders; those who smoke are three times more likely to face depression, more than those who do not (p. 32). Adding to cigarettes and alcohol, they (Ziedonis, Farren and George, 1998) also bring on board cocaine where they realise that 10-30% of cocaine disorders are associated with depressive disorders.

An added substance is cannabis. This substance is rated as the most widely used illicit substance in the world (European Monitoring Centre for Drugs & Drug Addiction, 2011; United Nations Office

on Drugs and Crime, 2011). In relation to the issue of Depressive Disorders, LevRan, et al., (2013), point to the DD's strong association with cannabis intake. This position is supported by Moore et al., (2007).

From the studies, "depressive disorder is frequently found as a comorbidity among patients with substance abuse" (Sharma, 2013, p. 96). This presence points to substance abuse being a condition that appears to facilitate depressive disorders. With the continued increase in substance abuse, it is recommended that correct interventions be put in place, to curb the subsequent increase in mental health challenges. Having looked at five factors contributing to depressive disorders: personality, life events, professionalism, health related conditions and substance abuse, the following section brings together the effects of depressive disorders. These effects have been discussed in prior subsections and this part offers a synthesis.

In relation to Hen's condition, his personality (quiet, introspective and thorough in his undertakings), life events (having been in the military and having been from a foreign country), professionalism, health related conditions (his ageing state), could have aggravated his getting into depression. He was not abusing any substances and he was already retired, though earlier on he did serve in the military. In his retirement, he was serving as a catechist and was also involved in offering guidance to young married couples. Could these situations have led him into unconsciously experiencing burnout? Among his duties was to ring the morning bell for the morning Mass, a duty that he did come rain come sunshine. Evidently, he had no rest or even a break at all. This lifestyle, gives information on contributory factors that could have led Hen towards depression. This section on factors that may lead towards depressive disorders sheds light on precautions that individuals, families and even employers need to take to safe-guard their staff. There should be moments of debriefing for those whose jobs entail deep emotional states. All persons, irrespective of their engagements, need moments of rest. Also, as staff age, it is important that increased psychological care is availed. These preventive measures would go a long way in minimizing cases of depressive disorders.

Effects of Depressive Disorders

Depressive disorders lead to a notable reduction of functioning. It is thus noted as "the leading cause of disability worldwide in terms of total years lost due to disability" (WHO, 2012, p. 6). In the classification of depressive disorders, Bruce (2021) lists the effects as: Feelings of tension and restlessness; trouble concentrating due to thoughts of something awful may happen, feeling that one might lose control of self; feeling sad and loss of interest in activities that one previously enjoyed; feeling bad even when good things happen; feeling particularly down in the mornings; weight loss; poor sleep (sleeping too much or too little); suicidal thoughts; change in appetite (eating too much or too little); feeling constantly uneasy; talking a lot; fidgeting and pacing around; acting impulsively; lack of energy/ fatigue, low self-esteem, trouble making decisions, feeling hopeless; having mood episodes that range from high energy (up mood) to low energy (depressive periods); hallucinations (seeing or hearing things that are not there), delusions (false beliefs), and paranoia (wrongly believing that others are trying to harm you); mood swings, irritability, anxiety, trouble concentrating, fatigue, and feelings of being overwhelmed.

Also, Tylee et al., (1999) as well as Cesar and Chavoushi (2013), give the somatic as well as the psychological effects related to each category. In addition to what is in Bruce (2021), they add palpitations/ feelings of increased heartbeat, and concomitant organic medical condition (e.g. backache, arthritis). They also have reduced self-esteem and self-confidence as well as being unresponsive to circumstances. Others include wanting to cry, apathy, non-motivation, having decreased interest in hobbies/friends, and finally having unwelcome thoughts. These lists may appear repetitive due to the

different synonyms used for similar feelings. Notable is that depressive disorders may lead to suicide, "Almost 1 million lives are lost yearly due to suicide, which translates to 3000 suicide deaths every day. For every person who completes a suicide, 20 or more may attempt to end his or her life" (WHO, 2012, p. 6). This shall be further discussed towards the end of the paper.

Hen almost committed suicide. He not only attempted to set the house on fire while inside, but he attempted suicide through taking poison, drowning and even hanging himself. These attempts left many onlookers surprised and even worried of the ending of such a man who had lived a pious life. This informs persons of wavy faith, to be weary of depressive disorders and not to jump into quick conclusions in cases of suicide. This also warns on stigma and cautions those who speedily spiritualize matters of mental health. Like any other severe condition, proper steps need to be taken in the diagnosis, that is to be done by the appropriate professionals. In addition, psychosocial interventions need to accompany pharmaco-interventions, so that together depressive disorder cases are contained and recovery effected. Even before these curative measures, it is important that preventive interventions to enhance wellness, are embraced.

Interventions towards Preventive Measures and Lowered Depressive Disorders

(i) *Reduction of Risk*. Behavioural Health Evolution (2008) singles out three factors, also called coping skills aimed at proactively reducing the chances of getting depressive disorders and/or reducing the negative effects of vulnerability to depressive disorders. These are (a) relaxation skills for dealing with stress and tension; (b) social skills for connecting with people, dealing with conflict, and getting support; (c) coping skills for managing persistent symptoms such as depression, anxiety, and sleeping problems (p. 3). They also refer to other coping skills under the title involvement in meaningful activities. These include involvement in work, school, parenting or other caregiving responsibilities, as well as home-making (p.3). Therefore, training/school-based programs targeting cognitive, problem-solving and social skills for children and adolescents, as well as exercise programs for the elderly, are beneficial preventive interventions towards the reduction of vulnerability to depressive disorders. Table 8 elaborates each, giving reading sources for each.

Major task	**Sub-task**	**Activity elaboration & Conclusions**	**Source**
Relaxation skills to deal with stress & tension	Relaxation	Exercises are associated with risk reduction from coronary heart disease, stroke & obesity. Persons not engaged in physical exercises have twice as much chances of getting Clinical Depression than those who do. Physical exercises, including aerobics and resistant exercises, decrease the risk of developing depressive disorders and are also effective in treating the disorders.	AliAsghari, Sohrabi, & Masuodi (2012).
	Dealing with stress (relaxation)	Relaxation techniques were more effective at reducing self-rated depressive symptoms than no or minimal treatment. However, they were not as effective as psychological treatment. Data on clinician-rated depressive symptoms were less conclusive. Further research is required to investigate the possibility of relaxation being used as a first-line treatment in a stepped care approach to managing depression, especially in younger populations & populations with subthreshold or first episodes of depression (p.2).	Jorm, Morgan, Hetrick (2008).
	Dealing with tension (relaxation)	*Be grounded*: stay still breathe in breath out slowly 10 times Notice: feeling thinking *Be unhooked*: notice your breathing feel your head, shoulders, chest movement, belly, and stay focussed	WHO (2020).

		notice the thought feeling & name it *(Here is my…. on/*in my …. *Act on your values*; what I want to be (values) not what I want to do (goals) e.g. I want to be kind caring generous supportive helpful patient responsible protective disciplined hardworking committed brave persistent forgiving grateful loyal respectable honourable respectful trustworthy fair just To be ……..... ……..…. …….. ……. *Be kind* - No matter how bad the situation *Make room*- the sky always has room for the weather, no matter how bad the weather is & always changing. Our thoughts & feelings are like weather, make room for them, no matter how bad/changing they are & let them not hurt you	
Social Skills "behaviours, verbal & non-verbal that used to communicate effectively with other people" (p.20).	Connecting with people	"Ability to express both positive and negative feelings in the interpersonal context without suffering the consequent loss of social reinforcement" (Ndegwa, 2021, p.20).	Ndegwa (2021 p. 20). DeMatteo, Arter, Parise, Marcie & Panihamus (2013). Del Prette, & Del Prette (2013) Ndegwa (2021).
	Dealing with conflict	social skills of civility; assertive social skills; empathetic social skills; social skills to express positive feelings.	
	Getting support	social skills of work	
Coping & preventive skills towards Depression	Manage early symptoms of depression Manage early symptoms of anxiety	Negative thought processes: (i) *All-or-nothing thinking*: You view a situation in only two categories instead of on a continuum. Example: "If I'm not a total success, I'm a failure." (ii) *Catastrophizing*: You predict the future negatively without considering other, more likely, or just as likely outcomes. Example: "I'll be so upset, I won't enjoy myself at all." (iii) *Disqualifying or discounting the positive*: You tell yourself that positive experiences, deeds, or qualities don't count. Example: "I did a good job on the project but that doesn't mean I'm good at my job; I just got lucky." (iv) *Emotional reasoning*: You think something must be true because it "feels" true. Example: "I know I do a lot of things OK at work, but I still feel incompetent." (v) *Labelling*: You put a fixed, global label on yourself or others without considering evidence that might lead to a less extreme conclusion. Example: "I'm a total loser." (vi) *Magnification/ minimization*: When you evaluate yourself, another person, or a situation, you unreasonably magnify the negative and/or minimize the positive. Example: "Getting a mediocre grade proves how stupid I am." (vii) *Mental Filter*: You pay a great deal of attention to one negative detail instead of looking at the whole picture. Example: Because I got one negative comment on my evaluation [which also contained several excellent comments], it means I'm doing a lousy job." (viii) *Mind reading*: You believe you know what others are thinking and fail to consider other, more likely or just as likely possibilities. Example: "They're thinking I don't know what I'm doing." (ix) *Overgeneralization*: You make a sweeping negative conclusion	Beck Institute (2021, p.3-4)

		that goes far beyond the current situation. Example: "Because I felt uncomfortable at the meeting, I don't have what it takes to work here." (x) *Personalization*: You believe others are behaving negatively because of you, without considering more reasonable explanations for their behaviour. Example: "My neighbour didn't say hello to me because I did something to upset them." (xi) *"Should" and "must" statements*: You have a precise, fixed idea of how you or others should behave. Example: "I shouldn't make any mistakes." (xi) *Tunnel Vision*: You only see the negative aspects of a situation. Example: "The whole day was terrible." You don't consider that you felt better when you got dressed, cleaned up the kitchen, went for a walk, and talked to a friend on the phone.	
	Manage early symptoms of sleeping disorders	- Sleep disturbance is the most prominent symptom in depressive patients and was formerly regarded as a main secondary manifestation of depression. *Co-relation between sleep and depression*: "Sleep disturbance may activate the sympathetic nervous system and β-adrenergic signalling, which can release neuromodulators and activate nuclear factor (NF)-κB mediated inflammatory programs. Then NF-κB will increase inflammatory cytokines, such as IL-6 and TNF, by activating the expression of inflammatory genes. These inflammatory cytokines are highly correlated with the occurring of depression disorders, meanwhile, inflammatory activity in turn can influence sleep, but the specific interacting mechanisms remain unknown" (p. 2326) *Suggested treatment include*: CBT-i therapy consist[ing] of a combination of treatments that include the following: (a) stimulus control, which aims to strictly limit the role of the bed (sleep-ing and sex) and restrict its association with stimulating behaviours; (b) sleep hygiene, which aims to develop a favourable sleep habit and create a comfortable environment that precedes sleep; (c) sleep restriction, which involves controlling the time spent in bed to im-prove sleep efficiency and thereby reinforce the 'bed-sleep con-nection'; (d) relaxation training, which is a series of practices that can help people to relax both mind and body before bedtime and (e) cognitive therapy, which offers education to change incorrect conceptions about sleep. Additional treatment of insomnia and depression: (i) eszopiclone coadministered with fluoxetine was associated with favourable sleep improvement and antidepressant response. However be cautious because there is a co-relation between the use of high dosages of hypnotics and worse depression outcomes. (ii) Studies indicate that antidepressants plus CBT therapy were favourable in patients with comorbid insomnia and depression such as CBT combined with antidepressants with standard antidepressant treatment (iii) other treatments linked with both insomnia and depressive disorders include Sleep deprivation as well as Deep Brain stimulation (for resistant depression). Also, notable is that insomnia and depressive disorders may also be linked with other mental disorders, behavioural disorders, substance disorders as well as anxiety disorders. Further studies are needed on these relationships between mental disorders, depression and insomnia	Fang, Tu, Sheng, Shao (2019, p. 2324). Krystal, Fava, Rubens, et al. (2007) Li, Bai, Lee, et al. (2014) Manber, Edinger, Gress, et al., (2008). Manber, Buysse, Edinger, et al. (2016). Fenoy, Schulz, Selvaraj, et al. (2016). Blank, et al. (2015). Fang, Tu, Sheng, Shao (2019, p. 2324).

Involvement in meaningful activities	School	Information on dealing with depression among students Awareness creation & screening of Depression in schools CBT treatment and management of depression in schools Interventions to deal with Depression among learners Preventive measures when dealing with learners	Parikh & Scott (2019) Siu (2016). Wong et al. (2014). Fazel, Hoagwood, Stephan, Ford (2014). Kindt (2014).
	Work	Job satisfaction has indirect impacts on depressive symptoms through the serial mediating effects of subjective well-being and life satisfaction; increasing job satisfaction contributes towards decreased depressive symptoms through promoting subjective well-being and life satisfaction.	Liu (2023).
	Parenting & marriage	Positive co-relation between marriage, wellness and reduced depressive disorders LGBTQ individuals face higher rates of depression than heterosexual people.	Sakine, & Nermin (2019) Canadian Mental Health Association (2020).
	Care-giving responsibilities	When care giving increases wellness and satisfaction, it can work towards reduced depressive disorders (Liu, 2023). However, many times are when there is increased stress levels. In that case the risk of depressive disorders increases	Northouse, Williams, Given, McCorkle, (2012) Hui-Choi, W. H. (2017).
Training, school-based programmes	Cognitive, enhancement	Role of CBT in managing and treatment of students	Wong et al. (2014).
	Problem-solving skills	The development of strong self-soothing, relationship and problem-solving skills contributes towards avoiding and positively dealing with depressive disorders	Sakine, & Nermin (2019). University of Saskatchewan (2020)
	Social skills for children and adolescents	Training in social skills among them eye contact, facial expressions, tone and volume of voice, body language and what we say.	Beck Institute (2021) DeMatteo, et al. (2013)
	Exercise programs for the elderly	In preventing depressive disorders and even in management, the elderly is asked to get out in to the world, engage in volunteer activities, and help others to feel better as this expands their social network. Also, they are obliged to join support groups, engage in activities such as taking care of pets and above all create time to laugh. The importance of healthy exercises, dieting and having enough sleep is also recommended.	Robinson, Smith, & Segal (2023).
Nutrition	Balced diet: carbohydrate, protein, vitamin, fruits/ minerals & water	According to the Australian Dietary Guidelines and the Dietary Guidelines for Adults in Greece, 12 foods are recommended: whole grains; vegetables; fruit; legumes; low fat & unsweetened dairy; raw and unsalted nuts; fish; lean red meats; eggs; chicken; olive oil; and limited intakes of sweets, refined cereals, fried food, fast food, processed meats, & sugary drinks.	Martinez-Gonzalez & Sanchez-Villegas (2016). Firth, Marx, Dash et al. (2019).

The second intervention, that is discussed in literature is awareness. One may look at it as part of the entire intervention process. It is due to its importance that the study finds it prudent to discuss it as a separate entity.

(ii) *Awareness* entails having the right information in relation to a specific happening, situation or thing. In this context, it is having the correct information about depressive disorders. It is only then that the individuals can use the information to both prevent and positively deal with depressive disorders (Glass, 2003). This paper seeks to "unearth depression".

The writeup started with the definition of depression, before going to the types of depression. At this level, the reader has also come across types of depressive disorders, and symptoms. Also, factors contributing to depressive disorders and the effects have been discussed. This section on interventions is now at awareness being a significant intervention.

Awareness on depressive disorders minimises stigma. Stigma is looked at a "cultural disease," whose bases are embedded in local values and power dynamics (Becker, 2019). Stigma is closely linked to stereotypes, prejudice, and discrimination (Fox, Earnshaw, Taverna, & Vogt, 2017). Due to this, attempts to successfully deal with stigma are to be localised. Depressive disorders in Africa, are associated with traditional beliefs that may be linked to issues such as witchcraft (Egbe, et al., 2014). Also, such patients are hardly seen as ailing but rather as people with problems (Longdon & Read, 2017). Due to this, the patients face challenges of treatment; on the one part, they do not see the need to seek help (and this applies to those staying with them) , and on the other part, there is hardly any conviction that if they sought the help, they would heal (Clement, et al., 2015). This paper seeks to clarify some of these beliefs and concerns, reiterating that depressive disorders is an ailment that calls for prompt diagnosis once the symptoms are identified, and treatment commenced.

(iii) *Self-Help* is an important approach to assist people with depression: Innovative approaches involving self-help books or internet-based self-help programs have been shown to help reduce or treat depression in numerous studies in Western countries" (Andrews et al, 2011: WHO 2012, p. 7). It is important that individuals play a significant role in shaping the direction of their lives. This entails being individually committed towards personal wellness including mental wellness. This commitment should address all areas of the human person among them physical, psychological, spiritual, cultural, emotional, as well as behavioural. As one matures, increased degree of self-care is essential (Lee, et al., 2021). Only then can one mitigate on the likelihood of them falling prey to depressive disorders. As noted previously under awareness, commitment towards continued increase in awareness, contributes towards self-help.

(iv) *Social Support*: Close meaningful relationships go a long way in helping prevent, reduce, and positively deal with DD (Behavioural Health Evolution, 2008). Such interactions are aimed at (a) awareness creation on matters of personality and mental health; (b) realization and acceptance of challenging issues such as substance abuse; (c) elucidating coping strategies in and outside the individual in relation to the imminent challenges (d) singling out and availing effective and sustainable ways of dealing with life challenges; (e) offering support towards pursuit of meaningful goals.

As the study looks at social support, family plays a significant role and specifically functional families (WHO, 2014 p. 17). Within the family (including religious families), individuals are able to get solace that in turn increases on their resilience to life matters (Sakine & Nermin, 2019). In addition to this, there are other families as realized in work places, students in learning institutions (Bell, Donkin, Marmot, 2013). These circles contribute positively to the wellbeing of the individuals. Certainly, dysfunctionality in these families may have counter effects.

The social circles affecting individuals also include the socio-political environment. This contributes to factors such as peace and security (Haslam, Cruwys, Haslam, & Jetten, 2015; Ang, 2021) and in turn lay foundation for economic growth leading to reduced poverty levels. These factors contribute towards the individuals feeling of hope and certainty (Hidayat, & Nurhayati, 2019). This

inner as well as outer peace is notably necessary for mental wellness. In addition, this wellness should entail gender equalities as well as human rights issues (WHO, 2014).

(v) *Professional Support*: Due to the severity of depressive disorders, it is important that interventions include the right mental health practitioners (Boyd, Zeiss, Reddy, & Skinner, 2016). Among these there are psychiatrists, psychologists, and counselling psychologists (psychotherapists) (Elliott & Ragsdale, 2020) among others. As noted by Patel et al., (2010), "intervention by a trained lay counsellor can lead to an improvement in recovery from depression. Other professionals that need to be largely included on matters depression are the clergy, as well as pastors (Bloem, 2018). This is because depressive disorders have a spiritual angle that calls for the right professional experts. All over the world but increasingly in Africa, large numbers of persons seek assistance from religious leaders (Haußmann, Beate, & Birgit, 2020; Lloyd, & Yasuhiro, 2022). With such realities therefore, caution should be taken so that the consulted religious leaders do not spiritualize all matters, to the detriment of the patients (Bloem, 2018). A combined effort should generate synergy. In addition, researchers in the field of mental health continue to be needed. Mental health continues to beg for discovery. It is only in this way that treatment is going to continue enhancing mental wellness (Monteiro, 2015; Kowalski, Morgan, & Taylor, 2016).

Table 9 adds to the list of interventions given this time aligning them on whether they are clinical or psychosocial

Intensity	**Clinical Intervention**	**Psychosocial Interventions**
Mild, Moderate & Severe	Antidepressants: "Selective serotonin reuptake inhibitors (SSRIs) and other newer antidepressants at full therapeutic dose are reasonable first line choices, whereas older tricyclic antidepressants and monoamine oxidase inhibitors should generally be reserved for treatment failure" (Ouhoff, 2019, p. 15). Also refer to Cleare, et al., 2015).	-Cognitive behaviour therapy, interpersonal psychotherapy and behavioural activation are recommended. These are used as an adjunct to medication in severe cases (Outhoff, 2019). -Also, mindfulness-based cognitive therapy can be added to usual treatment to prevent. This is mainly for patients with "≥ 3 previous episodes" (Outhoff, 2019, p. 16). -Socio-cultural factors that may be adding to or maintaining depression should be factored. -Occupational stress resilience strategies (p. 16), at individual but also at group, social and institutional levels (da Costa et al., 2017; Shanafelt et al., 2017) -Patients should also make time to exercise, pursue hobbies and have holidays. There is also need to spend quality time with partners, family and friends, limit alcohol use, self-monitor, -Have attitudes that promote constructive and healthy engagement and in line with challenges at work (Kumar et al., 2016).
This position by Ouhoff (2019) is supported by WHO, (2012, p.7), "Antidepressant medications and brief, structured forms of psychotherapy are effective. Antidepressants can be a very effective form of treatment for moderate-severe depression but are not the first line of treatment for cases of mild or sub-threshold depression."		

These are some notable interventions addressing depressive disorders. Together with the clinical interventions, an integral approach is required involving psychosocial interventions in order to prevent as well as treat and manage situations that promote the disorders. With this information, the following section addresses possible barriers making it difficult for the interventions to yield maximum results. Four main barriers have been discussed namely: lack of resources, lack of trained professionals, social stigma, and stereotypes.

Barriers to Effective Care Related to Depressive Disorders

(i) In Africa, *poverty* continues to plague the inhabitants (DFID, 2001-2010). Core among the areas that suffer, are education and health. This means that resources that are meant to be channelled to health-related research continue to be minimal, as funds that should be availed for preventive as well as curative health management, remain limited (WHO 2012). With other factors among them corruption (Kiingati, 2022) in these developing countries, health related resources remain highly depleted. This continues to be a major impediment towards appropriate care in the area of mental health, within which depressive disorders fall.

(ii). Together with the challenge of *limited resources*, there is lack of trained providers (WHO 2012). As per the WHO standards, the ratio of doctor to patient should be at 1:1000 (WHO, 2019). In Africa however, according to *the state of the health workforce in the WHO African Region* (2021) report, only "Nine countries (Algeria, Botswana, Cape-Verde, Gabon, Lesotho, Mauritius, Namibia, Seychelles and South Africa) of 47 in the Region had a density of doctors, nurses and midwives per 1000 population that attained or exceeded the MDG minimum density threshold of 2.28 doctors, nurses and midwives per 1000 population" (p. x). This means that the rest of the population has to seek health related assistance from persons that are not fully qualified. Appeals continue to be made to related governments as well as the Civil Society, to enhance their interventions towards improved health care, and more so in the area of mental health.

(iii) Social stigma continues to be a major concern in Africa more so in relation to mental health (WHO, 2012). Discussing doctors and depression, Henderson, Brooks, del Busso, Chalder, Harvey, Hotopf et al., (2012) identify how self, friends, and family can be sources of stigma. Also, professional colleagues as well as those of institutions where one operates can also add to the stigma. Such positions only leave the patients more isolated and vulnerable and thus prone to depressive disorders. It is important that conducive environments are created to facilitate care consultation moments that have ample time for the patients to explain themselves. This should include their view of value, fears associated with others knowing their conditions and of the treatment process, their lack of motivation and costs involved (Gerada, 2018; Batra, McPhillips, Shugerman, 2018). it is anticipated that addressing such factors, shall contribute positively towards lessened denials and improve on the promptness of seeking help (Batra, McPhillips, Shugerman, 2018).

The study has discussed these three barriers to interventions related to depressive disorders. This list is certainly not all inclusive but sheds light on the present challenges. As the study moves towards culmination, two aspects that are closely linked to depressive disorders, as seen in literature, are discussed. These are stress and suicide, in relation to depressive disorders. Each of these relationships is discussed independently.

Poverty, limited resources, social stigma come up as three major barriers to the interventions dealing with depressive disorders. On the part of poverty, social transformative efforts continue to inform on ways to improve health, education as well as household incomes. The discourse on any minute ways that individuals and societies can adopt to mitigate on the pangs of poverty, are welcome. Going back again to the case of Hen, poverty could easily have contributed to the condition. It is therefore, important that such cases are observed, mainly of retirees. Also, the academia are obliged to continue disseminating information to the public using whatever means, in order to curb ignorance. An ignorant nation, is a poor one and certainly it is a sick one.

Depression and Stress

Addressing the relationship between stress and depressive disorders, the work by Outhoff (2019, p. 13) makes a significant contribution. The author deals with the question, whether depression is a stress-induced organic disorder. The author discusses how "Stress increases circulating pro[mooting]-inflammatory cytokines, particularly TNFα [tumour necrosis factor alpha] and IL-6 [interleukin-6) that activate microglia [immune cells in the central nervous system; play important role

in brain infections and inflammations] ... leading to further[more/continued] pro-inflammatory cytokine release (p.13)". Cytokines are "low-molecular-weight proteins that regulate the nature, intensity and duration of the immune response by exerting a variety of effects [activation, proliferation and differentiation) on lymphocytes and/or other cells" (p.1) These proteins have a role in regulating haematopoiesis (production of all of the cellular components of blood and blood plasma**)**, innate and acquired immunity. Nevertheless, studies do not explain the direct relation between cytokines (increased by stress levels) and depression (Pasic, Levy & Sullivan, 2003, p. 186).

However, the authors point towards "the immune cascade [in stress which] may ultimately reduce monoamine neurotransmitters, and in particular serotonin, as well as hippocampal neurogenesis (associated with depression) (Outhoff, 2019, p. 13). Also, the author mentions of the "cycle of elevated chronic neuro-inflammation and glucocorticoid functional resistance [that] is accompanied by oxidative stress". With these insights, there appears to be a co-relation between stress and depression.

Based on this discussion, there appears to be a positive corelation between levels of stress and levels depressive disorders. However, increased studies are needed to be able to ascertain the levels of relationships. For the sake of this paper however, the position that a reduction of stress may positively reduce one's exposure to depressive disorders, is adopted. Less stress also may contribute towards better management of depressive disorder conditions.

Hen's lifestyle entailed high levels of stress. Information from the family had it that, prior to the ailment, two sons of Hen were on the verge of losing some property. Another of the sons had lost a job. This coupled with anxieties that come with ageing, could have aggravated Hen's acquisition of the depressive disorder. When individuals as well as families are able to have stress management strategies, among them relaxation, leisure, walks, venting out amidst other methods, such cases of depressive disorders can be reduced.

Depression and Suicide

Suicide is a world concern, rated among the 20 top leading causes of death (WHO, 2019); rated higher than malaria, breast cancer, or war and homicide. In Africa, Necho, Tsehay, & Zenebe (2021) give the following statistics: (i) suicidal ideation: 7.8% - 42%; (ii) suicidal attempt: 1.3% - 20.1%. They also note that 1.8% of world's global disease burden is linked to suicide, and that 85% of world's suicides are in low- and middle-income countries. A police report in Kenya, shows that in 2021, Kenya had reported 480 suicide-caused deaths in three months (April-July), with the youngest being 9 years and the oldest 76 years (Wainaina, 2021). This was a sudden increase from 2019 report that had 196 suicide caused deaths. Additional information was that from 2015 to 2018, 1442 attempted suicide cases had also been reported. These alarming records, show a concern in relation to suicide. Among the major causes of suicide, are AIDS, depression, stigma, and poor social support. As for additional information on the relationship between depressive disorders and suicide, the University of Saskatchewan (student wellness centre) (2020), states that depressed moods contribute to thoughts of suicide. They continue to state that 15 % of those with chronic depression end their lives by suicide. This is also supported by statements by the Government of Canada (2020), and Mood Disorders Society of Canada (2019). Founded on these realizations, this paper addresses depressive disorders, shedding light on the role of psychosocial interventions. In addressing the related variables, the paper starts by giving the factors signalling suicide. This sheds light on preventive measures that significant others may observe in relation to one moving towards depression.

Factors signalling suicide:

Language is significant in identification of suicidal ideation. However, while some may be overt, some are covert expressing passive ideation (Harmer et al., 2023). The communication from the patient may express burden, feeling trapped, unbearable pain and even despair. Depending on the different cultures, persons associating with the patient need to be attentive.

Behaviour is also notable. This could be picked by persons coming into contact with the individual that may be depressed, and is contemplating suicide. Among notable behaviour and environmental traits associated with suicide are psychiatric disorders, history of suicidal attempts, hopelessness, sexual minorities and occupation. Also, situations where individuals suffer chronic severe pain, neurologic disorders also contribute (WHO, 2014). Issues of substance use are another contributory factor.

Mood change is the other factor that signals moves towards suicide. One struggling with depression exhibits depressed moods, anxiety, loss of interest and rage. Also, there are moods of irritability and feeling humiliated (ADAA, 2016).

Information on suicide, and the indicators, are meant to assist, individuals that may be struggling with such ideations. It also adds to informing persons living with or near persons that may be struggling with the ideations. It is anticipated that the information shall contribute towards awareness and thus towards the reduction of the conditions.

This section tallies well with Hen's case. As mentioned earlier he wanted to commit suicide to avert thoughts that were troubling him. This is where he understood that others, including close family members were planning to eliminate him. Also, his interpretations were that since he originated from a foreign country, there were plans to exile him. These faulty thoughts, brought about by the depressive disorder state, led him towards suicide. It is indeed by God's grace that that he did not die following his many attempts. The earlier conversations that he had had with Tim, were a clear indicator of a sick person. However, again ignorance did not allow Tim to get the message. This paper therefore, works towards elucidating on such matters. One aspect that cannot be overlooked is that of prayer and faith. The faith showed by Tim's mother, and the calling upon the Divine to intervene, played a significant part in getting the matter under control. For believers, this was a miracle. On that note therefore, faith and prayers, cannot be overlooked in the management of depressive disorders. Due to the complexity of the disorders, it is important that the interventions are also all inclusive.

Conclusion

This paper has discussed depressive conditions, giving the definitions, as well as prevalence. It has also addressed the aspects of distribution of depressive disorders as per age and gender. The subsequent sections have looked at types of depressive disorders as well as contributors to the disorders. This is followed by the effects as well as the needed interventions. In the end three issues have been discussed. The first gives the barriers that hinder the interventions. Also there are two discussions on depressive disorders and stress, as well as and suicide. This paper has attempted to unearth depression with an aim to shedding light on the disorders. Throughout the discussion, literature has been cited to inform the discussion. Also, the case of Hen, has also been used to address the processes, that appertain to the depressive disorders. As its final quest, the paper proposes a psychosocial self-test kit on one's vulnerability towards depressive disorders.

A Proposed Psychosocial Self-test Kit on One's Vulnerability towards Depressive Disorders

A. PERSONALITY: I feel that I am very much bent towards

	Very High	Slightly High	High	Slightly Low	Very Low
Type A					
Active, getting things done on time, target oriented					
Type B					
Calm collected, not linked with overachieving, less time bound					

B. BASIC NEEDS: How do I rate my ability and that of my family to access?

	Very High	Slightly High	High	Slightly Low	Very Low
1. Enough and proper food					
2. Descent housing					
3. Proper medical care					
4. Proper education					
5. Leisure (sports, entertainment places etc.					
6. Security					
7. How do I rate the financial situation of my household?					

C. (A) HEALTH (physiological)

	Very Good	Slightly Good	Good	Slightly Poor	Very Poor
C-1 How would I rate my health?					

C-2 Do I have a physical challenge/disability?

YES		NO	

C-3 Do I have any permanent and/or repeated health condition? (Diabetes, High/low blood pressure, HIV/AIDS etc)

YES		NO	

C-4 If Yes (to C-2 and/or C-3), how long have I had this challenge?

Over 10 years		**6-9 years**		**1-5 years**		**Below 1 year**	

C-5 If Yes (to C-4), how do I feel about this challenge?

Very at ease		**Slightly at ease**		**At ease**		**Slightly troubled**		**Troubled**		**Very troubled**	

C. (B) HEALTH (psychological)

	Very High	Slightly High	High	Slightly Low	Very Low
1. How would you rate your self- awareness on matters emotions?					
2. How would you rate your self-awareness on your thought processes?					
3. How would you rate your self-awareness on matters related to your behaviour?					

C. (C) HEALTH (compulsion-disorder)

Do you suffer from any behavioural compulsion? e.g., sex, eating, internet/phone, work, power, etc.

YES		NO	

If yes, how would you rate the severity of the compulsion?

Very High **Slightly High** **High** **Slightly Low** **Very Low**

Do you struggle with any substance intake? e.g., alcohol, cigarettes/tobacco, miraa/khat, bhang etc.

YES		NO	

If yes, how would you rate the severity of the compulsion?

Very High **Slightly High** **High** **Slightly Low** **Very Low**

D SOCIAL

How would you rate your relationship with your family members?

Very Good **Slightly Good** **Good** **Slightly Poor** **Very Poor**

How would you rate your ability to make and maintain friendship?

Very High **Slightly High** **High** **Slightly Low** **Very Low**

How would you rate your relationships? (With neighbours; with work colleagues)

Very Good **Slightly Good** **Good** **Slightly Poor** **Very Poor**

E SPIRITUAL

How would you rate your relationship with God/Supreme Deity?

Very Good **Slightly Good** **Good** **Slightly Poor** **Very Poor**

How would you rate your relationship with the Church/Religion?

Very Good **Slightly Good** **Good** **Slightly Poor** **Very Poor**

In general, how would you rate your level of happiness (satisfaction, wellness)?

Very High **Slightly High** **High** **Slightly Low** **Very Low**

NB:

(i) The degree to which one is aware of their personality with its strengths and limitations, the more one is likely to positively manage the self, and thus prevent oneself fom falling prey to depressive disorders.

(ii) As for the length of time that one has had a challenge, the answers and the effect may vary. In general, however, it is taken that the longer one has had the condition (challenge), the more the adaptability and hence the lesser the negative influence on one's likelihood towards depressive disorders. Inversely, those whose challenge is recent, may still be going through the initial four stages of loss: denial, anger, bargaining, and depression (Kubler-Ross & Kessler, 2005). When at the final stage (acceptance), one may be at a lesser risk of having depressive disorders related to the challenge.

(iii) The degree to which one is able to attain basic needs, health, social, spiritual, happiness, the more they are likely to prevent themselves from suffering from depressive disorders. On this note, the more the responses are towards very high, very good, the better the ratings in avoidance of depressive disorders. However, for the case of compulsions, the higher the individual is in compulsivity, the higher the probability of one developing depressive disorder.

Other Self Rating Scales

Readers are encouraged to also make use of other proven self-rating scales among them:

1. Beck Depression Inventory (BDI; Beck 1961; Beck 1996)
2. Zung Self-Rating Depression Scale (SDI; Zung 1965)
3. Center for Epidemiologic Studies Depression scale (CES-D; Radloff 1977).
4. General Health Questionnaire (GHQ; Goldberg 1972)
5. Geriatric Depression Scale (GDS; Gompertz 1993; Kurlowicz 1999)
6. Hospital Anxiety and Depression Rating Scale (HADS; Zigmond,1983)

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