A META-ETHNOGRAPHY OF MALE TERTIARY STUDENTS' EXPERIENCE OF DEPRESSION

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Abstract

Depression is one of the most common psychiatric disorders across the globe. Major depressive disorder is regarded as the fourth highest cause of disability worldwide and the second between the ages of 15 and 44. This mental illness is often associated with psychiatric comorbidities, functional impairment and in severe cases with fatal consequences. Recent research findings have reported that the incidence of depression peaks in the 20s age range, an age group that faces certain unique vulnerabilities within industrialised societies. Comparatively little research attention has been directed to men with depression, and less so towards a male population between their late adolescence and mid to late 20s. The extant published research of depression among this population remain scattered and unintegrated. Hence, a meta-ethnography was conducted to synthesise existing literature about the experience of male tertiary students with depression. Five primary qualitative research studies were analysed with this qualitative meta-synthesis approach. The data analysis produced three overarching themes within these men's experiences with depression, namely semblance of strength, behind the mask and redefining masculinity. The first theme was associated to three subthemes, namely indifference to pain, the angry man and the self-managed man. The second theme was also related to three subthemes, namely absent help-seeking, masking depression and pain behind the mask. The first two themes are strongly related phenomena and often emanate from similar prevailing ideals of masculinity. Whereas, the third theme stands separately in that it represents a move away from a more commonly held sense of masculinity, to one that allowed some individuals to respond to depression in a different manner.

Keywords

Major depressive disorder, Male tertiary students, Hegemonic masculinity, Emerging adulthood, Qualitative meta-synthesis, and Meta-ethnography.

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APA: American Psychiatric Association

DSM: Diagnostic and Statistical Manual of Mental Disorders

ICD: International Classification of Diseases

MDD: Major Depressive Disorder

WHO: World Health Organisation

Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature:

Date: 2016-01-27

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Chapter 1: Introduction

1.1. Introduction

The focus of this research project is on male tertiary students' experiences of depression. Within the qualitative research community, some efforts have been made to give voice to their experiences. However, the findings emanating from these efforts remain unintegrated. The impetus behind this study was to synthesise existing qualitative research by means of a meta-ethnography, in order to enhance our knowledge of this phenomenon.

Chapter one serves to contextualise the subject of enquiry, namely depression among male tertiary students. The discussion addresses the burden of depression on society in terms of epidemiological findings as well as conditions that are commonly concomitant with depression. Attention will then be turned specifically to tertiary students. This section highlights the importance of the study in the context of mental health. Subsequently, an outline of the aims of this research project is included.

1.2. Depression

Depression is one of the most prevalent psychiatric disorders worldwide and poses a significant concern to mental health care. The prevalence of depression has been on the increase (Gotlib & Hammen, 2008; Sharif et al., 2011). It is considered the fourth highest cause of disability across the globe and second between the ages of 15 and 44 (Oliffe & Phillips, 2008). As many as 350 million people experience Major Depressive Disorder (MDD) worldwide (World Health Organization, 2012). According to global census data (Andrade et al., 2003), the lifetime prevalence of MDD ranges between 8-12%, with rates ranging from 3% in Japan to 16.9% in

the United States of America. Andrade et al. (2003) also indicated that approximately 75% of people who have had one episode of major depression experience recurrent episodes. People diagnosed with depression are not only at risk for recurring episodes, but also for additional mental health problems.

Depression is often associated with co-morbid psychiatric and physical syndromes, including substance-related disorders, eating disorders, borderline personality disorder (American Psychiatric Association, 2013), anxiety related disorders, cardiovascular disease, strokes, diabetes, epilepsy (Andrade et al., 2003) and in severe cases, MDD can result in suicide (WHO, 2012). Approximately 1 million successful suicides occur annually (WHO, 2012) and 30-70% of those deaths are associated with a mood disorder, most commonly with MDD (Banks, 2001; Möller-Leimkühler, 2002). Thus, the seriousness of MDD is exacerbated by its association with other debilitating and potentially fatal co-morbidities and consequences.

Historically, depression has not been identified and reported equally across gender groups. One of the most consistent findings regarding MDD has been a female preponderance in its epidemiology (APA, 2013; Murphy, 1998; Oliffe & Phillips, 2008). However, research findings (Addis, 2008; White & Holmes, 2006) indicate a fourfold greater prevalence of completed suicides among men. How should one then make sense of the strong association between MDD and suicide, as frequently reported in literature (APA, 2013; Banks, 2001; Oliffe & Phillips, 2008; Walinder & Rutz, 2001)? Several authors have proposed that MDD is an underdiagnosed syndrome among the male population and have postulated a variety of reasons for this phenomenon (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Strike, Rhodes, Bergmans, & Links, 2006; Winkler, Pjrek, & Kasper, 2006). Continuing from the assertion that MDD is more common among men than epidemiological studies indicate, as well as the findings that suicide occurs more frequently among men than among women, it can be argued that investigations into MDD among men are vital in relation to the health of this population.

Not only does depression deserve greater consideration in men, but more specifically in male tertiary students. Male tertiary students typically fall within a developmental period marked by many demanding and challenging situations, including transitions to unknown environments, academic pressure (Khawaja & Bryden, 2006), instability (for instance relating to relationships, occupations and habitation), identity exploration (Arnett, 2004), working towards independence (Arnett, 2007) and striving to conform to prevailing norms (Danielsson, Bengs, Samuelsson, & Johansson, 2011). Men within this period may be vulnerable to functionally

impairing and distressing experiences like alcohol abuse (Courtenay, Mccreary, & Merighi, 2002), stress (Misra & McKean, 2000) as well as depression (Khawaja & Bryden, 2006) and suicide (Winkler et al., 2006). Arnett (2004) proposed a construct to describe this developmental period within the context of industrialised societies, which he referred to as *emerging adulthood*. This period pertains to post-adolescents (over 18 years) who have finished secondary education and have not yet committed to marriage, parenthood or a long-term stable occupation. Many people within this developmental period enrol into tertiary educational programs, which may extend their education by as little as one year, or as much as six years, or more. Subsequently, this period of life may range from 18 through to mid to late 20's. Several of these individuals leave their parental homes in order to attend a college or university. Emerging adulthood is a relatively newly conceptualised developmental period, but as a theory it has already made a positive contribution to scholarly work (Arnett, 2007).

Arnett (2004) further argued that people within emerging adulthood experience their environment in ways that differ significantly from those of the same age 30 years ago. Before the 1980s, the majority of 21 year olds have completed their educational careers (or were close to completing it), entered into a long-term occupations, were married (or about to be married) and have become parents (or were expecting a child soon). During that time, most people in their early 20s could be considered adults. In contrast, modern day emerging adults experience a freedom that their predecessors did not, as they tend not to make these same long-term commitments until mid to late 20s. Emerging adulthood reflects a period of exploration, in terms of different romantic relationships, study opportunities, occupational opportunities, and traveling. This may be exciting on the one hand. However, on the other hand it is also associated with instability, which can lead to greater experiences of uncertainty and render these individuals vulnerable to distressing experiences such as anxiety and depression.

The experience of MDD can be highly distressing and impairing. This can be particularly disconcerting among men, as MDD among this population group too often go undetected (Brownhill et al., 2005) and thus untreated. This in turn leaves men vulnerable to the perpetuation of depressive episodes and other associated debilitating co-morbid syndromes and potentially fatal consequences. Men within the developmental period of emerging adulthood may be increasingly at risk for the experience of MDD due to the added instability and uncertainty associated with this stage of life.

1.3. Justification and aims

Considering findings such as these, MDD can be regarded as "a major contributor to the global burden of disease" (WHO, 2012). In addition to the symptomatology associated with MDD, which can be highly distressing in itself, MDD can also have financial, occupational and interpersonal ramifications. These include the costs of medication, the cost of health care services, loss of income due to impaired functioning (Oliffe & Phillips, 2008) and social withdrawal (Garland, Fox, & Williams, 2002), possibly leading to the loss of significant relationships. Baker et al. (2014) reported that health outcomes are substantially worse among male population groups, than females.

Men with MDD may be conceptualised as an at-risk group. They are less likely to receive intervention, compared to women, for this disorder and subsequently are more likely to experience other functionally impairing, or at times fatal, consequences, such as substance abuse and suicide (APA, 2013; Murphy, 1998). Poorer morbidity and mortality among men have been linked to certain norms of masculine and health related behaviours of men that are often marked by a reticence for help-seeking (Baker et al., 2014). Rihmer (1996) reported that suicide risk is greatest when the rates of diagnosis and professional intervention are disproportionally low, as is the case with men in depression. The uncertainty associated with the time period when men typically engage in tertiary education, namely emerging adulthood (Arnett, 2004), may place them further at risk. Based on these findings, the quality and quantity of research should be improved in relation to men in depression (Addis, 2008), and more specifically men within the emerging adulthood period. This is vital because the continued under-detection of depression may undermine emerging adults' performance in education, career opportunities and even social endeavours (Danielsson et al., 2011), as well as life satisfaction and even life expectancy.

In order to ascertain the feasibility of this proposed research, an online literature search for primary studies on tertiary male students who experience depression was conducted. Upon conducting this search it became apparent that attention has increasingly been directed towards this problem within this population recently. However, a majority of the attention continues to be directed towards the female population. A similar observation was made by Addis (2008). An additional finding from this preliminary search was that a relatively small number of studies, apart from Addis' (2008) proposed theory development, attempted to juxtapose and synthesise the findings regarding depression among men. Synthesise of qualitative research

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studies have been on the increase recently (Toye et al., 2014). Sandelowski, Docherty and Emden (1997) argued that qualitative researchers tend to work in isolation from one another, resulting in their findings forming "little islands of knowledge" (p. 367), removed from each other. Although this observation was made almost two decades ago, the preliminary search revealed a continuation of the disconnection of qualitative research findings.

In relation to male tertiary students who experience MDD, no studies were found that synthesised primary qualitative research findings. This research project is thus the first to synthesize qualitative primary studies on depression among male tertiary students. The impetus behind this research project was the identified gap in literature, depression's contribution to the global burden of disease and male tertiary students' particular vulnerabilities for developing depression. This will serve to create a framework for conceptualising depression among male tertiary student. A framework like this holds the potential to inform future research and clinical practice pertaining to this phenomenon.

In doing so, this research was directed at answering the following question: What do primary qualitative research studies reveal about male tertiary students' experiences of depression?

This question was answered by means of a meta-ethnography, a method proposed by Noblit and Hare (1988). This qualitative meta-synthesis was used to synthesise five primary research studies that were published between 2001 and 2014. In line with the research question and the research method, this project address two research aims, namely to:

a) Conduct a meta-ethnography of the findings of primary qualitative research studies exploring male tertiary students' experiences of depression, and

b) Keep account of who conducted research in this field and what type of research was conducted, in order to contextualise the study as well as acknowledge and understand the sources of data.

1.4. Outline of study

This dissertation is divided in several chapters. Chapter two addresses literature that pertains to depression in general as well as more specifically depression among male tertiary students. This chapter attempts to cover the salient ideas and concepts in relation to the subject of enquiry. It outlines the evolution of our conceptual and etiological understanding of depression, from the ancient Greeks to the present. This is followed by considering the impact gender has

on depression, help-seeking and suicide. The chapter is concluded by considering depression among tertiary students. The literature review incorporates theoretical understandings of depression, hegemonic masculinity and emerging adults into the discussion. Chapter three addresses the research design and offers an outline of the method and methodology, as well as a discussion of the steps employed to undertake this research project. Chapter four communicates the analysed data from the five primary studies in detail. This is conveyed in terms of three overarching themes and six subthemes. The fifth and last chapter provides a discussion of the research project. This is done by recapitulating the preceding chapters and then linking the analysed data with the relevant literature, as discussed in chapter two. This is followed by a contextual analysis which addresses the second research aim. The chapter is concluded by addressing the limitations of the study and potential avenues for future research.

1.5. Conclusion

Depression contributes significantly to the burden of disease worldwide. Although a large body of research on depression does exist, attention paid specifically to men's experiences are disproportionately small, with a very small proportion thereof directed at male tertiary students and depression. The studies that were conducted in relation to this phenomenon remain scattered across the academic field. No studies were found that attempted to synthesise these islands of knowledge. This research project aims to fill that gap. In doing so, the intent is to provide a framework by which professionals can conceptualise male tertiary students' experiences of depression in order to inform their management thereof, as well as to inform future research.

Chapter 2: Literature Review

2.1. Introduction

The aim of this chapter is to lay a conceptual foundation for the research synthesis. On the one hand it serves as an orientation for understanding the experience of depression among male tertiary students. On the other hand it aids in understanding the results obtained from the meta-ethnography. The core concepts of the study are men (gender), depression (mental health) and tertiary students (specific developmental group). This literature review addresses the extant research pertaining to these core concepts as well as specific theories.

The initial focus will be on the development of the conceptualisation of depression, dating back to the ancient Greeks and continuing to contemporary understanding. Two important issues for this study are gender-based differences in depression as well as help-seeking behaviour. Subsequent to discussing these issues, the topic of suicide is addressed. In this regard there seems to be a significant gender-based variance that has been noted in research and literature. Finally, this chapter concludes with a discussion on depression specifically among tertiary students.

2.2. The history of depression

2.2.1. A historical view on the conceptualisation of depression.

Descriptions of distressing experiences that resemble our contemporary understanding of depression can be found as far back as ancient Greece. Hippocrates, a fifth century BC Greek physician (Solomon, 2001), described a woman who experienced loss of sleep, decreased appetite, increased thirst and nausea and referred to her presentation as melancholia (Greist, 1992). Melancholia was derived from the Greek phrase *melaina chole*, meaning black bile (Solomon, 2001). However, melancholia was not seen as an illness on its own, rather as one possible manifestation of an underlying disease. The other possible manifestation of this disease was mania, a term that was used to denote a generic madness. According to Aretaeus, also a Greek physician, mania was an illness that caused people to be irritable, passionate, overly active, joyous and immature and to have an easy disposition. People with this illness considered themselves to be gods, famous or being the centre of the world. For the next two millennia these two illnesses continued to be regarded as two sides of the same coin (Stone, 2006).

During the Medieval period melancholia and mania were conflated under the term melancholia. This became a very broad term and included anxiety, sadness, demoralisation, a tendency towards solitude, the risk of suicide, and even lovesickness. In addition, melancholia was associated with certain vegetative symptoms, such as general slowed movement, immobility and mutism (Stone, 2006).

Philosophers of the Renaissance era romanticised melancholia. It became associated with great depth, soulfulness, complexity and even intellectual prowess. Dejection was associated with insight and fragility was regarded as the price of an artistic and complex nature. It was argued that artists and philosophers were more likely to experience melancholia than the common man, because they were more aware of their inadequacy in the knowledge of God (Solomon, 2001).

Robert Burton (as cited in Solomon, 2001), a dean of divinity at Oxford during the seventeenth century, published an encyclopaedia in which he organised the varied conceptualisations of melancholia presented through history. His book, *The Anatomy of Melancholia,* became the most widely used text on the subject, until Sigmund Freud published *Mourning and Melancholia* in the early nineteenth century. Burton distinguished general sadness, displeasure, ill disposition and social withdrawal from melancholia, which he deemed a more severe experience that warranted a classification as an illness. The use of the term melancholia continued until the mid-nineteenth century, before being replaced by the term depression (Burke, 2009). Although depression already came into use in the eighteenth century, initially only to refer to low spirits (Stone, 2006).

In the late nineteenth century Emil Kraepelin (as cited in Stone, 2006) proposed a psychobiological understanding and categorisation of depression. He classified mood disorders as manic-depressive insanity. Manic symptoms included flights of ideas, hyperactivity and euphoria, while depressive symptoms included depressed mood, inhibition of thought and weakness of volition. Later on Kraepelin distinguished between two types of psychoses, namely manic depression as a mood psychosis and dementia praecox as a cognitive psychosis. Dementia praecox was later reformulated into schizophrenia by Eugen Bleuler.

In the 1950s Karl Leonhard expanded on Kraepelin's work. Whereas Kraepelin regarded manic-depressive illnesses as a unitary broad entity, Leonhard proposed that unipolar (mania or depression, without episodes of the other) and bipolar (manic and depressive episodes in the same individual) were two distinct entities (Stone, 2006). Although some contemporary researchers, such as Akiskal (2003), continue to argue in favour of a broad bipolar spectrum,

current widely used psychiatric nosologies, such as the Diagnostic and Statistical Manual of Mental Disorders fifth edition (DSM-5) (APA, 2013), continue the more modern tradition of classifying depression as a disorder distinct from a bipolar syndrome, where depression occurs in conjunction with mania.

From this discussion one can see how the understanding of melancholia, and later depression, developed and allowed for the expansion of other mental illnesses, such as mania and psychosis. Initially, it was regarded as a broad descriptor of more generic experiences of distress. However, over time it became more refined in describing a low mood and the accompanying symptoms, as opposed to euphoria and hyperactivity as well as distortions in the perception of reality.

2.2.2. A historical view on the etiology of depression.

As mentioned earlier, Melancholia was derived from the Greek phrase meaning black bile (Solomon, 2001). This related to a medical practice of the time called humoral theory. The humoral theory proposed that illness was associated with four bodily fluids, namely phlegm, blood, yellow bile and black bile. An excess of any one of these fluids resulted in different types of illness. It was believed that black bile originated in the brain and that an excess of this fluid was responsible for symptoms of melancholia such as sadness, decreased appetite, sleeplessness, restlessness, hopelessness, irritability, anxiety and suicide. Based on this theory, Hippocrates posited that melancholia was an illness of the brain. The treatment options of the time included orally administered medicine (such as mandrake, hellebores plants, cathartic or emetic) and offering advice (for instance, King Perdiccas II's melancholia was alleviated when Hippocrates advised him to marry the woman he loved) (Solomon, 2001). The understanding of melancholia as an illness that related to excessive black bile continued from the time of the ancient Greeks, through the Medieval period and into the Elizabethan times (Stone, 2006).

During the Medieval Ages, the Roman Church advocated a different approach to the causal understanding of melancholy. According to Solomon (2001), Saint Augustine stated that the main feature that separated humans from animals was their capacity for reason. It followed that the loss of reason reduced a man to the level of animals. Based on this reasoning, a condition such as melancholia was perceived to be indicative of a loss of reason, and consequently as a loss of God's favour. At times it was even attributed to possession of an evil spirit. In this view, melancholia was seen as punishment from God for man's sinful soul. One of the sins most

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often attributed to melancholia was sloth. Sloth referred to a lack of industry, negligence, exhaustion, lethargy and dejection. This often resulted in the loss or deterioration of a person's possessions or his/her own body. Today, sloth would most likely be understood as a behavioural manifestation of depression. However for the medieval Church it reflected one of a number of deadly sins, outlined by the Church, and consequently deserving punishment. During the Inquisition of the thirteenth century, people were even fined or imprisoned for this sin.

Two major movements occurred at the turn of the twentieth century that had a fundamental impact on the future of the field of mental health. Freud initiated the psychological conceptualisation of mental disorders, which led to all kinds of psychoanalytical theories proposed within the social sciences. On the other hand, Kraepelin's psychobiological approach set in motion a more absolutist understanding of depression based on biochemical explanations (Solomon, 2001).

Psychoanalytical theories proposed that something from within an individual prevented the person from functioning normally. Freud posited that in melancholia the ego experiences a breakdown and becomes poor and empty. He posited that this breakdown was the result of anger turned inward on oneself. He found that people with melancholia were unable to give expression to their grievances of the world around them and instead directed blame to themselves in an attempt to avoid the possible abandonment that they feared would have resulted from aiming their anger at others (Solomon, 2001). Over the next century, many other psychological theories were proposed to explain this phenomenon. Some of these followed in the tradition of Freud's psychoanalytical theory, while others veered off in different directions. At present psychological theories emphasise several risk factors that may predispose or precipitate the onset of depression. These risk factors include, but are not limited to, experiencing loss early on in life, such as losing a parent; stress and intense grief reactions (Greist, 1992). Other theories propose that depression may emanate from cognitive distortions or learned helplessness (Sadock & Sadock, 2007).

Kraepelin (as cited in Stone, 2006) acknowledged the impact environmental factors might have in the onset of depressive or manic episodes. However, he stated that the true reason underlying the onset of depression and mania was a "permanent internal change" (p. 12), which he attributed to hereditary. In the 1930s his hypothesis was given credibility by means of twin studies by Rosanhoff, Handy and Plesset (as cited in Stone, 2006). Biological functions became

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increasingly associated with behaviour and emotions throughout the twentieth century and several more biochemical theories were developed. In addition to the genetic hypothesis, these theories emphasised the role played by neurotransmitters (Solomon, 2001), hormones (Robbins, 2006) and aging (Stone, 2006).

As with the conceptualisation of depression, the etiology of depression has been viewed in many ways. Early civilisations attributed melancholia to excessive bodily fluids and a loss of God's favour. A significant turning point in our understanding of the causes of depression was introduced by Freud, who turned attention away from black bile and sin, towards a view that appreciated internal, psychological factors. Kraepelin's psychobiological approach also played a vital role in our contemporary view that acknowledges biological as well as psychological factors in the etiology of depression.

2.3. Current conceptualisation of Major Depressive Disorder

Over the last two and a half millennia the understanding of mental illness has become increasingly more refined and also diversified. This has especially been the case following the advent of two taxonomy systems that are currently widely used when dealing with mental illness, namely the DSM and the International Classification of Diseases (ICD). The DSM was and continues to be compiled and published by the American Psychiatric Association (APA) and its latest edition, the DSM-5 was published in 2013 (APA, 2013). The ICD is a product of the World Health Organisation (WHO) and is currently in its tenth edition, which was endorsed in 1990 (WHO, n.d.). There are some differences between the criteria these two taxonomies outline for the diagnoses of MDD (DSM-5), and Depressive Episode (ICD-10), albeit slight. However, greater attention will be afforded to the DSM conceptualization here, because this is the system that was utilised by the primary research studies that were analysed in this research project.

The studies that were analysed in this research project were conducted when the DSM-IV-TR was still the most up-to-date version of the APA nosology system. However, the symptom

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[1] The changes that were implemented in relation to depressive disorders from DSM-IV to DSM-5 were: 1) the inclusion of a new diagnosis, namely Disruptive Mood Dysregulation Disorder; 2) the move of Premenstrual Dysphoric Disorder from an Appendix to the main body of mental illnesses and 3) the creation of a new category, namely Persistent Depressive Disorder, which incorporated Chronic Major Depressive Disorder and Dysthymic Disorder. The changes associated with MDD were 1) an acknowledgement of the possibility of the co-occurrence of at least three manic symptoms (insufficient for the diagnosis of a Manic Episode) within a Major Depressive Episode by the specifier "with mixed features" and 2) the omission of the exclusionary criteria of Bereavement as depressive symptoms lasting less than two months (APA, 2013).

patterns that form the basis for the diagnosis of MDD remained unchanged from the fourth edition, text revision to the fifth edition (APA, 2000; APA, 2013).[1] In both the DSM-IV and DSM-5, symptoms of depression become significant and warrant a diagnosis of MDD when they impair a person's daily functioning and/or cause clinically significant levels of distress, and persist for a period of two weeks or more. The core symptoms of MDD can be seen in the DSM criteria, as outlined below.

Major Depressive Disorder

Diagnostic Criteria

A. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning: at least one of the symptoms is either (1) depressed mood or (2) loss of interest or pleasure.

   Note: Do not include symptoms that are clearly attributable to another medical condition.

   1. Depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad, empty, hopeless) or observation made by others (e.g., appears tearful). (**Note:** In children and adolescents, can be irritable mood.)
   2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation).
   3. Significant weight loss when not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day.
      (**Note:** In children, consider failure to make expected weight gain.)
   4. Insomnia or hypersomnia nearly every day.
   5. Psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down).
   6. Fatigue or loss of energy nearly every day.
   7. Feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick).
   8. Diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others).
   9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The episode is not attributable to the physiological effects of a substance or to another medical condition.

Note: Criteria A-C represent a major depressive episode.

Note: Responses to a significant loss (e.g., bereavement, financial ruin, losses from a natural disaster, a serious medical illness or disability) may include the feelings of intense sadness, rumination about the loss, insomnia, poor appetite, and weight loss noted in Criterion A, which may resemble a depressive episode. Although such symptoms may be understandable or considered appropriate to the loss, the presence of a major depressive episode in addition to the normal response to a significant loss should also be carefully considered. This decision inevitably requires the exercise of clinical judgment based on the individual's history and the cultural norms for the expression of distress in the context of loss.

D. The occurrence of the major depressive episode is not better explained by schizoaffective disorder, schizophrenia, schizophreniform disorder, delusional disorder, or other specified and unspecified schizophrenia spectrum and other psychotic disorders.

E. There has never been a manic episode or a hypomanic episode.

   Note: This exclusion does not apply if all of the manic-like or hypomanic-like episodes are substance-induced or are attributable to the physiological effects of another medical condition.

Note. From APA (2013)

A depressed mood is either described by the person or, when it is denied, may be observed by others by means of the person's facial expression or demeanor. It often occurs that people with MDD seek out assistance due to reasons other than depression, such as sleeping difficulties, either hypersomnia or insomnia, stress or interpersonal problems. They often struggle engaging in physical or cognitive demanding tasks, as they struggle to maintain focus and easily become fatigued. Suicidal ideation may range from a passive wish not to wake up in the mornings, believing others are better off if s/he were dead, thoughts of committing suicide, to formulating a plan, failed suicide attempts, or in severe cases successful suicide. Suicidal ideation and attempts are often associated with thoughts of hopelessness, feeling overwhelmed and giving up as the person fails to foresee any improvement or change in their distressing experience(s) (APA, 2013).

Within the APA nosology, certain coding specifiers allow for greater specificity in describing the presentation of a MDD within an individual (APA, 2013). These specifiers indicate whether it is a single or recurrent episode, the current severity (mild, moderate or severe), whether psychotic features are present and the remission status. Specifiers also allow for the indication of anxious distress, mixed features, melancholic features, atypical features, mood-congruent / incongruent psychotic features, catatonia, peripartum onset or seasonal pattern.

Depressive symptoms may be experienced in isolation or to a lesser degree of severity. It may manifest as pessimism, anger, fatigue, acting out, everyday blues or normal sadness. This frequently occurs in reaction to environmental stressors, such as interpersonal conflict, loss of a job or loss of a significant other. However, in general these symptoms tend to be of shorter duration (less than 2 weeks), the person's functionality continues unimpaired, or close to normal, in significant domains of his/her life, and recovery occurs without professional intervention (Carter & Golant, 2012). It is when these symptoms impairs daily functioning and/or the distress becomes intolerable and when this persist for an extended period of time that a diagnosis of MDD and professional intervention becomes warranted (APA, 2013)

2.4. Current etiological understandings of Major Depressive Disorder

Both the APA and the WHO endorse a biopsychosocial understanding of the causal nature of MDD (APA, 2013; WHO, 2015). Within the biopsychosocial perspective it is postulated that biological, psychological and social factors interact in the development of depression (Robbins, 2006).

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Neurotransmitters, hormones and heredity play a significant role on a biological level. According to Robbins (2006), various neurotransmitters are considered important biological factors in depression. Serotonin and norepinephrine have been linked to psychological reactions such as aggression and depression, dopamine and endorphins have been associated with a person's ability to experience pleasure and GABA have been found at a reduced level among people with depression. In addition to neurotransmitters, Robbins (2006) stated that hormonal changes also play a significant role. Sudden reduction of testosterone may be especially influential among older men. Among women, estrogen and progesterone have been found to be related to depressive features after the onset of menses (Bhatia & Bhatia, 2002). A contemporary significant interest is the impact of corticotrophin-releasing factor (CRF) on hormonal and behavioural responses to stress. Dysregulation in the CRF system has been associated with depression. In terms of heredity and genetics, the interaction among multiple genes and environmental factors are seen as causally significant, rather than linking depression to a single gene. Genetics may predispose a person to a mental disorder such as depression, but environmental stressors are required to trigger the associated symptoms (Wurtman, 2005).

Psychosocial influences on MDD in the general population are diverse. Even within an individual, different psychosocial experiences may result in depression (Robbins, 2006). This includes the influences exerted on a person by the surrounding social context as well as the person's response to the social environment (Mahalik, 2008). Robbins (2006) stated that these include childhood experiences such as loss, trauma and abuse as well as parental influences such as an absent father or mother. Another psychosocial consideration includes the effect of certain societal requirements. These requirements may be very rigid and not leave a lot of room for deviation. Those who do not develop into these roles adequately may be regarded as inferior and less desirable and even perceive themselves as failures. These societal requirements are not necessarily stated explicitly, but may develop based on perceptions of normative group behaviour. Based on their perceptions of the behaviour of other men and women, they conceptualise what is acceptable behaviour as well as what is deviant behaviour. Loss also plays an important role in the development of depression, including loss of occupations, status and romantic relationships and an often accompanying loss of self-esteem. The psychosocial part of this model also allows for psychoanalytical considerations, such as oedipal fixation and the role this can play in a sex/love split in future romantic relationships (Mahalik, 2008).

2.5. Gender and depression

Fewer men are diagnosed with MDD, compared to women. Epidemiological findings indicate a one and a half to three fold greater prevalence of MDD among women (APA, 2013). This is further evidenced by Afifi's (2007) findings that women are on the receiving end of mental health care services far more frequently than men. Some argue (Möller-Leimkühler, Bottlender, Strauß, & Rutz, 2004; Ogrodniczuk & Oliffe, 2011; Rochlen et al., 2010) that these differences reported in epidemiological studies do not necessarily reflect the true nature of the prevalence of MDD because depression in men has been, and continues to be, under-reported. A variety of reasons have been proposed for this phenomenon. Some have suggested that MDD among men is under-reported due to the use of generic diagnostic criteria that are insensitive to depression among men (Brownhill et al., 2005), that men are more reluctant to express concern and seek help in relation to their mental health (Winkler et al., 2006) and when men do seek out mental health care services, the fragmented pathways associated with this service delivery results in reduced engagement (Strike et al., 2006). This suggests that gender may play a significant role in the presentation of depression. As a result, more detailed exploration into the nature of this difference will prove useful.

2.5.1. Gender.

When addressing differences between men and women, it is essential to understand the distinction between *sex* and *gender*. Afifi (2007) reported that these two terms are often erroneously used interchangeably, which can become confusing. Sex refers to biological characteristics that differentiate between men and women. Gender refers to differences between males and females based on biological characteristics as well as cultural, social, historical and psychological factors, although biological determinants are often excluded. Gender informs how men and women are expected to think and behave in a given society. Sex differences relate to these factors (of gender) as they are associated to sex (Branney & White, 2008). A gender approach to psychopathology seeks to explore how gender, including gender inequality, affects mental health (Afifi, 2007). With respect to MDD, this approach considers how gender related self-concepts and cultural or social norms influence men and women's experiences and responses to MDD (Möller-Leimkühler & Yücel, 2010), as well as exploring gender-based differences in the epidemiology of MDD.

When discussing gender, it is vital to keep in mind that gender is not fixed (Connell, 2002) and that an individual may have both masculine and feminine features (Twenge, 1997). Connell

(2002) argued that the traits stereotypically associated with a specific gender have historically and culturally been subject to change. As men and women think and behave in ways associated with their gender, they perpetuated gender norms. However, as they diverge from these norms, they are actively involved in creating new possibilities for gender based norms. Twenge (1997) explored gender-based changes within a 20-year period, from the 1970s to the 1990s. She found that both men and women systematically endorsed the stereotyped traits associated with the opposite gender to a greater extent over this period. Similar findings were reported by Möller-Leimkühler and Yücel (2010). They assessed the gender-role orientation of students and found that only 38 percent of women primarily endorced feminine traits and 22 percent of men endorced masculine traits, while the remainder were spread across undifferentiated, androgynous and opposite gender catogories. These findings indicate that men and women do not necessarily follow the gender-based norms of their time and society to the letter. Instead, it appears that men display more feminine features and women display more masculine features at present than their counterparts of 40 years ago. As members of society alter their behaviour, they are actively involved in either perpetuating or altering normative gender-based expectations within their society (Twenge, 1997).

Despite findings indicating a convergence of gender norms, such as those outlined by Twenge (1997), there continues to exist differences among femininity and masculinity. Danielsson and Johansson (2005) found that women displayed a greater readiness to communicate emotional difficulties as well as greater proficiency in articulating feelings and emotions. Other socially desirable or typical traits associated with women include being understanding, gentle (Twenge, 1997), fragile, nurturing (Oliffe & Phillips, 2008), and the homemaker (Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011). Men, on the other hand, were found to be more inclined to express concern over physiological complaints, especially more serious complaints such as cardiovascular conditions, as opposed to seeking help in relating to emotional difficulties. Masculinity was found to be associated with assertiveness, independence (Twenge, 1997), being tough, being the breadwinner, possessing power, authority, resources (Oliffe et al., 2011), self-assurance, confidence, sovereignty, and a language devoid of emotional expression (Danielsson & Johansson, 2005). In line with these findings, Danielsson and Johansson (2005) postulated that when faced with psychological difficulties, people who adhere to masculine norms might withdraw into silence, express physical complaints, become aggressive or abuse substances, as opposed to articulating their psychological distress. They found that this was particularly the case among those with higher socio-educational backgrounds. Whereas, men

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from lower socio-educational backgrounds were more inclined to express weakness and would more readily change.

2.5.2. Women and depression.

It has been established that women experience a greater number of traditional depressive symptoms (Branney & White, 2008). Women's experience of depression tends to be more in line with the DSM-5 symptomatology, as outlined earlier. The symptoms most often found among women include worry, spells of crying, feelings of loneliness and helplessness, suicidal ideation, increase in appetite and weight as well as non-diagnostic symptoms such as physical pains and a stooped posture. Para-suicides are significantly more common among women than men (Mościcki, 1997; Oquendo et al., 2001).

Relating to gender differences in depression, research has started to focus on differences among men and women in exposure to certain stressful life events as well as their responses to stressors (Nolen-Hoeksema, 2001). Breslau, Davis, Andreski, Peterson and Schultz (1997) found that even when faced with similar stressors, women tend to be more vulnerable to developing depression than men. However, more recently Afifi (2007) stated that women were only at greater risk for MDD in the face of stressors associated with children, reproduction and housing and not with stressors associated with work, finances and marital relationships. Nolen-Hoeksema (2001) argued that this gender-based difference could be attributed to difference in coping strategies, self-concepts and biological responses.

Women have been found to display different coping mechanisms than men. Women attempt to cope through emotional release, engaging more in religion, reading (Rutz & Rihmer, 2007), eating, seeking help, talking about their problems (Brownhill et al., 2005) and ruminating when faced with distress (Nolen-Hoeksema, Larson, & Grayson, 1999). Nolen-Hoeksema (1991) proposed a gendered responding framework, which postulated that the way a person responded to a depressed mood played a vital role in the exacerbation and duration of their depression. More recently this construct was re-evaluated (Nolen-Hoeksema, Wisco, & Lyubomirsky, 2008). They reaffirmed that ruminating on one's symptoms, on possible causes and consequences are predictive factors for the development of MDD. It was found that rumination impairs one's ability to think, solve problems, engage in instrumental activities, and interpersonal relationships. In terms of gender, women were found to be more likely to ruminate as a response to their depressed mood than men, hence leaving women more vulnerable to MDD (Addis, 2008).

One specific stressor that may increase women's vulnerability to depression is trauma. Historically, women have been more vulnerable to experiencing trauma than men. Exposure to certain traumas, such as sexual abuse, have been linked to increased feelings of helplessness in controlling certain significant aspects of their lives. Weiss, Longhurst and Mazure (1999) found that women experience sexual abuse at least twice as often as men. Their research also indicated that people who experience sexual abuse have an increased risk for developing depression, especially when the abuse occurs during childhood. Childhood abuse alters the way a person responds to stress on a biological and psychological level (Weiss, Longhurst, & Mazure, 1999), as well as the person's perspectives of themselves and of others (Zahn-Waxler, 2000), which in turn affects the person's vulnerability to depression.

Another factor that may account for the female preponderance in depression is their regulation of stress on a biological level. Research has found the hypothalamic-pituitary-adrenal (HPA) axis plays an important role in regulating stress (Nolen-Hoeksema, 2001). In simple terms, the adrenal gland releases hormones in response to the chemical secretion of the hypothalamus and the pituitary. When dysregulation occurs in the HPA, a person may be increasingly vulnerable to developing depression in response to a stressful life experience. Dysregulation is found more frequently among women (Weiss et al., 1999). The higher frequency among women has been linked to the higher likelihood of trauma in the lives of women, and exposure to trauma is known to influence HPA dysregulation. An additional contributing factor to the regulation of HPA funtioning is ovarian hormones (Young & Korszun, 1999). During times where women experience rapid changes in ovarian hormones (e.g. puberty, premenstral period, postpartum period and menopause), they may experience dysregulation in their responses to stress and may consequently be more at risk to develop depression.

According to these findings, it appears that the gender-based normative practices and biological processes of women may leave them more vulnerable to develop MDD as outlined by the DSM. This appears to be the case especially when exposed to traumatic childhood experiences and/or stressful life events later on in life.

2.5.3. Men and depression.

Oliffe et al. (2011) reported that there is a growing body of knowledge displaying interest in the link between depression in men and masculinity. According to Branney and White (2008), hegemonic masculinity is the most widespread approach for conceptualising men's gender in contemporary academia. A central premise of this approach is the idea that gender is something

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that is *done*, as opposed to something that *is*. Gender-based norms are considered to be established and maintained by the practice thereof. That is to say, that the more commonly a behaviour is practiced within a particular gender, the stronger the likelihood is that it will be established as a gender-based norm. Furthermore, the continued practice thereof serves to maintain it as a norm. Hence, masculine features are those that are commonly practiced by men in a particular context. Those most commonly practiced are the most ingrained and hence the most dominant aspects of masculinity.

Gender differences in depressive symptomatology can be understood in terms of underlying gendered practices. Research indicated that men tend to adhere to masculinities that emphasise power, control, self-reliance, strength and stoicism (Oliffe et al., 2011). According to an evolusionary perspective, this emenates from older societies, where aggression was a desirable trait among men, as it aided in the protection of and provision for one's family. Men had to respond quickly to stressors in order to either eliminate, or alternatively to flee from it. However, in today's society, aggressive responses can have negative and even legal consequences. On the other hand avoidance may have negative social and occupational consequences. Contemporary men may thus be pressured to supress these innate urges as a result, which can leave them vulnerable to depression (Robbins, 2006).

O'Brien et al. (2005) found that young men continue to perceive masculinity as associated with being strong and silent, specifically in relation to emotions. This is in line with Branney and White's (2008) premise that the expression of depression is seen as un-masculine. Those who do not develop according to these societal expectations adequately may be regarded as inferior and less desirable and even perceive themselves as failures. Expectations like this can drive certain individuals into repressing the more feminine features of themselves in order to avoid rejection (Mahalik, 2008). Cheryan, Cameron, Katagiri and Monin, (2015) reported that when men felt that their masculine identity was threatened, they attempted to restore this identity by distancing themselves from feminine preferences and exaggerated masculine features. The consequence of norms like these may be that "developing boys are socialised into emotionally inarticulate young men, unable to express depression" (Branney & White, 2008, p.261).

The adherence to masculine roles have been associated with certain coping mechanisms, such as avoidance, resisting help, self-monitoring, numbing and escaping (Brownhill et al., 2005; Emslie, Ridge, Ziebland, & Hunt, 2006). They found that men attempted to avoid their experience of distress by burying themselves in their work, or engaging in physical activities,

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such as swimming, walking, running, riding bike, working on a car or working in the garden. This served to distract them from their problems, clear their heads and calm down so they could engage with the problem in a calmer state of mind. Alternatively, men also took time off from work when in distress. This allowed them time to think and gain perspective or to attempt to solve their problems. Some would attempt to numb or escape emotional distress, through means of drugs and alcohol. This did not allow for a release of the actual pain, which was kept inside, internalised and built up over time. Brownhill et al. (2005) emphasised the disparity between men's reluctance for help-seeking and a strong need to stay in control of situations and feelings, and women's proclivity for aknowledging their problems and seeking help.

When men fail to deal with their experiences of depression, destructive consequences often follow as they engage in behaviours that can be risky, dangerous and even life-threatening. For instance, engaging in interpersonal violence, destruction of property, substance abuse and suicide. These behaviours signify a physical release of built up emotional pain (Brownhill et al., 2005). These are "ways of doing depression that enact particular masculinities" (Branney & White, 2008). Cochran and Rabinowitz (2003) added that men experiencing depression exhibit difficulties with impulse control, substance abuse, gender roles, anxiety, anger, irritability, risk taking, impoverished relationships, lack of emotional expression, and emotional numbness. Findings like these may be taken to indicate the existence of a form of depression that diagnostic scales based on DSM and ICD nosologies will fail to identify as depression. Some have even proposed the possibility of a *male depressive syndrome* (Rutz, von Knorring, Pihlgren, Rihmer, & Walinder, 1995).

Rutz and Rihmer (2007) argued that the lower prevalence of diagnosed depression in men, compared to women, may be an artefact and that it does not necessarily reflect the actual occurrence of depression. Research among American Amish (Egeland, Hostetter, & Eshleman, 1983), American Jewish and orthodox Jewish Israelian populations (Levav, Kohn, Dohrenwend, & Shrout, 1993) suggested a very different picture. Alcohol abuse is a stigmatised practice in these cultures and, in the Amish community in particular, aggressive behaviour is also regarded as taboo. This research indicated that diagnosed depression was equally prevalent among men and women and that suicide rates were as low among men as among women. Findings like these point to the idea that epidemiological differences among men and women are not necessarily due to biological differences alone. Instead, culture-based norms may play a significant role.

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2.5.4. Help-seeking and gender.

Research indicated that gender differences do not necessarily appear in the experience of depression itself, but more in the expression thereof (Brownhill et al., 2005). One prominent gender-based difference in the expression of depression relates to help-seeking behaviour. In primary health care settings, women receive the majority of interventions for mental health issues. This is indicative of women's proneness to seek help in relation to psychological symptoms. However, in specialist mental health care setting, such as psychiatric hospitals, the gender difference is less marked (Afifi, 2007). In these settings, admission is less contingent on deliberate help-seeking, but more on psychopathology severe enough to necessitate hospitalisation. Research by Angst and Ernst (as cited in Diamond, 2008) reported that 75% of those who sought help in relation to suicidal ideation were women, despite the fact that 75% of completed suicides that year were committed by men. Findings like these suggest that women are more prone to seek out professional help, which men are more inclined to avoid. By avoiding, men's psychopathology may perpetuate and exacerbate until hospitalisation is required or fatal consequences follow. Some authors have suggested that this forms part of men's distinctive health or illness related behaviour (Galdas, Cheater, & Marshall, 2005; Möller-Leimkühler, 2002; Oliffe & Phillips, 2008).

As noted earlier, norms that ascribe emotions as a feminine characteristic and not a part of masculinity are common. Acknowledging emotional pain is seen as an alignment with femininity and as a risk to their sense of masculinity (Brownhill et al., 2002). These norms have an impact on men's ability to identify their emotional difficulties, their expression thereof as well as their help-seeking related behaviour (Branney & White, 2008). When men are socially conditioned to supress their experiences of distress, delayed help-seeking tends to follow (Brownhill et al., 2002). Men are more inclined to risk their health, than promote it, by denying any illness and avoiding health care interventions as far as possible (Addis & Mahalik, 2003; Courtenay, 2000; O'Brien et al., 2005). Men faced with emotional distress would rather engage in self-treatment behaviour before seeking advice or assistance from others. When men do engage in help-seeking behaviour, it is most commonly in relation to physical or behavioural conditions, such as chest pains, self-harm, and substance abuse. Consequently, as men mask their distress, their depression can easily be overlooked (Brownhill et al., 2002).

Courtenay (2000) proposed that men's help-seeking behaviours are linked to certain aspects of masculinity, in particular to self-reliance, stoicism, aggression and physical strenth.

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Experiencing and responding to distress are often perceived as signs of weakness. In light of these findings, men may chose to conceal their emotional distress due to a number of reasons, such as embarrassment, shame and a belief that they are, or should be strong enough to deal with emotional distress without professional intervention. Failure to disclose their distress can also result from doubts in the willingness and competence of the general medical practitioner to assist, which is often the first line of help seeking (Brownhill et al., 2002).

2.5.5. Depression, suicide and gender.

Depression is known to significantly increase the risk for suicide (Möller-Leimkühler, 2002). Women seek help for suicidal ideation more frequently than men (Diamond, 2008) and when women do attempt suicide, they are more likely to be unsuccessful (Milner & De Leo, 2010; Mościcki, 1997; Oquendo et al., 2001). Men, on the other hand, more often successfully commit suicide. Oquendo et al. (2001) indicated that women are twice as likely to attempt suicide, whereas men are four times more likely to complete suicide.

These findings indicate that suicide is a particular concern when addressing psychopathology in men, especially MDD. However, due to men's inhibited help-seeking behaviour, they often do not receive help in time. This was evident in Lithuania. According to WHO (as cited in Rihmer & Akiskal, 2006), Luthiania had the highest suicide rate at the time and 90% of successful suicides were commited by men. In this country, alcohol consumption was rife, male help-seeking was scarce and diagnosed depression was uncommon among the male population. In order to address the high rate of suicide, centres were put in place for crises intervention. However, the client base at these centres were found to be predominantly female and suicide rates in the country continued unchanged. This highlighted the fact that accessibility to mental health services were not enough. Innovative approaches would be necessary in order to foster greater acceptance and use of mental health services by men (Rutz & Rihmer, 2007).

On the Swedish island of Gotland, suicide also became a particular concern. As a result, a "psychological autopsy" (Rutz & Rihmer, 2007, p. 396) was conducted in order to investigate this problem. The results indicated that men who successfully commited suicide displayed both common MDD symptoms, as well as symptoms not generally included in psyhiatric nosologies. The more generic MDD symptoms that were found included disturbed sleep, fatigue, indecisiveness and depressive thought distortions. Whereas, the less common symptoms that were found included impaired stress tolerance, impulse control difficulties, burn out, irritability, morning uneasiness, abusiveness, antisocial behaviour, self-pity and

alcoholism. Based on these findings, the Gotland Male Depression Scale was developed and an education program was implimented on the island in 1994. Under this educational program, general medical practitianers, other caregivers and the general public were informed of this *male depressive and suicidal syndrome.* Subsequently, during the mid to late 90s, more men made contact with the health care system and received professional intervention. Suicide mortality among men decreased significantly during this period (Rutz, Walinder, Von Knorring, Rihmer, & Pihlgren, 1997). Considering the strong association between suicide and mood disorders, in particular MDD (Oliffe & Phillips, 2008), the finding of the Gotland study can be useful when conceptualising men's experience and expression of MDD. This can inform professional understanding and response to MDD among men.

Oliffe, Ogrodniczuk, Bottorff, Johnson and Hoyak, (2012) reported of men who acted in opposition to prevailing masculine norms that promote the perception that emotionality is a sign of weakness and associated with femininity. These men reached out to friends, family and health professionals with regards to their depression and suicidality. They regarded this as taking up a fight against their experience of suicidal ideation, which allowed them to overcome their suicidal urges. They reported of the courage it took to ask for help and regarded this as an act in line with their masculinity, instead of perceiving it as a threat thereto.

2.6. Depression among tertiary students

2.6.1. Emerging adulthood.

Arnett (2007) postulated a construct, *emerging adulthood,* to describe a relatively novel developmental period of life among industrialised societies, stretching from late teens to middle or late 20's. This reflects a post-adolescent time in an age bracket associated with the majority of tertiary students and described a stage of life where people have not made definite long-term commitments in terms of occupations, marriage or parenthood.

Arnett (2004) postulated that emerging adulthood is characterised by five main features. Firstly, it is an age of identity exploration. Emerging adulthood is a period where people are less dependent on their parents, since most have left home, however they are also not yet fully committed to adult roles, in terms of occupation, marriage or parenthood. This provides a very suitable period for the exploration of different roles within love and work, and in doing so exploring their own identities, relating to what they are and what they want in life. Secondly, it is an age of instability. Most emerging adults are aware that they are required to have a plan

in order to move from adolescence into adulthood. However, in a majority of the cases these plans are subject to frequent alterations. This is a natural consequence of the exploration that is characteristic of this time. Alterations may occur due to a variety of reasons; including changes of interest in the academic field, or in the job market or even in romantic involvements, or merely exploring the available options. Even something like residence is often not a stable feature during life as a tertiary student. As a result, this period tends to be marked by instability, as an inseparable co-occurrence of exploration. Thirdly, it is an age of self-focus. Decisions are made from a more self-focussed perspective. These include daily decision, such as what to make for dinner, to study or go out, and when to go home, if at all; as well as more lasting decisions, such as to study or work full-time, what to study, to change a study major, etc. This is unlike adolescence, where parents and teachers are more influential, and adulthood, where one's family (wife and children) have to be considered when making decisions, both daily and long-term decision. Fourthly, it is an age of feeling in-between. The emergence of the criteria that constitute adulthood develop gradually, and so do people's experience of being an adult. They have left their families of origin and the associated obligations, but have not yet committed to new ones. As a result, most emerging adults do not feel like they have reached adulthood yet, neither do they feel like adolescents anymore. Finally, it is an age of possibilities. Those at this stage of development tend to be filled with high hopes and expectations, as little permanent decisions have been committed to and the future remains open to a variety of outcomes. Their aspirations all seem to be attainable and for most emerging adults the array of paths forward are greater than at any time before or will be again.

2.6.2. Depression among emerging adults.

In the DSM-5 (APA, 2013) it was reported that the incidence of depression peaks in the 20s age range. The WHO (as cited in Winkler et al., 2006) confirmed that suicide is more common in men, and that this is especially the case during late teens and 20s. Patton et al. (2009) stated that suicide is two to four times more likely among young men than young women. Based on these findings, men in the emerging adulthood life period appears particularly at risk for depression and suicide.

Danielsson et al. (2011) investigated depression among young people aged 17 - 25. A significant finding from their study was that this group predominantly strove to conform to prevailing norms, particularly in relation to gender-based norms. Conforming to one's normative practices were linked to self-esteem, feelings of acceptance, security and happiness.

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They found that two particularly influential agents in relation to the formation of prevailing norms among this age group were the media and peers. Norms typically endorsed by the media and peers included that depression is a disorder particular to women, that men are expected to be strong and self-sufficient and that dependence on others is a sign of weakness and something that is shameful. As a result, men in this age group were disinclined to share their experiences of sadness and vulnerability with others, even when these distressing experiences became increasingly severe. When faced with depression, these young men were more inclined to respond with aggression, anger and irritability, whereas the young women more willing to express their worry and sadness. As a result of these young men's responses to depression and disinclination to seek help, Danielsson et al. (2011) concluded that depression is an under-identified problem within this population.

Möller-Leimkühler and Yücel (2010) found that the *male depressive disorder* proposed by authors such as Rutz et al. (1995), is not unique to males within a tertiary student population. Their findings indicated that female students may be even more at risk to this phenomenon than their male counterparts (29% vs. 22%). One explanation proposed for this was that externalising symptoms, such as irritability, anger and aggression, were experienced to a greater extent than has traditionally been associated with femininity. However, due to societal norms, the expression of aggression was less common among the females than males. However, changing norms appears to have allowed for a convergence of gender roles and that externalising behaviour has become more tolerable among females.

Depression among male tertiary students has been attributed to a number of factors. Tremblay, Morin, Desbiens, and Bouchard (as cited in Oliffe et al., 2010a), established links between depression in this population and moving away from social support structures by going off to college, financial strain associated with high education costs and pressure to perform academically. Courtenay, Mccreary and Merighi (2002) added alcohol use as a significant factor among college men. Excessive alcohol use increased the risk for depression and it provided a method to self-medicate depressive symptoms. Additionally, excessive drinking increased the risk for men to be the victim or perpetrator in violence and rape, both of which have an impact on men's mental health.

Literature has indicated that depression among students may have a different presentation from other population groups (Kitamura, Hirano, Chen, & Hirata, 2004; Smith, Rosenstein, & Granaas, 2001). For instance, changes in sleeping and eating patterns are common features of

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depression. However these are often changing variables among students with or without depression, due to a variety of reasons, such social and academic schedules. These and other findings spurred Khawaja and Bryden (2006) on to develop the University Student Depression Inventory (USDI). Within this inventory they conceptualised both generic depressive features as well as less common features as part of university students' experience of depression. The generic features included depressed mood, anhedonia, physical fatigue, mental fatigue; concentration difficulties, low self-esteem, pessimism, feelings of emptiness and suicidal ideation. One of the novel features introduced in this inventory related to academic motivation. This could be identified by either motivation itself, or procrastination related to education. Another novel feature was the exclusion of sleeping and eating patterns, because altered sleeping and eating patterns are common occurrences even among non-depressed tertiary students.

2.7. Conclusion

Depression has been noted in human experience since the time of the ancient Greeks. Initially, the term melancholia was used to denote a distressing experience comprised primarily of vegetative symptoms. It was seen as one manifestation of a disease, with the other manifestation being mania. The understanding of this illness went through several changes through the years, including describing a more generic sense of distress and regarding it as part of an artistic and philosophic disposition. Robert Burton distinguished melancholia from less severe experiences of general unhappiness. Emil Kraepelin proposed a psychobiological understanding of manic-depressive insanity and classified it as a mood disorder. Karl Leonhard distinguished unipolar depression from a bipolar syndrome. This understanding continues to characterise contemporary conceptualisations of depression, as outlined in the DSM-5.

Similar to the conceptual understanding of depression, theories regarding the causes of depression went through several changes. During the time of the ancient Greeks, Hippocrates postulated that melancholia was the result of excessive black bile in a person's body. During the Medieval times, the Church attributed it to man's sinful soul and the subsequent loss of God's favour. The current biopsychosocial understanding was set in motion by both Freud's psychoanalytic theories and Kraepelin's psychobiological approach with a greater focus on biochemical explanations.

In terms of epidemiological findings, research has found a greater prevalence of MDD among women, compared to men. However, this has been attributed to several reasons that signify an under-reported male depressive syndrome. It has been suggested that the gender difference found in epidemiological studies are limited and do not necessarily reflect the true prevalence of MDD. Depression among men often go undetected. One reasons for this is the notion that men may express depression in a different way from women. As a result, diagnostic criteria may be insensitive to men's depression, as these criteria tend to be based on depressive presentations found among a predominantly female population. Another reason is that men tend to view emotional distress as a feminine characteristic and hence as un-masculine. Consequently, their help-seeking behaviour is inhibited and they tend to avoid external assistance or numb their distress by means of self-medication. As a result, men's experience of MDD often perpetuates or exacerbates until hospitalisation is required, or fatal consequences follow.

Research indicates that the incidence of MDD peaks in the 20s age range. As emerging adults attempt to explore the possibilities available to them, they often experience instability and struggle to find their place in society. This population is particularly interested in conforming to prevailing cultural norms and acceptance. This has been linked to reduced help-seeking behaviour and subsequently the perpetuation and even exacerbation of distressing experiences such as MDD.

In conclusion, research findings suggest a male depressive syndrome that differs from more generic conceptualisations found in nosologies. Part of this syndrome is reduced help-seeking, which leaves men more vulnerable to functional impairment and possible fatal consequences. These risks are particularly high among emerging adults. The following chapters will explore research findings that suggest a male depressive syndrome and the experience and expression thereof, in particular among male tertiary students, in an attempt to create a framework to understand this phenomenon.

Chapter 3: Research design

3.1. Introduction

This chapter describes the design that was adopted by this research project to answer the research question of this study: "What do primary qualitative research studies reveal about male tertiary students' experiences of depression?" In order to explore their experiences, a qualitative research approach was utilised. A meta-synthesis methodology was used to integrate findings from an array of already published, or primary studies. More specifically, this study adopted Noblit and Hare's (1988) method of meta-ethnography. This approach uses already published findings from other research studies as the primary source of data. Hence, the data for this study was the analyses that other researchers made based on their raw data.

The chapter begins by describing the research approach, methodology and method. This will be followed by an outline of the analysis, according to the seven steps originally outlined by Noblit and Hare (1988), from formulating the research question and determining what primary research studies to include, to how the findings were synthesised and the manner in which the findings were expressed. The chapter will then be concluded with the ethical and quality considerations that had to be taken into account.

3.2. Qualitative research

Meta-synthesis studies use primary studies of a qualitative nature as data and bring these studies together using qualitative research strategies. As such, meta-syntheses are also regarded as qualitative studies. Qualitative research is defined as an investigation of aspects of social life, focussing on the interpretation and meaning of social processes (Jupp, 2006). Qualitative approaches are employed when research seeks to explore human elements within particular phenomena (Given, 2008). It is interested in producing and/or enhancing understanding about experiences and processes (Harper & Thompson, 2012) and about how people perceive and experience the world around them (Given, 2008). This is a useful approach in mental health matters, which concerns people's well-being. As this research project is concerned with the experience and mental well-being of men with depression, a qualitative approach was deemed appropriate to address the research question. Data are collected and made sense of in order to enrich the understanding of people's complex and rich backgrounds and experiences, as a means of improving care and support (Harper & Thompson, 2012).

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Qualitative research is often placed in contrast to quantitative research. In simplistic terms, the difference between qualitative and quantitative research is that one is based on non-numerical and the other on numerical data (Babbie, 2002). Quantitative approaches seek to collect, analyse and communicate data in numerical form, as opposed to narrative form. According to this approach, gradations of quality are translated into numerical form that can be analysed based on statistical methods (Given, 2008). This is often used in the establishment of causal relationships between variables (Harper & Thompson, 2012). However, qualitative research is interested in how people construct their realities, based on their subjective interpretations about the world around them (Jupp, 2006). The distinction between qualitative and quantitative research has become less clear cut in recent years, as many studies employ mixed-method approaches (Given, 2008). The approach taken in this research project was qualitative in nature.

3.3. Research methodology: Meta-synthesis

Meta-synthesis was the research methodology used. A qualitative meta-synthesis serves as a way of enhancing the contribution of findings from qualitative research to the development of knowledge. It allows for a more comprehensive understanding of phenomena (Zimmer, 2006). Meta-synthesis is an interpretive integration of research findings that are qualitative in nature (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). It is "research of research" (Paterson, Thorne, Canam, & Jillings, 2001, p. 5). This approach is used when there are a number of published qualitative studies relating to a similar subject matter that one wishes to integrate. Studies employing different methods can be accommodated within this synthesis approach (Zimmer, 2006). A meta-synthesis is then used to create substantial claims about the phenomenon, which reach beyond the understanding of each individual study. Meta-synthesis differs from other integrative research methodologies in that it explicitly acknowledges their objective as the production of new knowledge based on extant research (Given, 2008). According to Thorne et al. (2004), the synthesis intends to create something that is more than the sum of its parts, by producing new interpretations. The existing research can come from a variety of different approaches, such as interpretive descriptions, grounded theory, phenomenology and ethnography (Given, 2008).

The approaches under this methodology use systematic, structured and auditable processes in order to generate overarching claims about the phenomenon under investigation and do so by means of inductive derivation. In scientific research, inductive reasoning is concerned with

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relating particular observations to a broader theoretical proposition concerning the topic of interest, as a way of enhancing theory (Given, 2008).

3.4. Research method: Meta-ethnography

There are numerous possible qualitative synthesis approaches. One of the most important considerations in choosing a method is deciding whether the aim is to aggregate findings or interpret findings in order to develop conceptual understandings of a phenomenon (Toye et al., 2014). The latter was in line with the goals of this research process and hence a meta-ethnography was employed.

According to Harper and Thompson (2012), meta-ethnography is probably the most influential research method for synthesising qualitative research. This research project specifically employed Noblit and Hare's (1988) method of meta-ethnography. Meta-ethnography is a research method that is employed when one wishes to synthesise studies that are related to each other by topical foci, and it is applicable to qualitative studies (Given, 2008). Since the introduction of meta-ethnography in the 1980, it has undergone certain developments (Atkins et al., 2008). For instance, search strategies are reported, as was done by Malpass et al. (2009). Additionally, meta-ethnography is not limited to synthesising ethnographies only. Rather, an array of qualitative studies can be used (Britten et al., 2002). The most essential requirement is that the studies to be synthesised should be related to a similar topic. When studies concern essentially different topics, it makes little sense to attempt a synthesis. A meta-ethnography can be used primarily under three circumstances, namely when studies 1) relate to similar topics, 2) attempt to refute each other or 3) seek to build successive lines of argument (Noblit & Hare, 1988).

The method proposed by Noblit and Hare (1988) moves beyond the mere aggregation of research findings. Their method was used to translate the themes of different studies into each other in order to produce something new. Although this method was developed in 1988, it has increasingly gained prominence over the years for synthesising qualitative research findings (Atkins et al., 2008).

Meta-ethnographies are based on an interpretative epistemological framework (Noblit & Hare, 1988). This means that the understanding established through research are based on people's interpretations of their own experiences. As such, interpretive enquiry is concerned with interpretations of interpretations (Given, 2008). Within this framework, meta-ethnography

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takes up a position of objective idealism, which is based on the premise that reality is based on our collectively shared understanding thereof. This falls on a continuum with subjective idealism on the one extreme and naïve realism on the other. According to subjective idealism no unitary objective reality can be found, as reality is based on a multitude of different human constructions thereof. Whereas, naïve realism is based on the premise that reality is not contingent on human constructions thereof and can be known directly. Meta-ethnography is more closely aligned with idealism than realism (Barnett-Page & Thomas, 2009).

According to Noblit and Hare (1988), the review and synthesis of qualitative research studies have four key assumptions. These assumptions are directly related to the epistemological paradigm outlined above. First, social realities vary significantly. Hence, the aim of research is not to establish definite, indisputable laws. Instead, the aim is to understand these variations in order to enrich human discourse. Second, reviews of qualitative research studies have the potential of developing new, possibly unanticipated, understandings of the topic being explored, while at the same time illuminating limitations of the preceding state of the discourse. Third, the accumulation of studies does not necessitate an improvement of understanding. Instead, it merely illuminates one of several areas of the perpetual discourse of ever changing and varied social realities. This implies a relativist ontology, where no single understanding can adequately explain a phenomenon at all times and places (Jupp, 2006). Noblit and Hare stated that "any interpretation, metaphor, or translation is only one possible reading of that studied" (1988, p.14). The work of a meta-ethnography is subject to the researcher. The results of such a study may reveal as much about the researcher's perspective as about the subject of enquiry, for "the analysist is always translating studies into his own world view" (Noblit and Hare, 1988, p. 25). Lastly, according to this approach, it is more reasonable to expect that the development of knowledge can inform our ability to anticipate human behaviour, rather than to predict it. This is in opposition with positivists, who aim to accumulate knowledge in order to improve their ability to predict the world. These four assumptions are applicable to most qualitative research approaches, specifically those employing an interpretive paradigm.

The primary distinction between a meta-ethnography and other methods of syntheses is the translation theory of synthesis it uses. This differs from the more aggregative theory used by methods such as integrative research reviews and meta-analysis. According to Noblit and Hare (1988), this translation theory proposes the use of reciprocal translations of concepts and metaphors of the studies that were analysed. An essential part of this approach was the creation of overarching metaphors that encapsulate ideas and concepts of the different studies. These

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metaphoric reductions were intended to present the meanings of the studies through abstractions, while preserving the complexities of and relations between the concepts of each study. Atkins et al. (2008) defined reciprocal translation as "The comparison of themes across papers and an attempt to match themes from one paper with themes from another, ensuring that a key theme captures similar themes from different papers" (p.6). This approach allowed for the development of a conceptual framework. Rather than working from a priori frameworks, the translations were developed inductively (Noblit & Hare, 1988).

3.5. Analysis

Sandelowski, Voils, Barroso and Lee (2008) stated that systematic reviews of qualitative research studies must be rigorous, transparent and repeatable. In light of these guidelines the search strategies employed in this study were outlined in detail. Noblit and Hare (1988) proposed seven phases for conducting a meta-ethnographic synthesis. These steps will be outlined in the following section, as they have been applied to this study. These phases are not necessarily sequential, as they often overlap and occur parallel to each other.

3.5.1. Phase 1: Getting started.

Like all other research projects, this meta-synthesis started with a certain area of interest. The initial step after identifying an intellectual interest was to read up on the topic and the related settings, arguments, issues and controversies. This allowed for the identification of potential opportunities for further investigation (Noblit & Hare, 1988). The impetus behind my initial interest was a study related to suicide among men on the Swedish island of Gotland in the mid-1980s (as cited in Rutz & Rihmer, 2007). These findings suggested the possibility of a depressive syndrome among men that differ from the generic conceptualisation of depression found in diagnostic manuals, such as the DSM (APA, 2013). There appeared to be indications of differences in both the experience and presentation of depression. It was this study on suicide and the suggestion that men express and experience depression differently that peaked my initial interest and led to further explorations.

As my search into this phenomenon expanded, three things became evident. Firstly, publications regarding depression among men were far fewer than depression among women. According to Addis (2008) approximately three times more publications were produced regarding depression among women. Secondly, research about depression among male tertiary students made up only a small proportion of the studies that focused on this mental health

problem among men. Lastly, during my exploration of the literature on this topic, it was found that most qualitative studies investigating depression among male tertiary students were isolated from each other. For instance, no articles were found that synthesised or reported of synthesised studies of extant research on this topic. Hence, a need was identified to systematically juxtapose and combine primary qualitative studies conducted on male tertiary students who experience depression.

3.5.2. Phase 2: Deciding what is relevant to the initial interest.

After identifying a gap in literature, it was necessary to develop an exhaustive list of studies that could potentially be included in the synthesis (Noblit & Hare, 1988). This was done in accord with the prevailing culture within what is regarded as good quality research (Toye et al., 2014). Once the general area of interest was established, a research question had to be developed. Based on the research question, a preliminary search was conducted in March 2014 to identify primary studies relevant to the area of interest, in order to ascertain the feasibility of this research project. The research question at this stage served as a preliminary guide to search for and retrieve studies that were possibly relevant. If the study was not feasible, the research question would have had to change. This was however not necessary. From here on, the search was an iterative process (Barnett-Page & Thomas, 2009) and the search for more studies continued until September 2014.

In the search for primary studies, specific search terms were used. In order to specify the population, 'male tertiary students', 'male college students' and 'male university students' were used. In order to specify the problem, 'depression', 'major depression' and 'major depressive disorder' were used. Lastly, in order to specify the type of primary studies, 'qualitative', 'ethnography', 'narrative', 'phenomenology' and 'case study' were used. These search terms were combined with each other across an array of online databases, including EbscoHost, Jstor, Proquest, PsycInfo, Pubmed, Science Direct, Scopus, UPeDT and Google Scholar.

Due to the high volume of published studies, the process of identifying relevant papers can be overwhelming (Toye et al., 2014). In order to improve the effectiveness of screening potential studies, this search was done independently by myself, my research supervisor and a Research Masters student from the University of Pretoria. The initial search indicated that numerous studies touched on the idea of depression in male tertiary students. However, only a few focused exclusively on this topic. Certain inclusion and exclusion criteria were established in

order to clarify the focus of this study. According to Tricco, Tetzlaff and Moher (2011), it is vital to define and report such criteria in a transparent manner in order to avoid any ambiguity and improve credibility of systematic reviews. The inclusion criteria were:

1) The primary studies had to employ qualitative methodologies. This was specified in light of the research goal intending to increase understanding of the experiences of depression among the sample population. According to Sandelowski (2008), findings from qualitative research has meaning in its ability to explain and illuminate experiences. Depression does not always present in a textbook fashion and by employing qualitative methodologies, those affected by MDD are given the opportunity to give voice to their experiences.

2) Participants were limited to male tertiary students. Men were chosen as the target population because of the greater preponderance of focus given to female participants in research into MDD. Addis (2008) stated that there is a lack of research on men experiencing depression, which holds socio-political and health concerns. Additionally, several authors have postulated that MDD is underdiagnosed, particularly among men (Brownhill et al., 2005; Strike et al., 2006; Winkler et al., 2006) and that MDD may present in a unique way within the male population, different from generic conceptualisations as put forward by nosologies of psychopathologies (Rutz & Rihmer, 2007; Rutz et al., 1995; Winkler et al., 2006). During the search for research studies that address MDD in men, it was found that the majority of research focussed on adolescent, adult and geriatric population groups. Relatively little attention was given specifically to the developmental period between late adolescent years and early to mid-20s. Yet, recent research indicated that one of the developmental stages where MDD peaks is in the 20s (APA, 2013).

3) The male students had to attend tertiary educational institutions in industrialised countries, such as the United States of America in the West or South Korea and Japan in the East (Arnett 2004). The developmental period of emerging adulthood, as outlined by Arnett (2004), is primarily a phenomenon found in industrialised countries and people who extended their educational careers to a tertiary level. Focussing on research studies conducted in these settings would thus serve as the most appropriate source to inform the influence this newly conceptualised period of development has on men's experience of MDD.

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4) Depression, as identified by a formal diagnosis or self-identified. Self-identified depression was included as the research studies found were not predominantly clinical samples. Instead, most of the studies conducted with tertiary students recruited participants by spreading flyers on campus, inviting students who experienced depression to participate.

Certain exclusion criteria were also employed, namely:

1) Studies where the target population's experience of depression could not be separated from that of other population groups, for instance younger males, older men and women. Several studies, for instance Brownhill et al. (2005), Garlow et al. (2008) and Hysenbegasi, Hass, and Rowland (2005), were found where the findings were reported in such a way that it was not possible to identify the experiences of male tertiary students with depression separately from other population groups. These studies were excluded, as their findings included extraneous variables that would not allow clear extrapolation of the experiences of male tertiary students with depression.

2) Mixed method studies were also excluded. Some studies were found that employed both qualitative and quantitative research methodologies. However, in light of the first inclusion criteria, these were excluded.

3) Studies that were not published in English were excluded. Due to the limitations of the researcher's linguistic fluency, only studies published in English and Afrikaans could be considered. However, no Afrikaans studies were found.

The sample consisted of five primary research studies published between 2001 and 2014. According to Sandelowski and Boshamer (2006), a sufficient number of studies for a meta-synthesis study depends upon the quality of the studies. The quality of the studies included were judged based on their inclusion in peer reviewed journals and one being an accepted doctoral dissertation at a university of good standing. Five studies were thus considered a sufficient amount, keeping in mind the financial and time constraints and remaining in the scope of a minor dissertation. Of these studies, one was a doctoral dissertation and four were journal articles, published in Health: An interdisciplinary journal for the social study of health, illness and medicine, Health Sociology Review, Qualitative Health Research and the Journal of Mental Health. Descriptions of the five studies that were analysed are found in the table below:

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Table 1

List of primary studies used in the Meta-Ethnography

Name of authors	Title	Year of publication	Country of study	Participants	Qualitative approach
Mentink, J. W.	Major Depression in collegiate student-athletes: Case study research	2001	United States of America	Purposive sampling 2 men	Grounded theory, based on case studies and utilising narrative analysis
Oliffe, J. L., Galdas, P. M., Han, C. S. E., and Kelly, M. T.	Faux masculinities among college men who experience depression	2012	Canada	Purposive sampling 25 men	Thematic analysis
Oliffe, J. L., Kelly, M. T., Johnson, J. L., Bottorff, J. L., Gray, R. E., Ogrodniczuk, J. S., and Galdas, P. M.	Masculinities and college men's depression: Recursive relationships	2010	Canada	Purposive sampling 26 men	Inductive thematic analysis
Oliffe, J. L., Robertson, S., Kelly, M. T., Roy,	Connecting masculinity and depression among international male university students	2010	Canada	Purposive sampling 15 men	Inductive thematic analysis with Interpretive,

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P., and Ogrodniczuk, J. S.					constructivist and post-modern deconstruction paradigms
Tang, M. O. T., Oliffe, J. L., Galdas, P. M., Phinney, A., and Han, C. S	College men's depression-related help-seeking: A gender analysis	2014	Canada	Purposive sampling 21 men	Interpretive description

Based on the above mentioned criteria, a number of articles were excluded. The following table includes examples of the studies that were excluded and the reason therefor, however it is not exhaustive:

Table 2

List of studies excluded from this research project

Name of authors	Title	Year of publication	Reason for exclusion
Andrews, B., and Wilding, J. M.	The relation of depression and anxiety to life-stress and achievement in students	2004	Quantitative methodology and unable to separate findings for male student from female students
Brownhill, S., Wilhelm, K.,	Detecting depression in men: A matter of guesswork	2002	Mixed method and unable to separate findings of male students from male teachers

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Barclay, L., and Parker, G.			
Brownhill, S., Wilhelm, K., Barclay, L. and Schmied V.	'Big build': Hidden depression in men	2005	Unable to separate findings of male students from male teachers
Garlow, S. J., Rosenberg, J., Moore, J. D., Haas, A. P., Koestner, B., Hendin, H., and Nemeroff, C. B.	Depression, desperation and suicidal ideation in college students	2008	Quantitative methodology and unable to separate findings for male student from female students
Greenberg, S. T., Shepard, S. J., Chuick, C. D., and Cochran, S. V.	Clinical and personality features of depressed college males: An exploratory investigation	2009	Quantitative methodology
Hazoon, R., and Barahmand, U.	A study of the relationship of alexithymia and dissociative experiences with anxiety and depression in students	2013	Quantitative methodology and unable to separate findings for male student from female students
Hysenbegasi, A., Hass, S. L., and Rowland, C. R.	The impact of depression on the academic productivity of university students	2005	Quantitative methodology and unable to separate findings for male student from female students

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Mahalik, J. R., and Rochlen, A. B.	Men's likely responses to clinical depression: What are they and do masculinity norms predict them?	2006	Quantitative methodology
Moller Leimkuhler, A. M., Heller, J., and Paulus, N. C.	Subjective well-being and 'male depression' in male adolescents	2007	Quantitative methodology and population were not enrolled at tertiary institutions
Moreno, M. A., Jelenchick, L. A., Egan, K. G., Cox, E., Young, H., Gannon, K. E., and Becker, T.	Feeling bad on Facebook - Depression disclosures by college students	2011	Quantitative methodology and unable to separate findings for male student from female students

3.5.3. Phase 3: Reading the studies.

Most research syntheses "move quickly to analysing the characteristics of the study relevant to the topic of interest" (Noblit & Hare, 1988, p. 28). However, in qualitative research, such as a meta-ethnography, this phase is more dynamic and less clear cut. Noblit and Hare (1988) went on to say that meta-ethnographies require extensive attention be given to the details of the texts, which was allowed for by repeated re-readings. The synthesis developed throughout the project. Even from early readings of the studies, similarities, overlaps and connections started to be identified. However, it was only after multiple readings that these were finalised into the themes and subthemes that will be discussed in the following chapter.

Upon first reading, the focus was on identifying possible primary research studies that would pertain to this project. The studies were re-read with the intent to understand the context of the research studies, including the sample particulars, author particulars and the methodologies employed. More re-reading were done in order to extract significant themes from each of the articles and to juxtapose the studies so they could be synthesised.

3.5.4. Phase 4: Determining how the studies are related.

When working towards putting studies together, it is essential to identify the relationship between the various studies. According to Noblit and Hare (1988), this can be done by creating lists of significant ideas, concepts, phrases and metaphors for all the primary studies and to juxtapose them. Towards the end of this phase, one can start making assumptions about the relationships between these studies.

As mentioned earlier, Noblit and Hare (1988) suggested three ways that studies could be related to each other. 1) They roughly concern similar topics, 2) they refute each other and 3) they build successive lines of argument. When a meta-ethnography addresses studies that have similar subject matters, as was the case in this synthesis, the aim is to develop reciprocal translations of the studies. This translation process was iterative in that each study was translated into the metaphors or concepts of the others and vice versa. This was done by using metaphors from one study that incorporated that of another, as well as by developing a new metaphor that would encapsulate ideas from different studies.

Table 3

Subject matter of the analysed primary studies

Name of authors	Year of publication	Goal(s) of the study / research question	Inclusion criteria	Level of academic enrolment	Participant ages
Mentink, J. W.	2001	Further the understanding of depression in student-athletes, their response(s) to depression, their help-seeking behaviour, possible warning signs and	1) History of MDD while competing in intercollegiate athletics, 2) Recovered from a Major Depressive Episode	Tertiary degree	27 (mean: 27)

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Authors	Year	Research Question	Inclusion Criteria	Sample	Age Range
					the perception(s) of those around the depressed students.
Oliffe, J. L., Galdas, P. M., Han, C. S. E., and Kelly, M. T.	2012	Exploring the complexities of the behaviours that might be indicative of college men's depressive symptoms	1) University attending men, 2) Self-identified or formally diagnosed with depression	20 undergraduate, three graduate and two graduated university students	19-28 (mean: 23.2)
Oliffe, J. L., Kelly, M. T., Johnson, J. L., Bottorff, J. L., Gray, R. E., Ogrodniczuk, J. S., and Galdas, P. M.	2010	What are the connections between masculinities and college men's depression?	1) 18 or older, 2) Self-identified or formally diagnosed with depression	19 undergraduate and seven graduate university students	19-28 (mean: 23.2)
Oliffe, J. L., Robertson, S., Kelly, M. T., Roy, P., and Ogrodniczuk, J. S.	2010	How do masculinities inform and influence participant experiences of depression?	1) International university students enrolled at Canadian universities, 2) Self-identified or formally diagnosed with depression	Unspecified number of undergraduate and graduate university students	19-28 (mean: 22.6)

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| Tang, M. O. T., Oliffe, J. L., Galdas, P. M., Phinney, A., and Han, C. S | 2014 | Describing the connection between masculinities and college men's depression-related help-seeking | (Inferred, as this was not explicitly stated) 1) College men, 2) Self-identified or formally diagnosed with depression | 12 undergraduate and nine graduate university students | 19-25 (mean: 22.3) |

From the table above it can be seen that the primary research studies included in this meta-ethnography are related to each other in terms of a similar general area of interest. The participants were all tertiary students within the developmental period of emerging adulthood who were either self-identified or formally diagnosed with depression. The chosen studies focused on these male tertiary students' experience of depression, considering how it relates to masculinity, behaviour, help-seeking, possible warning signs and the perceptions of others.

Noblit & Hare (1988) suggested that to determine the relation between the content of the studies one can create lists of themes or metaphors. These lists can then be used to juxtapose the findings and establish their relation. More recently, studies have used grids or tables to compare themes (Atkins et al., 2008). Initially, lists were created for each of the studies to outline the significant themes found in each. From this point, a grid format was utilised to lay out the extrapolated themes in order to ease the process of comparing these. Through multiple readings of the studies and the thematic lists, an eventual structure of three overarching themes with six subthemes were laid out. The overarching themes were "semblance of strength", "behind the mask" and "redefining masculinity".

3.5.5. Phase 5: Translating the studies into one another.

One aspect of translating the studies into one another involves finding ways that the findings of the studies are like each other. While doing this, it was essential to protect the particulars of each study, to respect the entirety of the meaning conveyed by each study and to allow for comparisons. The key concepts and metaphors of each study had to be preserved as well as its relationship with the other key concepts and metaphors of that study (Noblit & Hare, 1988).

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These concepts, metaphors and their interactions were then compared with the concepts, metaphors and their interactions of the other studies.

When moving to this step in the research process, it is essential to understand what the findings of completed studies actually entail, as this comprised the primary data for this meta-ethnography and for any integrative research study (Sandelowski & Barroso, 2002). Malpass et al. (2009) described three different levels of possible data, based on three levels of interpretation, namely 1) first order constructs, referring to people's interpretations of their own experiences; 2) second order constructs, which are the interpretations made by the researchers about the first order constructs (interpretations of interpretations); and 3) third order constructs, which occurs when multiple second order constructs are synthesised and interpreted to create a novel understanding of the subject of enquiry (interpretations of interpretations of interpretations). According to Sandelowski and Barroso's (2002), findings that form the data source for integrative research align with second order constructs. They defined findings as "the databased and integrated discoveries, judgements, or pronouncements researchers have offered about the events or experiences under investigation" (Sandelowski & Barroso, 2002, p. 214). Based on this definition, certain information from the primary research studies were not used for this study, based on the following criteria:

- Direct quotations from research participant, as this represented primary research data.

- Any information that formed part of the interviews, surveys or questionnaires, even if not direct quotations.

- Remarks that referred to other studies or literature.

It is important to clarify that based on these criteria, the findings from the primary research studies were extracted. This required multiple readings of the texts in order to ensure they were as accurately understood as possible. Key findings and themes were identified within each of the studies and compared to one another in order to establish their similarities and/or differences.

3.5.6. Phase 6: Synthesising translations.

The next phase involved creating a new whole from the translations developed in the previous phase, a whole meant to be something greater than a mere aggregation of the different studies (Noblit & Hare, 1988). The translations were compared to each other in order to determine if

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certain concepts or metaphors of one study could encompass concepts and metaphors of the other studies, or if certain types of translations could be identified. This phase involved analysing the different interpretations and translating them into one another.

This was done by initially working through one research report to identify the themes. Then comparing the first report to a second, in order to juxtapose the themes of both and identify differences and/or commonalities. This was then juxtaposed to a third report and so on, until all the studies were analysed. The sequence of studies were random. In some instances, novel overarching themes were established to incorporate several themes found within the different studies. On other occasions, concepts of one study was incorporated under that of another that it was found to be related to.

Finding themes that encapsulated the core findings of the various studies proved to be one of the most complex steps of this project. The five studies presented with their own themes, which combined to 21 themes in total. These were performance, understanding, symptoms, façade, communication, assistance, treatment, advice, halo effect, the angry man, the solitary man, the risk-reliant man, mind matters, stalled intimacy, lethargic discontent, locating sex and gender as the cause of depression, limits of self-disclosure, self-managed men, denying weakness, limiting self-disclosure and mustering autonomy, and redefining strength.

After the first round of translating the studies into one another, the themes that were identified were 1) college men and masculinities, with subthemes of strength, stoicism and independence, 2) masculinity and depression, with subthemes of masking depression, reluctance to seek help, self-management, underachievement, generic depressive symptoms and anger, irritability and aggression, and 3) the aftermath of masculinity among depressed male college students, with subthemes of exacerbation due to embodiment of masculine ideals, redefining masculinity, benefiting from social support and response to treatment. However, these themes were still too narrow and not sufficiently integrated.

In order to refine these themes, the studies were worked through again and three overarching themes were identified, with six subthemes. These were 1) semblance of strength, with subthemes of appearance of indifference, the angry man and the self-managed man, 2) behind the mask, with subthemes of absent help-seeking, masking depression and pain behind the mask, and 3) redefining masculinity.

3.5.7. Phase 7: Expressing the synthesis.

The prevailing norm for communicating results of research syntheses is in a written format. When considering the method of communicating the research results, it was important to consider the audience and purpose of the research. Writing with a specific audience in mind did not necessitate a reduction of the findings of the study. Rather, to ensure the format and language used would enable the audience to understand the phenomena according to the interpretations and perspectives of others. To do so require that one understands the audience in a similar way as one understands the studies to be analysed, as the one will be represented to the other based on both their commonalities and uniqueness (Noblit & Hare, 1988). This research project was conducted as part of the requirements for a degree of Masters of Arts in Clinical Psychology at the University of Pretoria. With this in mind, the synthesis was expressed in written format to be evaluated according to these requirements.

3.6. Ethical and quality considerations

The studies that form the data for this research project were obtained from the academic domain, which fell within the public domain. Hence, no ethical clearance was needed to use the information as data for this research project. Since I was still a student at the time when this research study was conducted, and hence in the process of developing the appropriate expertise and experience required (O'Leary, 2004), I worked under the supervision of a more experienced and knowledgeable expert in the field, particularly in relation to men in depression and meta-synthesis research.

Ethical principles of good quality research was adhered to. In order to develop research that is open, accountable and verifiable, special attention was given to auditability and transparency (Thorne et al., 2004), which contributed to the replicability of the research study (O'Leary, 2004). In terms of transparency, a detailed exposition of the research method was included. This in turn, provided greater clarity by which the research process can be traced or audited by others in order to enhance the reproducibility of the study (O'Leary, 2004).

This research project sought to yield a quality product by employing an established synthesis method. Meta-ethnography is an acknowldedged and widely used method by respectable scholars and across different academic disciplines (Harper & Thompson, 2012).

3.7. Conclusion

Within this chapter, an outline was provided pertaining to the research that was employed to answer the research question. Meta-ethnography, a qualitative meta-syntehsis method, was used, according to the seven steps proposed by Noblit and Hare (1988). The way these steps were applied to this particular research project was discussed in this chapter. From an list of potential studies related to the area of interest, five primary research studies were chosen and synthesised. The chapter was concluded with a discussion on the ethical and quality considerations that were relevant to this study.

Chapter 4: Analysis

4.1. Introduction

After careful readings and analysis of the five primary research studies, three predominant themes emerged from these findings that encapsulate the experiences of male tertiary students with depression. The themes are further divided into several sub-themes. The overarching themes are: Semblance of strength, behind the mask and redefining masculinity. These three themes will be discussed separately in this chapter. However, it is important to highlight that in the findings of the primary research studies, the first two themes of the creation of an image of strength and hiding behind a mask were strongly related phenomena and often emanated from similar prevailing ideals of masculinity among the participants. The third theme, redefining masculinity, stands separately from the first two, in that it represents a move away from the more commonly held sense of masculinity, to one that allowed some individuals to respond to depression in a different manner.
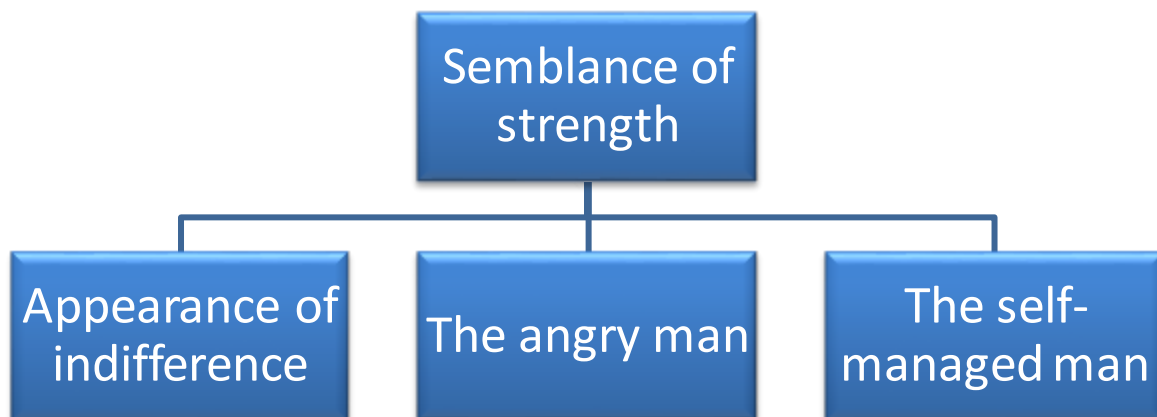
4.2. Semblance of strength

Figure 1. Theme 1: Semblance of strength

One of the most pervasive themes across the five primary research studies was a strong motivation among these male tertiary students to preserve their masculinity. All the men[1] that partook in the studies were either self-identified or formally diagnosed with depression. Despite the emotional distress at the core of this mental health challenge, these men appeared primarily concerned with the preservation of their internal experience of masculinity, as well as with their outward portrayal thereof. As part of maintaining an appearance of strength, subthemes of appearance of indifference, anger and self-management were extrapolated in the primary research studies. The next section will outline the internal representation of masculinity held by male tertiary students with depression. This will then be linked to their presentation of anger and their efforts to manage their own distress.

4.2.1. Appearance of indifference.

Throughout the studies, the researchers found that men displayed an inclination to maintain a certain image, both towards themselves and to those around them. The primary studies emphasised a connection between certain forms of masculinity and men's drive to maintain an appearance of indifference to pain.

Oliffe, Galdas, Han and Kelly (2013) highlighted the need of men to conform to models of masculinity that portray strength. These authors found that men's response to distress was often influenced by a fear of the possibility of contravening strength-based ideals of masculinity. Oliffe, Robertson, Kelly, Roy and Ogrodniczuk (2010b) found that these masculine ideals were prescriptive of how men should function on a subjective, internal level, as well as how to perform on an objective, publically visible level. These findings signified that male tertiary students held an internal representation of what are expected of them in terms of internal experience and external behaviour. Furthermore, they were motivated to uphold these expectations as they attempt to fit into society.

These masculine ideals took various forms in the studies. One of the most common and seemingly influential of these was the expectation to maintain a strong, silent and action driven image, irrespective of external circumstances or internal duress (Oliffe et al., 2010b). This was supported by Oliffe et al. (2013), who found that men felt a need to maintain an image of strength, while hiding emotionality. Tang, Oliffe, Galdas, Phinney and Han (2014) also found

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[1] Men and male tertiary students are used interchangeably to refer to the same population.

that masculine discourses fostered a need to remain strong and stoic. These discourses included socially reinforced ideals that promoted the denial of weakness as a sign of a strong character and a strong mind. Taking up the challenge to fight depression was seen as the manly recourse. Denying weakness was essential in men's attempts to rise to the challenge of depression. Oliffe et al. (2010b) supported this by referring to how men attempted to control and counter depression and the associated feelings by drawing on fighting qualities. Fighting depression allowed men to maintain their masculine identity in the face of what was regarded as a subordinate and marginalised status. This was seen as an internal battle fought in private. However, despite the fight being private, the victory was ideally meant to be publically visible. Preserving an image of stoicism was seen as a means of avoiding stigma, for the men themselves and for their families. In doing so, men were seen to live up to the socially ascribed masculine roles of being the protector and provider (Oliffe et al., 2010b).

The need to fight depression appeared to be linked to a desire among men to be independent and autonomous (Oliffe et al., 2013). This was also evident in Oliffe et al.'s (2010a) findings of masculine ideals that promote self-reliance and being able to solve problems, as well as in Oliffe et al.'s (2010b) findings that linked men's self-image of control and autonomy to their sense of masculinity. Depression was seen as an enemy that could, or should, be defeated alone. Fighting this battle alone allowed them to maintain this sense of masculinity. The alternative, seeking assistance from others, was seen as a compromise of their manliness and a taint on their sense of masculinity. Seeking help was seen as a form of submission, a sign of weakness and related to a fear of shame and stigma (Oliffe et al., 2013).

Publically acknowledging the experience of depression risked men's image of rationality, decisiveness and intellectual competence (Oliffe et al., 2010a). Men were expected to be robust, rational (Oliffe et al., 2010b) and physically tough and active (Oliffe et al., 2010a) at all times. In attempts to suppress and escape the negative thoughts and feelings associated with depression, men sought to engage in activities that promoted masculine ideals allowing them to feel strong, by portraying confidence, taking risks and being brave and daring (Oliffe et al., 2013). In doing so, they attempted to show to others, as well as to themselves, that they were still man enough. In light of their fight against depression, men associated successful masculinity with victory over this illness (Oliffe et al., 2010b). Successful masculinity was often measured by material ends and depression was regarded as a barrier that had to be overcome in order to live up to the expectations of being profitable men (Oliffe et al., 2010a).

Oliffe et al. (2010a) found that men regarded depression as a female illness. Men ascribed women's inclination to greater emotionality to their greater proclivity towards this mood disturbance, as it rendered them more vulnerable to feeling overwhelmed. Male tertiary students opposed the experience of vulnerability and sensitivity, as they associated this with femininity and a subordinate form of masculinity. The participants in these studies appeared particularly concerned about burdening others through expressing emotions, which they regarded as signs of weakness and being ineffectual (Oliffe et al., 2013). However, the expression of anger appeared to be the exception to the unemotional ideal of masculinity. Anger was associated with masculine expressions by means of actions, such as verbal aggression (Oliffe et al., 2013). An inability to inhibit emotions, displays of compassion (Oliffe et al., 2010b), deviation from idealised masculine performances such as an insatiable libido and idealised preferences of heterosexual desires were all associated with a subordinate masculinity (Oliffe et al., 2010a).

Depression, perceived as a female illness, was regarded as un-masculine and equated with weakness. Subsequently, some participants displayed a fear that public acknowledgment of depression would result in others perceiving them as weak (Mentink, 2001). The weakness associated with depression was seen on a continuum, ranging from being susceptible to being formally diagnosed. Men who were formally diagnosed with depression were regarded as inferior to other men, and even to women (Tang et al., 2014). Seeking help was associated with acknowledging this illness and in doing so acknowledging weakness. Oliffe et al. (2010b) found that many men internalised these socially sanctioned masculinities and self-identified as weak because they were unable to defeat depression.

Even though depression was associated with a subordinate and marginalised status, fighting this experience allowed men to maintain their idealised masculine identities (Oliffe et al., 2010b). Men in these studies appeared motivated by socially sanctioned expectations to appear strong, irrespective of the situation. Based on these findings, men appear to hold to the premise that by maintaining a semblance of indifference to emotional distress and environmental stressors, they are able to align themselves with dominant strength-based masculine ideals.

4.2.2. The angry man.

A strong relationship between anger and depression were found in these studies. However, the relationship is by no means linear in the sense that anger is a substitute for depression.

Furthermore, some of the participants displayed an awareness of the purpose and consequences of expressing their anger.

Anger related issues were common among the male tertiary students (Mentink, 2001; Oliffe et al., 2013; Oliffe et al., 2010b). Oliffe et al. (2013) outlined how anger was regarded as a way for men to express themselves without violating their sense of masculinity. For some, anger was directly related to their depression (Oliffe et al., 2013), however for others this link was not explicitly made (Mentink, 2001). Few of the men were able to unravel the triggers or origins behind their anger outbursts. Oliffe et al. (2013) found that many of the male tertiary students perceived the expression of anger as a familiar way to find respite from the frustration and irritability that often accompanied their depression. Anger was seen as a means to release tension. These men also disclosed that part of their intent behind the expression of anger was to communicate their pain. This was supported by Oliffe et al. (2010b), who found that anger was used in an effort to counter the experience of weakness associated with depression, as well as a way to convey distress.

The participants were able to reflect on certain aspects of their expression of anger as well as some of the consequences thereof. The expression of anger appeared to cause some discomfort, despite the purpose of release (of tension and a sense of un-masculinity) it was meant to have. Some men regarded their explosive episodes as troublesome (Oliffe et al., 2013) and concerns were reported about the visibility of these anger outbursts (Mentink, 2001). The men described their outbursts in various forms, such as verbal abuse (for instance yelling or threatening others) or even physical acts of aggression towards other people born out of an uncontrollable rage (Oliffe et al., 2013). Another form was described as uncontrollable self-directed anger, which could take the form of verbal abuse directed towards the self (Oliffe et al., 2010b).

Oliffe et al. (2010b) found that the intense anger and self-loathing emerged as a result of men's failure to successfully fend off their experience of depression. Oliffe et al. (2013) reported that men attempted to counter this unease with themselves by fending off criticism of others, whether real or perceived. Additionally, anger allowed them to assert their power (Oliffe et al., 2013) and show that they were not as weak as the depression made them feel (Oliffe et al., 2010b). There was an admission that their aggression was not always provoked. Sometimes conflict was sought out in order to find relief from feeling depressed.

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Even though anger outbursts allowed men some purchase on dominant masculinities, it was often accompanied by negative ramification. For some it exacerbated the feelings they wished to subdue (Oliffe et al., 2013). For others it led to self-harm, especially when the anger was self-directed (Oliffe et al., 2010b). Guilt and sadness often followed acts of aggression, leaving men with deep remorse and a sense of failure as a result of their loss of control. This was commonly associated with worsened depressive symptoms (Oliffe et al., 2013). Oliffe et al. (2013) also reported that most men considered their angry behaviour as out of character and displayed some concern over the impact their volatile affect could have on their personality and interpersonal relationships.

In relation to masculine ideals of strong and stoic men who can maintain a cool and unemotional image, an exception of emotional expression was found that was not seen as a violation of their masculinity. This exception took the form of anger. However, this angry man persona had an inherent risk of exacerbating these male tertiary students' depression as well as additional ramifications such as injury and criminal offenses (Oliffe et al., 2013).

4.2.3. The self-managed man.

The male tertiary students within these studies displayed a proclivity towards managing their own depression. Their self-management included various strategies that served different purposes. This desire towards self-management appeared connected to certain masculine ideals and a fear weakness.

Men deliberately attempted to hide their distress from others. Additionally, they employed various mechanisms of self-management to counter and find respite from their depression (Oliffe et al., 2013; Oliffe et al., 2010a; Oliffe et al., 2010b; Tang et al., 2014). Part of managing their own depression was limiting self-disclosure thereof (Tang et al., 2014), avoiding pharmaceutical therapy (Oliffe et al., 2010b; Tang et al., 2014) and taking up a solitary battle against this illness (Oliffe et al., 2010b). A common finding was the employment of potentially harmful strategies (Oliffe et al., 2013). These included self-medication, by means of alcohol and tobacco, or illicit drugs such as marijuana (Oliffe et al., 2010a) and ecstasy, as well as risky behaviour and intentional self-harm (Oliffe et al., 2013). Examples of risk taking and self-harm includeds riding bike at night without a helmet or light, walking in a dark forest in search for wild animals and washing hands with Lysol and toilet cleaner in order to feel pain.

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Men's reliance on risk was associated with an increased vulnerability to accidents as well as suicide. This was supported by Oliffe et al. (2010b), who found that one of the more extreme attempts to manage their depression was by means of suicide. This appeared to be a final attempt to address an unmanageable experience, escaping the power of depression by surrendering to it.

Some of the men in the studies displayed healthier coping mechanisms, such as engaging in physical activity, including athletics. Mentink (2001) reported that athletics was a vital coping mechanism for the student-athletes, as it helped them maintian mental stability. Tang et al. (2014) stated that working towards physical fitness and health represented a method to alleviate depression while at the same time preserve a sense of autonomy. Additionally, Oliffe et al. (2010b) reported that some men expressed some of their troubles to friends. However, this was done within informal discussion with other men. When men did disclose some of their difficulties to other men, both parties were intent on maintaining discretion regarding their discussions to protect them against being seen to seek, need or give help.

The desire towards self-management appeared connected to masculine ideals of maintaining independence, being able to solve problems (Oliffe et al., 2010a; Tang et al., 2014) and staying in control (Oliffe et al., 2010b), as well as with a fear of appearing weak manifested by seeking help (Oliffe et al., 2013). Oliffe et al. (2013) found that self-medication strategies served to distract men from their problems and to find relief from their depressive symptoms and associated distressing feelings. It was seen as a manly recreational activity and a manly method to deal with stress. Hence, participation in this release strategy allowed men to avoid being marginalised for experiencing depression. Oliffe et al. (2010a) found that self-medication was particularly useful to manage excessive rumination and introspection as well as to reduce negative thoughts. Risky and self-harm behaviour was often done in an attempt to counter the numbness that frequently accompanied these men's depression (Oliffe et al., 2013). Oliffe et al. (2013) found that these behaviour allowed men to experience a sense of bravery, daring and risk taking, which was in line with their masculine identities.

In terms of avoiding pharmacotherapy, men displayed concerns that medication could cloud their self-management and serve as an acknowledgement of having depression (Oliffe et al., 2010b) and hence acknowledging weakness (Tang et al., 2014). Some men appeared to take a stand against medication, arguing that it was not authentic, that it was forced, not the right way and that no form of medication could be as perfectly synthesised as the chemicals in their own

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bodies. They held a belief that they could overcome their depression naturally (Tang et al., 2014).

In summary, theme one highlights male tertiary students' affinity towards strength-based masculine norms, as described in these studies. These socially sanctioned masculine ideals ascribed how men should function internally and how they should conduct themselves in public. Men in their student years felt pressure to uphold these norms and maintain a semblance of strength, regardless of the circumstances. Even in the face of intense emotional duress, they were motivated to maintain a semblance of indifference to whatever pain they may experience. For many of these men, one accepted form of expressing themselves was through anger. Their anger was directed both towards other people as well as towards themselves. The masculine ideals held by these men also served as the impetus behind their efforts to manage their experience of depression by themselves. Their self-management included risky and potentially harmful strategies and the avoidance of medication. Even though some men engaged in healthy coping mechanisms, a preponderance of the behaviour associated with the men's masculine ideals often led to an exacerbation of depressive symptoms and the associated distressing feelings. Hence, the solutions men attempted to apply, often added to their problems.
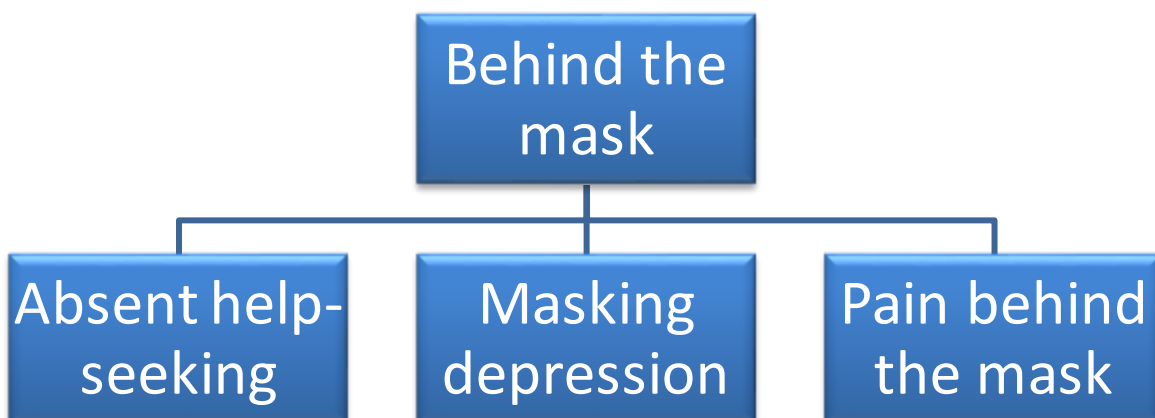
4.3. Behind the mask

Figure 2. Theme 2: Behind the mask

A meta-ethnography of male tertiary students' experience of depression

Whereas the first theme highlighted male tertiary students' desire to maintain an appearance of strength, this theme will elucidate male tertiary students' experiences behind the mask they sought to uphold. The previous section touched on the premise that men perceive help-seeking as a sign of weakness. Here, the phenomenon of absent help-seeking will be addressed more directly, as will men's tendency to mask their inner distress and the pain that occurs behind their masks, which is often exacerbated by their masculine-driven behaviour.

4.3.1. Absent help-seeking.

The dominant discourses related to strength and stoicism, as outlined earlier, appeared particularly salient in men's reticence to seek assistance from other people, including from peers, family members and professionals (Tang et al., 2014). Oliffe et al. (2013) also found that men were reluctant to seek and accept help from professionals.

Mentink (2001) described how men struggled to publically acknowledge their experience of depression. Even when trying to speak to someone about their distress, this was done in vague terms and subsequently there was no certainty that the other party even grasped what they tried to convey. In general, they appeared to avoid the topic of depression, even with those closest to them.

This inhibited self-disclosure appeared to be influenced by an anticipation of negative ramifications. For the student-athletes in Mentink's (2001) study the fear was related to being prevented from continuing to participate with their sporting activities. For others, an additional fear of stigma was found (Oliffe et al., 2010b). Help-seeking was associated with femininity and seen as conflicting with masculine ideals. Masculinities that promote autonomy were strongly linked to men's disinterest in seeking help, as doing so would constitute an act of weakness. Men appeared to associate shame with revealing their experience of depression (Oliffe et al., 2013). They were particularly reticent in seeking professional help.

Pharmaceutical intervention and a formal diagnosis of depression was an anticipated result from seeking professional help. This was strongly avoided because of a perception that receiving medication would signify their distress as a major mental health concern (Oliffe et al., 2010b) and a formal diagnosis was regarded as proof of weakness. Some of the men even feared that a formal diagnosis would increase their vulnerability to depression. Whereas the denial of weakness and hence denying any need for help, enable men to embody strength-based

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masculine ideals (Tang et al., 2014). When men did seek professional help, they were highly cautious in this endeavour.

Tang et al. (2014) found that the men who did receive professional intervention were meticulous in maintaining the secrecy thereof. Some even defaulted their treatment because of fear that others would find out about their depression and their need for professional help. The search for professional help and accepting it was regarded as an additional insult to these men's experience as being weak and ineffectual. Hence, they were more inclined to stand up to the challenge of depression themselves without external assistance.

The tertiary students in these studies appeared reticent to admitting their experience of depression, as others could consequently perceive them as subordinate according to masculine ideals. As a result, they appeared concerned with the potential ramification of seeking external assistance, whether from peers, family or professionals, as a result of a fear that others would come to learn of their depression and view them as weak.

4.3.2. Masking depression.

The male tertiary students within these studies were motivated to put forth an appearance of well-being, even in the midst of internal distress. This often inhibited men within social contexts, including romantic relationships. Various strategies and motivations were associated with the solitary practices related to masking their depression (Oliffe et al., 2013).

Tang et al. (2014) found that the male tertiary students in their study displayed a desire to come across as depression-free. They appeared intent on creating the impression of well-being, despite struggling with this mood difficulty and having internalised the sense of weakness they associated with this illness (Oliffe et al., 2010b). Their drive to create an impression of strength was especially strong at times when their depression became detectable to others or when inhibitions about acknowledging their depression became fragile (Oliffe et al., 2013). Tang et al. (2014) reported that most men in their study vigilantly avoided giving away any indication about their distressing internal experience. Oliffe et al. (2010b) also found that men actively tried to conceal the fact that they had depression or any details related to it. For the student-athletes in Mentink's (2001) study, their ability to maintain high standards of performance hid their depression from those around them.

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At times these men's elaborate secret-keeping strategies were accompanied by self-isolation (Oliffe et al., 2010a). They hid not only their emotionality from others, but often even hid themselves (Oliffe et al., 2013). Oliffe et al. (2013) found that even men who had existing social connections with friends and family preferred to isolate themselves during times when they were depressed. Mentink (2001) also described a tendency to withdraw socially and Oliffe et al. (2010b) reported that men preferred to deal with their depression by themselves. Masking depression also had a significant effect on intimate relationships or the possibility of developing ones.

Oliffe et al. (2010a) found that many men were especially reticent towards developing intimate relationships. Those that were in romantic relationships found that their partners' capacity to provide support diminished over time, as they became increasingly fatigued. Those that were not romantically involved preferred to maintain a single and emotionally unattached status.

Several reasons were postulated for men's inclination to mask their distress. It appeared that men did not feel safe to disclose their vulnerabilities, fears (Tang et al., 2014) and feelings towards others (Mentink, 2001). Masculine ideals related to strength and stoicism appeared strongly linked to men's proclivity to hide their depression. Masking their depression enabled these men to preserve some sense of masculinity and were perceived as signalling strength for these individuals. Having depression was a significant blow for these men's sense of masculinity. However, by covering up this experience, they were at least able to quell their concerns about others findings out about this perceived weakness (Tang et al., 2014).

For a lot of these men, the impetus behind their self-isolation related to feelings of vulnerability (Oliffe et al., 2013) as well as a fear that others might identify their experience of depression (Oliffe et al., 2010a) and perceive this as a sign of weakness (Mentink, 2001). Tang et al. (2014) indicated a worry among male tertiary students that public knowledge about depression could reduce one's worth within his social group and/or lead to further marginalisation by others. Oliffe et al. (2013) found that depressed men felt uncomfortable in social situations, and were concerned about their capacity to maintain a party persona. They preferred to hide themselves away, instead of risking potential ridicule that they believed would follow the public exposure of their perceived subordinate masculinity (Oliffe et al., 2013). This was especially evident in the midst of other men (Oliffe et al., 2013; Tang et al., 2014).

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Oliffe et al. (2010a) indicated that some men preferred social isolation in order to protect themselves as well as to protect others. Some maintained a semblance of stoicism in order to protect their families from stigma (Oliffe et al., 2010b). Some indicated that their inhibition of self-disclosure was motivated by a fear of burdening others with their problems (Oliffe et al., 2013; Oliffe et al., 2010a).

Relating to intimate relationships, the men displayed a fear of having to disclose their depression if they were to develop an intimate relationship (Oliffe et al., 2010a). There was doubt over the possibility of finding someone able to cope with their depression. They also expressed concerns in terms of their ability to connect with someone else, their capacity to sustain a meaningful long-term relationship, being attractive and worthwhile as a partner and their ability to live up to masculine ideals of sexual performance and preferences. Some of their depressive symptoms added to their disinterest in connecting with others, such as fatigue, altered eating patterns (reduced eating often exacerbated fatigue, whereas eating binges were found to have a detrimental effect on self-esteem and comfort in social circumstances) (Oliffe et al., 2013), feelings of incapacity and hopelessness (Oliffe et al., 2010a).

Male tertiary students with depression appeared motivated to hide behind a mask, for which a variety of reasons were identified. They appeared concerned that others would see the weakness that they felt, that they would be ostracised and that they would burden others. As a result, they purposefully attempted to hide their distress, put on an image that was discordant with their internal experience and often withdraw socially. Putting on this mask allowed these men to maintain some sense of strength-based masculinity.

4.3.3. Pain behind the mask.

The analysis so far has outlined men's creation of an image of well-being. This was done in part to convince themselves that they still possessed some sense of masculinity and in part to convince others that their masculinity was still intact. The following discussion pays attention to men's experiences behind their masks.

Primary research studies outlined the experiences of men behind the masks they put on as painful, distressing and potentially fatal. Their distress was often exacerbated by the mask they put on. Mentink (2001) found that the appearance of well-being prevented others from noticing their distress, even from those closest to them. According to Tang et al. (2014), this dislocated a potentially vital source of support.

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A common feature among these male tertiary students was the experience of failure. Perceiving themselves as failures was associated with an exacerbation of depressive symptoms (Oliffe et al., 2013). Men were often burdened by thoughts of what they have not achieved or expected as unlikely to achieve in the future (Oliffe et al., 2010a). This often related to poor academic performance, growing debt and poor career prospects. Oliffe et al. (2010a) reported that poor academic performance frequently led to panic, as academic shortcomings threatened the futures of these students. Pessimism and uncertainty were prominent (Mentink, 2001; Oliffe et al., 2010a) and unsatisfactory intellectual performance was related to experiences of discontent. Additional concerns were raised about the public visibility of their academic shortfalls (Oliffe et al., 2010b). The experience of depression contributed to these men's sense of failure, as they were not able to overcome this illness (Oliffe et al., 2010b) and as they regarded depression as a stumbling block in their pursuit of material prosperity, which was associated with being profitable men (Oliffe et al., 210a).

Several other distressing experiences were associated with these male students' experiences behind their masks. Some reported feeling miserable and having lost a sense of their identities (Mentink, 2001). Oliffe et al. (2010a) found that men experienced discontent and unhappiness as well as lethargy, cognitive wondering and impaired interpersonal relationships. Helplessness and hopelessness were also prevalent, in terms of recovering and regaining what they lost due to the depression (Mentink, 2001; Oliffe et al., 2010a). Some felt slowed down mentally and physically, bed ridden and cut off from those close to them (Oliffe et al., 2010a). Sleeping difficulties and appetite changes were also common, ranging from binge eating to barely eating at all (Mentink, 2001; Oliffe et al., 2013). Men often lost the comfort they used to find in certain activities and places due to their self-isolation (Oliffe et al., 2010a). Mentink (2001) reported paranoid ideation, pessimism, a generic reduced motivation, anxiety, and panic attacks. A loss of libido, ranging from less interest than previously to a complete absence of desire, as well as a loss of interest in socialising was found (Oliffe et al., 2013; Oliffe et al., 2010a). Finally, self-harm and suicidality was also a risk (Mentink, 2001; Oliffe et al., 2013; Oliffe et al., 2010b).

Oliffe et al. (2013) reported that the image men created to protect their sense of masculinity had very little positive effects, if any. Instead, it mostly resulted in exacerbation of what was already distressing experiences. Men's ability to establish meaningful connections with others were impaired (Oliffe et al., 2010a) and social support was often lost (Tang et al., 2014) due to men's secretive behaviour, avoidance of relationships (Oliffe et al., 2010a) and even due to

their brooding demeanour (Oliffe et al., 2013). Men's attempts to protect themselves and their sense of masculinity by isolating themselves was in reality un-therapeutic. Oliffe et al. (2013) found that it did little in terms of providing respite from their distress. In fact, it appeared to have worsened their experience of loneliness and pain. Guilt, sadness and remorse were also associated with men's attempts to protect their masculinity.

Despite men's elaborate and vigilant attempts to maintain their sense of strength, the above findings suggest that their experience of depression took a significant toll on their well-being. Behind the mask that these men worked hard to uphold, were experiences of real and distressing pain associated with their depression. Maintaining a semblance of strength appeared to have had the opposite effect from what the men intended, as it often led to worsening of their distress and prevented them from potential support from other people, including those close to them as well as professionals.

4.4. Redefining masculinity

Within the preceding themes it was seen how many men denied their experience of depression, which they perceived as a weakness and something they were reluctant to disclose to others, as well as how this led to the employment of various strategies to hide their distress. This often limited their help-seeking behaviour, as they perpetually attempted to embody masculine ideals of strength and autonomy. However, Mentink (2001), Oliffe et al. (2010b) and Tang et al. (2014) reported of a few male tertiary students who negotiated these masculine ideals in their responses to depression. This theme might be relatively less in terms of content, however it is significant in terms of understanding the reasons and strategies of those few who sought help in light of their depression.

Mentink (2001) reported of men who reached out to others in search of assistance. The students took a chance and spoke to their parents about their difficulties. They were reportedly relieved after disclosing this and described this experience as a lifeline in the struggle against depression. It followed that one of these students learned that his father had also experienced depression previously. Reaching out to others was a normalising experience for these men and allowed for a realisation that they were not the only ones who had to endure such distress. It led to increased hopefulness that the depression could end and even helped with the process of treatment. Oliffe et al. (2010b) also reported of men who contradicted the more general self-management style adopted by men. These men addressed their depression within their peer

group in an indirect manner. Without directly referring to their depression, they were able to discuss more specific problems that added to their depressed mood. They regarded this as a beneficial experience.

According to Mentink (2001), receiving a formal diagnosis allowed at least some individuals to experience a sense of relief, as it allowed greater understanding and appreciation of the reason for their distress. This was followed by pharmaceutical intervention, which alleviated some of the depression related symptoms, such as sleeping difficulties and anxious distress (Mentink, 2001; Tang et al., 2014). They also found those close to them as being supportive of the treatment process. Subsequent to treatment, they reported a more positive perspective in life, improved quality of life as well as greater ease and comfort in disclosing this experience to others (Mentink, 2001).

Tang et al. (2014) reported certain factors that were vital in men's willingness to seek help. These were permission by others for the self-disclosure and the knowledge that other men also experience depression. Oliffe et al. (2010b) added that confidence in the recipient's interest in their self-disclosure was vital in the success of self-disclosure. Having their depression affirmed by others was significant in regarding their self-disclosure in a positive light as well as in normalising their experience of depression. This was also associated with a reduction in shame. A significant factor in normalising their experiences was approval from other men about their self-disclosure and help-seeking (Oliffe et al., 2010b; Tang et al., 2014). It was especially helpful to know that they had peers with similar difficulties. There was still an acknowledgment that disclosing their depression and seeking help could be perceived by others as signalling vulnerability. However, these few men were unapologetically willing to act differently.

For some, help-seeking was critically examined and redefined in line with a strength-based masculine enterprise. It was positioned as a manly act by these few participants. As such, it was regarded as an embodiment of the masculine ideals of strength and autonomy to take the step out in the search for help, instead of signalling weakness. Acceptance of professional help was regarded as in line with the masculine ideal of independence, as this was an autonomous step to manage their own depression (Tang et al., 2014).

This comparatively shorter theme highlighted the fluidity of social constructs, such as masculinity. As male tertiary students acted, in line and out of line with masculine norms, they

partook in the co-construction of the future of these social norms. Some men, although few, acted in opposition to the general interpretation of masculine ideals, such as strength and autonomy, by seeking help. In doing so, they redefined the meaning of these forms of masculinity and associated it with manly virtues (Tang et al., 2014). For these men, several benefits became evident from their help-seeking, which fostered an alleviation of depressive symptoms both as a result of the social support and medicinal intervention that followed (Mentink, 2001; Oliffe et al., 2010b; Tang et al., 2014).

4.5. Conclusion

This chapter elucidated several experiences of male tertiary students who encountered depression. A significant finding among these students was the entrenchment of masculine ideals that promote strength, autonomy and un-emotionality. Men felt pressure to maintain this masculine image irrespective of any form of emotional distress. Most of the men in these studies appeared to have internalised these prevailing masculine ideals and were strongly motivated to maintain an appearance of indifference to the pain associated with their depression. Publically acknowledging their depression and associated difficulties were seen as an admission of weakness, which was regarded as a move away from their masculinity. Additionally, admission of depression was avoided because this was primarily regarded as a female illness. This illness was associated with emotionality, which was in direct contravention of men's conceptualisation of masculinity. As a result, men put on a semblance of indifference, in part to avoid the stigma they anticipated would follow from displaying any signs of weakness, and in part to prove to themselves that they were still masculine men. Denying weakness was seen as part of taking up the fight against depression, in line with the expectation that men should be able to solve problems autonomously.

One exception to the ideal of un-emotionality was the expression of anger. This was perceived as a manly and socially acceptable way of expression. For many men, anger served to counter their internal experience of weakness associated with their depression and to prove to themselves that they were still masculine. Some acknowledged that anger outbursts were also used in attempts to convey their pain. However, their expressions of anger typically did not achieve what these men intended. Instead, they were often left with remorse, a sense of failure, relational difficulties and increased sadness.

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A further way men tried to embody masculine ideals was by managing their depression by themselves, including the avoidance of pharmaceutical treatment. Instead, men attempted to manage their depression with self-medication, risk taking and intentional self-harm. Self-medicating with alcohol, tobacco and illicit drugs allowed men to distract themselves from their problems and self-medication was also regarded as a manly way of dealing with distress. Risk taking enabled a sense of bravery and daring. Whereas self-harm often served to counter the numbness that often accompanied depression. On the extreme, men considered addressing their depression by means of suicide. However, some employed healthier strategies to manage their distress, including exercise and informal discussions with friends regarding their distress.

These studies suggested a vastly discordant experience behind the mask of indifference that these men attempted to uphold. Men appeared to hide behind this mask and avoided seeking help because of a fear that other people could perceive them as un-masculine for admitting to a problems that they needed help with. Instead, they vigorously avoided giving away any indication about their depression and maintained an impression of well-being. Their elaborate secret-keeping was often accompanied by self-isolation as a further means of protecting their masculinity. Many also reasoned that this was an embodiment of the protector role associated with masculinity, by protecting their families of the anticipated stigma associated with depression and not burdening others with their problems. However, this mask often led to an exacerbation of an already distressing experience. Behind the mask were difficulties such as feelings of failure, misery, discontent, lethargy, impaired interpersonal relationships, helplessness, hopelessness, altered sleeping and eating patterns, paranoid ideation, pessimism, reduced motivation, decreased libido, anxiety related symptoms, and the risk of self-harm and suicide.

Opposed to the findings of hiding behind a mask of strength and indifference, there were a few men who acted differently. While acknowledging the generally accepted masculine ideals, a small portion of men unapologetically engaged in help-seeking behaviour and reported the beneficial effects thereof. In doing so they actively negotiated the meaning of these ideals of masculinity. They partook in the co-construction of masculine ideals and redefined help-seeking as a manly virtue and expression of strength and autonomy.

Chapter 5: Discussion

5.1. Introduction

The aim of this chapter is to consolidate the work of this research project. This is done in line with the research aims that were outline in the first chapter: 1) To use meta-ethnography to create a synthesis of the findings of primary qualitative research studies exploring male tertiary students' experiences of depression; and 2) Keep account of who conducted research in this field and what type of research was conducted, in order to contextualise the study as well as acknowledge and understand the sources of the data.

The discussion chapter first recapitulates the research design employed by this project. Next, the themes that were extrapolated from the primary research studies are reflected on. This will be followed by a discussion on male tertiary students' experiences of depression by connecting this project's data analysis with broader literature pertaining to this phenomenon. Considering the findings from the analysis chapter through the lens of the literature review chapter will form part of creating a framework that can be used to conceptualise male tertiary students' experience of depression.

As mentioned in the research design chapter, the epistemological framework of meta-ethnographies is objective idealism. This approach posits that reality as we perceive it is based on our collective understanding thereof (Barnett-Page & Thomas, 2009). In this regard, the synthesis was a collection and merging of scholarly understandings. Being situated in the interpretivist paradigm, the contexts that both participants and researchers inhabit are important. In light of this standpoint, a contextual analysis follows, in order to situate the primary research studies into their appropriate contexts and to portray the backdrop that potentially informed their contribution to our shared understanding of reality. The contextual analysis addressed the countries of the studies, ethnicity and sexual orientation of the participants, discipline of researchers and journals of publication. This will be followed by potential shortcomings of this study and identified possibilities for future research. A summary of the research project concludes the chapter.

5.2. Review of the research design

A brief review of the research design is a means towards contextualising the findings and laying a platform for the discussion that is to follow. Noblit and Hare's (1988) method of meta-

ethnography was employed, based on the seven phases outlined by these authors. This qualitative meta-synthesis approach was used in order to synthesise several primary research studies.

First, an area of interest was identified and refined based on a gap found in the extant research related to subject of enquiry. Once the general area of interest was identified, a research question had to be generated. Next, a preliminary search was conducted in order to create an exhaustive list of primary studies relevant to the subject of enquiry and to assess the feasibility of this project. Up to this point there was a personal interest, scholarly interest and a gap in research. The list of published primary studies was narrowed down to fit the scope of this study. Certain inclusion and exclusion criteria were used and five primary studies were identified to serve as the focus of this synthesis. What followed was numerous readings of the five studies in order to understand the contexts of the studies, identify how the studies were related to each other and extract their findings. The findings across the studies were juxtaposed to each other by means of reciprocal translation. This fostered the process of identifying significant themes across all the studies and creating a structure of three overarching themes with six related subthemes.

5.3. Thematic structure of the synthesis

In the previous chapter a detailed description of the structure of the synthesis was proposed. Based on the findings extracted from the five primary research studies, three overarching themes were illuminated, as well as six subthemes. The first theme is the semblance of strength men seek to uphold. This is associated with three subthemes, namely: 1) Appearance of indifference, 2) The angry man, and 3) The self-managed man. This theme outlines the strength-based masculinities men adhere to, regardless of internal distress, and how these socially sanctioned masculine ideals inform men's internal experiences and publicly visible conduct. The second theme concerns men's experiences behind this mask. This theme is associated with three subthemes, namely: 1) Absent help-seeking, 2) Masking depression, and 3) Pain behind the mask. This theme elucidates men's inclination to hide the pain and distress they experience during depression, as a result of fear and shame associated with portraying any sign of weakness. It also explores how these behaviours add to the already distressing experience of depression. The third theme is redefining masculinity, a shorter but by no means less significant theme. Here is included a section that describes how a few men acted in

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opposition to the generic conceptualisation of masculine ideals of strength and autonomy and how they actively redefined these masculine virtues.

5.4. Male tertiary students' experiences of depression

As Paterson et al. (2001) stated, meta-synthesis work is "research of research" (p. 5), as the work of this study is based on completed research projects. As such, my understanding of the subject of enquiry is based on that of the researchers who conducted the five studies, which formed the sources of data. I did not have direct contact with the male tertiary students. However, the researchers of the five research projects did have direct contact through their interviews with the participants. By doing so, they had the opportunity to explore the lived experiences of these individuals, which was what they conveyed through their findings. My analysis is thus based on the analyses of the authors of the five primary studies. According to Noblit and Hare, (1988) the analysis of studies within a meta-ethnography is a translation into the view of the analyst and serves as one possible reading of that studied.

The findings of this meta-ethnography is based on a triple hermeneutic process (Weed, 2005). In this context, hermeneutics refer to people's interpretations of and the meaning they attach to themselves and the world around them. Double hermeneutic follows when researchers attempt to develop an understanding of people's experiences, which is based on their interpretations of their reality (Alvesson & Sköldberg, 2009). Triple hermeneutics refers to meta-synthesisers' attempts to interpret the interpretations that other researchers made about the experiences of people, which is subject to their own interpretations (Harper & Thompson, 2012). The findings that are discussed in this chapter as thus regarded as third order constructs (Malpass et al., 2009), which are interpretations (of the researcher) of interpretations (of the authors of the five primary studies) of interpretations (of the male tertiary student participants).

In light of the first aim of this research project, the next section first conceptualises male tertiary students' experiences of depression, based on the data synthesis of the five primary studies. Thereafter, the wider literature available related to this topic is integrated.

5.4.1. According to the synthesis.

All the participants in the analysed studies either self-identified as depressed or were formally diagnosed therewith. This mental illness is commonly associated with distress. However, the findings indicated that a preponderance of male tertiary students in the studies were primarily

focussed on preserving a semblance of strength, regardless of their environmental circumstances or internal distress. In service of this, they displayed a drive to appear indifferent to pain, even in the face of depression. These men appeared to have internalised ideals of masculinity, that ascribe how they should function internally as well as how they should conduct themselves in public, by virtue of their maleness. These ideals were socially sanctioned and took various forms. The internalised masculine ideals fostered expectations that these men should be strong, silent, unemotional, action driven, physically robust, rational, intellectually competent, decisive, independent, in control, and able to solve problems. Based on these ideals, the male tertiary students appeared to feel pressured to uphold a certain image, towards themselves in order to preserve their experience of masculinity and towards others to convince them of their masculinity. The impetus behind this pressure was linked to a fear of anticipated ramifications of contravening these masculine ideals, such as shame, stigma and being ostracised.

It was found that men associated depression with a subordinate and marginalised status and regarded it as a female illness. Men ascribed women's greater proclivity towards this mood disturbance to their inclination to greater emotionality, as it rendered them more vulnerable to feeling overwhelmed. Men formally diagnosed with depression were regarded as inferior to other men, as well as to women. In line with the ideals of masculinity, the men attempted to control and counter their depression by drawing on fighting qualities. They took up this battle against depression in an attempt to preserve their masculine identities. Depression was seen as a barrier they had to overcome. Denying weakness was an integral part of this battle and it was regarded as indicative of a strong character and a strong mind. Seeking help was disregarded, as it was anticipated that action in this direction would take them away from their sense of masculinity.

One exception to the unemotional image men felt expected to uphold, was the expression of anger. It appeared that anger outburst were a common feature among these men with depression, which was expressed as either verbal or physical aggression. These were regarded as manly forms of self-expression. The expression of anger was attributed to frustration and irritability that developed in the course of depression. Additionally, it was seen as a way to counter the experience of weakness the men associated with having depression or as an effort to communicate their pain. However, instead of providing respite, their anger was often

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associated with an exacerbation of distress. It was frequently followed by guilt, sadness, feelings of failure and disruptions in interpersonal relationships.

An additional way male tertiary students attempted to maintain an image of strength was by managing their depression independently, which often included avoidance of pharmacological intervention. This aligned with masculine ideals of independence, problem solving and staying in control. It was also often maintained by a fear of exposing their perceived weakness to others. In accordance with their solitary self-management, men employed various mechanisms of management, including self-medication, risky behaviour, intentional self-harm and engagement in physical activities. These behaviours allowed men to experience a sense of bravery, daring and risk taking, as a counter to the distress of their depression. Solitary self-management had an inherent risk. Men who engaged in these behaviours were at an increased vulnerability to harmful or fatal consequences, such as accidents or suicide.

According to the findings expressed by the studies of enquiry, the semblance of strength that these men upheld by appearing indifferent to pain, bursting out with anger and managing their own depression, appeared to be a mask that hid the reality of their painful experience associated with depression. Thus far, it was outlined how men felt pressure to uphold a certain image. However, men appeared to be trapped behind the masks they upheld. They felt unable to convey their distress to anyone, whether to those closest to them or to professionals. These men were inhibited from admitting their depression and seeking help by the strength-based masculine norms they upheld. Seeking external assistance was seen as an acknowledgment of an inability to manage this problem on their own and hence as an admission of weakness. Men were intent on avoiding this admission to themselves and preventing knowledge of their perceived weakness from reaching public awareness. Those men who did receive professional assistance were meticulous in keeping it discreet and even defaulted treatment due to a fear of the fragility of the secrecy of this information. The entrenchment of these socially sanctioned norms appear to instil a fear for potential ramifications strong enough to withhold men from seeking help from a distressing experience such as depression.

In service of masking their depression, men were not only reticent to seek help, they were also vigilant in hiding any signs indicative of their distress. Men appeared motivated to maintain an impression of well-being, despite experiencing various forms of internal distress. A frequent feature that accompanied their inhibited emotional expression, was social withdrawal. A common finding in the studies was men who hid themselves away from others during times of

depression. This entailed withdrawing from those closest to them as well as a reluctance to develop any new relationships, especially of an intimate nature. Part of this self-isolation was driven by a fear of having their perceived weakness exposed. It was also attributed to avoiding burdening others with their problems, a disinterest in relationships as a consequence of depressive symptoms (for instance fatigue and diminished self-esteem) and various feelings of insecurities (for instance about their ability to meaningfully connect with others, to sustain a relationship and their desirability as a partner). In an effort to retain a sense of masculinity, hiding behind an image that was discordant with their internal experience resulted in increased isolation.

Behind the mask men appeared so intent to uphold, were painful, distressing and potentially fatal experiences. This was often further exacerbated by their elaborate secret-keeping and self-isolation, as this dislocated potential social support. Men's accounts of their depression behind the semblance of well-being were marked by experiences of failure, misery, discontent, withdrawal from familiar activities and places, lethargy, impaired relationships, helplessness, hopelessness, impaired eating and sleeping, paranoid ideation, pessimism, reduced motivation, decreased libido, anxiety related difficulties, and risk of self-harm and suicide. Despite vigilant attempts to counter and hide their depression, men's depression had a significant impact on their well-being. Efforts to maintain an image associated with strength-based masculine ideals often led to a worsening of distress and left men stuck behind their appearance of indifference, unable to benefit from potential support from those around them.

Despite the proclivity of most men towards inhibited help-seeking, the studies referred to a few cases where men defied the more generally internalised understandings of strength-based masculine ideals. These few acknowledged the generally accepted masculine ideals. However, they appeared to unapologetically reach out to others for help in relation to their depression. In doing so, they revealed the fluidity of social constructs, such as masculine ideals, and negotiated its meaning. These men acknowledged the benefits of doing so, as it led to social support and medicinal intervention, which allowed an alleviation of depressive symptoms. It was reported that key to these few individuals' help-seeking were permission to self-disclose, knowing that other men also experience depression and being assured of an interested recipient of the disclosure. They were not ignorant to the possibility that their help-seeking could be perceived as indicative of vulnerability. However, they took part in redefining help-seeking as a strength-based practice, as opposed to a sign of weakness. Accessing external assistance,

which included professional help, was aligned with strength and autonomy in their efforts to manage their depression. As such, they actively partook in co-constructing the future of these social norms.

5.4.2. Research analysis in light of relevant review.

When the synthesis of the five primary studies was compared to the broader literature, certain similarities and discrepancies were found. These will be the focus of the next section, in order to hold the synthesis of this project up against relevant research findings regarding the subject of enquiry.

5.4.2.1. Men and depression.

According to literature, gender based norms are important in the understanding of depression. For instance, Oliffe et al. (2011) found that men's experiences of depression were associated with underlying gender-based norms (Oliffe et al., 2011). Socially sanctioned norms of masculinity fostered expectations of strength, control, self-reliance, and being silent about emotions (O'Brien et al., 2005; Oliffe et al., 2011). Danielsson et al. (2011) found a similar inclination among people aged 17 to 25 to conform to prevailing gender-based social norms. Adherence to gender-based norms was linked to self-esteem, feelings of acceptance, security and happiness. Based on these norms, men were expected to maintain a certain image. Branney and White (2008) stated that men displayed expectations of being regarded as inferior, less desirable and failures if this image was not upheld. A similar finding was evident in the five primary studies of this research synthesis, where it was found that men's ability to align to masculine norms was associated with their self-evaluations as well as with expectations regarding social acceptance.

Danielsson et al. (2011) found that male tertiary students' efforts to uphold strength-based masculine norms and hide their internal distress was associated with the angry man presentation as described in this synthesis. These men displayed an inclination to respond to experiences of depression with aggression, anger and irritability. However, according to Möller-Leimkühler and Yücel (2010), the experiences of aggression, anger and irritability were not unique to male tertiary students. It was reportedly a common feature among female tertiary students as well. Based on this, it was suggested that women in this developmental period were also at risk to developing a male depressive disorder, as was proposed by authors such as Rutz et al. (1995). Möller-Leimkühler and Yücel (2010) found that the difference between male and female

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tertiary students was especially in the expression of anger and not necessarily on the experience thereof. Even though they reported a convergence of gender roles, a distinction persisted regarding what was socially acceptable conduct among women and what was socially acceptable conduct among men. As a result, the female participants were more inclined to inhibit their anger, resulting in it being hidden, as opposed to not experiencing it at all.

Findings in line with the self-managed man subtheme of the research synthesis were also found in literature by Brownhill et al. (2005) and Emslie et al. (2006). In these studies men were found to engage in self-medication practices such as drug and alcohol use. This was also a feature among male tertiary students with depression. Alcohol use was common among this population and it was found to put men at greater risk for developing depression. An addition these authors reported, that did not emerge in the data synthesis, was that alcohol use among college men was associated with increased risk for violence and rape, both as perpetrators and as victims. Brownhill et al. (2005) also found that men attempted to avoid their experiences of depression by excessively engaging in work, distracting themselves with physical activities or taking time off in order to solve their depression-related problems. However, the data analysis revealed an additional method, namely self-harm. As with the findings of this study, Brownhill et al. (2005) reported that men's self-management did not necessarily lead to an alleviation of their distress. Instead, it often resulted in a build-up thereof and at times with risky, dangerous and potentially life-threatening behaviour, such as interpersonal violence, destruction of property and suicide.

Despite the façade men sought to uphold, men with depression displayed additional difficulties with impulse control, gender roles, anxiety, impoverished relationships, and emotional numbness, as indicated by Cochran and Rabinowitz (2003). The findings of this research synthesis also point out anxiety related difficulties, impaired interpersonal relationships and numbness. However, impulse control and gender role difficulties were not explicitly reported. Although poor impulse control could possibly be deduced from the reports of men's anger outburst. This research project revealed additional distressing experiences characteristic of men's depression, namely helplessness, hopelessness, paranoid ideation, decreased libido and risk of self-harm.

According to several authors (Khawaja & Bryden, 2006; Kitamura et al., 2004; Smith et al., 2001), depression takes on a different presentation among tertiary university students. The University Student Depression Inventory (USDI), developed by Khawaja and Bryden (2006),

outlines several symptoms associated with depression among this population. These include dysphoria, anhedonia, physical fatigue, mental fatigue; concentration difficulties, low self-esteem, pessimism, feelings of emptiness, suicidal ideation, and academic motivation, indicated directly in terms of motivation or indirectly by means of procrastination. Men during this developmental life period were also particularly at risk for suicide (Patton et al., 2009; Winkler et al., 2006). Most of these symptoms were found among the male students within the five primary research studies, with the exception of concentration difficulties and feelings of emptiness. Reduced motivation was found in generic terms and not specifically related to academic pursuits. Anhedonia was not explicitly found. However, it could possibly be inferred from men's withdrawal from familiar activities and places. Altered sleeping and eating patterns were noted in the findings. However, Khawaja and Bryden (2006) reported that this was a common feature among tertiary students, even those who did not experience depression. Consequently, they disregarded these as features indicative of depression within this population. Tremblay, Morin, Desbiens and Bouchard (as cited in Oliffe et al., 2010a) associated depression within this population group with moving away from their social support, financial strain and academic pressures. The synthesis associated academic performance and growing debt with men's experience of failure, which was a prominent feature in their depression.

Arnett (2004) described five main features as characteristic of emerging adults, namely identity exploration, instability, self-focus, feeling in-between, and possibilities. The information published in the primary research studies did not specify participant characteristics such as their involvement in the job market, romantic commitments and parental commitments. These are essential aspects to Arnett's (2004) conceptualisation of this developmental period. However, it appears that they were not in line with the foci of the primary research studies. As a result, no discussions followed on possible exploration and/or instability within these areas or the experience of being in-between. The drive(s) behind decisions such as field of study or tertiary institution were not made explicit and prevented a discussion on whether or not their decisions were made from a self-focused perspective.

Most of the participants displayed an affiliation with socially sanctioned masculinities, which could suggest an entrenchment of these norms within their identity formation. Additionally, the array of different fields of study the participants came from, as can be seen in appendix A, point to at least one area where possibilities were aplenty. Significantly, all participants of the

five primary studies extended their educational careers to a tertiary level, which is in line with Arnett's (2004) understanding of emerging adulthood. As a result, they faced financial strain and academic pressure, which were contributing factors to the experience of depression among the male emerging adults in the synthesis.

5.4.2.2. Men and help-seeking.

Men's depressive related behaviours have been found to be marked by a lack of help-seeking, according to authors such as Galdas et al. (2005), Möller-Leimkühler (2002) and Oliffe and Phillips (2008). In line with masculine ideals that promote self-reliance, stoicism and strength (Courtenay, 2000), men appear to have been conditioned to supress their experiences of distress (Brownhill et al., 2002). As mentioned before, men who were faced with emotional distress were more inclined to attempt self-management before seeking help from others. This was regarded as a risk to their health. However, it appears that the ideals of masculinity were so strongly entrenched that men would risk their health before risking their masculinity. There are some studies that indicate that men consequently denied their depression and avoided health care interventions as far as possible (Addis & Mahalik, 2003; Courtenay, 2000; O'Brien et al., 2005).

Brownhill et al. (2002) indicated that men avoided seeking help out of fear of embarrassment and shame. They also attributed it to an internalised expectation that they should be strong enough to deal with emotional distress, even depression, without professional intervention. Additionally, these researchers found that some men withheld from seeking help due to doubts about the competence and even about the willingness of professionals to assist. This research synthesis also found that men experienced an expectation that they should be able to overcome depression on their own. It also found that men's absent help-seeking occurred as an attempt to prevent their depression from reaching public awareness and the associated anticipated stigma as well as to avoid burdening others with their depression.

Several research studies discuss how the expression of emotions are seen as a feminine trait and that men are reluctant to engage in the expression of emotion. Even the acknowledgement of emotional pain was aligned with femininity and regarded by men as a risk in terms of their sense of masculinity (Brownhill et al., 2002). In this regard, Branney & White (2008) posited that depression was regarded as un-masculine. Danielsson et al. (2011) indicated a similar finding among male tertiary students, as they considered depression as a disorder particular to

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women. It was associated with dependence on others, which in turn was regarded as a weakness and shameful. The research synthesis also found that men regarded depression as a feminine illness and hence as subordinate to masculinity. Other scholars have also found that adherence to strength-based norms were associated with emotional repression (Brownhill et al., 2005; Emslie et al., 2006). Not only do norms like these inhibit men's help-seeking behaviour, it appeared to have impacted men's ability to even identify their experiences of emotional distress (Branney & White, 2008), resulting in the development of boys that "are socialised into emotionally inarticulate young men, unable to express depression" (Branney & White, 2008, p.261).

Brownhill et al. (2002) reported in their study that when men did engage with professional health services, it was in relation to non-mental health related matters. These men were more inclined to seek out professional assistance for physical and behavioural conditions, such as chest pain, self-harm and substance abuse. A consequence of this help-seeking behaviour was that men's depression was often overlooked. This was not a theme that emerged from the five primary studies of this research synthesis. It is not clear whether or not the men in the synthesis had been overlooked in the past.

5.4.2.3. Men and suicide.

Although suicide was regarded as a risk factor for the male tertiary students in the synthesis and there were reports of suicidal ideation, suicidality was much less prominent in the five primary studies than in the broader literature. The WHO (as cited in Winkler et al., 2006) reported that men in their late teens and 20s were particularly at risk for suicide. Oquendo et al. (2001) found that men who attempt suicide are four times more likely to succeed than women. Rutz and Rihmer (2007) related this to men's absent help-seeking, which prevents them from receiving help before this fatal outcome.

Issues related to high suicide rates have inspired several investigative attempts. Rutz and Rihmer (2007) reported of one such an enquiry that was conducted on the Swedish Island Gotland. This "psychological autopsy" (p. 396) indicated that men who successfully committed suicide displayed certain characteristic symptoms. These included disturbed sleep, fatigue, indecisiveness, thought distortions, impaired stress tolerance and impulse control, burn out, irritability, morning uneasiness, abusiveness, antisocial behaviour, self-pity, and alcoholism. Even though suicidal ideation was less prominent in the research findings of this synthesis and

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no suicide attempts were reported, these male tertiary students did display some of the features that the Gotland study associated with men who commit suicide. These included altered sleeping patterns, lethargy, irritability, anger outbursts, and excessive alcohol use. These findings and the reported instances of suicidal ideation supported the idea that the men in the primary studies were at risk for suicide.

The five primary studies of the analysis allowed for greater clarification on a number of matters. Both the literature and the research synthesis explored men's propensity to strength-based masculine ideals. However, the masculine ideals that male tertiary students internalised were outlined more specifically, as were the consequences of the embodiment of these ideals. In terms of self-management, the literature (Courtenay et al., 2002) suggested that alcohol use placed men at greater risk for depression as well as for violence. The literature (Brownhill et al., 2005) also indicated that men excessively engaged in work as a self-management strategy. In addition to these findings in the broader literature, this synthesis also identified self-harm in this regard. Deception and self-isolation were more prominent features in the studies synthesised. Additional findings were outlined in the synthesis regarding the distressing experiences behind the mask of these students. Suicide was a more prominent feature in the literature (Rutz & Rihmer, 2007). Lastly, some of these studies reported on men who attempted to redefine the meaning attributed to strength and autonomy in gender-based norms.

To conclude, this section highlighted the findings from this synthesis and the broader literature that pointed to a disparity between the impression male tertiary students seek to maintain and their experience of depression behind this image. As was the case within the synthesis, the literature (O'Brien et al., 2005; Oliffe et al., 2011) also found that the impetus behind this was men's drive to embody strength-based ideals of masculinity. Their alignment with these masculine norms restrained them from acknowledging their depression and seeking help, despite the distress they experienced related to their depression.

5.5. Contextual analysis

The contextual analysis is a reflection on the contexts from where the primary research studies were conducted. This section includes discussions on the particulars of both the research participants and researchers. According to Paterson et al. (2001), a potential pitfall in qualitative systematic reviews occurs when the findings are decontextualised from its original situated contexts. This is in reference to the characteristics of the research and its participants,

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which are not necessarily part of the findings addressed in the data analysis. By addressing the context of the research, this section will explore the potential impact it could have had on the findings of the data analysis. The focal areas of this contextual analysis are: Country of study, ethnicity and sexual orientation of the participants, discipline of researchers and journals of publication.

5.5.1. Country of study.

The only limitation placed on finding studies in this regard related to universities from industrialised countries. This inclusion criteria was set in light of the conceptualisation of the tertiary students according to an emerging adulthood developmental period, which is particular to industrialised countries. Four of the studies originated in Canada and one in the United States of America. No studies were found outside this region. In particular, no studies were found in South Africa.

As can be seen in appendix B, the Mentink (2001) study was conducted in the United States of America, and Oliffe et al. (2013), Oliffe et al. (2010a), Oliffe et al. (2010b) and Tang et al. (2014) in Canada. The contexts where the studies emanated from had a significant influence on the findings that emerged from their analysis. Both these countries adhere to specific hegemonic masculine ideals (Ramsay, 2011). The Conformity to Masculine Norms Inventory (Mahalik, 2003) outline an array of ideals associated with masculinity that align with the ideals the men in these studies adhered to. These included emotional control, risk-taking, violence, dominance, self- reliance, and pursuit of winning and status.

Ramsay (2011) explored work conducted on the topic of masculinity primarily during the twentieth century. He found that several publications addressed the negotiation of dominant gender-based norms within the Canadian culture and explored the counterpoints to the historical ideals of masculinity. Reflecting on the countries of origin of these studies, it could be posited that the location of interest into the subject of enquiry could be accounted for by the possible change in dominant gender-based norms within Canadian society. As outlined by Ramsay, several authors have questioned the ideals espoused by these norms, exposing the fluidity of these social constructs. This possibly signifies an approach that questions the impact of masculine ideals and roles on men's experience of depression. Additionally, it opens up a dialogue of change in terms the meaning associated with strength-based masculine ideals.

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5.5.2. Ethnicity of participants.

All the studies provided an outline of the ethnic origins of their participants. As detailed in appendix C, the students that partook in the five studies were from across an array of ethnicities. Both male tertiary students from the Mentink (2001) study were American. The Oliffe et al. (2013) study reported eight Anglo-Canadian, eight East-Indian / South Asian, five Chinese, one Latino, one Middle Eastern and two mixed participants. Oliffe et al. (2010a) included 11 Anglo-Canadian, eight South Asian, five Chinese, one Latino and one Middle Eastern participants. Oliffe et al. (2010b) reported 13 Asian, one Latino and one Middle Eastern participants. Lastly, the Tang et al. (2014) included six East-Indian / South Asian, five Anglo-Canadian, five Chinese, one European-Canadian, one Latino, one Middle Eastern and two mixed participants.

According to the immigration statistics of these two countries, a population diversity like this is to be expected at tertiary institutions. Statistics of the United States of America (as cited in Schwartz & Montgomery, 2002) stated that foreign born residents compose 12 % of the American population and that 26% Americans are ethnic minorities. Bélanger and Bastien (2013) reported that two-third of Canada's demographic growth can be attributed to immigration. The findings that were reported by these authors reflected experiences across a diverse population. The discussions that followed were based on all these ethnicities. There was limited discussion addressing any form of difference between the various cultures. Perhaps no differences were found among the different population groups, or such a discussion did not serve as a part of the researchers' goals. The reason for omitting such a discussion was not made clear in the studies. An understanding of the cultural differences in experiencing depression would require further investigation.

It was reported that all these students attended universities in the United States of America or Canada. As such, all these participants were exposed to the cultures associated with the industrialised cultures of these two countries. However, not enough information could be ascertained regarding the amount of time all these students spent in these two countries, apart from Mentink (2001) and Oliffe et al. (2010b). As a result, no clarity could be found regarding the extent of acculturation that could have occurred within these individuals or the impact thereof on the findings. Schwartz and Montgomery (2002) reported that acculturation can have an important impact on the identity process and outcome of identity status within the tertiary student population. This could prove to be a valuable area of further investigation.

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5.5.3. Sexual orientation of participants.

All the studies, except for Oliffe et al. (2010b), provided details regarding the sexual orientations of their participants, as can be seen in appendix D. Mentink's (2001) study included two heterosexual men. Oliffe et al. (2013) included 22 heterosexual, two homosexual and one bisexual men. Oliffe et al. (2010a) reported 23 heterosexual and two gay men, as well as one man who questioned his sexual orientation. Lastly, Tang et al. (2014) included 18 heterosexual, two homosexual and one bisexual participants.

A preponderance of participants aligned to a heterosexual orientation, with only a small portion identifying with homosexual, bisexual or an uncertain orientation. Oliffe et al. (2010a) reported certain doubts related to participants' ability to conform to masculine ideals of sexual performance and preferences. However, this discussion was limited and no other study referenced to the link between male tertiary students' depression and experiences related to sexual orientation. This could be an important factor to explore more directly in the experiences of male tertiary students with depression. Especially in light of certain studies (Jorm, Korten, Rodgers, Jacomb, & Christensen, 2002; Westefeld, Maples, Buford, & Taylor, 2001; Zietsch et al., 2012) that highlight differences of risk factors and/or experiences between heterosexual, homosexual and bisexual individuals.

5.5.4. Discipline of researchers and journal of publication.

Appendix E indicates the disciplines and journal of publication. Mentink's (2001) study was conducted within an educational discipline. This was a dissertation for a Doctoral degree and not published in a journal. The Oliffe et al. (2013) study was conducted by researchers from nursing science and was published in Health: An interdisciplinary journal for the social study of health, illness and medicine. Oliffe et al. (2010a) was a study from psychology, psychiatry and nursing science disciplines and published in Health Sociology Review. The Oliffe et al. (2010b) study was composed by researchers from psychiatry, nursing science and social work fields and published in Qualitative Health Research. Lastly, Tang et al. (2014) was a study conducted by researchers from nursing science and published in the Journal of Mental Health.

In generic terms, this presented a homogeneous group. However, as depression is primarily a mental health matter, it is to be expected that mental health professionals would predominate research inquiries into this phenomenon. Within the field of mental health there were a variety of disciplines represented. Of note, is that only one study had psychological representation.

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This alerts to the possibility of future research, where the field of psychology could direct greater attention to this phenomenon in line with the development or evaluation of psychological theories pertaining to this line of inquiry.

The journals in which these studies were published were directed at an international and interdisciplinary audience, across health, mental health and social service professions, including nurses, psychologists, sociologists, anthropologists and cultural theorists. Thus, the findings would be accessible to a broad array of professionals that could come into contact with male tertiary students who experience depressions.

5.6. Limitations of the study

One limiting factor of this study was the restriction of including only English studies. This restricted the study in terms of demographics of participants, as different languages and the associated different cultures could have resulted in different findings. However, due to the researcher's limitations in terms of linguistic fluency, only English and Afrikaans could have been considered and no Afrikaans studies were found. Additionally, in light of the context of a minor dissertation and financial and time constraints, an alternative was not pragmatic.

In light of research, such as Schwartz and Montgomery (2002) and Zietsch et al. (2012), acculturation and sexual orientation can have an important impact on someone's experience in terms of mental health related matters. However, the lack of detail regarding the impact these features had on the participants' experience of depression limited this research project's capacity for discussion on these matters. The studies also did not allow for discussion on the potential impact of factors such as socio-economic status or health literacy, as acknowledged by Tang et al. (2014).

Within the theme of redefining masculinity, there were findings of men who were more willing to accept help, including professional intervention. However, it was not clear how these men came into contact with this external assistance in the first place, whether it was self-initiated or as a response to enquiries by others. This limited the discussion on how these men came to first made contact with external sources of assistance.

5.7. Areas for future research

A prominent gap was found in current literature directed at the subject of enquiry within the South African context. Future research could assess the validity of these findings among South African male tertiary students, or to explore the possibility of alternative or additional themes within this population. In light of the numerous cultural groups within the South African context, forthcoming studies could explore the differences and/or similarities among these different cultures in terms of experiences of depression among male tertiary students. This could include an investigation into the impact of acculturalisation to an industrialised society on the experience of depression. Prospective projects could also explore the impact that factors such as ethnicity, acculturation and sexual orientation could have on male tertiary students' experience of depression. Comparative research could also be done in terms of the population group of this study and older or younger male populations or with a female population. Lastly, more direct attention could be afforded to those individuals who stepped out and sought help in a subsequent research project.

5.8. Conclusion of research

The research aim of this study was to enhance the understanding of the extant research on male tertiary students' experiences of depression. As such, this research project answered the research question and did so by means of a meta-ethnography. The data analysis that ensued produced various themes within these men's experiences according to the findings of five primary research studies. The themes were semblance of strength, behind the mask and redefining masculinity. These were related to subthemes, namely appearance of indifference, the angry man, the self-managed man, absent help-seeking, masking depression and pain behind the mask. This research project served to synthesis the themes, concepts and metaphors of five primary studies within the proposed overarching themes and subthemes. As such, the synthesis produced something that was more than a mere aggregation of findings, which is in line with a core premise of meta-ethnographies, to produce a whole that is greater than the sum of its parts (Thorne et al., 2004). These themes and subthemes serve to provide a framework for conceptualising male tertiary students' experiences of depression. In turn, this can inform future research and clinical practice of this mental illness within this population group.

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Appendix

Appendix A

Participants' field of study

Name of authors	Year of publication	Participants' field of study
Mentink	2001	2 Sport scholarships, of which 1 majored in Communications
Oliffe et al.	2012	9 Commerce 7 Engineering 6 Arts 1 Sciences 2 Undeclared / unknown
Oliffe et al.	2010a	8 Sciences 7 Arts 4 Engineering 2 Technology 1 Commerce 1 Nursing 1 International relations 2 Undeclared / unknown
Oliffe et al.	2010b	Unknown
Tang et al.	2014	8 Engineering 7 Arts 5 Sciences 1 Commerce

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Appendix B

Country of study

Name of authors	Year of publication	Country of study
Mentink	2001	United States of America
Oliffe et al.	2012	Canada
Oliffe et al.	2010a	Canada
Oliffe et al.	2010b	Canada
Tang et al.	2014	Canada

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Appendix C

Ethnicity of participant

Name of authors	Year of publication	Ethnicity of participant
Mentink	2001	2 Americans
Oliffe et al.	2012	8 Anglo-Canadian 8 East-Indian / South Asian 5 Chinese 1 Latino 1 Middle Eastern 2 mixed
Oliffe et al.	2010a	11 Anglo-Canadian 8 South Asian 5 Chinese 1 Latino 1 Middle Eastern
Oliffe et al.	2010b	13 Asian 1 Latino 1 Middle Eastern
Tang et al.	2014	6 East-Indian / South Asian 5 Anglo-Canadian 5 Chinese 1 European-Canadian 1 Latino 1 Middle Eastern 2 mixed

Appendix D

Sexual orientation of participants

Name of authors	Year of publication	Sexual orientation of participants
Mentink	2001	2 heterosexual
Oliffe et al.	2012	22 heterosexual 2 homosexual 1 bisexual
Oliffe et al.	2010a	23 heterosexual 2 gay 1 questioning
Oliffe et al.	2010b	Unknown
Tang et al.	2014	18 heterosexual 2 homosexual 1bisexual

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Appendix E

Discipline of researchers and journal of publication

Name of authors	Year of publication	Discipline of researchers	Journal
Mentink	2001	Education	Not published in a journal
Oliffe et al.	2012	Nursing Science	Health
Oliffe et al.	2010a	Psychology Psychiatry Nursing Science	Health Sociology Review
Oliffe et al.	2010b	Nursing Science Social Work Psychiatry	Qualitative Health Research
Tang et al.	2014	Nursing Science	Journal of Mental Health

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