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SOUTH AFRICAN MEN'S EXPERIENCES OF DEPRESSION AND COPING STRATEGIES

by

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Thank you to everyone that has been a part of my journey thus far.

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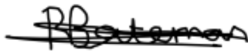
DECLARATION

I, **Ryan Bateman (14213657)**, declare that this mini-dissertation (***South African men's experiences of depression and coping strategies)*** for the degree, Magister Artium (Clinical Psychology) in the Department of Psychology at the University of Pretoria, has not previously been submitted by me for this degree, at this or any other university. The work contained in this mini-dissertation has not been previously submitted to meet the requirements for an award at this or any other higher institution. To the best of my knowledge and belief, the mini-dissertation contains no material previously published or written by another person except where due reference is made.



12/07/2021

SIGNATURE **DATE**

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ETHICS STATEMENT

I, **Ryan Bateman (14213657)**, declare that I have obtained the applicable ethical approval for the research titled ***South African men's experiences of depression and coping strategies*** (see APPENDIX A: FORMAL ETHICAL CLEARANCE LETTER). This study was approved on the **16th of February 2021**, with **reference number HUM012/0420** from Prof. Innocent Pikirayi, the Deputy Dean of Postgraduate Studies and Research Ethics, in the Faculty of Humanities at the University of Pretoria.

12/07/2021

AUTHOR SIGNATURE **DATE**

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ABSTRACT

Title: South African men's experiences of depression and coping strategies
Supervisor: Prof. B.J.M. Steyn
Department: Psychology
University: University of Pretoria
Degree: Magister Artium (Clinical Psychology)

Major Depressive Disorder is regarded as a major contributor to the global burden of disease. It is considered as the fourth highest cause of disability across the globe and second highest between the ages of 15 and 44. It is a serious mental health condition that affects individuals' physical and mental health and is often associated with comorbidities, functional impairment and at times fatal consequences. Men with depression are considered as an at-risk group as research has shown that males are less likely to receive intervention or health care compared to women, due to hegemonic masculine norms. Within the qualitative research community, some efforts have been made to give voice to men's experiences of depression and help-seeking, as well as the coping strategies that they deploy to manage such symptoms. However, comparatively little to no research has focused on the South African population, and specifically on Black men's experiences. Similarly, only a few studies have concentrated on the positive, helpful and/or adaptive coping strategies used by men to manage their internal distress. Thus, this study contributed to a growing body of knowledge and filled a gap in current literature.

This research was qualitative in nature and deployed Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis, in order to analyse the eight individual interviews conducted. The analysis produced various themes and subthemes that elucidated the experiences of masculinity, depression, help-seeking and coping mechanisms among Black men in South Africa. The three overarching themes included: Real men don't cry; Sadness hurts, but sharing hurts more; and Dark days, take control; all of which were related to several subthemes. The analysis indicated that Black men in South Africa do experience depressed moods and internal distress. However, they may deny such experiences due to their subscription to strength-based masculine ideals. They instead foster a mask of indifference to such pain by denying or supressing their emotions in order to assimilate into masculine norms. This was even more apparent in Black African cultures where hegemonic masculine norms were further entrenched and encouraged. Furthermore, public and self-stigma were commonly

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cited as a reason why the men in the study felt the need to uphold this image of indifference and keep subscribing to such dogmas.

This translated into the men's experiences and attitudes towards help-seeking, where they would often reject or be reluctant to disclose their emotional distress to professionals or to those closest to them. This was due to the perception that help-seeking is in line with femininity, which diverts/shifts away from the masculine ideals they sought to uphold. Another aspect introduced was how these concepts intertwined with Black African cultures. Namely, it may be more difficult for Black men in South Africa to openly express their experiences of depression or seek help psychologically, as these are Westernised terms and are uncommon in Black communities. However, a more traditionally accepted help-seeking route was to go to a traditional healer or Sangoma. Considering the men's overall reluctance to seek help, they engaged in coping strategies in order to manage depressed feelings, as this was more in line with the masculinity expectations of autonomy, unemotionality and problem solving. Negative coping mechanisms were seen as a celebrated and normalized way for men to numb or supress their emotional distress, while still enacting masculinity. Lastly, although positive coping strategies were posited as a way for men to directly engage in distressful emotions, this was more difficult to adopt as they were perceived to be aligned with more feminine traits.

This research created a framework that can be used to conceptualise Black South African men's experiences of depression, help-seeking and coping strategies. This research is of utmost importance considering that men are noted to be more likely to experience functional impairments or fatal consequences due to their reticence for help-seeking. As such, men and future public health messaging could capitalise on this research in order to improve help-seeking and self-management behaviour amongst this population. This is particularly relevant considering our current context of the COVID-19 global pandemic.

Keywords: Major Depressive Disorder, South African men, help-seeking, coping strategies, and qualitative thematic analysis.

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LIST OF ABBREVIATIONS

APA: American Psychiatric Association………………………………………………….20

BDI-II: Becks Depression Inventory-II……………………………………….……...…...18

DSM: Diagnostic and Statistical Manual of Mental Disorders…………….…….……….....29

ICD: International Classification of Diseases…………………………………...………29

MDD: Major Depressive Disorder…………………………………………..………….12

WHO: World Health Organization…………………………………………….……….12

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CHAPTER 1:

INTRODUCTION TO THE STUDY

1.1. Introduction

The emphasis of this research project is on South African men's experiences of depression and coping strategies. Some efforts have been made within the qualitative research community to give voice to men's experiences of help-seeking for depression and the coping mechanisms that they deploy to manage such symptoms. However, little research has focused specifically on the positive, helpful and/or adaptive coping strategies used by men and even fewer studies have investigated the South African context. Thus, the impetus behind the study was to not only address an important topic, but also endeavoured to contribute to a growing body of knowledge and filling a gap in current literature.

Chapter 1 serves to contextualise the topic of investigation, namely depression among South African men. The chapter will address the burden of depression on society, as well as the gender-specific patterns noted in research. Attention will then be paid specifically to research findings in terms of the coping strategies that these men utilise in order to manage such internal distress. This section intends to highlight the value of this research in the context of mental health. Finally, the aim and objectives of this research is included and an overview of the chapters will be provided.

1.2. Depression (conceptual context)

Depression, characterised by feelings of sadness and/or hopelessness, is one of the most prevalent psychiatric disorders worldwide, holding substantial concern for mental health care (Watkins, Green, Rivers, & Rowell, 2006). The prevalence of depression has been on the increase (Gotlib & Hammen, 2008) and is regarded as the fourth highest cause of disability around the world and second highest between the ages of 15 and 44 (Oliffe & Phillips, 2008). Internationally, more than 264 million people of all ages suffer from Major Depressive Disorder (MDD) (World Health Organisation [WHO], 2020). It is a severe mental health condition that affects individuals' physical and mental health, and is often associated with comorbidities, functional impairment, and at times fatal consequences (WHO, 2014; WHO, 2017).

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MDD is often linked to comorbid psychiatric and physical conditions, such as: anxiety disorders (panic disorder, generalised anxiety disorder), obsessive-compulsive disorder, substance-related disorders, eating disorders, personality disorders, post-traumatic stress disorder (Mimura, 2001), cardiovascular disease, strokes, diabetes, epilepsy (Hopko, Mclndoo, & File, 2017), and in some cases, MDD can result in suicide (WHO, 2020). It is estimated that nearly 800 000 people die due to suicide every year, with suicide being the leading cause of death between 15 and 29-year-olds (WHO, 2014; WHO, 2020). Möller-Leimkühler (2002) stated that up to 70% of those deaths are associated with MDD. The seriousness of MDD is thus further intensified by its connection with other potentially fatal comorbidities and consequences.

A number of researchers have noted gender-specific patterns in the incidence and prevalence of depressive symptoms, whereby men's depression is diagnosed at half the rate of women (Van de Velde, Bracke & Levecque, 2010). Women are similarly reported to be twice as likely to seek and receive help for their depression compared to men (Branney & White, 2008). However, a disturbing trend reported by Oliffe and Phillips (2008) is that depressed men are four times more likely to complete suicide than women. A growing body of literature has emerged, proposing that hegemonic constructions of masculinity may be one cause of this discrepancy as it discourages health-positive behaviours; such as soliciting advice, using health services and speaking openly about health problems (Addis & Mahalik, 2003; Seidler, Rice, Dhillon, & Herrman, 2019). This is significant as the continued under-detection and under-representation of depression in men may negatively affect domains such as education, career, interpersonal worlds, as well as life satisfaction and expectation. Thus, considering findings such as these, it can be argued that explorations into MDD among men is imperative to the health of this population.

Research has also examined sex-differences in depression in terms of coping styles/strategies, with women showing greater propensity toward rumination, and men showing more harmful and maladaptive responses, such as aggression, substance abuse, and reckless behaviour (Butler & Nolen-Hoeksema, 1994; Tamres, Janicki, & Helgeson, 2002; Twenge & Nolen-Hoeksema, 2002). Namely, some studies have found that men may be more likely to use inappropriate or ineffective coping strategies, emphasising harmful externalizing behaviours (Proudfoot et al., 2015). For example, this included isolating themselves, gambling, substance-abuse, or over-working in order to numb or distract from the problem (Proudfoot et al., 2015).

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It was noted that use of such ineffective strategies to cope with depression contributed to prolonged distress, lower detection, delays in treatment, and exacerbation of problems (Proudfoot et al., 2015).

Given that men in distress are often reluctant to seek help, may have difficulty disclosing problems to health professionals, and that previous research has often focused on men's negative responses to depression, this necessitates the need for research that will reveal new methods to reach men. Little research, however, has examined the positive, helpful or adaptive strategies used by men to prevent and/or manage depression (Hoy, 2012). This gap in literature was identified as a concern by Proudfoot et al. (2015) who noted that improving self-management among men may have a far greater impact on their health than any improvement in specific medical treatments. Thus, these authors stated that "there is a need to identify men's adaptive responses to depression and stress so that public health programs can be developed, especially for men who may otherwise avoid help-seeking" (Proudfoot et al., 2015, p. 2). Thus, not only does depression deserve greater consideration in men, but greater attention and investigation should be drawn to men's adaptive, helpful, and/or positive coping strategies that they use to manage such depression.

1.3. Justification, aim and objectives

Considering the findings mentioned above, MDD can be regarded as "a major contributor to the global burden of disease" (WHO, 2020, p. 1). This is supported by Mathers and Loncar (2006) as they have noted that depression is anticipated to become the prominent cause of disease burden within developed countries by the year 2030. Contextualising the available data, an epidemiological study found that there was a 9.7% lifetime prevalence of MDD within the South African population (Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). However, despite such alarming prevalence rates, a review of the current literature shows that no such study on the South African population has been included in any of the qualitative reviews on men and depression, or men and help-seeking. This is evident in the meta-synthesis reviews conducted by Hoy (2012), as well as Krumm, Checchia, Koesters, Kilian and Becker (2017), as neither study included any data conducted in South Africa. In other words, although there is a growing body of international research, very few studies have been done on the South African population. Thus, this study endeavours to fill a gap in research within the South African context.

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Furthermore, men with depression can be considered as an at-risk group, as research has shown that males are less likely to seek or accept intervention or health care compared to women and are thus more likely to experience functional impairments or fatal consequences (Möller-Leimkühler, 2002; WHO, 2020). Such poor morbidity and mortality rates among men have been associated to certain hegemonic masculine ideals, as well as health related behaviours of men which are often characterised by a reticence for help-seeking. Moreover, given men's underutilisation of health services, it is vital to consider how men manage their depression naturally or cope in the absence of clinical intervention, specifically emphasising the positive and/or helpful coping strategies that these men utilise (an area that is relatively unexplored). By researching South African men's experiences of depression and the coping strategies that they use in their day to day to cope with such internal distress, men and future public health messaging could capitalise on this research by emphasising and utilising the different strategies as a form of self-management. This is particularly relevant considering our current context of the COVID-19 global pandemic. The latest research on these matters indicate that the various socioeconomic, psychological, and health-related impacts of the COVID-19 pandemic may heighten the risk of suicidal behaviours (Courtet, Olié, Debien, & Vaiva, 2020; Gunnell et al., 2020; Reger, Stanley, & Joiner, 2020; Tull et al., 2020). Specifically, Khan, Ratele and Arendse (2020, p. 1) note that "uncertainties caused by the COVID-19 pandemic, coupled with global responses such as lockdowns, have heightened depression, anxiety, isolation, loneliness, financial concerns, anger, irritability, relationship conflicts, fears, and increased use of alcohol and tobacco."

Thus, using the suggestion by Cochran and Rabinowitz (2000) to *simply ask men*, this study seeks to answer the research question of: What are South African men's subjective experiences of depression and the coping strategies that they utilise to manage it? As such, the aim of this study is to explore South African men's experiences of depression.

The question and aim of this research was answered by means of a thematic analysis, a method proposed by Braun and Clarke (2006). This qualitative thematic analysis was used to analyse eight individual interviews in order to extract common themes and ideas. In line with the research question and aim, and in service of a nuanced and in-depth study, the objectives of this research project are:

a) To explore South African men's attitudes to and perceptions of help-seeking for depression.

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b) To explore South African men's coping strategies, specifically emphasising men's positive or helpful coping strategies, in managing and/or coping with depression.

1.4. Theoretical framework

A theoretical framework provides direction and meaning to the research process, and acts as a basis from which to conduct research (Osanloo & Grant, 2016). Namely, it aids the researcher in presenting the impetus behind the study, data collection techniques, and methods to interpret and communicate the research findings (Merriam, 2009).

This study was grounded in the concept of social constructionism, the notion that human development is socially situated and knowledge is constructed through interaction with others (Adams, Collair, Oswald, & Perold, 2004). In other words, social constructionism is a theory of knowledge, explaining the association between objective reality and the ability of individual perception (Andrews, 2012). The theory posits that social perception and expressions construct reality, and thus the only reality worth attention is the reality that is perceived (Leeds-Hurwitz, 2009). However, this accompanies the consequences that reality and social constructs can vary and be multiple depending on the society and the events surrounding the time period in which they exist (Galbin, 2014). An example of such social construct is money or the concept of currency, considering that people in society have agreed to give it importance/value (Andrews, 2012). In other words, money is essentially inked on a piece of paper. However, individuals' perceptions about money and its perceived value have in turn constructed the reality of money itself, making it valuable in society. Another example is the concept of self/self-identity (Galbin, 2014). Based on Cooley's (1902, p. 126) self-theory of the looking-glass, he stated that: "I am not who you think I am; I am not who I think I am; I am who I think you think I am." This conveys the notion that individuals in society create ideas or concepts that may not exist without the people or language to validate them.

According to Creswell (2009), social constructionism enables qualitative analysis to reveal insights on how people interact with the world, serving as a useful theoretical framework. Social constructionism was thus deemed appropriate for this research in order to study the personal experiences of masculinity and how it affects aspects such as depression and coping among South African men. Furthermore, this theoretical framework helps centre the research as one can argue that gender itself is a social construct. Gender, according to West and Zimmerman (1987, p. 127), "is not simply what one is, but what one does as it is actively

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produced within social interactions." Thus, gender can be considered as an accomplishment: "the activity of managing situated conduct in light of normative conceptions of attitudes and activities appropriate for one's sex category" (West & Zimmerman, 1987, p. 136). These performances of doing gender in turn serve to create and reinforce these dogmas and discourses.

1.5. Research paradigm, design and methodology

1.5.1. Research paradigm

A research paradigm can be defined as a lens through which individuals see the world, and a system by which social phenomenon can be examined and explained (Khaldi, 2017). Paradigms inform researcher's perception and understanding about the nature of knowledge, as well as how is can be accessed. Research paradigms are usually guided by three main tenets, namely: ontology, epistemology, and methodology (Denzin & Lincoln, 2011). "Ontology relates to one's perspective of reality, epistemology to one's relationship about what is known, and methodology to how specific knowledge is obtained" (Ellis, 2016, p. 14).

This study adheres to and is grounded in the philosophical principles put forth by the interpretivist paradigm. Developed as a critique of positivism in the social sciences (Black, 2006), interpretivism holds specific ideas and attitudes about the nature of knowing and reality. Namely, interpretivism rejects the positivist paradigm's postulation of one unified truth that is objectively knowable, to instead suggest that humans are social beings who create and reinforced shared meaning through their interactions with others (Larkin & Thompson, 2012). As such, the ontological assumption of this study is subjectivism as it believes that social reality is shaped from the views and experiences of the individuals concerned with their existence (Denzin & Lincoln, 2005). In other words, rather than external or objective truths, subjectivism is the belief that reality is a fixed subjective experience (Denzin & Lincoln, 2005). Taking this ontology into account, this research is based on a few epistemological assumptions regarding knowledge. This includes: that reality and knowledge is socially constructed, the data is subjective as the participants are seen as the experts regarding their own experiences, it is subject to amendments as the participants knowledge and experiences are variable to change when interacting with the environment, and multiple as different individuals will have varied experiences and thus varied knowledge (Kankam, 2019).

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1.5.2. Research design

Considering that this research is focused on the personal experiences of depression among South African men, a qualitative design that is exploratory in nature was deemed appropriate. Qualitative research can be defined as an exploration into facets of social life, focusing on the interpretation and meaning of public practices (Jupp, 2006). It is concerned with how individuals create their realities based on their subjective perceptions of the world around them (Larkin & Thompson, 2012). As such, a qualitative design was deemed appropriate for this study as it will allow for the exploration of how South African men construct their realities and make sense of their own individual experiences. Furthermore, this study will be exploratory in nature as it wishes to investigate the research topic to yield new insights and understandings rather than provide conclusive evidence.

1.5.3. Participants

This study conducted research on eight South African men who felt that they were experiencing depressive symptoms. The sample was accessed at a local support group dedicated to assisting and counselling men through topics such as: depression, substance abuse, and general life challenges. As this site and sample were selected for the purpose of having access to specific individuals who can answer the research question best, this study at first employed a non-probability and purposive sample technique (Tongco, 2007). Additionally, the research further utilised snowball sampling as it asked the men from the group to provide referrals to recruit participants required (Johnson, 2014). In other words, the existing sample nominated other potential data sources who would be able to participate in the research (Johnson, 2014). Due to such snowball sampling technique favouring the selection of participants from the same background and cultural group that share similar values, this resulted in the selection of eight Black South African men that comprised of the sample. This selection of a more homogenous cultural group assisted in making this research a more focused study that served to add to the current body of literature (Jones, 2015).

1.5.4. Data collection methods

To collect the data necessary for this research, this study employed the Becks Depression Inventory-II (BDI-II), as well as individual in-depth interviews. As the researcher acknowledges that most, if not all, participants would not have received a formal diagnosis of MDD, this study utilised the BDI-II as a screening tool for depressive symptoms. Moreover,

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this research utilised individual in-depth interviews which consisted of a semi-structured format and comprised of open-ended questions (see APPENDIX A). The interviews sought to elicit a deeper understanding into the participants' experiences and perceptions of depression and coping strategies. The interviews were conducted online via Zoom and took approximately 60 minutes for each individual as to ensure that the participants' were comfortable and gave a detailed response (Ritchie, Lewis, Nicholls, & Ormston, 2013).

1.5.5. Data analysis

The research data for analysis consisted of the participants' responses elicited during the individual interviews. Braun and Clarke's (2006) thematic analysis was implemented in order to analyse and interpret the data. This method is commonly believed to be foundational in qualitative analysis as well as compatible with the social-constructionist paradigm (Ellis, 2016). Thematic analysis provided a valuable and adaptable research technique to offer a comprehensive and rich interpretation of the data, as it allows for the identification, analysis and reporting of patterns (themes) within qualitative research (Braun & Clarke, 2006). Finally, thematic analysis is considered beneficial to this study as it accounts for the active role the researcher plays in reflecting and reporting on the data.

1.5.6. Reflexivity in research

Reflexivity comprises of my critical awareness and evaluation of how my own position within the research might have impacted it (Treharne & Riggs, 2014). In other words, I have to be conscious of my own emotions, biases, and attitudes, and the influence it could have on my choice of subject, methodology and analysis of the identified themes (Treharne & Riggs, 2014). As such, a personal introspective reflection will be provided in the fifth chapter, where I focus the investigative lens on myself as the researcher. This is crucial as in qualitative research, and according to my interpretive paradigm, my role has been vital to the research process (Treharne & Riggs, 2014).

1.6. Outline of study

This mini-dissertation is separated into five distinct chapters. Beyond Chapter 1 already being outlined, Chapter 2 focusses on the extant literature pertaining to depression, help-seeking as well as the coping strategies men utilise to manage and/or cope with such distress. The chapter endeavours to cover the salient thoughts and notions regarding the subject of enquiry. It first

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summarises the development of the conceptual and etiological understanding of depression. This is followed by a discussion on the impact that gender has on facets such as depression, help-seeking, and coping strategies. The literature review thus integrates the theoretical knowledge concerning depression, hegemonic masculinity and coping mechanisms.

Chapter 3 directs its attention to the research design of the study. Specifically, it provides a detailed discussion of the method and methodology undertaken by this study to answer the research question. The chapter concludes with the ethical and quality considerations that had to be taken into account. Chapter 4 communicates the analysed data from the eight individual interviews. The fifth and final chapter aims to consolidate the research. This is achieved by reviewing the preceding chapters and integrating the analysed data with the relevant literature examined in Chapter 2. Lastly, Chapter 5 will be concluded by considering the limitations of the study, prospective directions for future research, as well as a personal reflection regarding the research process.

1.7. Orthography

This study deals with the nature of MDD and how South African men seek help to cope with depression, as well as the variety of coping strategies among South African men. Due to the psychological and qualitive nature, the APA (6th Edition) referencing style is the required style for this study. Both the in-text and the reference list was done according to the guidelines based on the sixth edition of the *Publication Manual of the American Psychological Association (APA)*. Noteworthy terms that were used in the text are emphasized by an italic typeface.

1.8. Conclusion

Depression substantially contributes to the global burden of disease. Despite a plethora of research focusing on the mental illness, attention afforded explicitly to men's experiences are disproportionately small, with an even smaller portion thereof directed to the South African population. The same is true for the coping strategies that these men utilise in order to cope and/or manage with such depression. Given the assumption that men seek help less frequently than women, very few studies have focused on the coping strategies these men utilise in the absence of professional care. Moreover, of the limited studies that have directed there attention to this subject of enquiry, research has traditionally identified the negative, maladaptive and unhelpful coping strategies that men use to either avoid or distract themselves from the pain.

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This research project thus aims to fill this gap by focusing on South African men's experiences of depression, as well as the positive and/or helpful coping strategies that these men utilise in their day to day lives in order to manage their depressive symptoms. In doing so, the intent of this research is to both add to the existing body of knowledge, as well as inform future public health messaging.

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CHAPTER 2:

LITERATURE REVIEW

2.1. Introduction

Chapter 2 strives to lay a conceptual foundation for the research. It serves as an orientation for understanding the experiences of depression among men and the coping strategies that they utilise in order to manage such symptoms. This is done by addressing the existing research pertaining to the core concepts of depression (mental health), men (gender), help-seeking, and coping strategies.

Initially, this chapter will outline the theoretical framework of postmodernism and social constructionism that grounds this research. Next, this chapter will turn its attention to the conceptualisation of depression, focusing on how the term has developed and progressed over time. Subsequently, the literature review will consider the important issues of depression and help-seeking behaviour. Namely, it will highlight the significant gender-based variance in these concepts that have become apparent in existing research. Furthermore, these findings will be contextualised within the South African context, where relevant research conducted on the South African population will be discussed. Lastly, this chapter will turn its attention to a discussion on the coping strategies that men utilise in order to manage and/or cope with their internal distress.

2.2. Postmodernism

Postmodernism is an extensive movement that became prevalent from the 1950s onwards (Wilson, 1997). It is often characterised by an attitude of scepticism, as it is largely a reaction against the intellectual assumptions of premodernism and modernism (Wilson, 1997). Specifically, rather than depending on one approach to knowledge, postmodernists advocate for multiple ways of knowing as they adopt a pluralistic epistemology (Travers, 2006). Hence, postmodern thinkers commonly depict knowledge assertions and value systems as contingent or socially-conditioned, "framing them as products of political, historical or cultural discourses and hierarchies" (Travers, 2006, p. 267). In other words, postmodernists decline the notion of an objective, fixed and universal basis to knowledge and reality (Bloor & Wood, 2006). The proponents of this approach rather argue that due to reality being culturally dependent and the fact that culture both transforms over time, as well as varies between different communities, one can logically assume that reality is not identical or uniform for everyone (Travers, 2006).

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Knowledge, according to postmodernists, is essentially disjointed and unstable, and thus cannot be objectively achieved (Wilson, 1997). As such, postmodernism appreciates the subjective and multiple perceptions of individuals and societies instead of predetermined rules for thoughts and behaviours (Travers, 2006). In line with this, the postmodern approach ascribes value to multiple meanings rather than the single, authoritative voice of the researcher (Bloor & Wood, 2006). This is due to the fact that knowledge has been constructed with the linguistic and other meaning-making recourses of a particular culture, which can fundamentally vary given that the world could be seen in different ways by different cultures (Burr, 2003). It is clear that this system of thinking permits diverse interpretations and understandings in certain situations, which researchers need to be cognisant of when designing their study or interpreting results (Merriam, 2009). Corresponding to such postmodernist thinking, "social constructionism developed as an understanding of the different ways of experiencing and understanding life, influenced by multiple interactive constructions of meaning (generated linguistically), and in interpersonal interactions within social settings" (Ellis, 2016, p. 24).

2.3. Social constructionism

One approach in psychology that has emerged from postmodern thinking is social constructionism (Watson & Kuit, 2007). It originated as an effort to confront and understand the nature of reality and is essentially an anti-realist, relativist stance as it views knowledge as constructed rather than created (Hammersley, 1992). This is in line with Adams et al. (2004), as they note that reality is constructed through social interactions, where reality in this context signifies individuals' subjective experiences and understandings about the world rather than the objective reality of the physical world. Thus, apart from the "inherited and developmental aspects of humanity, social constructionism hypothesizes that all other aspects of humanity are created, maintained and destroyed in our interactions with others through time" (Owen, 1995, p. 161). In other words, within the social constructionist thread of postmodernism, the notion of reality being socially constructed accentuates the continuous mass-building of world views by individuals in a dialectical interaction with society (Schwandt, 2003). According to this view, such multitude of realities encompass the perceived worlds of human social existence and activity, steadily crystallized by habit and upheld by language principles, maintained by socialization, provided continuous legitimacy by religion, culture and philosophy, and individually indoctrinated by upbringings and education to become part of the identity of people and societies (Andrews, 2012).

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Hence, according to Burr (2003), social constructionism refers to reality being constructed by a group of interconnected images, statements, metaphors, meanings, and perceptions. Social constructionism thus challenges traditional ideas and has its basis in the premise that all individuals possess distinct interpretations and understandings of social processes (Burr, 2003). This approach therefore strives to describe the manner in which people understand and make sense of different realities and interactions within the world (Burr, 2003). Terre Blanche and Durrheim (2006, as cited in Adams et al., 2004, p. 356) note that social constructionism is thus "about interpreting the social world as a kind of language, a system of meanings and practices that construct reality." As such, the predominant discourses within the time and context inform the means by which sense-making occurs (Galbin, 2014).

Considering the relevance and application of social constructionism to this study, it is important to highlight what Burr (2000) classifies as the four key doctrines to consider when operating within the social constructionist framework. Firstly, due to individuals experiencing reality in distinct and different ways, it is unfeasible to ascertain a single objective truth about life and its meaning (Burr, 2003). As such, it is imperative consider each person as the active agent in their own life, appreciating that individuals' personal realities comprise of the subjective meanings they derive from their own experiences (Adams et al., 2004).

Secondly, facets such as history, traditions, and religion inform the way that people give meaning to their life experiences (Burr, 2000). Considering that individuals construct reality through their interactions with others (Beyer, Du Preez, & Eskell-Blokland, 2007), the researcher needs to be mindful that various discourses regarding gender, masculinity and help-seeking, and its meaning exist. In other words, a multitude of realities exist depending on how the individual's beliefs, customs, and values of their culture influence their perceptions of the world (Freedman & Combs, 1996). Moreover, these different constructed realities also interact with each other on a daily basis and are passed down from one generation to the next, influencing the *lenses* through which people see their lives and the world (Andrews, 2012). For men, the history and culture of masculinity and what it means to be a man can thus play a significant role in their identity formation (Creswell, 2009).

Thirdly, "language impacts the way in which knowledge is created and sustained through social interaction" (Ellis, 2016, p. 26). In other words, individual's social interactions continuously develop and grow their knowledge, in turn impact the specific ways they experience and

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interpret their realities. This is fundamentally shaped by the use of language within different communities and cultures as it informs how people construct, explain and describe their own subjective realities (Beyer et al., 2007). As the use of language goes beyond spoken word to include the way societies value certain events or phenomenon (Galbin, 2014), no single explanation or description of human behaviour can be regarded as the only or absolute truth. This influences studies grounded in the theoretical framework of social constructionism as participants may provide different and varied *truths* during the research process (Galbin, 2014).

Finally, social constructionism posits that “people are active participants in their own meaning-making processes, which are derived from their own personal experiences and situations” (Ellis, 2016, p. 26). This is an important consideration for researchers as they need to evaluate and reflect on each participant within his/her specific context, given that experiences and perceptions can be understood in different ways (Galbin, 2014). Thus, it is important to note that this research not only studies and seeks to understand depression and masculinity among men, but specifically endeavours to explore these concepts among Black men within the South African context. As such, it will be important to appreciate and frame the context for these participants in order to truly understand their experiences.

Social constructionism as a theoretical framework is crucial to this study, as it will provide the researcher a chance to gain an insider perspective into the lives and experiences of the participants. Working from this framework, it helps one to understand how concepts such as depression, gender, and masculinity have been constructed and maintained through social interactions. Thus, these concepts can be understood as objective reality only in so far as individual’s subjective reality have created, shared and reinforced them. This is true as one could say that the term and understanding of depression is a westernized concept. In Zimbabwe, rather than the term suggesting an emotional experience, the word depression has been noted to imply a physical illness often characterised by somatic complaints (Patel, Abas, Broadhead, Todd, & Reeler, 2001). Patel et al. (2001, p. 481) expands on this by stating that there is “no equivalent term for the concept of depression or the experience of emotional distress in African languages.” These ideas can similarly be related to the concepts of gender and masculinity, where it has been created by social interaction but may differ between contexts and cultures (West & Zimmerman, 1987). Social constructionism helps one to understand and explore the unique experiences of the participants, understanding how the concepts relate to them and

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begin to construct their life and interactions. To assist with this, the notions of depression, gender, masculinity, and help-seeking will be expanded upon moving forward in this chapter.

2.4. History of depression

What is now recognized as major depression, clinical depression, and generally talked about as MDD by many health care professionals, was previously known as melancholia (Greist & Jefferson, 1992). This disorder has an extensive history, with comparable ailments being described as far back as ancient Greece. Hippocrates, a fifth Century BC Greek physician, described a woman who experienced an increased thirst, nausea, decreased appetite, loss of sleep, and referred to her presentation as melancholia (Solomon, 2001).

In Ancient Greece, disease and illness was believed to be due to an imbalance in four basic bodily fluids, or humors, namely: phlegm, blood, yellow bile and black bile (Bos, 2009). Namely, different types of diseases were thought to be the result of an excess in any one of these fluids. Personality traits were equally believed to be determined by the dominant humor in a particular person (Bos, 2009). Derived from the Ancient Greek melas, meaning *black,* and kholé, meaning *bile*, melancholia was defined as a distinct illness with specific mental and physical symptoms by Hippocrates in his *Aphorisms* (Stone, 2006). Hippocrates characterised all “fears and despondencies, if they last a long time” as being symptomatic of the ailment (Jouanna, 2012, p. 232). Black bile was thought to originate in the brain and that an excess of this fluid resulted in the symptoms of melancholia, such as sadness, restlessness, anxiety, irritability, hopelessness, decreased appetite, sleeplessness, and suicide (Stone, 2006). The perception of melancholia as a disease that was caused by an excess of black bile continued into the Elizabethan period (Stone, 2006).

The humoral theory fell out of favour during the Medieval Ages before it was revived in Rome by Galen (Jouanna, 2012). During the Medieval Ages, a different approach to the causal understanding of melancholy was advocated by the Roman Church. Saint Augustine, according to Solomon (2001), proposed that the core attribute, which separated humans from animals was their capacity for reason. Consequently, it was believed that a loss of reason reduced a man to the level of animals. Grounded in this thinking, melancholia was identified to be indicative of a loss of reason, and in turn as a loss of God’s favour (Solomon, 2001). Sometimes it was even attributed to an evil spirit possessing the individual. In accordance with this understanding, melancholia was believed to be a punishment from God for individual’s sinful soul (Solomon,

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2001). The sin of sloth (representing exhaustion, dejection, negligence, a lack of industry, and lethargy) was most often implicated in melancholia.

During the 17th Century, Robert Burton (as cited in Solomon, 2001), published an encyclopaedia in which he organised the diverse conceptualisations of melancholia presented throughout history. In his book, *The Anatomy of Melancholia*, Burton differentiated general sadness, social withdrawal and displeasure from melancholia, which he believed to be a more severe experience that necessitated a classification as an illness (Solomon, 2001). The use of the term melancholia continued until the mid-nineteenth century, where it was later substituted by the term depression (Misbach & Stam, 2006). The term depression was derived from the Latin verb *deprimere,* "to press down" (Depression, 2020, p. 1). While melancholia remained the prevailing diagnostic term, depression gained growing popularity in medical discourses and was a synonym by the end of the century. German psychiatrist, Emil Kraepelin, was perhaps the first to use depression as an overarching term, discussing diverse types of melancholia as *depressive states* (Davison, 2006).

At the turn of the 20th Century, two major movements occurred that had an essential influence on the future of mental health. Freud introduced a psychological conceptualisation of mental disorders, which resulted in psychoanalytical theories being proposed within the social sciences. Conversely, Kraepelin's psychobiological approach triggered a more absolutist interpretation of depression centred around biochemical explanations (Solomon, 2001).

Firstly, psychoanalytical theories suggested that something from within an individual prevented the person from functioning normally. Freud had compared the state of melancholia to mourning in his 1917 paper: *Mourning and Melancholia.* He theorised that objective loss, such as the loss of a valued relationship, results in subjective loss as although the object has not perhaps died, it has been lost as an object of love (Carhart-Harris, Mayberg, Malizia, & Nutt, 2008). Hence, the individual grieves for a loss that he/she is unable to fully comprehend or identify, and thus this process takes place in the unconscious mind. In a process termed the libidinal cathexis of the ego, the libido that was attached to the object of affection is now withdrawn into the ego (Carhart-Harris et al., 2008). The consequence of this is an identification of the ego with the abandoned object, resulting in a compromised ego that begins attacking itself (Carhart-Harris et al., 2008). This causes severe melancholic symptoms as the extraordinary diminution in the patient's self-regard is revealed in their belief of their own

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inferiority, unworthiness and blame (Carhart-Harris et al., 2008). In other words, Freud "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" (Eksteen, 2015, p. 18). A number of other psychological theories were offered over the next century to account for this phenomenon (Solomon, 2001).

The second influential movement was the psychobiological categorisation and understanding of depression proposed by Emil Kraepelin (as cited in Stone, 2006). The author suggested that a "permanent internal change" (p. 12), which he attributed to hereditary factors, was the true cause underlying the onset of depression and mania. His theory was given credibility in the 1930s by Roasanhoff, Handy and Plesset (as cited in Stone, 2006) through their research on twins. As a result, behaviour and emotions became increasingly associated with biological functions during the 20th Century, resulting in several more biochemical theories being developed. Beyond such genetic hypotheses, these theories emphasised the role played by aging (Stone, 2006), hormones (Robbins, 2006) and neurotransmitters (Solomon, 2001).

The influential system put forth by Kraepelin unified nearly all types of mood disorders into *manic-depressive insanity* (Davison, 2006). Manic symptoms comprised of hyperactivity, flight of ideas and euphoria, whereas depressive symptoms encompassed depressed moods, weakness of volition and inhibition of thought. Shortly thereafter, Kraepelin differentiated between two types of psychoses, namely dementia praecox as a cognitive psychosis and manic depression as a mood psychosis (Davison, 2006). Eugen Bleuler later reformulated dementia praecox into the term schizophrenia that is known today (Davison, 2006). Furthermore, Karl Leonhard expanded on Kraepelin's work in the 1950s. Rather than Kraepelin's hypothesis of manic-depressive illness 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" (Eksteen, 2015, p. 16).

It becomes clear from the preceding discussion that the understanding of melancholia, and later depression, has been viewed in a number of different ways throughout the years. Excessive bodily fluids and a loss of God's favour were often attributed to melancholia in early civilisations. Freud introduced a defining moment in the understanding about the causes of depression. Rather than understandings that emphasised black bile and sin, Freud directed

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attention to a view that acknowledges internal, psychological factors. Kraepelin's psychobiological approach on the other hand similarly played an essential role in the contemporary understandings that appreciated the implication of psychological, as well as biological factors in the etiology of depression.

2.5. Current conceptualisation of Major Depressive Disorder (MDD)

It is apparent that knowledge regarding mental illness has progressively become more refined and diversified throughout history (Foerschner, 2010). This is especially true considering the arrival of two taxonomy systems that are currently used worldwide with regards to mental illness, namely the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM). The ICD is a product of the World Health Organisation (WHO) and is currently in its 10th edition, which was indorsed in 1992 (WHO, 1992). The DSM is compiled and published by the American Psychiatric Association (APA), and its latest edition, the DSM-5 was published in 2013 (APA, 2013). There are slight distinctions between the two taxonomies for the diagnosis of a Depressive Episode (ICD-10), and Major Depressive Disorder (MDD) (DSM-5). However, the DSM conceptualisation will be afforded greater consideration in this research as this system is more commonly endorsed within the South African context. Using the DSM-5 (APA, 2013), depressive symptoms become noteworthy and warrant a diagnosis of MDD when they persist for a period of two or more weeks, and impede on an individual's ability to function in their day-to-day lives and/or cause clinically significant levels of distress. The core symptoms of MDD can be seen in the DSM-5 diagnostic criteria, as outlined below.

Table 1.

Diagnostic criteria for Major Depressive Disorder

Major Depressive Disorder
A. Five (or more) of the following symptoms have been present during the same two-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.

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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.
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 specific plan, or 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 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 judgement 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.

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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 can either be conveyed by the person experiencing the symptoms or, when it is denied, can be observed by others through the individual's demeanour (Westerbeek & Mutsaers, 2008). It is reported that individuals with MDD often seek out assistance due to reasons other than their depression, such as stress, sleeping difficulties, interpersonal problems, or suicidal ideation. Importantly, suicidal ideation may range from a passive ideation, where the individuals believe that others are better off if he/she were dead, thoughts of committing suicide, and the desire to not wake up in the morning, to active suicidal ideation where the individual begins to plan how to do it, failed suicide attempts, or in severe cases successful suicides (Cheek, Goldston, Erkanli, Massing-Schaffer, & Liu, 2020). Thoughts of hopelessness and giving up as well as feelings of being overwhelmed are often attributed to such suicidal ideation and attempts, as the person fails to foresee any improvement or change in their distressing experience(s) (APA, 2013).

Such depressive symptomology may be experienced in isolation, and may differ in severity, duration and symptom pattern. It may manifest as normal sadness, everyday blues, fatigue, pessimism, anger, or acting out (Nolen-Hoeksema, 2001). This occurs frequently in relation to environmental stressors, such as a period of adjustment, interpersonal conflict, as well as a loss of job or loss of a significant other, to name a few. However, generally, recovery occurs without professional intervention, functionality continues unimpaired, and the symptoms tend to be shorter in duration (less than two weeks) (Carter & Golant, 2012). As noted above, a diagnosis of MDD and professional intervention only becomes warranted when these symptoms persist for an extended period of time, when the distress becomes intolerable and/or the symptoms are severe enough to impair daily functioning (APA, 2013).

Certain coding specifiers within the APA allow for greater specificity in describing the presentation of MDD within an individual (APA, 2013). Specifically, these specifiers denote the current severity (mild, moderate or severe) of the episode, whether it is a single or recurrent episode, as well as the remission status (APA, 2013). They also allow for the indication of melancholic features, mood-congruent/incongruent psychotic features, atypical features, mixed features, peripartum onset, seasonal pattern, catatonia or anxious distress (APA, 2013).

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2.6. Current etiological understanding of Major Depressive Disorder (MDD)

With regards to the current etiological understanding of MDD, both the WHO and the APA endorse a biopsychosocial model (APA, 2013; WHO, 2020). This model proposes that biological, psychological and social factors are all significant and interconnected with regards to either promoting health or causing illness. In other words, contrary to previous beliefs that the body, mind and environment were independent and distinct facets, this model suggests that they are linked and interdependent on one another (Blazer & Hybels, 2005). Thus, what affects the body will affect the mind; and vice versa. As such, the biopsychosocial model beseeches clinicians to understand and explain phenomena such as depression by evaluating all relevant factors that may be contributing to the development and/or maintenance of the disorder.

A complex set of biological processes have been implicated in the etiology and course of MDD, including brain structure and functioning, neurotransmitters and neuroendocrine processes, interrelated mechanisms of genetic vulnerabilities, and the immune system (Thase, 2008). Aspects such as serotonin and norepinephrine have been associated to psychological reactions such as depression and aggression. An individual's ability to experience pleasure has been linked to dopamine and endorphins (England, Sim, & National Research Council, 2009). Reduced levels of GABA have also been found among individuals diagnosed with depression (England et al., 2009). Currently, the most promising gene implicated in the etiology of depression is the serotonin system (5-HT). This serotonin neurotransmitter bears weight on an extensive range of physiological functions, such as sensorimotor reactivity, appetite, sleep, aggression, thermoregulation, sexual behaviour, and emotions (Neumeister, Young, & Stastny, 2004). "Deficits in the central 5-HT system, such as reduced 5-HT concentrations, impaired uptake function of the 5-HT transporter, altered 5-HT receptor binding, and tryptophan depletion, have been linked to a number of psychological problems and psychiatric disorders, including depression" (Neumeister et al., 2004, p. 518).

In addition to these neurotransmitters, a prevailing method that has recently emerged in the neurobiology of depression emphasises the underlying dysregulation of the body's reaction to stress, encompassing brain responses and the neuroendocrine system (Thase, 2008). Significant factors are the HPA axis, as well as the related corticotrophin-realising hormone (CRH) and the locus coeruleus-norepinephrine (LC-NE) systems (Boyce & Ellis, 2005). These components include the cortical and limbic pathways bidirectionally interconnected via assorted hormonal and neurotransmitter circuits (Boyce & Ellis, 2005; Meyer, Chrousos, &

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Gold, 2001). Major Depressive Disorder has also been associated with elevated cortisol and related neurohormones (Plotsky, Owens, & Nemeroff, 1998). A number of studies have revealed higher cortisol levels and abnormalities in cortisol regulation in depressed individuals (Plotsky et al., 1998). Moreover, in response to psychological stress, depressed individuals exhibit slower recovery of cortisol levels than non-depressed controls (Burke, Davis, Otte, & Mohr, 2005). Similarly, with reference to genetics and hereditary factors, depression is known to run in families (Kendler, Gatz, Gardner, & Pedersen, 2006). This phenomenon is associated with both environmental and genetic processes (Kendler et al., 2006). In a review of twin studies, approximately one-third of the risk for MDD was found to stem from genetic factors (Kendler, Gatz, Gardner, & Pedersen, 2006; Sullivan, Neale, & Kendler, 2000). Likewise, the risk of developing MDD increases about two and a half to three times for those who have a first-degree relative suffering from depression. It is noted that while genetics may predispose individuals to a mental illness, such as depression, the associated symptoms are required to be triggered by environmental stressors (Wurtman, 2005).

In the general population, psychosocial influences on MDD are diverse. Even within an individual, various psychosocial experiences may be implicated in the development of depression (Robbins, 2006). This comprises of the pressures exerted on a person by their social context as well as their reaction to such context (Mahalik, 2008). Nevertheless, the most common psychological factors implicated in depression include impaired emotional intelligence (the ability to perceive, understand, and express emotions), characteristic negative patterns of thinking, judgment problems, and deficits in coping skills (Gibb, Beevers, Andover, & Holleran, 2006; Scher, Ingram, & Segal, 2005). To a certain extent, these psychological factors can be influenced by biology (e.g. individual's innate temperament, or their biologically-based personality traits) as well as by social factors, such as what coping behaviours are modelled by people as they grow up (e.g., by their parents and teachers) (England et al., 2009).

Individuals may also become depressed as a consequence of social factors such as harassment (bullying), early separation, experiencing traumatic situations, or a lack of social support (Gibb, Butler, & Beck, 2003). These stressful social situations have been found to be capable of turning on and off genes, ultimately triggering changes in one's brain functioning (England et al., 2009). Through this path, a social stressor has been noted to elicit a physical response that can cause depression. Social and environmental causes of depression can also be far more

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subtle than actual trauma. Individuals do not necessarily have to have been abused as children to grow up feeling pessimistic about their future prospects or themselves. How they have been taught to think about their self-worth or respond to difficult stressors can also have a strong influence on the individual becoming depressed (Gibb et al., 2003).

The biopsychosocial model advocates, and which scientific evidence has tended to corroborate, that factors such as biological, psychological and social processes all influence one another in interdependent ways. As such, any number of these factors could be implicated in the cause of depression, which on their surface appear independent but in reality consists of an amalgamation of all. Furthermore, as one aspect tends to impact the others, it is feasible to have a physical reaction to a psychological or a social stressor, and vice versa. Due to this interdependent nature, it is vital to consider all factors when attempting to comprehensively understand and explain depression.

2.7. Gender and depression

Although there exists an understanding of the causal nature of MDD across all individuals, research has consistently shown disparities between genders (male and female) in the prevalence and expression thereof. Namely, studies have shown that fewer men are diagnosed with depression compared to women (Van de Velde et al., 2010). Epidemiological findings reveal a one and a half to three fold greater prevalence of MDD among women contrasted to men (APA, 2013), which was corroborated by a survey conducted in Great Britain (Meltzer, Gill, Petticrew, & Hinds, 1995). A similar, although less pronounced, female preponderance was also discovered for other subtypes of depression such as recurrent brief depression, minor depression, and dysthymia (Angst, 1997; Bebbington, 1998). This is further evidenced by Afifi (2007), finding that women receive mental health care services far more frequently than men do. However, lower rates of male depression does not necessarily imply better mental health in men, considering that men display considerably higher rates of substance use (Martin, Neighbors, & Griffith, 2013), as well as account for three-quarters of suicides in Western countries (Cochran & Rabinowitz, 2000; Davidson & Lloyd, 2001; Good & Brooks, 2001). This is supported by researchers Ogrodniczuk and Oliffe (2011), as they claim that the reported differences in epidemiological studies do not reflect the true nature of the prevalence of MDD as it has, and continues to be, under-reported in men. As such, "gender differences in depression are of great psychosocial and medical interest, especially differences in prevalence rates,

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symptom profile, severity, distress/suffering, impairment, coping, help-seeking and prescribed treatments" (Angst et al., 2002, p. 201).

An array of explanations have been offered for these gender differences. Some have proposed that MDD among men is under-reported due to the use of generic diagnostic criteria that are insensitive to depression among men (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Rice, Fallon, Aucote, & Möller-Leimkühler, 2013). According to the concept of *male depression,* men may experience atypical depressive symptoms (Kilmartin, 2005). This includes aspects such as hostility, substance abuse, aggression, irritability, and increased risky behaviour (Angst et al., 2002; Kilmartin, 2005; Möller-Leimkühler, Heller, & Paulus, 2007; Sigmon et al., 2005). In other words, there is evidence that shows more externalising symptoms for men, which may in turn impede detection in primary care settings since standard diagnostic screening instruments are insensitive to these male-specific symptoms (Möller-Leimkühler, 2000; Sigmon et al., 2005; Wilhelm, 2009). Martin et al. (2013) support such findings as they reported that gender disparities in the prevalence of depression disappear when male-type symptom screening is supplemented with traditional depression instruments. Other explanations include the reluctancy of men to convey their distress and/or seek help in relation to their mental well-being (Winkler, Pjerk, & Kasper, 2006). Furthermore, if men do seek out mental health care services, the disjointed routes associated with this service delivery is reported to result in reduced engagement (Strike, Rhodes, Bergmans, & Links, 2006). Nevertheless, this implies that gender may play a considerable role in the presentation and expression of depression. As such, a more through and comprehensive examination into the nature of this disparity will prove useful.

2.7.1. Gender

When addressing such differences between men and women, it becomes imperative to understand the distinction between sex and gender as these terms are often used interchangeably. According to Afifi (2007, p. 385), "sex denotes biologically-determined characteristics, while gender indicates culturally- and socially- shaped variations between men and women." In other words, a person's sex can be defined as the biological anatomy of an individual's reproductive system (Prince, 2005). Gender, however, refers to a social role encompassing a series of behaviours and attitudes that are usually deemed acceptable, appropriate, and/or desirable based on that individual's biological or perceived sex (Branney

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& White, 2008). Gender is thus related to how individuals are perceived and expected to think and act as men and women based on cultural, social, historical and psychological factors (Dornan, 2004). Gender roles are neither fixed nor given, but actively defined and constructed through social interaction and ideologies adopted in society (Dornan, 2004). Consequently, by symbolically connecting specific attributes and traits to each gender, these characteristics function to produce and reproduce gender roles (Robertson, 2011).

Gender roles are usually centred around two conceptions, namely femininity (the social expectations of how women *should act*) and masculinity (the social expectations of how men *should act*) (Prince, 2005). Although there are some exceptions and variations, traits that are traditionally cited as feminine include gentleness, empathy, sacrifice, compassion, tenderness, emotionality, humility, and sensitivity (Thomas, 2001). Hegemonic/traditional masculine ideals, on the other hand, as conceptualised by Connell (2012) include the desire to appear powerful and successful (Ogrodniczuk & Oliffe, 2011), virile (Courtenay, 2000), invulnerable and strong (Emslie, Ridge, Ziebland, & Hunt, 2006), self-reliant and unemotional (Addis, 2008). Hegemonic masculinity in this research is thus based on aggression rather than co-operation, stoic endurance rather than emotionality, hardness rather than vulnerability, strength rather than weakness, and autonomy rather than dependence (Howson, 2006).

As this study is concerned with men's experiences of depression and coping strategies, emphasis will be placed on these hegemonic constructions of masculinity. Seidler (2006) has criticised the concept by stating that nuances of men's experiences and emotions cannot be captured by the rigid hierarchical gender order. Others have suggested that the concept is too simplistic and reductionistic as it does not consider variations such as *caring masculinities* (Elliott, 2016). However, this study utilises this definition as it can still yield significant insights regarding the constructions or cultural ideals of masculinity in a society. Meuser (2003, p. 136) claims that although hegemonic masculinity may not be a precise depiction of the daily routines and practices of men, "its importance lies in being an interpretive pattern for locating oneself in the gender order." As such, hegemonic masculine ideals can nevertheless provide cultural reference points for the types of ideologies and expectations men confront in constructing their masculine identities and practices. Such conceptualisations are crucial to this study as a gendered approach to psychopathology strives to investigate how gender impacts and intersects with mental health (Afifi, 2007). With regards to MDD, this approach thus

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studies how gender related self-concepts and cultural or social norms influence men's experiences and responses to MDD (Möller-Leimkühler & Yücel, 2010).

2.8. Men and help-seeking

Research has shown that rather in the *experience* of depression itself, gender differences appear more in the *expression* thereof (Brownhill et al., 2005). Significantly, help-seeking behaviour is noted as one prominent gender-based difference in the expression of depression (Cusack, Deane, Wilson, & Ciarrochi, 2006; Doherty & Kartalova-O'Doherty, 2010; Levant, Wimer, & Williams, 2011; McCusker & Galupo, 2011; Möller-Leimkühler, 2002; Wenger, 2011). Help-seeking can be firmly defined as a coping mechanism, whereby the need to seek help is elicited when task demands surpass individual's coping abilities or resources (Chan, 2013). The procedure of help-seeking can thus be recognized and appreciated as deliberate actions that starts with awareness, problem recognition, and definition (Cornally & McCarthy, 2011; Rickwood, Deane, Wilson, & Ciarrochi, 2005). Help-seeking is therefore regarded as a vital health behaviour, as it is claimed that the avoidance thereof has harmful health effects (Addis & Mahalik, 2003).

This is significant as a growing body of literature has shown that, as a group, men of different ages, nationalities, and ethnic backgrounds (Kessler, Chiu, Demler, & Walters, 2005) seek professional help far less frequently than women (Addis & Mahalik, 2003; Emslie & Hunt, 2009; Fields & Cochran, 2011; Fridgen et al., 2013; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011). Addis and Mahalik (2003) state that men's reluctance to seek help extends to issues as widespread as physical disabilities, traumatic life events, substance abuse, and mental illness. This reluctance has been noted to be particularly predominant for emotional problems such as depression (Möller-Leimkühler, 2002), where men's reluctance to seek help is more pronounced (Good, Dell, & Mintz, 1989). Specific to mental health, studies have found that men are half as likely to seek psychiatric services, psychotherapy, and counselling compared to women (Judd, Komiti, & Jackson, 2008). Much of men's health research over the past decade has focused on the search for explanations on such reduced help-seeking behaviour.

To date, several aspects have been identified as contributing to men's perceived reluctance to help-seeking (Chan & Hayashi, 2010). The most frequently considered aspects are stigmatisation (Vogel et al., 2011), gender (Addis & Mahalik, 2003), the tendency to disclose

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(Eisenberg, Downs, Golberstein, & Zivin, 2009), and the severity of distress (Robertson, 2007). Out of these factors, the gendered construction of hegemonic masculinity and the subsequent stigmatisation is most often cited as the strongest influence across different contexts (Courtenay, 2000; Lee & Owens, 2002). For example, Danielsson and Johansson (2005) noted that the social construction of femininity offers a vocabulary that is “rich in feelings and emotional nuances” (p. 175), making it easier for women to seek help for mental health matters. In opposition, the authors noted that men are often left without a language that enables them to easily articulate psychological or emotional distress, due to the discourses within masculinity being *emotionally impoverished*.

Reviews of the literature suggest that male socialisation also seems to play a significant role in shaping beliefs and attitudes that are detrimental to help-seeking in men (Gonzalez, Alegria, & Prihoda, 2005; Juvrud, 2013). It has been noted that the traditional hegemonic masculine characteristics/ideals (such as self-reliance, endurance, superiority, and emotional strength) are incompatible with *help-seeking behaviours* such as speaking openly about health problems, using health services, and asking for advice (Mathewson, 2009). In other words, depression and help-seeking is noted to conflict with gender-related values and beliefs about what constitutes as strength, such as not expressing emotions or feeling vulnerable or dependent on others (Emslie et al., 2006; Vogel, Wade, & Hackler, 2007). Thus, acknowledging emotional pain and seeking psychological help is seen as an alignment with femininity, and in turn implies “loss of status, loss of control and autonomy, incompetence, dependence and damage of identity” (Johnson, Oliffe, Kelly, Galdas, & Ogrodniczuk, 2012, p. 6). This admission of vulnerability may thus compromise masculine identity further (Galdas, Cheater, & Marshall, 2005; Möller-Leimkühler, 2002). Significantly, Cheryan, Cameron, Katagiri and Monin (2015) found that when men were under the impression that their masculine identity was in jeopardy, they attempted to restore this identity by exaggerating masculine traits in order to distance themselves from feminine preferences. As a result, behaviours related to vulnerability and weakness, as is the case with help-seeking, were often viewed in a negative light and avoided by men (Pederson & Vogel, 2007). These norms are argued to have a bearing on men’s ability to identify their emotional distress, their expression thereof as well as their help-seeking behaviour (Branney & White, 2008).

As noted above, the consequences of norms like these may be that “developing boys are socialised into emotionally inarticulate men, unable to express depression” (Branney & White,

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2008, p. 261). Addis (2008) similarly posited that men may decline help-seeking or decided to conceal their depression, due to the socialisation that they should internalise distressing emotions in order to assimilate into acceptable masculine norms. This is in line with the premise by Branney and White (2008) that the expression of depression is perceived as un-masculine, and thus refuting depression may be a means for men to enact masculinity (Schofield, Connell, Walker, Wood, & Butland, 2000). Men may hence "disguise their depressive symptoms" (Kilmartin, 2005, p. 97) and utilise aspects such as substances in order to blunt their negative affect (Mahalik & Rochlen, 2006). This is done to both maintain their own sense of masculinity as well as ensure that others perceive them to embody such doctrines and ideals. Men's need to disguise and conceal their depression is further explained by in-depth qualitative studies, as they have drawn attention to significant levels of both public- and self-stigmatisation as a possible cause.

The negative opinions society holds towards those who seek professional help (public stigma) has been noted as a crucial barrier amongst men (Corrigan, 2004). Mahalik (2003) argues that although many individuals encounter stigma related to mental health difficulties, men experience a gender-specific stigma against help-seeking. Namely, that society is less capable to accept a lack of emotional control and perceived weakness from a man than from a woman (Mahalik, 2003). Additionally, researchers have proposed that men, in particular, may be more likely to be affected by and thus internalise this public stigma (Johnson et al., 2012; Primack, Addis, Syzdek, & Miller, 2010; Vogel et al., 2007), especially men with higher levels of conformity to traditional masculine ideals (Hammer, Vogel, & Heimerdinger-Edwards, 2013). This has been referred to as self-stigma, the internalisation of the negative views of society towards mental illness and help-seeking (i.e. adopting society's views and believing oneself as *inferior* or *weak* for needing to seek counselling). As such, seeking help or psychological services as a male may constitute as an admission that they cannot solve their own problems (Addis & Mahalik, 2003).

Accordingly, the act of seeking help may be viewed as a personal failure or a sign of weakness for men, who are often under the impression that they will be ostracized or criticized if they see a mental health care professional (Vogel, Wade, & Haake, 2006; Vogel et al., 2007). Such stigma may impede the utilization of needed mental health care, with research findings suggesting that men are more likely than women to cite stigma avoidance as a reason for not seeking help (Corrigan, Druss, & Perlick, 2014; Ojeda & Bergstresser, 2008). This is

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commonly referred to in the literature as the gender role conflict, where the adherence to socialised gender roles results in restricting one's own behaviour or emotions and devaluing dimensions of oneself or others such as emotionality (Courtenay, 2000; O'Neil et al., 1986; Pederson & Vogel, 2007). For example, men who internalise the traditional masculine ideological view that they should be tough, competitive and emotionally in-expressive, would be less likely to communicate emotions even when they believe it may benefit them (O'Neil et al., 1986). In support of this internalisation, researchers have "found that self-stigma mediates the relationship between perceptions of public stigma and help-seeking attitudes" (Vogel et al., 2011, p. 369). As such, greater levels of public stigma resulted in greater levels of self-stigma, and greater self-stigma was connected to less favourable attitudes towards, and avoidance of, psychological help-seeking (Vogel et al., 2011).

In their help-seeking model, Pederson and Vogel (2007) built on these findings by discovering that the relationship between men's gender role conflict and their attitudes towards help-seeking was mediated by self-stigma. In other words, greater adherence to hegemonic masculine ideals and the conflict emerging from that adherence have been linked with a diminished willingness to seek psychological help (Smith, Tran, & Thompson, 2008), as well as increased negative attitudes towards help-seeking (Berger, Levant, McMillan, Kelleher, & Sellers, 2005). This is further supported by qualitative research as it has provided evidence for the negative relationship between masculinity and health related behaviour in depressed men (Emslie et al., 2006; Kalmuss & Austrian, 2010; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). An example of this is a study conducted by Mahalik (2003). Using the Conformity to Masculine Norms Inventory (CMNI), the author found a significant negative relationship between high scores on the inventory and attitudes towards seeking psychological help. Specifically, the author found that high identification with traditional masculine dogmas was correlated with less help-seeking behaviour and more negative attitudes toward psychological help-seeking.

Many studies have likewise established that men's attitudes, intentions and behaviour regarding help-seeking are negatively impacted by their acceptance of traditional masculine norms (Mahalik, Burns, & Syzdek, 2007; Mahalik, Lagan, & Morrison, 2006; Smith et al., 2008). Some have stated that men may experience fear, discomfort, shame, and/or embarrassment around asking for help (Gonzalez et al., 2005; Hernan, Philpot, Edmonds, & Reddy, 2010; Pederson & Vogel, 2007; Rickwood et al., 2005). Supplementary studies have

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also reported that gender socialisation (Rickwood et al., 2005) as well as macho ideals further inhibit men's tendencies to engage in help-seeking (Möller-Leimkühler, 2002). This evidence was earlier observed by Hoy's (2012) meta-ethnography of 51 different studies. The most common barrier identified by men in this review was social stigma, an apprehension regarding the perceived negative judgements of friends and family (Hoy, 2012). Most surprisingly was the men's anxiety regarding the gaze and judgements of other men as this appeared to dominate their concerns (Hoy, 2012). Specifically, they spoke about their fears of exposing their vulnerable self to other men, expecting to be ostracized or made fun of for being soft, weak, feminine, or homosexual for doing so (Hoy, 2012).

2.8.1. Men and help-seeking in the South African context

Although there exists this plethora of research on men and help-seeking in the last decade, there are two noticeable concerns and gaps that can be addressed in order to add to the current body of literature and understanding. The first being that research on men's mental health has predominately focused on documenting the correlation between poor health behaviours such as reduced help seeking and the acceptance of traditional masculine norms (Hoy, 2012). The majority of this research have theoretical explanations and interpretations based on a quantitative methodology (Whorley & Addis, 2007). While this is useful, lacking from prevailing literature are the perspectives of men themselves (Oliffe, 2006; Rochlen & Hoyer, 2005). Authors Rochlen and Hoyer (2005) state that help-seeking among men could be considered through a social marketing outlook to establish in-depth knowledge of how men view the *product* of psychological help-seeking. This perception exploration, according to Hoy (2012), can be most effectively done through talking to a variety of men about their experiences and perspectives regarding help-seeking and mental health.

This leads into the second key concern/gap noticed in the current literature. Namely, that many of the prolific researchers that have studied masculinity and help-seeking behaviours have focused their research only within Westernised cultures (Addis & Mahalik, 2003; Courtenay, 2000). However, their findings are accepted as universally applicable. In other words, conventional medical research findings are merely generalised to other groups and/or populations despite almost solely being orientated towards White middle class men (Sloan, Gough, & Conner, 2010). This is supported by the systematic review conducted by Seidler et al. (2016) as the majority of their studies (76%) published between 1995 and 2015 were

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conducted in the United States of America and Canada, while the remainder were conducted in Sweden and Australia. Similar results can be found in Hoy's (2012) meta-ethnography study on 51 studies. The vast majority of the studies in the research were conducted in the United Kingdom, the United States of America, Canada and Australia, while the rest were similarly conducted in Western countries. This can be considered as problematic as it excludes the voices and experiences of individuals in non-Westernised countries.

Specific to the South African context, the South African Stress and Health (SASH) study conducted between 2003 and 2004, found a 9.6% lifetime prevalence of depression and a 4.9% 12-month prevalence (Herman et al., 2009; Stein et al., 2008; Tomlinson et al., 2009). Notably, of those with a lifetime prevalence of depression, it was reported that only 8.2% had consulted a therapist or psychiatrist during the last year (Tomlinson et al., 2009). Research focusing specifically on the African context have begun to outline possible reasons as to why individuals do not engage in help-seeking when they suffer from a mental illness. This includes perceptions that the mental disorder is a somatic illness (Okello & Neema, 2007), confusion surrounding where and how to seek help or feeling embarrassed (Seedat, Stein, Berk, & Wilson, 2002), as well as beliefs that they would recover without treatment or being unable to identify the illness as a treatable disorder (Trump & Hugo, 2006). Stigma and misconceptions about the severity and cause of the mental illness are also listed as common barriers (Corrigan, 2004; Sartorius, 2007), particularly in poor resource communities where local culture has a profound influence on individual's lives (Ae-Negibise et al., 2010; Crawford & Lipsedge, 2004). Additionally, amongst Zulu individuals in South Africa, Crawford and Lipsedge (2004) found that mental health issues were considered to be only understood by traditional healers from their own culture.

Pretorius's (2004) definition of the general role played by indigenous/traditional healers is the most concise synopsis. A traditional healer was defined as: "someone who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as the prevailing knowledge, attitudes and belief regarding the physical, mental and social wellbeing of disease and disability in the community" (Pretorius, 2004, p. 536). Nevin (2001) found evidence that over 80% of the South African population will visit a traditional healer before going to a Western medical doctor, as they provide a culturally relevant way of interpreting and treating the illness (Gilbert, Selikow, & Walker, 2002). This

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is supported by Tangwa (2007), noting that traditional medicine has established itself as being a more attractive means of health care to many South Africans due its affordability and accessibility. Additionally, as opposed to Western practices solely focusing on a medical perspective, traditional medicine is noted to be sensitive to psychological, environmental and spiritual influences (Pretorius, 2004). Msotho, Louw, Calitz, and Estehuyse (2008) thus argue that mental health care in South Africa has been in the hands of spiritual and traditional healers for centuries.

Furthermore, Jackson (1991) proposes that Western psychiatric discourses may stress psychological factors in depressive disorders, whereas traditional perspectives tend to emphasise somatic complaints. In Zimbabwe, rather than the word depression suggesting an emotional experience, the term has been noted to imply a physical illness often characterised by somatic ailments (Patel et al., 2001). As such, Westernized conceptions of depression may not correspond with traditional African beliefs. Patel et al. (2001, p. 481) expands on this by stating that there is "no equivalent term for the concept of depression or the experience of emotional distress in African languages." Hence, there is often unconformity as to how depression is constructed and/or understood by different cultures. This is crucial as it may help to explain some of the discrepancy of why men in the South African context do not seek help for emotional problems such as depression.

Considering studies that specifically sought to understand the link between masculinity and help-seeking in a South African context, research conducted by Kriel (2003, p. 38) emphasised that "hegemonic masculinity is a dominant and pervasive form of masculinity" amongst this population. In the study, hegemony was connected with the notion of an *ideal man* and was used by participants as an optimal standard for moulding and gauging the masculinity of themselves and others (Kriel, 2003). This ideal reflects the type of hegemony to which Frosh, Phoenix and Pattman (2002) refer to when convey their ideas on masculinity being associated with "heterosexuality, toughness, power and authority, competitiveness and the subordination of other men" (Chadwick, 2007, p. 85). In his research conducted amongst a sample of White, South African men, Bushell (2006) suggests that gender discourses had a moderating effect on help-seeking behaviour. The researcher found that the thoughts and actions which were generally believed to be *in,* exhibited the prevailing or hegemonic masculine ideals within this context (Bushell, 2006). Conversely, thoughts and actions which were usually believed to be *out* were stereotypically connected with lower brands of masculinity and femininity, and were

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commonly characterised by the exclusion or censure of the men who took part in these (Bushell, 2006). In line with this, the author found that seeking psychological help was generally perceived as an *out* behaviour within this context, and therefore was evaded or restricted due to the fear of feeling or being seen as *unmasculine* in any way (Bushell, 2006).

However, while certain aspects of masculinity in South Africa can be understood using international research, it remains essential to make allowance for how this countries own culture, traditions, religion and history have shaped and constructed the notion. This is because the condition of gender relations and masculinities within South Africa are "powerfully bound up with the history of this country" (Morrell, 2001, p. 140). This is supported by Attwell (2002) as the author states that perceptions of what it means to be a man in South African has been significantly affected by the ideological and socio-political shifts that have occurred since 1994.

Considering that depression is highly prevalent among the South African population as well as the possible varying perspectives of masculinity and help-seeking, there is comparatively little to no research on the attitudes of lay persons towards mental illness within the South African community. As such, research investing the link between masculinity and help-seeking in the South African context is essential in extending what is already known and contributing to a growing body of knowledge.

2.9. Coping strategies

Beyond help-seeking behaviour, research has also investigated gender-differences in depression in terms of coping styles/mechanisms. According to Lazarus and Folkman (1984, p. 141), coping can be defined as "constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person." Coping strategies thus constitute the thoughts and/or actions taken by individuals in order to manage a stressor that exceeds their capacity to adapt (Lazarus & Folkman, 1984). Coping is commonly conceptualised as a buffering mechanism by sociologists, in that stress is less harmful to health when one holds high levels of self-esteem, mastery, or social support (Thoits, 2009). While it is clear that coping styles play an important role in mediating between stressful experiences and the psychophysiological reactions to such experiences, research investigating the relationship between gender and coping styles have produced mixed results. Some researchers have found no consistent differences between men

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and women's coping styles (Hamilton & Fagot, 1988; Pritchard & Wilson, 2006), while others have found that women use more emotion-focused coping strategies (such as rumination and worry) (Day & Livingstone, 2003; Hong, 2007; Matud, 2004; Nolen-Hoeksema, Larson, & Grayson, 1999) whereas men use more problem-focused strategies (such as actively strategizing about or confronting a problem) (Matud, 2004; Ptacek, Smith, & Dodge, 1994; Thoits, 1991).

Specific to MDD, a finding that has emerged in relation to such coping is that men and women appear to have different ways of responding to depressive affect and negative mood (Nolen-Hoeksema, 2012). Men were shown to exhibit more externalising and maladaptive responses, while women displayed a greater propensity toward rumination (Butler & Nolen-Hoeksema, 1994; Tamres et al., 2002).

Women have predominately been noted to cope with distress and depressive affect through talking about their problems (Brownhill et al., 2005), eating, seeking help, ruminating (Nolen-Hoeksema et al., 1999), emotional release as well as engaging more in writing, reading, and religion (Rutz & Rihmer, 2007). Research studies have indicated that compared with these characteristic presentations by women, men are more inclined to externalize their depression (Oliffe & Phillips, 2008). This includes engaging in numbing and escaping behaviours, avoidant behaviours, irritability, and emotional withdrawal (Brownhill et al., 2005; Emslie et al., 2006). Investigators have found that men endeavoured to avoid their experience of distress by burying themselves in their work, or engaging in physical activities, such as swimming, walking, running, and so on (Brownhill et al., 2005; Oliffe & Phillips, 2008). "This served to distract them from their problems, clear their heads and calm down so that they could engage with the problem in a calmer state of mind" (Eksteen, 2015, p. 28). It is noted that some men even engage in substances such as drugs or alcohol in an attempt to numb or escape their emotional distress (Brownhill et al., 2005).

Of significance, is that most studies found that when men were unsuccessful in their attempts to manage their depression, destructive consequences often follow as they participate in behaviours that can be dangerous, risky and even life-threatening (Addis, 2008; Proudfoot et al., 2015; Yousaf, Grunfeld, & Hunter, 2013). Safford (2008) noted that men who hold traditional masculine ideals might be more likely to engage in *externalising* behaviours such as acting out their feelings by using substances and/or by expressing aggression. For instance,

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men with depression were typically found to engage in substance abuse, destruction of property, interpersonal violence, and suicide (Addis, 2008; Branney & White, 2008; Safford, 2008). These behaviours are reported to signify a physical release of built up emotional pain (Brownhill et al., 2005), and are classified as "ways of doing depression that enact particular masculinities" (Branney & White, 2008, p. 6). Men experiencing depression were further noted by Cochran and Rabinowitz (2003) to exhibit difficulties with impulse control, risk taking, gender roles, irritability, improvised relationships, emotional numbness, lack of emotional expression, anxiety, and substance abuse, to name a few.

This is further supported by Brownhill et al. (2005) as they propose that men are more likely to a adopt maladaptive behaviours in response to depression. In their study examining men's experiences with feeling *down in the dumps*, the authors found that the men engaged in maladaptive self-management strategies such as active violence and suicide (Brownhill et al., 2005). These findings have subsequently been echoed by other researchers, suggesting that men are more likely to "act out" their depression in unhelpful and destructive ways (Wilhelm, 2009, p. 102). Such acting out has been hypothesised as masked depression, with authors suggesting that it may be a means for expressing underlying negative affect (Cochran & Rabinowitz, 2000). "The key assumption underlying this framework is that restrictive masculine role norms can both exacerbate depression, while at the same time making depression more invisible due to prohibitions against men expressing sadness, grief, and depressive affect" (Caperton, 2015, p. 22). Thus, according to O'Brien, Hunt and Hart (2007), attempts to control and be silent about negative affect is one way of doing masculinity. In other words, it may be more desirable for a man to mask his depression (possibly engaging in violence or suicide), rather than the perceived loss of masculine identity that comes with expressing his emotions. This is sustained in a meta-ethnographic approach suggesting that men expressed emotions of anger, emotional withdrawal and hostility as well as subsequently engaged in coping strategies such as sexualisation, alcohol, drugs, risk taking and over-working in order to distract, avoid or numb from their depressive internal states (Addis, 2008; Hoy, 2012). The use such maladaptive and ineffectual coping strategies thus contributes to treatment delays, lower detection and prolonged depression.

2.10. Men's coping strategies

It is clear that research to date has predominantly concentrated on the barriers to help-seeking for men, such as the restraints imposed by socially sanctioned ideals of masculinity (Yousaf et

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al., 2013); and on the unhelpful ways men try to cope and/or manage with their depression in the absence of clinical intervention. However, a comparatively small number of studies have identified the positive coping mechanisms used by men to manage their depression, including: meditation, taking time out, problem solving, stronger social connections, physical activities, and reframing negative events (Brownhill et al., 2015; Ramirez & Badger, 2014). Although this research does exist, Hoy (2012) noted that men's maladaptive responses are far more predominant in the existing literature. This is substantiated in a review of qualitative research, as it found that even where positive coping strategies were mentioned, it was generally only incidental to the main focus of the study (Whittle et al., 2015).

Proudfoot et al. (2015) addressed this gap and found that the men in their study either used, or were open to using, a broad range of emotional, cognitive, social, practical and problem-solving tactics to preserve their mental health. A predominance of the responses fell into three primary groupings of: improving relationships and/or social connections, physical health, and specific pleasurable activities. Examples included reading, writing, listening to music, speaking to friends and family, exercising, having sex, and going outdoors (Proudfoot et al., 2015). These findings are supported in a study by Fogarty et al. (2015). They found that instead of purely responding to issues as they arose, the men in their study "actively engaged in attempts to prevent depressed moods and made conscious choices about when or how to take action" (Fogarty et al., 2015, p. 182). Similar to other studies, they discovered strategies that emphasised problem solving (Brownhill et al., 2005; Nolen-Hoeksema, 2012) or reframing depression in helpful ways (Addis, 2008; Cleary, 2012) were of particular importance. The men in their study expressed comfort with employing these strategies as it assisted them in feeling in control of their difficulties without conflicting with social expectations concerning manliness (Fogarty et al., 2015).

Although these two studies have begun to investigate the relatively unexplored aspect of men's positive coping strategies, they call for further research to be conducted in this area. Given this as well as men's underutilisation of health services, it is vital to consider how men manage depression naturally or cope in the absence of clinical intervention, especially in the South African context where no such research exists. Men and public health messaging could capitalize on this research and the positive coping mechanisms identified as a means to manage with their own depressive symptoms, in an adaptive way that does not conflict with traditional masculine ideals.

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2.11. Conclusion

In conclusion, Chapter 2 attempted to lay a conceptual foundation for the research, serving as an orientation for understanding the experiences of depression among men and the coping strategies that they utilise to manage with such internal distress. This was done by addressing the extant research pertaining to the core concepts of depression, men, gender, help-seeking, and coping strategies.

The chapter began by outlining the theoretical framework of postmodernism and social constructionism that grounds this research. Next, the chapter drew attention to the development of the conceptualisation of depression, considering how the concept has progressed over time. Similar to these amendments in conceptualisation, a review of the literature demonstrated that theories concerning the causes of depression have also gone through various revisions throughout the years. Subsequent to this, the chapter considered the important issues of gender-based differences in depression as well as help-seeking behaviour. A considerable body of work reveals that men are far less likely to seek help for health-related issues due to the dominant social expectations surrounding masculinity. While such knowledge does exist, a gap was found in the existing research, as previous studies have tended employ quantitative methods to mainly study Westernized populations. These studies/methods have generally excluded men's subjective perceptions, experiences and responses from other non-Western countries. Finally, this chapter concluded with a discussion on the coping strategies that men utilise in order to manage and/or cope with such depression. The literature review revealed that research to date has predominantly investigated men's use of unhelpful or maladaptive coping mechanisms. Little research, however, has investigated the helpful, positive and/or adaptive coping strategies used by men to prevent or manage such depression.

Considering that men may express depression differently from women, are less likely to seek and receive professional help, as well as engage in negative or maladaptive coping strategies, men can be considered as an at-risk group as they are more likely to experience functional impairments or fatal consequences. This becomes significant when one considers the gaps in current literature that fails to address men's subjective experiences of depression and the positive coping strategies that they utilise in non-Western countries. Thus, there is a need for further research to address these gaps in order to add to the current body of knowledge, as well as inform future public health messaging. This research thus aims to fill these gaps by focusing on South African men's subjective experiences of depression, as well as the positive and/or

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helpful coping strategies that they utilise in their day to day lives. The following chapter details the research design, approach and methodology undertaken by this research to achieve this aim.

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CHAPTER 3:

RESEARCH DESIGN

3.1. Introduction

Chapter 3 describes the design and methodology that was adopted by this study to answer the research question: "What are South African men's subjective experiences of depression and the coping strategies that they utilise to manage it?" In order to explore such subjective experiences and perspectives, a qualitative research approach that employed individual in-depth interviews was utilised. As the interviews serve to gain the experiences of men directly from the source themselves in one-on-one conversations, it is clear that this study seeks to collect and analyse primary data. The data was analysed using Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis. This is done to identify and extrapolate common themes in the data – such as the topics, ideas and patterns of meaning that come up repeatedly.

The introduction to Chapter 3 will focus on explaining the research approach, methodology and method. This will be followed by an account of the sample and data collection methods employed in this research. Subsequently, an outline of the analysis will be provided, where Braun and Clarke's (2006) six-phase framework will be detailed, from becoming familiar with the data to writing-up the findings in the discussion section of the research. The chapter concludes with the quality and ethical considerations that had to be taken into account during this study.

3.2. Research process

It is crucial to ensure that the research process conforms to scientific rigour and general creditability, as well as develops throughout the course of the study in a logical way (Merriam, 2009). The first step in any research process usually begins with a specific topic of interest, which for this study was the subjective experiences of depression and coping strategies among South African men. This is followed by deciding on a framework for the particular study, as it allows for the authentication and expanding on the manner in which the research is implemented. This will form the basis of the research, as a specific paradigm that is compatible with my thoughts on ontology, epistemology and methodology is adopted. Specifically, a paradigm can be described as a way of thinking (Durrheim, 2006), they are dynamic and may take years to develop. However, due to my belief that individuals make sense and meaning of

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their own experiences in unique ways, this research project is grounded in the interpretivist paradigm.

According to Jones (2015), it is also crucial to understand ones ontological and epistemological assumptions and how it aligns with their research paradigm, as there are issues related to what knowledge is and how it can be acquired. Simply put, "the study of the philosophy of knowledge, or 'what knowledge actually is', is referred to as *ontology*, and the philosophical study of how such knowledge is acquired is referred to as *epistemology*" (Jones, 2015, p. 18). Jones (2015) states that understanding and having awareness of ontology and epistemology is important to a study for three key reasons. Firstly, an awareness of the ontological and epistemological assumptions is important in order to have a framework to understand the notions inherent in the research, the position of the researcher, their decision during the research process, as well as how they analyse, interpret and discuss their findings (Jones, 2015). Secondly, the understanding of one's ontology and epistemology will help determine the most appropriate design to answer the research question (Jones, 2015). Finally, the author's third reason is that the researcher can alternatively allow their inclinations to focus on questions more suited to their ontological and epistemological assumptions (Jones, 2015). Considering such importance of the research paradigm as well as the ontology and epistemology, these aspects and how they specifically relate to this study will be further detailed and expanded on in the next paragraph.

3.2.1. Paradigm and assumptions

This study adheres to and is grounded in the philosophical principles put forth by the interpretivist paradigm. Developed as a critique of positivism in the social sciences (Black, 2006), interpretivism holds specific ideas and attitudes about the nature of knowing and reality. Namely, interpretivism rejects the positivist paradigm's postulation of one unified truth that is objectively knowable, to instead suggest that humans are social beings who create and reinforced shared meaning through their interactions with others (Larkin & Thompson, 2012). In other words, interpretivists accept multiple meanings and ways of knowing, and postulate that "objective reality can never be captured. I only know it through representations" (Denzin & Lincoln, 2005, p. 5). Goldkuhl (2012) states that the fundamental notion of interpretivism is thus to work with subjective meanings already existing in the world, for example: "to acknowledge their existence, to reconstruct them, to understand them, to avoid distorting them

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and to use them as building blocks in theorising" (Hartman, 2018, p. 29). As such, recognizing and narrating the meaning of human experiences and actions is the primary focus of the interpretivist paradigm (Fossey, Harvey, McDermott, & Davidson, 2002). This is suitable for the research study as it seeks to explore men's subjective experiences and meanings of depression and help-seeking.

This overarching paradigm of interpretivism is fully aligned with the social constructionist theoretical framework of the study. Similar to interpretivism, the objective of social constructionism is to understand the lived experience of individuals as it shares the postulation that meaning is created and negotiated by human actors (Andrews, 2012). Social constructionism and interpretivism both reject positivism as they are primarily focused on the observation that individuals possess understandings of society, and actively construct society and culture based on those understandings (Andrews, 2012). Therefore, social constructionism and interpretivism endeavour to understand the way people make meaning, "bringing a different emphasis upon empathic understanding of cultural context, for interpretivism, and upon the mediation of language and social interaction, for social constructionism" (Andrews, 2012, p. 41).

Considering the overarching paradigm of interpretivism, the ontological assumption of this study is subjectivism as it believes that social reality is shaped from the views and experiences of the individuals concerned with their existence (Saunders, Lewis, & Thronhill, 2009). In other words, rather than external or objective truths, subjectivism is the belief that nothing exists outside of individuals' thoughts as reality is a fixed subjective experience (Denzin & Lincoln, 2005). In line with this assumption, Stajduhar, Balneaves, and Thorne (2001) state that human experience is reality and reality is human experience. Taking this ontology into account, this research is based on a few epistemological assumptions regarding knowledge. This includes: that reality and knowledge are socially constructed, the data is subjective as the participants are seen as the experts regarding their own experiences, it is subject to amendment as the participants' knowledge and experiences are variable to change when interacting with the environment, and diverse as individuals will have varied experiences and thus varied knowledge (Kankam, 2019).

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3.2.2. Research methods

Now that one understands the overarching philosophical paradigm and assumptions that form the cornerstone of this research, it is important to consider the methods undertaken by this study in order to answer the research question. However, before one can expand on the methods themselves, it is wise to highlight what is meant by methodology and how it differs from methods; as Jones (2015) notes that there is sometimes confusion between the terms. Jones (2015, p. 112) states that "methodology is the overall research strategy that outlines how you go about answering your research question, justifying decisions about things such as what to study, who to study, what type of data to collect, what to do with the data, ethical concerns and so on." Methods, on the other hand, refer to "the techniques to collect the data" (Jones, 2015, p. 112). As such, while methods become an integral part of a methodology, methodology consists of far greater than simply the collection of data through various methods (Jones, 2015).

Considering that this research project is concerned with the personal experiences of depression and coping strategies among South African men, a qualitative design that is exploratory in nature is deemed appropriate. Qualitative research is focused on the interpretation and meaning of social processes, and can be defined as an investigation into aspects of social life (Jupp, 2006). In other words, qualitative research is aimed at gaining a deeper understanding of situations or individuals' perceptions, experiences, and behaviours in order to describe or explain certain phenomenon (Given, 2008). It is interested in how individuals create their realities based on their own subjective understandings of the world around them (Larkin & Thompson, 2012). Thus, a qualitative methodology enables a researcher to study participants perspectives with the aim of describing and understanding their experiences, rather than explaining it (Babbie & Mouton, 2001). This approach is useful in mental health matters as the research findings are made sense of in order to enhance the understanding of individual's rich and complex backgrounds, in turn empowering better care and support (Harper & Thompson, 2012).

Qualitative research is often placed in contrast to quantitative studies. In short, quantitative approaches seek to investigate observable phenomenon via statistical, mathematical or computational techniques (Given, 2008). This approach aims to analyse and communicate data in numerical form, and is often used in the establishment of causal relationships that can be used to generalize findings to a larger population (Harper & Thompson, 2012). On the other hand, qualitative designs are interested in gaining in-depth knowledge about individuals'

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understandings of their social realities and lived experiences (Larkin & Thompson, 2012). This method relies on data obtained from participant-observation, interviews, focus groups, and questionnaires to investigate *what* people think as well as *why* they think it (Larkin & Thompson, 2012). As such, a qualitative design was deemed appropriate for this study as it will allow for the exploration of how South African men construct their realties and make sense of their own individual experiences. Furthermore, this study will be exploratory in nature as it wishes to investigate the research topic to yield new insights and understandings, rather than provide conclusive evidence.

3.3. Sample

This study conducted research on eight Black South African men within a local support group. Initially, it was not intended only to focus on Black South African men, but due to the snowball sampling method used and the function of the gatekeeper (Jones, 2015), the final selection of participants resulted in identifying eight Black South African men that were available to share their experiences pertaining to the topic. As the study progressed, this more homogenous sample group appeared to be more appropriate to reveal the intended aim and objectives on a specific cultural group that is not well represented in the literature. The small sample size was deemed appropriate as this study sought to gain an in-depth and detailed account (an account which is difficult to attain with a larger sample size) of psychological well-being among South African men (Boddy, 2016). The sample was accessed at a local support group dedicated to assisting and counselling men through topics such as: depression, substance abuse, and general life challenges. The support group reportedly consists of mainly African and Coloured men who are emotionally struggling to cope. However, the group facilitator reported that while most of the men feel like they are experiencing depressive symptoms, many of the members have not sought help from professionals and thus do not have a formal diagnosis of MDD. Nevertheless, as this group comprises of South African men who feel that they are experiencing depressive symptoms, this sample offered new insights that have been previously unexplored in literature. Namely, while other studies (Lynch, Long, & Moorhead, 2018; Möller-Leimkühler, 2002; O'Brien et al., 2005; Turan & Erdur-Baker, 2014) have focused their research internationally, this study seeks to gain the perspective of men who feel that they are suffering from depression within the South African context.

The inclusion criteria for this study consisted of: South African men, who have some perception or inclination that they may be suffering from depression or depressive feelings,

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who are between the ages of 18 and 70, who have access to a computer and internet as the interviews will be conducted online, and who have an adequate grasp of the English language to engage in conversation during interviews. Considering the social distancing restrictions placed by the COVID-19 pandemic, all interviews were conducted online via Zoom. As this site and sample were selected for the purpose of having access to specific individuals who can answer the research question best, this study at first employed a non-probability and purposive sample technique (Tongco, 2007). Additionally, the research further utilised snowball sampling as it asked the men from the group to provide referrals to recruit participants required (Johnson, 2014). In other words, the existing sample nominated other potential data sources that would be able to participate in the research (Johnson, 2014).

To gain the sample needed, I first approached the facilitator of the group by sending him an email explaining the purpose and process of my research. Once consent had been granted, the facilitator of the support group helped in identifying and approaching potential participants for the study. The facilitator of the support group was sent an information sheet to hand out to potential participants, ensuring that they were informed before consenting to participate in the study. Once given enough time to consider their involvement, the participants provided their information to the group facilitator, who then passed the information onto me. I contacted each willing participant to gain informed consent and made arrangements regarding a date and time that was most suitable for them to collect the necessary data. As noted above, I then used a snowball sampling technique in order to identify and interview other participants. Thus, the members of the group that had agreed to participate in the study, spoke to other potential participants to ask if they were willing to share their experiences. The individuals who expressed an interest in participating were then contacted by me as well as sent an information sheet and consent form. Finally, a date and time to conduct the interview was arranged with the individuals who agreed to partake in the study.

An interesting development to note while recruiting participants was the general reluctance of individuals to engage in the topic of depression. It proved extremely difficult to find men who were willing to conduct the interview and speak openly about masculinity issues. Below is a message I received from someone trying to help me gain participants:

> *Final thing, reached out to a lot of people on request for thesis, it's definitely tricky. For African men, they won't admit it, won't talk about it if they've been depressed or*

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> *diagnosed and generally don't even seek help when they feel depressed. Then there's the trust issue which came up. And also men in general don't like to speak about anything related to feelings so there's that. In summary, have had no luck thus far.*

Such recruitment difficulties are important as I feel that it speaks to this research. Namely, men's difficulties with sharing or expressing emotions. They would rather hide and supress it than openly share such emotional distress as it is possibly seen as more feminine and a move away from masculinity constructs. As such, even gaining participants for this study demonstrates the power of masculinity ideals and how it could possibly restrict help-seeking as men do not feel comfortable sharing their emotions even on an anonymous platform.

Nevertheless, once all sampling techniques were employed and all participants interviewed, the final sample consisted of eight Black South African men. Their ages ranged between 25 years old to 42 years old, with the majority being between 29 and 35 years of age. Four of the participant's noted that they had been formally diagnosed with MDD, while the other four felt that they had experienced a depressive episode at some point in their life but had not sought professional help. While the socio-economic status did vary between the participants, the majority of the men stated that they came from poor or impoverished backgrounds. However, despite such backgrounds, almost all of the participants had a high educational level as they attended tertiary institutions. All of the participants currently had employment at the time of the interview. The entire sample could speak at least two languages, with all being proficient in English. Finally, all participants were computer literate and had access to the internet to conduct the interview.

3.4. Data collection

Above deciding on the target population and sample size to best answer the research question, this phase of the study requires the researcher choosing the process and methods for data collection. It is essential that qualitative researchers are clear about the *what*, the *why*, and the *how* when analysing their data (Attride-Stirling, 2001). This will ensure that the best methods are chosen in order to collect the richness of data needed in light of the aim and objectives of the study. To collect the data necessary for this research, this study deployed the Becks Depression Inventory-II (BDI-II), as well as individual in-depth interviews.

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3.4.1. Becks Depression Inventory-II (BDI-II)

As the researcher acknowledges that most, if not all, participants would not have received a formal diagnosis of MDD, this study will utilise the BDI-II (see APPENDIX E) as a screening tool for depressive symptoms. The BDI-II is a 21-item, self-report rating questionnaire, with established reliability and validity worldwide, that measures characteristic attitudes and symptoms of depression (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Osman, Kopper, Barrios, Gutierrez, & Bagge, 2004; Upton, 2013). Relying on the theory of negative cognitive distortions as central to depression, the BDI-II was developed by Beck et al. in 1961 (Beck, Steer, & Carbin, 1988).

The questionnaire was developed from clinical observations of attitudes and symptoms occurring frequently in depressed psychiatric patients and infrequently in non-depressed patients (Beck et al., 1961). The self-report rating questionnaire of 21-items were consolidated from those observations and ranked from 0 (symptom absent) to 3 (severe symptoms). "Anxiety symptoms are not assessed but affective, cognitive, somatic and vegetative symptoms are covered, reflecting the DSM-IV criteria for major depression" (Jackson-Koku, 2016, p. 174). The questionnaire is scored by adding the highest ratings for all 21 items. The maximum score one can achieve is 63 and the minimum score is 0, with higher scores indicating greater symptom severity (Jackson-Koku, 2016). In non-clinical populations, scores above 20 indicate depression (Kendall, Hollon, Beck, Hammen, & Ingram, 1987). In those diagnosed with depression, scores of 0-13 indicate minimal depression, 14-19 indicate mild depression, 20-28 indicate moderate depression and 29-63 indicate severe depression (Upton, 2013). Finally, the BDI-II takes five to 10 minutes to administer and is an effective screening tool for MDD.

3.4.2. In-depth interviews

Moreover, this research utilised the insights gained from the international research (discussed in the literature review) to construct in-depth and tailored questions that sought to elicit a deeper understanding/appreciation about South African men's thoughts, feelings and behaviours regarding depression and coping strategies (Legard, Keegan, & Ward, 2003). In other words, this research built on the current understanding to add richness and explore areas not yet unpacked, thereby enhancing and filling gaps in the current literature. Informed by the research question and objectives of the study, the in-depth interviews were conducted by me (the researcher) and consisted of a semi-structed format comprising of open-ended questions (see

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APPENDIX D) that has been adapted from Lavender, Khondoker, and Jones' (2006) interview schedule.

According to Babbie and Mouton (2001), interviews are the most often implemented data collection methods within qualitative research. Such qualitative interviews "provide the researcher with the opportunity to collect data which may not be directly observed, as the researcher may enter a participants' own reality, seeing the world through their eyes" (Ellis, 2016, p. 62). The in-depth interviews deployed by this research consisted of a semi-structed format. This format provides the researcher with a flexible interview guide, allowing for similar questions to be asked of all participants while still being more open-ended than a structured interview. In other words, this semi-structured formed aided in the general direction and nature of inquiry during the interviews, while allowing for the supplementation of follow-up questions, probes and comments (Durrheim, 2006). This provided the researcher with the ability to probe into the participants' responses, as well as to look for alternative and emerging topics of discussion (Durrheim, 2006).

As noted above, the interviews were scheduled on dates and times that were convenient for the participants. The interviews were conducted online via Zoom and lasted between 45 to 60 minutes for each participant, as to ensure that the participant was comfortable and gave a detailed response (Ritchie et al., 2013). All responses were digitally recorded and transcribed by me in English, including observations about the participant's behaviour throughout the interview (Ritchie et al., 2013). Such interviews were further analysed to extrapolate core themes and gain such in-depth understanding of South African men's experiences of depression and coping strategies.

3.5. Data analysis

As previously stated in Chapter 1, thematic analysis was used to analyse the data from the individual interviews, due to its rigor (Fereday & Muir-Cochrane, 2006), flexibility (Aronson, 1995), and common use in research (Attard & Coulson, 2012; Grindsted & Holm, 2012; Joffe, 2012). Thematic analysis allows for the identification, analysis, interpretation and reporting of patterns within qualitative data (Tuckett, 2005). Thematic analysis, according to Corbin and Strauss (2008), is useful in categorising research data into smaller units of meaning as well as accounts for my influence on the formulation of categories and themes. This is important considering that I have an active role in reflecting and thinking about the research data.

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Specifically, Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis was utilised. The first step that was followed was to become familiar with the data, involving a line-by-line reading and re-reading of all transcripts (Braun & Clarke, 2009). The second step was to generate initial codes, whereby I started to organise the data in a meaningful and systematic way (Braun & Clarke, 2009). The next step, step 3, was to search for themes, where I began to identify patterns that capture something significant or interesting about the data and/or research question in order to generate tentative thematic groundings (Braun & Clarke, 2009). In step 4, I reviewed, modified and developed the preliminary themes through continuous comparison across the individual transcripts and where promising themes were verified against coded transcripts (Braun & Clarke, 2009). Step 5 entailed the final refinement of the themes where the aim was to "…identify the essence of what each theme is about" (Braun & Clarke, 2009, p. 92). The sixth and final step was to write-up the findings in the discussion section of this study. "Thematic analysis also provides a rich description of data by searching across the data set, as it provides the researcher with the opportunity to constantly move back and forth between the various themes, data sets, and coded extracts of the data" (Ellis, 2016, p. 66). Therefore, a recursive process is employed during the different phases of data analysis (Braun & Clarke, 2006).

3.6. Trustworthiness and quality of research

While constructing a study, evaluating the results and determining the quality of the research, Patton (2002) notes that validity and reliability are two facets that all qualitative researchers should consider. Although the term reliability is usually used to evaluate quantitative studies, Stenbacka (2001) states that it can be used to assess qualitative studies where the purpose is on generating understanding. This is supported by Healy and Perry (2000) as they suggest that the quality and reliability of a study should be appraised according to its own paradigm. Taking this into account, the focus of this research, according to my interpretivist paradigm, was on the richness and meaningfulness of my interpretations. This holds true for this research as the sample, data collection and analysis were also chosen with the purpose of providing as rich and in-depth understanding of the participant's experiences as possible. The validity and reliability of this research was also supported by the data analysis of this study being conducted independently by myself, restricting outside influences from possibly contaminating the results.

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Moreover, I considered whether the methods of this research were explained in sufficient detail. Namely, the aim was to thoroughly outline the specific research design as proof of rigorous research. A comprehensive and in-depth description of the research methodology deployed was also provided, strengthening the dependability of this research. Special attention was further afforded to ensuring that this research is verifiable, open and accountable, enhancing aspects such as reflexivity and transparency in the validity of the qualitative research (Thorne, Jensen, Kearney, Noblit, & Sandelowski, 2004). The transparency and auditability of this research was expanded upon by providing a detailed discussion of the research methods, improving the reproducibility of this study as it can be traced and audited by others (O'Leary, 2004). Finally, the validity and quality of this qualitative research was heightened by the participation of a research supervisor, as well as two external evaluators.

3.7. Ethical considerations

As this research does include human participants, it is crucial to consider the ethics related to this study. Firstly, all individuals participating in this study did so voluntarily and received an information sheet (see APPENDIX B), as well as a consent form (see APPENDIX C) outlining the potential risks or benefits, privacy and confidentiality issues, as well as the handling of the results (Gajjar, 2013). If at any stage the participants desired to withdraw from the study, it was made clear that there would be no prejudice for doing so (Devettere, 2009). In order to ensure and maintain confidentiality and anonymity, each participant was assigned a pseudonym (Devettere, 2009). Furthermore, in reporting the analysis of the results obtained, all participants are referred to either using anonymous titles (such as participants or males/men) or the personalised pseudonyms assigned to them as to ensure that their names or any identifiable information is omitted.

All information and data collected is securely kept on a password protected computer, as well as in storage in the Department of Psychology at the University of Pretoria for 15 years (Gajjar, 2013). Furthermore, while there was no foreseeable risk towards the participants' physical, social, or mental health, if participants did require further psychological assistance in the event of re-traumatisation, they were suggested to contact the group facilitator or South African Depression and Anxiety Group (SADAG) at 011 234 4837. SADAG is Africa's largest mental health support and advocacy group, offering 24-hour counselling services. Above these ethical criteria being met, ethical clearance was obtained from the Postgraduate Studies and Ethics Committee in the Faculty of Humanities at the University of Pretoria (see APPENDIX A).

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Finally, measures were also employed to enhance the quality of this research. Namely, the entire research process (step by step) is thoroughly documented, enhancing the replicability and reliability of the study (Treharne & Riggs, 2014). Reflexivity was also utilised by looking at how the research is informed both by the methods and objectives, as well as my own personal circumstances, identity, and experiences (Treharne & Riggs, 2014). The above measures are implemented in order to enhance the overall credibility and quality of the study.

3.8. Conclusion

In conclusion, Chapter 3 provided an outline of the research design and methods adopted by this study to answer the research question: "What are South African men's subjective experiences of depression and the coping strategies that they utilise to manage it?" The chapter explained the research process by reviewing this study's design and methods. Namely, this chapter considered the paradigms and assumptions that form the cornerstone of this research. This was followed by a detailed account of the sampling, data collection as well as data analysis methods that were deployed by this research in light of its aim and objectives. Finally, this chapter reflected on the ethical and trustworthiness considerations that had to be taken into account to ensure the quality of the research.

The next chapter, Chapter 4, examines the research findings, including the themes, subthemes, and the categories that arose in the course of the data analysis.

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CHAPTER 4:

RESEARCH FINDINGS

4.1. Introduction

This study utilised Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis in order to analyse the eight individual interviews. This analysis was done in order to answer the research question: "What are South African men's subjective experiences of depression and the coping strategies that they utilise to manage it?" After careful readings and analysis of the data, three predominate themes emerged from the findings that encapsulate the experiences of Black men within the South African context. The overarching themes include: Real men don't cry; Sadness hurts, but sharing hurts more; and Dark days, take control. The themes are further divided into several subthemes. This chapter seeks to provide an outline of the themes, subthemes and categories that emerged during the research process and provide substantiation for them by means of relevant quotations.

4.2. Results of BDI-II

Before one can consider the themes and subthemes themselves, it is important to first highlight the results of the Beck Depression Inventory-II (BDI-II). Each of the eight participants completed the 21-item questionnaire that screens for depressive symptoms. As noted above, while the BDI-II was in no means to diagnose the participants, it served to add richness to the study as one can evaluate the participant's responses in context of their mental and emotional state at the time of the interview. In other words, this study will outline the participants' scores and the relevant meaning in order to add a reference point for the research, whereby the participant's responses can be cross referenced to their mental and emotional state while providing such answers. However, it is crucial to re-emphasise the main inclusion criteria that the participants were either diagnosed with MDD or felt that they suffered from depressive symptomology. Accordingly, all of the participants had the perception that they experienced above normal mood disturbances and depression, offering new insights as the men could talk about depression in an authentic way.

Utilizing the interpretation manual for the BDI-II, participant one scored an overall total of 13 out of a possible 63. This can be interpreted as participant one experiencing a mild mood disturbance at the time of the interview. Participant two similarly scored a total of 13, also indicating a mild mood disturbance. With a significantly higher total score of 30, participant

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three is noted to have experienced moderate depression at the time of the interview. Likewise, participant four equally received a total sore of 30, signifying moderate depression at the time of the interview. Participant five scored a total of 11, representative of a mild mood disturbance. Participant six had the lowest score overall, with a total of 7 on the BDI-II. This low score suggests that participant six was experiencing normal ups and downs at the time of the interview. With a total score of 9, the BDI-II suggests that participant seven was experiencing normal ups and downs. Finally, participant eight scored a total of 11, signifying a mild mood disturbance at the time of the interview.

To allow such data to be more accessible, the results of the BDI-II and the interpretations of the mental and emotional state of the participants at the time of the interview are represented in Table 2 below.

Table 2.

Results of the Becks Depression Inventory-II

Participant number	Total score	Interpretations
Participant 1	13	Mild mood disturbance
Participant 2	13	Mild mood disturbance
Participant 3	30	Moderate depression
Participant 4	30	Moderate depression
Participant 5	11	Mild mood disturbance
Participant 6	7	These ups and downs are considered normal
Participant 7	9	These ups and downs are considered normal
Participant 8	11	Mild mood disturbance

4.3. Research findings

With the results of the BDI-II in mind, this chapter will turn its attention to the themes, subthemes and categories that emerged during the research process. A portion of participant five's interview-coding can be found in APPENDIX F. As noted above, the thematic analysis revealed three overarching themes that encapsulated the thoughts and experiences of South

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African men, namely: Real men don't cry; Sadness hurts, but sharing hurts more; and Dark days, take control. With the intent of answering the research question, these themes capture the participants' views on masculinity, depression and help-seeking, as well as the coping strategies that they utilise to manage it, respectfully. Figure 4.1 serves as an illustration of the different themes, subthemes and categories of codes.

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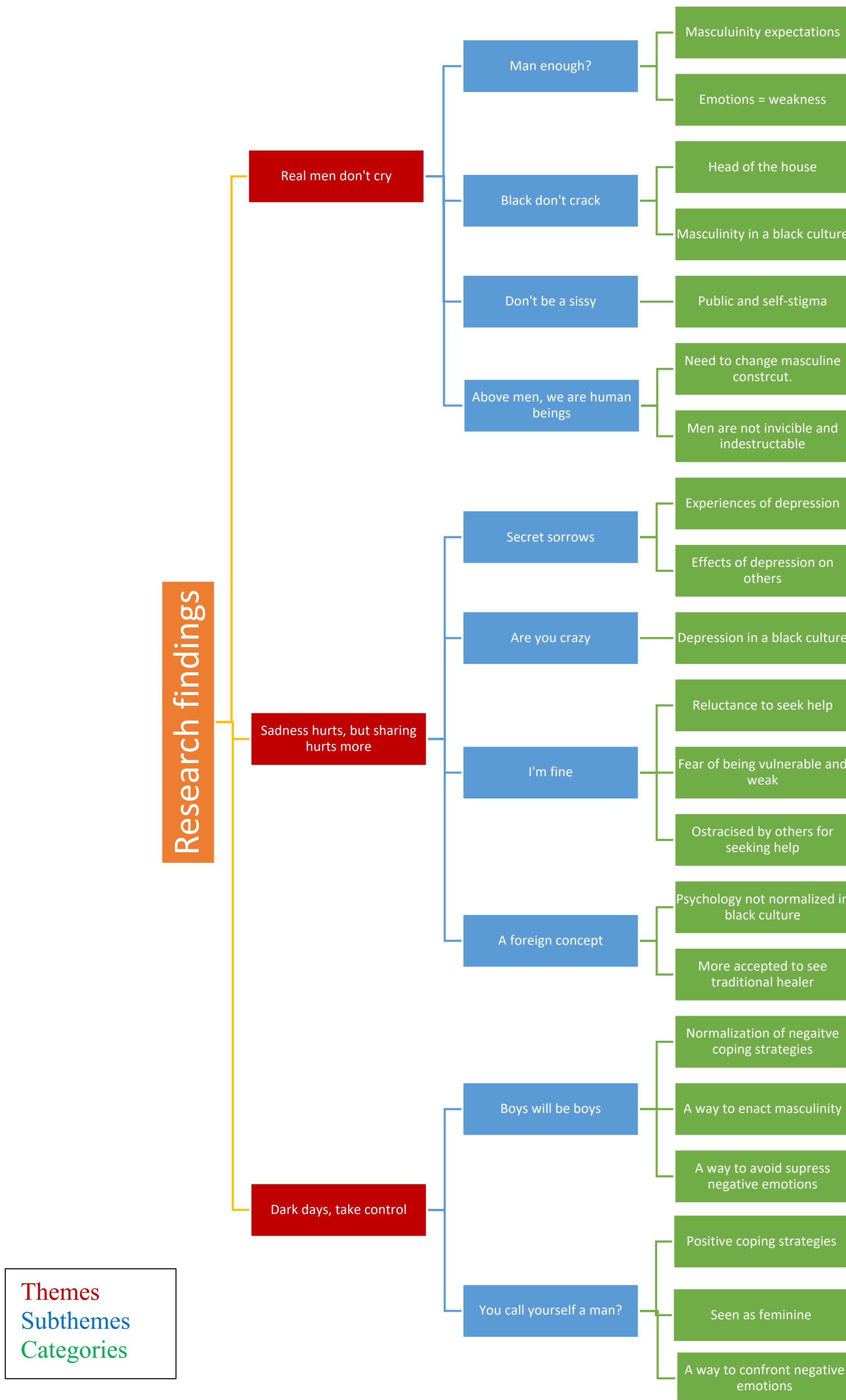

Figure 4.1: Thematic content of research findings

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4.3.1. Real men don't cry

A consistent theme that emerged throughout the research process was the participants' views on masculinity and what it means to be a man. All of the participants' expressed their thoughts on the traits traditionally seen as masculine, such as strength, courage, independence, leadership, and assertiveness. They described how such societal concepts influence and govern their behaviour on a day-to-day basis. As such, this is the first overarching theme that arose in the thematic analysis, which can be further divided into four subthemes, namely: Man enough? Black don't crack; Don't be a sissy; and Above men, we are human beings.

4.3.1.1. Man enough?

Many of the men in the study commonly described masculinity expectations, the notion that men have to be strong, a rock for their families, invulnerable, a protector and a provider. They explained such masculine traits as a backdrop, noting that subscribing to this ideal meant that they were not allowed to be weak, depressed or have any bad days as real men do not show emotions. As such, the men expressed the need to rather hide or supress negative emotions for the fear of being seen as less of a man. However, an interesting finding was that some participants refused to subscribe to such doctrines, noting how they are comfortable in going against the status quo. Nevertheless, whether the men in the study subscribed to such notions or not, all of the participants explained how dominant it was in informing their decisions and lives. This creates the first subtheme of: Man enough?

> *You're right in your observation, men, we men. We live in a, in a, in a masculine world where, like you said, men don't cry. Men are not allowed to show weakness. You can't be weak. You can't be you, can't show weakness or whether you're weak or you can't always show it because the world will look at you different. Well, we think you're soft.* [Participant 1]

> *Yeah, you are treated as less of a man. Oh, so you can't even deal with this small problem yourself. Are you a man? And you call yourself a man? No, such statements are thrown around a lot where a man is expected to be at the top of his game 24/7, 365. Mr. no days off. You know, a man is not allowed to show emotion, a man is not allowed to cry.* [Participant 1]

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You will hurt yourself and your father will look at you like… no, why are you crying? Don't cry. Toughen up. You're a man. [Participant 1]

There was a time where I couldn't show weakness around my wife because she had that mindset that oh no you're a man, you can't be weak, you know. You're a man, you can't be weak. You're a man, you can't be this. You're a man, you can't do that. So I realised I didn't have a confidant in her. So there's no need to bother showing any form of emotion towards her or showing any form of weakness. It will be taking, it will be misinterpreted and it will be used… It will be weaponized and used against. [Participant 1]

We keep instilling those same doctrines and principles in our children and in the younger generation and then they go well first looking at us and then looking at that themselves, you know. If daddy or uncle is always strong, then I also have to be always strong. I can't show any sign of weakness, you know. I can't, I can't show any sign of weakness and unfortunately it just keeps growing and growing and the message, that message of you can't be weak, you can't be weak, it's passed on down the line. [Participant 1]

Such sentiments were similarly shared by other participants during the interviews:

When all my life I have been fighting vulnerability, you know, being vulnerable is, as a Black man, is frowned upon… And I think that is particularly one of the reasons why I often felt like less of a man, you know, in a lot of respects. And that would be because my vulnerability kind of overshadows who I am now, regardless of what I've achieved, and what I've managed, and where I've come in life, etc, right. [Participant 3]

But how I would deal with that was usually just to suppress everything that I would feel. You know what I mean, like do everything in my power not to deal with the pain, do anything. [Participant 4]

I would always feel like I'm charged, I can't go out of my house being myself, I would have to wear a certain façade or something just to become, you know, it was like every

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time I walked out of my house it would become a stage for me, so it was no longer an actual stage, but life at large was becoming a stage. [Participant 4]

In the way that masculinity is viewed in society in the sense that if I cannot provide then I feel less than, you know. In the sense that if my emotional stability is not a 100% as to its core, then I'm less than what I should be or thought of. So, therefore I'm perceived more as a feminist or in the feminist sense than a masculinity sense, so I would rather hide it than show it, for a lack of better words, because now people now start bringing these questions into play, you know, about whether you are fit to play a gender or you're stuck in between and what you identify as. [Participant 5]

But then at the same time, there is that notion of big boys don't cry, real men don't cry. And that is another thing that I think is linked to it. Therefore, you can't seek help because you're not gonna fit the stereotype. [Participant 8]

While some of the men in the study subscribed to hegemonic notions of masculinity, there were a few participants who expressed the view that they did not endorse such traditional views. These sentiments are expressed below:

When whatever patriarchal masculinity whatever was developed, I was not there, I was not considered. Therefore, I'm not gonna subscribe to that because, one, how dare they say men don't cry when the first thing a doctor wants you to do to show life is cry. So, if I do need to cry, I will cry. On my terms, however. If it means I must go find a safe place to go cry, I'll do that. [Participant 2]

And I'm a chilled guy. But it's just that I'm not a typical guy who will have a family gathering and I'd want to chill around the fire with the men. Flip man, I wanna chill with my sister. I've got lots of… We're close and my cousins, you know. I'm a, I know. So, those kind of things, and they always attach it to masculinity and I'm, like, at first I was insecure about it but now I'm confident. Like, I love women but I'm just not saying that I'm trying to I have to prove myself or behave a certain way to be rendered a man, you know. [Participant 6]

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Like, in them it's, like, men don't cry and it's, like, men do that, men, no, like, I'm not that guy. I am not, I've never been… Tired of being with people trying to make me, like, or convert me into this hard oke. I'm not that guy. [Participant 6]

Yes, that's totally out of my values. Nothing makes you less of a man if it highly affects you and you need assistance. Pardon, I know there could, I know there are men like that. There are also women like that. But I for one, I've always been out there for help. I've always seeked, sought help I mean. I know of people that would be resisting that because they, as you say, they will be made to felt they are less of a man doing that. But it's not for me. [Participant 7]

I'll still be a man. Men cry. Men share their feelings. Men are human beings. So, I believe that if you are in a position where you can't see the light, you're due to cry I mean because you're going through stress or depression. Things are not falling apart. You have to cry. That's the nature. That's the nature of being a human being. [Participant 7]

I don't think I've ever subscribed to that thinking at all. I've always just been, like, very feminine, very soft-spoken person. So, I've never had to worry about coming into a room and being the macho person in the room or being this manly man, you know… Because I've never really seen myself as like, you know, a real guy so if I have to do this to that and not the other. [Participant 8]

4.3.1.2. Black don't crack

Despite the concept of hegemonic masculinity originating from Western societies, many of the participants noted that masculinity was even more entrenched and encouraged in African cultures. Considering that this study was done with Black South African men, many of the participants noted that race and culture strongly intertwined with the concept of masculinity for two main reasons. Firstly, the participants noted that many Black families grow up without a father being present in the home. Thus, boys have to learn from their mothers and society what it means to be a man, indoctrinating and internalizing such societal views. Secondly, a number of men explained that due to African cultures and traditions, as well as Black individuals struggles, concepts of the man needing to be the head of the house is strongly

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embedded. As such, the doctrines of being strong, invulnerable, a provider and a protector are highly fortified within Black communities and families, forming the third subtheme of: Black don't crack.

> *You know, are no Black men, Black men, Black don't crack, Black don't show weakness. Black don't this. Black don't that. Black don't this. All that illusion, all that machismo that is drummed into our subconscious from being young, now starts manifesting because from, from a kid we've been bottling things up.* [Participant 1]

> *So, yeah, I mean, that's, that's how everyone looks at it, like Black don't crack, or real men don't cry, and men must be strong and invincible.* [Participant 3]

> *When all my life I have been fighting vulnerability, you know, and being vulnerable is, as a Black man, is frowned upon.* [Participant 3]

It is clear from the above excerpts that the participants endorse the notion that Black don't crack, the idea that hegemonic masculinity traits are even more sanctioned and subscribed to within African cultures. As noted above, the participants stated that one reason for this is because Black families often have an absent father figure to teach the children what it means to be a man. Hence, they learn from societal views from a very young age of how they should be a man for their families.

> *Seven out of 10 times, most households are female led. Therefore, they, you don't understand family as a whole. Therefore, being a man at a, at default settings is already angry, and you already feel like you have a chip on your shoulder, and anything you would have… a so called chip on your shoulder will never be healthy. And if we always try, why did my dad beat me? Or my dad did this, I'm gonna do that. Therefore, it does not come from a healthy… Why can't I find the word… assembly line, that will come from a healthy assembly line.* [Participant 2]

> *If you look at our, the way our families, African families are mostly constructed. You know, you don't find a strong family unit where, like, in most instances. Like, people that I grew up with and around my neighbourhood were all coming from single mom*

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> *households. Not single dad households. And you know some of them being guys that are raised by females there is an attribute of, you know, you've gotta now be the head even though you don't have any sense of what that means… And you know you've gotta, kind of if you're the first born son for example, there's certain things that you know, your siblings or even your mom or the rest of your family will look to you to kind of provide and to do. So, you kinda have to assume the role a little bit faster without any coaching or help along the way.* [Participant 8]

> *Because you are assuming this role but at the same time you don't have any example of how that person is supposed to be. So, you know, you're getting your influences from outside of where you should actually be getting them from. Either from your friends, bad influences or you know people that you connect with. To fill that hole. And that's where you learn these things that are implied that a man does this and a man doesn't do that.* [Participant 8]

Above the father figure being absent, the second reason given by the participants of why masculinity traits are so strongly subscribed to in African cultures is because of traditions and history. It is noted that Black men are often fervently expected to be the head of the house, being strong and providing for the rest of the family. One participant even noted that Black men often go through initiation schools, where they are taught that they have to be strong, a provider, not show any flaws and be in control at all times in order to survive.

> *There was a time when I lived by that phrase "Black don't crack", for a long waste of time, you know what I mean, because you look at it from this perspective; we come from a culture of a struggle already.* [Participant 4]

> *Even if you can look at it from way back, from the time of your Shaka Zulu, a man has to be a provider, a man has to be the strong one for the family. You know, you have to go out and start your own family… And if you have to do that, it's a rough world out there, you have to protect these people, so you cannot show feelings. You know what I mean, so we are taught that you cannot show feelings because we have to survive by any means and I feel like in most cultures it's not the case.* [Participant 4]

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I mean this is why we go to like initiation schools and all of that and you are actually in initiation schools, you are actually taught that… That no, you are different from everyone else, you are not just different from women, but you are different from White men, you are different from coloured men, you are different from Indian men, you are different completely. You know what I mean and that is what makes us more like a "Black don't crack" because of we are taught survivalism from the get-go. You know we don't crack, because if you crack you're not going to survive. [Participant 4]

You know what I mean, not having a degree and all of that, no, you can have all these things, but if you're not a man, they're just worthless, they're useless, you understand, you can have all this money, but if you're not a man it means nothing. You know what I mean. So, these initiation schools teach you that, you know, this is why they become so important to us as Black people, because they teach you how to become that… You know what I mean and ya and basically before we westernized and all of that, that was actually our education, so it basically was… education was for men, you know what I mean… And that's where you would go to become a man because if you're taught to become a man you were taught how to survive for your family. [Participant 4]

These views and ideas are equally shared by other participants:

But being a Black man, there were items that are subscribed to, and the items that I couldn't like, I'd be told, like, in a conversation with some friends or family or whatever, they're like, no, we don't do that. When this happens in your house, you are the head of the house, you make sure that you put your foot down and whatever, and whatever. [Participant 3]

You're going to be the head of this family one day, like, and my dad is a first born, so, it's like, now all of a sudden by default I've got this huge responsibility as whoever's uncle there and whatever. Like, you must know these things. [Participant 6]

I feel where we are coming from sometimes because you know struggle, and I suppose this is the flip-side now, as a man in a Black family you take on so much. You, so much

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is put on your shoulders and you are not supposed to crack. You know, you must carry it. You must make something work of it. And your family must be okay. [Participant 6]

Yes, you have to carry everyone. You have to be strong. For all of your siblings. [Participant 6]

So, in, to sum it up, the notion that we are raised with is that if you show any form of weakness, how is the rest of the family that you head up supposed to follow you? So, basically no-one wants to follow a weakling, you know. So, that's almost like a tacit kind of indoctrination that we get. You are not supposed to show any flaws, you must be in control at all times. Everything must be your decision, right. [Participant 6]

4.3.1.3. Don't be a sissy

Thus far, the theme of real men don't cry has predominantly focused on traditional masculinity traits and how men either feel the need to subscribe to or go against such societal doctrines, as well as how this notion intertwines with race and culture in African communities. Beyond this, the men in the study also spoke about the consequences of stepping out of such dogmas. More specifically, they spoke about their experiences of stigma surrounding not subscribing to such traits, where friends and family would often ostracise them for being perceived as less of a man. Such ostracization occurred in the form of public stigma, where others would often mock or ridicule them, as well as self-stigma, whereby the beliefs of society was internalized and the men would stigmatise themselves for having and expressing emotions in the fear of backlash from others. This idea formed the third subtheme of: Don't be a sissy. This research will first look at instances of public stigma during the interviews and then how it turned into self-stigma.

I've been ostracised because they once thought I was, I was too soft, I was gay. Then I was ostracised, because I like girls too much. I was like in actual fact, whatever, I want to do what I do. What makes me happy. Because in actual fact, I don't know what your guys's rubric, I doubt you guys know what your rubric is for you mocking someone. [Participant 2]

I was, so I was always the softie amongst my peers and amongst my family and stuff and at first when you grow up you're made fun of about it. Like, you grow up. So, I

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knew that that's probably gonna come, you know, like, hey this one, you know, the soft one. [Participant 6]

Like, I've gotten to a point where I no longer feel offended. I'm okay with, like, my old uncles, like, thinking I'm a girl. [Participant 6]

It's you are shunned out of the masculinity community because you are different, you are too emotional for this role. [Participant 5]

It's just that we lack, as communities to some point, precisely Black communities, we lack that brotherhood and sisterhood. Because we tend to make jokes about what people are actually going through. You know, if I'd share something with you and then you would probably just go and tell people all over that, you know, that's how you start mocking at me. It becomes a joke. So, it's what people are scared of… That is why they do not share their feelings because whoever they actually inform, wherever they're going to might start being a circus. [Participant 7]

But with our society there's a lot of judgement and society in general, you know. When people reveal a sense of struggle in their life. [Participant 8]

It's huge and it even spills over into intimate relationships. I've had two possible relationships break down simply because, like, the ladies thought I wasn't, like, hard enough. [Participant 6]

You can't even tell your partner that you're having a bad day. You know, you, you will be traditionally looked at as a weak man, because why would you even say you're having a bad day? Why would you be feeling down? Why would you be everybody comes to you for answers. Lord forbid you have to go to someone else who answers, even go back to those same people because the same person who comes to you for answers, when you do go to them for a shoulder to cry on… you are frowned upon. [Participant 1]

These quotations illustrate the participants' experiences of public stigma, whereby friends and family have ridiculed and ostracised them for stepping out of hegemonic masculine norms. As

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noted above and according to research, such public stigma turns into self-stigma. More specifically, the participants expressed that they have internalized such societal views and began to stigmatize themselves for experiencing and expressing emotions.

> *I think at some point we tend to be more worried some about what society might have to say in whatever shortcomings or challenges that we actually go through. In other words we tend to live for others. You know, societal stunts. I mean when we're actually going through a pain.* [Participant 7]

> *So, being where I come from, if you look at any movies of Shaka Zulu, he is seen as a strong-willed man, you know, and it was a problem by, I thought like if I actually spoke of how what's going on is affecting me I'm going to be seen less than and therefore demoted from my position*. [Participant 5]

> *So you would now to start to look like less of a man. You know what I mean, you now start to look like less of a man you know what I mean, no you don't belong in a society, you can't fit in. You this, you that and that makes people reject you and all of that, but in my instance it was all in my head.* [Participant 4]

> *Ya, so for me it was more that and I think that's what happens with mostly men. You know, it's not that they feel like men don't cry and men don't do this, don't do that, but it's more like that rejection if you do cry.* [Participant 4]

4.3.1.4. Above men, we are human beings

It is clear to see from the preceding subthemes that the constructs of masculinity are highly prevalent and dominant both in society and in males lives, specifically African males. The men in this study all expressed the pervasiveness of hegemonic masculinity traits and the labels of what it means to be a man. Whether they felt they lived up to such expectations or not, all of the men expressed a need to dismantle and move away from the unrealistic ideal. In other words, rather than the rigidity of what it means to be a man, the participants expressed a view that they are human beings with emotions. As such, the fourth and final subtheme is: Above men, we are human beings. These viewpoints are expressed below:

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You know, I would suggest that men remove themselves from their masculinity, you know, and see themselves as just beings, you know, I think for me I think what makes us as a people and I'm not just talking about men in general, I'm just talking about every people, what makes us suffer the most is the fact that we have these labels, you know, that this is a table, this is a chair, this is a man, this is a woman, those things are actually what creates functionality in society, but in that functionality in society there's a dysfunction because then you would have to be brought into a certain category, you know what I mean… Like as a man you have to live this way, you know what I'm saying. So I always say remove yourself from that, you know what I mean, don't try to live your life as hey, I am a man, see yourself as a human being and take it from there. You know what I mean and you know for what it's worth, don't even see yourself as a human being, just be. [Participant 6]

So, you know, we need to, we need to take our foot off that pedal of men are X and men are Y. Men are human beings. Just like every other human being walking the face of the earth. Men are human beings. We have problems. We have issues. When things don't go right for us, it hurts us just as it hurts you. Male or female, now you females, it hurts us, you know, we have a bad day at work. It's sad. As a man, you know, I can be strong for everybody around me, when at times where I want to be coddled too, it doesn't make me less of a man. I want to be coddled, I want to be hugged. I want somebody to just hold tight and tell me everything's gonna be okay. [Participant 1]

So we can't keep, we can't keep painting this notion that man is indestructible and the Black man is indestructible and is unbreakable. And he has, because if we see Black don't crack and he's indestructible, it means we are basically attesting to the fact and agreeing and saying that a Black man has zero ability to feel emotions, zero ability to feel empathy, zero ability to feel compassion. Now, if we are saying that, then why do we expect the same Black man to be, to show empathy towards us? Or to show emotions, emotions, like love and care? Because if Black don't crack and Black is supposed to be strong, Black showing love and showing care is a sign of weakness. So, we can't say be strong, but be weak at the same time. So it's, it's, we are all going to have to just rewire our thinking. [Participant 1]

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So flip, if why, if we were able to update things and stay abreast of technology, how dare we not do things like so called culture, which changes as and when the members change? So, I'm open to a new New World Order. [Participant 2]

You know, but I think it's so hard to separate, you know, your beliefs and what you've been told all along. It just becomes a little bit, an uncomfortable sort of space for most people but it's a necessary uncomfortable. Because the adverse of it, or the negative side of it is one where we end up in situations where a man will shoot himself and shoot his wife and his kids for fear of just being, of coming out as a gay man or for fear of seeking help because he's actually in debt. [Participant 8]

For so, it's a sin for what we actually share that it makes you less of a man. It doesn't. It's you and that is actually what you are going through. [Participant 7]

It's okay to not be okay. [Participant 6]

Some of the participants expressed not only a desire to change, but noted that it can change. However, they stated that it is going to be a multi-generational shift in our thinking and it begins with how fathers educate their children.

I think it can change but the one thing we need to make peace with is that it's going to be a multi-generational act. It's not gonna change overnight because as we speak now some of the toxic traits I mentioned are happening in the hood. It's school holidays. Kids are getting up to dumb stuff. It's multi-generational and I think it starts with men being better fathers to boy children. You know, allowing them to express themselves, allowing them to be comfortable. [Participant 6]

So, it's, I generally believe it's a parenting aspect. I think it starts with being better fathers. So, it's on us. It starts with being better fathers, one. It starts with being better friends. And when I'm saying about friends I am talking about conversations and calling our means out when we f up, you know. So, its when a friend of mine adopts a certain view, says something about a lady or does something or treats his nephew, or his little brother, or his son a certain way. Still being able to call that out and over time

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if we indoctrinate that and we raise kids that are not subjected to this rigid framework of masculinity that we've grown up with and I think then, over time, they will be better than we are even. [Participant 6]

I think, so there's this church that I used to go to and they used to like encourage this thing in like men, you know, for the family, that you are the leader of the household and you need to make sure that things fall in place, but like, the way children perceive men is like there's this big superhero, this monster of a dad and he's mine, and all of that, but they need to also understand the other side, that daddy is vulnerable, you know that he is fine having to tell mommy sorry, he's fine having to tell mommy I love you, he's fine having to tell mommy I had a bad day. Therefore, I can also say that to mommy, but the minute the father doesn't say that to the mom or doesn't engage in that kind of conversation the child grows up thinking that it's okay, dad was strong, which means I have to be strong. [Participant 5]

One of the participants is actively beginning to defy and change such masculinity constructs as he runs a support group for men, where they are free to openly discuss their difficulties and issues without fear of reproach. The group feels like it normalizes and gives a safe space for men to speak about their challenges.

I think we, we always put the rules out there, that this is a safe space. What happens in a session, stays in a session kind of thing. And we really, really just want to help one another. And fortunately, we've invited to these groups, like men who are very strong and proud and understand themselves and have been through things. So, it's nice to learn from them. It really, genuinely is. But yeah, I think, I think that's, that's, that's, yeah, I would say, it's one of the most important things. Like also, when we speak to people, like we kind of also try to let them know that like, there's no point in taking up being part of a platform and feeling like you need to lie or hold back certain things because then you are quite genuinely not dealing with anything. You walk out there feeling like you've got allies, good allies. [Participant 3]

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4.3.2. Sadness hurts, but sharing hurts more

Now that this research has considered the construct of masculinity and the participant's experiences thereof, it continues by focusing on the second theme of Sadness hurts, but sharing hurts more. In line with the research question, this theme encapsulates the participants' experiences of depression and help-seeking, both positive and negative, in a South African context. This theme follows on from the previous one as these traits are traditionally seen as conflicting with hegemonic masculine ideals. Another interesting aspect that arose during the interviews was how African culture influences such facets. This overarching theme is broken down into four subthemes, namely: Secret sorrows; Are you crazy?; I'm fine; and A foreign concept.

4.3.2.1. Secret sorrows

Before considering the participants' views on help-seeking, it is important to first highlight the men's experiences of depression. Thus, this subtheme emphasises the participants' struggles with MDD and emotional distress, as well as its effects on their lives. This is significant as such experiences of difficult and sad moments are intrinsically in opposition to masculinity expectations of men, i.e. that they have to be strong as emotions are perceived as weak and feminine. Hence, Secret sorrows.

> *So yeah. Was, a year ago was diagnosed with, I forgot what she wrote on a piece of paper. But in short, I am on AD's (Anti-depressants) as we speak. I am on anti-anxiety meds.* [Participant 2]

> *Look, you know, when you kind of feel like you are a failure, you should have done better and beating yourself up. If I got a rand for every time someone told me not to be tough on myself, I probably be retired, comfortably. So, it's being tough on yourself. Not using hindsight as a reflection, but using hindsight as a way to really relive and beat yourself up over and over again, which has not led to positive results… I've gone through those where going to class didn't make sense because I still fall asleep during lectures, still fall asleep during exams. So, that a physiological, it had a physical impact.* [Participant 2]

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I think, arguably, I can say for the last 28 years, I've been struggling with depression. And it's been depression that has been formally diagnosed with I think it's type, type two or type one, type two bipolar. [Participant 3]

It just feels like an empty place. A very empty place. It's like sitting in a house with no furniture and when you raise your voice, there's a massive echo. You know. That's, that's what depression feels like for me. It's, it's, it's, it's a draining emotion. It's an emotion that forces you to question yourself fairly and unfairly. I feel physical pain when it comes to depression. And I speak physical because like my heart is swore, you know. Like, not necessarily like putting your hand on the fire. But it's, it's painful because you question yourself to such a degree that anything can break you… Like it's, it's such, it's an empty, hollow, purposeless place to be. [Participant 3]

And I think, and I think like, it's just unfortunate, because directly depression affects you, but indirectly it affects so many people that are around you. It renders you incapable of confronting your demons. It renders you incapable of taking responsibility, you know, because depression is never my fault. It's always somebody else's fault. [Participant 3]

There are days where I go throughout the day and not eating and thinking that I'm fine, you know, but deep down I'm really just unhappy…. And whether it be crying or whatever, just wanted to cry until I was exhausted, until I slept. [Participant 3]

Ya, depression and anxiety… Depression is a mother, I am not going to lie to you. Depression is a mother, you will feel, you know you go into a dark place. You know, you go into a dark place where nothing makes sense, where you feel like participating in life or on life's terms doesn't make sense to you. You know, like everything that you feel is just sadness, you are consumed by the feeling of sadness. You know what I mean, you thinking, you breathing, you just being alive, it's just sadness. [Participant 4]

So you go into that state of depression where you feel like nothing can help you. You know what I mean, so and if you feel like nothing can help you, you feel so alone. And, you know, I remember there were days when I would even lock myself in my room and I'm watching TV and I'm trying to watch the funniest comedies I can find, but I would

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not even smile. You know what I mean, because I'm just in that depression mode, I'm just in a dark place. [Participant 4]

It affected my life, no, it was crazy, because imagine if you are living with someone and you can't really talk to them because you feel they don't understand you and they themselves on the other hand, they feel like you are selfish because you just want to be by yourself. You know what I mean… It was bad because even my kids were affected by that, because they want to be with their father but their father don't want anything to do with them and you affected because the very same people that actually avail themselves to you to talk about these things, it's people that you actually don't want to give the truth, your truth to. [Participant 4]

Ja, like I, there was a period in my time where after being overworked for quite some time, all I ever wanted to do was sleep and there was like nothing else. I never wanted to do anything else and sleep was just all I wanted, but I couldn't get enough of it… Mhm, I felt so lethargic. Like, as if you had no purpose, just moving is just a pain. You just want to be in one place, always. [Participant 5]

No, I've never really been formally diagnosed. I've had situations where I really did go through dark times. That were tough but in that, in those phases and in those times I didn't really have the resources. Or I wasn't, like, really comfortable just doing anything about it… I think I only realized and acknowledged that it was dark when I was, like, turning 27, 28. You don't realise it when you're going through it. And that's why it's so tough to get out of. [Participant 6]

I might not have perhaps recognized that. Everyone goes through that. Whether it is small. Everyone goes through society that could be caused by serious of factors. To be true a program at work called Wellness for all the, you know the stuff that have just sited right now. So, I've gone through depression but I could control it. It's not something that I couldn't, fortunate for me. [Participant 7]

I go through hollows. You've got ambivalence, feelings. Where you definitely need support. You think of where are the people that actually know you in terms of coming

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to aide. You just feel lonely. It's as if the world has been shut down up until it's you see possibilities of having to come with a remedy on your side. [Participant 7]

The thing is I don't know if I, I mean at the point, at the time maybe I didn't know that it was depression. But I've never, like, seen anybody professional where I've been diagnosed with depression or anything like that, but I mean if I think back, one of the first initial feelings of feeling, like, down or low is I think when I realised my sexual orientation. Then I could see the world around me was different, you know. And that I couldn't fit in that world. [Participant 8]

That's when I started to realise that, you know, my emotions, I mean, I remember one time saying it, saying to my friend, I feel like I'm in a room that is full of people but I can't talk to anybody and no one can see me, no one can hear me… I think sad, mainly. And a sense of not being in control or not able to control my environment or how I feel. [Participant 8].

The above quotations highlight the participants' struggles with depression. However, despite the men in the study experiencing such powerful feelings, they still expressed a view that they would not share such emotions. Although this research will delve deeper into help-seeking later in the study, this reluctance to share was due to masculinity expectations as well as the stigma surrounding mental illness.

For those who grew up in a suburban city, they know about psychologists and psychiatrists and they want to seek help, but the problem is how their peers will see them you know, it's you are shunned out of the masculinity community because you are different, you are too emotional for this role. [Participant 5]

All like our big experiences of when we do (speak about emotions) we are kind of pushed out, so our friends mock us or ridicule us, or our families think that we're strange, or it's those kind of experiences that reinforce it, I think. [Participant 5]

So, when you are with a group of friends and they don't talk about this, it means you won't talk about this. [Participant 5]

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You can't even tell your partner that you're having a bad day. You know, you, you will be traditionally looked at as a weak man, because why would you even say you're having a bad day? Why would you be feeling down? Why would you be everybody comes to you for answers. Lord forbid you have to go to someone else who answers, even go back to those same people because the same person who comes to you for answers, when you do go to them for a shoulder to cry on… you are frowned upon. [Participant 1]

We bottle it up over time because it's what society has. It's where, it's the position society has put us in. [Participant1]

And it's just so that you don't let people in or let people understand that you are in this state. You just rather have them think of you with what they have of you, as strong as they think you are in their head. [Participant 5]

I have a friend who currently deals with depression, but the way he deals with it is by talking to me and he cannot talk to anybody else, and the minute he does they engage in these family meetings where they discuss whether this person is crazy or whether the, you know, the Sangoma route… And he just wants an ear and people are like oh, that's not normal, you don't give an ear to this abnormality. [Participant 5]

So ya, ya, so it was crazy and I didn't know that was mental illness, growing up in a Black community, that's just being a sissy type of thing, you know what I mean. I was just a scared little boy and you never really want to address it. [Participant 4]

So it's that type of thing. Like for example like even me, when I had this panic attack or this anxiety attack, I couldn't talk to anyone about it until about four, five years ago… Ya, I'd say four years ago and then I was able to…you know, I actually have anxiety, you know what I mean, because it was difficult for me to just open up to people about it. Because they're like what is that? People don't even understand what that is… My friends would still look at me and be like this is crazy, now this some really craziness, you know what I mean. [Participant 4]

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So, it was even foreign with the people that I confided in cause they couldn't understand. [Participant 8]

4.3.2.2. Are you crazy?

Another subtheme that arose during the interviews when speaking about men's experiences of depression is the stigma surrounding mental illness in Black communities. It is noted that depression is a Westernised concept, where there is no word or term for depression in African languages. Thus, terms such as depression and mental illness as a whole are seen as foreign concepts, and as a result may be stigmatised in Black African communities. This is due to a lack of understanding and a belief that the person is crazy or has a calling to become a traditional healer.

No there aren't, there isn't, there aren't. I am well versed and I am fluent in most languages of the country and I can't think of a word (for depression). [Participant 2]

You know, given the dynamic of our country, growing up in a Black community, these things are not even spoken about. If you are one with something like this, you are thought of as a crazy person and you need to probably attend some rituals to be cleansed, because this is not how men should be acting. [Participant 5]

So, for them to see you in that state, they want to expel it from you but not try to understand. So, they're not solving the problem but they're just solving the condition, or what, ja, the condition of the problem. [Participant 5]

You know in those sessions but it's not a normal thing amongst Black people. It's not normalised and I remember even after I started going, when I mentioned it to my mom, firstly it was panic, like, what's wrong? Like, are you sick? [Participant 6]

As a Black man, right, we grew up with the mindset that… oh no depression, what's that? That's White people disease. A Black man doesn't get depressed because a White man gets depressed, a Black man never gets depressed. [Participant 1]

I think it's definitely true because I, because it's what we know we'll default to that, right. And there's also so many barriers within that kind of seeking help in the western

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way because of the way it's gonna be diagnosed. It's not a commonly described diagnosis within a Black context, right. [Participant 8]

Or you'd probably have a calling to be a traditional healer because that's what most people actually would that kind of put being depressed and you know psychosis with… Where it's like, oh, okay, that person does have depression, where most people would be, like, he doesn't have depression he's got a calling. It's two different things. [Participant 8]

4.3.2.3. I'm fine

Moving on from depression itself, this subtheme focuses on the men's experiences of help-seeking for such depressive symptomology. While not all of the men have actually sought professional help when experiencing distressing emotions, all of the participants provided their views and attitudes towards help-seeking. Some of the men in the study have positive views, being an advocate for men to ask for help and assistance when need be. However, the majority of the participants expressed a negative attitude, conveying their fear of being vulnerable when expressing emotions, as well as the stigma and ridicule that comes with such vulnerability. Thus, this subtheme is termed: I'm fine, as many of the participants would rather supress or cope with the emotions on their own than engage in help-seeking. Beginning with the positive attitudes, the men in the study had this to say:

I'm an actual activist. I have probably sent five or six of my friends who have gone through life issues to psychologists. I'm an avid proponent of mental health. I can think of five, six people on the top of my head. [Participant 2]

And then I said, wait, you know what, if ever it was a toothache, I would have quickly run to the dentist. It's something more abstract and perhaps more severe, so you need to go and get help… The reason I chose the tooth, as opposed to any physical thing is because mental health could be as invisible as your tooth, that no one sees that you're going through it. But boy does it hurt. [Participant 2]

And that's how I felt about my mental health. About my health as a whole. I believe, for me, help is important. Holistically. Physical, emotional, financial, spiritual, the works. [Participant 2]

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> *My advice is, there is no re-runs in this life so just do it as best as you can. If you need help, get help. Because I promise you it can be done better and more effective. And sometimes it means, it requires you choosing yourself. Which means, sometimes you need to go against the status quo.* [Participant 2]

> *We all seek assistance no matter what degree the challenge or circumstance is. There's no way that you can be resilient for eternity. It's just that we're fortunate, some are fortunate enough to be in a position to not to actually go through the extent of having to be depressed and so on and so forth. But we do seek help. There's no way that you can do it all by yourself.* [Participant 7]

> *There are a series of programs in this day and age that one could go consult at. It's even made at work you know where that Wellness programs are there. Help is out there depending on the person.* [Participant 7]

As noted above, while there were a few who had positive attitudes towards help-seeking, many of participants did not share similar views. The majority of the men in the study described their reluctance and difficulty with seeking help. This was mainly due to the fear of being vulnerable or the stigma and ostracization that comes with help-seeking as it is seen as unmasculine. This research will first focus on the instances where the men felt reluctant to seek help due to the fear of being vulnerable.

> *Yeah, it was very difficult. I think, trying to lay myself bear and still protecting myself as well. Where I didn't feel like I was in a completely safe space… Yeah, that is, it was like a third person experience, that I couldn't believe I was sitting here apprehensive about really sharing every particular detail about my life that would render me vulnerable. And that was the difficulty of really being vulnerable, was protecting myself, protecting my brand, protecting who I was, and protecting myself from lifelong vulnerability.* [Participant 3]

> *You know what I mean, they don't want to talk or somebody won't actually go into the psychologist or go to a counsellor and all of that, why because of that feeling of nakedness, you know, if people know your truth, you feel exposed, you feel naked and*

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that makes it awkward. So ya, people need to be educated about this illness. [Participant 4]

But then when I got there and now I have to talk about my feelings, I have to you know, address issues and things that I've been through in my life, that's when it got scary, I was like okay now this is too engaging, this is too, you know what I mean? Like it was now a bit difficult, so that's when it got scary, because now when I had to follow-up with sessions, I would just relapse and not go and things like that. [Participant 4]

Was always feeling like okay I can't really express that this is how I actually feel about certain things because if this is how I actually feel about certain things, people will look at me different, so I felt the same when I went to speak to the doctor, but then when I had to now open up about that, I fear rejection, I felt like the doctor will also look at me different. [Participant 4]

But I mean that's why it's difficult to go to actually a psychologist or a counselor because you feel like they're going to force you to acknowledge certain things. You know what I mean and that makes it not okay. [Participant 4]

You know what I mean, so ya, it comes from that type of thing and that does affect us mentally, it does affect… it affects us a lot mentally because these are the types of things that make us feel naked whenever we… we will crack whenever we have to speak about emotions, whenever we would have to speak about how we actually feel. [Participant 4]

And I've seen it happen definitely where because by accident a man has had to be vulnerable, it's sort of switched because that's what we're running away from, it's that being vulnerable and being exposed. You know. Yes, ultimately then you have to seek help, but I think before you even get there you have to admit that you don't have things under control. Your shit is not tight. [Participant 4]

Apart from such fear of being vulnerable, and being forced to confront difficult emotions, the participants noted that they would not seek help because it is not normalized for men. They expressed a notion that they would be ostracised and ridiculed because it goes against what is traditionally seen as masculine.

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So, for me it's not a skin colour matter. It's just across the board where people from various spheres, cultures, religions and so on and so forth do not really make use of psychiatrists, psychologists and so on and so forth. Medical doctors and so on and so forth with regards to our well-being. [Participant 7]

I just refused to have control over it and that ultimately resulted in the first blow up. That blow up, she (my wife) advised me to get some help. I was, I was really resistant to it. [Participant 3]

Yeah, you're not allowed to, you can't even say it. You can't even, like you can't even say to your friends… I went to see a shrink yesterday. Everybody's gonna laugh at you. [Participant 1]

I promise you, I can imagine sitting with, forgive my language, sitting with four or five of my Nigga's and saying to them… Yo, guys, can you imagine? It's been very hectic, I have been seeing a shrink for the last six months. Everybody's just gonna laugh at me. And they tell me you, you seeing a shrink? Nigga, you crazy. Dude, what are you seeing a shrink for? That's some White people shit. You know. Black people don't see shrinks. Aren't you a man? Are you not strong enough to handle your own shit? Der, der der, der. So to avoid getting ridiculed by your friends, you just don't even ask for help. You don't even, you don't bother asking for help. Like. You, you can't. [Participant 1]

Black people don't go see shrinks. Black people don't do that. I think it's, it's beginning to grow now. But the Black people who are going to see shrinks are women, not men, Black men do not see themselves going to see a shrink. A Black man can't bring himself to talk about his problems or his challenges. A Black man can't. [Participant 1]

The issue of a man's clinic amongst Black communities is still seen as a foreign thing. It's still seen as something that would be jokeable. You joke around that… Which I don't know why. It's something that people are going through. I mean we're going through extremes of stresses and depression and so on and so forth and it highly affects some of the organs. That telling your friends that I need a men's clinic, then it becomes something that people will actually laugh about. [Participant 7]

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Seeing a psychologist and talking about your feelings is frowned upon. How do we as Black males and masculine males really communicate, we sit around the table, we have a beer, we have a whiskey, we talk smack. We raise our issues at home, our issues in the workplace. [Participant 3]

So that is why these feelings, we, I'm going to say we because I'm Black too, there's this belief that feelings actually make you weak… And because they treat you already like you have no feelings, you also become okay with that and you prefer it that way, because nobody even asks you anymore how do you feel about certain things. [Participant 4]

There is that notion of big boys don't cry, real men don't cry. And that is another thing that I think is linked to it. Therefore, you can't seek help because you're not gonna fit the stereotype. [Participant 8]

So, the knowledge of what is there from a western perspective is there but it's also they're interacting with it differently because it's not for them, it's for their kids. So, therefore it's okay because it's their kids but with them having to admit that there might be a problem or that they've got issues, is them admitting, you know, to not only themselves but I suppose to family and to society that they don't have things under control. And that's a big part of obviously masculinity because you wanna have the control, right. [Participant 8]

It's not normal, and basically, you seeking for help is always denied to you because you're not supposed to. [Participant 5]

But I think one of the things that saved me was actually me being soft, my vulnerability, being okay with, like, eventually, like, saying I need help or I'm going to see a therapist, like… because if I was still the hardcore oke, I would have tried to suppress it and just tried to carried on. You know, and I think for me having that, it actually helps me. [Participant 6]

And even when I get home I have some form of advice that I got, rather than being stuck in one place, engaging in a form of alcohol abuse, you know, what society deems the

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normal way for us to seek help, you know. That, for me, is not a norm, but being ostracised is also like it's a painful thing, it's like you have to choose between a rock and a hard place… like the ostracization and be accepted in a world where you feel you don't belong, or go and seek help and be ostracised. [Participant 5]

One participant noted that due to notions that men are not allowed to seek help or acknowledge emotions, they would rather go to a doctor for physical symptoms as it is more accepted and not such a move away from masculinity expectations.

I think it's not wanting to acknowledge that it's an emotional thing. So we rather just address the fact that hey, help me eat well, help me sleep again and all of that but don't worry about my emotions, I think I can handle that, but just focus on me eating again, me sleeping again or me having relationships again and all of that. [Participant 4]

4.3.2.4. A foreign concept

It is clear from the above excerpts that the majority of the men in the study did not resort to help-seeking when feeling depressed or going through difficult moments. Above the possible reasons already stated, some of the participants explained that they do not seek help from psychologists or psychiatrists as it is still a foreign concept in African communities. Similar to the term of depression, the men in the study noted that psychology is a Western concept that is not yet normalized or familiar in African cultures. Thus, considering that this study is focusing on help-seeking within a South African population, some of the participants noted that they would rather seek help from a traditional healer or a Sangoma. These were seen as more sanctioned and accepted routes as it caters to their traditional beliefs.

It's like, okay, I have this condition, now what? You get, we know of GP's, we know of all these other people, but especially to the Black community something like a psychiatrist or psychologist is very unfamiliar. [Participant 5]

I would say within Black families or a Black construct, there is a, we don't default to seeking help, psychologically… Right, the default is probably something like no, you know what you need to consult your ancestors or there's something that you know you haven't done right in your past. Or you need to connect with your lost family members or whatever the case may be. [Participant 8]

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Because if you go to a traditional healer, chances are your mom, your aunt, your whoever, has gone to that same person probably. Or will be able to know what they're gonna probably come back and say to you. Or even understand and relate to what you're telling them… But the other spectrum or the other edge of it is that going the western route could probably actually even alienate you further because no one else that you would need to kind of understand what you're going through will be on the same page with you. Just because they haven't been exposed to that, so… I think it's definitely part of that. You know that not knowing what we don't know and being scared of what, you know, that exposure could actually bring along with it. [Participant 8]

And it depends on how to deal with it within the Black communities and so on and so forth. There are people that you can consult… We do have people that we do consult when we go to such mental states… Black communities cater for such chronic illnesses. There are people that you must see. There are people but they're not out there to have licenses and so on. [Participant 7]

Yes, Ryan, our Black being is more of a spiritual background. We have inner cycles that perhaps some races cannot recognize. And then they meet and those inner cycles, those inner challenges that are spiritual related needs what you may even call a sangoma or so on… So, there are instances or circumstances that would actually need the Sangoma approach. There are instances or circumstances that need a westernized approach. But then you would differentiate between the two. You know because some of those related spiritual would not reflect when you consult with a western approach. [Participant 7]

But when you go through a Sangoma or [foreign language 43:31] because of that African being, that spiritual related being then it would reflect and you'd actually get responses, good feedback with regards to whatever you need to perform at that stage whether it's a ritual or whether it's something that is customary related. [Participant 7]

So, in this, in as much as you are a Black person doing rituals on, you still need a western approach… You know because both lack, they either lack something. A western should lack a spiritual Black thing that I need and a Black approach, a Sangoma, would

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lack a western… So, they need to be complimented at the same time and they need each other at the same time. [Participant 7]

It's, ja, for those that grew up in not a suburban city like Johannesburg or something like that it's more of an acceptable thing, because when you are thought of as not being normal that is the direct route. For example, my father recently passed away, in like March, at the end of March, so like literally over a month ago and before that he literally was, he was thought to have been under some psychological nonsense, so they actually took him to like, what you say, a traditional healer and they tried all these things and it didn't work, but from what I saw over the past couple of years is, the guy was actually depressed. [Participant 5]

4.3.3. Dark days, take control

Although men experience depressed moods, it is clear that they often do no resort to help-seeking for a number of reasons. Therefore, this research then turned to the coping strategies that men employ in the absence of help-seeking in order to manage with such low moments. The men in the study both spoke about the negative, as well as the positive coping strategies that they employ in order to deal with depressive symptoms. This theme is thus entitled Dark days, take control. This could either refer to the dark days and depressive moods taking control and absorbing the men or the men taking control and managing to cope with the dark days. However, before looking at the coping strategies themselves, this research will first look at some of the participants' ideas on such coping strategies as they all had different definitions.

I would describe coping strategies as a mask. Yeah, it feels like a mask, a facade, definitely a facade. So, it really just helps you not be yourself. Because you hate yourself so much. That it allows you to be something or someone that you're not, that you deem is a better human being than who you can potentially be. [Participant 3]

For me it's anything that re-balances me. So, if I'm too angry or too happy, cause when I'm too happy, I'm fidgety, like, I can't be still and sometimes that's where it gets dangerous because I want to link up with friends and you may end up drinking too much and… right. Or when I'm sad, right, I tend to wallow in that feeling too long. Once I

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get over it. So, just to get me on the balance side that would be a coping mechanism for me. [Participant 6]

Coping mechanisms they just… it's a capital, it's like when a business needs capital to be able to succeed and I think coping mechanisms are exactly that, for you to engage in life, for you to progress, for you to go anywhere you need these coping mechanisms, you know what I mean and you don't live life alone and at some point you want to be in a certain group or belong to a certain society and things like that… So ya for me that is like the management of your own recovery through depression, through anxiety, through you know whatever for your mental health. [Participant 4]

I definitely think that self-care in my view is related to self-love, you know and self-love is about my well-being. Am I the whole person? Am I okay? [Participant 8]

Self-help to me is like finding a way for myself to be able to pick through the situation, whereas a coping strategy would be something for me to try and bypass the situation for the time being, knowing that I'm coming back later, but for the time being I would not like to be engaged in it. It's like sleeping, you know, if you are broke, unemployed, and all of that, going to sleep makes it go away, but the minute you wake up it's there, so that's like a coping strategy, sleep. [Participant 5].

4.3.3.1. Boys will be boys

A common theme throughout the interviews was the use of negative coping strategies in order to manage with depressed feelings. Whether the participants engaged in them themselves or saw it happening around them, many of them described the normalization of men engaging in alcohol, drugs, partying, aggression, womanizing, buying expensive items, and so on. These facets were seen as negative coping strategies that were standardized in allowing men to avoid or escape difficult emotions. Such coping mechanisms were also seen as a way to enact masculinity as it is more accepted and masculine than confronting or speaking about depressive moods.

You know, unfortunately, the society we live in, you would either have to be find a shrink to talk to and pay, pay for it. And if you can't afford a shrink, confide in your friends. Lord help you if you have good friends you can confide in, confide in your partner, if

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you have a partner who actually respects you. And understands where you're coming from, you know, and when, when, when, when we remove these three things off the table, no, shrink to talk to because you can't afford it, no partner to talk to because your partner just doesn't get it and will probably really call you, because you've probably tried to talk to your partner in the past and they told you that you're not a man. You know, and then you don't have friends you can actually confide in, like, deep, deep these deep things. You know, you're now pushed into a corner where you have to find other means, other outlets to get…. For me, I've tried a few things and I realised something's just don't work. [Participant 1]

And look I'll be honest with you, like you said, you know, some people some people find dangerous, or aggression as a form of release and you know us as men bottling our emotions, and our feelings, and our disappointments, and our hurts in, is I think that is to blame for a lot of the ill in our society. You know, we take it we take out our frustrations on children, we take out our frustrations on women, you know, the rise in GBV (gender based violence) in the country is stemmed from frustration for men. Let's, let's call a spade a spade, that's where it stems from you know. Men drinking too much, men finding releases in alcohol, going to taverns and just getting shit faced or wasted or drink too much and then you know, we can we can we can likein a lot of the ills we face in our society to depression and a lack of understanding of how to deal with it. [Participant1]

These are some of the things, these are some of the, some of the, some of the negative arguments we take as men, as Black men, this is some of the negative outlets we take to, to deal with our frustrations and our anxiety and depression, you know. Drink a lot. Womanise. Drugs. You know, not just the soft outlets, now we're talking going over, overboard with some very, very hard drugs, you know, as other form of dealing with or coping with, you know. And then another thing is, you know, some of the some of us who have, who can afford it, buy expensive cars and go shooting down the freeway as a form of outlet. [Participant 1]

Well, I think they do, right. I mean, I think seeking help is usually the last straw that people pick, but majority of the time it's in the negative way of coping, right. You know like you're saying, you overdrink, you have multiple sex partners, you, you know, you

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take drugs, you know, excessively. And you just try to do all these things to not deal with that emotion and with that feeling. Just to make that monster sleep. [Participant 8]

Even more towards the White community, the Afrikaans community, and the macho-ness is like even bigger. So, now everybody's going Bushveldting and you don't feel like it and they look at you like, bruh, why are you this way? We'll just crack a beer and you'll feel better. [Participant 5]

We all know drinking, simply because that's all you're used to. The womanizing, like, just getting women to make you feel better about yourself, right. Partying. I think excessive partying is one of the worst ones… Because you try so much to prove to people that you are okay. [Participant 6]

And sometimes you overexert yourself in order to try to prove that you are a man and that's where, like, the self-destructive decisions come. I went through that phase, you know, where I would want to prove that I'm, like, a whole. That was the source of like some of my worst decisions I've made. [Participant 6].

Because the guy that drinks the most is the man. The guy that sleeps with the most women is the man. The guy that parties the most is the man. You know, the guy that wins the most fights… is the man. Those are literally all the negative coping mechanisms. [Participant 6]

Am I that arrogant, pompous asshole when drinks, starts becoming very talkative and loud? Yeah, because I'm hiding things that I'm not. I will never get drunk and talk about how I feel like a failure. Oh, I feel depressed. I feel this. But I'll get drunk and tell you that, like, I'm, I'm on an upward trajectory in this field or that field? I'm running this. I'm running that, you know, and it's actually quite embarrassed… It's a massive bandage, I think. I think you are correct. I do think it distracts. I do think that it takes you away from the truth. I think it's, it's an element that heightens your denial. So, I do think that it actually has a negative impact. [Participant 3]

I then got sucked into, number one, it was first cocaine, and then it became ketamine. And as of recent, it was alcohol… Drinking was more of a naughty thing. That was just

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like fun. You know. I was just so exposed to it. So what then happened is that as time went on, there was a void that I couldn't fill. There was a piece about me that I could not understand. And subsequently drinking was a big part. So, I was trying, I started drinking copious amounts of alcohol long before I experimented with, with designer drugs. [Participant 3]

Ya they do, most of them, I think they use the substances just to numb those type of feelings. You know what I mean, just so that they can maybe cope with certain things, I mean when you look at the underlying factors of the culture or tradition, it's usually because of the trauma's that they went through from childhood and all of that. [Participant 4]

You know, and it speaks to the most natural state of, like, drinking a lot, you're partying a lot and also, like, I think what prolonged it was that I never really stayed alone. I always, like, I'd share an apartment with my mate and so forth, so when you have company, you hardly ever chill alone, like, you know… But at that time remember also, like, the circles that you're in or the spaces that you're in, unfortunately your peers don't celebrate the constructive side. People will be, like, fuck you're fun. You know, what a trip. You know partying and the women and whatever. So, like, remember in that moment, in that phase there wasn't anything forcing me to kind of zone out and reflect. [Participant 6]

Alcohol. You know, sex, and social media, you know, and you know also drugs, ya. I've actually seen… I've seen actually… I've seen people use that just to cope with their own lives, not just depressing moments, but also even their highest moments, you know… There's people that can't even deal with success and their only way to deal with success is by being high all the time, because it suppresses certain feelings because they have to be on all the time. [Participant 4]

For me, it became quite a social substance. And over and above it being a social substance, it became something that I relied on. To, when I was having a bad day, a good day, or whatever it was, I really just drown my emotions in alcohol. [Participant 3]

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4.3.3.2. You call yourself a man?

Apart from the negative coping strategies stated above, all of the men in the study either used or were open to using a myriad of positive coping mechanisms. In opposition to the negative coping strategies that served to distract or avoid from difficult emotions, the participants stated that these coping mechanisms helped them to engage directly in the emotions and feel better or lighter as a result. However, some of the participants noted that they did so in private and would not tell their friends. In contrast to the negative coping mechanisms being normalized and accepted as a way to enact masculinity, it was noted that the positive coping strategies are seen as more feminine, and thus harder to adopt due to the ridicule and ostracization that they would receive from their peers. For this reason, this subtheme is titled: You call yourself a man?

> *I go hiking. I enjoy my solo hikes. A lot of people like hiking, but they like to hike in groups. I hate hiking in groups. I would go solo, I will pack a backpack through my phone in there, I can play music off my phone. So a few snacks and edibles in there and I just go, kind of walk and walk and walk and walk and walk and walk and walk and walk.* [Participant 1]

> *And sometimes again, so this is another thing I do. I would find a little Kopie or Hill and climb it and just scream my lungs out. You know, just bellowed till there's no more air in my lungs. Yeah, for me, it's therapeutic… Release all that negative energy, all that tension. Just let it all out. Another thing I enjoy is a good massage.* [Participant 1]

> *So it's, it's such little releases that get me, get me relaxed. Another thing I enjoy doing, okay, because I love water. I love the sound of running water. I love the beach. I love, so I would travel you know, or so and I go to the beach, find a place to stay, quiet. Alone. Just sit on the beach. Listen to the sound of the waves. Feel the air on my face and just relax. The sound of running water somehow just heals me. So that I do. Or, I find a lake or stream and I sit by it. You know, listen to music, listen to soft jazz music or listen to some classical music… Just that calming effect, just soothes. And, you know, do an hour or two of that and I feel rejuvenated. So those are some of the escapes I take to find myself again.* [Participant 1]

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Okay, uh, well, another thing I do. I lost my father. About 20 years ago, 21 years ago, in 99. I had to grow up real quick. I had to, I had to as the first son, I had to grow up real quick, you know, and since then, so sometimes when I get stressed or depressed, and I feel like I need an outlet or someone to talk to I would sit in the car and just have a conversation with him. Or, or stand in front of a mirror… Because I've been told, well not like I've been told, I know, I look like him. You know? So I look in the mirror and try to see his face. And just tell him how I feel and what I'm dealing with and stuff. And for me that works because I feel lighter. At the end of that conversation, I feel lighter. I feel, I feel more relief at the end of that conversation because I mean, I'm not gonna fool myself. I'm not talking to anybody because he's not around. He's dead. He's not, I'm looking at myself in a mirror. I'm sitting alone in the car so it's not like I am talking to anybody… That action of talking out, you know, regardless of who's sitting across from you, or who's sitting, you know, works. [Participant 1]

You know, and then started with my dad, but it was reinforced by an older gentleman I had met back then who told me okay, you know what? Poetry. Put your words on paper. [Participant 1]

You know, and look, me, me, me finding my own little escape is just my own way of dealing with my own issues, without the repercussions of having people throw things back in my face or weaponizing things to throw back at me. You know, it's not ideal. I can promise you one thing, it's not ideal, but it serves a purpose… You know, I'll be temporarily there's some sort of, you know, I regain some of my happiness back. [Participant 1]

And I journal and I pray and meditate, I run, listen to music as often as I can. And like I said, keep as positive as I can over and above the medicinal side of things. [Participant 2]

I will wake up and do a check-in, and how am I doing today? What do I need to do to ensure I can succeed? What's on my to do list? And I take whatever small win I can. I'll never leave the house without having made my bed, regardless of how late I am. I would rather be become even later because that won't change. I always ensure that I feel, I've dressed nice enough, whatever that means. Smell good. [Participant 2]

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But I've chosen, I've leaned on my coping mechanisms, whether the Bible or whatever of that sorts. Podcasts or whatever to keep me going. [Participant 2]

I love a sense of accomplishment. There's nothing better than writing things on my book and scratching them off as done. Give me some sort of, even though I am failing at this so-called Life thing, I'm at least kicking ass at work. Or if I'm doing rubbish at work, at least I am kicking ass in my thingy. Nothing better than cruising my rings and my watch. Small things like that. Like I said, I'm a winner. And it's important for me to do that. That means I must watch sports and see my team do well, for gosh sakes. I don't care how they did it, messy or whatever. I'll find my win from there. [Participant 2]

So that's what I do. I ensure that I don't, I do emotional hedging Ryan, so that my happiness doesn't come only from myself, but through other things. And therefore, when this doesn't work, I catch there. If that doesn't work, I work there. If that makes sense. So that is my coping mechanisms and how I deal with the lows, to answer your question… So, like I said, I've hedged my happiness, if I can call it that. My happiness does not lie in the same bank. Therefore, whenever the balance is low here, I'm able to tap into that and people are able to say, hey, are you okay? This and that. [Participant 2]

Reading is one of my things and also just I've researched on everyday growth on my spirituality, you know what I mean and I think the more I deal with that the more I become at peace with a couple of things in my life. So, ya, research on spirituality is actually the number one thing… So I explore all types of spirituality and it just makes sense to me because I don't think there is actually any form of spirituality that doesn't actually help a person, you know what I mean. So, I think the more you research it and the more you explore these avenues and all of that, you find yourself. [Participant 4]

I usually… I usually would try by all means to find myself in other people. So, I see people using talking to someone as a strategy to cope, so I talk to people, you know what I mean. I see people using sports, you know, as a coping strategy, so I would also watch sports with them and like all of that, but I feel like it's more a connection thing. You know what I mean, if you connect with your fellow men, break bread with your

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fellow men, try and live through them, it makes you feel better about yourself, so I think also ya, that's one of the coping strategies that I've seen people do and that I also do and that's very positive. [Participant 4]

Ya, I think… I think it's like these things like your gym or your sports, all these other things, I think they are just a jar of things that people can do, but you don't want to do it alone, so I think like it's where we can actually just jump in and not express our feelings, but really just get things off us. You know what I mean, so it's more of a connection type of thing. [Participant 4]

As someone who loves to sort of plan out their life and, you know, sort of the passing of my day, like it just dampened my view of life, you know, and since engaging in mountain biking what I've seen is that it gives me an excitement for the weekend or for the week. I'm somebody who generally doesn't get excited for the next day because I know it's like repeat of everything. But if I'm in the group and I'm hearing beginners, this is what we're doing, it's not about the mountain biking, but it's the experience of the journey that you are in, you know what I'm saying, so it's the engagement you have with the different people, because at first you're like me, you don't know everybody's name. You call Alan, Rob, Rob, Alan. You call whoever, whoever, and then as time goes on you realise this is freaking awesome and you look forward to that engagement, because you're in a state of euthanasia that was impossible to you before. Before, you are done with your week there's all this loading in and what's the number one thing that men love to do to try and get over this, it's at a bar, you know, at the Irish Rock or something, but now, here's something different, it works out for you, it costs you nothing except you being voluntary. [Participant 5]

And it was a series of trial and error, like it was the abuse (alcohol), from the abuse it was the sports, the sports had a change in the abuse at work and that just furthered the growth, and that's just what I do now. [Participant 5]

I feel like it helps me like solve these negative emotions because I can have the most negative day in my life, and I go for a cycle on a Tuesday, we call it the social snails ride, and by the time I come back even, I've enjoyed the company of the people on the ride but it's like my mind goes into a state of lethargy for the negative, and by the time

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I come back I actually try to understand from what point of view that person came or engaged with me in whatever negative conversation they had… So, for me, it like clears out the mind and I'm like fully refreshed for anything. So, my life as of doing mountain biking I feel happier, I feel better, so even if I do spend like a week not mountain biking I don't get into that depressed state anymore or, you know, I fall back where I was. I'm just like, you know, Sunday is coming, looking forward to this, and it's not I'm avoiding the situation. It's like, look, it's going to be there but they say life doesn't get any, it doesn't get any easier. You just get stronger. [Participant 5]

But you get those elements, like the art. So, I find drawing, music again, you know. Lego. I mean, I had a very frustrating week the other time and I went and I got a Lego set in fact… And I think it took me fifteen hours and I built that entire spaceship, you know. On Lego, right. I was great after that, like, everything was off, you know. I was so, like, uplifted, flip in fact I haven't felt down since then. [Participant 6]

I think there's just beauty in creating. So, that's what art is. You create. So, if I'm drawing, right, and I'm angry or sad, I'll just put pen on paper, I don't even know what I'm drawing. And the more the picture comes out and then I see a complete picture. I feel so much better, you know. When I'm building a Lego it starts with just one thing… And then you keep building, building and then all of a sudden, flip, you've got a one meter long spaceship in your lounge. That's it. [Participant 6]

Even cooking, like, if I'm angry but I don't know what I want to eat and I don't want takeaways and I cook. And the meal is great and I'm, like, flip I'm already feeling better… So, even writing, so for me it's like creating. Like having something to focus, you know. I just think creating is calming. Being a creator is calming. [Participant 6]

Personally, it makes me be at peace with that. Yes, cause in most situations if I feel like that, stuff has already happened. So, it's like controlling the controllable and being at peace with it, you know, like. For me that's what it does for me, just being at peace with it. [Participant 6]

Yes, I do workout. I workout three times a week. I do various of things. I sometimes go fishing. I'm the man who is wanting to explore new things all the time. I'm working on

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my research as well. That is also relieving me from stress related matters even though it could sometimes bring stress. [Participant 7]

I interact with a whole lot of people. I'm always there. I don't have this perfect life but I try by all means to have my mind you know occupied with a whole lot of good things that are, trying always to avoid stress related things. [Participant 7]

Yes, every time I go to gym I feel much more better. Even if my cellphone. You know I'm this person that also loves, I love my space. I love to think. I love to bring all that spirits close to me. To rejuvenate myself and think about shaping my life, shaping my future and so on and so forth. [Participant 7]

So, I think that also does assist that you get to think. I get to drive about 30 kilometers and I'll probably go to the sea or beach and just think, you know. Take a book, write. Or whatever that is that is actually clouding my mind, I'll write about it… If I need help then I'll write a number, a person that I'll actually consult. So, those are the things that keep me busy even when I'm snowed under at work, I interact. I speak. [Participant 7]

Takes the stress away from me. I'd love to, I love making pots outside. I love my steak. I just love making meals. I think after this now, I'm going to go and cook… I'm going to go and make breakfast. It's just relieves me. [Participant 7]

I mean I would probably say the main thing is giving myself the space to actually deal with whatever I'm going through. Because I hate the notion or the feeling of something hovering over me. [Participant 8]

Yes, so I think I like to just be on my own if I'm going through a lot of stuff. Try and figure out a way to get out of whatever that situation is. Gym is a big part of it as well because you know, just, I enjoy the experience of going to gym and you know, just listening to music or I go for a run, you know or a walk. Or I'll just go to church and I'll just pray about it… You know, if it's something that's really bothering me and I'm not finding a way out, it's just like seeking help from a higher source, you know. [Participant 8]

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But, yes, I think it is, mainly through only, eating a lot. Chicken lickin, all the bad stuff, McDonalds you name it… And then once I've gone through that then it almost felt like I've purged and now I'm fine. And now I can be fine again. [Participant 8]

I think it's in the doing, you know. It's in the actual going to gym and seeing what happens to me afterwards. You know, how I feel after that… You know, I feel good, I feel renewed, I feel like there's a different energy you know that I'm carrying with me… You know, it just feels like things are different and it's just, I can, you know, like, it just feels like this, a different mood. [Participant 8]

I mean it depends on what I am using. I think if I go running or if I go to the gym or if I exercise, it's a form of not dealing with it right then. You know, it's a rather a form of I need to escape, right and that's how I do, like, detach myself from a situation. And then there's other instances where you know I do it, like, it's okay, (name omitted) you're feeling this way, because you haven't dealt with whatever and I think about why do I feel like that and I confront what I need to do in order for that feeling to go away, right… But I mean I would say most of the time, it's probably looking for like an escapism kind of mechanism but then when it's time to like deal with it then I do, but sometimes, you know, it's outside of a professional help, it's more with me knowing that this is the problem and this is the reason why I feel like this. How do I stop myself from continuing to feel like this? How do I make this not an issue anymore? [Participant 8]

Although the majority of the participants already had positive coping strategies that they employed to manage depressed feelings, participant 3 noted that he was still trying to establish some positive ones that help him in difficult moments. While he did have some ideas, he was still open and wanted to learn of a few more that he could implement. As such, we discussed some possibilities of positive coping strategies and he noted that he would try them to see if they work for him. This demonstrates that although he did not have many coping strategies of his own, he was open and willing to find ones that work for him.

We're so accustomed to the negative we actually don't think of the positive ones. [Participant 3]

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I think the one that I'm like working on now is like gym. A lot of gym. I still prefer to spend time alone. I really don't like big crowds. I will be a part of them if it's necessary. And when I'm part of them, I fit right in. You would never say, but I think my absolute preference is being alone. Just doing my own thing. [Participant 3]

I really don't know what other coping mechanisms I can basically implement. Maybe like spending time with my son. A lot more time with my son and my wife. [Participant 3]

Yeah, no. Thanks. I will definitely give one of those a good shot, especially the writing piece. [Participant 3]

As aforementioned, even though the participants employed positive coping strategies, they stated that they did so in private as they are often seen as feminine. The participants continued to note that they are harder to adopt due to the ostracization and ridicule they would receive.

And I think healthy coping mechanisms aren't always considered the manliest of things. Right. Again, growing up out of my soft element, whenever I was angry or sad or crying or whatever and in fact even happy, I would draw. So, my mom, I filled up sketch books like a mad man. [Participant 6]

So, like, that's my coping thing, right. I've got a sketching book now and I'm turning 34. If I'm frustrated, I will draw. But the thing is that when my peers were outside playing soccer or anything and I'm inside drawing… If my dad was home Monday to Friday, he'd tell me to go outside and play with the other kids. [Participant 6]

You know and for me it became okay whereas other guys go out to drink and whatever. So, this stuff, there's gym, there's drawing, I think in fact the best coping mechanism has everything to do with the art, hey… I find the art so amazing. Again, you are considered to be a bit more on the feminine side if you're a guy and you're doing music. I mean, I remember where masculinity got the better of me in Grade seven in boarding school, I was doing the violin and my matric said, no, no junior of mine is going to do the violin, that's a lady's thing, you know. [Participant 6]

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Like, all these things man. Like, maybe running will help or whatever but I'm thinking about it, the more you do stuff, like, I mean even woman will be, like, dude you are building a puzzle all day, what's wrong with you? You know. But it is that, like most positive coping mechanisms tend to lean on the feminine side. According to society, not that they are. [Participant 6]

Right, but meditating is always looked like you're soft. You're going through stuff. Yoga, let's think about gym… Most men go to the weights, they don't go to yoga. But, like, I'm inclined to believe yoga relieves more stress. You know, like, it's a better way of relieving stress. [Participant 6]

For the longest time I couldn't tell my friends that I wrote poetry, I'll be honest with you. A lot of my male friends don't know I write poetry or write poems. The females know. There are a few females I have encountered in my life that know I write poems, but not my male friends. It will shock them if they find out participant 1 (real name omitted) you write poems, what? We don't see you as such. We don't think you're that kind of guy because writing is for weak men. [Participant 6]

So, but again, it goes back to what you're used to. But it's kind of sad that the coping, the healthy coping mechanism are what's considered to be feminine, because it makes it tougher adopt really. [Participant 6]

Another interesting aspect from the interviews was that men were not only ostracised due to positive coping strategies being seen as feminine. One participant noted that he was ostracised from the Black community due to the perception that he was trying to be better than everyone else.

Ja, I'm telling you, like it's been one of these, so I think I since I started mountain biking like with your dad and the group, you know, I've been sort been thinking better about myself, but in the same sense being ostracized from my own community is quite a sad thing because I don't know, you know, I don't if you've seen but like in terms of mountain biking, not road biking, there aren't a lot of people of color in there, if I can put it like that. So, I think I, on the group I think I'm the only one of color, as far as I have seen, and everybody is so accepting and so like cool about it, like my own

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community, they just think that I'm trying to be better, you know, than them, but I'm seeking help. [Participant 5]

Yes, they yank you in. I've tried across a multitude of disciplines, so I play the guitar, all forms of electric guitars and the acoustics. I tried that and I got really good at that, but it's like, but why are you doing this when you could be here engaging in this form of abuse with us? So, I left that, I started running and there was such a big lack of support and the people that supported me were not the people from the hood, and I got out of it because I was like always like alone and then cycling was like, what, you know, there's always this humongous group. There's a variety of people from all sorts of disciplines in life from which you can learn from, engage in conversation, and for me having someone older than me, for example, your dad and the other guys there. [Participant 5]

4.4. Conclusion

In conclusion, this chapter began by outlining the results obtained from the BDI-II. This served as a reference point to assess the participants' mental and emotional state at the time of the interview. Subsequently, using Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis, this chapter presented the findings from the eight individual interviews that elucidated the experiences of masculinity, depression, help-seeking and coping mechanisms among Black men in South Africa. Namely, it depicted the themes and subthemes that emerged during the analysis, while highlighting the quotes from the interviews that illustrated such points.

The next chapter, Chapter 5, aims to consolidate the work of this research project. This is done be reviewing the preceding chapters and then linking the analysed data with relevant literature, as discussed in Chapter 2. The chapter is concluded by addressing the limitations of the study, prospective directions for future research, as well as a personal reflection regarding the research process.

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CHAPTER 5:

DISCUSSION

5.1. Introduction

This chapter aims to consolidate the work of this study. This is done in line with the research objectives outlined in Chapter 1, namely: 1) To explore South African men's attitudes to and perceptions of help-seeking for depression, and 2) To explore South African men's coping strategies, specifically emphasising men's positive or helpful coping strategies, in managing and/or coping with depression.

This chapter beings by reviewing the research design deployed by this research. Thereafter, the themes that were extrapolated from the eight individual interviews are then considered. Subsequently, a discussion on South African men's subjective experiences of help-seeking and coping strategies will follow, linking this study's data analysis with broader literature. By evaluating the analysis findings against the relevant literature in Chapter 2, this study serves to create a framework that can be used to conceptualise Black South African men's experiences of help-seeking and coping strategies. This will be followed by possible limitations of the study, as well as potential avenues for future research. Finally, a personal introspective reflection will be provided, where the investigative lens will be focused on myself as the researcher. A summary of the research findings conclude the chapter.

5.2. Review of the research design

In order to contextualise the findings and discussion that is to follow, a brief review of the research design is warranted. This study was grounded in the concept of social constructionism, the idea that "human development is socially situated and knowledge is constructed through interaction with others" (McKinley, 2015, p. 1). As such, this study adhered to the philosophical principles put forward by the interpretivist paradigm. Interpretivism suggests that humans are social beings who create and reinforce shared meaning through their interactions with others (Larkin & Thompson, 2012). Furthermore, considering that this research project was concerned with the personal experiences among South African men, a qualitative design, that was exploratory in nature, was deemed appropriate. Such design allowed the researcher to investigate how the men constructed their realities and made sense of their own experiences based on their subjective interpretations of the world around them (Larkin & Thompson, 2012). Finally, thematic analysis was deployed in order to analyse and interpret the data as it allows

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for the identification, interpretation and reporting of patterns within qualitative research (Tuckett, 2005). Specifically, Braun and Clarke's (2006) six-phase framework for conducting a thematic analysis was utilised.

The first phase of coding began when I read and re-read the transcribed data from the individual interviews. The different responses of the participants were then given codes in order to encapsulate the experiences of each individual. The codes that were relevant, richly described and occurred frequently were grouped together into various themes, subthemes, and categories. Such themes and subthemes were constantly cross referenced between the different interviews in order to refine them and identify the essence of each. Throughout the course of writing the research findings in Chapter 4, the different codes were revisited and refined again as new ideas developed, consequently implementing a recursive process. This fostered the development of identifying noteworthy ideas across the interviews and created a structure of three overarching themes.

5.3. Thematic structure of the analysis

The previous chapter provided a detailed account of the structure of the analysis. Based on the findings from the eight individual interviews, three overarching themes came to light, as well as several subthemes. An interesting note is that the titles of the themes and subthemes in the previous chapter were based on common language used in society that either implicitly or explicitly reinforces masculinity expectations. The first theme was Real men don't cry, encapsulating masculinity expectations and ideals. This was associated with the four subthemes of: 1) Man enough? 2) Black don't crack, 3) Don't be a sissy, and 4) Above men, we are human beings. This first theme drew attention to the participants' views on hegemonic masculinity. A significant discovery was the endorsement of masculine ideals that promote strength, autonomy and unemotionality among the majority of the participants. Due to public or self-stigma, the men in the study felt pressure to maintain this masculine image, irrespective of any emotional distress they were experiencing. This was no more apparent than in Black men's experiences as they noted that such hegemonic ideals are even more encouraged in Black African cultures. However, whether they subscribed to such notions or not, all of the men called for a dismantling of such masculinity dogmas.

The second theme was Sadness hurts, but sharing hurts more, focusing on the men's experiences of depression and help-seeking. This theme was associated with four subthemes,

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namely: 1) Secret sorrows, 2) Are you crazy?, 3) I'm fine, and 4) A foreign concept. It first emphasized the men's struggles with mental illness as well as its effects on their lives. Secondly, while some men advocated for help-seeking, most of the participants were highly driven to preserve an appearance of indifference to their depression due to the internalisation of prevailing masculine ideals. Publicly recognizing their depression and associated difficulties was perceived as an admission of weakness, and regarded as a move away from their masculinity. Finally, theme two highlighted that depression and help-seeking psychologically was a foreign concept in Black African cultures. A more accepted help-seeking route was to see a traditional healer or a Sangoma as they catered to the spiritual needs inherent in African culture.

The third and final theme brought to light the coping strategies, both positive and negative, that the men employed in the absence of help-seeking. This theme was termed Dark days, take control and comprised of two subthemes, namely: 1) Boys will be boys and 2) You call yourself a man? Focusing on the negative coping strategies first, it was noted that aspects such as alcohol, drugs, aggression, womanising, and so on, were a normalized and accepted way to avoid or supress the negative feelings while still enacting masculinity. Secondly, the chapter highlighted the positive coping strategies that the men deployed to manage and directly deal with the emotional distress they experience. However, the men in the study noted that they often did this in private as it was perceived as feminine and thus they feared being ostracised.

5.4. South African men's subjective experiences

Research has shown that males are less likely to seek intervention or health care compared to women and thus are more likely to experience functional impairments or fatal consequences (Möller-Leimkühler, 2002; WHO, 2020). Such poor morbidity and mortality rates among men have been linked to hegemonic masculinity expectations, and the health related behaviours of men that are often marked by a reticence for help-seeking. However, this study sought to fill a gap in the current literature as very few studies have been done on the South African population, and more specifically on Black African men. Moreover, given men's underutilisation of health services, it was crucial to evaluate how they manage their depression naturally or cope in the absence of clinical intervention (an area that is relatively unexplored). In light of the aim and objectives of this research, the next segment of this chapter seeks to conceptualise Black South African men's subjective experiences of help-seeking for

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depression and the coping strategies they deployed, based on the data analysis of the eight individual interviews. Thereafter, the broader literature pertaining to this subject is integrated.

5.4.1. According to the analysis

All the participants in this study either self-identified as depressed or were formally diagnosed therewith. This mental illness is generally related to emotional anguish and/or distress. However, the findings from the analysis indicate that a predominance of the men were primarily focused on upholding a semblance of strength, irrespective of their emotional difficulties or internal states. These men appeared to have internalised hegemonic masculine ideals, i.e., the socially defined and indoctrinated expectations of how they should act by virtue of them being male. These ideals fostered beliefs that the men should be strong, stoic, invulnerable, silent, independent, in control, unemotional and able to solve problems. Such socially reinforced discourses promoted the denial of emotions and weakness as an indication of character strength. Accordingly, men were taught to internalise feelings such as sadness in order to assimilate into acceptable masculine norms.

Being socialised into and having internalised such dogmas, the men in this study appeared to feel pressure to uphold these expectations as they attempted to fit into society. In other words, they appeared dedicated to the preservation of their internal experience of masculinity, as well as with their outward portrayal thereof. As a result, the men noted that subscribing to such ideals meant that they were not allowed to be weak, depressed, experience difficult emotions or have any bad days, due to the perception that real men do not show emotions. These notions were reinforced by common phrases of: man up, big boys don't cry, real men don't cry, and you're a man. As emotionality and the expression thereof is seen as a more feminine trait, the men stated their fear that they would be seen as weak, soft, or less of a man and thus demoted from their masculine position. Hence, the men expressed the need to rather hide or supress negative emotions, maintaining a façade or mask in order to appear indifferent to pain or distress. This can be seen not only in the analysis of the data but also in the recruitment of participants for this study. A number of men approached to participate in the study expressed their reluctance and fear of expressing emotions. They would rather hide or supress their distress as it is possibly seen as more feminine and a move away from masculinity constructs. The participants need to uphold this image was often associated to their fear of anticipated

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ramifications for infringing on these masculine ideals, such as shame, stigma and being ostracised.

The men in the study spoke about the consequences of stepping out of such masculinity norms. More specifically, they spoke about their experiences of gender specific stigma surrounding not subscribing to such strength-based masculine ideals, where friends and family would often ostracise them for being perceived as less of a man. Such ostracization occurred in the form of public stigma, where others would often mock, ridicule or reject them as society is less apt to accept a lack of emotional control and perceived weakness from a man. The men in the study appeared to internalise such public stigma, resulting in self-stigma whereby the men adopted society's views and began to believe themselves inferior or weak for having and expressing emotions. It became apparent from the analysis that such stigma, either from society or themselves, were strong enough to keep the men trapped in strength-based ideals of masculinity and the need to supress or deny negative feelings.

Such masculinity tenants and views were noted to be even more entrenched and encouraged in Black African communities, where the participants commented on how race and culture strongly intertwined with the concept. This was no more apparent than in the phrase of *Black don't crack*, which many of the participants had internalised and lived by. Considering that the term of not cracking meant not showing emotions or any form of weakness, this phrase encompassed the idea and belief that Black men are meant to be strong and invulnerable, irrespective of circumstances. This is especially true when considering most of the participant's role model of Shaka Zulu, a formidable and influential warrior in the Zulu kingdom. When asked about this, the participants provided two main reasons for this construct. Firstly, the participants noted that boys have to learn masculinity expectations from their mothers and societal norms, as many Black families grow up without a father figure being present in the home. As such, the young boys internalize the values and characteristics idealised by society, living up to such expectations, as it is their only understanding of what it means to be a man.

The second reason given was due to be the robust traditions inherent in their culture. The men in the study explained that Black families have a historical and traditional view that the man should be the head of the house. This fact is another confirmation that the research findings of this study can be firmly embedded in the social constructionism theoretical framework. This entails the men having to be the provider and protector for the rest of the family, requiring the

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need to fervently subscribe to the masculine norms of strength, invulnerability, unemotionality, leadership, autonomy, and independence. One participant even commented on the initiation schools that many boys have to attend in South Africa, where they learn what it means to be a man in order to take care of their families. He noted that they are taught such traditional masculinity traits as a form of survival. Using the phrase given by other men, the participant noted that if Black does crack, there is a belief that they will not survive. Given these generational and cultural aspects, it appeared as though the Black men in the study subscribed even more robustly to strength-based masculinity doctrines as they are taught and expected to embody such traits in order to fulfil their roles and survive both as individuals and for their families. Similarly, men appeared to uphold these masculine expectations and ideals due to the public and self-stigma they would experience when going against such norms.

According to the analysis thus far, the men in the study felt a pressure to uphold a semblance of strength. This image was a mask where they hid or supressed the reality of their internal distress in order to assimilate into strength-based masculine norms. However, the men seemed to be trapped behind these masks as they expressed a fear and reticence for admitting their depression or seeking help. Whether it was to those closest to them or to professionals, the majority of the participants felt unable to express their distress to anyone. This is because help-seeking was said to contradict with gender-related values related to strength and stoicism, such as not expressing emotions, as well as not feeling vulnerable or dependent on others. Therefore, seeking external assistance was seen as an alignment with femininity and hence an admission of weakness. The men appeared committed in not only preventing public knowledge of their perceived weakness but also avoided admitting this to themselves. This was due to both public stigma (a concern over the perceived negative judgments and ramifications from friends and family), as well as self-stigma (the embarrassment and shame the men felt due to their perceived personal failure). Along these lines, the endorsement of masculine ideals and the potential ramifications for stepping out of such norms appeared strong enough to withhold the men from help-seeking.

Furthermore, considering that the expression of depression was seen as unmasculine, the men in the study appeared to restore their identity by distancing themselves from feminine preferences such as emotionality. As a result, behaviours linked to vulnerability and weakness, as is in the case with help-seeking, were viewed in a negative light and avoided by the men. Thus, denying and masking their depression was one way that the men attempted to enact

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masculinity. In service of this, the participants appeared to not only be reluctant to seek help, but were also cautious and observant in disguising any signs indicative of their distress. This included the participants hiding themselves away from others during times of depression due to the fear of having their perceived weakness exposed. Consequently, in the men's endeavour to preserve a sense of masculinity, supressing their emotions behind an image that was discordant with their distress lead to compounded isolation.

Conversely, in the participants' description of their depressive symptoms, it was clear that behind the mask they sought to uphold were painful and distressing experiences that could potentially lead to fatal consequences. Men's account of their depression behind the façade of happiness were inundated by experiences of discontent, sadness, loneliness, withdrawal, impaired relationships, helplessness, hopelessness, impaired eating and sleeping, reduced motivation, and anxiety related difficulties. Regardless of the men's efforts to oppose or disguise their depression, it still had a considerable effect on the their lives and well-being. Therefore, attempts to preserve an image related to strength-based masculine ideals often resulted in an exacerbation of the men's distress, leaving them trapped behind their masks, unable to benefit from possible social support.

Despite the tendency of most of the participants towards inhibited help-seeking, the analysis revealed that there were a few instances where the men challenged the hegemonic masculine ideals. These men acknowledged the strength-based norms. However, they seemed to unapologetically reach out for help with regards to their distress. They similarly advocated for help-seeking and encouraged other men to do the same. In doing so, "these men revealed the fluidity of social constructs, such as masculine ideals, and negotiated its meaning" (Eksteen, 2015, p. 77). These men noted the advantages of doing so, as it led to medicinal intervention and social support, allowing for the alleviation of depressive symptoms. These men took part in "redefining help-seeking as a strength-based practice, as opposed to a sign of weakness" (Eksteen, 2015, p. 77).

Beyond the men's attitudes towards help-seeking for depression and how it is affected by hegemonic masculine traits, the analysis revealed the degree to which Black African culture influences such facets. It was noted that depression and psychology are Westernized concepts, foreign and unfamiliar in Black communities. There is reportedly not even a term for depression in African languages. This led to the thinking that depression is a *White illness,*

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stigmatised in African communities due to an understanding and belief that the individual experiencing such depressive symptomology is abnormal or crazy. This can be hard as Black men may not have the vocabulary or phrases to express their emotional state, and even if they did, their families and communities might not understand their experiences. Similar views were held towards psychology and psychiatry as it is not normalised within Black African communities. It can thus be said that it may be harder for Black men to express their depression or seek help via a psychological route in South Africa. This is due to the men not only having to compete with gendered stigma, but also the stigma received from their communities based on cultural perceptions. However, rather than hiding or supressing such emotions, the men in the study noted that they do have traditionally accepted help-seeking routes. This included traditional healers and Sangomas as they cater to the spiritual and ancestral needs inherent in Black African cultures. Thus, although Black men in South Africa may not seek help via the Westernized route of psychology, they do have practitioners they can see as a primary means of health care (including mental health).

It is clear thus far that although men experience depressive moods, they often do not resort to help-seeking for a number of reasons. As such, the analysis focused on the coping mechanisms that the men deployed in the absence of help-seeking in order to manage their low moods. A number of men in this study described negative coping strategies. Whether the participants engaged in themselves or saw it happening around them, many of them described the normalization of men engaging in alcohol, drugs, partying, aggression, womanizing, buying expensive items, and so on. This was done in order to numb, avoid or escape the emotional distress they were experiencing. Such negative and maladaptive coping strategies were seen as an accepted form of release of negative emotions. Despite these coping strategies being unhelpful or destructive, it was seen as a way of experiencing depressive moods while still enacting particular masculinities. This is for two main reasons. Firstly, by numbing or avoiding negative emotions, the men internalised their distress in order to assimilate into masculine norms. This was seen as a more accepted and standardised way to cope with such experiences rather than expressing emotions or resorting to help-seeking. Secondly, such negative coping strategies were noted to be celebrated by peers, as one participant stated that the person that drinks the most or sleeps with the most woman is seen as *the man* and the embodiment of masculine traits. As such, these negative or maladaptive coping strategies were done as a way to preserve the men's identity of masculinity, as well as prove to others that they are okay, further displaying their masculinity publicly and in the eyes of others.

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Apart from such negative or maladaptive coping strategies, all of the men in the study used, or were open to using, a myriad of positive coping mechanisms. This included a broad range of emotional, social, and cognitive coping strategies to maintain their mental health. In other words, instead of just reacting to problems as they arose, the men actively engaged in attempts to manage their depressive moods. These strategies included: gym or sporting activities, hiking, meditation, music, art in the form of poetry or drawing, engaging in spirituality or faith in a higher being, connection with others and improving social relationships, cooking, journaling, and a massage, to name a few. In opposition to the negative coping strategies that served to distract from or avoid difficult emotions, the men noted that such positive coping mechanisms allowed them to engage directly with the emotions and feel lighter or better as a result. While such positive coping mechanisms are seen as more masculine when compared to expressing emotions and engaging in help-seeking, the participants noted that they mostly deployed these strategies in private and would not tell their friends as they tend to lean towards the feminine side. Specifically, this included coping mechanisms such as: art, poetry, meditation, building a puzzle, playing a musical instrument, and yoga. As a result, in contrast to the negative coping mechanisms being normalised and accepted as a way to enact masculinity, it was noted that the positive coping strategies were seen as more feminine and thus harder to adopt due to the ridicule and ostracisation they would receive from their peers and family members. Hence, although these positive coping mechanisms were seen as more beneficial than expressing emotions or seeking help, men were noted to be more likely to engage in negative coping strategies as it is a celebrated way to enact masculinity and preserve the men's semblance of strength.

In summary, the analysis indicates that Black men in South Africa do experience depressed moods and internal distress. However, they deny such experiences due to their subscription of strength-based masculine ideals. They instead foster a mask of indifference to such pain by denying or supressing their emotions in order to assimilate into masculine norms. This was even more apparent in Black African cultures where hegemonic masculine norms were further entrenched and encouraged. Furthermore, public and self-stigma was commonly cited as a reason why the men felt the need to uphold this image of indifference and keep subscribing to such dogmas. This translated into the men's experiences and attitudes of help-seeking, where they would often reject or be reluctant to disclose their emotional distress due to the perception that it is more in line with feminine traits and thus a move away from masculine ideals. Another aspect introduced was how these concepts intertwined with Black African cultures. It was noted

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to be more difficult for Black men in South Africa to express depression or seek help psychologically as these are Westernised terms and foreign in Black communities. However, a more traditionally accepted help-seeking route was to go to a traditional healer or Sangoma. Considering the men's overall reluctance to seek help, they engaged in coping strategies in order to manage depressed feelings as this was more in line with the masculinity expectations of autonomy, unemotionality and problem solving. Negative coping strategies was a way for men to numb or supress their emotional distress while enacting masculinity. Lastly, while positive coping strategies were posited as a way for men to directly engage in negative emotions, they were noted to be harder to adopt as they were perceived to be aligned with more feminine traits.

Finally, an interesting finding in the analysis is that regardless of whether the men in the study subscribed to strength-based masculine norms or not, all of the participants expressed a need to dismantle and move away from this unrealistic ideal. They noted that men and society need to move away from such gendered expectations of what it means to be a man or a woman. Rather, the participants said that men need to be seen as human beings with emotions and problems. This was to break down, improve and give permission for aspects such as men being able to express emotions and engage in help-seeking. However, the participants noted that it is going to be a multi-generational shift, and it starts with how fathers educate their children. The men in the study stated that fathers and society as a whole need to begin normalising emotions in young boys, encouraging and giving permission to men to express feelings such as depression without the fear of ostracization.

5.4.2. Research analysis in light of broader literature

Certain similarities and inconsistencies were found when the analysis of the eight individual interviews were compared to the broader literature. This becomes the focus of the ensuing section, holding the data analysis of the study against relevant research findings in broader literature.

5.4.2.1. Men and depression

Research has consistently shown disparities between males and females in the prevalence and expression of depression. Namely, studies have shown that fewer men are diagnosed with depression compared to women (Van de Velde et al., 2010), with epidemiological findings

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indicating a one and a half to three fold greater prevalence of MDD among woman (APA, 2013). According to Afifi (2007), women also receive mental health care services far more regularly than men do. However, researchers Ogrodniczuk and Oliffe (2011) claimed that these reported differences do not signify the true prevalence of MDD as it has, and continues to be, under-reported in men.

While a variety of explanations have been proposed for these gender differences, some researchers have suggested that MDD may be under-reported in men due to the use of generic diagnostic criteria (Brownhill et al., 2005; Rice et al., 2013). According to the concept of *male depression,* men may experience atypical depressive symptoms (Kilmartin, 2005). This includes aspects such as hostility, substance abuse, aggression, irritability, and increased risky behaviour (Angst et al., 2002; Kilmartin, 2005; Möller-Leimkühler et al., 2007; Sigmon et al., 2005). In other words, literature suggests more externalising symptoms for men, which may in turn impede detection in primary care settings since standard diagnostic instruments are not sensitive to these male-specific symptoms (Möller-Leimküler, 2000; Sigmon et al., 2005; Wilhelm, 2009). While this study's analysis seems to confirm such externalising symptoms, as the men engaged in aspects such as aggression and substance abuse, it revealed additional experiences that were representative of the men's depression. This included: impaired eating and sleeping, reduced motivation, sadness, helplessness, hopelessness, discontent, withdrawal from familiar activities, impaired relationships, and anxiety related difficulties. Thus, while this research is not refuting the concept of male depression and its difficulty in being detected, the findings from this study indicate that the men did experience symptoms more common and in line with the DSM-5 diagnostic criteria for a depressive episode.

Another reason given by literature in order to understand such differences is the gender based norms of femininity and masculinity. Traits traditionally cited as feminine included gentleness, empathy, sacrifice, compassion, tenderness, emotionality, humility, and sensitivity (Thomas, 2001). Hegemonic/traditional masculine ideals, on the other hand, as conceptualised by Connell (2012) included the desire to appear powerful and successful (Ogrodniczuk & Oliffe, 2011), virile (Courtenay, 2000), invulnerable and strong (Emslie et al., 2006), self-reliant, and unemotional (Addis, 2008). Hegemonic masculinity was thus based on aggression rather than co-operation, toughness rather than vulnerability, strength rather than weakness, autonomy rather than dependence, and stoic endurance rather than emotionality (Howson, 2006). Branney and White (2008) stated that if this image is not upheld, men display expectations of being

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regarded as inferior, less desirable and as failures. Thus, Kilmartin (2005, p. 97) noted that men may "disguise their depressive symptoms" and use substances to blunt their negative feelings, while striving to ensure that others perceive them to embody traditional masculine norms (Mahalik & Rochlen, 2006). While considerably less research has been done in comparison, studies focusing specifically on the South African population have produced similar results. Kriel (2003, p. 38), for example, found that "hegemonic masculinity is a dominant and pervasive form of masculinity" within the South African context.

Similar findings to these were evident in the analysis of the eight individual interviews, where it was found that the participants capacity to align with masculine norms were associated with their self-appraisal, as well as their expectations regarding social acceptance. In other words, the men in this study corroborate broader literature, as their subscription to strength-based masculine ideals appeared to dictate their thoughts and behaviour. This meant denying or supressing their negative emotions and maintaining a façade in order to assimilate into such hegemonic masculine ideals. However, absent from such body of work appears to be the analysis finding that such masculinity dogmas are even more sanctioned and expected in Black African cultures. Whether this was due to generational or traditional factors as outlined above, the analysis revealed that Black South African men may have felt a greater pressure and inclination to subscribe to hegemonic masculine norms even more fervently than the general population. It was noted how many of the boys in South Africa even have to attend initiation schools, where they are taught how to be a man and embody such ideals. Thus, it can be said that due to many of the prolific researchers having studied such concepts using White, middle class men within Westernised cultures, literature pertaining to this topic lacks such cultural nuances and differences evident in this study's analysis.

5.4.2.2. Men and help-seeking

Taking such gendered constructions into account, research has suggested that gender differences emerge more in the expression of MDD rather than the experience itself (Brownhill et al., 2005). One prominent gender-based difference relates to help-seeking behaviour (Cusack et al., 2006; Doherty & Kartalova-O'Doherty, 2010; Levant et al., 2011; McCusker & Galupo, 2011; Möller-Leimkühler, 2002; Wenger, 2011). A growing body of literature has shown that, as a group, men of different ages, nationalities, and ethnic backgrounds (Kessler et al., 2005) seek professional help far less frequently than women (Addis & Mahalik, 2003; Fields &

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Cochran, 2011; Fridgen et al., 2013; Vogel et al., 2011). Specific to mental health, studies have found that men are half as likely to seek psychiatric services, psychotherapy, and counselling compared to women (Judd et al., 2008). The gendered construction of hegemonic masculinity and the subsequent stigmatisation is most often cited as the strongest influence for men's perceived reluctance to seek help (Courtenay, 2000; Lee & Owens, 2002).

Reviews of the literature suggest that male socialisation appears to shape detrimental attitudes and beliefs towards help-seeking in men (Gonzalez et al., 2005; Juvrud, 2013). It has been noted that the traditional hegemonic masculine characteristics/ideals that promote self-reliance, stoicism and strength are incompatible with help-seeking behaviours, such as speaking openly about health problems, seeking advice, and utilising health services (Courtenay, 2000; Mathewson, 2009). Several studies have noted how acknowledging emotional pain and seeking psychological help is seen as an alignment with femininity, and in turn implies a "loss of status, loss of control and autonomy, incompetence, dependence and damage of identity" (Johnson et al., 2012, p. 6). Due to this compromise of masculine identity, studies have suggested that men may refuse to seek help or choose to conceal their depression (Addis, 2008; Addis & Mahalik, 2003; Courtenay, 2000; O'Brien et al., 2005). This is supported by Branney and White's (2008) premise that the expression of MDD is perceived as un-masculine, and thus, denying depression is one way that the men might enact masculinity (Schofield et al., 2000).

These findings from the broader literature are comparable to experiences of the eight men in this study. Similar to the research already conducted, the majority of the men were fearful and reluctant to disclose their emotional distress and engage in help-seeking, as it was noted to conflict with the strength-based masculine ideals that they sought to uphold. Therefore, seeking help was viewed in a negative light and avoided by the men due to the perception that it was perceived as an alignment with femininity, and thus an admission of weakness. Rather, the men denied or supressed their experiences of depression in order to assimilate into acceptable masculine norms. This was due to both public and self-stigma, where the endorsement of masculine ideals and the fear of potential ramifications appeared strong enough that the men would rather risk their health before jeopardising their masculinity. This is consistent with existing research as Hoy's (2012) meta-ethnography of 51 different studies found that the most common barrier identified by men for their reluctant help-seeking was stigma.

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A predominance of the research on this topic has noted that the negative opinions society holds towards those who seek help (public stigma) has been noted as a crucial obstacle amongst men (Corrigan, 2004). Research suggests that men's anxiety over the perceived judgments of others seemed to dominate their concerns, where they spoke about fears of being ostracized, exposing their vulnerable self, or being made fun of for being perceived as weak, feminine, soft, or homosexual (Hoy, 2012). Additionally, researchers have suggested that men, in particular, may be more likely to be affected by and thus internalise this public stigma (Johnson et al., 2012; Primack et al., 2010; Vogel et al., 2007), especially men with higher levels of identification with hegemonic masculine norms (Hammer et al., 2013). This has been referred to as self-stigma, the internalisation of the negative beliefs of society towards mental illness and help-seeking. Accordingly, such stigma may impede the utilisation of needed mental health care, due to the act of seeking help being viewed as a personal failure or sign of weakness (Corrigan et al., 2014; Ojeda & Bergstresser, 2008; Vogel et al., 2007). This is commonly referred to in the literature as the gender role conflict, where the adherence to socialised gender roles results in restricting one's own behaviour or emotions and devaluing dimensions of oneself or others such as emotionality (Courtenay, 2000; O'Neil et al., 1986; Pederson & Vogel, 2007). For example, men who internalise the traditional masculine ideological view that they should be tough, competitive and emotionally in-expressive, would be less likely to communicate emotions even when they believe it may benefit them (O'Neil et al., 1986).

Although the analysis of the eight individual interviews appears to validate the extant research on gender-role conflict, the current literature is limited on the experiences of men who go against such traditional masculine norms and who seek help in spite of them. The analysis thus adds to this body of knowledge as it revealed a few cases where the men negotiated masculine norms and unapologetically sought help. As previously noted, rather than a sign of weakness, these men took part in redefining help-seeking as a strength-based practice.

Furthermore, considering that this research sought to specifically understand the experiences of Black men in South Africa, it is important to relate the analysis results to the broader research pertaining to this population. The analysis findings demonstrated that it was harder for the men to express depression or seek help psychologically as these are Westernised terms and foreign concepts within Black communities in South Africa. The participants expressed that they would rather go to a traditional healer or Sangoma as they catered to the traditions and beliefs inherent in the African culture. This appears to hold true when compared to broader literature,

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where stigma and misconceptions about the cause and severity of the mental illness are listed as common barriers (Corrigan, 2004; Sartorius, 2007), especially in poor resource communities, where culture has a profound influence on individual's lives (Ae-Negibise et al., 2010; Crawford & Lipsedge, 2004). Additionally, amongst Zulu individuals in South Africa, Crawford and Lipsedge (2004) found that mental health issues were considered to be only understood by traditional healers from their own culture. Nevin (2001) further found evidence that over 80% of the South African population will visit a traditional healer before visiting a Western medical doctor, as they provide a culturally relevant way of interpreting and treating the illness (Gilbert et al., 2002).

5.4.2.3. Coping strategies

Beyond help-seeking, research has also examined gender-differences in depression in terms of coping styles/mechanisms. While some researchers have found no consistent differences between men and women's coping strategies (Hamilton & Fagot, 1988; Pritchard & Wilson, 2006), others have found that women use more emotion-focused coping strategies (Day & Livingstone, 2003; Hong, 2007; Matud, 2004; Nolen-Hoeksema et al., 1999) whereas men use more externalising and maladaptive responses (Butler & Nolen-Hoeksema, 1994; Tamres et al., 2002). Safford (2008) noted that men who hold traditional masculine ideals might be more likely to engage in externalising and maladaptive behaviours such as acting out their feelings by using substances and/or by expressing aggression. These behaviours were said to signify a physical release of built up emotional pain (Brownhill et al., 2005), and are classified as "ways of doing depression that enact particular masculinities" (Branney & White, 2008, p. 6). Such acting out has been hypothesised as masked depression, where men numb, avoid, or distract themselves from distressing emotions (Addis, 2008; Cochran & Rabinowitz, 2000). Thus, according to O'Brien et al. (2005), it may be preferable for a man to mask his depression by controlling and being silent about negative affect, rather than the perceived loss of masculine identity that comes with externalising his emotions.

The analysis of this research appears to confirm such literature. Whether the participants engaged in them themselves or saw it happening around them, many of them described the normalisation of externalising behaviours when they felt depressed. While this comprised of behaviours such as substance abuse and aggression as in the literature, the analysis added to this knowledge as the men included additional aspects such as partying, womanizing or buying

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expensive items. Such negative and maladaptive coping strategies were seen as a way to numb, avoid, or escape emotional distress, while still enacting particular masculinities. In agreement with existing research, this was seen as a more accepted and normalized way to cope with depressed feelings rather than expressing emotions or resorting to help-seeking. However, an additional finding in this research was that such maladaptive behaviours were also celebrated by other men, as one participant noted that the man that drinks the most or sleeps with the most woman is seen as *the man* and the embodiment of masculinity traits.

Although the predominance of existing research has focused on the unhelpful ways men try to cope and/or manage with their depression in the absence of clinical intervention, some research has identified the positive coping strategies men use. Similar to the findings of this research, Proudfoot et al. (2015), as well as Fogarty et al. (2015) noted that the men in their study either used or were open to using a broad range of strategies to maintain their mental health. Examples from Proudfoot et al. (2015) included reading, writing, listening to music, speaking to friends and family, exercising, having sex, and going outdoors. The men in this studied echoed such results, as well as expanded on positive coping strategies by providing a few of their own. This included hiking, meditation, art, spirituality, cooking, and a massage, to name a few. Furthermore, in opposition to the negative coping strategies that served to distract or avoid difficult emotions, the men noted that such positive coping mechanisms allowed them to engage directly with the emotions and feel lighter or better as a result. However, although the findings from this study confirm and add to the already existing body of knowledge, there is one major dissimilarly between the two. Fogarty et al. (2015) noted that the men in their study described comfort with using these strategies as it helped them to feel in control of their problems without conflicting with social expectations concerning manliness. Conversely, the participants in this study gave a different account. They noted that such positive coping strategies, while still preferable than help-seeking, were aligned with femininity traits and thus harder to adopt due to the ridicule and ostracization they would receive. Hence, men were noted to be more likely to engage in negative coping strategies as it was a celebrated way to enact masculinity. This account of positive coping mechanisms being perceived as feminine is absent from the dominant literature.

To conclude, the preceding section brough to light the findings from the analysis and the broader literature that indicated a discrepancy between the impression of indifference that the Black South African men sought to uphold and their experience of MDD behind this mask.

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Similar to the analysis, the literature also indicated that the incentive behind this was men's desire to exemplify strength-based masculine ideals. Their affiliation with masculine norms and the perceived stigma as a result of stepping out of such ideals restrained the men from acknowledging their depression and seeking help. Thus, men turned to coping strategies, both positive and negative, as a way to manage such depressive symptoms. However, another aspect that is absent in broader literature that came to light in the analysis was the participants' view that strength-based masculine norms need to be dismantled. The participants stated that society needs to begin to normalise emotions and help-seeking, viewing men as human beings rather than with the gendered lenses of what is expected of men and women. This discourse appears to be lacking in dominant literature and understandings.

5.5. Limitations of the study

During the course of this research, a few limitations came to light. Firstly, the size and selection of the sample could be considered a potential limitation. This research was qualitative in nature and thus utilised a small sample size of eight participants. This was done in order to provide rich, in-depth accounts and experiences of the men themselves. However, as a result, the findings of this study are very specific to this sample and therefore lack generalisability and transferability. Moreover, due to the Black South African sample, the research findings may also not be generalized to the broader South African men population as it consists of other major cultural groups. The fact that only Black South African men were selected was the result of the snowball sampling technique that favoured a more homogeneous group of participants that share similar backgrounds, cultures and values. Rather than a limitation of this study, it could be considered a strength as it provided a more focused enquiry on a particular group, namely Black South African men that are not well represented in current literature. A further aspect in relation to this was the sample itself. Considering that the sample comprised of both individuals who were formally diagnosed with depression as well as participants who just felt that they had experienced a depressive episode, the sample lacked homogeneity. In other words, the sample consisted of individuals who sought and received professional help as well as those who had never engaged in such services. This could be considered a limitation of the research as their views were integrated and reflected on as a whole, despite the potential that they may have had different attitudes towards help-seeking by virtue of their engagement with such mental health care.

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A second limiting factor of this study could be that it was conducted solely in English, with all of the participants needing to be fluent in this language. Seeing as this research focused specifically on Black men's experiences, it could have excluded a large number of potential participants and their perceptions. Beyond this, significant cultural knowledge and description may have also been lost in translation with the participants interviewed. In other words, cultural nuance may have been compromised when the participants tried to explain their experiences in a language other than their vernacular. However, due to the researcher's linguistic fluency limitations as well as in light of the context of a mini-dissertation and the financial as well as time constraints, a translator was not pragmatic.

Thirdly, due to the aim and objectives of this study and time constraints, new and interesting developments that arose during the analysis could not be explored further. This included sexual orientation, rural versus urbanised perceptions, the role of traditional healers and Sangoma's, cultural nuances, upbringing in terms of whether the participants were raised by a male or female, and role models such as Shaka Zulu. The lack of detail regarding the impact these features had on the participants' experiences of depression, help-seeking and coping mechanisms, limited the study's capacity for discussion on these matters. This is a limitation of the study considering research such as Schwartz and Montgomery (2002), finding that facets such as sexual orientation and acculturation can potentially influence an individual's experience of mental health aspects.

The final limitation of this research was the fact that the interviews were conducted online via Zoom calls. This was due to the social distancing restrictions placed by the COVID-19 pandemic. While it was useful to have such technology in order to conduct the interviews, this proved to be a limitation for two main reasons. The first being the unreliable nature of technology, where at times the interviews would buffer or cut out due to connection difficulties. This not only interrupted the interview process and made it frustrating for both the participants and the researcher, but certain words or sentences were lost during the interviews due to such connection issues. As such, although the researcher asked the participants to clarify certain aspects, nuances regarding the men's experiences may have still been compromised. Secondly, a degree of personal connection and relationship between the researcher and participants was lacking due to the interviews being conducted online. In other words, it proved difficult to establish the same rapport with the participants that would have been gained if it were done face-to-face. Considering the sensitive nature of the topic as well as men's overall reluctance

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to express emotions, it is possible that the participants may have been reserved or guarded with their answers due to such lack of rapport. This is an important limitation to consider as it might have affected the quality of the results and analysis in this research.

5.6. Areas for future research

A noticeable gap was found in the current literature, where there was a lack of research on this topic within the South African context, and specifically on Black men's experiences. While this study has made some attempts to fill this gap, it is recommended that ongoing research be conducted in this area. Future research could assess the validity of these findings among Black South African men, or explore the prospect of different or supplementary themes within this population. Moreover, considering the various cultural groups within the South African context, prospective studies could explore the differences and/or similarities between these diverse and multiple cultures. The more traditional help-seeking route of Sangomas could also be explored in further research, assessing the impact that masculinity expectations have on this form of help-seeking.

Furthermore, due to this research being limited by a number of factors, it may be useful for future researchers to carefully consider these limitations and cater for them. As such, forthcoming projects could explore the impact that facets such as ethnicity, acculturation, sexual orientation, and upbringing could have on this population's experiences of depression and help-seeking. More direct interest could additionally be afforded to those who stepped out of masculine norms and sought help, as well as on the men's accounts of needing to dismantle strength-based masculine ideals. Lastly, although this research added to the current gap regarding coping mechanisms (specifically the positive coping strategies) men utilised in order to manage their depression, further research is called for in this area. Future research can not only explore positive coping strategies in more detail but also study the unique findings from this analysis, namely that men are more likely to engage in negative or maladaptive behaviours rather than positive coping mechanisms.

5.7. Personal reflection

As the researcher, I will now turn the investigative lens on myself. Throughout this study, I had to be mindful of myself in order to appreciate how my own position within the research might have impacted my choice of subject, methodology and analysis of the identified themes (Treharne & Riggs, 2014). In other words, I had to be conscious of my own emotions, biases,

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and attitudes, and the influence it could have had on my understanding and interpretation of the data. This is crucial as in qualitative research, and according to my interpretive paradigm, my role has been vital to the research process (Treharne & Riggs, 2014).

I am a White, 26-year-old male. I have been interested in the topic of depression and masculinity for as long as I can remember. I first encountered such concepts through my father when I was a young boy. My father displayed traits indicative of a depressive episode. He often felt lethargic, sad, angry, hopeless, helpless, and would self-isolate from the rest of the family. Although I did not yet have the terminology for such experiences, my family and myself could recognize such symptoms and the fact that my father was struggling. However, despite this internal distress, my father consistently exhibited a reluctance to seek help. I was often inquisitive and baffled growing up by this reticence for help-seeking, especially considering his emotional struggles. With such questions and curiosity at the back of my mind, I had my own experiences with strength-based masculine ideals. This included the notions of big boys don't cry or man up when I hurt myself or displayed any emotional distress.

Such experiences were only entrenched later on when I went to an all-boys high school. During that phase, any signs of emotion were now linked to homosexuality and/or femininity. It was not long until I bought into such dogmas myself, later agreeing with my father's actions of not seeking help. This changed when I entered university and began learning about such topics, where I started to question and step out of such masculine ideals. However, when I did, I was quickly met with stigma and ridicule from others. This initiated an internal conflict of whether I go against such status quo or step back into and subscribe to masculine norms. This only sparked my interest and questions further regarding masculinity, wanting to know more about the topic and understand other men's experiences more in-depth. As such, I conducted my first research enquiry into this topic for a paper I had to submit in my third year of my undergraduate degree. I explored men's perceptions on *Men's Health* magazine, researching whether they felt the need to live up to the ideals portrayed. This path has led me to this research dissertation.

After doing more research of my own on the topic, I found a body of literature linking strength-based masculine ideals to men's reticence for help-seeking. This reminded me not only of my experiences but also those of my father, where he appeared reluctant to seek help for his depressive episodes. After exploring into this research further, I found the first gap of a disproportionately small number of studies having directed their attention to the South African

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context, and more specifically on Black men's experiences. I thus chose this as my topic for my research mini-dissertation. Moreover, when collecting studies for this research, I further noted that a predominance of current literature focused on the negative coping strategies men deploy in order to manage their depressive symptoms. This sparked an additional interest considering that men do utilise positive and/or helpful coping mechanisms, engaging in a few myself. As such, considering men's reluctance to seek help, I thought men and public health messaging could use the positive coping strategies identified by this research in order to manage their depressive symptomology in a helpful manner. This rounded out my subject of inquiry that informed my mini-dissertation.

Thus, it is clear how my own experiences throughout my life informed this research. It can also be said to have influenced my data collection and analysis as I focused on how the men constructed and understood their realities based on their own subjective interpretations. I had to be aware and mindful of these biases throughout the research process in order to restrict them from influencing my interpretation and analysis of the findings. However, I am of the opinion that my genuine curiosity and interest in this topic allowed for the analysis to be an authentic representation of the participant's views. In other words, while my own experiences influenced the initial choice of topic, I don't feel that they swayed the interpretation or reporting of results as I was sincerely interested in the candid, real and legitimate experiences of the men in the study.

5.8. Conclusion

In conclusion, the aim of this research was to enhance the understanding of the existing research on South African men's experiences of depression and help-seeking, as well as their utilisation of coping mechanisms. As such, this study answered the research question by means of a qualitative study that deployed thematic analysis. The data analysis that followed produced various themes and subthemes within these men's experiences according to the eight individual interviews conducted. The themes were: Real men don't cry; Sadness hurts, but sharing hurts more; and Dark days, take control, and were related to several subthemes. These themes and subthemes were then considered in light of broader literature, establishing a framework that could be used to conceptualise South African men's experiences of help-seeking and coping strategies. This research is of utmost importance considering that men with depression are considered as an at-risk group, with males being less likely to receive intervention or health care compared to women, and thus more liable to experience functional impairments or fatal

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consequences. Therefore, men and future public health messaging could capitalise on this research in order to improve help-seeking and self-management behaviour among this population. This is particularly relevant considering our current context of the COVID-19 global pandemic.

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Reference list

Adams, Q., Collair, L., Oswald, M., & Perold, M. (2004). Research in educational psychology in South Africa. *Keys to Educational Psychology*, *1*, 353.

Addis, M. E. (2008). Gender and depression in men. *Clinical Psychology: Science and Practice*, *15*(3), 153-168. https://doi.org/0.1111/j.1468-2850.2008.00125.x.

Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, *58*(1), 5-14. https://doi.org/10.1037/0003066X.58.1.5.

Ae-Ngibise, K., Cooper, S., Adjibokah, E., Akpalu, B., Lund, C., Doku, V., & Consortium, T. (2010). Whether you like it or not people with mental problems are going to go to them: A qualitative exploration into the widespread use of traditional and faith healers in the provision of mental health care in Ghana. *Internal Review of Psychiatry*, *22*(6), 558-567. https://doi.org/10.3109/09540261.2010.536149.

Afifi, M. (2007). Gender differences in mental health. *Singapore Medical Journal, 48*(5), 385.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: American Psychiatric Association.

Andrews, T. (2012). What is social constructionism? *Grounded Theory Review*, *11*(1), 39-46. https://doi.org/10.4135/9780857020147.n125.

Angst, J. (1997). Epidemiology of depression. In A. Honig, & H. M. VanPraag (Eds.), *Depression: Neurobiological, psychological and therapeutic advances* (pp. 17-29). Indent Chichester, US: John Wiley & Sons.

Angst, J., Gamma, A., Gastpar, M., Lepine, J., Mendlewicz, J., & Tylee, A. (2002). Gender differences in depression. Epidemiological Findings from the European DEPRES I and II Studies. *European Archeology of Psychiatry and Clinical Neuroscience, 252,* 201-209.

Aronson, J. (1995). A pragmatic view of thematic analysis. *The Qualitative Report*, *2*(1), 1-3. https://nsuworks.nova.edu/tqr/vol2/iss1/3.

Attard, A., & Coulson, N. S. (2012). A thematic analysis of patient communication in Parkinson's disease online support group discussion forums. *Computers in Human Behavior, 28*(2), 500-506. https://doi.org/10.1016/j.chb.2011.10.022.

Attride-Stirling, J. (2001). Thematic networks: An analytic tool for qualitative research. *Qualitative Research, 1*(3), 385-405. https://doi.org/10.1177/146879410100100307.

© University of Pretoria

Attwell, P. A. (2002). Real boys: Concepts of masculinity among school teachers. (Unpublished master's dissertation). Department of Psychology, University of KwaZulu-Natal, Pietermaritzburg.

Babbie, E., & Mouton, J. (2001). *The practice of social science research.* Belmont, CA: Wadsworth.

Bebbington, P. E. (1998). Sex and depression. *Psychological Medicine*, *28*(1)*,* 1-8. https://doi.org/10.1017/S0033291797006065.

Beck, A. T., Steer, R. A., & Carbin, M. G. (1988). Psychometric properties of the Beck Depression Inventory: Twenty-five years of evaluation. *Clinical Psychology Review*, *8*(1), 77-100. https://doi.org/10.1016/0272-7358(88)90050-5.

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*(6), 561-571. https://doi.org/10.1001/archpsyc.1961.01710120031004.

Berger, J. M., Levant, R., McMillan, K. K., Kelleher, W., & Sellers, A. (2005). Impact of gender role conflict, traditional masculinity ideology, Alexithymia, and age on men's attitudes toward psychological help seeking. *Psychology of Men & Masculinity, 6*(1), 73-78. https://doi.org/10.1037/1524-9220.6.1.73.

Beyer, J., Du Preez, E., & Eskell-Blokland, E. (2007). Social constructionism. In M. Visser (Ed.), *Contextualising community psychology in South Africa* (pp. 37-50). Pretoria, South Africa: Van Schaik.

Black, I. (2006). The presentation of interpretivist research. *Qualitative Market Research: An International Journal*, *9*(4), 319-324. https://doi.org/10.1108/13522750610689069.

Blazer, D. G., & Hybels, C. F. (2005). Origins of depression in later life. *Psychological Medicine*, *35*(9), 1241-1252.

Bloor, M., & Wood, F. (2006). *Postmodernism: Keywords in qualitative methods*. London, UK: Sage Publications Ltd. https://doi.org/10.4135/9781849209403.

Boddy, C. R. (2016). Sample size for qualitative research. *Qualitative Market Research: An International Journal*, *19*(4), 426-432. https://doi.org/10.1108/QMR-06-2016-0053.

Bos, J. (2009). The rise and decline of character: Humoral psychology in ancient and early modern medical theory. *History of the Human Sciences, 22*(3), 29-50. https://doi.org/10.1177/0952695109104422.

Boyce, W. T., & Ellis, B. J. (2005). Biological sensitivity to context: I. An evolutionary developmental theory of the origins and functions of stress reactivity. Development and Psychopathology, 17*,* 271-301. https://doi.org/10/1017/s0954579405050145.

© University of Pretoria

Branney, P., & White, A. (2008). Big boys don't cry: Depression and men. *Advances in Psychiatric Treatment*, *14*(4), 256-262. https://doi.org/10/1192/apt.bp.106.003467.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77-101. https://doi.org/10.1191/1478088706qp063oa.

Brickell, C. (2006). The sociological construction of gender and sexuality. *The Sociological Review*, *54*(1), 87-113. https://doi.org/10.1111/j.1467-954X.2006.00603.x.

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). 'Big build': Hidden depression in men. *The Australian and New Zealand Journal of Psychiatry*, *39,* 921-931. https://doi.org/10.1080/j.1440-1614.2005.01665.x.

Burke, H. M., Davis, M. C., Otte, C., & Mohr, D. C. (2005). Depression and cortisol indent responses to psychological stress: A meta-analysis. Psychoneuroendocrinology, 30, 846-856. https://doi.org/10.1016/j.psyneuen.2005.02.010.

Burr, V. (2000). *An introduction to social constructionism*. London, UK: Routledge.

Burr, V. (2003). *Social constructionism* (2nd ed.). New York, NY: Routledge.

Bushell, P. (2006). An exploratory study considering the perceptions and patterns of help seeking amongst adolescent boys, with a special focus on how ideas of masculinity might promote or act as a barrier to this process. (Unpublished honours project). Department of Psychology, University of KwaZulu-Natal, Pietermaritzburg.

Butler, L. D., & Nolen-Hoeksema, S. (1994). Gender differences in responses to depressed mood in a college sample. *Sex Roles*, *30*(5-6)*,* 331-346. https://doi.org/10.1007/BF01420597.

Caperton, W. D. M. (2015). Stay-at-home-father navigation depression: A consensual qualitative research study. (Unpublished doctoral thesis). Department of Philosophy, Marquette University, Wisconsin.

Carhart-Harris, R. L., Mayberg, H. S., Malizia, A. L., & Nutt, D. (2008). Mourning and melancholia revisited: Correspondences between principles of Freudian metapsychology and empirical findings in neuropsychiatry. *Annals of General Psychiatry, 7*(1), 9. https://doi.org/10.1186/1744-859X-7-9.

Carter, R., & Golant, S. K. (2012). *What to do when someone you love is depressed: A self-help and help-others guide.* New York, NY: Random House Publishing Group.

Chadwick, A. K. (2007). Constructions of masculinity and masculine identity positions within a group of white university students. (Unpublished master's dissertation). Department of Social Science, University of KwaZulu-Natal, Pietermaritzburg.

© University of Pretoria

Chan, M. E. (2013). Antecedents of instrumental interpersonal help-seeking: An integrative review. *Applied Psychology*, *62*(4), 571-596. https://doi.org/10.1111/j.1464-0597.2012.00496.x.

Chan, R. K., & Hayashi, K. (2010). Gender roles and help-seeking behaviour: Promoting professional help among Japanese men. *Journal of Social Work*, *10*(3), 243-262. https://doi.org/10.1177/1468017310369274.

Cheek, S. M., Goldston, D. B., Erkanli, A., Massing-Schaffer, M., & Liu, R. T. (2020). Social rejection and suicidal ideation and attempts among adolescents following hospitalization: A prospective study. *Journal of Abnormal Child Psychology*, *48*(1), 123-133.

Cheryan, S., Cameron, J. S., Katagiri, Z., & Monin, B. (2015). Manning up. *Social Psychology*, *46,* 218-227. https://doi.org/10.1027/1864-9335/a000239.

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science & Medicine, 74,* 498-505.

Cochran, S. V., & Rabinowitz, F. E. (2000). *Practical resources for the mental health professional. Men and depression: Clinical and empirical perspectives*. San Diego, CA: Academic Press.

Cochran, S. V., & Rabinowitz, F. E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research in Practice, 34*(2), 132-140.

Connell, R. (2012). Masculinity research and global change. *Masculinities & Social Change*, *1*(1), 4-18. http://dx.doi.org/10.4471/mcs.2012.01.

Cooley, C. H. (1902). Looking-glass self. *The Production of Reality: Essays and Readings on Social Interaction*, *6*, 126-128.

Corbin, J., & Strauss, A. (2008). Strategies for qualitative data analysis. In J. Corbin, & A. Strauss, (Eds.), *Basics of qualitative research*: *Techniques and procedures for developing grounded theory* (3rd ed., pp. 65-86). London, UK: Sage Publications. https://doi.org/10.4135/9781452230153.

Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International Journal of Nursing Practice*, *17*(3), 280-288. https://doi.org/10.1111/j.1440-172X.2011.01936.x

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist, 59*(7), 614-625. https://doi.org/10.1037/0003-066X.59.7.614.

© University of Pretoria

Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The impact of mental illness stigma on seeking and participating in mental health care. *Psychological Science in the Public Interest*, *15*(2), 37-70. https://doi.org/10.1177/1529100614531398.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science & Medicine*, *50*(10), 1385-1401. https://doi.org/10.1016/S0277-9536(99)00390-1.

Courtet, P., Olié, E., Debien, C., & Vaiva, G. (2020). Keep socially (but not physically) connected and carry on: Preventing suicide in the age of COVID-19. *Journal of Clinical Psychiatry*, *81*, 20com13370. https://doi.org/10.4088/JCP.20com13370.

Crawford, T., & Lipsedge, M. (2004). Seeking help for psychological distress: The interface of Zulu traditional healing and Western biomedicine. *Mental Health, Religion & Culture, 7*(2), 131-148. https://doi.org/10.1080/13674670310001602463.

Creswell, J. W. (2009). Mapping the field of mixed methods research. *Journal of Mixed Methods Research, 3*(2), 95-108. https://doi.org./10.1080/13674670310001602463.

Cusack, J., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2006). Emotional expression, perceptions of therapy, and help-seeking intentions in men attending therapy services. *Psychology of Men & Masculinity, 7*(2), 69-82. https://doi.org/10.1037/1524 9220.7.2.69.

Danielsson, U., & Johansson, E. E. (2005). Beyond weeping and crying a gender analysis of expressions of depression. *Scandinavian Journal of Primary Health Care, 23*, 171-177. http://dx.doi.org/10.1080/02813430510031315.

Davidson, N., & Lloyd, T. (2001). *Promoting men's health: A guide for practitioners*. London, UK: Bailliere Tindall.

Davison, K. (2006). Historical aspects of mood disorders. *Psychiatry, 5*(4), 115-118. https://doi.org/10.1383/psyt.2006.5.4.115.

Day, A. L., & Livingstone, H. A. (2003). Gender differences in perceptions of stressors and utilization of social support among university students. *Canadian Journal of Behavioural Science*, *35*(2), 73-83. https://doi.org/10.1037/h0087190.

Depression. (2020). In Oxford Online Dictionary. Retrieved from: https://www.oxfordlearnersdictionaries.com/definition/american_english/depression.

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. Denzin, & Y. Lincoln (Eds.), *The SAGE handbook of qualitative research* (3rd ed., pp. 1-32). Thousand Oaks, CA: Sage.

© University of Pretoria

Denzin, N. K., & Lincoln, Y. S. (2011). *The Sage handbook of qualitative research* (4th ed.). Thousand Oaks, CA: Sage Publications.

Devettere, R. J. (2009). *Practical decision making in health care ethics: Cases and concepts*. Washington, DC: Georgetown University Press.

Doherty, D. T., & Kartalova-O'Doherty, Y. (2010). Gender and self-reported mental health problems: Predictors of help seeking from a general practitioner. *British Journal of Health Psychology*, *15*(1), 213-228. https://doi.org/10.1348/135910709X457423.

Dornan, J. (2004). *Blood from the moon: Gender ideology and the rise of ancient Maya social complexity.* Melbourne, Australia: Oxford University Press.

Durrheim, K. (2006). Research design. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences* (pp. 33-60). Cape Town, South Africa: University of Cape Town Press.

Eisenberg, D., Downs, M. F., Golberstein, E., & Zivin, K. (2009). Stigma and help seeking for mental health among college students. *Medical Care Research and Review*, *66*(5), 522-541. https://doi.org/10.1177/1077558709335173.

Eksteen, H. O. (2015). A meta-ethnography of male tertiary students' experiences of depression. (Unpublished doctoral thesis). Department of Psychology, University of Pretoria, Pretoria.

Elliott, K. (2016). Caring masculinities: Theorizing an emerging concept. *Men and Masculinities*, *19*(3), 240-259. https://doi.org/10.1177/1097184X15576203.

Ellis, T. (2016). First team schoolboy rugby players' understanding of their future career trajectories. (Unpublished doctoral thesis). Department of Education, Stellenbosch University, Stellenbosch.

Emslie, C., & Hunt, K. (2009). Men, masculinities and heart disease: A systematic review of the qualitative literature. *Current Sociology*, *57*(2), 155-191. https://doi.org/10.1177/0011392108099161.

Emslie, C., Ridge, D., Ziebland, S., & Hunt, K. (2006). Men's accounts of depression: Reconstructing or resisting hegemonic masculinity? *Social Science & Medicine*, *62*(9), 2246-2257. https://doi.org/10.1016/j.socscimed.2005.10.017.

England, M. J., Sim, L. J., & National Research Council. (2009). *Depression in parents, parenting, and children: Opportunities to improve identification, treatment, and prevention*. Washington, DC: National Academics Press.

Fereday, J., & Muir-Cochrane, E. (2006). Demonstrating rigor using thematic analysis: A hybrid approach of inductive and deductive coding and theme development.

© University of Pretoria

International Journal of Qualitative Methods, *5*(1), 80-92. https://doi.org/10.1177/160940690600500107.

Fields, A. J., & Cochran, S. V. (2011). Men and depression: Current perspectives for health care professionals. *American Journal of Lifestyle Medicine*, *5*(1), 92-100. https://doi.org/10.1177/1559827610378347.

Foerschner, A. M. (2010). The history of mental illness: From skull drills to happy pills. Inquiries Journal/Student Pulse, 2(09), 1-4. http://www.inquiriesjournal.com/a?id=1673.

Fogarty, A. S., Proudfoot, J., Whittle, E. L., Player, M. J., Christensen, H., Hadzi Pavlovic, D., & Wilhelm, K. (2015). Men's use of positive strategies for preventing and managing depression: A qualitative investigation. *Journal of Affective Disorders*, *188*, 179-187. https://doi.org/10.1016/j.jad.2015.08.070.

Fossey, E., Harvey, C., McDermott, F., & Davidson, L. (2002). Understanding and evaluating qualitative research. *Australian & New Zealand Journal of Psychiatry, 36*(6), 717-732. https://doi.org/10.1046/j.1440-1614.2002.01100.x.

Freedman, J., & Combs, G. (1996). *Narrative therapy: The social construction of preferred realities.* New York, NY: W. W. Norton & Company, Inc.

Fridgen, G. J., Aston, J., Gschwandtner, U., Pflueger, M., Zimmermann, R., Studerus, E., Stieglitz, R. D., & Riecher-Rössler, A. (2013). Help-seeking and pathways to care in the early stages of psychosis. *Social Psychiatry and Psychiatric Epidemiology*, *48*(7), 1033-1043. https://doi.org/10.1007/s00127-012-0628-0.

Frosh, S., Phoenix, A., & Pattman, R. (2002). *Young masculinities: Understanding boys in contemporary society*. New York, NY: Palgrave.

Gajjar, D. (2013). Ethical consideration in research. *Education*, *2*(7), 1-8.

Galbin, A. (2014). An introduction to social constructionism. *Social Research Reports, 6*(26), 82-92.

Galdas, P. M., Cheater, F., & Marshall, P. (2005). Men and health help-seeking behaviour: Literature review. *Journal of Advanced Nursing*, *49*, 616-623. http://dx.doi.org/10.1111/j.1365-2648.2004.03331.x.

Gibb, B. E., Beevers, C. G., Andover, M. S., & Holleran, K. (2006). The hopelessness theory of depression: A prospective multi-wave test of the vulnerability-stress hypothesis. Cognitive Therapy and Research, 30, 763-772.

© University of Pretoria

Gibb, B. E., Butler, A. C., & Beck, J. S. (2003). Childhood abuse, depression, and anxiety in adult psychiatric outpatients. Depression and Anxiety, 17, 226-228.

Gilbert, L., Selikow, T. A., & Walker, L. (2002). *Society, health and disease: An introductory reader for health care professionals.* Randburg, South Africa: Ravan Press.

Given, L. M. (2008). *The SAGE encyclopaedia of qualitative research methods*. Los Angeles, CA: Sage Publications Ltd.

Goldkuhl, G. (2012). Pragmatism vs interpretivism in qualitative information systems research. *European Journal of Information Systems*, *21*(2), 135-146. http://dx.doi.org/10.1057/ejis.2011.54.

Gonzalez, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity/race in young adults? *Journal of Community Psychology*, *33*(5), 611-629. https://doi.org/10.1002/jcop.20071.

Good, G. E., Dell, D. M., & Mintz, L. B. (1989). Male role and gender role conflict: Relations to help seeking in men. *Journal of Counseling Psychology*, *36*(3), 295. https://doi.org/10.1037/0022-0167.36.3.295.

Good, G. E., & Brooks, G. R. (2001). *The new handbook of psychotherapy and counselling with men: A comprehensive guide to settings, problems, and treatment approaches, Vol. 1 & 2*. Washington, DC: Jossey-Bass.

Gotlib, I. H., & Hammen, C. L. (2008). *Handbook of depression* (2nd ed.). London, UK: Guildford Press.

Greist, J. H., & Jefferson, J. W. (1992). *Depression and its treatment*. Washington, DC: American Psychiatric Pub.

Grindsted, T., & Holm, T. (2012). Thematic development of declarations on sustainability in higher education. *Environmental Economics*, *3*(1), 777-780.

Gunnell, D., Appleby, L., Arensman, E., Hawton, K., John, A., Kapur, N. (2020). Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry*, *7*, 468-471. https://doi.org/10.1016/S2215-0366(20)30171-1.

Hamilton, S., & Fagot, B. I. (1988). Chronic stress and coping styles: A comparison of male and female undergraduates. *Journal of Personality and Social Psychology*, *55*(5), 819- 823. https://doi.org/10.1037/0022-3514.55.5.819.

Hammer, J. H., Vogel, D. L., & Heimerdinger-Edwards, S. R. (2013). Men's help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity*, *14*(1), 65. https://doi.org/10.1177/0011000009351937.

© University of Pretoria

Hammersley, M. (1992). On feminist methodology. *Sociology, 26*(2), 187-206. https://doi.org/10.1177/0038038592026002002.

Harper, D., & Thompson, A. R. (2012). *Qualitative research methods in mental health and psychotherapy*. Oxford, UK: John Wiley & Sons, Ltd.

Hartman, N. (2018). The development of the concept of dissociation within ego state theory. (Unpublished doctoral thesis). Department of Psychology, University of Pretoria, Pretoria.

Healy, M., & Perry, C. (2000). Comprehensive criteria to judge validity and reliability of qualitative research within the realism paradigm. *Qualitative Market Research, 3*(3), 118-126. https://doi.org/10.1108/13522750010333861.

Herman, A. A., Stein, D. J., Seedat, S., Heeringa, S. G., Moomal, H., & Williams, D. R. (2009). The South African Stress and Health (SASH) study: 12-Month and lifetime prevalence of common mental disorder. *South African Medical Journal*, *99*(5), 339-344.

Hernan, A., Philpot, B., Edmonds, A., & Reddy, P. (2010). Healthy minds for country youth: Help-seeking for depression among rural adolescents. *Australian Journal of Rural Health*, *18*(3), 118-124. https://doi.org/10.1111/j.1440-1584.2010.01136.x.

Hong, R. Y. (2007). Worry and rumination: Differential associations with anxious and depressive symptoms and coping behavior. *Behaviour Research and Therapy*, *45*(2), 277-290. https://doi.org/10.1016/j.brat.2006.03.006.

Hopko, D. R., Mclndoo, C. C., & File, A. A. (2017). Depressive syndromes and medical comorbidities. In R. J. DeRubeis, & D. R. Strunk (Eds.), Oxford library of psychology. The Oxford handbook of mood disorders (pp. 348-359). Oxford, UK: Oxford University Press.

Howson, R. (2006). *Challenging hegemonic masculinity*. London, UK: Routledge.

Hoy, S. (2012). Beyond men behaving badly: A meta-ethnography of men's perspectives on psychological distress and help seeking. *International Journal of Men's Health*, *11*(3), 202-226. https://doi.org/10.3149/jmh.1103.202.

Jackson, S. W. (1991). Acedia the sin and its relationship to sorrow and melancholia. In A. Kleinman, & B. Good (Eds.), *Culture and depression: Studies in the Anthropology and cross cultural psychiatric of affect and disorder* (pp. 43-63). California, CA: University of California Press.

Jackson-Koku, G. (2016). Beck depression inventory. *Occupational Medicine*, *66*(2), 174-175. https://doi.org/10.1093/occmed/kqv087.

© University of Pretoria

Joffe, H. (2012). *Qualitative research methods in mental health and psychotherapy*. Oxford, UK: John Wiley & Sons, Ltd.

Johnson, T. P. (2014). Snowball sampling: Introduction. *Wiley StatsRef: Statistics Reference Online*. https://doi.org/10.1002/9781118445112.stat05720.

Johnson, J. L., Oliffe, J. L., Kelly, M. T., Galdas, P., & Ogrodniczuk, J. S. (2012). Men's discourses of help-seeking in the context of depression. *Sociology of Health & Illness*, *34*(3), 345-361. https://doi.org/10.1111/j.1467-9566.2011.01372.x.

Jones, I. (2015). *Research methods for sports studies* (3rd ed.). London, UK: Routledge.

Jouanna, J. (2012). At the roots of melancholy: Is Greek medicine melancholic? In P. Van der Eijk (Ed.), *Greek medicine from Hippocrates to Galen: Selected papers* (pp. 229-258). Leiden, Netherlands: Brill.

Judd, F., Komiti, A., & Jackson, H. (2008). How does being a female assist help-seeking for mental health problems? *The Australian and New Zealand Journal of Psychiatry, 42*(1), 24-29. https://doi.org/10.1080/00048670701732681.

Jupp, V. (2006). *The Sage dictionary of social research methods*. London, UK: Sage Publications.

Juvrud, J. (2013). The relationship between sex-typing and help-seeking behaviors in adults. *UNLV Theses, Dissertations, Professional Papers, and Capstones*. Retrieved from: https://digitalscholarship.unlv.edu/thesesdissertations/1935.

Kalmuss, D., & Austrian, K. (2010). Real men do… real men don't: Young Latino and African American men's discourses regarding sexual health care utilisation. *American Journal of Men's Health*, *4*(3), 218-230. https://doi.org/10.1177/1557988309331797.

Kankam, P. K. (2019). The use of paradigms in information research. *Library & Information Science Research*, *41*(2), 85-92. https://doi.org/10.1016/j.lisr.2019.04.003.

Kendall, P. C., Hollon, S. D., Beck, A. T., Hammen, C. L., & Ingram, R. E. (1987). Issues and recommendations regarding use of the Beck Depression Inventory. *Cognitive Therapy and Research, 11*(3), 289-299. https://doi.org/10.1007/BF01186280.

Kendler, K. S., Gatz, M., Gardner, C., & Pedersen, N. (2006). A Swedish national twin study of lifetime major depression. American Journal of Psychiatry, 163, 109-114. https://doi.org/10.1176/appi.aip.163.1.109.

Kessler, R. C., Chiu, W. T., Demler, O., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the national comorbidity survey

© University of Pretoria

replication. *Archives of General Psychiatry*, *62*(6), 617-627. https://doi.org/10.1001/archpsyc.62.6.617.

Khaldi, K. (2017). Quantitative, qualitative or mixed research: Which research paradigm to use? *Journal of Educational and Social Research*, *7*(2), 15. https://doi.org/10.5901/jesr.2017.v7n2p15.

Khan, A. R., Ratele, K., & Arendse, N. (2020). Men, suicide, and Covid-19: Critical masculinity analyses and interventions. *Postdigital Science and Education*, *2*(3), 651-656. https://doi.org/10.1007/s42438-020-00152-1.

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *Journal of Men's Health and Gender*, *2*(1), 95-99. https://doi.org/10.1016/j.jmhg.2004.10.010.

Kriel, A. J. (2003). Masculinity: An analysis of individual positioning and coping related to hegemony. (Unpublished master's dissertation). Department of Psychology, University of KwaZulu-Natal, Pietermaritzburg.

Krumm, S., Checchia, C., Koesters, M., Kilian, R., & Becker, T. (2017). Men's views on depression: A systematic review and metasynthesis of qualitative research. *Psychopathology*, *50*(2), 107-124. https://doi.org/10.1159/000455256.

Larkin, M., & Thompson, A. (2012). Interpretative phenomenological analysis. In D. Harper, & A. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 99-116). Oxford, UK: John Wiley & Sons, Ltd.

Lavender, H., Khondoker, A. H., & Jones, R. (2006). Understandings of depression: An interview study of Yoruba, Bangladeshi, and White British people. *Family Practice*, *23*(6), 651-658. https://doi.org/10.1093/fampra/cml043.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. New York, NY: Springer Publishing Company.

Lee, C., & Owens, R. G. (2002). Issues for a psychology of men's health. *Journal of Health Psychology*, *7*(3), 209-217. https://doi.org/10.1177/1359105302007003215.

Leeds-Hurwitz, W. (2009). Social construction of reality. *Encyclopedia of Communication Theory*, *2*, 891-894. https://doi.org/10/4135/9781412959384.n344.

Legard, R., Keegan, J., & Ward, K. (2003). In-depth interviews. *Qualitative Research Practice: A Guide for Social Science Students and Researchers*, *6*(1), 138-169.

Levant, R. F., Wimer, D. J., & Williams, C. M. (2011). An evaluation of the Health Behavior Inventory-20 (HBI-20) and its relationships to masculinity and attitudes towards

© University of Pretoria

seeking psychological help among college men. *Psychology of Men & Masculinity, 12*(1), 26-41. https://doi.org/10.1037/a0021014.

Lynch, L., Long, M., & Moorhead, A. (2018). Young men, help-seeking, and mental health services: Exploring barriers and solutions. *American Journal of Men's Health, 12(1),* 138-149. https://doi.org/10.1177/1557988315619469.

Mahalik, J. R. (2003). Development of the conformity to masculine norms inventory. *Psychology of Men & Masculinity*, *4*(1), 3. https://doi.org/10.1037/1524-9220.4.1.3.

Mahalik, J. R. (2008). A biopsychosocial perspective on men's depression. *Clinical Psychology: Science and Practice*, *15*(3), 174-177.

Mahalik, J. R., & Rochlen, A. B. (2006). Men's likely responses to clinical depression: What are they and do masculinity norms predict them? *Sex Roles*, *55*(9-10), 659-667. https://doi.org/10.1007/s11199-006-9121-0.

Mahalik, J. R., Burns, S. M., & Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of men's health behaviors. *Social Science & Medicine*, *64*(11),2201-2209. https://doi.org/10.1016/j.socscimed.2007.02.035.

Mahalik, J. R., Lagan, H. D., & Morrison, J. A. (2006). Health behaviors and masculinity in Kenyan and U.S. male college students. Psychology of Men & Masculinity, 7(4), 191-202. https://doi.org/10.1037/1524-9220.7.4.191.

Martin, L. A., Neighbors, H. W., & Griffith, D. M. (2013). The experience of symptoms of depression in men vs women: Analysis of the national comorbidity survey replication. *JAMA Psychiatry*, *70*(10), 1100-1106. https://doi.org/10.1001/jamapsychiatry.2013.1985.

Mathers, C. D., & Loncar, D. (2006). Projections of global mortality and burden of disease from 2002 to 2030. *PLoS Medicine*, *3*(11), e442. https://doi.org/10.1371/journal.pmed.0030442.

Mathewson, S. H. (2009). *Constructions of masculinity and health-related behaviours among young men in Dakar, Senegal.* London, UK: Development Studies Institute, London School of Economics and Political Science.

Matud, M. P. (2004). Gender differences in stress and coping styles. *Personality and Individual Differences*, *37*, 1401-1415. https://doi.org/10.1016/j.paid.2004.01.010.

McCusker, M. G., & Galupo, M. P. (2011). The impact of men seeking help for depression on perceptions of masculine and feminine characteristics. *Psychology of Men & Masculinity, 12*(3), 275-284. https://doi.org/10.1037/a0021071.

© University of Pretoria

McKinley, J. (2015). Critical argument and writer identity: Social constructivism as a theoretical framework for EFL academic writing. *Critical Inquiry in Language Studies*, *12*(3), 184-207. https://doi.org/10.1080/15427587.2015.1060558.

Meltzer, H., Gill, B., Petticrew, M., & Hinds, K. (1995). *The prevalence of psychiatric morbidity among adults living in private house-holds*. OPCS Survey of psychiatric morbidity in Great Britain. London, UK: HMSO.

Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation*. San Francisco, CA: Jossey-Bass.

Meuser, M. (2003). *Modernized masculinities? Continuities, challenges and changes in men's lives*. London, UK: Routledge.

Meyer, S. E., Chrousos, G.P., & Gold, P. W. (2001). Major depression and the stress system: A life span perspective. Development and Psychopathology, 13, 565-580. https://doi.org/10.1017/s095457940100308x.

Mimura, M. (2001). Comorbidity of depression and other diseases. *Japan Medical Association Journal*, *44*(5), 225.

Misbach, J., & Stam, H. J. (2006). Medicalizing melancholia: Exploring profiles of psychiatric professionalization. *Journal of the History of the Behavioral Sciences*, *42*(1), 41-59. https://doi.org/10.1002/jhbs.20133.

Möller-Leimkühler, A. M. (2000). Men and depression: Gender-related help-seeking behaviour. *Fortschritte der Neurologie-Psychiatrie*, *68*(11), 489-495. https://doi.org/10.1055/s-2000-10030.

Möller-Leimkühler, A. M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders*, *71*(1-3), 1-9. https://doi.org/10.1016/S0165-0327(01)00379-2.

Möller-Leimkühler, A. M., Heller, J., & Paulus, N. (2007). Subjective well-being and "male depression" in male adolescents. *Journal of Affect Disorders*, *98*, 65-72.

Möller-Leimkühler, A. M., & Yücel, M. (2010). Male depression in females? *Journal of Affective Disorders*, *121*(1-2), 22-29. https://doi.org/10.1016/j.jad.2009.05.007.

Morrell, R. (2001). Corporal punishment and masculinity in South African schools. *Men and Masculinities, 4*(2), 140-157. https://doi.org./10.1177/1097184X01004002003.

Msotho, N. L., Louw, D. A., Calitz, F. J., & Estehuyse, K. G. (2008). Depression among Sesotho speakers in Mangaung, South Africa. *African Journal of Psychiatry, 11*(1), 35- 43. https://doi.org/10.4314/ajpsy.v11i1.30253.

© University of Pretoria

Nevin, T. (2001). Days of the Sangoma. Retrieved from: http://O-findgalegroup.com.inopac.up.ac.zam.

Nolen-Hoeksema, S. (2001). Gender differences in depression. *Current Directions in Psychological Science*, *10*(5), 173-176.

Nolen-Hoeksema, S. (2012). Emotion regulation and psychopathology: The role of gender. *Annual Review of Clinical Psychology*, *8,* 161-87. https://doi.org/10.1146/annurev-clinpsy-032511-143109.

Nolen-Hoeksema, S., Larson, J., & Grayson, C. (1999). Explaining the gender difference in depressive symptoms. *Journal of Personality and Social Psychology*, *77*(5), 1061.

Neumeister, A., Young, T., & Stastny, J. (2004). Implications of genetic research on the role of the serotonin in depression: Emphasis on the serotonin type 1A receptor and the serotonin transporter. Psychopharmacology, 174, 512-524. https://doi.org/10/1007/s00213-004-1950-3.

O'Brien, R., Hunt, K., & Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Social Science & Medicine*, *61*(3), 503-516. https://doi.org/10.1016/j.socscimed.2004.12.008.

Ogrodniczuk, J. S., & Oliffe, J. L. (2011). Men and depression. *Canadian Family Physician*, *57*(2), 153-155.

Ojeda, V. D., & Bergstresser, S. M. (2008). Gender, race-ethnicity, and psychosocial barriers to mental health care: An examination of perceptions and attitudes among adults reporting unmet need. *Journal of Health and Social Behavior*, *49*(3), 317-334. https://doi.org/10.1177/002214650804900306.

Okello, E. S., & Neema, S. (2007). Explanatory models and help-seeking behaviour: Pathways to psychiatric care among patients for depression in Mulango Hospital, Kampala, Uganda. *Qualitative Health Research*, *17*(1), 14-25. https://doi.org/10.1177/1049732306296433.

O'Leary, Z. (2004). *The essential guide to doing research*. London, UK: Sage Publications Ltd.

Oliffe, J. (2006). Innovative practice: Ethnography and men's health research. *Journal of Men's Health and Gender, 3*(1), 104-108.

© University of Pretoria

Oliffe, J. L., & Phillips, M. J. (2008). Men, depression and masculinities: A review and recommendations. *Journal of Men's Health*, *5*(3), 194-202. https://doi.org/10.1016/j.jomh.2008.03.016.

O'Neil, J. M., Helms, B. J., Gable, R. K., Gable, R. K., Laurence, D., & Wrightsman, L. S. (1986). Gender role conflict scale: College men's fear of femininity. *Sex Roles*, *14*, 335-350. https://doi.org/10.1007/BF00287583.

Osanloo, A., & Grant, C. (2016). Understanding, selecting, and integrating a theoretical framework in dissertation research: Creating the blueprint for your "house." *Administrative Issues Journal: Connecting Education, Practice, and Research*, *4*(2), 7. https://doi.org./10.5929/2014.4.2.9.

Osman, A., Kopper, B. A., Barrios, F., Gutierrez, P. M., & Bagge, C. L. (2004). Reliability and validity of the Beck Depression Inventory-II with adolescent psychiatric inpatients. *Psychological Assessment, 16*(2), 120. https://doi.org/10.1037/1040-3590.16.2.120.

Owen, I. (1995). Social constructionism and theory, practice and research is psychotherapy: A phenomenological psychology manifesto. *Bulletin of Psychology*, *46*(1), 161-186.

Patel, V., Abas, M., Broadhead, J., Todd, C., & Reeler, A. (2001). *Depression in developing countries: Lessons from Zimbabwe*. University of Zimbabwe Medical School, Harare.

Patton, M. Q. (2002). *Qualitative evaluation and research methods* (3rd ed.). Thousand Oaks, CA: Sage Publications, Inc.

Pederson, E. L., & Vogel, D. L. (2007). Male gender role conflict and willingness to seek counseling: Testing a mediation model on college-aged men. *Journal of Counseling Psychology, 54*(4), 373-384. https://doi.org/10.1037/0022-0167.54.4.373.

Plotsky, P. M., Owens, M. J., & Nemeroff, C. B. (1998). Psychoneuroendocrinology of depression: Hypothalamic-pituitary-adrenal axis. Pediatric Clinics of North America, 21, 293-307. https://doi.org/10.1016/s0193-953x(05)70006-x.

Pretorius, E. (2004). *Complementary/ alternative traditional health care in South Africa. Health and health care in South Africa*. Pretoria, South Africa: Van Schaik Publishers.

Primack, J. M., Addis, M. E., Syzdek, M., & Miller, I. W. (2010). The men's stress workshop: A gender-sensitive treatment for depressed men. *Cognitive and Behavioral Practice*, *17*(1), 77-87. https://doi.org/10.1016/j.cbpra.2009.07.002.

Prince, V. (2005). Sex vs. gender. *International Journal of Transgenderism*, *8*(4), 29-32. https://doi.org/10.1300/J485v08n04_05.

© University of Pretoria

Pritchard, M. E., & Wilson, G. S. (2006). Do coping styles change during the first semester of college? *The Journal of Social Psychology*, *146*(1), 125-127. https://doi.org/10.3200/SOCP.146.1.125-127.

Proudfoot, J., Fogarty, A. S., McTigue, I., Nathan, S., Whittle, E. L., Christensen, H., ... & Wilhelm, K. (2015). Positive strategies men regularly use to prevent and manage depression: A national survey of Australian men. *BMC Public Health*, *15*(1), 1135. https://doi.org/10.1186/s12889-015-2478-7.

Ptacek, J. T., Smith, R. E., & Dodge, K. L. (1994). Gender differences in coping with stress: When stressor and appraisals do not differ. *Personality and Social Psychology Bulletin*, *20*(4), 421-430. https://doi.org/10.1177/0146167294204009.

Ramirez, J. L., & Badger, T. A. (2014). Men navigating inward and outward through depression. *Archives of Psychiatric Nursing*, *28,* 21-28. https://doi.org/10.1016/j.apnu.2013.10.001.

Reger, M. A., Stanley, I. H., & Joiner, T. E. (2020). Suicide mortality and coronavirus disease 2019-a perfect storm? *JAMA Psychiatry, 77*(11), 1093-1094. https://doi.org/10.1001/jamapsychiatry.2020.1060.

Rice, S. M., Fallon, B. J., Aucote, H. M., & Möller-Leimkühler, A. M. (2013). Development and preliminary validation of the male depression risk scale: Furthering the assessment of depression in men. *Journal of Affective Disorders, 151*, 950-958. http://dx.doi.org/10.1016/j.apnu.2013.10.001.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help seeking for mental health problems. *Australian E-journal for the Advancement of Mental Health*, *4*(3), 218-251. https://doi.org/10.5172/jamh.4.3.218.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers*. London, UK: Sage Publications.

Robbins, A. (2006). Biopsychosocial aspects in understanding and treating depression in men: A clinical perspective. *Journal of Men's Health and Gender*, *3*(1), 10-18.

Robertson, S. (2007). *Understanding men and health: Masculinities, identity and well-being*. London, UK: McGraw-Hill Education.

Robertson, E. (2011). Constructed masculinity: How much do media representations dictate male identity? *In Annual American Men's Studies Association Conference Proceedings*. Men's Studies Press. https://doi.org/10.3149/AMSA.17.88.

© University of Pretoria

Rochlen, A. B., & Hoyer, W. D. (2005). Marketing mental health to men: Theoretical & practical considerations. *Journal of Clinical Psychology, 61*(6), 675-684. https://doi.org/10.1002/jclp.20102.

Rutz, W., & Rihmer, Z. (2007). Suicidality in men: Practical issues, challenges, solutions. *Journal of Men's Health and Gender, 4*(4), 393-401. http://doi.org/10.1016/j.jmhg.2007.07.046.

Safford, S. M. (2008). Gender and depression in men: Extending beyond depression and extending beyond gender. *Clinical Psychology: Science and Practice*, *15*(3), 169-173. https://doi.org/10.1111/j.1468-2850.2008.00126.x.

Sartorius, N. (2007). Stigma and mental health. *The Lancet*, *370* (9590), 810-811. https://doi.org/10.1016/S0140-6736(07)61245-8.

Saunders, M., Lewis, P., & Thronhill, A. (2009). *Research methods for business students* (5th ed.). England, UK: Pearson Educated Limited.

Schaub, M., & Williams, C. (2007). Examining the relations between masculine gender role conflict and men's expectations about counseling. *Psychology of Men & Masculinity, 8*(1), 40-52. https://doi.org/10.1037/1524-9220.8.1.40.

Scher, C. D., Ingram, R. E., & Segal, Z. V. (2005). Cognitive reactivity and vulnerability: Empirical evaluation of construct activation and cognitive diatheses in unipolar depression. Clinical Psychology Review, 25, 487-510.

Schofield, T., Connell, R. W., Walker, L., Wood, J. F., & Butland, D. L. (2000). Understanding men's health and illness: A gender-relations approach to policy, research, and practice. *Journal of American College Health*, *48*(6), 247-256. https://doi.org/10.1080/07448480009596266.

Schwandt, T. A. (2003). Back to the rough ground! Beyond theory to practice in evaluation. *Evaluation, 9*(3), 353-364. https://doi.org/10.1177/13563890030093008.

Schwartz, S. J., & Montgomery, M. J. (2002). Similarities or differences in identity development? The impact of acculturation and gender on identity process and outcome. *Journal of Youth and Adolescence*, *31*(5), 359-372.

Seedat, S., Stein, D. J., Berk, M., & Wilson, Z. (2002). Barriers to treatment among members of a mental health advocacy group in South Africa. *Social Psychiatry and Psychiatric Epidemiology*, *37*, 483-487. https://doi.org/10.1007/s00127-002-0577-0.

Seidler, V. J. (2006). *Transforming masculinities: Men, cultures, bodies, power, sex and love*. London, UK: Taylor & Francis.

© University of Pretoria

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review*, *49*, 106-118. https://doi.org/10.1016/j.cpr.2016.09.002.

Seidler, Z. E., Rice, S. M., Dhillon, H. M., & Herrman, H. (2019). Why it's time to focus on masculinity in mental health training and clinical practice. *Australasian Psychiatry*, *27*(2), 157-159. https://doi.org/10.1177/1039856218804340.

Sigmon, S., Pells, J., Boulard, N., Whitcomb-Smith, S., Edenfield, T., Hermann, B., LaMattina, S., Schartel, J., & Kubik, S. (2005). Gender differences in self-reports of depression: The response bias hypothesis revisited. *Sex Roles*, *53,* 401-411.

Sloan, C., Gough, B., & Conner, M. (2010). Healthy masculinities? How ostensibly healthy men talk about lifestyle, health and gender. *Psychology and Health*, *25*(7), 783-803. https://doi.org/10.1080/08870440902883204.

Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinicalimplications. *Psychology of Men & Masculinity, 9*(3), 179-192. https://doi.org/10.1037/a0012158.

Solomon, A. (2001). *The noonday demon: An atlas of depression*. New York, NY: Simon and Schuster.

Stajduhar, K. I., Balneaves, L., & Thorne, S. E. (2001). A case for the 'middle ground': Exploring the tensions of postmodern thought in nursing. *Nursing Philosophy*, *2*(1), 72-82. https://doi.org/10.1046/j.1466-769x.2001.00033.x.

Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South African. *The British Journal of Psychiatry*, *192*, 112-127. https://doi.org/10.1192/bjp.106.029280.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision*, *39*(7), 551-555. https://doi.org/10.1108/EUM0000000005801.

Stone, M. H. (2006). Historical aspects of mood disorders. In D. J. Stein, D. J. Kupfer, & A.F. Schatzberg (Eds.), *The American psychiatric publishing textbook of mood disorders* (pp. 3-13). Washington, DC: American Psychological Association.

Strike, C., Rhodes, A. E., Bergmans, Y., & Links, P. (2006). Fragmented pathways to care: The experiences of suicidal men. *Crisis, 27*(1), 31-38.

© University of Pretoria

Sullivan, P. F., Neale, M. C., & Kendler, K. S. (2000). Genetic epidemiology of major depression: Review and meta-analysis. American Journal of Psychiatry, 157, 1552-1562. https://doi.org/10.1176/appi.aip.157.10.1552.

Tamres, L. K., Janicki, D., & Helgeson, V. S. (2002). Sex differences in coping behaviour: A meta-analytic review and an examination of relative coping. *Personality and Social Psychology Review*, *6*(1), 2-30. https://doi.org/10.1207/S15327957PSPR0601_1.

Tangwa, G. B. (2007). How not to compare Western scientific medicine with African traditional medicine. *Developing World Bioethics, 7*(1), 41-44. https://doi.org/10.1111/j.1471-8847.2006.00182.x.

Terre Blanche, M., & Durrheim, K. (2006). Histories of the present: Social science research in content. In M. Terre Blanche, K. Durrheim, & D. Painter (Eds.), *Research in practice: Applied methods for the social sciences (*2nd ed., pp. 1-17). Cape Town, South Africa: University of Cape Town Press.

Thase, M. (2008). Neurobiological aspects of depression. In I. Gotlib, & C. Hammen (Eds.), Handbook of depression (2nd ed., pp. 187-217). New York, NY: Guilford Press.

Thoits, P. A. (1991). Gender differences in coping with emotional distress. In J. Eckenrode (Eds.), *The social context of coping* (pp. 107-138). Boston, MA: Springer. https://doi.org/10.1007/978-1-4899-3740-7_6.

Thoits, P. A. (2009). Compensatory coping with stressors. In W. R. Avison, C. S. Aneshensel, S. Schieman, & B. Wheaton (Eds.), *Advances in the conceptualization of the stress process* (pp. 23-34). New York, NY: Springer.

Thomas, R. M. (2001). *Recent theories of human development*. London, UK: Sage Publications.

Thorne, S., Jensen, L., Kearney, M. H., Noblit, G., & Sandelowski, M. (2004). Qualitative metasynthesis: Reflections on methodological orientation and ideological agenda. *Qualitative Health Research, 14*(10), 1342-1365. https://doi.org/10.1177/1049732304269888.

Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *South African Medical Journal*, *99*(5 Pt 2), 367-373.

© University of Pretoria

Tongco, M. D. C. (2007). Purposive sampling as a tool for informant selection. *Ethnobotany Research and Applications*, *5*, 147-158.

Travers, M. (2006). Postmodernism and qualitative research. *Qualitative Research*, *6*(2), 267-273. https://doi.org/10.1177/1468794106065242.

Treharne, G. J., & Riggs, D. W. (2014). *Ensuring quality in qualitative research*. *Qualitative research in clinical and health psychology*. London, UK: Macmillan Publishers Limited. https://doi.org/10.1007/978-1-137-29105-9_5.

Trump, L., & Hugo, C. (2006). The barriers preventing effective treatment of South African patients with mental health problems. *South African Psychiatric Review, 9*(4), 249-260.

Tuckett, A. G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse*, *19*(1-2), 75-87. https://doi.org/10.5172/conu.19.1-2.75.

Tull, M. T., Edwards, K. A., Scamaldo, K. M., Richmond, J. R., Rose, J. P., & Gratz, K. L. (2020). Psychological outcomes associated with stay-at-home orders and the perceived impact of COVID-19 on daily life. *Psychiatry Research, 289*, 113098. https://doi.org/10.1016/j.psychres.2020.113098.

Turan, N., & Erdur-Baker, O. (2014). Attitudes towards seeking psychological help among a sample of Turkish university students: The roles of rumination and internal working models. *British Journal of Guidance & Counselling*, *42*(1), 86-98. https://doi.org/10.1080/03069885.2013.831031.

Twenge, J. M., & Nolen-Hoeksema, S. (2002). Age, gender, race, socioeconomic status, and birth cohort difference on the children's depression inventory: A meta-analysis. *Journal of Abnormal Psychology*, *111*(4), 578. https://doi.org/10.1037/0021-843X.111.4.578.

Upton, J. (2013). Beck Depression Inventory (BDI). In M. D. Gellman, & J. R. Turner (Eds.), *Encyclopaedia of behavioural medicine* (pp. 1303-1334).) New York, NY: Springer. https://doi.org/10.1007/978-1-4419-1005-9_441.

Watkins, D. C., Green, B. L., Rivers, B. M., & Rowell, K. L. (2006). Depression and black men: Implications for future research. *Journal of Men's Health and Gender*, *3*(3), 227-235. http://doi.org/10.1016/j.jmhg.2006.02.005.

Watson, M., & Kuit, W. (2007). Postmodern career counselling and beyond. In K. Maree (Ed.), *Counselling for career construction: Connecting life themes to construct life portraits: Turning pain into hope* (pp. 73-85). Pretoria, South Africa: Van Schaik.

© University of Pretoria

Wenger, L. M. (2011). Beyond ballistics: Expanding our conceptualization of men's health related help seeking. *American Journal of Men's Health*, *5*(6), 488-499. https://doi.org/10.1177/1557988311409022.

West, C., & Zimmerman, D. H. (1987). Doing gender. *Gender & Society*, *1*(2), 125-151. https://doi.org/10.1177/0891243287001002002.

Westerbeek, J., & Mutsaers, K. (2008). Depression narratives: How the self became a problem. *Literature and Medicine, 27*(1), 25-55. https://doi.org/10.1353/lm.0.0017.

Whittle, E. L., Fogarty, A. S., Tugendrajch, S., Player, M. J., Christensen, H., Wilhelm, K., Proudfoot, J. (2015). Men, depression, and coping: Are we on the right path? *Psychology of Men & Masculinity, 16*(4), 426-438. https://doi.org/10.1037/a0039024.

Whorley, M. R., & Addis, M. E. (2007). Effects of scholarly productivity expectations on graduate training in clinical psychology. *Clinical Psychology: Science and Practice*, *14*(2), 172-174. https://doi.org/10.1111/j.1468-2850.2007.00076.x.

Wilhelm, K. A. (2009). Men and depression. *Australian Family Physician*, *38,* 102-105.

Wilson, B. G. (1997). The postmodern paradigm. In C. Dills, & A. Romoszowski (Eds.), *Instructional development paradigms* (pp. 297-309). Englewood Cliffs, NJ: Educational Technology Publications.

Winkler, D., Pjerk, E., & Kasper, S. (2006). Gender-specific symptoms of depression and anger attack. *The Journal of Men's Health & Gender*, *3(1),* 19-24.

World Health Organization. (1992). *The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines.* World Health Organization. Retrieved from: https://apps.who.int/iris/handle/10665/3798.

World Health Organization (2014). *Preventing suicide: A global imperative*. World Health Organization. Retrieved from: http://apps.who.int/iris/bitstream/10665/131056/1/9789241564779_eng.pdf?ua=1.

World Health Organization (2017). *"Depression: Let's talk" says WHO, as depression tops list of causes of ill health*. World Health Organization. Retrieved from: https://www.who.int/news-room/detail/30-03-2017--depression-let-s-talk-says-who-as-depression-tops-list-of-causes-of-ill-health.

World Health Organization (2020). *Depression.* World Health Organization. Retrieved from: https://www.who.int/news-room/fact-sheets/detail/depression.

Wurtman, R. J. (2005). Genes, stress, and depression. *Metabolism*, *54*(5), 16-19.

Van de Velde, S., Bracke, P., & Levecque, K. (2010). Gender differences in depression in 23 European countries. Cross-national variation in the gender gap in depression. *Social*

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Science & Medicine, *71*(2), 305-313. https://doi.org/10.1016/j.socscimed.2010.03.035.

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology, 58*(3), 368-382. https://doi.org/10.1037/a0023688.

Vogel, D. L., Wade, N. G., & Haake, S. (2006). Measuring the self-stigma associated with seeking psychological help. *Journal of Counseling Psychology, 53*(3), 325-337. https://doi.org/10.1037/0022-0167.53.3.325.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counselling. *Journal of Counseling Psychology*, *54*(1), 40. https://doi.org/10.1037/0022-0167.54.1.40.

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2013). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review, 9*(2), 264-276. https://doi.org/10.1080/17437199.2013.840954.

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APPENDIX A:
FORMAL ETHICAL CLEARANCE LETTER

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

16 February 2021

Dear Mr RM Bateman

Project Title:	South African men's experiences of depression and coping strategies.
Researcher:	Mr RM Bateman
Supervisor(s):	Prof DJF Maree
Department:	Psychology
Reference number:	14213657 (HUM012/0420) (Amendment)
Degree:	Masters

Thank you for the application to amend the existing protocol that was previously approved by the Committee.

The revised / additional documents were reviewed and **approved** on 16 February 2021 along these guidelines, further data collection may therefore commence (where necessary).

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

We wish you success with the project.

Sincerely,

Prof Innocent Pikirayi
Deputy Dean: Postgraduate Studies and Research Ethics
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail:PGHumanities@up.ac.za

Research Ethics Committee Members: Prof I Pikirayi (Deputy Dean); Prof KL Harris; Mr A Bizos; Dr A-M de Beer; Dr A dos Santos; Ms KT Govinder Andrew; Dr P Gutura; Dr E Johnson; Prof D Maree; Mr A Mohamed; Dr I Noomè; Dr C Puttergill; Prof D Reyburn; Prof M Soer; Prof E Taljard; Prof V Thebe; Ms B Tsebe; Ms D Mokalapa

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APPENDIX B:

PARTICIPANT INFORMATION SHEET

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

TITLE OF THE STUDY

South African men's experiences of depression and coping strategies

Hello my name is Ryan Michael Bateman. I am currently a Masters student in clinical psychology at the Faculty of Humanities, University of Pretoria. You are being invited to take part in my research study. Before you decide to participate in this study, it is important that you understand why the research is being done and what it will entail. Please take some time to read the following information carefully, which will explain the details of this research project. Please feel free to ask me if there is anything that is not clear or if you need more information.

WHAT IS THE PURPOSE OF THE STUDY?

- The purpose of this study is to understand South African men's experiences of depression. Very few studies have been done on South African men's attitudes towards help seeking for depression and more specifically on the coping strategies that these men utilise in order to cope and/or manage with such depression. As such, I have decided to conduct a study on your perceptions of help-seeking for depression as well as the coping strategies (specifically emphasising the positive and/or helping coping strategies) that you utilise to manage such depression/ feeling down.
- The overall aim of this study is to gain a deeper understanding of your experiences and the coping strategies that you utilise with the hope of publishing the research in order to help other men that may be in similar circumstances.

WHY HAVE YOU BEEN INVITED TO PARTICIPATE?

- You are invited to participate because you are a South African male who is experiencing depressive symptoms.

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- You have also complied with the following: you are older than 18 years of age, you have access to a computer and internet, and you have an adequate grasp of the English language.
- You will be excluded if you: do not feel like you are suffering from depressive symptoms, are younger than 18 years old, or you do not have access to the internet.

WHAT IS THE NATURE OF MY PARTICIPATION IN THIS STUDY?

- You will be asked to participate in a one-on-one in-depth interview where I will ask a series of open-ended questions in order to explore your experiences. This interview will be digitally recorded and transcribed for the purposes of the research. This interview is expected take approximately 60 – 90 minutes.

CAN I WITHDRAW FROM THIS STUDY EVEN AFTER HAVING AGREED TO PARTICIPATE?

- Participating in this study is voluntary and you are under no obligation to consent to participation. If you do decide to take part, you will be given this information sheet to keep and be asked to sign a written consent form. You are free to withdraw at any time and without giving a reason. You can decide not to take part in the study without negative consequences or being penalised.

WILL THE INFORMATION THAT I CONVEY TO THE RESEARCHER BE KEPT CONFIDENTIAL?

- Anonymity and confidentiality will be ensured by assigning code names to each participant, and that will be used in all research notes and documents. Findings from this data will be disseminated through conferences and publications. Reporting of findings will be anonymous, only the researcher of this study will have access to the information.
- Please note participant information will be kept confidential, except in cases where the researcher is legally obliged to report incidents such as abuse and suicide risk.

WHAT ARE THE POTENTIAL BENEFITS OF TAKING PART IN THIS STUDY?

- There will be no direct benefit to you for participating in this study. However, I hope that information obtained from this study may add to the current knowledge regarding South African men's experiences of depression and the coping strategies that they employ.

WHAT ARE THE ANTICIPATED RISKS FROM TAKING PART IN THIS STUDY?

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- There are no foreseeable risks to your physical, social, or mental health.

WHAT WILL HAPPEN IN THE UNLIKELY EVENT THAT SOME FORM OF DISCOMFORT OCCUR AS A RESULT OF TAKING PART IN THIS RESEARCH STUDY?

- Should you have the need for further discussions after the interviews and/or require psychological assistance due to re-traumatisation, you are suggested to contact the facilitator of the support group, or SADAG at 011 234 4837. South African Depression and Anxiety Group (SADAG) is Africa's largest mental health support and advocacy group, offering 24-hour counselling services.

HOW WILL THE RESEARCHER(S) PROTECT THE SECURITY OF DATA?

- Electronic information will be stored for period of 15 years. Future use of the stored data will be subject to further Research Ethics Review and approval if applicable.
- All raw data (e.g., the transcriptions of the interviews and the research report itself) will be locked in a cabinet for a period of 15 years in the Department of Psychology at the University of Pretoria.

WHAT WILL THE RESEARCH DATA BE USED FOR?

- Data gathered from the participant would be used for research purpose that included;
- Dissertation, article publication, national and international conference presentations
- For administration purpose or policy briefs
- For further research inform of secondary data analysis.

WILL I BE PAID TO TAKE PART IN THIS STUDY?

- No, you will not be paid to take part in this study.

HAS THE STUDY RECEIVED ETHICS APPROVAL?

- This study has received written approval from the Research Ethics Committee of Faculty of Humanities, University of Pretoria. Ethical approval number is HUM012/0420. A copy of the approval letter can be provided to you on request.

HOW WILL I BE INFORMED OF THE FINDINGS/RESULTS OF THE RESEARCH?

- The findings of the research study can be shared with you by Ryan Bateman after one year of completing the study. Thus, the report and findings from this research projected can be communicated to you from May 2022.

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WHO SHOULD I CONTACT IF I HAVE CONCERN, COMPLAINT OR ANYTHING I SHOULD KNOW ABOUT THE STUDY?

- If you have questions about this study or you have experienced adverse effects as a result of participating in this study, you may contact the researcher whose contact information is provided below. If you have questions regarding the rights as a research participant, or if problems arise which you do not feel you can discuss with the researcher, please contact the supervisor, and contact details are below.

Thank you for taking time to read this information sheet and in advance for participating in this study.

Researcher
Name Surname…………… Ryan Bateman …………………………….
Contact number……………0716853992……………………………….
Email address…………… ryanbatman95@gmail.com ………….

Supervisor
Name………………… Prof. Ben Steyn …………………………
Contact number………(012) 420-6048………………………….
Email address………… ben.steyn@up.ac.za ………….

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APPENDIX C:

WRITTEN CONSENT TO PARTICIPATE IN THIS STUDY

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

I, ___________________ (**participant name**), confirm that the person asking my consent to take part in this research has told me about the nature, procedure, potential benefits and anticipated inconvenience of participation.

STATEMENT	AGREE	DISAGREE	NOT APPLICABLE
I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without any consequences or penalties.			
I understand that information collected during the study will not be linked to my identity and I give permission to the researchers of this study to access the information.			
I understand that this study has been reviewed by, and received ethics clearance from Research Ethics Committee Faculty of Humanities of the University of Pretoria.			
I understand who will have access to personal information and how the information will be stored with a clear understanding that, I will not be linked to the information in any way.			
I give consent that data gathered may be used for dissertation, article publication, conference presentations and writing policy briefs.			
I understand how to raise a concern or make a complaint.			
I consent to being audio recorded.			

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I consent to being video recorded.			

I consent to having my photo taken.			
I consent to have my audio recordings /videos/photos be used in research outputs such as publication of articles, thesis and conferences as long as my identity is protected.			
I give permission to be quoted directly in the research publication whilst remaining anonymous.			
I have sufficient opportunity to ask questions and I agree to take part in the above study.			

Name of Participant ________ Date ________ Signature ________

Name of person taking consent ________ Date ________ Signature ________

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APPENDIX D:

INTERVIEW SCHEDULE FOR INDIVIDUAL INTERVIEWS

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Interview Guide (informed by Lavender, Khondoker, & Jones, 2006)

- Welcome, thank you for participating and introductions.
- Explaining the purpose and aim of the interview… The study is to understand the participants experiences with depression and the coping strategies they utilise in their daily lives to cope/manage with such depression.
- Go over information sheet and gain written consent for conducting the study.
- Explain the audio recorder and transcribing. The study is anonymous. i.e. your name will not be mentioned.
- Ask if they have any questions, require further clarity.
- Begin the interview.

Interview schedule

1. Can you tell me a bit about yourself?
2. Have you ever been formally diagnosed with Major Depressive Disorder (MDD). If so, please could you tell me when were you diagnosed and by whom.
3. If you have not been formally diagnosed, can you tell me some of your experiences that have made you believe that you meet the criteria for this diagnosis.
4. Can you please tell me what it is like, in general, to live with depression and/or depressive symptomology?
5. Have you noticed any body changes or symptoms while feeling depressed?
6. Have you noticed any changes or difficulties in relationships while feeling depressed?
7. Have you noticed any environmental changes or difficulties since feeling depressed?
8. What effect, if any, has depression had on your daily life?
9. Have you sought help for such symptomology? If so, what prompted you to seek help? If not, what do you think has impeded you from seeking help?
10. What was the experience like of seeking help?

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11. Can you tell me some of the aspects that made it both easy (enablers) and difficult (barriers) to seek help?
12. Do you feel that being a man impacts seeking help? I.e. the constructions of masculinity (the idea that men don't cry) makes it harder to see help?

I'd now like to ask you about your understanding of self-management, or self-help, in the context of living with depression.

13. Can you give me an idea of what self-management (or self-help) means to you?
14. Can you tell me the things you do, if any, that improve your quality of life or help you manage your depressive symptoms?
15. How did you find out about these activities/ actions?
16. What effect has it had on your health? – Physical, social, or emotional?
17. What helped you (i.e. enabled) to take these strategies/ actions?
18. Anything that makes/made it difficult to take these actions (i.e. barriers)?
19. How often do you use these strategies?
20. Do you feel like these strategies help you to avoid the negative feelings or help you to deal with them directly?
21. What other self-help strategies have you heard about that you would like to try?
22. Do you feel that your self-help, if any, has changed over the years, and why do you think that?
23. What support, if any, do you get from others, like family members, friends, or residents to assist you with your depressive symptomology?
24. Is there anything you would want to share with other men who suffer with depression?

- Do the Becks Depression Inventory-II
- Thank you for participating

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APPENDIX E:

BECKS DEPRESSION INVENTORY-II (BDI-II)

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

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11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

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20.

0	I am no more worried about my health than usual.
1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
2	I am very worried about physical problems and it's hard to think of much else.
3	I am so worried about my physical problems that I cannot think of anything else.

21.

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex than I used to be.
2	I have almost no interest in sex.
3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

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APPENDIX F:

PORTION OF TRANSCRIPTION FROM INTERVIEW-CODING 5: THEMES, SUBTHEMES AND CATEGORIES OF CODES

Text	Initial codes	Refined codes	Themes
• No, I've not been diagnosed by a doctor but I have self-diagnosed, I think. • Ja, after reading up online, and then you're like, wow. There's a certain behaviour that's associated with my emotions and whatever is going on, so it must possibly be this. • Ja, like I, there was a period in my time where after being overworked for quite some time, all I ever wanted to do was sleep and there was like nothing else. I never wanted to do anything else and sleep was just all I wanted, but I couldn't get enough of it. • And I was extremely antisocial. You try all means to make sure that you are not yourself. • I felt lethargic. Like, as if you had no purpose, just moving is just a pain. • It actually did it, but being the person that I am I was in denial of the fact that it changed anything, you know, the response would be, I have not changed, you have changed.	- Diagnosis of depression - Diagnosis of depression - Experience of depression - Effects of depression - Effects of depression - Assigning blame	- Masculinity expectations - Men= strong and invincible. Emotions = weakness. - Group giving permission to be vulnerable and express emotions - How we begin to dismantle masculinity through generational shift - Public and self-stigma= emotions mean you are less of a man - Normalization of alcohol as fun and a way to enact masculinity - The development of coping strategies and being ostracised for employing positive ones - Positive coping strategies	- **Masculinity expectations (big boys don't cry).** - Men = strong and invincible. - Public and self-stigma - Black don't crack - Coping strategies as a way to deal with difficult emotions

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• And it's just so that you don't let people in or let people understand that you are in this state. • You just rather have them think of you with what they have of you, as strong as they think you are in their head. • You know, given the dynamic of our country, growing up in a Black community, these things are not even spoken about. • If you are one with something like this you are thought of as a crazy person and you need to probably attend some rituals to be cleansed • This is not how men should be acting. • It's not normal, and basically, you seeking for help is always denied to you because you're not supposed to. • But especially to the Black community something like a psychiatrist or psychologist is very unfamiliar • The current generation are actually releasing that this is the case and they are fostering movements in place to try and cater for it. • But as for the older generation, or let me say people born from the mid-90s downwards they never really got exposed to any of this, so it's like you said, it's like a foreign object in the body. So, for them to see you in that state, they want to expel it from you but not try to understand.	- Hide or bottle up emotions - Men = strength - Emotions = weakness - Masculinity and mental illness in a black community - Depression = western concept - Stigma around mental illness - Depression = western concept - Men = no depression - Help-seeking - Men = no emotions. Men are meant to be strong. - Help-seeking - Depression = western concept - More understanding and acceptance in younger generation - Depression = western concept - Older generation is lack of understanding and acceptance	- Participants experiences of depression and its effects on others - Depression as a Western concept. More accepted to see traditional healer - Seeking help	- Participants experiences of depression and help-seeking in a south African context

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• So, they're not solving the problem but they're just solving the condition • It's ja, for those that grew up in not a suburban city like Johannesburg or something like that it's more of an acceptable thing, because when you are thought of as not being normal that is the direct route. • My father recently passed away, in like March, at the end of March, so like literally over a month ago and before that he literally was, he was thought to have been under some psychological nonsense, so they actually took him to like, what you say, a traditional healer. But from what I saw over the past couple of years, he was actually depressed. • He grew ill because of his depression and it affected his mind, the way he thought and in the end he, one day he just told me that, you know what, I feel like I just want to go like this. • So, for people who do not know better, for a lack of better words, that's, that's where they go and seek help. • But for those who grew up in a Suburban City, they know about psychologists and physiatrists and they want to seek help. • But the problem is how their peers will see them, you know. It's you are shunned out of the masculinity	- Deal with symptoms and not cause. Lack of understanding - Cities and modern = more acceptable to see psychologist. - Sangomas as a traditional form of help-seeking. - Traditional healer is more acceptable and know to Black community - Still did not acknowledge depression. - Depression = western concept - Experiences of depression - Seeking help- traditional route = Sangoma. Maybe don't understand depression.		

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community because you are different, you are too emotional for this role. • So, when you are with a group of friends and they don't walk about this, it means you won't talk about this. • People are growing and understanding, especially with the younger generation. • Seeking help is like pointing a rifle at your chest and hoping that you won't get a hole in there. • I have a friend who currently deals with depression, but the way he deals with it is by talking to me and he cannot talk to anybody else, and the minute he does they engage in these family meetings where they discuss whether this person is crazy or whether the, you know, the Sangoma route. • And he just wants an ear and people are like oh, that's not normal, you don't give an ear to this abnormality. • In the way that masculinity is viewed in society in the sense that if I cannot provide then I'm being less than. • If my emotional stability is not a 100% at its core then I'm less than what I should be or thought of. • So, therefore I'm perceived more as a feminist or in the feminist sense than a masculinity sense. • So, I would rather hide it than show it	- People who have exposure to other forms of help-seeking will explore it. - Masculinity expectations - Emotions = weakness - Stigma and ostracised for seeking help - Depression and emotions not normalized - Mask or hide emotions - Generational shift in accepting depression/ emotions and depression - Seeking help - Depression & emotions = stigma. Labelled as weird and crazy. - Sangomas as possible form of help-seeking. - Labelled as crazy or abnormal when expressing emotions. Stigma		

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• Because now people now start bringing these questions into plat, you know, about whether you are fit to play a gender or you're stuck in between and what you identify as • So how it currently works is that one person speaks out and like a large majority becomes sympathetic towards them, so but the way they speak out is by fostering… to have a place to speak. • So I saw this thread once upon a time on twitter where it says men go through a lot, and then it's just like follow this thread and they just listed all these issues, and depression, and whatnot. And the majority of the people that responded to the thread by likes were men, you know, because they could sympathize with what this guy was saying but they weren't willing to be vocal. They just needed somebody to be there for them so that they can actually have a place to sort of let society know. • Ja. You do find fair and few of those, but they are more open to speaking to speaking to like a smaller group, you know, and this thing is bigger than a smaller group. • So, I think I since I started mountain biking like with your dad and the group, you know, I've been sort been thinking better about myself, but in the same sense being ostracized from my own community.	- Being strong and providing= masculine - Emotions = weakness. Less of a man - Emotions = labelled as feminine - Hide or mask emotions - Ostracised by society as less than a man - Normalizing emotions and giving a safe space to express it - Normalizing emotions and giving a safe space to express it		

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• And everybody is so accepting and so like cool about it, like my own community, they just think that I'm trying to be better, you know, than them, but I'm seeking help. • This is like my form of seeking help and it helps, you know. I get on the ride and [audio cut 0:22:40.7], maybe I'll speak to your dad or somebody else and they've been through this and they just tell me like a little, good, some good piece of advice and it helps me out and I forget about the entire thing for like the next two hours. • And even when I get home, I have some form of advice that I got, rather than being stuck in one place, engaging in a form of alcohol abuse, you know, what society deems the normal way for us to seek help, you know. • That, for me, is not a norm, but being ostracised is also like it's a painful thing, it's like you have to choose between a rock and a hard place. Like, the ostracization and be accepted in a world where you feel you don't belong, or go and seek help and be ostracised. • So I play the guitar, so all forms of electric guitars and the acoustics. • I tried that and I got really good at that, but it's like, but why are you doing this when you could be here engaging in this form of abuse with us?	- Men not willing to normalize these emotions - Mountain biking as positive coping strategy - Ostracised for positive coping strategy - Seeking help - Ostracised for seeking help - Coping strategy for seeking help		

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• I started running and there was a big lack of support and the people that supported me were not the people from the hood. • So, I appreciate them being there, so their presence, because it gives me a safe space to sort of seek help, you know, because asking them, seeing the way their personalities are, they're not judgemental or any of that, actually, that's how the entire group is. • White community, the Afrikaans community, and the macho-ness is like even bigger. So, now everybody's going Bushveldting and you don't feel like it and they look at you like, bruh, why are you this way? We'll just crack a beer and you'll feel better. • So, being where I come from, if you look at any movies of Shaka Zulu, he is seen as a strong-willed man, you know, and it was a problem by, I thought like if I actually spoke of how what's going on is affecting me I'm going to be seen less than and therefore demoted from my position, you know, and it was so weird when I initially spoke and I took a chance and she accepted me. • I went to my mom one day and I actually said to her I love you, and what's shocking was she didn't know how to respond. She just moved away in a hast and it's been good [inaudible 0:32:44.4] not familiar with men being	- Speaking to people as a form of seeking help - Normalization of alcohol as a form of coping strategy - Ostracised for taking positive coping strategy - Positive coping strategy - Roped into masculine norms		

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that [inaudible 0:32:47.5] able to share that, so it's like a, it's a work in progress, but there are people that would love for men to actually be more vulnerable. It's just, they're not ready to respond and we can't judge them for not being ready, because we ourselves had also kept this stigma of a role going on for so long. • Yes, very much so. It's more, what's the term for it, they are trying to cure a symptom and not the disease, you know, it's actually one is encouraged to do that, you just cure the symptom and not the disease because of the view of masculinity and, like it's for people who do not have an outlet like, for example me, it's just a go to tool, because you either do that or you're forced into a place whereby you are completely alone and you don't have that much. • Self-help to me is like finding a way for myself to be able to pick through the situation, whereas a coping strategy would be something for me to try and bypass the situation for the time being knowing that I'm coming back later. • It reminds me of a quote or a, it was sort of a meme quote but it was so relevant in that sense that it said, you know, people forget how men are. They start. Asking, as you get older, are you married? Do you have a house?	- Lack of support for positive coping strategy - Cycling as a form of a positive coping strategy. - Non-judgmental environment to express feelings. - Masculinity expectations - Normalization of alcohol- crack a beer with the boys - Bottle up emotions - Emotions = weakness. You will be demoted from your position. - Self-stigma		

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Do you have kids? But they always forget the key aspect, which is, are you happy? • So, there's that mountain biking, there's my musical instrument, my guitar. • Since engaging in mountain biking what I've seen is that it gives me an excitement for the weekend or for the week. • You realise this is freaking awesome and you look forward to that engagement because you're in a state of euthanasia that was impossible to you before. Before, you are done with your week there's all this loading in and what's the number one thing that men love to do to try and get over this, it's at a bar, you know, at the Irish Rock or something, but now, here's something different, it works out for you, it costs you nothing except you being voluntary. • And there's a period whereby I spent about six months working in and out of the office like around the clock, so twenty-four-seven, three sixty five, and my mind was like literally going crazy. So, the first thing that I did to try and fall asleep at night was like abuse alcohol to its core. Like I drank whatever strongest bottle there ever was, rum and all of that, just to try and fall asleep at night and it worked for a while, but then your body becomes	- Stigma around not sharing emotions - People don't know how to act when men are vulnerable - Why men feel the need to engage in negative coping strategies.		

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chemically used to the abuse and it needs a stronger dose, and I realised that doesn't work. So, the, one of the CEO's at the time was a mountain biker and he always came in and he became like a five-year old. He's a fifty-year old guy that became like a five-year old when he spoke about mountain biking. • And it was a series of trail and error, like it was the abuse, from the abuse it was the sports, the sports had a change in the abuse at work and that just furthered the growth, and that's just what I do now. • I feel like it helps me like solve these negative emotions because I can have the most negative day in my life, and I go for a cycle on a Tuesday, we call it the social snails ride, and by the time I come back even, I've enjoyed the company of the people on the ride but it's like my mind goes into a state of lethargy for the negative, and by the time I come back I actually try to understand from what point of view that person came or engaged with me in whatever negative conversation they had. So, sometimes you also find that people are people and they [inaudible 0:47:43.9] something that happened to them. So, for me, it like clears out the mind and I'm like fully refreshed for anything. So, my life as of doing mountain biking I feel happier, I feel better, so even if I do spend	- Definitions of self-help and coping strategies. - People focus on the constructs for men and don't really ask them how are they doing. - Positive coping strategies he uses - Positive effects of coping strategies - Positive effects of coping strategy - Mountain biking as opposed to alcohol		

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like a week not mountain biking I don't get into that depressed state anymore or, you know, I fall back where I was. I'm just like, you know, Sunday is coming, looking forward to this, and it's not I'm avoiding the situation. It's like, look, it's going to be there but they say life doesn't get any, it doesn't get any easier. You just get stronger. • It's awesome to engage children from a young age, meaning that no, it's okay, you know, dad is a strong guy but it's okay for you to feel this way, it's okay for you to, you know, it's better you start that off so when they grow up they have that in mind. • I think, so there's this church that I used to go to and they used to like encourage this thing in like men, you know, for the family, that you are the leader of the household and you need to make sure that things fall in place, but like, the way children perceive men is like there's this big superhero, this monster of a dad and he's mine, and all of that, but they need to also understand the other side, that daddy is vulnerable, you know that he is fine having to tell mommy sorry, he's fine having to tell mommy I love you, he's fine having to tell mommy I had a bad day. Therefore, I can also say that to mommy, but the minute the father doesn't say that to the mom or	- Normalization of alcohol for men to cope with issues. - Participant abusing alcohol as a form of coping. - Realised it no longer worked for him and how he found mountain biking.		

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doesn't engage in that kind of conversation the child grows up thinking that it's okay, dad was strong, which means I have to be strong. You know, as much as the mom has an influence, the paternal part is extremely important, especially in men, because their role models. • Ja, so personally, I would actually like ask them to actually go out there and be more outdoorsy because being indoor is a problem. So, I would, in small things like if there's a botanical garden next to you or like a place like Rietvlei, go there, not trying to engage in the sport, but just go there for like a small thing, like a 20-minute hike and you'll find people along the way.	- Development of coping strategies. From abuse to mountain biking – trail and error. - Positive effects of mountain biking - Coping strategy helps to deal with the emotion directly		

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	- Normalizing emotions from a young age. Generational approach to dismantle masculine identity. - It becomes a generational thing. Masculinity is what the father teaches the son. Thus, the dad needs to normalize emotions and the fact that it does not make you less of a man.		

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	- Advice for men is to go more outdoors, to engage with people along the way. This can be a positive coping strategy.		

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