Exploring common constructs and everyday language of depression among Indian men in Gauteng

A mini-dissertation submitted in partial fulfilment of the requirement for the degree

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Dedication

This mini-dissertation is dedicated in memory of Adri Prinsloo.

This one is for you.

As you have promised, you always had my back, and for that;

I thank you.

Acknowledgements

- To my Amma and Appa, it is only through your countless sacrifices, constant encouragement and prayers that I have achieved these successes. Thank you for supporting my every dream. I owe you this and so much more. God bless you both. I thank you and I love you.
- To my brothers, thank you for always believing in me and supporting me throughout these years. I love you both.
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- To my Lord Shiva and Goddess Kali, you have held onto your child when she needed you the most. I will praise you for as long as I live.

With gratitude,
Vashnie Sithambaram

Om Namah Shivaya

Declaration

I, V. Sithambaram (student number 14134170) hereby declare that this mini-dissertation, which I submit for the degree of Master of Arts Clinical Psychology at the University of Pretoria, is my own work and has not been previously submitted by me at any other university. Where secondary material or resources have been used, I have given careful acknolwedgment to and referenced in accordance to the university requirements.

Signature

Date 31 August 2022

Abstract

Depression is known to be one of the most common mental health disorders, which, if severe, may predispose sufferers to suicidal ideations as well as suicidal attempts. There are approximately 804 000 completed suicides annually worldwide, with men accounting for 57% of this figure. Research that has been conducted regarding depression among men is limited, specifically within the Indian community in South Africa, where social and cultural norms dictate men's perception of what depression is, what causes depression and, essentially, how to respond to mental illnesses such as depression. These socially and culturally-constructed norms often serve as barriers to preventing men from seeking the help they require. In the aim of exploring how these socially-constructed norms shapes Indian men's own construction of depression, this study used a qualitative design, specifically purposive sampling, to recruit seven participants and conducted semi-structured interviews to collect data. Data were analysed through thematic analysis and interpreted within the principles of social constructionism. A total of seven themes and 11 sub-themes were discovered. These themes included findings about the understanding of depression within the participants' community, expectations placed on participants as Indian men and their attitude towards seeking professional help. The findings suggested that the fear of being stigmatized was the most prevalent barrier preventing men from seeking the help they needed. Recommendations for addressing depression in men in the participants' communities include more psycho-education and guaranteed confidentiality, so they are able to gain access to the help they need without the fear of being stigmatised.

Key words: Depression, Indian culture, social constructionism, gender roles, stigmatisation, masculinity

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CHAPTER 1

INTRODUCTION TO THE STUDY

Introduction

This chapter provides an introduction to the research titled *Exploring the common constructs and everyday language of Depression among Indian men in Gauteng*. It further entails the background and justification of the study, as well as a discussion of the aim and research question. An overview of the methodology used in the study is also presented, and the chapter will subsequently conclude with an overview of the chapters to follow. .

Background and justification

Major depression is considered to be one of the most predominant and escalating mental disorders which exist globally (Berk et al., 2020; World Health Organisation [WHO], 2017). The World Health Organisation (2021), states that approximately 270 million people are diagnosed with depression, with it being the most significant predisposing factor leading to suicide. They further proclaim that in the year 2012, 804 000 people completed suicide across the globe, which accounts for at least 50% of all violent deaths among the male population (WHO, 2014). Although depression may not necessarily be viewed as a direct cause of death, people who are diagnosed suffer great distress in their personal and professional lives (American Psychiatric Association [APA], 2013; WHO, 2021).

Depression is considered as a serious health condition, which, when at a severe stage, can predispose the individual to suicidal ideations and eventually suicidal attempts (APA, 2013). For this reason, depression continues to be the second leading cause of death, with over

700 000 people dying due to suicide every year (WHO, 2021). This is particularly prevalent among the worldwide population aged between 15-29 years (WHO, 2021).

According to the work of Holmes and White (2006), the alarming rates of suicide in Africa envelopes a fourfold increase in the number of completed suicides among men. Although this study is currently considered outdated, their findings proved significant in a study conducted by Kootbodien et al. (2020), which revealed that suicide rates per 100 000 population were 2.07 among men and 0.49 in women. This indicated that the fourfold increase remained consistent from 1997-2016 (Kootbodien et al., 2020).

Statistics provided by WHO (2021), show that 63% of the world's suicide rate recorded for the year 2002 were completed by men. In 2014, statistics showed a varying difference in the suicide rates between men and women, with low to middle income countries (including South Africa), presenting with a rate of more than 57% completed suicides among men than in women (WHO, 2014). These statistics are acknowledged as the result of depression being under-diagnosed among the male population (Barclay et al., 2005; Christensen et al., 2015; Griffith et al., 2013; Hoy, 2012).

The under-diagnosis of depression may be linked to the difference in how men convey their symptoms. A narrative review conducted by Christensen et al. (2015) states that men tend to externalise and somaticize their symptoms. This review by Christensen and colleagues, as well as other scholars, added that the diagnostic criteria adopted for the diagnosis of depression was predominantly inclined towards detecting depression in women and did not account for the contrasting symptoms displayed by men (Christensen et al., 2015; Griffith et al., 2013; Liang & George, 2012). Under-detection of depression in men stems

equally from the lack of awareness both men and their surrounding communities have of depression, as well as constructed gender-based roles and distorted perceptions of depression; factors which result in stigmatisation and the failure to seek help (Corby et al., 2011).

As evidenced above, the presentation and experience of depression in both men and women are influenced by a myriad of factors. In addition to gender roles, culture is a subsequent factor influencing how depression is perceived and expressed among individuals. Kleinman (2004) postulates that depression is oblivious to boundaries, therefore all ethnicities are affected equally. He adds that culture inevitably provides a framework which guides the manner in which depression is experienced by individuals, the language they adopt to communicate their symptoms, as well as decisions they make with regards to possible treatment, or the refusal thereof.

Overall, it is culture that serves as the link that allows for the interrelated connection between predisposing risk factors and social systems, together with additional psychological factors. Cultural backgrounds impact significantly on the diagnosis being made, with possible management and treatment options that follow, in addition to the various cultural-specific syndromes an individual may experience (Kleinman, 2004; Matsumoto & Juang, 2004). Historically, healthcare professionals would often overlook cultural dynamics and instead opt for a more uniform way of understanding and treating people, endorsing a westernised interpretation of mental disorders such as depression, omitting or neglecting cultural orientations of individuals (Ally, 2008).

Today we see an enhanced appreciation for said cultural dynamics. For instance, the DSM-5 addresses the issue of culture by introducing a Cultural Formulation Interview (CFI)

as part of the diagnostic manual which incorporates causes, barriers and preferences related to the patient's cultural background (American Psychiatric Association, 2013).

There have been several published works of research which engage with the cultural components of depression (e.g., Ally, 2008; Anderman, 2010; Helman, 2007; Kirmayer, 2001; Kleinman, 2004; Laher, 2014; Matsumoto & Juang, 2004); however, this has been very limited within the Indian population (Liang & George, 2012; Loo & Furnham, 2013; Rao, 2009). Research that does exist focuses predominantly on women (e.g. Bemath et al., 2018; Jain & Levy, 2013), and although there is research on Indian men's experiences of depression (e.g. Addis & Mahalik, 2003; Hoy, 2012; Liang & George, 2012) there is none that addresses how depression is constructed within the Indian male population, specifically in South Africa. Consequently, this research will explore gender dynamics and expectations within the South African Indian community and how this impacts the perception of depression constructed by men within this community itself.

Brief description and statement of the research question

Depression is a serious mental disorder and the importance of studying it in different cultural settings and among different genders is supported by the scientific community (Anderman, 2010; Kleinman, 2004; Laher, 2014). Although there is evidence of recent interest in depression as experienced or constructed by South African women and/or men (e.g., Ally, 2008; Ally & Laher, 2008; Bulbia & Laher, 2013; Laher, 2014) this is still largely an unexplored research domain, especially amongst the Indian community.

Explorative qualitative research is thus indicated and gives rise to the research question of the proposed study: What can be understood about Indian men's construction of depression?

Aim of the study

The aim of this study is to understand what constructions a sample of Indian men in Gauteng have of depression. The goal was to accomplish this by adopting a methodological and paradigmatic stance, which assists in acquiring data that is rich and descriptive in nature. The discussion on the form of methods used and social constructionist lens are to follow.

The objectives of this study were therefore threefold. Firstly, to inquire about the understandings and constructions Indian adult men have about what depression is. Secondly, their perceptions of what the causes of depression may be and, lastly, to explore the common discourse Indian adult men have about help-seeking for depressive symptoms. In addition, this study will serve as a method to create awareness within the Indian community through interactions with participants, and the findings thereof.

It will further provide an opportunity for knowledge within the South African context, where depression among Indian men specifically has rarely been explored. It will also serve to provide a platform for men of the Indian community to give an active voice to their opinions and concerns about mental health, whilst having the possibility of stigmatisation eradicated due to the use of pseudonyms for the participants in the study. Although the ability to generate widespread discourse of depression within the Indian community extends far beyond the scope of this study, the researcher hopes that the findings of this study will assist in creating awareness for the participants and their respective households.

Methodological overview

This study endorsed the use of a qualitative research method characterised by non-probability (purposive and snowball) sampling techniques. Qualitative research is a

methodology which is interactive and exploratory in nature (Harper & Thompson, 2011). Its use in research permits clear documentation of participants' narratives, perspectives, experiences and behaviours through the use of various data collection methods, including interviews (Jameel et al., 2018). The qualitative research method was chosen for this study as a method of gaining a comprehensive understanding of the participants' understanding and constructs of depression. This method allows for a more mindful inquiry into topics of a sensitive nature, such as depression, which should not be reduced only to statistics (Busetto et al., 2020; Jameel et al., 2018).

The methodology also entails the use of thematic analysis guidelines and, is further informed by a social constructionist paradigm. The underlying principle of social constructionism is that knowledge is a product of human interaction and social connection (Burr & Dick, 2017). Social constructionism argues that all individuals are born into a social world, therefore everything which is learned is seen as a product of socialisation with the use of language.

Social constructionism was used as a guiding paradigm in this study as it allowed the researcher to explore beyond the individual, and inquire about social and cultural realms. This broader perspective provided insight into how these elements have caused an evolution in the participants' social lives, and knowledge thereof. In other words, social constructionists argue that knowledge and reality are fluid; it is always evolving through the use of language and discourse. Social constructionism views language as a pivotal process which members of society use to share and construct knowledge.

Social interactions are seen as a method of creating a multitude of constructs in which people enact everyday within their communities. For example, what people know and understand depression to be is based on the interactions they have had with others who have experienced it. It can therefore be understood that constructs of a particular phenomenon, such as depression, are created and enacted by the people during daily interaction.

Conducting the study entailed recruitment methods which involved the use of pamphlets distributed at local stores within the Gauteng area. Further recruitment measures extended to the use of social media platforms such as Facebook, as well as word of mouth, in order to reach a broader target and potential participants for the study. An important point to take note of, is that all participants were 25 and over, and self-identified as being an Indian male.

A sample size of seven was used for this study. All participants who were interested in participation and met the full inclusion criteria had contacted the principal researcher in an attempt to initiate an appropriate time for semi-structured interviews. Semi-structured interviews involve open-ended questions, which are compiled within an interview guide. Following the data collection process, all participants' data were analysed and the resulting themes will be discussed in the findings and discussion chapter of the research.

Overview of remaining chapters

This dissertation forms a consolidation of five chapters, including this introductory chapter. Chapter Two includes a literature review, which offers a comprehensive discussion on the definition of depression, as well as previous research on Indian communities' perspectives of depression, including aetiologies, and treatment for depression. This chapter also reviews the construction of gender roles and depression, and, finally, discusses help-

seeking in a collectivist culture, with a focus on barriers to treatment that ultimately perpetuate depressive symptoms. Chapter Three of the research paper includes the methodology that underpins the study. It places a particular focus on the recruitment of participants, data collection methods, analysis, ethical considerations and the endorsed paradigmatic stance.

Following the above, Chapter Four engages with the findings of the study, with an emphasis on themes elicited during the data analysis process. Chapter Five discusses the findings of the study and includes a reflexivity section on the research process, highlighting both prospective and retrospective reflexivity. The reflexivity section will focus on the relationship between the researcher and the research, and how this may have impacted the literature review, data collection, and data analysis. The chapter will conclude with a discussion of the study's strengths and limitations, as well as recommendations for future studies related to the topic.

Conclusion

Depression is considered to be one of the most common disorders to exist globally; with a high prevalence among men (WHO, 2017). In spite of these statistics, depression in the male population still goes undiagnosed.

According to the literature provided in this chapter, the misdiagnosis of depression among men is largely due to the misperceptions society has about how depressed men are likely to present. Socially-constructed gender roles exert significant pressure on men to behave in a manner that represents strength and masculinity; as such, depressive-related symptoms may go unnoticed.

The literature in this chapter also provides an introduction into the influential role of the social and cultural background of an individual, and how it effects the way in which depression is constructed, understood, presented and, ultimately, to how it is responded. Previous literature has focused on depression in women, and students, but depression among the male population in South Africa, especially within the Indian community, is limited. For this reason, this study aims to explore the various constructions and everyday language Indian men in Gauteng have of depression. The following chapter will provide insight into the previous literature that have informed this topic.

CHAPTER 2

LITERATURE REVIEW

Introduction

In this chapter, existing literature which addresses the topic of depression among the male population is explored. More specifically, it focuses on how the definition of depression is defined by the dominant western culture, and how this definition may differentiate from the manner in which Indian communities perceive depression and its presenting symptoms.

This chapter further explores how gender roles and expectations manifesting within an individual's culture may influence the manner in which they perceive depression. In addition, it explores how the Indian culture informs the attitude men within the community have towards depression, including seeking professional help, with a significant view into the alternative ways used by men to cope with depressive symptomologies.

Depression: As defined by clinical classification systems

There are two widely-acknowledged classification systems used to diagnose mental disorders, namely; the Diagnostic Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association, and the International Classification of Diseases (ICD) published by the WHO. According to the DSM-5, a person may only be diagnosed with a Major Depressive Disorder should they present with specific symptomologies, inclusive of; a depressive mood and anhedonia, as well as a fluctuation in the individual's weight (APA, 2013).

Anhedonia is defined as the loss of interest or pleasure in activities previously enjoyed (APA, 2013). It often presents itself as a decreased capacity for enjoyment, or described as the disappearance of physical and emotional response to pleasurable stimuli (De Fruyt et al., 2020).

Furthermore, the individual tends to experience either insomnia or hyper-insomnia, or heightened levels of fatigue – he/she/they may not want to wake up from bed or engage in any form of activity. Moreover, they possess negative cognitions about the self, encompassing feelings of worthlessness. This results in a diminished self-esteem and poor self-confidence. The DSM-5 further attributes a decreased level of concentration to symptoms presented in a depressed person, in addition to recurrent suicidal ideation, all of which must be present for a period of at least two weeks, present most of the day, nearly every day and must be observable by others (APA, 2013).

Both of these classification systems incorporate criteria for the diagnoses of depression, which to a great extent remained consistent. This is with exception to a single symptom (hopelessness), which is found in the ICD-11 and not the DSM-5 (Berk et al., 2020). Additionally, in the DSM-5, a clear distinction is made between symptoms related to bereavement (sadness due to the loss of a loved one), and the onset of a depressive episode is made. This distinction is excluded in the ICD-11 classification system. Instead, diagnosis as per the ICD-11 is based on strict adherence to the duration and number and severity of symptoms, excluding reliance on the clinical judgement of a clinical or counselling psychologist (as in the DSM-5), as a way of guiding diagnosis when symptoms are not always clear (Berk et al., 2020).

What remains noteworthy is that both the DSM-5 and ICD-11 offer practitioners and social scientists constructions for the purpose of diagnosis and research. These nosologies, however, do not necessarily reflect an individual's full experiences of depression. This may explain why some researchers have highlighted that men do not express depression in the same manner in which it is presented in the DSM-5 or ICD-11, which may contribute to the under-diagnoses of men (Christensen et al., 2015).

Understanding the difference between sadness and depression

With the high number of depression cases in the male population being under-reported, the difference between normal sadness and depression needs to be highlighted. Among the many reasons include the following: a lack of awareness of symptoms and failure to differentiate between sadness, anger and depression remains one of the most significant reasons why men fail to engage in help-seeking behaviours (National Institute of Mental Health, 2017).

Sadness can be defined as a level of unhappiness, unrest and mental agony (Livestrong, 2011). In spite of having a negative impact on an individual, it is understood to be a normal human response to situations which are perceived as upsetting. Sadness is often precipitated by the loss of a loved one, failure to achieve a goal, or unwanted change and adjustments (Livestrong, 2011; Shirai & Suzuki 2017). According to the medical perspective, sadness remains deeply embedded in each individual and forms the core symptom for the diagnosis of depression (Bayle & Mouchet-Mages, 2011).

While sadness may cause a person tremendous discomfort and emotional pain, the symptoms (tight chest, tearfulness and powerlessness), do not endure for a long period and do not cause impairment to the individual’s level of functioning (Livestrong, 2011).

Should the feeling of sadness intensify, however, and individuals experience difficulties in completing tasks as usual, they are likely to be entering the beginning phase of a major depressive episode (APA, 2013).

Other common depressive disorders which exist include; Persistent Depressive Disorder (depressed mood for at least two years), and Post-Partum Depression (depressive symptoms following the birth of a child), among others. Persistent Depressive Disorder, often known as chronic depression, is usually diagnosed when an individual presents with a depressed mood consistently for a period of at least two years (APA, 2013). According to the DSM-5, individuals may also present with a reduced/increased appetite, decreased concentration, low motivation and fatigue, without remission for at least two months at a time (APA, 2013).

Post-Partum Depression (PPD), although exclusive to females, is diagnosed soon after childbirth (APA, 2013). As per the DSM-5 diagnostic criteria, PPD may be diagnosed once an individual meets the following criteria: depressed mood, anhedonia, a change in appetite, feelings of guilt and worthlessness, anxiousness attaching and forming a bond with the baby, as well as fears of harming either themselves or the baby (APA, 2013). Although the discussions of the various types of depression remain important, this study will focus on using the concept of depression as encompassing all of the subtypes.

A collectivist Indian community

Regardless of context, every person is considered to be a cultural being, who occupies residence within a culturally constructed system of meaning (Kirmayer & Swartz, 2013). For this reason, culture should be given relevance with regards to global mental health. The manner in which an individual has been socialised within their specific cultures has an

influence on the epistemological stance they take towards their responses to mental disorders, such as depression (Zaumseil, 1998). According to Kirmayer and Swartz (2013), culture influences mental health in varying ways, including how symptomology of mental disoders are shown, the course it takes as well as the outcome of the illness. They further claim that culture informs coping mechanims and help-seeking behaviours on an individual and familial level. This is especially so within collectivist societies such as Indian communities in South Africa (Laher, 2014).

The individualism–collectivism division has endured for many years and still remains essential in describing the nature of society (Buggle, 2020). According to literature provided by Chadda and Deb (2013), the construct of collectivism emphasises interdependence as being the principal value among human beings.

Chadda and Deb further report that collectivism is essential in creating and maintaining social cohesion and equilibrium within the family system. Although collectivist societies perceive this cultural norm as maintaining homeostasis (obedience-permitted harmony), an individualist (out-group) may view this interdependence as subordination for survival and support at the expense of member's self-development and exploration (Buggle, 2020).

Preliminary literature argues that absolute dependence and conformity shows an impact on a member's individual interpersonal interactions, individual thoughts and behaviours. The individual members are constantly required to adjust and re-adjust for the comfort of the family (Buggle, 2020).

In India, significant emphasis is put on the importance of following cultural practices and traditions which characterise the culmination of the various religions that encompass the Indian culture (i.e., Hinduism, Islam and Christianity, among others). It is these practices that essentially form the identity of an Indian person.

According to Ally (2008), many South African Indians have families have originated from India and, as such, it is expected that the Indian identity/ies they have been given will be passed down to future generations. Literature provided by Chawla and Mohapatra (2017), however, argues that although cultural values and standings may be traced to India's ancient history, immigration, globalisation, and exposure to education, has caused a transformation in the way Indian culture has been transmitted to latest generations. For example, previously Indian people resided in joint families, and although this may still be common today, nuclear families have become the newly desired family structure. Chawla and Mohapatra further add that in spite of culture being modified through generations and religions among Indians, the underlying values and teachings still remain strong and are therefore enforced to date.

According to Helman (2007), culture can be defined as a framework inherent to an individual's societal background, which is embedded and embraced by members of that community. It informs the manner in which one views the world, prescribing how to experience and engage with it, with other individuals, supernatural forces, the environment and religious belief systems. Furthermore, culture allows for a way in which these norms may be transferred to the next generation, by the use of symbols, language and art.

Culture encompasses a crucial role in the lives of many and influences behavioural and emotional responses to situations. As such, it contributes to psychological vulnerability, along

with the presentation, expression and also individuals' attitude towards the onset of mental illnesses (Ally, 2008). Research conducted by Good et al. (2013), revealed that an individual's display of emotional expression is not uniform among cultural contexts. They further alluded to emotions as being a cultural artefact, as it is the very essence of feelings and emotions that are embedded in the cultural context in which one belongs.

With this, it is apparent that one's cultural identity cannot be viewed as independent from their psychological wellbeing, as it is the cultural context that informs how one responds. Essentially, it is culture which organises the experience and presentation of depression.

Causes of depression: The western perspective

Depression is understood to be a highly-recognised disorder which has been studied for several years, yet the aetiology of depression still holds a complex and multi-faceted nature to date. Research shows that when it comes to depression, there is no one-size-fits-all, and although individuals may present in a similar way (as per DSM criteria), the circumstances under which their symptoms are embedded may differ (Bowden et al., 2020). In the following sections, the researcher highlights a brief description of a few possible aetiologies of depression; such will include genetic, neurobiological and economic factors.

Genetics

Research by Bembnowska and Josko-Ochojska (2015) indicates depression experienced by mothers predisposes children to depression in future. This was later confirmed by Augustyn and colleagues (2018), during their study of intergenerational continuity of depression. Their findings suggest that a positive relationship exists between mothers who were diagnosed with depression and their offspring experiencing depressive symptoms during adolescence. This

was particularly significant in adolescents who were exposed to environments of depression before the age of two (Arteche et al., 2011). In their research of maternal postnatal depression, Arteche and colleagues (2011) discovered that postnatal depression often led to maternal figures experiencing difficulties bonding with their infants, causing an insecure parent-child attachment and risk for future psychological distress.

Bembnowska and Josko-Ochojska (2015) further report that individuals with first-degree relatives who have had a depressive episode are 1.5 to 3 times more vulnerable to experiencing a depressive episode at least once in their lifetime. Their research further revealed studies which report depression shares an association with genes that occupy a fixed position on chromosomes 8, 15 and 17. Research conducted by Cui and colleagues (2020) denote that an individual's susceptibility to depression is impacted by diverse environmental, endocrine, hereditary and epigenetic factors. They further reported that with the rise of developmental behaviour genetics, researchers have focused their attention on the genetic predispositions to the gender differences in depression. However, their findings suggested there was not sufficient evidence for genetic heterogeneity in men and women with depression, as genetic markers could not be identified at the time.

Neuro-chemical imbalances

Previous research which has explored the neuroscience behind depression focused much attention on the abnormalities in the levels of monoamines (a neurotransmitter) in the person's brain (Bembnowska & Josko-Ochojska, 2015; Harmer & Kaltenboeck, 2018). These monoamines include erotonin, norepinephrine, dopamine, and gamma-aminobutyric acid (GABA); all of which are required to function on an optimal level to allow for effective physiological and emotional functioning of an individual. Harmer and Kaltenboeck (2018)

report that advanced technologies and brain imaging has revealed that depressive symptoms may be related to a decrease in the production of serotonin transporter binding within the midbrain and amygdala of the brain. While this may be true, Bembnowska and Josko-Ochojska (2015), report that a change in the production of all neurotransmitters is likely to interfere with the brain's equilibrium, essentially resulting in depressive-like symptoms including a low mood, anehdonia and tearful affect, among others.

Financial strain

Financial strain, debt, and financial stress is said to occupy a cause-and-effect relationship relative to mental illnesses such as depression (Money and Mental Health Policy Institute, 2017). As per literature provided by Keane et al. (2012), *financial strain* is an amalgamation of the behavioural, cognitive, and emotional responses towards financial stressors, when an individual fails to meet the demands of their financial responsibility. The failure to meet these demands on a monthly basis seems to present an alarming crisis for mental health within both men and women of the working world, specifically in an era where the world suffers the tremendous impact of the Coronavirus.

According to Schulz and colleagues, financial strain serves as the strongest precipitating factor of depression, alongside a myriad of other co-morbid mental and physical health challenges (Keane et al., 2012). In addition, people with financial debt are known to be twice as vulnerable to depression relative to those who do not have any financial challenges (Money and Mental Health Policy Institute, 2017).

Although both men and women are at risk of financial stress, research reports that financial strain on men and the inability to provide for their families is one of the prominent reasons

men experience depressive episodes (Oliffe & Oyrodniczuk, 2011). According to Oliffe and Oyrodniczuk, financial strain leaves men incapable of meeting the expectations of a breadwinner. As such, feelings of 'not being man enough', fear, embarrassment, and feelings of powerlessness are experienced. This essentially leaves men feeling dispossessed of their masculinity, power and success.

Other symptoms experienced by men with financial stress include constant worry, anxiety, tension and sleep disorders, among other social dynamics, such as marital and child-parent problems (Keane et al., 2012). Supplementary to the emotional challenges, financial strain acts as a barrier for men to access and finance their mental health rehabilitation and healing processes.

These difficulties experienced by men were confirmed in a study conducted by Chesley (2011), which aimed at examining how individual and interactional processes maintained gender differences. In the study, more than 50% of the male participants reported they often struggle with meeting the expectations of masculine ideals, such as being the financial provider in the household. The male participants in this study go on to report that their perception of gender roles, and men having to consistently be the provider, was birthed by belief systems, which were reinforced by their family and social networks (Chesley, 2011).

The longstanding traditions of hegemonic masculinity, notwithstanding, modern day spousal relationships involve men and women who are challenging gender stereotypes and expectations (Powell & Rushing, 2015). A present example of this is the non-traditional roles of employed mothers and stay-at-home fathers.

Although women make up approximately 47% of the labour force, childcare and family rearing are still seen as solely a woman's prerogative (Powell & Rushing, 2015). As a result of men being socialised to behave congruent to masculine ideals, stay-at-home/caregiver fathers receive ridicule and scrutiny for behaving outside of societal norms, essentially reinforcing financial and social pressure on men (Chesley, 2011).

Mental health in the context of the Covid- 19 pandemic

The current study was conducted during stage one of the Covid-19 pandemic. The following section provides a brief description on the challenges of Covid-19, and its effect on mental health. The Covid-19 virus has been defined as an extremely infectious and pathogenic viral infection that originated from Wuhan, China and has rapidly spread across the globe (Bashir et al., 2020). In addition to it causing significant impact on an infected individual's physical well-being, it has also amplified the gap between mental illness and access to mental health care resources (Nguse & Wassenaar, 2021).

According to literature provided by Besada and colleagues (2019), mental health in South Africa has rarely been given first priority, with only five percent of the public health budget being allocated to the alleviation of mental illness and mental health care. With mental health services having to previously adopt the back seat within the healthcare system, COVID-19 has caused an upsurge in the prevalence of mental illnesses across the globe (Hosseinian – Far et al., 2020). According to the Human Science Research Council (2020), 33% of South African citizens were diagnosed with depression, 45% with fearfulness, and acute feelings of isolation during the first lockdown duration (March 2020). The lockdown period, and quarantine, both involved compelled separation of individuals from their family, friends, and what they had known to be the norm (Alwatani, 2021).

Although statistics reveal that the infection rate goes beyond 33 million cases globally in the year 2020, research produced focuses predominantly on numbers and statistics alone, without much attention given to the individuals behind these numbers (Bhattacharya, 2020). Findings produced by Nguse and Wassenaar (2021), indicates that COVID-19 has led to individuals presenting with symptoms typical of anxiety, post-traumatic stress disorder, mood disorders, phobias, and obsessive-compulsive disorder. Other research indicated an increase in anxiety and depression when being constantly reminded of the global pandemic and death rates (Hosseinian-Far et al., 2020). Another reason why the rate of depression and anxiety has increased is owed to individuals not committing to their therapy appointments, either due to financial strain or a fear of contracting the infection from others (Nguse &Wassenaar, 2020).

Additionally, research findings produced by Bhattacharya (2020) in India, indicated isolation, despondency, financial stress, and social ostracism to be common themes among men and women who were either infected, or knew of someone who had contracted COVID-19. His research findings also highlighted other significant socio-economic, psychological and financial impacts, including; reduced work force, job loss, significant lifestyle changes, frequent panic attacks, depression and paranoia, among others.

Causes of depression: The Indian perspective

Subsequent to highlighting the significance of culture on one's conceptualisation of depression, research conducted by Bhugra et al. (2008) states that mental health and illness thereof, are viewed by the Indian culture from traditional systems. Although the Western nosologies of depression depict a dichotomy between mind and spirit, the Indian community

holds a holistic system of belief, which views individuals as being a culmination of the mind, body and spirit, characterised by an interdependent relationship.

For this reason, perceived causes of mental illnesses such as depression are often based on religious and superstitious beliefs, such as possession, witchcraft, black magic and karma, to name a few (Loo & Furnham, 2013). These beliefs are discussed in the next sections.

Witchcraft

The term '*witch'* is derived from the English word *Wicca*, which means female magician (Devi et al., 2006). Witchcraft, within the Indian community, may be understood as the premeditated act of harm to an individual by the use of magic or enchantment (Ally & Laher, 2008).

Findings provided by Dwyer (2003), note that witches are innately malevolent, aggressive and become jealous of those with success. With the above being their driving force, witches are known to cause both illness and misfortune, either with the use of poisonous herbs or the chanting of spells (Devi et al., 2006; Dwyer, 2003). Dein (2003), further states that the symptomologies which manifest as a result of this bewitchment often include social withdrawal, decrease in appetite, insomnia, a sense of hopelessness and helplessness, as well as marked lethargy and lack of motivation. These symptoms are echoed within the DSM-5 for the criteria of a major depressive episode (APA, 2013). It is therefore clear that symptoms of depression within the Indian community may very well be perceived through supernatural beliefs.

Karma

Additionally, the law of karma occupies predominance in how depression is perceivably caused within the Indian culture. Karma may be understood as a cause-effect relationship, which is said to characterise events within an individual's past, present and future life – i.e., the doings of one's previous lifetime will determine the quality of their future lives. Conjointly, research conducted by Rao (2009), revealed that the Indian patients in his study expressed significant feelings of guilt, dishonour and unworthiness because of their perceived previous sins and failures and concluded that this illness they were experiencing was not only a punishment, but a test from their religious belief systems.

The evil eye

For many Indians in South Africa, the evil eye remains a reality and holds a significant place in their scriptures and belief systems (Rassool, 2019). The concept of the evil eye traces back to 5000 years ago, and has strong presence in Christian, Muslim, Jewish, Buddhist and Hindu homes (Abbasi, 2017). In North India, the evil eye is often known as "Nazar", which speaks to the belief that one is able to cause another significant distress and harm by just looking at them with evil intentions, embedded in rivalry and jealousy (Dwyer, 2003).

The effect of the evil eye is said to cause illness, broken marriages, change in appearance as well as convulsions, the constant need to cry, and loss of appetite among others (Abu-Rabia, 2005; Spiro, 2005). Other signs that an individual may be impacted by the evil eye include poor interpersonal relationships, feelings of religious unworthiness, an inability to concentrate, anxiety, depression and suicidal impulses (Rassool, 2019). Research shows that the symbol of the evil eye is considered one of the strongest images across the globe, and in spite of cultural

advancement and transitioning, the evil eye remains popular among the younger generation through the use of evil eye amulets, jewellery, and fashion trends (Abbasi, 2017).

Spiritual possession

Another integral perception of depression in Indian communities is the possession of an Earth-bound spirit or "bhut" (Betty, 2005). As per the varying Indian cosmologies, when an individual has passed on, the soul transitions from the body to its next state (reincarnation) through the completion of various rituals, which allow for the release of the deceased person's Karma, and hence a complete release of the soul (Betty, 2005). In the case of these rituals being omitted, however, Betty (2005) claims the soul is understood to be a lingering soul or *bhut*. These souls may find the need to embody or possess a physical state in their desire to complete unfinished business or perform evil deeds.

Those who become affected or 'possessed' by these *bhut* are said to exhibit destructive behaviours towards the self and others (Betty, 2005). Moreover, the presentation of such *bhut* possessions includes moans, shaking of the body, strange speech, hallucinations and epileptic seizures (Betty, 2005; Dwyer, 2003).

Laher and Padayachee (2011) claim that many of the Western nosologies of mental illness tend to diagnose the spiritual and supernatural aetiologies of mental illness (evil eye, possessions, karma, and so forth), as a symptom of psychological disturbance and resemblance of a dysfunctional state. With the limited understandings that the Western practice of psychotherapy has of cultural constructs of depression, it is likely they may reject the supernatural aetiologies. This, ultimately, creates a barrier that prevents people from the Indian community from seeking help.

From the South African perspective, this is particularly significant, as research shows patients with mental illness desire much more than a diagnosis. Instead, they request that the cultural experiences of their illnesses be acknowledged as well (Bracken & Thomas, 2004). In addition, Hassim and Wagner (2013) report that formulations of psychopathology remain ignorant to South Africans' cultural perspective. This essentially compromises healthcare practitioners' capacities for a holistically effective treatment plan.

Treatment for depression: The medical model

Since the beginning of the 19th century, the medical model, also known as the biomedical model, was the most widely-used approach amongst healthcare professionals. The term biomedical is derived from the Greek word '*Bios'* (*life*) and the Latin word '*Medicus'* (*healing*) (Singh, 2020). The core belief of the biomedical model of mental disorders is that it emphasises the effect of external pathogenic agents and biological abnormalities. This means that mental disorders, such as Major depressive disorder, Schizophrenia and Attention-Deficit/Hyperactivity Disorder are seen as products of brain dysfunction (Deacon, 2013; Singh, 2020).

With an exploration into depression specifically, history shows a multitude of effective treatments which include a combination of psychotherapies and psychotropic medications which have been tailored to attend to depressive symptoms in particular (Dar et al., 2019). From a biological approach, intervention incorporates the use of antidepressants such as Selective Serotonin Reuptake Inhibitors (SSRI's), and Serotonin and Norepinephrine Reuptake Inhibitors (SNRI's) (National Institute of Mental Health, 2016). Other approaches include the use of Electroconvulsive therapy (mainly for severe depression), with psychotherapeutic

interventions, including Psychodynamic therapy, Cognitive Behavioural Therapy and Interpersonal Therapy, among others (Andrews et al., 2019; Dar et al., 2019).

Culturally informed treatment methods for depression

Cultural norms and values have become the spokesperson for several domains in a person's life, including predicting the decisions they make about the type of service or treatment they may seek (Hassim & Wagner, 2013). The manner in which one seeks psychological help may be defined by two sectors, namely; the folk sector and the popular sector. The folk sector consists of practices one would seek if they did not feel a sense of security from the medical model of treatment, or do not feel comfortable with how the medical approach explains their problems. Traditional healers, shamans, herbalists, and priests make up the folk sector (Helman, 2007).

In the view of Zabow (2007), indigenous healers are prominently utilised as an alternative to westernised mental healthcare services in South Africa. He further stated that this is largely a result of indigenous cultures, concurring that mental illness is related to bewitchment or evil spirits, and hence must seek religious or traditional forms of help.

Research by Chisaka et al. (2019) indicates that although there have been attempts to integrate the western approach with traditional medicine and perspectives, traditional healing still remains a preferred option among many citizens globally (WHO, 2013). With South Africa being a country rich in traditions, the folk sector has allowed patients who seek help to feel understood, as they were being treated by those who shared their cultural beliefs, and respectfully attended to their difficulties in a holistic manner (including social, relationship, and spiritual well-being) (Chisaka et al., 2019).

Research on traditional healing suggests two forms of indigenous healers (Zabow, 2007), namely; herbalists (provide herbal medication) and faith healers (utilise prayer as a method of healing). Literature further propagates that the reason individuals prefer alternative sources is because they believe the conventional mental healthcare system does not account for the diverse cultures and their understanding of mental illness (Hassim & Wagner, 2013; Zabow, 2007).

Alternatively, the popular sector is comprised of lay society members, which are typically women, who obtain vast experience interpreting and treating certain illnesses. This sector is adopted by those who want to gain some form of understanding around their mental illness but prefer conversing with family, members of churches and to gain relief through medication without prescription (Cihangir-Cankaya et al., 2012; Helman, 2007).

An Indian perspective on treatment methods for depression

Only one study that examined treatment methods for depression in the Indian community could be found. Bhugra and Campion (1998) conducted descriptive research on the indigenous treatment of mental illnesses.They engaged with participants – which included various Indigenous healers in South Africa – who revealed their commonly practiced interventions for various mental illnesses, including depression. Taking into account that Indian communities attribute the aetiology of depression to supernatural forces, it is significant that their method of intervention coincides with this belief as well. The following paragraphs highlight treatment methods and recommendations within the various religions among the Indian community, including Christianity, Hinduism and Islam.

From a Christian perspective, people who experience depression are seen as experiencing a time of spiritual darkness and suffering. As a result, Christian institutes often recommend that direction and guidance from a spiritual leader and fellow Christians may allow for healing and purpose (Hermes, 2003; Rabior, 2005). This spiritual guidance often directs the distressed individual towards prayer and scripture, which highlights understanding that God is close, to seek prayer and support, see suffering as a blessing in disguise, overcome loss and, finally, let hope lead to courage and restoration of meaning (Lin, 2011).

Similar to the Christian perspective, Hindus also believe that any form of illness should not be seen as separate from the mind and separate as the body; mind and spirit remain intertwined (Laher & Padayachee, 2011). For this reason, prayer and chanting phrases such as '*Om'* is beneficial in bringing healing and restoration.

Bhugra and Campion (1998) report that many Hindu communities also seek the help of a *Siddha*, who adopts the use of a *Thayath* (copper plate with Holy Scriptures). This is usually followed by a ritual which is conducted at the affected individual's house. Findings by Bhugra and Campion (1998), further noted that Ayurvedic methods of treatment (seeds, herbs, holy ash and water) is also used among Indian Hindu populations. Other methods used by the Indian Muslim population include the extraction of Koran scriptures, as well as holy water and oils, to help cleanse the individual's home with the aim of eradicating any bad spirits (Bhugra & Campion, 1998).

Alternate sources of help for depression

A study which explored help-seeking among students at the University of KwaZulu-Natal confirmed that participants were more likely to seek help from non-professionals (Motau,

2015). The top six sources listed in order of preference by the participants included; close friends, family members, general practitioners, other, and lastly psychologists. Participants further explained that close friends were easier to access and always available to them. For most participants, a need for interpersonal connection and trust was significant, and was already formed with close friends, which allowed for easier for communication and disclosure.

Participants who opted for no help confessed to having no knowledge of how to begin accessing mental health services (Motau, 2015). Others, who sought help from general practitioners, believed the cause of their illness or distress to be pathological, and sought help with a scientific (medical) background, as evidence-based methods would be of more benefit. Other forms of help sought by participants would include herbal medication, drug traders and financial institutions for troubles underpinned by finance.

Motau's study (2015) provided an overview of how people are more inclined to value alternative methods of help, in spite of them being aware of psychological forms of assistance. According to Chisaka and colleagues (2019), this a prevalent occurrence. Participants found it easier to access alternative methods and found comfort and relief therein. These alternatives provided care without the stigmatisation, fear and critical judgement perceived to be part of psychological help-seeking methods.

Gender roles and depression

Subsequent to the abovementioned perceived causes of depression, it is acknowledged that Indian communities place substantial emphasis on a hierarchical system of gender, to the extent of which it is imposed on and internalised during childhood (Kakar & Kakar, 2009). It

is this classification culture and the need to acquire a level of status and power in the community which strongly influences the level of self-worth of an individual.

In India, as a traditionally patriarchal society, having power and status was synonymous with being male (Brody, 2000). It is for this reason that Indian communities are acknowledged for placing great prioritisation on gender roles and are known for their high levels of gender discrimination.

These rigid gender stereotypes are still widely-practiced in Indian households and are considered a threat to the well-being of individuals within the community, ultimately increasing their vulnerability to psychological distress (Brody, 2000; Carson & Chowdhury, 2006).

From the lens of social constructionism, gender is a social construct continuously being produced and reproduced, shaping an individual's behaviour and, essentially, their identity. This view further considers gender as being a social construct which has held power in the division of men and women (Anderman, 2010; Courtenay, 2000; Edwards, 2015; Payne et al., 2008).

In other research, gender is understood as something with which people engage and perform through behaviour, rather than a biological trait which is assigned to an individual at birth, based on their external genitalia (Payne et al., 2008). This understanding resonates within the works of Edwards (2015), who reports that gender should be considered to be fluid, as opposed to a fixed disposition of biology.

It is therefore understood that those who occupy the male gender role in Indian communities are placed at a greater advantage than others through cultural discourses and practices. However, supplementing this perceived advantage are the substantially greater expectations and responsibilities which must be met. Men are often expected to display remarkable strength and robustness, alongside courage, competitiveness and rationality, thus significantly diminishing room for the expression of "soft" emotions and displaying vulnerability (Payne et al., 2008). Additionally, these societal prescriptions require men to conform to the norms which epitomise masculinity (Courtney, 2000).

Research conducted by Horowitz et al. (2017) acknowledges these findings, as evidence highlights that the most valued traits in men include morality, financial success (i.e., being rich and being the breadwinner), strength and the ability to lead. An inability to conform to these expectations meant that men were negatively evaluated and seen as weak (Fischer et al., 2003).

In order to uphold a complementary relationship with society, there is an expectation for men to 'protect the image of their families'. This often comes at the expense of men's self-expression and, even the sacrifice of an opportunity to heal, so that homeostasis is maintained (Call & Shafer, 2018; Liang & George, 2012). A study conducted by Liang and George (2012), revealed that Indian men experience numerous life stressors, such as: the expectations to promote the family name and status by taking responsibility and generating an impressive salary that will not only support himself but contribute to the well-being of the entire household. These expectations were imparted onto men from a young age, with its impact extending into their eventual career choices.

Indian men were expected to pursue high-paying and reputable jobs (doctor, lawyer, engineer) so as to maintain the family reputation (Liang & George, 2012). This often meant that pursuing one's passion was seen as failing the family, and not given the desired blessing and support of their respective family members. Moreover, men were applauded for working long hours, in spite of it distancing them from their support system and causing disruptions in their interpersonal relationships.

Findings provided by Edwards (2015) as well as Horowitz and colleagues (2017) suggest that men within the millennial age group (anyone born between 1981 and 1996) (Dimock, 2019) fall more prone to societal pressure, as they are expected to engage in masculine behaviours such as being interested in sport, throwing the first punch, having more than one sexual partner, exerting dominance and being heterosexual. For the prupose of greater understanding with regards to the construct of masculinity, Itulua-Abumere (2013) describes masculinity as being the thoughts, behaviours and languages, that are socially, and culturally specific, and which are regarded as non-feminine. These include dominance over the next person, violent/aggressive behaviour, interest in sexual conquest and in sports. Raewyn Connell's theory of masculinity addresses at least four forms of masculinities, namely; hegemonic masculinity, subordinate masculinity, marginal masculinity and complicit masculinity (Fernandez-Alvarez, 2014). However, for the purpose of this study, attention will be given to hegemonic masculinity. *Hegemonic masculinity* is often understood to be a form of masculinity which is context specific, and which condones inqualities between men and women, and masculinity and femininity (Messerschmidt, 2019). Becker and colleagues (2020) report that hegemonic masculinity is a social construct which has transcended through culture, various public institutions as well as societal norms and belief systems which encourage men's dominance over women or other men. It is a social contsruct which is embedded within social

pratices, interactions, and behaviours that lead men into believing that conforming to the traits of traditional hegemonic masculinity meant they received admiration, acknowledgment and were able to preserve the power within the hierarchy system (Edwards, 2015). Although this social teaching has been peservered historically, Becker and colleagues (2020) argue that the gender expectation of men needing to be masculine only creates a false reality of what it means to be a man.

Given the social pressure for men to conform to the ideals of masculinity, it is expected that any behaviour, thought or emotion which deviates from the socially constructed norm (such as being homosexual), is expected to be accompanied with judgement, and essentially detrimental psychological consequences. Preliminary research suggests that depression with suicidal ideation among homosexual men occurs at a rate three times higher than the larger population (Carrie et al., 2017). Carrie and colleagues further reported that apart from these men being seen as emasculated, they also experienced significant relationship difficulties, institutional discrimination, homophobic remarks and alienation, among others.

Therefore regardless of what the behaviour may be, if a man acts outside of what he is socially expected to do, he is at risk of being alienated and steretyped by society. Evidently, it is the significant pressures and expectations seem to be the driving forces behind attempted or completed suicide by men (Liang & George, 2012). Evidence of such cases were published in The Guardian newspaper, which reported on the suicide of a staggering 60 000 farmers in India, who resorted to suicide due to their inability to financially secure the needs of their families, after an event of climate change caused an interruption in the successful growth of crops (Safi, 2017).

In spite of these expectations becoming cumulatively difficult and causing detrimental impacts on their mental well-being, men create a façade in the face of adversity due to the fear of being condemned or shamed should they engage in help-seeking behaviours for depression (Bathje & Pryor, 2011; Hoy, 2012). It is this fear of being stigmatised which is fundamentally the most significant and powerful barrier that evokes pessimistic attitudes in individuals and propels them into avoiding psychological help.

Preliminary literature proclaims men assume seeking professional help would have various social implications, that others may view them as not having power and a sense of control over their own life situations (Barclay et al., 2005), resulting in negative self-cognitions, a loss of self-reliance and a tarnished self-worth (Long et al., 2016).

For this reason, seeking help outside of communal recommendations is not incorporated into the coping mechanisms available to most men. Instead, men typically consider seeking professional help as a last option, if at all. This essentially prompts men into rejecting help in an attempt to prove or maintain their manhood to their families – by refusing to admit that they felt depressed, ill, or required time off (Courtenay, 2000; Hoy, 2012).

Seeing that suppression of distress is encouraged, a significant portion of men would rather embrace risky behaviours (Connell & Messerschmidt, 2005; Courtenay, 2000; Oliffe & Phillips, 2008). A study conducted on South Indian men's experiences revealed that their suppressed distress manifested in an overtly destructive manner, in order to alleviate emotional pain associated with depression (Liang & George, 2012). Such externalising symptoms of depression usually included aggressive and violent behaviour and substance abuse (Connell & Messerschmidt, 2005).

Barriers to help-seeking behaviours

The previous section placed significance on the influence of socially-constructed gender roles. Literature provided by Brody (2000) highlights the importance of being born male, and how the virtue of being considered male within an Indian community automatically meant power and status, in addition to expectations and societal pressure. Men have been always placed in a position of authority and prestige, however, with this power came the pressure to perform, and embody the ideals of hegemonic masculinity (Courtney, 2000). This often meant that sharing emotions or vulnerability was forbidden. As such, men who do suffer with depression find it easier to suppress their emotions than have to face the possibility of being stigmatised. Previous studies found that the fear of stigmatisation served as the biggest barrier preventing men from seeking help. The following section discusses this barrier, with a particular focus on public and self-stigma (Bathje & Pryor, 2011).

Stigmatisation

As mentioned in the discussion above, stigma plays a significant role in the attitude men have towards depression and how their experiences are expressed. Stigmatisation of those who are mentally ill serves as a powerful barrier to seeking help for depression. Corrigan and Watson (2004) claim that stigma can be seen as a multi-faceted phenomenon, with the two types of stigmas which impact an individual's decision to seek help being public and self-stigma.

Bathje and Pryor (2011) state that individuals may be susceptible to both public and self-stigma. Public stigma refers to the various criticising behaviours, perceptions and attitudes society has of those diagnosed with mental disorders. It can further be defined as the stereotypes held by the public, which have been agreed upon and transmitted through the process of socialisation.

Self-stigma is understood as being a result of internalising the external derogatory and debilitating comments from one's surrounding culture and extended community (Bathje & Pryor, 2011). An individual thus takes public stigmas as a true reflection of mental illness, leading to the onset of fear, embarrassment and a debilitating sense of self, characterising self-stigma; this leads to high levels of suicide among men (accounting for 50% of all violent deaths completed by men) (WHO, 2014). Both public and self-stigma of depressed men thus have potential deleterious effects.

Subsequent to the above, it is evident that it is not exclusively the endorsement of cultural norms and prescriptions of the ideal man which influence the presentation, expression and attitude towards seeking professional help for depression; it is also men's rejection of feminine ideals. From a very young age, comments such as "boys don't cry", become embedded in their belief systems, ultimately preventing men from presenting symptoms without the fear of being called "weak" or vulnerable.

These stereotypes worked twofold in birthing the belief that the therapeutic space is dominated by women, and perpetuated the avoidant behaviours men display towards help-seeking for depression (Courtenay, 2000; Fischer & Farina, 1995; Moller-Leimkuhler, 2002). In support of this, a meta-ethnographic study conducted by Hoy (2012), found that the majority of men associated depression with weakness, stating it was reflective of feminine qualities (e.g., in the study, findings showed Mexican immigrants often associated the word depression with the term 'menopausic'). Consequently, men often deny their symptoms in order to avoid being stigmatised (Hoy, 2012).

Subsequent to the abovementioned, it is this internalised stereotype and fear of being ridiculed or labelled as 'feminine' that men, in spite of a desire for self-expression, remain restricted and fixated in their constructed gender roles. This inhibited response remains evident in the 2017 National Survey of all Registered Psychology Practitioners. This research report revealed that despite growing awareness of mental illness over the years in South Africa, only 20,3% of psychologists are male whilst a total of 78,8% self-identified as female. These statistics yet again allude to the hesitancy Indian men occupy in bringing their concerns forward and challenging stereotypes of psychology being a predominantly feminine field of practice. Furthermore, of the psychologists registered at the Health Professions Council of South Africa (HPCSA), only 6,8% identified as being Indian (HPCSA, 2017). Indian men's hesitancy in seeking help can therefore also be seen as a result of not being able to access a psychologist who comes from the same cultural background.

Help-seeking in a collectivist culture

The behaviours of social networks have a direct impact on the perceptions and actions individuals take towards addressing symptoms of distress (Angemeyeret al., 2001). It is recognised that people are more likely to change their negative opinions of psychological services if the significant people in their lives approve. Hence, the negative attitude men hold towards depression and their reluctance to seek help, could largely be motivated by families and a culture who devalue psychological services in the aim of providing their own support structure (Larson et al., 2007).

Individuals that come from collectivist societies base their very personhood on their community, and it is the word of the community which guides the actions of people in order to maintain homeostasis (Chadda & Deb, 2013). As a consequence of the fear of

disappointing the family and the community at large, they begin to adopt the constructed stereotype that they are to blame, ultimately leading to low self-esteem and social withdrawal.

Consequently, Indian men show apprehensiveness towards embarking on help-seeking pathways due to the anticipation of there being great censure and disapproval by the family, primarily owing to the idea that any problems experienced should not be communicated outside of the family unit with health professionals or any service providers (Helman, 2007). Additionally, in these communities, the boundary between the self and others, or personal and public is obscured – family always takes precedence and plays an integral role in all decisions. As such, help-seeking behaviours and an individual's diagnosis of depression would be discussed with nuclear and extended family alongside community members (Laher, 2014). This leads to a magnetisation of guilt and defamation unto the family name and the individual himself, owing to the loss of his societal standing and privacy. For this reason, the treatment and healing of depressive symptoms within South African Indian communities are family-oriented (Laher, 2014) and include healing methods such as prayer, recitation of the holy books (Quran, Bible and Bhagavad Gita), meditation, yoga, singing of sacred hymns, the use of amulets and engaging with spiritual leaders (Spiro, 2005).

Conclusion

The literature discussed in this chapter explores how depression is defined by Western nosologies, with specific reference to the DSM-5 and ICD-11 diagnostic criteria, which are currently being used as reference for the diagnoses of depression. The difference in how depression is perceived in the Western world and Indian communities was also discussed.

Significant awareness was brought to the dichotomy of the mind and spirit within the Western medical community's conceptualisation of depression. Notable consideration was given to how this dichotomous way of thinking leaves the Indian perception of aetiology repudiated. For this reason, this chapter provided a platform for indigenous treatment methods used by Indian communities to also be discussed. The chapter then makes mention of the hierarchical nature glorified within Indian communities, which often positions men at the top of the gender construct. Although this may be seen as an advantage by many, it often leaves men open to significant pressure from the expectations of their families and communities at large. In spite of their distress, men withdraw from emotional expression due to cultural expectations and generational public stereotypes, exacerbating self-blame and increased chances of suicide.

The following chapter highlights the research methodology, with a detailed description of the type of research and recruitment and sampling methods used during data collection. It further provides insight into the data analysis procedure, as well as the ethical considerations taken during this study.

CHAPTER 3

RESEARCH METHODOLOGY

Introduction

The aim of this chapter is to outline the research methodology used in conducting this study. This will include a description of the qualitative research design, followed by an outline of the steps taken towards answering the research questions, aim and objectives. It also illustrates how the paradigmatic stance of the study is upheld by the method of data analysis. This chapter will then conclude with a discussion of the ethical considerations and steps taken towards ensuring a trustworthy study.

Qualitative research

Given that the aim of this research was to synthesise data rich in participants' construction of depression within the Indian male community, a qualitative research design was employed, as it is most suited to the research question. Qualitative research is a form of methodology which is interactive and exploratory in nature (Harper & Thompson, 2011). Its use in research permits clear documentation of the participants' narratives, perspectives, experiences and behaviours through the use of various data collection methods, including interviews (Jameel et al., 2018).

The qualitative research method was chosen for this study in order to gain a comprehensive understanding of the participants' accounts, which illustrate their own understandings and constructions of depression. The qualitative research method further allows for a more mindful inquiry into topics of a sensitive nature, such as depression, which should not exclusively be reduced to statistics (Busetto et al., 2020; Jameel et al., 2018).

Theoretical Formulation: Social Constructionism

For this study, social constructionism will be employed as the paradigmatic stance, or "lens", through which the research project will be viewed. Although the social constructionist theory has been found in the works of various other theorists, the birth of the social constructionist theory is originally attributed to the work of Kenneth Gergen (Cruz et al., 2016).

Social constructionism is frequently found in the field of both research and clinical psychology. In a clinical practice, the patient/client's narrative is often viewed as a cumulative result of their social and intimate relationships,. In the field of research, however, the research process is seen as a collaborative project between the researcher and the participant (Cruz et al., 2016; O'Reilly & Lester, 2017).

In social sciences, social constructionism may be characterised by differing perspectives, but also unified through particular assumptions. This is summarised by Burr (2015), Galbin (2014), and Nightingale and Cromby (1999) as: 1) an emphasis is placed on social processes and how members of society construct meaning of their reality through language; 2) the language and concepts being used are historically and culturally influenced (i.e. the meanings of depression are a product of the culture, tradition and community one inhabits); 3) truths about the world are maintained through social practices and, 4) social constructionism promotes a critical stance towards challenging the foundation of conventional, taken for granted knowledge of the world.

Cruz and colleagues (2016) expand on the theoretical underpinnings of social constructionism by stating the following: social constructionism is anti-realist theory which views psychology as a socially-constructed discipline. Findings of any study will thus depend

on the moment when research is conducted, and can therefore not be generalised, absolute or replicable. Social constructionism is also viewed as an anti-essentialist theory, which holds that people are in a constant movement and growing process.

For this study, epistemology is accepted as inter-subjective, which means that knowledge is seen as a human artefact – created via language and through interaction with people (Cunliffe, 2008). Knowledge cannot be discovered in an objectively knowable world, such as in the positivist approach. It is, however, also not a manifestation of internal subjective processes as promoted by the phenomenological approach. Instead, it can be appreciated as a collective endeavour and the consequence of the various dynamics within relationships (Cunliffe, 2008; Gergen, 1985). The construction of meaning is thus an integration of social processes and negotiations.

Ontologically, social constructionism is frequently referred to as a relativist approach, which accentuates the importance of flexibility in how discourse is used to construct reality (Andrews, 2012; Willig, 2013). The relativist approach, however, is not favoured by all researchers as some prefer a less radical strand, with the aim of adopting a more moderate version, which seeks to establish associations between discourse within a specific localised reality and more widespread socio-cultural contexts (Willig, 2013). For example, this study aims to explore various constructions Indian men have of depression – how they perceive it, understand it and react to seeking help or treatment.

Adopting a social constructionist stance and an inter-subjective (i.e., co-constructionist) epistemology specifically, has implications in all areas of this study. All texts, including the ensuing literature review, are considered a product of co-constructive processes between

authors, discourse and readers. Furthermore, taking into account epistemology and axiology, value-free research is not possible from a social constructionist perspective.

Representation of data is likely to be influenced by my own perspective as the researcher and co-creator in the research process, therefore I hold significant power. The implications thereof and ways of addressing it are addressed in the section "Quality in qualitative research". Additionally, thematic analysis is chosen as the method of analysis and the implications of embedding the method in social constructionism is explicated in the data analysis section.

Sampling method

This study utilised a non-probability sampling method. Adopting this approach postulates that not all sample units comprising the target population will acquire an equal opportunity of being selected (Matabane, 2015). Moreover, this study also employed the purposive/judgemental sampling method, allowing for greater focus and selectiveness. According to Alkassim and colleagues (2016), the purposive sampling technique requires the researcher to have a set objective and recruit participants whom are willing and able to provide information, either through knowledge or experience. This was accomplished by the researcher creating a set of criteria, which was then used in the identification and selection of participants who were able to provide their opinions and beliefs on the phenomena under study. In line with the qualitative research tradition of seeking rich descriptions of experiences and the scope of a mini-dissertation, this study aimed to select a relatively small sample of seven participants (Willig, 2013).

As indicated in the inclusion criteria, the target population of this study were adult South African Indian men (i.e., a non-student sample preferably above 25 years) and resided within the Gauteng area. The decision to use this specific age is motivated by Eric Erikson's stages of development, where individuals above the age of 25 have obtained a stage of emerging adulthood, where interpersonal relationships are salient and a reasonable sense of identity has been developed through a form of out-of-school experience (McLean & Syed, 2012).

In addition, this particular age range was pursued based on the researcher's interest to explore a sample that had yet to be researched. Many prior studies which have explored the construct of depression focused predominantly on the student population. In his meta-ethnographical study, Eksteen (2015) tabulates a number of these studies which have explored depression among male and female students, including those by Becker et al. (2011), Bolteroff, et al. (2010), Galdas et al. (2014), and Mentik et al. (2001), amongst others.

This study was conducted in Gauteng province. According to the "Growing Gauteng Vision and Action Plan 2019 – 2030" provided by the Gauteng Provisional Government at the Gauteng Disability Summit (2020), Gauteng is recognised as the financial and technological nerve centre of Africa. It is further known for its career boosting prowess and is often awarded the term of being South Africa's golden economy (Gauteng Disability Summit, 2020).

Additionally, with Gauteng holding a position of great material success, many flood to the 'golden city' in the hopes of jobs and a more individualistic culture. As such, it should also be noted that although the Indian community is known for its collectivist nature, the participants who were interviewed have also been exposed to the experiences of an

individualistic culture. Although the researcher highlights a brief description of the context in which the study took place, it is important to note that this particular context was also chosen for the purpose of convenient access to participants, as the researcher had closer proximity to potential participants, should in-person interviews be preferred.

Additionally, as part of the inclusion criteria, all participants interviewed were required to be able to speak and comprehend the English language well. This allowed for communication to flow smoothly, preventing meaningful data from getting lost in translation or for there to be any form of misinterpretation by the researcher.

In keeping with the goal of this research, the study was aimed at gaining an extensive understanding of the sample of Indian men's knowledge of depression; as such, participants interviewed may fall into the category of those who have either personally experienced depression or into the category of those whose construction is embedded within society's truths.

It must also be acknowledged that during the interview process participants were not obligated to disclose whether or not they had been diagnosed with depression, or if they knew someone who had experienced depression. Given the sensitivity of the topic, the researcher did not want to pose questions that may have caused emotional distress to participants. However, during the interview process, this information had been disclosed voluntarily by participants. This categorisation of whether or not the participant's knowledge is shaped by personal experiences is clearly indicated on Table 1, which highlights each participant's demographic characteristics, including age, occupation, tertiary education, and marital status.

Lastly, this study involved participants who self-identified as Indian, regardless of their religious affiliation.

Recruitment process

Prior to conducting the study, permission was granted from the University of Pretoria's Faculty of Humanities Research and Ethics Committee (HUM041/0221). Pamphlets with information regarding the purpose of the study (see Appendix 5), the inclusion criteria, as well as researcher's contact details, were distributed to the public at local stores, male salons/barbershops, as well as gyms.

The recruitment strategy also extended towards the usage of social media platforms such as Facebook, as a way of expanding the possible reach of the recruitment strategy. This proved most effective, as the majority of the participants reached out to the researcher via the above social media platform. Individuals who were interested in participating in the study were able to contact the researcher via email or phone using the details provided. Upon the participant's inquiry of the study, the researcher ensured that each participant was properly informed with regards to the purpose, justification and process of the study, subsequent to their rights and responsibilities as a participant and questions that they may have. The recruitment process ended once the researcher established data saturation (i.e., participants began responding with similar information and no new information was being established).

Data collection method

Considering the current Covid-19 pandemic and the social restrictions being imposed at the time, face-to-face interviews sometimes proved to be a challenge. Upon the phase of data being collected for the study, South Africa was declared to be on a Level 1 lockdown, which still permitted work-related travel and meetings.

For the safety of the participants and researcher, as well as convenience of both parties, however, interviews took place virtually unless an in-person meeting was preferred and permitted by the participant. This allowed the participant to feel more at ease because the interview had taken place in an environment with which they were most comfortable

The informal method of interviewing via a virtual platform eradicated the stressors that came with in-person interviewing (Self, 2021); for example, participants feeling nervous or uncomfortable being seated directly across the researcher. Moreover, since the lockdown restrictions were enforced in 2020, many people had to modify the way in which they worked, causing them to have to adjust and internalise to a new normal, which many seemed to have become accustomed (Aghakhani et al., 2021). Lastly, virtual meetings served as a more cost and time effective method, as the interviews could be done at any location preferred by the participants (Self, 2021). This also meant that the researcher was able to reach a greater geographical range, as participants were able to engage from any location within Gauteng. This way, their participation corresponds with their own schedule and needs (Dineva & Nedeva, 2020). The participants were also given the option of an in-person meeting if preferred.

Semi-structured interviews were used to collect the data. This is a form of qualitative research method which combines the benefits of, and serves as a middle ground between standardised closed-ended and open-ended questions (Adams, 2015). Each interview took between 40 – 60 minutes, and five out of the seven interviews were audio recorded, following consent given by the respective participant. The remaining two interviews required the researcher to make notes during the interview process. Unlike the formal interview, the semi-structured interview takes place in a conversational manner, and was chosen as it allows to

focus on specific themes, through the use of a combination of open- and closed-ended questions, as well as probes, which are prepared prior the interview (Raworth, 2019).

The interview guide (Appendix 4) was informed by the research aims and preliminary literature that provided a background on the topic of depression among the male population. In addition to this, the researcher was able to access and explore previous studies and research questions to adjust and develop questions that would effectively address the understandings and constructs of depression among the male population. Apart from questions that aimed to elicit Indian men's understanding of depression, questions which explored the social structures, family, and barriers thereof were also a significant part of the interview guide. In addition, questions indicated by the literature regarding the participants' demographics such as age, marital status, and level of education were also included as a means to gain context behind their narratives. As the final step, all interviews were transcribed verbatim to assist with the data analysis process.

Data analysis

For this study, the researcher employed thematic analysis as informed by a social constructionist position. According to Braun and Clarke (2006), thematic analysis is recognised as the most predominantly used qualitative data analysis method, as it provides structure to a rich and descriptive set of data.

It additionally permits readers the opportunity to gain a greater sense of the important themes that dominate in a realm that is under-researched and therefore less known (i.e., depression among South African Indian men) (Braun & Clarke, 2006).

In their literature Braun and Clarke (2006) further report that thematic analysis is ideal, as it is not linked to any particular epistemological position and is therefore able to draw from a social constructionist framework.

With the underpinnings of a social constructionist framework emphasising the lack of a universal truth, the researcher makes use of this form of analysis, as it allows for insight into the multiple realities that have been constructed by the participants within their respective social and cultural processes.

During the analysis procedure themes were elicited on a latent level by an inductive approach. This means the analysis was data driven (i.e., data collected formed the foundation from which themes emanated) (Braun et al., 2017). Using this form of analysis, the researcher identified and provided an understanding of how ideologies, concepts and assumptions via language shape the construction of depression among the Indian male community members in this study (Braun & Clarke, 2006; Ibrahim, 2012).

The steps for thematic analysis stipulated by Braun and Clarke (2006) were followed during the course of the data analysis process to establish a pattern in the data collected. The analysis process began with the researcher familiarising herself with the data; this involved the researcher immersing herself into the depths of the content through repetitive reading, and searching for patterns and meanings. However, this was only conducted once the interview data had been transcribed, to have a verbatim account of the verbal and non-verbal communication. During this process, the researcher has also made use of notes which included her thoughts, ideas and feelings regarding the appealing extracts within the data collected.

The second step; establishing possible initial codes, which involved the researcher generating a list of areas of interest within the content provided, and subsequently organising them into meaningful groups of data. The second step was also assisted by the use of analysis software (NVivo), which allowed for easier organisation and structuring of the initial codes. Following this, themes were identified by sorting and collating all the relevant coded data and extracts. Each theme was then given a label and attached a meaning. This was achieved by identifying the essence of what each theme meant, and providing a detailed description for each of them. As the final step, a detailed report displaying the data findings was produced.

Quality in qualitative research

Qualitative research is interactive and explorative in nature (Harper & Thompson, 2011). It entails constant engagement between the researcher and the data and is therefore understood to challenge the preferred scientific rigor and objectiveness (Willig, 2013). As such, this study will engage with various guidelines to ensure it is both rigorous and coherent. These guidelines focus primarily on researcher reflexivity, transparency, credibility and research sensitivity. In an attempt to ensure this rigor and improved quality, the study will abide to the 15-point checklist provided by Braun and Clarke (2006) throughout the research process. In an effort to ensure transferability and dependability of the research, the researcher will engage with a detailed and comprehensive description of the research process by documenting each stage in a step-by-step format, which will entail a clear representation of the research context (Hadfield et al., 2018).

Due to the inter-subjective epistemology of social constructionism, biased-free research is not possible. In service of this notion and of transparent research I will make use of a personal reflexivity journal, which will record, for instance, how my own identity,

experiences and gender influence the research (Willig, 2013). This journal will also entail how my position as an insider (having the same ethnic background) and as an outsider (being female), will impact the manner in which the participants convey their constructions of depression and, fundamentally, how it will impact the research findings.

These reflexive writings will, in consultation with my supervisor, be incorporated in the analysis by considering how I in my positionality helped construct the research process and findings.

Lastly, in order to ensure credibility of my data, copies of my interpretations of the interview will be sent to the respective participant, to allow for participant validation/checks (Hadfield et al., 2018; Willig, 2013). This is not in order to determine the "accuracy" of my understandings or to establish the truthfulness thereof, but rather to offer the participants the opportunity to elaborate on or challenge these interpretations. The use of this strategy is thus in agreement with the moderate relativist perspective of social constructionism.

Ethics

As this study will involve human participation, significant precautionary measures will be adopted to prevent any form of foreseeable psychological harm to the participants' well-being, as a direct result of this study. To ensure ethical procedures are adhered to throughout the study, the following measures will be adopted.

Subsequent to obtaining ethical approval from the Faculty of Humanities Research and Ethics Committee at the University of Pretoria, suitable participants showing interest received a detailed information sheet (Annexure two) prior to their interview commencing. This

document included details regarding the purpose of study, consequences of participating, confidentiality and the handling of data, together with other concerns regarding withdrawal from the study and informed consent. This allowed for the participants to ask questions if they had any uncertainties.

In an attempt to safeguard participants' identities and maintain confidentiality, this study used pseudonyms in replace of identifying information (Brinkmann & Kvale, 2017). Moreover, each participant was required to sign an informed consent form preceding the start of their interview (Willig, 2013).

This served to inform participants of their rights as a participant, making them aware that their involvement in the study is voluntary, thus withdrawal was permitted at any time during the data collection process, without questions, judgment or fear of being penalised (Devettere, 2016; Willig, 2013).

This document also included consent for the purpose of audio recording the interview, transcription of data, and the use of data for further research purposes. Data collected was secured on my password protected laptop and stored at the University of Pretoria for a period of 15 years (Gajjar, 2013). Lastly, steps were taken to ensure that each participant's psychological, emotional and personal safety and well-being was preserved and respected after each interview (Willig, 2013), as they were provided with relevant resources to access the necessary psychological services from the South African Depression and Anxiety Group as well as Lifeline, if they required it.

Reflexivity

"There is no neutrality; there is only greater or less awareness of one's biases" (Rose, 1985, p. 77)

With social constructionism being the guiding lens of this study, it is appreciated that an individual's understanding, knowledge and therefore perspective is essentially created by the use of language through interaction with those who surround him/her (Cunliffe, 2008). During the process of data collection, the semi-structured interviews, although guided by a pre-planned schedule, offered participants the opportunity to engage in an interaction. For this reason, the following section will highlight the researcher's membership in relation to the population under study, and how her insider-outsider role may have essentially impacted data collection and the interpretation that followed.

According to Buckle and Dwyer (2009), an insider researcher is understood as the researcher occupying a similar identity, language, culture, or experience with the population under study. Alternatively, occupying an outsider position is understood as the researcher not having any commonalities with the population being studied. However, there are often cases in which researchers can never really occupy an entirely inside or outside position (Milligan, 2016). As such, this section will highlight the researcher's insider and outsider position during the current study.

With the researcher having grown up in an entirely Indian collectivist community, she not only occupies an insider position but has also been able, to a certain extent, share experiences and perspectives. Living in a collectivist society meant that values and beliefs were an extension of the community itself. One of these beliefs that still remains among many Indian communities is that depression, let alone mental illness, is not a topic that triggers interest. As such, many who suffer with symptoms of depression either resort to maladaptive coping mechanisms or spiritual rituals to assist in the alleviation of their sufferings.

Given the researcher's background and her insider position, she was able to gain access to a population that may be otherwise closed off to others who did not come from a similar culture. As such, participants showed a willingness to share their experiences with regards to depression amongst men in the Indian community, with the knowledge that the researcher understands where they may be coming from.

According to research, this insider position is what further allows participants to feel comfortable and accepted (Buckle & Dwyer, 2009). Although the researcher's insider position may have allowed a common ground between herself and her participants, it also seemed to cause participants to engage in a vague manner, with the presumption that the researcher may already be aware or share the same experiences. As such, probing and the request for participants to expand on their responds were often utilised during the interviews.

In addition to the above, it must be acknowledged that when conducting research that is explorative in nature, remaining objective or detached from data collected can prove to be a challenge. Although reflexivity was conducted, qualitative research is not excluded from researcher bias. Occupying an insider position, I as the researcher, have also been groomed in an environment that thrived on ignorance and lack of knowledge when it came to mental illness. It was only exposure to social structures such as tertiary studies in the field of psychology that my awareness of mental health had grown. Emanating from the background of a therapist in training, it is also natural that I would want to assist in building the awareness of mental health especially within the Indian community. As a result, it is possible that I as the researcher may have given significant attention to themes that highlighted the above challenges within the Indian community, as there had always been an internal drive to psycho-educate, and create social change through awareness. Although this form of research-

bias may have impacted significantly on the manner in which the reader had perceived the findings, it was driven from a desire to draw focus to a problem that seemed to be ongoing for generations.

Upon reflection, the researcher acknowledges that despite her background offering certain similarities with the population, her experiences as an insider were not entirely homogenous to that of her participants, and differences were greatly emphasised during the data collection process. Essentially, occupying an outsider position allowed the researcher to understand more greatly the experiences of a subculture within the Indian community (i.e., Indian men). Holding an outsider position as a female allowed a more valuable role.

During the interview, participants seemed to have taken a more educating stance, in that they were willing to express the difficulties men endure without hesitance. This was enlightening, as it revealed their appreciation for being asked about their experiences and societal norms with regards to men and depression. Although holding an outsider position may have defined the relationship the researcher had with the participants, it did not seem to hinder the data collected, as participants still showed appreciation for the researcher's willingness to learn and capacity to value their individual experiences.

This section would be incomplete if the role of researcher-therapist was not explored. Stepping into the shoes of a qualitative researcher whilst still occupying the background in clinical psychology proved to be a challenge in reframing and redefining the relationship the researcher had with the participants.

This is concurred by Burton and colleagues (2016) who claim that boundaries between the researcher and the researched can often become blurred especially in the exploration of sensitive topics. For this reason, Burton et al. emphasise the importance of cautioning against

boundary dissolution. With this, a conscious effort had to be made to ensure that the researcher did not slip into an automatic response of offering therapy to her participants, especially when participants described difficult feelings. Moreover, it is expected that holding strong beliefs about mental health and help seeking, would trigger the mental health advocate in every therapist, especially when engaging with participants who do not believe in mental illness. For this reason, the researcher had to consciously observe herself and the direction in which she had taken her interviews.

Burton and colleagues (2016) argue that with a clear policy in confidentiality and self-reflexivity, the therapist-researcher role may still prove to be significant during the interview process. The researcher's background in psychology assisted in applying effective communication skills. This allowed the participants to feel at ease and comfortable during the interview process. Additionally, active listening proved to be beneficial during interviews to where recording was not consented.

Conclusion

In this chapter the researcher provided a detailed description of the methodology used in this study. The chapter highlighted how a qualitative research design, which was explorative and interactive, was used to gather data that was rich and descriptive in nature. A social constructionist paradigmatic stance was given particular focus as the theory's underlying priciples guided and informed the manner in which the study was conducted. This chapter also discussed how semi-structured virtual interviews and thematic analysis were used to collect and analyse the data respectively. The inclusion criteria used, and the sample recruited was described in this chapter. Lastly, this chapter provided information on how ethical clearance, detailed participant information sheets, and consent forms were used to keep the participants informed, safeguard their identity, and ensure confidentiality. Reflexivity and

adherence to the steps provided for sata analysis served as measures to ensure that the quality and credibility of the study was achieved.

CHAPTER 4

FINDINGS

Introduction

This study was aimed at exploring the common constructs and everyday language of depression among a sample of Indian adult men in Gauteng. In order to achieve this aim, semi-structured interviews were used to gather relevant and descriptive data. This was followed by thematic analysis, which allowed for the establishment of significant themes to be discussed in this chapter. During the data collection process, questions probed enabled the researcher to answer the following research questions:

1. What understandings do Indian men have of depression?
2. What do Indian men perceive to be the cause of depression?
3. What are the common discourses Indian men have about help-seeking for depression?

During the data analysis procedure, seven themes and 11 sub-themes were discovered. In the aim of discussing these themes and sub-themes, this chapter is divided into three sections. Section one expands on the participants' responses with regards to how depression may be perceived within the Indian community, how depression is often considered taboo and, finally, the gender differences in how depression is presented.

Section two presents the participants' perceptions of what causes depression, including two sub-themes, namely; expectations placed on Indian men and Covid-19 in the context of mental health.

Section three provides a discussion on the views participants have on help-seeking for depression, including their ideal form of community support. To end this chapter, a conclusion of the findings is provided.

Participants' demographic profiles

During the interview process, each participant was asked about their occupation, age, marital status, and if they had received any form tertiary education. These questions were asked as a means to get to know the background of each participant, in addition to building rapport.

The seven participants' demographic characteristics are depicted in Table 1. Their ages ranged from 28 – 48; two were married, and only one participant did not have any tertiary education. All participants were employed in corporate businesses, with positions that usually required them to be office-based.

The table also informs the reader if the participants' responses were either based on their personal experience with depression, or if they knew someone who had been diagnosed with depression. It is important to acknowledge that participants were not asked about whether or not they had personally experienced depression. Instead, this information was established when participants reflected on what may have shaped their understanding of depression. Only one of the participants acknowledged to have experienced a depressive episode.

Table 1

Demographic characteristics of participants

Participant	Age	Occupation	Marital status	Completed tertiary education	Experienced depressive episode	Knows someone with depression

1	35	Sales manager	Married	Business management		X
2	28	Graphic designer and personal trainer	Single	Graphic design diploma		X
3	31	Graphic and web designer	Single	Graphic design diploma		X
4	30	Discovery Health customer services	Single	Management and communication studies		X
5	48	Workshop manager	Married	None		X
6	39	Studio director	Single	Multimedia and design, art and science	X	
7	32	Financial advisor	Single	Business finance honours		X

Presentation of findings

In this section, the seven themes generated during the analysis are discussed under three sections. Section one, titled participants' understanding of depression, discusses the following themes: Understanding of depression within the Indian community. This theme will then further eleaborate on the sub-themes that were established.

Section two, titled participants' perception of what causes depression, discusses the following themes: Expectations placed on Indian men by families and Depression in the context of covid-19.

Lastly, section three, titled participants' views on help-seeking for depression, discusses the following themes: Attitudes towards help-seeking for depression, Barriers to help-seeking, Coping mechanisms alternative to psychotherapy and lastly, Ideal forms of community support for men with mental illness.

These sections, along with their respective themes and sub-themes are tabulated in Table 2.

Table 2

Categorisation of themes and sub-themes

Section one: Participants' understanding of depression	
Theme	**Sub-theme**
1. Understanding of depression within the Indian community	1.1 Depression is taboo 1.2 Gender differences within depression
Section two: Participants' perception of what causes depression	
Theme	**Sub-theme**
2. Expectations placed on Indian men by families	
3. Depression in the context of Covid-19	
Section three: Participant's views on help-seeking for depression	
Theme	**Sub-theme**
4. Attitudes towards help-seeking for depression	
5. Barriers to help-seeking	5.1 Fear of stigmatisation
6. Coping mechanisms alternative to psychotherapy	6.1 Speaking to a loved one 6.2 Alcoholism and substance use 6.3 Depression in the context of religion 6.4 Engaging in a hobby 6.5 Avoidance of the issue 6.6 Excessive physical exercise 6.7 Impulsive behaviours
7. Ideal forms of community support for men with mental illness	7.1 Awareness campaigns for mental illness 7.2 Guaranteed confidentiality

Section one: Participants' understanding of depression

When asked about their understandings of depression, the participants seemed to display hesitance before answering; many of them admitted that their understandings were very basic. However, even with their basic knowledge of depression, all of the participants

highlighted an understanding characterised by symptoms they are likely to see in a depressed person.

In an attempt to explore the foundations of their knowledge, participants were asked about the broader Indian community's understanding of depression, to which all participants responded similarly, indicating a pattern of a lack of knowledge and understanding of depression within the Indian community. In this section, one theme is presented with two sub-themes.

Theme one will highlight how depression is understood within the Indian community, with particular focus on the two sub-themes, which discusses depression as being taboo in the Indian community and the gender differences in how depression may present, depending on one's gender.

Theme 1: Understandings of depression within the Indian community

In their responses regarding how the Indian community has shaped their understanding of depression, all seven participants reported they were taught that mental illness did not exist. For this reason, participants admitted to having a basic understanding of what depression is. According to the participants, their unawareness of depression is greatly shaped by the lack of knowledge they perceive their respective Indian communities to have of mental illness, including depression. One of the participants expressed this as follows:

> *"Uhm, to be honest, I would say firstly their knowledge, if I had to rate it from 1-10, it's probably a one in terms of knowledge and understanding" (p1)*

Growing up in an Indian family, no priority was placed on communicating about topics of mental health, especially in relation to the men of the community. Concepts such as suffering,

vulnerability, feelings and Indian men were considered exclusive from each other. As a result of these concepts, along with depression, not having a place at the dinner table, Indian men were socialised into believing that being strong meant not being vulnerable and not showing any emotion. It was a socially-constructed notion that the ideal Indian man needed to be stoic and reserved. This essentially means that Indian men were taught by family members from a very young age that men needed to represent strength and power. These constructs were also propagated by movies, and fathers who portrayed strong masculine ideals that the younger generation internalised growing up.

In their responses, many of the participants seemed to have internalised these notions, allowing it to have become their identity over time, stating that just by the virtue of being born into an Indian culture they should not entertain the idea of depression. They reported often giving into the excuse of "It's the way Indians are" (p5) or "It's not me, I deal with my feelings because that's how Indian men are grown up to be" (p5).

Secondly, participants highlighted that growing up they were often groomed into believing that they were not allowed to feel sad or speak about emotions related to it, and this was a generational pattern that continued for years. They were taught that "You don't have obstacles in your life; you're too young to think about anything like that*"* (p5). In fact, they report that if they do speak up, it is often met by condescending language and remarks that often make them feel weak or as if they have failed at being a man. This was expressed by participant four in the following extract:

> "*So, for example in our community we live in. I would think most Indian people would brush the depression off with, 'You know what, there's something wrong with you', or they don't take it as seriously as they should. I think maybe there's a lack of*

understanding or education on what depression is. But I feel it is taken very lightly in our community" (p4)

For this reason, "*seeking help is probably the last option*" (p5) for men within the Indian community. Additionally, when asked about family support, participants made evident that as a result of the lack of knowledge and ignorance in the Indian community, many Indian homes experience challenges with offering their men the support they need.

During the interviews, at least three participants believed that the support they see within Indian families is partial, in that it is often one-sided and based on the family's willingness to help. Another participant reported that if Indian families were more aware of depression and the seriousness of the condition, they would be more willing to assist their loved ones. For this reason, support depended on increased understanding, and knowledge of the condition.

From all of the information provided regarding the Indian community, the one pattern that was prevalent and set the foundation for many of their responses was the lack of understanding the Indian community had of depression. However, participants also claimed that despite them growing up in communities which prioritised physical health over mental health, their own understandings of depression seemed to have been more enhanced due to work, tertiary education and social media exposure.

Participant 4 reported "*a slightly greater understanding of depression"*, as he was aware of the "*channels that one would seek out in the event that you need further guidance"*. It is evident that going through management courses, working in the medical aid field and being in a leadership position at work required them to have a form of basic understanding when it came to mental health and depression specifically. It is because of this, that many of them were able to develop sensitivity to the issue of mental illness.

When exploring their own understanding of depression, participants' responses mainly reflected symptoms they predict someone to present with if diagnosed or suffering with depression, which included behavioural, physical and psychological changes. In addition, participants highlighted a pattern in their understanding, which emphasised that depression was a mindset, and a form of negative patterns of thought. Participant 1 highlighted that his understanding of depression was not only patterns of negative thinking but the inability to think positively. *"Almost always want to see the bad in every situation. So, it's again, just tough for them to be optimistic and positive about situations"*. Alternatively, Participant 2 perceives depression to be a form of "*mental block*", which prevents the depressed individual from being themselves. In the following quotes, participants expand on their view of depression being a mindset.

> *"I don't want to say it's a mindset, but it is. It's an inner battle that somebody fights with; it holds them down, definitely to cause them from being normal, the normal person that they are" (p6)*

> *"They usually have a sort of lacking in many ways, especially when it comes to positive kinds of thought. So, their optimism is very low. Their will to live is lacking, they lack joy and happiness" (p1)*

> *"What I have noticed is they're quiet, very, very distant and also very, I would say aggressive as well. Or actually, let me correct that, passive-aggressive, in the sense of a lot of sarcasm is also being seen as well, a lot of side comments are being seen in people that are depressed, because if you are surrounded by people that are happy, it tends to annoy you" (p7)*

The second most prevalent understanding that participants revealed was that depression caused the individual to feel a loss of control. According to four of the participants, depression was something that felt "beyond your control", and if diagnosed it would cause someone to feel this loss of control in all areas of their lives, including their work, social and intimate areas of their life.

Other understandings reflected that depression was due to a biological change in the brain, which caused a depressed person to develop certain negative feelings that were beyond their control. Given the above findings, participants highlight that in spite of being raised in a community that has a poor understanding of mental illness greater exposure to topics such as depression is likely to stimulate more supportive conversations within the Indian community.

Sub-theme 1.1: Depression is taboo

Whilst exploring the understandings of depression within the Indian community, a sub-theme was discovered during the data analysis procedure. This sub-theme led to the revelation that depression is taboo within the Indian community.

During the interviews, all of the participants reported that depression was not well understood in the Indian community and any form of mental illness, including depression, is met with feelings of hostility. Additionally, as it has been stated, anyone who presents with symptoms of depression is confronted by various stereotypes and condescending remarks.

As such, for a family to have someone who suffered with such an illness meant that not only will these labels be attached to the family name, but so will feelings of shame and humiliation. For this reason, one of the participants reported that as a result of Indian families priding themselves in maintaining a good reputation, those who do show symptoms of depression are forced to pretend *"nobody is experiencing it"* (p6), and somehow silence their

suffering (*"if it's something in someone's mind, they need to get over it"* (p6)). In the following extracts participants explain from their own experiences, how depression is seen as being forbidden among their Indian communities.

> *"Oh, it's actually taboo, I think in the broader side of it; it's like we, we are not allowed to say that we are depressed, we are not allowed to sit down and talk about it because it's not seen as it being serious, in our community, you know, it's - I think - it's like you know, 'Oh, you could be overreacting, just get along with it.'" (p7)*

> *"Coming back to the way Indians are, we're afraid of too much of a scandal, too much of pride and to let it all out in the rest of the community, whether it's depression, cancer… people are very proud, I don't know why. Certain things we just rather hide it from everybody" (p5)*

In addition to the stress and possible anguish an Indian man with possible depression may experience, he is further faced with the pressures of protecting the family name, and fear of disappointing family members. This not only perpetuates the depressive symptoms but also causes men to further isolate themselves from any form of help that could be available to them.

> *"It's almost like you have disappointed all of them, so it becomes more like, let's keep it a secret even if you not feeling well, let's not let our uncles and aunties know about it, let's make sure we hush, hush about it" (p7)*

Sub-theme 1.2: Gender differences in the presentation of depression

During the interviews participants were asked about possible gender differences in the presentation of depression. A second sub-theme that emerged among the participants' responses was that women were more expressive than men.

Four of the seven participants reported they believe women show similar behaviours to men when depressed. These include social withdrawal, isolation and a lack of interest in activities. However, in their responses they indicated that although the symptoms may be similar, women seem to present with a greater intensity of the symptoms as opposed to men. One participant emphasised this by reporting that he experienced depressed women to *"break down"* (p6) more often than a depressed man would.

Based on personal experience, another participant confirms the above; when he disclosed that since his spouse had been diagnosed with depression he had come to learn that when she experiences a depressive episode *"it's a little more obvious, she will try and keep her distance from me…she prefers to have alone time, so she prefers to be in her own space" (*p1). As a result, he had to adapt and establish ways to approach her in a manner that was supportive rather than harmful to her emotional well-being. The following quotations are of other participants who share the view that although some women are more expressive about how they feel, they are also more likely to experience greater forms of social withdrawal and isolation.

> *"They also show signs of a lack of interest… they would like to open up with their feelings, it's socially accepted that you know, that a woman would feel hurt. Whereas a man should just rather deal with his emotions and carry on" (P4)*

"From my personal experience… I would say they sometimes become very withdrawn, at a point where they go distant for a while, very quiet" (P7)

"From what I've seen, they completely shut down; there's no contact whatsoever, they will be by themselves. Some will try to take their lives, or resort to the famous one which is cutting… and they will tell you, I just want to be alone or I don't know what to do. They are very vocal" (P2)

Alternatively, the other three of seven participants reported that although women may break down and show the above-mentioned symptoms, they are also likely to seek help for these symptoms. According to their responses, women appear more expressive about their feelings and symptoms, and are therefore likely to receive the help they need at a much earlier stage than men would.

The analysis of the interviews found that men are more afraid of vocalising their emotional states in order to achieve a strong and powerful appearance in the face of others. In the following quotes, two participants expand on their view that women are more likely to express themselves and therefore are more effective in obtaining the necessary support.

"You know what, to be honest, women have a bit more understanding and are a bit [more] clear when it comes to things like this because they are really much more open. So, they will speak about it…to a family member or a friend, and that person, you know, will try and help them" (P3)

> *"...I've seen them break down far more and not let their guards up the way guys do. I think guys want to have a structure where you stand strong and you don't let your weakness show, but girls have broken down far more…they are not afraid to show how they are feeling…far [more] stronger you know, I think they deal with it far [more] better" (P6)*

During the interview process, participants were asked about how depressed men were likely to behave. Four of the seven participants' responses were based on personal experience, where they had either witnessed a loved one with depression, or experienced a depressive episode themselves. In all of their responses, a common theme of 'avoidance' (as per participants' words) was established.

According to the participants, a depressed man is understood to present with avoidance of his distress and any form of social interaction or activity that is likely to trigger their symptoms. In other words, depressed men would keep away from going to events or interacting with friends and family members to whom they were close. Instead, they tend to self-isolate, or are usually seen leaving an event or social gathering earlier than expected as a means to steer clear of speaking about how they really feel.

During the interviews, the participants' responses also indicated that this avoidance is not only limited to social gatherings but may also impact the individual's work. This means that depressed men are also likely to show high absenteeism from work or other daily responsibilities. The participants further report that this avoidance is often revealed by depressed men creating a facade that makes them come across as *"more than normal, when I say more than normal, is that they're over happy"* (P5).

Participant Six disclosed that when experiencing a depressive episode, he often had to compel himself to suppress his emotions and attend to his daily responsibilities with the same emotional state, energy and enthusiasm as he would when not experiencing a depressive episode. This was mainly due to the fear of letting other people see a side that may possibly be taken as weakness and failure, especially since he held a position of leadership in the work environment. The following quotes not only expands on the view of Participant Six's experience; it also reveals other participant's confirmation that men find it easier to hide from their feelings or situations that may require them to face their emotions.

> *"I tend to push it aside, I tend to lower it down, I tend to want to smile more and not make people see that I'm depressed. So, in that alone, in a nutshell, it's this happy looking person but I'm not happy about it. I live on the outside, but I think, I was at a certain point, very sad on the inside" (P6)*

> *"Because they feel like, if they are out there, we're going to have to speak about what's happening to them and really, that's not exactly what they want to do. So, they'd rather just stay away from everyone you know" (P3)*

> *"Yes, I would say, you could, especially from personal experience, what I've noticed is, they're quiet, very, very distant, and also very, I would say aggressive as well. Or actually let me correct that, passive-aggressive, in the sense of a lot of sarcasm is also being seen as well, a lot of side comments are being seen in people that are depressed. Because if you are surrounded by people that are happy it tends to annoy you" (P7)*

In addition to the above pattern, Participant Seven reported that he grew up witnessing his father experience depression. Within those years he was able to recognise not only his father's avoidance and self-isolation but also passive-aggressiveness and sarcasm as a means to safeguard himself. Apart from this, he reports that depressed men are also likely to present with irritability and can be easily triggered around others.

Section Two: Indian Men's Perceptions of What Causes Depression

During the interview process, participants were asked about their perception of what causes depression among men. Some participants felt this question was difficult and required time to think about it before responding. It must be noted, however, that during the analysis procedure, a common theme about expectations became apparent. Participants emphasised the burden that is placed on men to provide and perform. Embedded within these expectations they highlighted financial stressors and providing for their families' needs, all while being unable to speak about what they may feel, even when trying to meet these demands.

In this section, two themes are discussed, namely; the expectations being placed on Indian men and the stressors of the Covid-19 pandemic as being the two main reasons men are likely to present with depression.

Theme 2: Expectations Placed on Indian men

Another prevalent theme that emerged is the expectations placed on Indian men to perform within their community and work environment. With the expected standard/caliber that keeps rising (i.e., expected increases in salaries, materialistic achievements and marital expectations), Indian men are continuously expected to achieve whilst simultaneously

maintaining a strong persona and being indifferent to the pressures with which they may be faced.

According to the participants, the competition in an Indian family is high, and men, irrespective of culture or religion, are faced with daily expectations to perform physically, financially and socially. As a result, these men constantly find themselves comparing their own successes or failures to the man next to them (e.g., family, friends and colleagues), which essentially keeps them functioning with the perspective that they need to do and be more in order to feel accepted.

It is a socially-constructed norm that men are expected to "fight back" (and win) in all areas of their lives, because doing so indicates a sign of masculinity, strength and everything that contradicts weakness. This means that from a young age, men are taught to stand up to others, to never turn down a challenge, and to rather prove to others their strength, power and confidence in all areas of life. This was shown to men by the male figures in their lives, by superhero movies (where men were depicted as the heroes), and by other forms of social media. A participant also indicated that this social norm has been internalised by Indian men over the years and continues to be a teaching point for the current generation as well as the generations to come.

> *"If you are a boy, and you get into a fight, you need to pick up your fists and fight back…it is these kinds of things that the Indian community is teaching the young, that there's basically a gender expectation that if you are male, you need to be strong" (P4)*

As evidenced above, participants felt that the Indian community showed a lack of understanding when it came to depression. Similarly, participants reported that this lack of understanding is also shown in their reduced ability to acknowledge the expectations placed on men within the Indian home. As such, when and if men succumb to these pressures, instead of recognising their struggles, they attribute their symptoms to that of burnout, or a failed attempt to take on the responsibilities of the family.

In spite of these pressures being placed on men, they are afraid to speak out or ask for help because if they do, they are placed in a position of possibly *"disappointing their families"* (P3). A dominant thread reported by all of the participants is the expectation that "Men are *made* [emphasis added] to be the breadwinner of the family… They have to always be there and not have any issues, you know, be there to support and provide" (P3). Another participant put it as follows:

> *"... Let's look at it not from an Indian guy. He just takes care of himself and when he gets married, he has to take care of his wife, he needs to take care of his wife's family, he needs to take care of his wife still, his wife's sisters, everybody becomes some responsibility, and that becomes something that you know, you need to be a strong man" (P6)*

Embedded within this responsibility, is the expectation for men to provide financially for their families. However, one of the participants expressed his belief that although men may be able to fulfill this expectation, acceptance and recognition within the Indian family depended on a man's capacity to show financial accomplishments and success.

"From a financial point of view, the benchmark just keeps on rising. It comes to a point where you have to wear a certain type of clothing, you have to drive a certain type of car or you have to look a certain type of way in order to be accepted in the Indian community" (P7)

As a result of the above expectations, men are continuously comparing themselves to other men and are continuously seeing themselves relative to others, instead of viewing their accomplishments as reflective of their own abilities and success.

This competition and self-comparison seems to be maintained within Indian families, where comparisons are a part of showing others that they are succeeding – a success of the son meant a success of the family. Participants reflected that the pressure this puts on Indian men is further precipitated by the "*unsupportive"* (P7) and expectations-filled conversations that are being initiated within the Indian home.

When probed, it was expressed that these conversations focus less on how men may be doing and more about what they have accomplished materialistically and/or academically since the last time they were seen by a particular family member or friend. Consequently, men are placing expectations on themselves to drive towards a standard that seems unattainable and unrealistic.

"I think also the comparisons between families and friends and things like that also puts a lot of pressure on Indian males" (P7)

"I think what I also noticed in the Indian community, [is] there's a lot of rivalry and unhealthy competition between families… so if my cousin is doing X at my age, then they question why you are not doing it. And then you get that unhealthy competition,

and you find yourself trying to live up to the expectations to get your parents' approval" (P7)

When asked about gender differences in relation to depression, participants reported that similar to how expectations are placed on men, so too, are they are placed on Indian women in the community.

Although, embedded in these, is the expectation that "*women are supposed to be weaker" (P4)*. It is considered normal for a woman to cry, or express her feelings without being stereotyped for being weak. Whereas, for men who step outside of the norm and decide to speak up, *"it's a bit more difficult. Guys may feel 'I am not being much of a man because I'm speaking about my feelings and things'" (P3)*. Consequently, men are filled with the guilt of feeling they are not 'man enough' and will not be accepted by their society if vulnerability is shown.

With ongoing expectations placed on men to perform, two participants expressed that the only way in which they could escape the expectations and lack of understanding, was for them to relocate as a means to achieve independence and, in some cases, individualism. They expressed feeling free from the need to always perform and succumb to the opinions and expectations of their surrounding community. For example, one of the two participants reported that since his relocation, he was able to be himself, and express himself without the fear of being judged or fearful of not being accepted.

Theme 3: Mental Health in the Context of Covid-19

Aside from the expectations placed on men from their respective families, Covid-19 was also perceived by participants to be one of the causes of depression among men. Although

this was not reported by all seven participants, two participants did report that the challenges experienced during the Covid-19 pandemic had a significant role in their lives.

Participant Three reported that the restrictions placed on many citizens in South Africa, including working from home, led to the closure of many businesses. Participant Three added that this put a strain on many who managed their own businesses, like himself, who often worried about where their next pay check was coming from.

> *"But I guess more, more with Covid, I think that would have really put a lot of people in a depressed state, you know, whether you, whether you're male or female… especially from a business point of view, we're trying to understand, where's the next cheque coming from, why is that client so quiet this month? Am I going to be getting any revenue into my business this month? Do I need to find more ways of, new ways of working you know, things like that there. So, definitely from a working side of view, from my point of view, I think that would play a big role in you know, somebody being depressed." (P3)*

The second participant (P6) who reported on the difficulties of Covid-19, expressed earlier in his interview that he had also experienced a depressive episode, and that communicating to others face-to-face allowed him to feel a sense of relief and healing. Although, with the Covid-19 pandemic, many restrictions, such as social distancing, and the wearing of facemasks, limited individuals such as himself from being able to freely communicate to others. In the following quote he expresses that a longstanding fear of contracting an infection has been instilled within him. For this reason, social interaction no longer seems to serve has his first form of coping.

"I think sometimes the most awesome thing I've done is speak to a total stranger or when I was on the Gautrain, and you know, you're never gonna see them again, you end up just getting a whole lot out there. I think now with all this COVID stuff that's happened, although it didn't go away, but people are not going to be approachable to the next person for a very long time. I won't. Personally, if I jump into the Gautrain, I won't really go sit next to somebody anymore, even if COVID is years away [past], *but the fear or something is engrained in me already" (P6)*

Section Three: Participants' Views on Help-seeking for Depression

In order to establish the views men have about depression, the researcher asked detailed questions to establish the participants' attitudes towards help-seeking for depression and whether or not they were for or against it. This section discusses possible barriers to help-seeking, alternate coping mechanisms, and the participants' ideal form of community support.

During the interviews, common sub-themes which emerged included a fear of stigmatisation, adaptive and maladaptive coping mechanisms, as well as the participants' recommendations regarding how to assist men with depression.

During this section of the interview, the participants were required to engage with their internal feelings regarding help-seeking, and, more specifically, if they would consider seeking help for themselves. It was noted that all participants communicated their feelings and opinions openly and without any hesitation. Four themes, some with sub-themes, are presented in the following sections. These will include a discussion on the participants' attitudes towards help-seeking, the barriers to help-seeking, and the various alternatives they

are likely to use to cope. This section will end with the participants' views on what the ideal form of community support would look like for them.

Theme 4: Participants' Attitudes Towards Seeking Help for Depression

In order to discover Indian men's attitudes towards seeking help for depression, all participants were asked about their personal views regarding help-seeking. Additionally, participants were asked about the first source of help they would likely seek when in distress.

During the interviews, six of the seven participants reported that they believed it was beneficial for depressed men to seek help. One of the participants reported that seeking professional help was the only way to alleviate depressive symptoms.

Another one of the six participants admitted that due to having witnessed loved ones experience depression, he had begun "*advocating for mental health" (P7)* and help-seeking. This included using social media as a platform to endorse mental health sensitivity and awareness. Moreover, he reported that he and his friends often offered their time to accompany friends to their therapy sessions as a means to show support and encouragement. These views are illustrated in the following quotations:

> *"We do encourage each other; we get to speak to a psychologist or a psychiatrist, we would actually accompany you or make sure that they go with you for the first session ... if you do want to go please do and we extend that we would accompany you, they would support when you need it" (P7)*

> *"My personal opinion, I would think people who are depressed should go to somebody professional to handle the situation" (P2)*

"I think it's not something that should make you feel less of a man if you get help" (P3)

"I personally feel that it's important to seek help when it's early or when you first realize that, you know, something is wrong, leaving something for long only causes more issues" (P4)

"... I do believe that it's necessary and probably because it is something that is a mental issue, so the only way you can fix it is by getting professional help" (P1)

Contradictory to the above views, another participant reported more negative views towards help-seeking. According to him, his views are strongly shaped by his upbringing in which mental illness did not exist. He further reports that people have good and bad days, and that this should be understood as being normal. His upbringing within a *"strict"* (P5) family, shaped his belief that *"you go on with life… brush it under the carpet"* (P5). As such, he reports finding restoration in alternate coping mechanisms, including the suppression of his difficult emotions.

Of greater significance, the researcher discovered that although six of the seven participants advocated for help-seeking, none of them believed seeking professional help would be their own first source of contact when in distress. Instead, one of the most prevalent responses was that men were more likely to seek help from a friend, family member, spouse/partner, pastor, General Practitioner and, lastly, a psychologist, although it is

noteworthy that even when considering seeing a therapist for themselves, the participants displayed a reluctance and felt they were *"on the fence"* (P1) about it.

> *"I think, for one, professional help takes a lot of time. I mean, if I go to somebody new, right now, I'm being seen every week. I see professional people, for things that I have gone through. And they have helped. Sometimes I just feel like you need that real person that's next to you. That has gone through this. No one has gone through from a textbook point of view but one has actually gone through real world stuff. And relate, rather than just sitting there with a checkbox and seeing if you're hitting the right buzzwords, are you saying the right, or your eyes are doing the right things or wrong things. Rather, someone who listened" (P6)*

Theme 5: Barriers to Help-Seeking

During the interviews, the researcher explored each participant's view of what may be preventing themselves, as well as other men, from seeking help. Whilst exploring these barriers, common themes that emerged included the fear of stigmatisation, which served as the biggest barrier preventing help-seeking. Participants believed men were not allowed to express themselves and that seeking help for depression, or any other type of distress, put them in a position of having to be vulnerable. Another common finding was that these participants mostly sought alternate sources of help instead of therapy, mainly due to financial challenges and a poor understanding of what therapy entailed.

Sub-theme 5.1: Fear of Being Stigmatised

From the many reasons that seem to prevent men from seeking the help they require, the fear of being stigmatised ranks on the top of the list. All seven participants reported that

seeking any form of professional help (i.e., a therapist) was not applauded by society. Growing up, men have been socialised to drive towards masculine ideals (i.e., strength, independence, leadership and courage).

> *"Feel like less of a man. You know, things like that there. That masculinity thing plays a part to try and avoid it. Let me keep my manhood by not talking about it. But instead, I want to say something. I don't want to deal with judgment" (P3)*

As indicated in the above extracts, participants highlighted that anything contradicting the above-mentioned masculine ideals represented a loss of their manhood. As such, participants indicated that becoming vulnerable and expressing their emotions may only be an invite for prejudice from society.

> *"I think it's the stigma, the stigma attached to you know, who's gonna, who's gonna see me, who's going to basically see me going out to a psychologist, you go through to the psychologist, what if the psychologist is going to tell me, you know? Is it really confidential? What explanation am I going to give to the next person?" (P4)*

In their responses participants highlight a common pattern of behavior. This pattern encompasses men's fear of being ostracised by their community, friends and loved ones. This fear results in two types of behaviors; one which includes men questioning their feelings, and symptoms of depression; and two, where men deliberately look for explanations for their feelings and behaviour so they may still appear acceptable to society.

> *"It's basically the whole, yet again, the stigma behind the fact that men are supposed to be strong and women are supposed to be weaker. There's, if you are basically, if you are depressed, why seek help? You should rather just, you know, deal with your emotions in your own way, and let's say it gets to the worst point, which is suicide, then you're classified as weak"* (P4)

In addition, one of the participants highlighted the stigma that accompanies gender differences. Men are constantly expected to be the stronger gender, and are judged if they do not fulfill this particular stereotype. This participant emphasises that in spite of men being depressed and may being in need of help, they are instead shunned by society. As a result, when men reach a point at which suicide is considered, instead of being helped, they are further made to feel debilitated and weak by stigmatising commentary and pejorative language (for example, being called a coward or not man enough). Essentially, this participant indicates that while society exerts considerable pressure on men to perform and be mentally, physically and emotionally 'strong', community members are not willing to assist in creating an effective and helpful environment to allow men to prosper in all areas.

The pattern of fear and stigmatisation was also apparent when participants were asked about their feelings towards seeking professional help. During the interviews, participants highlighted *"You feel a bit afraid, you know?" (P3)*. They reported feeling a fear of being judged by others for seeing a therapist, and an even bigger fear of not knowing what to say when being questioned about it, either at work or by loved ones. In the extract below, Participant Six, who reported to have seen a therapist claims that although he may have found some aspect of therapy to be helpful, he still feels hesitancy when it comes to seeing a therapist as a first source of contact. He reports that speaking with a therapist can feel

judgmental, when they listen to merely attach a diagnosis to the individual. Others, such as Participant One, reports deliberately having found reasons, such as financial priorities, to avoid seeing a therapist even if they needed it.

> *"Sometimes, I just feel like you need that real person that's next to you. That has gone through this. Not has gone through from a textbook point of view but one who has actually gone through real world stuff, and can relate, rather than just sitting there with a checkbox and seeing if you're hitting the right buzzwords, are you saying the right things, or if your eyes are doing the right things or wrong things. Rather, someone who listened" (P6)*

> "*I've always found reasons not to go, and I make up stuff" (P1)*

Theme Six: Coping Mechanisms Alternative to Psychotherapy

As indicated in the above findings, participants reported avoidance with regards to help-seeking for depression. Although they may seek assistance from friends and family, the researcher explored alternate coping mechanisms on which the participants are likely to rely when alleviating their own symptoms of distress. The following section highlights various coping mechanisms which became apparent during the data analysis process.

These included speaking to a friend or loved one, finding a hobby, embracing the benefits of their respective religions, avoidance of the issue at hand, alcoholism/substance abuse, exertion through exercise and the misuse of finances.

Sub-theme 6.1: Speaking to a Loved One

From the list of coping mechanisms reported, the most commonly identified mechanism was to communicate to a friend or loved one. Six of the seven participants reported that when

they were in a stressful situation, they often sought help from their friends, families or spouses, as it allowed them to feel more at ease.

In their responses, they highlight the importance of a trusting relationship. It was significant that they were made to feel understood, with unconditional acceptance and no judgment. With this being the basis of the relationship, men allow themselves to be liberal and engaging. On the other hand, Participant Six emphasised the importance of gender, as he describes feeling more comfortable with men than women. It is evident that although men tend to conceal their emotions, there is a shared, collective experience that serves as the foundation for trust and vulnerability among themselves as men.

> *"I'll speak to someone who I'm extremely close to…I think they make you feel comfortable speaking about it. You won't feel afraid" (P3)*

> *"And the only time he breaks down is by himself with his guys. I've experienced that with just friends, males being around males, and when there's a few drinks start going, the truth and the actual sad side of their lives come out. I feel a little bit more comfortable talking to another guy who has experienced that than speaking to a female" (P6)*

Sub-theme 6.2: Alcoholism/Substance use

Given the participants' responses, alcohol seems to be the second most prevalent coping mechanism. The age differences among the participants notwithstanding, they still believed that alcohol served as an antidote for any form of distress. However, Participant Seven also reported that "*Every day I get an invite to come to the bar, you know, come let's chill, let's have a beer, but you can never just have one or two beers" (P7).*

This was a significant finding, as it highlighted how men who are in distress oftentimes use alcohol or drugs for two reasons; to suppress their emotional pain, and to enhance sociability so as to avoid loneliness.

> *"I know from the Indian side of things, a lot of our guys deal with, you know, alcoholism, drugs and things like, obviously, not the best way to deal with things like I said, some guys find it really hard to speak about these things" (P3)*

Sub-theme 6.3: Depression in the Context of Religion

Apart from engaging with people of significance, relying on prayer also seemed to be a coping mechanism for four of the seven participants. These participants reported that going to their religious institutions, reading scriptures, and speaking to religious leaders were beneficial to them.

Having a pastor, church counsellor, or molana readily available allowed them to feel a sense of relief and hope that things may become easier to bear. Being connected with their religion allowed these men to comfortably express themselves without feeling dishonored for their emotions. In fact, participant one believes that men who do have religion in their lives were likely to overcome their difficulties, relative to one who does not engage in religious practices.

> *"I do believe that there are actually a lot of benefits that come from religion… And I actually almost think that if you actually do have religion in your life, you would probably be better equipped dealing with these things than someone who doesn't." (P1)*

In the above paragraphs, the researcher highlights the participants' perceived benefits of religion in alleviating distress or other related symptoms. Whilst engaging on this topic of religion, Participant Four expressed a differing opinion of religious teachings.

Although religious scriptures and teachings may seem beneficial to some, Participant Four is of the opinion that it may simultaneously reinforce gender stereotypes. According to his response, religious scriptures often depict a male figure as being the person of authority, someone who possesses extraordinary strength, wisdom, and leadership, while women occupy a passive and follower role. Although the teachings may be of benefit, the depiction of gender roles place men at a position of having to keep up with the expectations even their religion has indirectly placed upon them.

> *"The leader basically, or the main prophet, was a male. So, in terms of the belief system, in most cases, the person who has basically the authority at this particular temple is usually a male figure. So, indirectly, it's basically already pointing towards the fact that a male figure is supposed to be a leader. Whereas, the female is basically the person that always follows the male. So, if you are given the expectation of always being in need, something life-changing happens. That's basically you already have this built-up belief that you're supposed to be the leader no matter what" (P4)*

Sub-theme 6.4: Finding a Hobby

Lastly, two of the seven participants reported that having a hobby was another way of coping with depression. Participant One describes depression to be something that drains a person's energy, and choosing to engage in an activity of interest is a way he has been able to restore his energy.

On the other hand, Participant Five uses his activities of interest (watching television, building, and working on a vehicle) as a means to distract themselves from the issue at hand, or, in some cases, allow time for reflection.

> *"Try and do something that usually gives me energy, you know… I like to cook for example, so maybe, I will then just cook, or choose to cook that day, because by choosing to do that activity, again it gives me the energy to deal with whatever I need to deal with. It gives me enough capacity or energy to then go back and work on it or just deal with whatever I need to deal with" (P1)*

Sub-theme 6.5: Avoidance of the Issue at Hand

During the interviews, the most harmful pattern of coping among depressed men was to avoid the issue at hand. All seven participants at some point within the interview signified a pattern of avoidance and desire to hide from their emotional distress.

Participant Three indicated that this tendency to conceal emotional pain is a direct result of gender stereotypes and that men are not allowed to show emotions. As such, avoidance has become a behaviour that these men have learnt from social norms. Given his response, Participant Three highlights yet again a fear of stigmatisation, which prevents men from managing with their emotions effectively.

A characteristic of this avoidance often meant that men would isolate and engage in social inhibition as a means to protect themselves from shameful comments of society. Alternatively, men who are depressed avoid their emotional pain by engaging in activities that would normally be considered outside of their comfort zone. For example, someone who does not enjoy sport, unexpectedly engaging in sport-related activities.

Although these changes in behaviour may seem significantly easy to identify, this is not always the case with friends and families who have lost loved ones. During the interview, Participant One disclosed a personal experience in which he had lost a friend to suicide, and to this day he admits not being able to identify depressive symptoms among men as a result of them successfully being able to conceal their distress. This ability for depressed men to effectively create a facade is an opinion that was shared among all seven participants.

> "*Listen, just, you know, brush it off, pick yourself up and go on. So that's, that's my understanding of how things work, because that's what I do… I think that is part of the problem because most guys don't want to, you know, besides even admitting it, they never even really want to show that they are going through something" (P1)*

> *"Depression among men, you don't really see it at first unless you know the person well enough. Other than that, they just go about the day-to-day; they carry on with whatever routine they have, and you won't really know until it's too late" (P2)*

> *"So Indian men [have] a tendency to hide everything. Probably may find another hobby. But random hobby, probably try to do something that has nothing to do with that, doesn't relate to the kind of person that I know you know you to be" (P5)*

Sub-theme 6.6: Excessive Physical Exercise

In as much as exercise and visits to the gym were considered healthy forms of coping by one of the participants, at least two of the seven participants reported excessive forms of exercise (i.e., two or more hours at a time, or twice a day), which can also be considered an

unhealthy form of coping. One of the participants who shares this view claims that exercise may oftentimes be used by depressed men to substitute their feelings with physical pain.

> *"But I think some, or let's just say the few [who] are doing it, and I think a bit of an unhealthy way of dealing with it, are the ones who find obsessions. So, if you find someone that goes to gym and gets obsessed with the gym, you know literally going to the gym twice a day for two hours at a time" (P1)*

Sub-theme 6.7: Impulsive Behaviours

Participant Six reported that apart from alcohol and substances, men also tend to find other outlets as means to alleviate their depressive symptoms. He highlights a change in eating habits and engaging in reckless sexual behaviours, or spending their money on material pleasures as a means to distract them from their emotional pain.

> *"Eat[ing] and going out, you know, [the] opposite sex, temptation, if you're financially okay, you throw your money on things that are not needed; you buy yourself a motorcycle, you buy yourself a new car, waste your money on stupid things. So, I think it's all different types of mechanics and tools that they will use to cope" (P6)*

Theme 7: Ideal Form of Community Support for Men with Depression

Based on the above findings, it is evidenced that a lack of knowledge and understanding about depression and fear of stigmatisation served as pivotal factors in limiting men from reaching out for assistance and engaging in help-seeking behaviours.

As such, all participants were given an opportunity to express what an ideal form of community support may look like for them. This was an attempt to understand what these participants required to feel comfortable and open in order to engage in discussions about depression. The following sub-themes highlight a need for more psycho-education, awareness campaigns and a guarantee in confidentiality.

Sub-theme 7.1: More awareness campaigns about mental health and mental illness

When asked about their ideal form of community support, all seven participants emphasised a need for an increase in mental health awareness campaigns. Participants were of the opinion that psycho-education needs to be implemented within school curricula, so vocabulary such as help-seeking, depression and mental health can be learnt about from a younger age. Their responses speak to a great need to repair the lack of understanding and awareness among the Indian community by triggering conversations about mental health and gender stereotypes at school and home. As a result of this, children may learn that boys are allowed to be vulnerable and that both men and women are equally empowered to express their feelings without a fear of being judged.

> *"I think we need to get that the stereotype of being depressed is an overreaction or that you're not strong enough. And that's something that we should encourage, especially in our community" (P7)*

> *"Start instilling values from a little age that it's okay to deal, it's okay to be, it's okay to deal with certain stages in your life, it's okay to deal with depression. It's basically okay for men and women to chat or to talk openly about the way that they feel. In terms of the community showing support, maybe there should be more support*

initiatives to advertise something in the paper that focuses more on the emphasis on mental health. Do you know, are you feeling depressed? Do you want to talk to somebody? Reach out here, have a social gathering" (P4)

According to the participants, frequent awareness campaigns, pop-up counseling sessions, and more advertisements (i.e., billboards, mobile advertisements) on where to seek help, is likely to trigger curiosity in the community. The participants state that by improving the awareness within the community, more people are likely to develop sensitivity towards mental illness and may be able to respond to and manage symptoms more effectively. In essence, participants requested a need for greater support, unconditional acceptance and active listening from their fellow community members.

"It means that I need to feel safe enough to go up to anyone in my community and actually talk about it… when I speak, I don't want to have to feel judged… I don't want someone to think of me as if something is wrong with me. I would want the other person to engage with me and listen to me and ask me questions and try to understand and, as I said, to feel accepted" (P1)

Sub-theme 7.2: Guaranteed confidentiality

With the exception of the above recommendation, Participant Two also reported in the below extract, a need for greater confidentiality within the process of help-seeking. Highlighted within the barriers to help-seeking, participants reported fears of being stigmatised and judged by others who knew their struggles. This fear has continued to hold back a considerable number of depressed men from seeking the help they need. In his

response, he suggests that an ideal form of community support would therefore require guarantee privacy and acceptance.

Creating a supportive environment with these values as the foreground, men will be able to step into a space of openness and vulnerability. This was of significant importance to participants, as they reported that they often felt men were misunderstood in the Indian community, as there was no room provided for them to be vulnerable and express how they truly felt. This was something that was noted as significant, because, as participants highlight throughout, a lack of knowledge in the Indian community often meant topics such as mental illness were foreign to the culture and met with feelings of hostility and dismissal.

> *"Well, first, first and foremost, I think they can be a bit more private. What I mean by that is, if I go and tell, for example, a friend what is happening to me, I don't expect that person to go and, you know, distribute that information to anybody… So that's the other thing that may prevent males from speaking about issues, because they know, if they tell somebody, it's going to come out, then the family members are going to start laughing(P2)*

Conclusion

This chapter presented the findings of the data collected in this study. These findings have been structured within three sections, and were informed by this study's research questions. The data analysis yielded a total of seven themes and 11 sub-themes. The findings suggest that depression is not only poorly understood among members of the Indian community, but is also considered taboo within many Indian homes.

Participants view depression to be predominantly caused by the expectations placed on Indian men, as well as the recent Covid-19 pandemic, which has caused several financial strains. Seeking professional help for depression was not a popular option for many of the participants, therefore the findings also suggest alternative coping methods that participants were likely to use. Finally, this chapter also explored the ideal form of community support as recommended by participants. Chapter five provides a discussion of the findings of the study, as well as the strengths and limitations thereof.

CHAPTER 5

DISCUSSION AND CONCLUSION

Introduction

This final chapter will provide a conclusion to the study titled *Exploring common constructs and everyday language of depression among Indian men in Gauteng*. In this chapter, the researcher expands on the findings by providing a comprehensive interpretation of the themes and sub-themes presented in chapter four. It further provides a discussion on this study in its entirety. This chapter also provides insight into the strengths and limitations of this study and, to conclude this chapter, recommendations based on the findings of this study are provided for future research.

Interpretation and discussion of findings

In this section, the findings presented in chapter four are discussed. As noted in chapter one, the aim of this study was to explore the common constructs Indian men had of depression. This meant exploring their understanding of what depression is, their perceptions of what causes depression, and ultimately, what their perspectives were on seeking help for depression.

The need for this study arose from statistics reporting that in spite of depression being one of the most escalating disorders to exist globally, there still remain hundreds of thousands of people who have committed suicide due to depression (WHO, 2014). Previous studies have already addressed depression among women and students extensively, with limited research with regards to depression among men, particularly in the Indian community in South Africa.

This study therefore paid particular interest to the responses of participants from an Indian community where societal norms, teachings and beliefs played an influential role in the

shaping of men's construction of what depression was and what it meant for them, especially since it was not a topic that was readily entertained within many Indian households.

The following sub-sections will provide insight into these realities, as the researcher discusses the themes and sub-themes discovered. Although the previous chapter structures the findings into three sections, the rest of the chapter will provide a more integrated discussion of the findings.

Understandings of depression within the participants' Indian community

As indicated previously, the participants in this study initially displayed hesitancy when expressing their understandings of depression. They were still, however, able to provide a basic knowledge of how depression is likely to present in a person. This was evident in their ability to provide the various biological, psychological and social symptoms related to depression. It must be acknowledged that the participants who reported having a basic understanding of depression were those who had been exposed to contexts where mental health discussions were offered; either through tertiary education or work-related courses.

The only participant who expressed not knowing anything about depression reported that he was not given the experience of tertiary education and did not hear of depression growing up. This again speaks to the various forms of exposure and personal interactions with society which assist in the individual constructions each participant had of depression.

According to literature provided by Gureje and colleagues (2007), phenomena and constructs can be considered unique in different cultural contexts; similarly pathological disorders like depression should be considered unique to each context.

Participant Five's understanding of depression may be considered poor, yet it still reflects a context in which such concepts did not exist and therefore did not form part of his reality.

Causes of depression within the participants' Indian community

The findings also reveal the participants reported the main cause of depression among men is the expectations placed on men by their families. With Indian men being compared to other members of their families, they are constantly being put under pressure to perform and succeed in all areas of life.

As mentioned in Chapter Two of this study; Indian communities have always placed emphasis on a hierarchical system when it comes to gender (Kakar et al., 2009). According to Brody (2000), Indian communities have been known for their patriarchal nature; this meant that men held a position of prestige, whilst women were considered to be the inferior and weaker gender. Therefore, when participants speak of a pressure to perform, they speak to the social and cultural gender roles that have been produced and reproduced overtime. Each of these participants comes from a particular context, which recommends what it means to be masculine. These societal roles are imprinted on men from birth, and teach them ways to behave, respond, and interact so they are considered to be socially appropriate. To follow the gender roles of what it meant to be masculine, undoubtedly meant a man was successful.

According to the current study's findings, discourses around the construct of masculinity typically included vocabulary such as 'strong', 'provider', 'leadership', 'success' and 'achievement' among others. This created the understanding among the participants of this study, that being 'vulnerable' was not a word/term that corresponded with what it meant to be a man. In fact, a lack of masculinity was always often equivalent to failure, lack of manhood and shame that was brought onto men and their families.

Growing up with such high standards being placed on men, it is easy to understand why they are sometimes their own worst critics; they have been groomed into believing that they need to be the alpha-male and better than the man next to them. This not only conformed to the gender roles that have been recommended for them, but also reinforces the construct of masculinity. This was apparent in an interview with Participant Seven, who expressed this concern, and how this may lead to a boundless cycle of producing and reproducing gender norms, dissatisfaction and lack of self-fulfillment in their respective lives. Literature provided by Arendse, Khan and Ratele (2020), speaks to this very issue of how men are placed at a greater vulnerability to depression and suicide as a result of gender roles and expectations. These authors claim that as a consequence of socially constructed norms, men are put under substantial pressure to conform to traditional masculine ideals that, essentially, leaves them at a higher risk for depression, as well as health-impeding behaviours.

In Chapter 2 of this study, literature has also been provided with regards to Indian communities and their understanding of what may be causing mental illnesses. Literature provided by Bhugra and Campion (1998) as well as Laher (2014) both allow the reader to appreciate why a diagnosis of any mental illness may not always be welcomed in the Indian home. Both works explored how mental illness has been conceptualised in non-western cultures.

Being a resident of a multicultural country such as South Africa, mental illness needs to be viewed in a holistic manner. For this reason, spiritual aetiologies of depression needed to be explored. Findings in the abovementioned studies by Bhugra and Campion (1998), as well as Laher (2014) reveal that mental illness is oftentimes attributed to that of ill will, black magic, witchcraft, the evil eye or spiritual possessions. As a result of this playing such a crucial role

in the Indian community background, participants were asked their view of the role religion played in their own constructions of depression. This was specifically important as cultural explanations of depression play an influential role in the language that is used to speak about depression as well as the method of health care that is accessed (Keikelame & Swartz, 2015).

Interestingly, the findings indicated that the participants in this study did not find spiritual causes of mental illnesses to be significant to them, as they did not find it necessary to speak about during their interviews. Instead, they held a different perspective regarding the role religion had played; some viewed religion as a coping mechanism, while others believed religious scriptures have served as a foundation for gender differences and, most importantly, the expectations placed on men.

To understand the inconsistency of findings between this study and those of Bhugra and Campion (1998), and Laher (2014), the difference in the years of which each study was conducted must be acknowledged. Much has evolved, including the prevalence of social media and tertiary courses, which have introduced participants to topics of mental health. The researcher does not have the capacity to generalise that the participants of this study have transgressed from their religious or spiritual beliefs. However, with the findings of this study, it is evident that through their personal experiences, participants have attained greater knowledge to allow for perspectives that may differ from their previously held belief systems. Essentially, the participants' perceptions of what causes depression is a construction of years of exposure that may have transformed and evolved over time.

Indian men's attitudes towards seeking help for depression

The findings presented in Chapter Four emphasised participants' views that the Indian community did not prioritise mental health enough. In fact, it was the lack of knowledge and

understanding of what mental illnesses were that led the participants to respond with the attitude that depression was taboo or non-existent. 'Depression' was not a term that existed in their vocabularies and, if someone had presented with symptoms of thereof, they were faced with judgment and the possibility of being ostracised from the family.

Given the theoretical underpinnings of this study, depression is considered to be socially and culturally constructed via the daily discourses between individuals (Kidd et al., 2011). For the longest period, the terms 'depression', or 'mental illness' were exclusive to Western countries and cultures. Depression and mental health literacy was not something that many focused on in non-western countries (Furnham et al., 2014).

Consequently, depression was never engrained into the daily vocabulary of non-western cultures, including Indian families. If someone did experience depressive-related symptoms, they were constructed differently from how the Diagnostic Statistical Manual of Mental disorders (DSM) may interpret depression. How depression is constructed differs among contextual periods and cultures (Gureje et al., 2007).

The participants of this study emanate from one ethnic background, but from differing contextual backgrounds (different age groups, communities, religion), where the word 'depression' may have not been spoken in their daily dialogue. If depression has not been part of their language, it fails to become a part of their dialogue and, essentially non-existent in their reality. It is for this reason that many of the participants reported that even though depression is currently being vocalised in their 'new' contextual environment (work/tertiary education), it is still forbidden and dismissed in dialogues with their loved ones or friends in their hometowns (former contextual period where depression did not exist in their vocabularies). The principle of social constructionist theory is that it is anti-essentialist, with

the belief that people are in a constant state of movement and growing (Cruz et al., 2016) may also be applied to the participants of this study. Their progress into a new context and time period is what may also account for the change in perceptions of what causes depression, and why the participants of this study did not attribute any value to spiritual etiology, as traditional Indian communities may have.

With depression not being a part of a daily dialogue and therefore not adequately understood, four of the seven participants who did speak of it or presented with depression were met with stereotypical responses from their community. According to the participants, this was particularly true for men within Indian communities, who were not allowed to feel sad or depressed, because these symptoms were foreign to the constructed masculine ideals with which men ought to present.

According to social constructionist teachings, individuals co-create their realities (Pearce, 2009). Given the findings of this study, individuals not only construct their own realities, but fall prey to social and cultural constructions of reality as well. The participants of this study emphasise the pressures that fall onto them to conform to gender roles. Men are oftentimes expected to present as physically and emotionally strong, powerful and unbothered by life's pressures. Should a man, intentionally or not, deter from what is socially and culturally expected, he is made to feel inadequate in his community.

For this reason, men have been instilled with the fear of stigmatisation and therefore deliberately choose to live their life as a facade, by pretending to always be strong, powerful and confident, even when this may not always be their reality. Even with help, and resources being available, these participants highlight that they will not choose professional help as

their first choice because, although they may be experiencing distress, it is far less than the pain that may come from being judged and stereotyped for seeking professional help (in the form of psychological services).

Given the findings in Chapter Four, it is evident that the participants' knowledge of depression and their attitudes towards seeking help for depression has been greatly shaped by the values, teachings and beliefs of their households and communities at large. Kirmayer and Swartz (2013) report that an individual or community's perception of mental illnesses such as depression is a product of cultural insititutions and practices that influence and maintain social arrangements surrounding mental health and illness, for example, that being diagnosed with depression means weakness and that mental illness is taboo. It is evident that culture fundamentally constructs concepts that communities can use to describe, think and speak about mental illness. However, these concepts are not always advantageous or hopeful to someone who suffers from mental illness.

As a consequence of mental illness not being spoken about and given enough (positive) attention whilst growing up, the participants' attitudes towards help-seeking for depression has taken a more divided position. Findings suggested that due to their personal experiences (i.e., either experiencing an episode, or knowing someone who did), participants have developed an advocating stance for mental health, by promoting the benefits to friends and loved ones, as well as encouraging others to seek professional help for their distress. This is where it ends, however, as the very same participants were opposed to seeking professional help as their first option when searching for their own healing and support. Although this was the popular opinion among six of the participants, the seventh participant held more of a negative view towards help-seeking for depression or any other mental illness. To this

participant, remaining consistent with family teachings, which involved a suppression of emotions, was the only way men were supposed to deal with their difficulties.

Indian men were taught by their elders and paternal figures that men ought to display leadership and stoic qualities; it is only then is he considered to be a man. Anything contradictory to these qualities, including expressing his emotions, qualified him for stereotypes, unconstructive judgment and the description of not being man enough. It can therefore be seen that men's (including the participants in this study) reluctance to seek professional help is embedded within society's view that depression is taboo, and seeking help for it not only brings shame onto the person diagnosed, but to the collective community as a whole.

This societal teaching has become internalised by men to the extent of suppression and avoidance being their automatic responses to situations. For this reason, it must be acknowledged that even with exposure to courses and workshops, help-seeking for depression will only be taken seriously when it starts from the home itself, and when there is a willingness to change generational patterns.

Coping mechanisms alternative to psychotherapy

Given the above findings, it is evident that depression may often be considered forbidden in some Indian homes. The consequence of this may then fall onto the men who may be suffering with depression, because they are then left to endure their pain with little to no support from their surrounding community and loved ones. For this reason, alongside the stigmatisation and stereotypes that men face, men are forced into searching for alternate methods to cope, apart from psychological assistance.

These alternative methods of coping were explored during the interview process. The findings suggested that the participants' responses regarding help-seeking were divided into adaptive and maladaptive coping mechanisms. The maladaptive coping mechanisms seemed to be the most popular among depressed men. According to the findings, men find it easier to avoid their pain by either concealing their emotions, or avoiding situations which trigger emotionally laden content. While this provides temporary relief, it simultaneously reinforces isolation and an exacerbation of possible depressive symptoms. Other maladaptive coping mechanisms included the excessive use of alcohol and physical exercise as a means to numb their pain, or replace it with a physical one. The adaptive coping mechanisms that were mentioned included speaking to a loved one, engaging in a hobby, and relying on prayer, as well as religious support.

According to the findings in this study, men show preference for speaking to someone with whom they share a trusting relationship and are able to provide them with unconditional acceptance, no judgment and essentially, provide an alleviation of their distress.

Given the above, it is evident that participants are of the opinion that men find it easier to avoid emotional expression because being vulnerable would jeopardise their manhood. These findings were echoed by Barclay et al., (2005), as well as Liang and George (2012), who have both addressed the topic of avoidance among depressed men. Research findings provided by Barclay and colleagues (2005) revealed that men who are enduring depressive symptoms use a multitude of maladaptive coping mechanisms, including avoidance, and escapist behaviours.

In the above two cited studies, as well as the current study, participants have highlighted a pressure to conform to gender stereotypes and maintain their power. As Liang and George

(2012) have reported, masculine meant success and depression was equivalent to inadequacy. This statement not only reflected their findings but the realities of the participants within this study as well. The consistencies within each of these studies not only communicate the difficulties that men of all ethnicities may be facing, but it is evident that despite the rate of growing information and access to knowledge, some societal norms, constructs and belief systems have failed to transform and meet the needs of its men. Consequently, men's fear of expression and help-seeking for depression has endured for several years.

Ideal forms of community support for men with depression

In addition to the alternative coping mechanisms used by the participants, the interviews also explored ideal forms of community support, as suggested by the participants.

During the interviews, participants shared a considerable amount of information with regards to their feelings about depression, help-seeking for depression and how the lack of information about mental illness has shaped the understandings of many communities. For this reason, they ask that more public campaigns and community projects be held to ensure that knowledge about mental health is distributed.

Chodkiewicz and colleagues (2020), conducted research which addressed the importance of mental health promotion, specifically with regards to the male population. Their research recommends the importance of developing mental healthcare services that are specifically created to address the needs of the male population, and implemented in a male-sensitive language (Chodkiewicz et al., 2020). This way, the barriers preventing help-seeking are destabilised and men, within Indian as well as other ethnic communities, can learn about depression and eventually allow for more support for men, guaranteed confidentiality in their healing process and support for help-seeking.

Methodological overview of the study

As a part of the data collection procedure, the sample in this study involved the recruitment of seven participants. Although this was within the desired range, there were certain setbacks the researcher experienced during the recruitment process. Potential participants would contact the researcher with an interest in the study; however, once the participation information sheet had been provided to them, they would decline consent. According to them, reading the content of what the study entailed and seeing the details of SADAG and Lifeline made them feel afraid that they would be required to talk about their feelings and in some cases may even find out that something may be "wrong" with them. Again, this confirmed the difficulties some Indian men have with being vulnerable, to the extent of avoiding discussions that may potentially trigger emotionally laden content**.**

In addition, data in this study were collected through the use of seven semi-structured virtual interviews that were audio recorded and transcribed verbatim. As noted in Chapter Three, due to restrictions placed on South African residents during the Covid-19 pandemic, virtual interviews were conducted for the safety of the researcher and the participants (Self, 2021).

Questions asked during the interview focused particularly on the belief systems, norms and teachings that assisted in constructing the perceptions participants had of depression. Data collected and transcribed was then explored and analysed through the use of thematic analysis. The analysis process yielded seven themes and 11 sub-themes, which is discussed in the upcoming sections.

During the interview procedure, all participants permitted consent to be interviewed, although the researcher once again experienced some of the participants' uncertainty, as only

five of the seven participants consented to be audio-recorded. This may have been due to the fear that their identity may be revealed and their stories known to others apart from the researcher. This fear of being exposed was also seen in four of the seven participants when they had decided to keep their camera off during the virtual interviews. This can also be attributed to the participants need to protect their privacy, as video platforms usually has the risk of the researcher gaining entrance into the participant's home or private space (Carter et al., 2021).

It must also be acknowledged that while the lack of a face-to-face interview may have made the non-verbal nuances difficult to attain, it may have allowed the participants to feel more confident to engage in an honest and liberal manner, knowing that their identities were protected. In addition, virtual interviews and meetings have become the new way of interacting within many corporate businesses. For this reason, many of the participants may have felt more relaxed with the chosen mode of data collection, essentially improving response rates (Self, 2021).

Participants were also under no obligation to disclose whether or not they had been diagnosed with depression. However, it is important to acknowledge that this was something that had been reported during the interviews, when participants were asked about their understandings of depression, and what depression may look like for them. In response, many of these participants drew on their own personal experience or the knowledge they had from knowing someone who suffered with depression.

In terms of the methodological position of this study, the theoretical underpinnings of social constructionism were adopted to explore how depression and the understanding thereof

have been socially constructed. Essentially, it views how society's own constructions have shaped the individual constructions Indian men now have of depression and help-seeking for depression.

Social constructionism, at its foundation, views knowledge as being socially constructed (Wong, 2018). However, it further posits that knowledge is only developed through the agreement of others, which allows for it to be considered a reality. The principles of social constructionism therefore suggest that knowledge is reliant on people, and the values of the community in which people live.

For this reason, social constructionism has held a foundational role, as participants reported on their own understandings and meanings of depression through the several interactions they have been exposed to growing up within their own communities. Findings have revealed various similarities or, as social constructionism would term, agreements, in the participants' constructions of depression. As such, we can acknowledge that these findings reveal a reality that the participants in this study may be facing. It is important to note that although the sample in this study may not be used to generalise the reality of a greater population of men, the findings do reveal the participants' own realities and a truth that many men, regardless of nationality, may possibly be experiencing.

Strengths and limitations of the study

This study involved a sample of seven participants. As a result of the small sample size, this study is limited in that its findings cannot be generalised to the larger South African Indian male population. This study, however, has gathered rich and descriptive data that provides an indication of the participants' constructions of depression amongst Indian men in their communities, with a particular exploration of the realities the Indian men in this study

have experienced with regards to how depression is understood, responded to and managed in their personal lives, and surrounding community.

Secondly, the researcher holding an insider-outsider position during the data collection process proved to be beneficial, as it allowed the participants to engage liberally. They also appreciated the willingness of the researcher to learn more about the Indian male perspective. The insider position further assisted in allowing the researcher to gain access to a population and information that may not have been easily accessible otherwise.

It must be acknowledged that while the insider position provided access to the participants, it also impacted the data collection process (as indicated in Chapter Three), as the participants often assumed the researcher had a similar experience (pressure by family to maintain an appearance that fitted the gender norm, and negative attitudes to mental illness having chosen to study psychology).

Having shared the same ethnic background, and being exposed, to some extent, to a similar response to depression, the researcher was able to offer appreciation for the participants' experiences. On the other hand, it could also be argued that should a researcher of another ethnic background conduct such a study, the findings may or may not be of a different nature. Additionally, having a researcher of another ethnic background and experience may have also yielded differing and equally valuable interpretations.

Finally, with this study being guided by the principles of social constructionism, the researcher had to appreciate each participants' reality is co-constructed, and that there is no fixed truth to be discovered. This means that although these findings are of significance at this moment in time, they are not absolute and subject to change.

These findings portrayed each participant's lived experience, interaction and, in turn, their constructions of their own realities of depression. Although this may stand true now, with future discourses and knowledge being generated, it is important for the researcher to acknowledge these findings are subject to change in the future and can therefore not claim to reflect the ultimate truth of every Indian man's construction of depression.

Recommendations

Policy makers, researchers, community leaders and mental health practitioners need to make a greater effort in promoting mental health within communities which require greater assistance and access to those services. It is therefore recommended that more psychological services be made accessible to both men and women of Indian communities in South Africa.

Professional psychological help being offered in close proximity will allow residents to consider psychotherapy as a form of coping and possibly become a prioritised measure in the future. Having psychological services available will be able to assist those who do suffer with depression to improve their emotional well-being.

Those who have had the opportunity to experience psychological assistance have reported feeling more capable and confident in managing with their symptoms. Additionally, psychological assistance proves beneficial in building insight, growth and self-development (Ross, 2017). It is therefore evident that the benefits of psychological assistance and mental healthcare far outweigh the physical and emotional damage that come with maladaptive coping mechanisms (alcohol use, drug abuse, misuse of finances, aggressive/violent behaviour).

It is also recommended that funds be allocated towards the co-ordination and facilitation of awareness campaigns within local communities in which depression is rife, including those

within the Gauteng region. These campaigns should provide focus on mental health, and mental illnesses, such as depression. This should involve the co-operation of mental healthcare practitioners who are qualified to provide psycho-education, such as the symptoms and management of mental illnesses.

Awareness campaigns should include the use of multiple information platforms to ensure that information reaches a broader age group (for example, television, social media, pamphlets, newspapers). By providing multi-platform awareness campaigns within collectivist societies, communities will not only develop greater knowledge and understanding, they may also plant a seed of curiosity. These campaigns, as proposed by the findings of this study, should be highlighting common disorders, the symptoms to look out for, as well as the differences in how disorders may present in different genders and, most importantly, ways to receive help.

In addition, exposure to greater knowledge may also lead to the learning of new information, and the breaking of traditional belief systems collectivist Indian societies may have of mental illnesses. Participants in this study sincerely and liberally expressed their request for more awareness campaigns, as this would mean they would finally be able to let down their barriers and access the help and support they need, without judgment.

Mental healthcare also needs to be implemented into the local school curriculum. This will ensure children will be exposed to topics of mental illness from a young age, and will be highly likely to generate conversations around topics of mental health at home.

The first recommendation for further studies is that research be conducted to address the gender differences in the context of mental illness. This will also facilitate greater awareness

among communities who still remain uncertain about mental illnesses and what to expect when their loved ones suffer from a particular disorder.

It is also recommended that further research be conducted with men and women of different ethnic backgrounds. This will be effective in gaining a more comprehensive understanding of whether or not the constructions the participants of this study had of depression is echoed among the different genders of differing cultural backgrounds within the South African context.

Conclusion of the research

The aim of this study was to explore the common constructs and everyday language of depression. This was achieved by the use of qualitative methodological measures, including semi-structured interviews as a means to acquire rich and descriptive data. The data collected was thereafter shaped and brought to form with the use of thematic analysis and social constructionism as the foundation.

Themes that stemmed from this study revealed that some Indian communities (particularly where the participants of this study grew up) possess a lack of understanding of depression, as it is often labeled a taboo topic. As a result of this lack of awareness and understanding, men and women within Indian communities may not be able recognise the symptoms of depression, should they themselves or someone they know be experiencing it.

The participants in this study believe that expectations placed on men to perform is the dominant reason men are likely to suffer from depression. In spite of this, psychological help seemed to have been last on their list of sources of help.

Instead, participants in this study listed adaptive and maladaptive alternative coping mechanisms that were preferred. Men often attribute this reluctance to seek help to the fear of

being stigmatised. For this reason, they have provided recommendations of what the ideal form of community support would look like for them.

Finally, this study is unique in that its sample (Indian men from Gauteng) has not been previously studied with regards to constructions of depression in men. For this reason, and due to the findings of this study, the researcher chooses to conclude this research by emphasising the importance of greater awareness campaigns, and easier accessibility to mental healthcare services; not just within the local communities of Gauteng, but in other provinces of South Africa, where depression and other mental illnesses remain rife. Depression is not an illness that knows boundaries; individuals of every ethnicity and any place of residence are being exposed to causes of depression on a daily basis. Starting awareness campaigns will allow for communication to begin and awareness to spread to the people who may require it the most.

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ANNEXURE ONE

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Humanities 100. Since 1919

21 January 2022

Dear Miss V Sithambaram

Project Title:	Exploring common constructs and everyday language of depression among Indian adult men in Gauteng
Researcher:	Miss V Sithambaram
Supervisor(s):	Miss CA Prinsloo
Department:	Psychology
Reference number:	14134170 (HUM041/0221)
Degree:	Masters

I have pleasure in informing you that the above application was **approved** by the Research Ethics Committee on 21 January 2022. Data collection may therefore commence.

Please note that this approval is based on the assumption that the research will be carried out along the lines laid out in the proposal. Should the 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 Karen Harris
Chair: Research Ethics Committee
Faculty of Humanities
UNIVERSITY OF PRETORIA
e-mail: tracey.andrew@up.ac.za

Room 7-27, Humanities Building, University of Pretoria, Private Bag X20, Hatfield 0028, South Africa
Tel +27 (0)12 420 4853| Fax +27 (0)12 420 4501|Email pghumanities@up.ac.za | www.up.ac.za/faculty-of-humanities

ANNEXURE TWO

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Participant Information Sheet

Title of the study: Exploring common constructs and everyday language of depression among Indian adult men in Gauteng.

An introduction to the study:

My name is Vashnie Sithambaram, currently registered as a student in the Masters of Arts (MA) Clinical Psychology program at the University of Pretoria and the researcher of this study. My research will focus predominantly on attempting to understand the meanings Indian men construct of depression. This will entail discussions pertaining to common discourses around depression, your personal attitudes about seeking help for depression, as well as potential barriers preventing help-seeking.

Participants interested in this research are required to identify with the following inclusion criteria: 1) the individual must identify as being an Indian male, 2) participant must be at least 25 years or older, 3) the participant must not be a registered student at any university, college or school and, lastly 4) participant must reside within Gauteng.

What will my participation entail?

Should you agree to participate in this study, you will be required to partake in a semi-structured, one-on-one interview with myself as the researcher. This will take place on an online platform – either Zoom or Google Meets (this will be decided on what is most convenient for you) or an in-person meeting if preferred. This will ensure that both your health and safety is being prioritised and protected. The interview will proceed for a period of 45-60 minutes, where you will be asked a few questions on the abovementioned topic. This

interview will be recorded only with your consent. Should you agree to participate, you will also be emailed an electronic copy of a consent form, which you will be required to sign and return to the researcher via email. Please note, that your participation in this study is purely voluntary and you are under no obligation to participate.

Will my information be kept confidential?

As a researcher, it remains my ethical responsibility and legal obligation to ensure that your privacy is respected and maintained throughout the study. All information provided will be kept confidential between you and myself as the researcher. Any form of identification will therefore be removed and replaced with pseudonyms (false names) in the aim of keeping your identity anonymous. As such, data that is shown and discussed with my supervisor will have already been made anonymous and data collected will be safeguarded on a password-protected computer. The final report will then be electronically sent to you in order to verify if the information given has been correctly captured.

What are the potential risks of engaging in this study?

It is important to note that communication relating to depression can carry some form of risks. As the researcher of this study, it is my ethical responsibility to safeguard participants from any foreseeable harm. Should you feel that participating in this study has caused you any form of physical or emotional discomfort, appropriate measures will be taken to ensure that you are provided with the necessary resources for the South African Depression and Anxiety Group and Lifeline, who will provide you with the required psychological services.

LifeLine	011 728 1331
SADAG	011 234 4837

What are the benefits of this study?

Depression among men is a topic that is rarely engaged. As such, research on depression amongst Indian men in the South African context is rare. By participating in this study, you will be contributing to a growing body of literature on the construction of depression among the Indian male population. Data collected as a result of this research will increase awareness and serve as the foundation for future research.

Withdrawal from research

Any participation is this research is considered voluntary and therefore withdrawal from this study will be permitted at any time. Should you decide to withdraw, the data you have provided will be discarded without any penalisation or judgement.

What if I have questions?

If you have any questions about the study, you are welcome to contact myself, Vashnie Sithambaram at **vashniesithambaram@gmail.com**, alternatively you may contact my research supervisor on the following details should you have any concerns about your rights as the participant or if you wish to report any problems you may have experienced during your participation in this study.

Prof Claire Wagner
Research supervisor
University of Pretoria
Claire.wagner@up.ac.za

ANNEXURE THREE

Faculty of Humanities
Fakulteit Geesteswetenskappe
Lefapha la Bomotho

Informed consent

Title of study: Exploring common constructs and everyday language of depression among Indian adult men in Gauteng.

I _____ voluntarily agree to participate in this study

- I hereby declare that I have been provided with a Participation Information Sheet, which has specified all the details of the abovementioned study.
- I accept that I have been given an adequate explanation of the purpose, nature, risks, and benefits of this study and I was afforded the opportunity to ask questions.
- I understand that should I experience any psychological distress following my participation in this study, I can contact LifeLine or SADAG on the following details;

  LifeLine (011) 422 4242

  SADAG (011) 234 4837
- I understand that despite my decision to participate in this study, I have the right to withdraw at any time without being penalised or questioned.
- I understand that my participation will take place either in person or on an online platform of my choice (Zoom/Google Meets).
- I understand that my participation in this study is voluntary and will not be rewarded with any form of remuneration.
- I hereby grant/deny permission for my interview to be audio recorded. Please indicate your preference using a cross (x) in the appropriate box

  Permission granted ☐

  Permission denied ☐
- I understand that all information which I will provide will be kept confidential and my identity will be made anonymous with the use of a participant number (e.g., participant 1)

- I hereby agree that I have been given the contact details of the researcher should I have any further questions related to this study.
- I have received a signed copy of this informed consent form.

Researcher's contact details

Ms V. Sithambaram

Vashniesithambaram@gmail.com

081 512 9317

Supervisor's contact details

Prof C. Wagner

Claire.wagner@up.ac.za

(012) 420 2319

_____ _____

Participant's signature **Date**

ANNEXURE FOUR

Interview Schedule

Good morning/afternoon,

Thank you for volunteering to participate in my study. My name is Vashnie Sithambaram, and I am currently registered as a Clinical Psychology Masters student at the University of Pretoria. The study that is being conducted aims to explore depression among Indian men in Gauteng. This includes exploring attitudes, perceived causes of depression, and different ways Indian men seek help for depression.

Before we get started, I should remind you that your participation is voluntary. This means that you are allowed to withdraw from the study at any time. The interview is likely to take 45-60 minutes. With that being said, do you have any questions or need clarification on anything before we get started?

1. **To get started, could you tell me something about yourself?**
   (Probe for occupation, area of residence, age, tertiary studies, and marital status)

2. **In your own opinion, what do you understand depression to be?**
   Probe: why do you say that? (What experiences have led to this understanding?)
   Probe: in your opinion, what is the broader Indian communities' understanding of depression?
   Probe: how does your understanding differ from this?
   Probe: how have your experiences with work and tertiary education influenced your understanding of depression?

3. **What role do religious institutions play in Indian men's attitude towards depression?**
   Probe: why do you say that? / Can you please elaborate?
   Probe: Do religious institutions play a role in help-seeking among men?

4. **What does depression look like among men?**
   Probe: how do men who are depressed behave?
   Probe: is there a difference in how women may experience depression?
   Probe: what may be causing this difference?

Probe: what role does the Indian community play in maintaining this difference?

5. **What may be causing depression among Indian men?**

   Probe: why do you say that?

6. **What role does family play in depression among the men in their families?**

   Probe: why do you say that?

7. **What are your beliefs on seeking help for depression?**

   Probe: what would be your first source of help for depression?

   Probe: how are Indian men dealing with depression?

   Probe: do you believe Indian men find it difficult to seek help for depression?

   Probe: what may be preventing them from seeking help?

   Probe: does the Indian community support/not support Indian men who try to seek help?

   Probe: How so?

   Probe: what are alternative ways men try to manage their depression?

   Probe: ideally, what would community support look like for you?

Now that we have come to the end of the interview process, I thank you for your open participation and willingness to disclose. Is there anything else that you would like to ask or add before we end?

As stated in the participant information sheet, should you feel that you need someone to speak to or debrief after this interview, I have provided the details of SADAG and LifeLine on both the consent form and participant information sheet.

Should you have any questions following this, you are welcome to contact myself on the details that I provided on the participation information sheet.

Thank you.

ANNEXURE FIVE

Research Participants Needed

EXPLORING COMMON CONSTRUCTS AND EVERYDAY LANGUAGE OF DEPRESSION AMONG INDIAN ADULT MEN IN GAUTENG.

DEPRESSION IS CONSIDERED TO BE THE MOST ESCALATING MENTAL DISORDER ACROSS THE GLOBE.

- 264 million people diagnosed with depression
- 804 000 suicides
- 506 520 completed suicides among men

This research aims to explore the conversation about depression and help-seeking among Indian men in Gauteng.

How do I qualify?

- I self-identify as an Indian male
- I am at least 25 years
- I am competent in the English language (I.e read, write, and speak)
- I am a South African citizen residing in Gauteng

Who do I contact?

Researcher's contact details

Vashnie Sithambaram
C: 081 512 9317
E: vashniesithambaram@gmail.com