Xhosa men's constructions of depression

By

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Abstract

The research aimed to use social constructionism as a methodology to explore Xhosa men's constructions of depression. The theoretical framework chosen for this research was intersectionality. Purposive sampling was conducted to obtain between four to six participants who self-identified as Xhosa men. In the end four participants were interviewed through semi structured interviews. Interviews were conducted in the language of convenience for the participants. This was noted to be a mixture of English and isiXhosa. The interviews were transcribed and translated to English. Thematic analysis was used as a method of analysis. The analysis followed a systematic process which consists of six steps that were proposed by Braun and Clarke. Emerging themes related to how culture influenced Xhosa men's constructions of depression, how masculinity influences Xhosa men's constructions of depression, and How masculinity and the Xhosa culture intersect and interact in men's constructions of depression. The findings showed that Xhosa men valued and accepted their cultural values, and gender roles, and thus their constructions of depression were influenced by that. The findings also revealed that depression also played a role in how Xhosa men construct gender and their culture. Hence highlighting the idea of intersectionality.

Key words: Depression, DSM-5, intersectionality, social constructionism, masculinity, Xhosa culture

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CHAPTER 1: INTRODUCTION TO STUDY

Introduction

This research dissertation aims to explore how Xhosa men construct depression. The research participants are a non-clinical population, as the aim is not to explore the experiences of men who have been diagnosed with depression. Rather the study aims to explore the constructions of depression available amongst Xhosa men from the general population. This study is conducted from a social constructionist methodology, which means that it is a co-construction between the participants and me as the researcher. Thus, it does not present "the" truth but rather "a" truth amongst the participants of this study. This chapter presents a brief outline of what is to follow in this research dissertation.

The background of this study will be detailed, with a specific focus on research around depression, gender and culture. Thereafter the justification, aim and objectives of the study will be discussed. Intersectionality as the theoretical framework of this study and social constructionism as the methodology will be briefly outlined. Lastly, this chapter will also provide a preview of the sequence and content of the remaining five chapters of the dissertation.

Background

The study is primarily focussed on the topic of depression. For this research dissertation the diagnostic criteria the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5) was used as one of the ways of understanding depression. The DSM-5 criteria for depression are not necessarily the same as people's constructions of depression, it is the psychiatric construction of depression. The DSM is a manual classifying mental disorders with associated criteria, in order to assist in making a more reliable diagnosis of mental disorders (American Psychiatric Association [APA], 2013).

According to the *Diagnostic and Statistical Manual of Mental Disorders, 5th edition* (DSM-5), depression is characterised by the presence of sad, empty or irritable mood together with somatic and cognitive changes that significantly affect the individual's capacity to function (APA, 2013). In order to make a diagnosis of depression, the following criteria are stipulated by the DSM-5, at least one of the symptoms: depressed mood or loss of interest, accompanied by at least five other symptoms present in the same two-week period (APA, 2013). The other symptoms include significant weight loss or weight gain, increased or decreased appetite nearly

every day, fatigue, recurrent thoughts about death, feelings of worthlessness, and clinically significant impairment of the individual's social, occupational or other important areas of functioning (APA, 2013). The same criteria are used to diagnose across genders and cultural groups.

Diagnostic systems such as the DSM and the World Health Organization's (WHO) ICD (International Classification of Disease) offer typologies of the disorder for the purpose of diagnosing, they do not include the phenomenology of depression or the way in which cultures view depression (i.e. cultural constructions) (Philips et al., 2012). The DSM-5 does, however, provide a cultural formulation interview (CFI) which allows clinicians to assess the impact of culture on the presentation of mental illness (APA, 2013). The impact of culture as discussed in the DSM-5 includes the values, knowledge and orientations that individuals derive from being members of multiple social groups. This study investigates these dimensions of depression and more particularly the intersections between depression, cultural constructions and gender expectations. In other words, the study is about more than just DSM criteria of depression.

According to a recent report by the World Health Organisation (2017), depression is identified as the leading cause of ill health and disability worldwide with more than 300 million people living with depression. Between 2005 and 2015 there has been a more than 18% increase in the prevalence of depression worldwide (WHO, 2017). Evidently, depression is increasing, it is a serious mental health issue all over the world, and a similar picture holds true for South Africa.

A local study estimates the prevalence of depression to be 27% with significantly more women than men diagnosed (Tomlinson, Grimsrud, Stein, Williams, & Myer, 2009). Worldwide research has consistently reported women to be about four times more likely than men to be diagnosed with depression (Murphy, 1998; Ojea & McGruire, 2006; Van de Velde, Bracke & Levecque, 2010; WHO, 2017). However, there seems reason to believe that more men may be suffering from depression than prevalence studies suggest (Burrows & Laflamme, 2006; Gonzales, 2008; Kilmartin, 2005; Lepine & Briley, 2011).

The primary arguments about men suffering from depression more than prevalence studies show are that men seem to experience and express depression differently than women and that diagnostic nosologies such as the DSM are insensitive to these male-type depressive experiences and expressions (Kilmartin, 2005). For instance, Kilmartin has argued that the

diagnostic criteria for depression as stipulated by the DSM, focus on typically feminine symptoms; therefore, it is no surprise that women are more readily diagnosed (2005). In contrast to women, men are socialised to "act out" thus their depression may present through chronic anger and self-destruction (Kilmartin, 2005). These acting out behaviours include risk-taking behaviour, for example, physical and sexual risk-taking, substance abuse and over involvement in work (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Kilmartin, 2005). Such externalizing behaviours are not part of the DSM-5 diagnostic criteria, thus men's depression may go unnoticed and undiagnosed. The underdiagnosis of depression is also true in different cultures where depression can present differently and mean different things (Garfield, Isacco, & Rogers, 2008; Lincoln, Taylor, Watkins, & Chatters, 2010), as will be further discussed in the literature review.

Furthermore, the under-diagnosis of depression in men could be linked to gender norms and how these impact on men's help-seeking behaviour. Gender norms or masculine/masculinity-centred ideologies are ideas held by individuals in a society about what it means to be a man (Mansfield, Addis, & Mahalik, 2003). These gender norms may vary from person to person and between cultures and over time (Mansfield et al., 2003). Connell (2000) makes a similar argument that different cultures and different periods in history construct different masculinities. In large-scale multicultural societies, it is likely that there are multiple definitions of masculinity and different expressions of it (Connell, 2000). This is why we refer to masculinities and not masculinity. A systematic review of the role of masculinity in men's help-seeking for depression found that men resisted help-seeking (Seidler et al., 2016). The resistance was evidenced by the engagement in treatment against their will, only when their internal resources become depleted and symptoms are severe (Seidler et al., 2016). The resistance is due to treatment being dependent on behaviours which are considered contradictory to traditional masculine norms such as emotional disclosure. Instead of seeking help, men with depression used maladaptive coping strategies. According to Courtenay (2000), men are more likely than women to rely on themselves when experiencing depression and to "talk themselves out" of the depression. Those who sought help described how they limited disclosure, minimized the severity of symptoms, and the depth of the need of help as a means to maintain masculine status (Seidler et al., 2016).

The denying/minimizing of mental health problems is believed to form part of men's gender norms, therefore, the consequence of violating gender norms (i.e., seeking help for a mental health problem) for men is that they may face ridicule and punishment (Garfield, Isacco,

& Rogers, 2008). In addition to masculine norms, higher rates of suicide among men than women also highlight the possible under-diagnosis of depression in men.

According to Lepine and Briley (2011), depression affects quality of life and may sometimes result in suicide. Similarly, Bryant-Bedell and Waite (2010) argue that undiagnosed and untreated depression may lead to suicide. Despite the fact that fewer men than women are diagnosed with depression, men are four times more likely than women to commit suicide (Lepine & Briley, 2011; Murphy, 1998; Nock et al., 2009). In a study conducted in South Africa in six different cities, findings suggested significantly higher rates of suicide among men than women (Burrows & Laflamme, 2006). The apparent lower prevalence of depression and associated higher rates of suicide in men raises questions about the accuracy of diagnosing depression in men. It also highlights the idea that men do not seek help as readily as women do. Women may willingly admit to and seek professional help before completing suicide. It thus raises questions about the role of gender in mental health issues and depression in particular. Similar to gender, culture is an important dimension in the study of mental health. This is so because different cultures may understand and experience mental health phenomena in relation to their cultural norms and as such, it is important to consider culture in the study and context of mental health.

More than a decade ago, Dragums and Tanaka-Matsumi (2003) argued that the interplay between culture and human behaviour and experience has moved to the centre among the concerns of contemporary psychology. More recent studies argue that individuals understand, communicate and experience mental health symptoms in ways that are influenced by their culture (APA, 2013; Bhugra, 2008). It has also been argued that there is a strong need for a focus on within-group research in order to understand the diversity and similarity of experience within a particular cultural group (Lincoln, Taylor, Watkins, & Chatters, 2010). A study by Watkins and Jefferson (2013), found that black men experience depression differently to other races, however stating that even within this group there are nuances to note. For example, the differences in historical and cultural experiences of these black men influence their experience and understanding of depression differently. Culture was mentioned amongst other factors such as age, stage of their life course, class and education (Watkins & Jefferson, 2013). Therefore, considering the multicultural context of South Africa, with eleven official cultural groups, investigating how culture constructs mental health issues such as depression is important.

During the Apartheid regime, the South African population was divided into three racial groups, namely White, African/Black, Indian, and Coloured. Prior to apartheid, South Africa consisted of and still consists of indigenous cultural groups. Within the black racial group, there are nine ethnic groups divided based on language, culture, and different historical backgrounds (Neff, 2007). The different ethnic groups are amaXhosa, amaZulu, amaNdebele, emaSwati, Vavenda, Vatsonga, Basotho, Batswana, and Bapedi. My study subscribes to the relativist notion of culture and mental health in that it aims to gain a greater understanding of how depression is understood within a specific cultural group, the Xhosa culture. From the relativist perspective, the assumption is that even though Xhosa men may have an overarching culture, there are differences even within that culture.

South Africa is a culturally and ethnically diverse country, as it is shown above and is discussed in the literature review. Furthermore, South African diversity is atypical in that the apartheid regime politicised existing ethnic diversity, privileging specific socio-cultural and ethnic groupings (Van Der Merwe, 1996). However, despite this diversity, the discipline of psychology in South Africa continues to be defined by Eurocentric and Western ideas (Johnston, 2015). The segregation that was evident socio-culturally was also evident in University training, clinical psychology internship sites and even in the development of psychological assessments (Johnson, 2015).

As early as 1985 and 1993 research has called for the indigenization of psychology and the giving of a voice to African psychology (Bodibe, 1993; Dawes, 1985). Indigenous psychology refers to ways to understand human behaviour within the cultural context in which it is displayed and developed (Johnston, 2015). However, South Africa has had challenges grappling with South African diversity as well as seeking to provide relevant responses to its needs (Johnson, 2015). Jackson (2006) argues that mental health interventions need to be culturally sensitive. Proving the need to develop indigenous psychology is a study by Ramgoon, Dalasile, Paruk and Patel (2011) which noted that long before the arrival of scientifically tested treatments human beings used indigenous knowledge and religious rituals to cure illnesses. Studies such as Laher (2014), and Lehti, Hammarstrom and Mattson (2009), which are discussed in the literature review, are also examples in the movement towards indigenizing psychology. This mini-dissertation also seeks to contribute to and to honour indigenous forms of knowledge and indigenous psychology.

Justification, aim and objectives

From the literature in the background information section discussed above, it is thus evident that men are probably under-diagnosed or misdiagnosed thus not receiving treatment or appropriate treatment. This highlights the importance of the topic of men and depression. However, the participants of this study were not experiencing depression, thus this is an exploratory study which is intended to explore general constructions. These general constructions do not serve as generalizations amongst all Xhosa men, but rather they are the constructions that exists amongst the participants in this study. This kind of study was chosen because of a lack of similar studies (such as the one by Laher (2014) which is discussed in the literature review) on non-clinical populations. To do this a qualitative research approach is appropriate. From the background information, it also becomes apparent that individual's understanding of mental health is influenced by culture. Considering this, this kind of study adds to the body of knowledge around specific cultural groups and their understanding of depression.

As mentioned above, this study followed a qualitative research design. Qualitative research is aimed at understanding the meanings that people attach to phenomena within their social world (Ritchie, Lewis, Nicholls, & Ormston 2013). A somewhat similar aim holds for thematic analysis which is aimed at identifying and analysing meaning in a set of data (Joffe, 2012). In addition, thematic analysis can be applied across a range of philosophical approach (Braun & Clarke, 2006), thus it allowed me to choose social constructionism as the methodology of this study. A qualitative approach and thematic analysis as the method for this study helped to answer the research question which is concerned with meaning and understanding of depression by a specific population. Furthermore, qualitative research demonstrates the diversity of perspectives (Flick, 2018). Thus, using a qualitative approach allows for a focus on a specific cultural group such as the Xhosa ethnic group. Furthermore, the assumption of this study is that gender, culture and mental health do not exist in isolation. Rather, they intersect, interact, and inform or influence each other reciprocally. This assumption is the reason why intersectionality was chosen as the theory of this study. The theory is further discussed in the literature review.

Therefore, the study aimed to explore Xhosa men's constructions of depression. In light of the aim of the study, the research question was formulated as:

“How do Xhosa men construct depression?”

To further explore the research question, utilise the theory and to enhance the richness of the analysis, the following objectives were formulated:

- How does culture influence Xhosa men's constructions of depression?
- How does gender influence Xhosa men's constructions of depression?
- How does being a man (gender) and being Xhosa (culture) intersect and interact in men's constructions of depression?

Synergy between the research approach, method, methodology and theory

The study followed a qualitative research design and utilised thematic analysis as a method of analysis. Thematic analysis offers researchers the choice of situating their studies in different philosophical traditions such as social constructionism or interpretivism (Braun & Clarke, 2006). For the purpose of this study, I accepted the assumptions of social constructionism as a philosophical foundation or the methodology that underlies the method. The principle reason was that the study did not intend to explore the *experiences* of Xhosa men diagnosed with depression. In such a case, a phenomenological philosophical foundation would have been appropriate. Rather, my intention and interest were to explore those discourses and constructions from the perspective of Xhosa men in general.

The choice of social constructionist assumptions also was fitting with intersectionality as a theoretical approach. Culture, gender and mental health in this regard are not seen as natural "givens" or subjective experiences, but social identities constructed *by* people and *through* language. This approach represents a shift from an a-contextual view to one which takes into account multiple facets to individuals and dynamic contextual influences (Banks & Kohn-Woods, 2002). Intersectionality highlights the problem of complexity and a need for an interdisciplinary based solution (van Mens-Verhulst & Radtke, 2008) and focuses on the interaction of social constructions, such as race, gender, age, class, and ethnicity in shaping people's beliefs and experiences (Shields, 2008). It is this dynamic interaction and intersection of the above-mentioned constructions that this study aimed to explore. The theory of intersectionality was not used to force-fit findings into certain categories. Rather it was used as a framework in which to explore the dynamics and inter-relatedness of the constructions provided by the participants.

According to Griffith (2012), men's health should be understood on the basis of how gender has social and health implications while, bearing in mind that gender is also dependent on other social categories (i.e., Xhosa culture) for meaning. From this perspective, one can thus appreciate that mental health problems such as depression, together with gender and culture are in a continuous field of interaction with each other (Banks & Kohn-Woods, 2002). The above speaks to the complexity of the relationship between these factors as it suggests an influence *on* gender, while an influence *by* gender is also suggested.

Outline of the dissertation

This dissertation is divided into five chapters, a reference list, and an appendix section. The *first chapter,* which is the current chapter gives an introduction to the study. In addition, this chapter introduces the research background, the research question as well as the justification, aim and objectives of the study. Lastly, the chapter introduces the rationale for the study.

Chapter 2 provides a comprehensive literature review. The literature focuses on an in-depth discussion of the key concepts of this study, such as intersectionality and the main assumptions of it. It also includes a discussion on gender and masculinity, as well as a discussion on culture and specifically the Xhosa culture. Furthermore, this chapter explores masculinity in the Xhosa culture. Lastly, the chapter engages studies that have been conducted on depression and different cultural groups internationally and in the South African context.

Chapter 3 presents the research methodology and method employed for the research. The discussion on the methodology includes a discussion of the epistemology and ontology of social constructionism. Furthermore, this chapter includes a discussion on the step by step process on how the research was conducted.

The *fourth chapter* is a presentation of the findings and discussion of the findings, this involves relating the literature to the findings of this study. Each participant was briefly introduced, in terms of their demographics as well as my impressions of them during the interview. Furthermore, each interview was analysed thematically, and the most prominent themes are discussed in this chapter. The discussion was structured with the objectives of the study in mind. Extracts from the interviews conducted are included throughout the presentation of and in support of the findings.

Chapter 5 offers a summary of the research findings, a section on reflexivity and concludes with a discussion on the limitations of the research, the implications of this research and how it may impact future research.

The *reference list* contains a list of all the citations across different chapters. The *appendix section* that includes the invitation to participate in the research, informed consent form and the interview protocol in English as well as a translated transcript of one of the participants.

Summary of chapter

This chapter postulates the need to study the constructions of depression in different cultural groups and the male gender. This study pays special attention to the Xhosa culture. The context of the research was illustrated in terms of the background, the justification, aim and objectives of the study, and the rationale of the study. To conclude this chapter, the format of the report was outlined. The following chapter explores current and past literature that is relevant to this study.

CHAPTER 2: LITERATURE REVIEW

Introduction

The literature review starts with a discussion of intersectionality which is the theory chosen for this study. The concept of intersectionality originated from black American feminists and it was further developed within the humanities and social sciences (Christensen & Jensen, 2014). The central assumptions will be introduced first because the rest of the chapter addresses gender, culture and mental health/depression as social identities that intersect and interact.

The social identities of the participants are Xhosa men who are not diagnosed with depression. The concept of depression was briefly defined in the previous chapter in the background section, and as such, it is not defined in this chapter. The discussion on gender pays special attention to the definition of gender, and subsequently masculinity. It is important to note that for this study gender is defined and discussed from the social constructionist perspective. Furthermore, culture and ethnicity are defined and discussed. The section on culture and ethnicity also includes an engagement with the nature of the Xhosa culture, masculinity in the Xhosa culture, and culture-bound syndromes in this ethnic group.

Following the discussions mentioned above, studies on the intersection of depression, gender and culture are reviewed. These studies focus on specific cultures which were not only South African cultures, thus this section of the literature review included both international and local literature.

Intersectionality as a theoretical perspective

Shields (2008) defines intersectionality as a mutual relationship amongst social identities. This means that each social identity takes its meaning in relation to another identity. Differently put, intersectionality is a theory that shows the multiple identifications that form part of everyday life and the power relations that exists in them (van Mens-Verhulst & Radtke, 2008).

Consistent in these definitions is the idea of social identities mutually reinforcing one another (Shield, 2008). Therefore, merely acknowledging these social identities independently misses the point of intersection, which is that they influence each other (Hunting, 2014; Van

Mens-Verhulst & Radtke, 2008). Christensen and Jensen (2014) argue that social identities not only intersect but they interact with each other as well. This means that each is dependent on the other and that they are in constant interaction.

More than a decade ago, Banks & Kohn-Wood (2002) conclude that research indicates disparities in mental health and racial minority populations, as well as gaps and inequalities in treatment received by different racial groups. Bearing these disparities in mind it is thus important to study issues of mental health and treatment among ethnic minorities and different racial groups. It is also important to consider how these different ethnic groups perceive the aetiology, epidemiology, and symptomology of mental illnesses across gender and race (Banks & Kohn-Wood, 2002; Hunting, 2014). From an intersectional perspective, researchers are urged to pay special attention to the unique ways in which different ethnic groups and gender interact to affect psychological processes (Banks & Kohn-Wood, 2002).

For example, Banks and Kohn-Wood's study found that adherence to treatment or help-seeking among African American women may be closely related to the likelihood of adherence to culturally defined beliefs about disclosing personal problems to mental health care professionals (2002). Chantler (2005) suggests that through the use of intersectionality the structural dimensions of inequality in individual's limited access to services may be addressed. Van Mens-Verhulst and Radtke (2008) add that intersectionality has the potential to point out new perspectives on understanding and treating health problems for different social groups. However, Banks and Kohn-Wood (2002) propose that one way in which we may come to a deeper understanding of the influence of social identities is to determine the extent to which individuals endorse these aspects of themselves. In relation to this study, it means, for instance, that those aspects of Xhosa masculinities that participants embrace, may shed light on how depression is constructed. Likewise, those constructions of depression that are sanctioned or challenged by the Xhosa culture, may inform us about the ways Xhosa men are allowed or disallowed to deal with depression.

This highlights the notion that Xhosa people's understanding of psychopathology may differ based on how they experience and perform their gender and Xhosa culture. This is also true even for people who belong to the same ethnic group. Therefore, it is important to gain an in-depth understanding of these social identities in order for us to inquire into how they may be performed differently by different people (Banks & Kohn-Wood, 2002). Considering the

above argument, the following are three main tenets of intersectionality as postulated by Bowleg (2012). These will assist to outline a clear idea of intersectionality.

Bowleg (2012) postulates three core tenets of intersectionality that she argues are relevant to public health:

1. Social identities are not unidimensional and independent of each other, but rather they are dependent and are multiple.

2. Intersectionality focuses on currently and previously oppressed groups such as the black population. Thus, the starting point in public health should be to acknowledge that people come from multiple social groups, some of which may be oppressed groups. However, intersectionality does not assume that all identities that an individual holds are equally oppressed and as a result, it also focuses on privileged groups as well. Thus, it studies the population's health from its own context and not as a deviant to the norm (i.e. the norm being the non-marginalized or non-oppressed group). In other words, more specifically in research philosophy terminology, an intersectional stance is ideographic in that it takes heed participants of contexts and the identities performed within it.

3. Social relationships, such as sex, gender, and race intersect with each other and they also intersect with structural factors such as poverty and discrimination to produce inequalities in health outcomes. Hunting (2014) argues that studies that only focus on social identities such as gender without taking into account how health may be influenced by ideological power can lead to a narrow understanding of health differences as resulting from an individual's behaviour.

In relation to this study, gender (masculinity) and the Xhosa culture are some of the social identities held by men in this study; and these identities play a role in shaping each other. Furthermore, considering the history of apartheid in South Africa, the black population was one of the oppressed groups. While black men were the oppressed group but by virtue of holding the social identity of being a man and upholding masculine roles and norms this placed men in a privileged position (Rosenfield & Mouzon, 2013). This highlights the idea that not all social identities that individuals hold are oppressed, in this context, this means that black men may be privileged by holding the identity of a man, while they are oppressed as black men. In the context of depression (e.g., diagnostic issues) and research on depression, women have

been studied far more often than men (Addis & Cohane, 2005). The argument is generally that mental health care misrepresents and pathologized women (van Mens-Verhulst et al., 1999). Similarly, a study conducted in Ghana on common understands of women's mental health, found that many people attributed women's mental health to factors inherent to women's nature (Ofori-Atta et al., 2010). This depicted women as being inherently weak while men were strong. Intersectionality has brought to light "factors beyond gender that influence men's health experiences; thus, studies on men's health should approach gender as inevitably intersected by other social categories" (Hunting, 2014, p. 5). Therefore, this study acknowledges that while masculinity may not be considered oppressed it may be marginalized in existing conceptualizations of depression (Addis, 2005). Lastly, and of great importance is how the Xhosa culture, manhood (gender) and depression intersect with one another; each shaping each other.

Mental health practitioners need to be sensitive to a patient's cultural backgrounds and ethnic identities, and this is emphasized by the whole notion of intersectionality (van Mens-Verhulst & Radtke, 2008). Although mental health practitioners may recognize the different social identities held by patients, they may treat these identities as independent of each other (van Mens-Verhulst & Radtke, 2008). Intersectionality is a shift from acontextual, unidimensional and direct effect perspectives to methodologies that consider multiple aspects to individuals, multiple effects on outcomes, and dynamic contextual influences (Banks & Kohn-Wood, 2002). Thus, in thinking about psychopathology it could be thought of as a field of interactions rather than direct linear relationships (Banks & Kohn-Wood, 2002).

To make it more specific; depression, gender, and culture can be thought of as a field of interactions, all dimensions affecting one another, mutually. Therefore, it is important to study depression not as a unidimensional and acontextual dimension but rather as a dimension interacting and intersecting with other dimensions such as gender and culture.

Gender and masculinity

The issue of gender and specifically the male gender is central because the study aimed at exploring depression specifically from the perspective of men. For the purposes of this study masculinities theory was used to further understand gender. This theory is one of many other theories such as the gender role theory. It is widely used in the study of men and especially,

help-seeking, mental health, and cultural groups (Gläser, 2004; Messerschmidt, 2000; Wedgwood, 2009).

Gender is a multidimensional, context-specific social identity that changes according to time and place (Johnson & Repta, 2012). It is about much more than an individual's sex or sex differences between men and women. Sex is a biological construct that encompasses differences in anatomy, physiology, genetics, and hormones in species (Johnson & Repta, 2012). Gender, on the other hand, is a multidimensional social construct assigned to and enacted by individuals based on their sex; it involves different roles, limitations, responsibilities, and experiences (Johnson & Repta, 2012). It thus provides order to social practice (Connell, 2005). Similarly, Butler (2007) argues that gender is a cultural interpretation of sex, as a result, gender can be constructed differently based on culture. However, culture is not a singularity and involves many aspects.

In this regard, gender is constructed and shaped by multiple systems such as religion, media, social systems and political systems (Johnson & Repta, 2012). This means that it interacts with multiple systems such as the ones mentioned above. In other words, gender is a "product" of the way these systems construct it but also that gender influences these systems by responding to them. Therefore, it is a co-construct depending on available discourses. Miglietta and Maran (2017) note that social identities are constructed within cultures and time. It is consequently impossible to separate gender from political and cultural intersections from which it is constructed and maintained (Butler, 2002). It becomes expressed through values, expected roles, social systems, and through responsibilities assigned to individuals and groups (Johnson & Repta, 2012). Therefore, gender is important to consider in health research as it structures people's lives in ways that both permit and limit health (Johnson & Repta, 2012).

One of the dimensions of gender is called masculinity (Johnson & Repta, 2012). Masculinity is theorized as a range of behaviours, practices, traits, and characteristics that are typically, and expected to be taken upon by men (Johnson & Repta, 2012; Swarr, 2012). The construction of masculinity is shaped by multiple factors such as age, ethnicity, social class, and nationality (Rogers, Sperry, & Levant, 2015). Such factors also include growth and development. Coles (2009) argues that while men change as they grow, so do their conceptualizations of masculinity, and this is to accommodate these changes that they go through. This is evident in the Xhosa culture (discussed in Culture and Xhosa ethnic group section below) where before traditional circumcision the idea of masculinity means something

different to a man before he undergoes traditional circumcision. These social practices are associated with the position of men in society and they are socio-culturally agreed upon (Connell, 2005). Connell suggests that the physical body is central to the cultural interpretation of gender, thus the body should not be avoided in the understanding of masculinity construction (1995). Thus, she argues that masculinity is a certain feel to the skin, certain body shape, ways of moving, and possibilities in sex (Connell, 1995). However, Connell (2000) further suggests that masculinity is not inherent to the male body, but rather that it is a way in which the body is defined. Therefore, if we consider that masculinity is culturally constructed, it is better referred to as masculinities as there are multiple cultures, thus multiple masculinities (Rogers, Sperry, & Levant, 2015).

There are different kinds of masculinity and two primary types are "hegemonic" and "subordinated" masculinities (Ratele, 2014). It is important to first clarify that what is hegemonic in one culture may not be hegemonic in all cultures. In other words, hegemonic masculinity is the culturally dominant ideal of masculinity (Coles, 2009). When masculinity is associated with superiority in gendered relationships, character traits such as assertiveness, competitiveness, independence, and control it is referred to as hegemonic masculinity (Rosenfield & Mouzon, 2013). Hegemonic masculinity is the embodiment of the currently honoured way of being a man; however, as stated above this masculinity may not be performed by all men; making it normative rather than the norm (Ratele, 2014). This type of masculinity is said to be a question of how a particular group of men holds positions of power and wealth, and how they legitimate these positions and reproduce them (Newburn & Stanko, 1994). The concept of hegemonic masculinity allows for one to acknowledge that although multiple masculinities are coexisting, there is a particular masculinity that holds power and privilege over other forms of masculinities and is considered the most honoured "way of being a man" (Morrel, Jewkes, & Lindegar, 2012). In other words, despite the existence of a dominant ideal about gender, which reinforces the power of certain groups, there exists a range of ways in which gender can be performed (Alsop, Fitzsimons, & Lennon, 2002).

Hegemonic masculinity functions on the subordination of alternative masculinities, such as gay masculinity and those of minority race/ethnic groups (Connel, 1995). These alternative masculinities are referred to as subordinate masculinities. When compared to hegemonic masculinity, subordinate masculinities are positioned as inferior and as the "other" (Schippers, 2007). Thus, that which is expelled from hegemonic masculinity is considered subordinate to hegemonic masculinity (Budgeon, 2014). According to Connell and

Messerschmidt (2005), the sociological theory of hegemonic masculinity puts forward that constructions of masculinities from minority groups (e.g. racial minority) are strongly influenced by the group's oppression. They argue that this is because these masculinities are a product of both the majority and minority culture; thus, they negotiate between these two cultures. Interestingly Schippers (2007) suggests that there are no subordinate masculinities rather that there is a hegemonic femininity enacted by men. Thus, what Connell referred to subordinate masculinities, Schippers considers it fused with femininity. However, while it is important to acknowledge that there are multiple masculinities, it is also important to avoid simplifying categories of masculinities (Connell, 1995). This is to avoid stereotypes such as "gay men are sensitive", "factory workers are heterosexual". Coles (2009) suggests that to avoid this we need to think of masculinities in relation to other demographics such as race and class.

There are two arguments that the concept of hegemonic masculinity is fundamentally based on, and both arguments have gone under scrutiny and criticism (Christensen & Jensen, 2014). The first argument is that of male oppression and dominance on women. Critics have argued that the concept of hegemonic masculinity assumes that all masculinities, even subordinate masculinities, are patriarchal (Christensen & Jensen, 2014). Some studies have investigated whether gender equality friendly masculinities exist (Aarseth, 2009; Forsbery, 2007; Groes-Green, 2011). A study conducted in Norway found that there are men in support of the demand for gender equality (Aarseth, 2009). In the African context, similar findings were found in Mozambique where a group of men was found to favour the well-being of women, respecting them and their agency (Groes-Green, 2011).

The second fundamental argument of hegemonic masculinity is around hierarchies found within masculinities. Christensen and Jensen (2014) have questioned the adequacy of the analytical tools, offered by authors such as Connel, for getting a full understanding of subordinate masculinities. In other words, are these tools enough for us to understand the idea that masculinities can strengthen male privilege (hegemonic masculinities) and at the same time oppress and weaken other male privileges (subordinate masculinities)? To aid this, Christensen and Jensen propose the use of intersectionality as a tool. They argue that social identities can support the dominant position in male privilege of some men while some social identities may challenge and weaken certain male privileges. This argument highlights the importance of this study in investigating the interaction of masculinity with other categories such as the Xhosa culture and depression.

To conclude, Schippers (2007) summarizes the notion of masculinity as "a social position, a set of practices, and the effects of the collective embodiment of those practices on individuals, relationships, institutional structures, and global relations of domination" (p. 86). Although there are dominant masculinities, they are socially and culturally constructed bringing in the complexity of the concept of gender. It is important to then study how men's gender practices position them, privileges them but also constrains them (Connell, 2005).

Culture and the Xhosa ethnic group

The participants of this study are from the black culture and specifically the Xhosa cultural group. The differentiation between race, culture (defined below) and ethnicity is important to define. Race refers to a socially constructed classification of humans based on external physical features such as skin colour, hair texture and facial features (Murry et al., 2004). Ethnicity not only encompasses race but also culture (i.e., language, beliefs, norms, and behaviours) (Murry et al., 2004).

Culture refers to dynamic and continuously learned and changing behaviour, beliefs, attitudes, and ideas that are shaped by members of a group (Loest, Britz, & Pauw, 1997). Just like gender culture is not stagnant, it is an open system that changes in time and place (APA, 2013; Korbin, 2002). In the ever-changing world, individuals and groups are exposed to different cultures which they use to develop their own identities and making sense of experience (APA, 2013). These features make it essential to not overgeneralize culture.

In South Africa, there are three official racial groups, namely White, Black, Indian and Coloured. Within these four groups, there are eleven official cultural groups, nine of which fall under the black people racial group. The nine may be referred to as ethnic groups. "Ethnicity is a culturally constructed group identity that is used to define people and communities" (APA, 2013, p. 749). It is informed by a common history, language, geography and other shared characteristics that distinguish it from other groups (APA, 2013). One of these ethnic groups is the amaXhosa people.

The isiXhosa speaking people are a group of clans (amaXhosa, amaHlubi, amaBhaca, amaMfengu, amaXesibe, abaThembu, amaMpondo) within the Nguni, Bantu-speaking people, in South Africa (Braathen, Vergunst, Mji, Mannan & Swartz, 2013). Before urbanization, the amaXhosa people occupied the rural areas of the Eastern Cape Province (Loest et al., 1997).

Although they are still predominantly residing in the Eastern Cape province, they now reside everywhere in South Africa including urban areas.

The Xhosa culture is traditionally patriarchal and places great importance on the role played by the ancestors in guiding tradition and cultural practices (Braathen et al., 2013). A definition that is widely used to describe patriarchy is that of Morrel (1998), who defines patriarchy as a composed unity of production, sexuality, reproduction and socializing children. The nature of patriarchy is such that it allocates, distributes and secures power to men over women (Jewkes & Norrell, 2010). It consists of societal norms based on formal rules and assumed rules that place men and women within the household, family, and labour market (Kalabamu, 2006). Furthermore, patriarchy is said to legitimate the above mentioned as natural and as inevitable (Kalabamu, 2006). Therefore, masculinity is a key element of patriarchy. In other words, the patriarchal structure of the Xhosa culture informs the way masculinity is constructed for Xhosa men. Furthermore, how it constructs masculinity is in such a way that it bestows power on Xhosa men in relation to Xhosa women. The next paragraph discusses a Xhosa cultural practice that influences the construction of masculinity and speaks to patriarchy in the Xhosa culture.

In many African cultures male circumcision is practiced as an initiation into adulthood (Gwata, 2009; Ndangam, 2008). Examples of African countries that practice traditional initiation include some tribes in Uganda, Western Kenya, and some ethnic groups in South Africa. Compared to medical circumcision, traditional circumcision is overseen by traditional practitioners hence it is termed traditional circumcision as opposed to medical circumcision (Gwata, 2009). The practice of circumcision carries religious, spiritual, social, biomedical, aesthetic, and cultural dimensions (Gwata, 2009). For the Gisu of Uganda, this practice symbolizes manhood and validates it through enduring initiation school (Ndangam, 2008). While for the Luhyia of Western Kenya, it is not only a rite of passage but also means the father of the first son attains a special title as well as the right to own bull (Ndangam, 2008). A similar symbolism to the Ugandans holds for the Xhosa culture in South Africa.

In the Xhosa culture, this ritual is often referred to as "going to the mountain or going to the bush" (Gwata, 2009, p. 5). It is performed between the ages of 15 and 25 on all boys. During the process of initiation, the initiate goes through a process of seclusion during which he is looked after by an experienced male elder (Meel, 2008). This process takes place in the bush; hence it is usually referred to as going to the bush/mountain. For the first 8 days, the

initiate is expected to only eat salt-free foods (Vincent, 2005). This process which takes place in the bushes, it takes about four to six weeks. Upon arrival home, the initiate is given new clothes to wear for several months, and these clothes represent a mark that they are now a man (Meel, 2008; Vincent, 2005). Gwata (2009, p. 6) frames this transition as "the creation of socially responsible men". During this period boys are considered as becoming men through the adoption of an approach to life, which is considered responsible (Gwata, 2009). Essential to this transition period is the test of courage and endurance (Gwata, 2009). Therefore, it is a cultural practice that influences the construction of masculinity (Anikwa, Govender, Ndimande, & Tumbo, 2013; Gwata, 2009). That is why Mfecane (2016) suggests that the notion of masculinity in the Xhosa culture is embodied in the concept of "indoda", which is a traditionally circumcised person. In other words, being a Xhosa man means that after circumcision a man has to adhere to certain ways of life.

Evidently, traditional male circumcision in these cultures is linked to notions of manhood and masculinity (Ndangam, 2008). Connell suggests that the physical body is central to the cultural interpretation of gender, thus the body should not be avoided in the understanding of masculinity construction (1995); thus, the circumcised penis forms part of the cultural definition of the male body in the Xhosa culture. Similarly, Mfecane (2016) argues that the body is a principal way of proving and defending Xhosa manhood, which makes it central in theorizing Xhosa masculinity. However, although the penis is a physical representation of "indoda", once the man is reintegrated into the community his manhood is measured also through his dress code, responsibility, respect and avoidance of violence (Mfecane, 2016). When these are enacted by a man who has not been circumcised it does not make him "indoda", it has to be preceded by circumcision in order to be regarded as a sign of being a man (Mfecane, 2016).

When likened to Connel's idea of hegemonic and subordinate masculinities, "indoda" embodies hegemonic masculinity, while "inkwenkwe" (i.e. a male who has not undergone traditional circumcision) embodies subordinate masculinity (Mfecane, 2016). In other words, a traditionally circumcised man is regarded as a real man, he embodies the most honoured form of masculinity regardless of his class or sexual orientation (Mfecane, 2016). "Indoda" is granted respect ad acceptance from their community and the male Xhosa community (Gwata, 2009). Thus, it legitimizes membership in the community of Xhosa men. The man further gets rights to address other males at male gatherings (Ndangam, 2008). In addition, this initiation also creates a strong bond between these young men (Ndangam, 2008). In a way these young

men develop a culture that is specific to them as men; non-initiates are not allowed to engage in this culture. Such a culture can be seen from the fact that initiates develop a different way of speaking, this is in terms of the terms that they use to refer to certain things (Ndangam, 2008). For Xhosa men becoming a man is symbolic of eligibility to marry, to own land, and to participate in family court (Gwata, 2009). Furthermore, traditional circumcision affords those circumcised with certain privileges and social power, while those uncircumcised are regarded as not supposed to get married or eat with the circumcised (Kepe, 2010).

As mentioned above those who have not undergone traditional circumcision due to refusal or being a young boy are referred to as "inkwenkwe" (Gwata, 2009; Mfecane, 2016). These men represent the subordinate masculinity. Those who refuse to engage in this ritual risk discrimination, marginalization, or even being forced to get traditionally circumcised (Ndangam, 2008). Furthermore, they may experience exclusion from social groups, being ridiculed, and being treated as servants of the circumcised man (Gwata, 2009). Like the notion of subordinate masculinities being infused with femininity, Gwata (2009) argues that uncircumcised men in the Xhosa culture are delegated tasks such as cooking and cleaning. Such tasks are typically associated with femininity in the Xhosa culture. Thus, Gwata (2009) and Mfecane (2016) found that the traditionally circumcised man represents hegemonic masculinity, while the uncircumcised man represents subordinate masculinities (2009).

This section of the literature review focused on traditional circumcision as an ethnic practice, particular to amaXhosa, that constructs masculinity as the ability to endure, privilege to social power, and eligibility to marry and take part in family discussions. The prevailing discourse then is one of the circumcised men being superior to the uncircumcised man. This is not the only practice or discourse defining masculinity for Xhosa men as some Xhosa men in urban areas opt for medical circumcision, although this is frowned upon. However, still a majority of Xhosa men undergo traditional circumcision, but the point is that there are changes that have occurred over time. The participants in this study illustrate how adherence to the cultural tradition of masculinity still occurs despite other social-cultural changes taking place. They are mostly from urban areas, but they all still opted to perform the traditional male circumcision as a rite of passage.

Culture and Depression

The DSM tradition represents a Western view of mental health problems (i.e., psychiatric disorders) while there are also other more culture centered understandings/constructions available. Previously, black Africans were thought to be emotionless and as such rarely suffered what the Western culture termed depression (Ellis, 2003). Even though emotions are a universal experience, the expression of emotions in different circumstances, as well as the identification of when emotions are abnormal is culturally dictated (Bhugra, 2008). For example, all humans may feel low in their mood, but cultural factors determine what is "low", what terms are used to express the low mood, when and how they are seen as pathological and where help is sought from (Bhugra, 2008). According to an older study by Ellis (2003) traditional African culture has not concretized the concept of depression and as such it has remained rather unclear. However, due to the flexible and changing nature of culture, this might have changed over time.

The DSM-5 acknowledges the influence of culture in mental health. It argues that how individuals understand, communicate and experience their symptoms is influenced by their culture (APA, 2013). The DSM-5 proposes that the influence of culture is indicated in the following: cultural syndromes, cultural idioms, and cultural explanations (APA, 2013).

Cultural syndromes are a group of symptoms that tend to present at the same time and are considered as a coherent pattern of experience within that cultural groups. Cultural idioms of distress on the other hand denote ways in which individuals in cultural groups express distress; these may not be specific symptoms. These idioms are said to essentially provide a collective and shared way of talking about personal or social issues. The cultural groups may have specific meanings and explanations for the causation of these symptoms; these are referred to as cultural explanations. According to the DSM-5, these three cultural influences are associated with patterns of help-seeking (APA, 2013), which is further discussed later in the literature review. An example of cultural influences on mental health is well captured in a South African study by Laher (2014).

In most African countries, a person comprises four interacting layers, which are the physical body, physiological functions, psychological functions as well as the inner layer, which is spirituality (Laher, 2014). Mental illnesses are often viewed as spiritual illnesses linked to the supernatural environment (Laher, 2014). Among cultural groups such as the amaZulu and amaXhosa people, a spiritual illness may include spiritual possessions such as *Abaphansi basifulathele*, which happens when the ancestors are not pleased with the people

due to a failure to appease them. It may further include *Ukuthwasa* a spiritual calling to become a traditional healer, and *Amafufunyane* (Laher, 2014). People with *Amafufunyane* normally have auditory hallucinations, however, when all these spiritual possessions happen for a good purpose and the person is not harmed, and then no diagnosis for spiritual illness is made (Laher, 2014).

Furthermore, Tomlinson and colleagues (2007) suggest that in a South African village (i.e. rural setting) individuals had no distress as defined by the criteria for depression in the DSM, but rather a somatic representation of depression. When referring to suffering from depression participants reported that they suffer from "nerves" which were also seen as part of emotions, such as sadness, tension, and weepiness (Tomlinson et al., 2007). Similarly, Ellis (2003) argues a somatic representation of depression for example, in IsiZulu a person may express not feeling well as *angizwa umzimba,* which directly translates to *'I cannot feel my body'*. This suggests that there seems to be alternative representations and communication of depression in different cultures, compared to the DSM symptoms.

Such complexities indicate just how much the concept and experience of depression is complicated in a multicultural context. Ellis (2003) lists words that approximate the idea of depression in one of the South African languages, isiZulu. These are *dhangala* which means to be worn out of body and mind, *khathele/ukukhathala* used to convey fatigue, as well as a sense of worry. In both isiZulu and isiXhosa upset, hurt, heartsore, sadness, grief or worry are all conveyed using the work *ukukhathazeka* (to be offended) (Ellis, 2003). The use of one word to describe these different feelings highlights the importance of cultural context and language in communicating and hence constructing experiences of emotional states. This poses challenges for researchers and clinicians alike.

Ellis (2003) distinguishes between different ways in which depression may present in certain African cultures in South Africa. These are somatic complaints, fatigue variants, messages of distress, and problematic relationships. Depression in traditional African cultures may present as bodily complaint denoted with the following terms; *ikhanda,* which refers to a headache, *iqolo* (backache), *wonke umzimba* (whole body pain) (Ellis, 2003). It may further be expressed as fatigue using some of the following terms *ukukhandleka* (tiredness), *ukuphela amandla* (loss of energy). Messages of distress are similar to those used in the Western culture, for example, in the Zulu culture patients may report *inhliziyo imnyama* (loss of appetite), *ukuqwasha* (sleeplessness). This may be a metaphor indicating that one is out of touch with

one's body, and possibly the real world (Ellis, 2003). In the DSM tradition, such symptoms may be considered to represent dissociation, depersonalization, and/or derealisation.

From these examples, it becomes evident that cultural groups in SA may experience symptoms related to depression that do not correspond neatly with diagnostic criteria. Furthermore, if we look at the reported culturally specific symptoms, we will notice that there is some overlap with the DSM criteria. This underlines the importance of culturally sensitive health care practitioners. For example, when a Zulu person consults with a clinical psychologist two worlds holding different experiences, meaning, culture and language meet. Their constructions of what depression means may consequently be very different. Psychologists may typically be working within the criteria of diagnostic nosologies thus using Western and psychiatric constructions of depression. The person consulting a psychologist is more likely to rely on cultural discourse, popular media and so forth in order to construct meaning about depression (Ellis, 2003). However, caution should also be taken even in the case that both practitioner and patient are of the same cultural group.

In this instance, Lehti, Hammarstrom, and Mattsson (2009) argue that belonging to the same culture does not necessitate the same expression or experience of depression. They argue that aspects of an individual such as their level of education could influence things like the expression of pain. Therefore, in the South African context, the understanding of depression is complicated as it is intertwined with cultural beliefs as well as discourses such as nosological systems, and popularised discourses such as serotonin deficiency. This further underscores the importance of cultural sensitivity and competence, hence a study such as this is important.

The intersection between culture, gender, and mental health

The experience of depression may not only differ across cultures but also between genders (Lehti, Hammarstrom, & Mattsson, 2009). A meta-ethnographic study on men's perspectives on psychological distress and help-seeking by Hoy (2012) reviews 51 studies and suggests an interplay between mental health, masculinity, and culture. The study revealed that men hold a somewhat negative perspective on the label of depression. This was due to the association between depression and femininity - a label that defies masculinity for men. Men, according to Brownhill, Wilhelm, Barklay, and Parker (2002) are socially conditioned not to express emotions, which is tied to the notion of "boys don't cry". While it is more acceptable for women to express "soft and sad" emotions, it is decidedly un-masculine to do so for men

(Brownhill et al., 2002; Hoy, 2012). However, there were also those men who perceived depression as a normal reaction to life stresses; as a result, these men found it surprising that depression is labelled a disorder (Hoy, 2012).

Hoy's (2012) review also indicates how depression and masculinity interact in the way men understand the causes of depression. According to some authors, men attribute depression to financial challenges and particularly an inability to provide for their families (Aliston & Kent, 2008; Hoy, 2012; Ritchie, 1999). According to Hoy (2012), financial stability and the ability to provide is a "masculine signifier". The need to abide by the masculine role of "provider", the importance placed on it, and fear of failing to do so, increase men's risk for stress and resultant depression. Hoy's study illustrates the complex intersection between masculinity and mental health where masculinity informs the perceived cause of depression. However, different cultures have different notions of what it means to be a man. This adds further complexity to understanding men's constructions of depression.

Several studies have investigated depressed men and the notion of masculinities specific to certain cultures. It appears as if cultural values and associated traditional masculine norms do have an indirect influence on depression for Asian men (Iwamoto, Liao, & Liu, 2000). For example, Iwamoto, Liao, and Liu (2000) argue that even though Asian men may fulfill these traditional masculine roles and norms, these expectations create additional burden and strain on men which may result in depression. Attitudes towards depression amongst Latino men include feelings of being ashamed to discuss emotional problems outside of family, believing that antidepressants are addictive, and endorsing self-reliant attitudes (Cabassa, 2007). Similarly, black African American men also seem to believe that there is pressure to remain "tough" and "holding it together" and that there is a stigma attached to mental health problems by their families and the community (Hoy, 2012; Watkins & Neighbors, 2007). The importance of culture-specific masculinities is further emphasized in Hoy's findings (2012). Men immigrating to Western countries expressed distress caused by having to abide by those male gender roles different from their own culture and this possibly contributed to their depression (Hoy, 2012).

Korner et al (2011) argue that illness is socially and culturally constructed through language. Similarly, Addis and Cohane (2005) suggest that our thinking about men's mental health should begin with the recognition that gender (masculinity) emerges at the intersection of a series of interwoven social formations involving historic, interpersonal and psychological

threads. Therefore, depression cannot be understood independent of the discourses, which construct it within specific cultural groups (Korner et al., 2011).

Help-seeking and the help-seeking encounter

The literature discussed above essentially brings forth the importance of acknowledging culture and gender in mental health and how it influences people's understanding of depression. Consequently, this means that health care professionals may find that they have a different understanding of depression to that of the depressed person. This section discusses help-seeking and the experiences and relationship between the healthcare professional and the depressed person. It underscores some of the difficulties that both parties may experience.

From the studies discussed above *(the intersection between culture, gender, and mental health)* it is evident that men experiencing depression may experience difficulties expressing their symptoms due to the fear of stigmatization and the fear of deviating from the cultural and gender norms. Contrary to these findings, a study by Emslie et al. (2006) found that Canadian men were willing to talk about their feelings and experiences in vivid imagery. However, there was still the fear of being labelled by their families as weak, feminine, and as an insult to masculinity (Emslie et al., 2006). About 57% of the studies reviewed by Hoy (2012) revealed that the most common barrier to help-seeking amongst men is the fear of social stigma - negative judgment from friends and family. As a result, a majority of the studies that Hoy (2012) reviewed revealed that men used alcohol, drugs, risky sexual behaviour, or work distraction as a means to cope with distress and depression. Snyder and Palvers (2001) refer to these as avoidant coping processes. Alternatively, Hoy (2012) also found that men may use adaptive coping strategies. These included seeking support from other men through comradery.

Furthermore, as is evident from the literature, people may not always recognize depression as an illness or disease. Instead, depression may be perceived as a result of displeasing the ancestors, due to witchcraft or breaking a taboo (Ellis, 2003). A study by Lehti, Hammarstrom, and Mattsson (2009) highlights the difficulties that may arise in talking to people who perceive depression differently from what the practitioner does. For example, general practitioners in this particular study (from Sweden) reported difficulties talking about depression with individuals from foreign countries, as mentioning depression in their culture was considered an insult. This is because for participants in their study depression in their cultural groups was seen as being "mad". Furthermore, an interesting finding in this study was

the difficulty differentiating between nonverbal expressions of depression and cultural behaviour (Lehti, Hammarstrom, & Mattsson, 2009); such as the avoidance of eye contact.

Lehti, Hammarstrom, and Mattsson (2009), further found that general practitioners reported that patients were used to the authoritative orientation by the doctor, thus when a doctor asks "what do you think yourself" the doctor would be considered unskilled. This meant that patients seen by these doctors would have a problem with being asked about their thoughts and opinions, which was likely to make diagnosis and treatment difficult. The role of general practitioners is very important in the detection of depression and subsequent referral of such individuals to psychologists and psychiatrists.

Payne (2014) brings to the fore the issue of black people's experience with "the system". He argues that African Americans may show guardedness in clinical settings and this may be misrepresented as paranoia. As a result, African American patients may take time to develop therapeutic alliance with their therapist due to difficulties with immediate interpersonal trust (Payne, 2014). Such distrust may present as an unwillingness to cooperate, defensiveness, irritation towards the clinician; and these are not part of the diagnosis but need to be worked through with the patient by taking time to establish rapport (Payne, 2014). This might be true for black South Africans as well because of the history of the apartheid system.

Prior to 1994, mental health services served the needs of the racial minority group, the White population, while the Black population was under-served (Van Wyk & Naidoo, 2006). For example, psychological services were located in urban areas that were not accessible to the racial majority (Ruane, 2006; Van Wyk & Naidoo, 2006). Even post-apartheid the black population seems to consider psychology as dominated by white Afrikaner males (De le Ray & Ipser, 2004). A study by Ruane (2010) found that black participants described psychologists as "old white men" and "racist and unavailable to communities", while black psychologists were considered difficult to locate. Suffla and Seedat (2004) note that psychology has been criticized for providing pseudoscientific justifications for apartheid. These studies emphasize how complicated the nature of the relationship between psychologists and the black population in South Africa is. Not only are barriers racial in nature, but they are also cultural. It appears with the racial separations that took place in South Africa prior to 1994, the black population may feel that the white population does not understand their culture as well as indigenous knowledge of illnesses.

Cultural beliefs are considered a major barrier to help-seeking for some South Africans (Ruane, 2010; Tompson, Akbar, & Bazile, 2002). Ruane's study reported that participants were reluctant to trust professionals that were not active in their community as they were unaware of the nuances in the black communities (2010). Much older studies by de la Rey and Ipser (2004) and Whitehead (2003), hold similar sentiments that psychology will only be relevant in South Africa once it begins to embrace the knowledge held by laypeople and traditional healers.

There is a very large body of research on men, depression, and help-seeking. Thus, cultural factors (being black), the culture of psychology (considering the South African History), gender (masculinities) and facing a "feminine" mental illness (depression) all intersect and interact to influence help-seeking. Although participants in this study are not currently diagnosed with or self-identify with depression, this section on help-seeking is included in order to highlight what research indicates men may or may not do in terms of help-seeking in the event of experiencing depression.

Summary of chapter

This chapter reviewed literature with a specific focus on intersectionality, gender and masculinity, culture and the Xhosa ethnic group, and culture and depression. This review considered different perspectives. Thus, the literature reviewed was both from a Western perspective and of an African perspective.

Intersectionality as the chosen theoretical orientation was reviewed and defined. The major tenets thereof were discussed. Lastly, intersectionality was reviewed in relation to its relevance to this study.

A social constructionist perspective to gender was reviewed and sex and gender were defined and differentiated. In addition, masculinity was reviewed as one of the focuses of this study. Attention was also placed on the power dynamics involved in the construction of masculinity.

Culture, South Africa, and the Xhosa ethnicity were also reviewed. Culture was defined and the diverse cultural context of South Africa was described. As the research participants are Xhosa, the Xhosa ethnic group, the nature of the Xhosa culture, and masculinity in the Xhosa culture were reviewed.

Furthermore, a cultural perspective of depression was reviewed. This review has its focus on culture-bound syndromes such as ukutwasa. It was noted in the review the importance of understanding cultural beliefs in order to make an accurate diagnosis.

In response to intersectionality as theory, a review of research emphasizing the intersection between depression, different cultures, and gender was undertaken. The conclusion drawn was that it is important for health care practitioners to have cultural competence. Consequently, studies on help-seeking behaviour and the help-seeking encounter were briefly reviewed.

CHAPTER 3: RESEARCH DESIGN: METHODOLOGY AND METHOD

Introduction

This chapter addresses the methodological assumptions of my study as well as the research process or method. Carter and Little (2007) are of the opinion that the concepts of epistemology, method, and methodology are not defined and used consistently by researchers. Similarly, Willig (2009) argues that methodology and method are often used interchangeably; but they refer to different aspects of the research process. Some authors may use methodology to refer to formal theories, schools of thought, disciplines such as Anthropology, and methods (Carter & Little, 2007). In other cases, some researchers may place much focus on the methods at the expense of the fundamental principles that ground the research (Gelo, 2012). Gelo (2012) argues that this results in research that is merely technical rather than scientific.

Thus, it is important to clarify what methodology and methods refer to. Methodology refers to the logic of the method, meaning that these are principles that inform and justify the method (Carter & Little, 2007; Gelo, 2007). Some of these methodologies may be prescriptive about methods, while others may not be, but essentially, they all provide the overall strategy for formulation, analysing and evaluating methods (Carter & Little, 2007).

Methodologically this study is situated in social constructionism. As such it influenced the philosophical assumptions (i.e., epistemology and ontology) upon which the study rests. This decision to situate the study in social constructionism was informed by the research question, the theoretical orientation of the study (intersectionality) as well as thematic analysis which was the chosen method of analysis.

Method, on the other hand, refers to the practical activities of research, such as sampling, data collection, data analysis, and reporting of findings (Carter & Little, 2007). In other words, it is the what and the how of research (Gelo, 2012). As mentioned above, the methods used are informed by the methodology. Furthermore, the methodological assumptions of a study (i.e., ontology and epistemology) inform the stance taken on the role of the researcher, the truth claims and types of knowledge possible and measures to ensure credible research inquiry (Gelo, 2012). These will also be discussed in this chapter as well as the processes taken to avoid a breach of ethical conduct.

Research Approach

The following is a discussion on the approach that this research takes. The research was conducted qualitatively using social constructionism as the methodology.

Qualitative approach.

Qualitative research refers to various empirical procedures that are aimed at describing and interpreting the experiences and meanings that participants attach to phenomena and events in a specific context (Ponterotto, 2005). In other words, qualitative approaches are interested in how people make sense of their world and their experiences. This kind of approach to research emphasizes (inter)subjectivity, uniqueness and the importance of understanding phenomena in the context in which they occur (Gelo, 2007). Therefore, qualitative research is not concerned with replicating, repeating, and generalizing its findings (Gelo, 2007).

The specific characteristics of qualitative methods depend on the assumptions (i.e. ontology and epistemology) from which the research is grounded (Ponterotto, 2005). Some of these methodologies include grounded theory approaches, narrative theory, various phenomenological tradition, and social constructionist approaches (Carter & Little, 2007; Flick, 201; Willig, 2013). Data collection methods that are used in qualitative research elicit reports about real-world events and processes (Percy, Kostere, & Kostere, 2015). These data collection methods include observation, interviews, focus groups, and a collection of texts (Gelo, 2007). Data analysis techniques include for instance thematic analysis, narrative techniques, grounded theory, discourse, conversation, and interpretive phenomenological analysis (Gelo, 2007; Willig, 2013). Qualitative research approaches, such as those associated with constructionist and interpretivist epistemologies, typically acknowledge the role of the researcher and its influence in the research process and findings (Willig, 2013). As such it is assumed that value-free research is not possible.

Philosophical underpinnings

Research is based on certain philosophical underpinnings that include ontology, epistemology and methodological assumptions. This section contains the ontological and epistemological assumptions of this study. A discussion on the philosophical underpinnings and methods serves to show the internal consistency of the study (Carter & Little, 2007). The ontology of a study informs the departure of the study, as well as the epistemology and

methodology (Grix, 2002). Thus, ontology relates to claims about what exists and what makes up what exists (Blaike, 2000). The ontology held by this study is **relativist**, which holds that reality, truth and knowledge are not absolute and that they exist in relation to culture, historical context and society (Grix, 2002). As a result, a study that is founded on relativism does not aim to make generalizable claims as it believes that value-free research is not possible. Where ontology is concerned with the nature of reality, epistemology is concerned with how we come to know of such a reality (Quale, 2007). The epistemological assumption of this study is **intersubjectivity.** While positivist epistemology holds that reality is objective and value-free, intersubjectivity holds that value free research is impossible (Gergen & Gergen, 2007). This means that reality is between people. The epistemological and ontological assumptions of this study are consistent with the assumptions of social constructionism, which is the methodology of choice.

Social constructionist methodology

The chosen methodology for this study is social constructionism. Although social constructionism can be used as a theory, Gergen and Gergen (2007) and Willig (2013) indicate that social constructionism is one of the methodologies of qualitative research. Research proceeding from a social constructionist methodology typically employs qualitative methods because social reality is assumed to be in a constant state of construction (Addis & Cohane, 2005). As I discussed in the introduction section, the chosen methodology informs the epistemological claims of research, as well as the methods employed in conducting the research.

The birth of social constructionism to psychology is attributed to Kenneth Gergen. Gergen (1973) proposed that psychology is an outcome of human interaction with itself, history, culture and social context within a specific time.

Major tenets of social constructionism. Gergen identified what he believed to be three major arguments which are central to social constructionism (1973). The first tenet is that of *the communal origin of knowledge* which stands in opposition to the idea of individual knowledge and the idea of a truth that is free from human agency. This argument highlights the centrality of co-construction in social constructionism. The second tenet argues the *centrality of language.* This speaks to the relationship of language to knowledge and community. Thus, according to this assertion knowledge is expressed through language. The

third and final tenet that Gergen proposed was t*he ideological saturation of knowledge.* The argument here is that knowledge is politically and morally saturated.

More arguments on the major tenets of social constructionism developed over the years. A more recent argument is that of Burr (2004). Burr's ideas are similar to those of Gergen. Burr elucidates four philosophical positionings of social constructionism. She argues that social constructionism holds a critical stance on knowledge that is taken for granted about us and the world. According to Edley (2001), social constructionism challenges the common-sense view. Common sense assumes that the world has distinctive qualities and that representations are copies of something original (Edley, 2001). Social constructionism thus argues all knowledge including the most basic taken for granted knowledge of everyday life is constructed and maintained by social interactions. The second argument is that there are no universal understandings of the world, but rather culturally and historically specific understandings. The third point that Burr suggests is that these understandings are formed through social interactions and language. This highlights Gergen's ideas of "the communal origin of knowledge" and the "centrality of language". Furthermore, this point also highlights the process of co-construction that happens between people. Lastly, Burr argues that these social interactions result in social constructions of events.

The major tenets of social constructionism are consistent with the epistemological assumptions of this study. Gergen (1973) and Burr (2004) suggest that knowledge is not objective and external to us, but rather it is inter-subjective, historically and culturally relative. This means that knowledge does not reside within the individual's mind, but is situated in the space that language has between people/s. Therefore, human beings are not only producers, but they are beneficiaries and/or victims of reality (Pearce, 2009). In other words, humans are both participants and observers of knowledge production. Knowledge is furthermore dependant on the historical time and space and the cultural context in which it was co-created. Thus, knowledge is not objective and "out there" neither is it subjective in that it happens within the person. Rather, for social constructionists, knowledge is **intersubjective**. The question of epistemology in social constructionism highlights the integral role played by language in this theory. The function of language is not just to mirror reality but rather it is to produce reality (Edley, 2007). Quale (2007) suggests that we learn to attach meaning to words and we expect that certain members of society will attach the same meaning to that word. Thus, language is the vehicle through which we co-create knowledge.

Furthermore, both Burr (2004) and Gergen (1973) highlight the centrality of time and place, that the time and place in which something is constructed is important to how it is constructed. Therefore, social constructionism is interested in how individuals position themselves in relation to cultural discourses and the types of conversations they have with people in their lives (Mcloed, 2009). The dialogues on reality are constantly unfolding and in motion (Pearce, 2009). As a result, **ontologically**, social constructionism is **relativist**, which means that there are multiple realities rather than a single reality that is constructed (Ponterotto, 2005). In social constructionism no one account is more objective or accurate than the other, as such there is no such thing as "the" truth (Gergen & Gergen, 2007). But instead there are multiple truths. Burr's argument adds the idea that these constructions sustain patterns of social action that may exclude others. Therefore, it is not whether an account or meaning is true that matters, but rather the implications for life that follow from taking any truth claim seriously (Gergen & Gergen, 2007). This brings in the power dynamics involved in knowledge production. Power is at the heart of social constructionism, it allows, supports and encourages the analysis of various forms of social inequality such as gender, ethnicity and mental health (Burr, 2004). This is with the view of challenging these inequalities through research. Because of power dynamics that are involved in knowledge production, this mini-dissertation contains a reflexivity section (see *chapter five*) which reflects on the power dynamics which were at play in developing this research.

More closely related to this study social constructionism argues that race, ethnicity and social class, amongst others, are all constructed alongside masculinities (Addis & Cohane, 2005). A social constructionist perspective to gender highlights the different ways gender itself is actively constructed at a variety of social levels, from the micro-interactional to the cultural (Addis & Cohane, 2008). Central to the assumption in social constructionist frameworks is the idea of multiple *competing* masculinities, continuously being constructed and contested (Addis & Cohane, 2005). Concerning this study, social constructionism accounts for the assumption that Xhosa men's constructions of depression are related to their cultural background. Further, the assumptions related to the impact of history and the assumption related to the involvement of human interaction in knowledge production relate to the study in that understandings of depression are not solely produced by individual knowledge of depression but rather the individual's interaction with his social world and its history. Therefore, the Xhosa man's tradition (past and current), as well as culture, is of importance in understating how he constructs depression. Lastly, the aim of this research is to not take for granted that depression

is experienced and constructed as per the DSM, which is another construction by predominantly the American psychiatry community This relates to the critical stance that social constructionism takes on taken for granted knowledge.

One of the main assumptions of social constructionism is that knowledge is not universal, as it is culturally and historically specific. This is important as most of the participants in this study are from urban areas, but it seems as if they mostly embrace the rural discourse about their culture and about what it means to be a Xhosa man. There is only one participant who is from a rural area in the Eastern Cape, but he sometimes visits the urban environment.

Social constructionism, psychology, and research. Social constructionism is applied to both clinical practice and research (Losantos et al., 2016). When applied to clinical practice, individual narratives are understood as a result of social relationships, and the need to maintain social expectations (Anderson, 2012). When applied to research, the research question is seen as a collaborative process between the researcher and participants (McNamee, 2012). For the purposes of this mini-dissertation, the focus is on the relevance of social constructionism to research in psychology. In research, the idea of a collaborative process suggests that the role of the researcher in data collection and analysis is clearly present. Thus, the findings are not presented objectively but rather as inter-subjective constructions of both the researcher and participants (Losantos et al., 2016).

Losantos et al. (2016) discuss several factors that are important in research when using social constructionism as a philosophical underpinning. To begin with, they argue that social constructionism understands psychology as a socially constructed discipline, through interactions in a specific time, place, and culture. Consequently, the findings depend on the time and place that the research is conducted. Such findings may not be generalized or replicated; however, they are meaningful as they broaden our knowledge on some of the constructions that exist on depression. This is further made clear by the ontology and epistemology of this study, that value-free research is impossible because the participants and myself are co-constructing the research.

Research question, aim, and objectives

The aim of the study was to explore Xhosa men's constructions of depression. In light of the aim of the study, the research question was formulated as:

“How do Xhosa men construct depression?”

To further explore the research question and enhance the richness of the analysis, the following objectives were formulated:

- How does culture influence Xhosa men’s constructions of depression?
- How does gender influence Xhosa men’s constructions of depression?
- How does being a man (gender) and being Xhosa (culture) intersect and interact in men’s constructions of depression?

Research process

The following section addresses those aspects pertaining to the method or the "doing" of this study. The design of the study (i.e., the choices made about how to collect data, whom to include and how to analyse transcripts) were informed by the social constructionist methodology and intersectionality as the theory of the research study.

Sampling

A purposive sampling strategy was used to recruit participants. Purposive sampling involves the selection of participants with specific characteristics, who are most likely to assist in answering the research question (Bryman, 2012).

Thus, the criteria for participation were any adult Xhosa man from the age of 18-60. It was understood that if the person self-identified with the male gender, that he would be considered a man. It is important to note that the participants of this research were not necessarily part of a vulnerable population, as the focus of this research is on general perspectives on depression. It is thus not concerned with men diagnosed with depression. Participants did not have to be proficient in English because both participants and researcher were proficient in isiXhosa thus allowing participants the liberty to speak in their home language. In addition, participants were encouraged to speak in a language they are comfortable with because as discussed above, according to social constructionism language plays an important role in the construction of knowledge. In order to recruit participants, I made a poster and information leaflets (Appendix 1 and 2) about the study. These were placed and distributed in Grahamstown, Eastern Cape (which has a predominantly Xhosa native population) at the local church, hair salon, and football club. The aim was to recruit about 4-6 Xhosa men. If more participants were needed following the initial recruitment strategy, then snowball sampling

would have been implemented. Snowball sampling is an approach where the researcher accesses participants through referrals by other participants, thus participants refer the researcher to other potential participants (Noy, 2008). However, this method of sampling was not utilised as I was able to obtain enough participants by using leaflets and the poster.

This study made use of a small sample. This choice was informed by the qualitative nature of the study as well as the scope thereof. Studies similar to this study have used approximately the same number of participants (Ally & Laher, 2008; Nyman, Josephsson, & Isaksson, 2012). Furthermore, a qualitative research approach usually entails a small number of participants (Percy, Kostere, & Kostere, 2015). Qualitative studies such as this one are approached from an idiographic perspective. An idiographic approach to studies refers to one that is subjective, unique and often cultural (Bryman, 2012). Similarly, Ponterotto (2005) suggests that idiographic research places its focus on understanding the individual as unique and complex. Furthermore, idiographic studies, such as a constructionist qualitative study, small samples are used because analysing a big sample could result in the loss of subtle inflections of meaning (Brock & Wearden, 2006). This is especially true considering that idiographic studies are descriptive in nature and detailed in presentation (Ponterotto, 2005). In terms of the scope of the study, mini-dissertations, or dissertations of limited scope also tend to use fewer participants than would be required for a doctoral study.

If it so happened that a participant was experiencing depression at the time of the interview or had experienced depression in the past, then he would have received a referral for psychological counselling free of charge. Furthermore, in such a case a participant's diagnosis and/or experience would have been taken into account in the analysis. Thus, such participants would not have been excluded from the study, despite their history of depression. This stance was taken to avoid potential discrimination against men who may have wanted to share their experiences of personal depression despite the study's parameters. The advice from the department of psychology's research committee was followed in this regard. The participants were asked whether they have been diagnosed with depression before or currently, and none of the participants reported being depressed at the time of the interviews.

Participants

The table below provides the basic demographic information of each participant.

Participant's Pseudonym	Age	Level of Education	Rural/Urban
Sakhumzi	37	Grade 10	Rural
Nceba	34	Tertiary level	Urban
Siyanda	24	Tertiary level	Urban
Abongile	22	Tertiary level	Urban

Table 1 Participant's and their demographics.

Data collection

Ethical clearance was obtained from the University of Pretoria Faculty of Humanities Ethics Committee. Following this, I began the recruitment of potential participants. The research could only commence after ethics approval was obtained. When individuals interested to participate in the study contacted me, I explained the purpose of the study as well as the need for them to provide informed consent. Once all questions were clarified I arranged for a day, time and place to conduct interviews. These were convenient for the participants and myself and the place was safe and private within the recruitment area, such as the local library discussion rooms. On the day of the interview, consent, the nature, and purpose of the study were explained again, and questions clarified. Once written consent *(See Appendix 3)* was granted the interviews commenced.

Data collection was conducted using semi-structured interview which was guided by an interview schedule *(See Appendix 4)*. The semi-structured interviews lasted approximately one hour but there was no time limit that the interviews were expected to last. The interview schedule was formulated based on the research question, literature review and the aim and objectives of the study. The interview schedule included prompt questions as well. Interviews were conducted by myself in the participant's preferred language (isiXhosa and/or English). In the interviews, all participants spoke in English and at times also IsiXhosa. The interviews were audio recorded and transcribed and translated (where necessary) verbatim by myself. Semi-structured interviews are referred to as interviews where the researcher has specific topics to be covered or a list of questions (Bryman, 2012; Willig, 2013). However, unlike structured interviews, the research participant has great leeway in how to respond (Bryman, 2012). This

also means that the researcher can include questions that were not originally part of the semi-structured schedule.

Semi-structured interviews are much like an in-depth conversation about a certain topic. Therefore, they allow participants the chance to frame their understanding as they will and to mention what they feel is worth mentioning. This aided in capturing the participants' understandings and perceptions of depression in an in-depth manner. In addition, semi-structured interviews also allow the researcher to obtain rich data while the aim of the study remains in focus.

Thematic analysis as method of analysis

The data consisted of four interviews which were soon after the interviews transcribed verbatim by myself. To analyse this, Braun and Clarke's (2006) method of thematic analysis was used. Thematic analysis is a method of identifying, analysing and reporting patterns within data; it minimally organises and describes a data set in rich detail (Braun & Clarke, 2006). In a general sense, thematic analysis aims to highlight the most important groups of meaning present in a set of data (Braun & Clarke, 2006; Joffe, 2012). Thematic analysis is considered a flexible method of analysis as it is not strictly tied to a particular theoretical or methodological approach (Joffe, 2012). However, Braun and Clarke (2006) insist that researchers should embed their thematic analysis within a chosen methodology or theory. Therefore, for this study, the constructionist approach to thematic analysis was used. Thematic analysis conducted within a constructionist approach seeks to theorise the socio-cultural contexts (Braun & Clarke, 2006). Qualitative research, intersectionality, and social constructionism are all context sensitive, and as a result, the findings of the study are sensitive to context. This means that the data was understood from the context of the participants. Furthermore, themes that are generated from a constructionist paradigm of thematic analysis go beyond the surface, they examine underlying ideas and ideologies (Braun & Clarke, 2006). Braun and Clarke refer to such themes as latent themes. This also means that the findings of such a study is not descriptive but transformed by the researcher's interpretation.

I utilised Braun and Clarke's (2006) six steps to analyse the transcripts. The first step I followed was to familiarise myself with the data. During this step, I listened to the audio recordings and made notes during the transcription phase. Once the audio interviews were transcribed, I read the transcript more than once. While listening to the audio recording, I

further noted some interesting information that could assist to answer the research question. Following this step, I started generating initial codes. Braun and Clarke (2006) liken codes to the material used to build a house, they are the building blocks to building themes and not the themes themselves.

The third step entailed searching for themes. This process is an active process whereby themes are generated rather than discovered (Braun & Clarke, 2006). The themes are built from clustering codes which were generated in the second step. Once I generated potential themes, I reviewed them as a quality check. To achieve this Braun & Clarke (2006, p. 65) suggest asking yourself the following questions "Is this a theme?", "Does it tell me something useful?", and "What does it include and exclude? ". Once the themes were reviewed, I began the process of defining and naming the themes. Lastly, the themes were written into a report as presented in *Chapter 4* of this mini-dissertation.

In order to address the last objective, the findings of the study were translated into the approach of intersectionality. The themes, for the most part, related back to the aim and objectives of the study. This was somehow expected because the interview guide was formulated with the aim and objectives in mind. Furthermore, the aims and objectives were also informed by intersectionality as theoretical lens. Hence the themes also spoke to theory. It is important to clarify that an a-priori coding framework was not used to identify the initial codes. This would have closed the possibility of identifying constructions outside of what the study sought for. As discussed above, the benefit of semi-structured interviews is that they allow for the exploration of other interesting avenues that may not have been captured by the initial questions. An a-priori framework may have disallowed such additional rich contributions.

Ensuring and enhancing the quality of research

Positivists have questioned validity in qualitative research; however, naturalist investigators such as Guba have formulated ways to ensure validity in qualitative studies (Shenton, 2004). Guba proposed four criteria in pursuit of the trustworthiness of qualitative research (Shenton, 2004). Guba's criteria are argued to correspond with the criteria employed by positivist researchers. These include credibility, transferability, dependability, and confirmability. Following the discussion on these four criteria, is the discussion of enhancing the quality specifically for research conducted from a social constructionist approach.

According to Shenton (2004) **credibility** in qualitative research refers to how much the study truly reflects the phenomenon being studied – this can be achieved in several ways. Guba suggests an early familiarity with the culture of the participants, this fosters trust between the researcher and participants (Shenton, 2004). I share the same ethnic group as the participants, this aided in rapport building. Another way to ensure credibility is through data collection. The study used semi-structured interviews deliberately as these allowed the participants to better explain their understanding without the limits of a structured set of interview questions. For example, when I did not fully grasp what a participant was reporting, I probed them for examples and more detail. Furthermore, I was careful not to assume that I understood by virtue of sharing the same ethnicity as the participants, and as a result, this encouraged me to seek clarification in a number of instances. This kind of conversation allowed for a rich set of data reflecting what was being studied well.

Transferability. Transferability is concerned with whether the study can be applied in a different situation (Shenton, 2004). In order for this to be possible the parameters of the study need to be clearly defined (Shenton, 2004). The study took place in Grahamstown, Eastern Cape. The population in Grahamstown is predominantly of Xhosa ethnicity, and for this study people that identified as men between the ages of 18-60 years were chosen. Social constructionism was employed as the methodology and intersectionality as the theory. Individual interviews were conducted with each participant. There was no time limit for the interview. Semi-structured interview questions were constructed by myself and my supervisor, and prompts were included in the interview schedule. The data was analysed using Braun and Clarke's steps to conducting a thematic analysis.

Dependability. In order to achieve dependability, the research process should be reported in detail, which enables future researchers to repeat the study (Shenton, 2004). This study achieved this in chapter three through a detailed description of the research process. Detailed descriptions included a step by step account of the methodological commitments, theoretical approach and the research method that I followed.

Confirmability. Confirmability refers to ensuring that the findings are a result of the ideas of the participants rather than the researcher (Shenton, 2004). To achieve this my supervisor would challenge assumptions I had as I was generating themes so as to ensure that the voice and discourse of participants were not silenced by my own assumptions or over-interpretation of what they brought to the study. This is not to say that the study represents the

"truth" of what participants said. Rather, in accordance with social constructionist notions, the aim was to keep in the fore that the findings of the study are a co-creation and not a pure representation of either my or the participants' truths or knowledge.

Social constructionism stresses the principle of co-construction. The researcher is thus part of the construction of the reality and "truths" presented in the study (Morrows, 2005). In addition, Morrow (2005) speaks of researchers that are both an insider and outsider, which means that the researcher and participants share the same culture and ethnicity (insider) but they identify with different genders (outsider). Both Morrow's assertions above underscore the importance of reflexivity to ensure that the research is credible. As a result of this reflexivity was applied during the research process and it was documented in *Chapter 5* of the mini-dissertation. How I achieved this practically was through consultation with my supervisor about the influence that my gender, mental health, and cultural positioning have on the research process. Furthermore, through the use of supervision and attentiveness to the voice of the participant I guarded against an emphasis on my own interpretations. In this regard, quotations from participants' interviews were provided in support of the findings. Another important aspect to note for credibility in social constructionist terms was the power dynamics between myself and the participants especially considering the difference between my occupation and theirs. This was similar in terms of my status as the researcher while they were participants. This status may have positioned me as an expert in the field thus influencing the responses that participants gave to my questions. This too is explored in more depth in the reflexivity section in *Chapter 5.*

Ethical considerations

Ethics clearance was first obtained from the Humanities' Faculty Ethics Committee at the University of Pretoria. The study did not seek to explore individuals' experiences of depression as a phenomenological study would. Rather, the focus was on those social constructions available in the Xhosa culture. Ethically sound research practices were applied, in keeping with the Health Professionals Act (1974) using the following criteria:

Participants were asked to provide verbal and written consent *(See Appendix 3)* to participate in the research study. Informed consent is achieved when an informed and capable individual voluntarily chooses to participate in a research study (Anderson & Mukherjee, 2007). In addition, the voluntary nature of the study was made clear both in verbal and written

form and participants were informed that they could withdraw at any given point of the study without any negative consequences. It was made clear that they could refuse to answer any question. Furthermore, consent requires renegotiation (Field & Morse, 1992; Kvale, 1996). Therefore, on the day of data collection, participants were reminded of consent and the liberty to withdraw from the study at any point. Participants were allowed to ask questions regarding the research study. The written informed consent forms and verbal communication were both in understandable language. Lastly, confidentiality was ensured, through the use of pseudonyms.

Qualitative research is carried out within research ethics that emphasise participant autonomy and informed consent, confidentiality, avoidance of harm and fairness (McLoed, 2009). The researcher was sensitive to the participant's safety and mental well-being (Willig, 2013). I used DSM 5 criteria as well as my clinical judgment and knowledge of the alternative presentation of "male depression" to ascertain if a participant was or had been depressed. In addition, participants were asked whether they are or had been depressed before. Orb, Eisenhauer, and Wynaden (2001) note that it is the moral obligation of the researcher to refer participants for counselling should they need. Because of the potential vulnerability of the population, the availability of psychological support services was communicated again at the end of the interview. Psychological support services were obtained from family South Africa (FAMSA) a non-profit organisation that offers counselling services to both families and individuals free of charge. Approval from this organisation was obtained *(See Appendix 5),* and participants have been provided with FAMSA contact details.

Summary of chapter

This chapter focused on the method and methodology used for the research study. The study was conducted from a qualitative research approach because it is concerned with the formation of meaning and obtaining an in-depth understanding of the phenomena of study.

Social constructionism as the methodology was discussed in this chapter. This methodology was chosen because it argues that race, ethnicity and social class amongst other social identities are all constructed alongside gender. This is in keeping with the assumptions of the theory of this study, intersectionality.

The specific method used to conduct this research was also outlined in this chapter. This includes the sampling processes, data collection, method of analysis, measures to enhance qualitative research, and ethical considerations.

CHAPTER 4: RESEARCH FINDINGS AND DISCUSSION

Introduction

This chapter presents the findings of four Xhosa men's constructions of depression, explore their meaning and discuss them in light of the available research as well as intersectionality. The study was concerned with the influence of cultural values and beliefs on these men's construction of depression, the influence of gender on their constructions, and the intersection between both culture and gender on their constructions of depression.

Following thematic analysis as a method of analysis, each interview was analysed. The specific steps followed were described in *Chapter 3* under the method of analysis section of the mini-dissertation. In terms of how the themes were presented in this chapter, they were presented according to their relevance to the objectives of the study.

The chapter first introduces the men who participated in the study. In order to maintain the confidentiality of the participants, each participant is assigned a pseudonym. Following the introduction of the participants, this chapter presents an analysis of the themes in relation to literature. Thus, this chapter is structured such that the findings and discussion are integrated.

Introduction to research participants

Each participant is introduced below, focussing on their demographics. The introductions also include how I experienced the participants as well as my experience of the interview with each of them.

Sakhumzi

Sakhumzi was the first participant interviewed for the research. He is a 37-year-old Xhosa male. He is not married, unemployed and does not have children. His highest level of education is grade 10. He identifies as a born-again Christian.

On our first meeting, Sakhumzi was very enthusiastic about the interview. He expressed gratitude and honour to be a part of this research study, expressing that he had never been interviewed before. This made me worry that maybe he would feel the pressure to sound correct and give me information that he thought I wanted to hear. However, to my surprise, he appeared confident in what he had to share and did not seem like he was pressured to please me. I noted that throughout the interview he referred to me as "my sister" which in my opinion suggested

a level of identification with me. This could have been because of the shared culture. I enjoyed the interview with him, and I felt that I learnt a lot from him.

Prominent themes in Sakhumzi's transcript were around; religion and depression, his role as a man, and traditional Xhosa beliefs.

Nceba

Nceba was the second participant interviewed for the research. He is a 34-year-old Xhosa male. He is not married and does not have children. Nceba is currently pursuing a master's degree in Law.

Throughout the interview, Nceba appeared confident and at times he would come across as though he wanted to impress me. At times he appeared to struggle to answer the question and I found that I had to rephrase the questions and redirect him back to the original question. Initially, I assumed that he would be hesitant to discuss matters to do with ubudoda (manhood) because to me he seemed traditional in his manner. When asked whether he was affiliated to any religion he reported that he is traditional.

Nceba's prominent themes were around depression as a mental illness, and traditional Xhosa expectations.

Siyanda

Siyanda was the third participant interviewed for the research. He is a 24-year-old Xhosa male. He is not married and does not have children. He is currently pursuing a diploma. He reported that he identifies as Christian.

During our interview, Siyanda appeared confident and enthusiastic about sharing his views. I enjoyed his interview the most and I found him to be articulate. He explained and gave examples to situations which made it easier for me to follow. During the interview, I felt like an equal to him, in that I did not strongly feel the gap between me being a clinical psychology student and him not being one.

Following the analysis of Siyanda's transcript themes were noted to be predominantly around gender expectations, the Xhosa values, and alternative exposures to information.

Abongile

Abongile was the last participant to be interviewed for the research. He is a 22-year-old Xhosa male. He is not married and does not have children. He is currently pursuing a degree in Veterinary science.

During our interview, Abongile also came across as confident, although at times he seemed hesitant of what he was saying. It seemed as though he was doubting whether I understood what he was saying. I found him to be pleasant. When I asked him whether he identifies with any religion, he said he is a child of God. He laughed and said no he is Christian. I thought he preferred being referred to as a child of God but maybe he felt hesitant about that hence he changed his mind and used humour to lighten the situation. This made me wonder about how prominent his religious identity would be in the findings.

Prominent in his transcript were themes about the role that Christianity plays in his understanding of depression, family expectations and manhood in relation to his Christian identity.

Findings and discussion

There was a substantial number of common themes across the construction of depression of the four participants related to how Xhosa men construct depression. For example, participants emphasized values and beliefs such as; struggling being depicted as a weakness or ancestral displeasure, the role of responsibility and taking care of one's family as a man and how that impacts on their understanding of depression. Furthermore, the construction of manhood in "ulwaluko" (traditional circumcision), the expectations thereof, and belonging in that group seemed to resonate with the participants, particularly how it impacts on the construction of depression and suffering. However, participants also noted the exceptions to the rules placed by culture and dominant masculinity discourses, as well as how the picture gets complicated with the presence of religion, class differences, and age. These findings were similar to findings from the literature, and sometimes these findings offered a unique contribution to literature. The themes identified and presented in this section answer the research objectives which are: How does cultural influence Xhosa men's constructions of depression, how does gender influence Xhosa men's constructions of depression, and how does being a man (gender) and being Xhosa (culture) intersect and interact in men's constructions of depression.

The table below indicates all the themes in the findings, linked accordingly to the three main focuses of the study:

Three main focuses of the study:	**Themes:**
Cultural beliefs and values that influence Xhosa men's constructions of depression.	● Suffering is ancestral displeasure. ● Strength and weakness in the face of life's challenges/depression. ● As long as your neighbour doesn't know. ● Talk to those who understand your manhood and wear a blazer if you must ● The picture gets complicated: Religion, class, and age
The influence of gender on Xhosa men's constructions of depression.	● We are providers and representatives of our families. ● Men are never defeated ● Big boys don't cry ● The exception to the rule: Alternative priorities and responses to expectation
The intersection between the Xhosa culture and male gender in the construction of depression.	● Membership into ubudoda ● The need to be the alpha male

Table 2 List of themes.

Cultural beliefs and values that influence Xhosa men's constructions of depression

Across all four participants there were a number of themes regarding the cultural values and beliefs that influence Xhosa men's constructions of depression; however, the most dominant were "suffering is ancestral displeasure", "the shame attached to struggling", "you're born to be able to deal", "as long as the neighbour doesn't know", and "talk to those who understand our manhood". An interesting and unexpected theme is religion, class and age as some of the influences in the construction of depression. This theme speaks to when the participants deviated from the norm and they became the exception to the rule placed by the social/cultural expectations. These norms were constructed by the Xhosa culture, gender and prevailing discourses around the phenomena of depression. The theme is worth noting because it highlights the main assumption of intersectionality which is the intersection and interaction

of social identities. Furthermore, this theme is an example of the role that context and other social identities (i.e. religious orientation, social class, and age) plays in constructing meaning.

Suffering is ancestral displeasure.

One of the participants strongly reported on the involvement of ancestral beliefs in how some Xhosa people understand and construct their world. Braathen et al., (2013) agree with these findings, that ancestors play an important role in how Xhosa people perform tradition and culture. Prominent in this participant's report was the belief that in the Xhosa culture when one experiences suffering, at times, it is considered indicative of the ancestor's unhappiness with the individual. Thus, such an individual is experiencing symptoms as a sort of punishment and he or she is culturally constructed as the recipient of the wrath of the ancestors' displeasure. The individual experiences symptoms from a source higher/external to himself because of wrongdoing. The symptoms are understood in this way, as opposed to them being an indication of mental illness as we would find in traditional nosologies. Alternatively, Laher (2014) found that mental illnesses amongst the amaZulu and amaXhosa may be perceived as more than a sign that the ancestors are pleased with an individual (Laher, 2014). Laher's study found that mental illnesses may also be a sign to a calling to become a traditional healer, they may also be a sign that one is spiritually possessed. Thus, mental illnesses such as depression may be understood in relation to ancestors, either in a positive manner (i.e. calling to be a traditional healer - ukutwasa) or in a negative way (i.e. the recipient of ancestral wrath). The importance of pleasing the ancestors and the consequences of the ancestral displeasure are well expressed by Sakhumzi.

"When I look at the other Xhosas, when things are not going well, for instance, I've seen it when someone has been disappointed by life and then they take for granted that there must be something they are not doing right so they brew some traditional beer. . . they assume that their ancestors are mad. . . So, what I'm trying to say is that I think that is the way they understand it" Sakhumzi, page 7

"Other Xhosas like me believe that in order for everything to go well with you, the minute you start working you have to go slaughter something in the kraal at home. . . Other Xhosas usually buy a bottle of brandy and thank their ancestors" Sakhumzi, page 6

Sakhumzi here shares that from his interactions with some Xhosa people as a Xhosa man he has noticed that any experience of unhappiness, discomfort or difficulty is associated

with communication by the ancestors. Thus, he reports that because of the belief that suffering is an indication of the ancestor's unhappiness, depression may thus be constructed and understood from that belief. He seems to suggest that depression is co-constructed as a sign or symptom to ancestral displeasure with an individual as opposed to a mental illness residing from within the person. The response to this is to atone or do something that will please the ancestors such as slaughtering as a sign of atonement. Thus, what is evident here is that the living and the ancestors co-construct what pleases and displeases the ancestors, and what is expected from the living (such as atonement sacrifices). In a different context and a different ethnic group, Ellis (2003) found that depression was constructed as located in the body. For example, he found that patients in clinical practice may complain of, *ukukhandleka* (tiredness), *ukuphela amandla* (loss of energy), *ikhanda* (headache). Tomlinson et al. (2007) found similar findings to Ellis. The multiple differences in context between Ellis (2003) and my study might explain the difference in the findings. This highlights, once more the importance of context and how there are various constructions of depression depending on the context. It also highlights the unique nature of my findings in comparison to the literature.

Literature suggests that men from different cultural groups, (such as some Asian cultural groups and Latino cultural groups) reported that depression is caused by the pressures that masculine ideologies place on men (Cabassa, 2007; Iwamoto, Liao, & Liu, 2000; Watkins & Neighbors, 2007). The findings from my study, however, seem to suggest that although there is a discourse that depression is experienced emotionally (i.e. inside of the individual), the aetiology is externally located in a powerful source. The powerful source referred to here are ancestors in the Xhosa culture. As such depression is punishment and contrary to the discourse of it being due to the experience of men feeling pressure from masculine ideologies or adverse life circumstances. This highlights the interaction between culture and depression in the co-construction of the causes of depression. Bhugra (2008) highlights this notion, as he argued that all humans experience a low mood, however culture determines when that mood is cause for concern, as well as where to seek help. The DSM refers to this as cultural explanations (APA, 2013). As such culture does not only provide men with certain discourses to explain the reason for depression, for discourses about how to deal with it, in this instance mainly through practices that would please the ancestors, is also culturally informed.

Strength and weakness in the face of life's challenges/depression

The following theme speaks to beliefs held about strength and weaknesses in the Xhosa culture. What becomes clear in this theme is that in the Xhosa culture it seems as though depression does not exist.

In addition to the belief that suffering and struggling are communications from the ancestors two participants, Siyanda and Abongile, bring forth the association made between struggling and weakness. The two participants describe a belief that when a man experiences suffering, the man is considered to be weak. The participants seemed to suggest that this is particularly true for men. Brownhill and colleagues (2002) agree with these findings, they report that "soft" emotions are considered un-masculine when they are expressed by men, while they are not considered the same way when expressed by females. Siyanda suggests that the showing or acting out of difficulties will be seen as weakness. Thus, in relation to depression and the symptoms thereof, when a man succumbs to these difficulties this is an indication of weakness of character or a weak man. This instance suggests the interaction and intersection of culture and gender in the construction of depression - of how to deal with the challenges of depression. Thus, although these two participants acknowledge the suffering that's involved in experiencing depressive symptoms or any form of difficulty, they emphasize the association between that kind of suffering and weakness. Furthermore, they suggest that instead of the acknowledgement that these feelings and experiences might be a sign or symptom to a mental illness they are rather constructed as weakness of character and the inability to be a "real" Xhosa man. This is similar in most cultures (such as some Latino, Asian, and black American cultures) where men will mask, deny, and suppress their depressive symptoms because of various masculine ideologies (Cabassa, 2007; Hoy, 2012; Watkins & Neighbors, 2007). These three studies go further to suggest that the pressure to abide by these masculine ideologies causes depression. This brings me to the next point which is the idea that it is in the nature of Xhosa men to be able to manage with difficulties.

"If I show you where I'm struggling, I feel you have been exposed to my weakness" Siyanda, page 4

"So, if now you are deep, if you go now to this level of depression, especially in such a culture, that's where now you show a sign of weakness" Abongile, page 1

This theme also speaks to one of the values that some Xhosa people may hold, a value that individuals have the inherent ability to deal with difficulties. This value is especially applicable to men as opposed to women. Most of the literature only suggests that men are expected not to express these emotions and difficulties (Brownhill et al., 2002; Cabassa, 2007; Hoy, 2012; Watkins & Neighbors, 2007). But the findings to my study suggest that not only are men not expected to express emotional difficulties as a result of life's challenges but rather that they have the inherent ability to deal with difficulties. This theme illustrates the construction of depression from a discourse about how a Xhosa man is not in a position to not be able to handle difficulties, and therefore difficulties can never and should never result in a "crippling" condition. According to the DSM, the main premise of mental illness is that it affects your daily functioning negatively and may likely result in the need for professional help (APA, 2013). With that in mind, this theme seems to speak to a discourse that suggests that a man can and should never be in that position, as culture dictates that men have the inherent ability to deal with challenges. Cabassa (2007) referred to this as a culture that encourages men to be self-reliant. To do otherwise would be indicative of a flawed man who is displaying shortcomings in dealing with challenges that Xhosa masculinity deems appropriate and necessary. Although the population studied by Cabassa and the Xhosa men population are different and are found in different contexts, there seems to be an overlap between the expectations that are placed on men generally. Siyanda explicitly shares this notion of Xhosa men being expected to be capable to deal with challenges.

"No, that it does not exist. It's denial more than anything because you can't be at a position where you can't deal with things; you're brought up to be able to deal" Siyanda, page 3

In Siyanda's response in the above quote, he is replying to my question that, in his interactions with Xhosa people if he thinks they identify depression as a mental illness or even acknowledge it as a "thing". From this extract, he seems to be suggesting that for some Xhosa men the construction of depression cannot exist because one should not be in a position where they are so affected by challenges that they end up in that position. Thus, he suggests that from the Xhosa culture, any challenge is constructed as manageable and therefore, there is no recognition of the possibility of challenges resulting in an illness or position where one needs help.

"It doesn't matter how old you are the moment you are a man you have to find a way to deal with it. Say no I'm not coping I need help, no" Siyanda, page 3

"Xhosas see depression as taboo and like a man cannot have depression" Abongile, page 2

In these two extracts, Siyanda and Abongile go further to apply this truth for Xhosa people, specifically to Xhosa men. Siyanda suggests that for a man to say they are not coping and that they need help, that is unacceptable. Abongile on the other hand explicitly suggests that in the Xhosa value and belief system depression is taboo and that a man cannot have depression. Both extracts seem to allude to the idea that men should be able to deal with difficulties, therefore, depression does not (cannot) exist. This theme elaborates on the unique contribution of this study around the idea that not only are Xhosa men expected to "have it all together" but they are also thought of as inherently unable to be depressed. This discourse is one that may be perceived as honouring to Xhosa men especially when one thinks of traditional hegemonic masculinity ideal. But the discourse may also have negative consequences in terms of what it allows Xhosa men to be and not to be, particularly in terms of facing difficulties. For example, while it may be pleasing to be thought of as able to deal with any difficulty you are faced with, it can also mean that when a man is overwhelmed with difficulties, he is not given the option to seek help. Hoy (2012) found that the most common reason why men do not seek help is the fear of stigmatization by family and friends. What is also interesting in the extracts above, Siyanda seems to suggest that these expectations apply once a boy goes for traditional circumcision and thus becomes a man. This may mean that these expectations do not apply (as much) to boys but mostly apply to "indoda" (a man). Thus, culture and the notion of a man construct the expectations for men. The point discussed above leads to the question of an equivalent term for depression in the Xhosa culture especially considering how the aetiology of depression could either be understood as ancestral communications or weakness of character or manhood.

I noticed that participants struggled to find a term that is equivalent to depression in the Xhosa language. This may further speak to the idea that the symptoms are not interpreted as a mental illness but rather weakness or ancestral displeasure. Therefore, without that construction of a mental illness, the concept of depression does not exist. Furthermore, the lack of an equivalent term underscores the social constructionist idea that language plays an integral role in the construction of reality. This is in the sense that words, language and dialogue shape reality and if a word for something does not exist, then it is not part of reality or only has a vague representation in it.

"It's not a subject that is found to be real. So, I cannot really say what role it plays because it's almost like it doesn't even exist" Siyanda, page 1

"So, depression in my culture is seen as something like, weak as a man" Abongile, page 1

Siyanda suggests that a term for depression in isiXhosa does not exist. Therefore, if there are no words for depression in isiXhosa then the idea of depression or the reality of depression does not exist. Korner et al (2011) support the idea that illnesses are socially and culturally constructed through language. But it is important to note that, while a strict term for depression may not exist in isiXhosa, the symptoms exist but they may be constructed differently to the western society. The DSM refers to this as the idea of cultural explanations for the causes of these symptoms (APA, 2013), such as ancestral displease as found in this study. Thus, culturally there is a different reality of depression symptoms in comparison to the reality constructed by diagnostic manuals. Tomlinson et al. (2007) argue that what is defined and constructed as depression in categories such as the DSM may be constructed and made sense of differently in a different culture. This highlights the importance of cultural context.

"To us, one the mind is not like in the right way of thinking, like if you picked up that eish! something is not going straight there, we just declare it in our mind that you're just mentally sick. You didn't go further to say, there's different types of mental sicknesses. . . So, we just declare that he is crazy, he is losing his mind because they are at St Marks" Nceba, page 3

In this extract, Nceba talks about how they view mental illness in his community. He speaks about a psychiatric hospital called St Marks in the Eastern Cape, and he reports that whenever a person was admitted at the hospital the community would just declare them as crazy. Thus, for Nceba, he reports that in his community when they notice that something might be wrong with a person mentally, they acknowledge it as a "mental sickness". He further goes on to share that, however, they do not have specific names for mental illnesses, but rather that whenever a person is not well mentally, they are just labelled as mentally sick. What is interesting to note is that two other studies conducted among the Xhosa people found terms that are used to refer to depression, these included suffering from "nerves", "*angizwa umzimba", "dhangala"* (Ellis, 2003; Tomlinson et al., 2007). Although some of the participants from both these studies including this mini-dissertation are of the Xhosa ethnicity, a difference is noted in the terminology used by participants. This highlights intra-cultural differences, as well as the differences in discourses found in different contexts. This is referred

to as the relativist notion of culture, as discussed in the background section of *Chapter 1*. Nceba's extract suggests that there are thus no differentiations in mental illness just a reference to being "crazy", and this is similar to Siyanda saying that it "almost" does not exist. In both instances, it is constructed as something that exists, but in vague form. In addition, it seems as if a mental institution has the power over defining someone as mentally ill. The community then uses the admittance into a mental institution to make sense and to construct the idea of "when you go there, you are crazy". This speaks to the processes of co-construction, where the society, as well as institutions, construct the reality and knowledge of mental illness. It also illustrates the importance of context in how people make sense and create an understanding of their physical reality (the hospital) in creating a discourse around it.

Therefore, from the discussion above it seems that in terms of the Xhosa culture and depression, it is constructed mainly as something that does not exist for two reasons. The first reason is that men are constructed as strong and cannot become depressed which speaks to the intersection of culture and gender. The second reason is that there is no language or term for depression as known as a western concept in the isiXhosa language.

As long as the neighbour doesn't know.

Common amongst the participants was the mention of the importance of secrecy and not revealing challenges faced by the family to neighbours or people outside of the family. Participants in the study spoke about the need to keep difficulties in the family with the concerns of what other people would say if they knew. This overlaps with Cabassa's findings which suggest that men in the Latino culture were ashamed to discuss issues of depression outside of family due to the fear of stigmatization (2007). Similarly, a study on African American men found that there is a stigma that is attached to mental health issues (Watkins & Neighbors, 2007). While this theme does not necessarily speak to how Xhosa people construct depression, it does speak to help-seeking behaviour once one experiences difficulties, in this case, depression symptoms. Furthermore, although different contexts may construct issues around mental health differently, one does find that there are overlaps in some of the discourses around mental health and men.

"As long as the neighbours don't know as long as this is not embarrassing you then its fine whatever you do" Siyanda, page 6

"He said that he couldn't live anymore it was better if he was dead because what will he say to the people" Sakhumzi, page 3

These two extracts convey the concern with others knowing the difficulties that one experiences. Sakhumzi goes on to make an example of a man who said he would rather die than to have people know of his suffering. His extract speaks to suicidality and possibly the reasons behind it. Bryant-Bedell and Waite (2010) are of the opinion that untreated depression may lead to suicide. Sakhumzi seems to make sense of this as that individuals may resort to suicide as a means to escape having to involve others into their problems, and also having to bear the stigma and shame that is attached to mental health problems in men. Siyanda speaks directly to help-seeking, he suggests that when Xhosa men experience difficulties whatever help they sought, it should not involve other people knowing the "embarrassing" difficulties. This is similar in other contexts as shown by Hoy's (2012) study which found that the most common barrier that stops men from seeking help is the fear of negative judgement. Sakhumzi in another extract shares that *"You have to be careful and choose someone you trust" (page 9).* These extracts, in essence, introduce an importance placed on secrecy and keeping neighbours out of family difficulties, which thus speaks to ways in which people in the Xhosa cultural group may then approach help-seeking. Help-seeking seems to be constructed as exposing the family to shame and embarrassment. This is why it is important for healthcare professionals such as psychologists to invest in building rapport with their patients (Ruane, 2010).

This theme addressed issues of stigma and coping - self-stigma, public stigma as well as the family's fear of shame and stigmatization by the community. The way to cope with this is to keep a family secret. However, while participants from this study consider these difficulties a family secret, some studies have argued that even families may stigmatise mental health problems (Hoy, 2012; Watkins & Neighbors, 2007). The consequence of stigmatization and keeping of a secret is that help-seeking is negatively affected. This leaves the burden within the boundaries of the family or sometimes just within the men himself because at times the family may not be aware of the issue either. However, while men may not communicate with, or be reluctant to communicate with healthcare professionals or even their families, the next theme introduces the idea of men communicating with one another.

Talk to those who understand your manhood, and wear the blazer if you must

"You know when a man (in the cultural sense) wears the blazer that thing is symbolic. When you wear your blazer, you are said to be covering up your problems and embarrassments, especially those in your household. Usually, they have their heads looking down right, so that means you are covering up. It means no matter what might be stressing you or eating at you, it is not something that you can now go around talking about" Siyanda, page 1 and 2

Introducing this theme is an extract by Siyanda, he relates the value of secrecy to manhood. In the Xhosa culture, following the traditional circumcision, the "ikrwala" (new man) wears a certain attire for a number of months. The attire includes formal pants, a blazer, formal shoes, a shirt and a cap or head wrap. Furthermore, the "ikrwala" is also expected to apply "imbhola" (traditional powder) which comes in the colour white, red or orange. Siyanda speaks to the symbolism of that attire and speaks to the importance of covering up one's problems so that others are not aware of them. In other words, covering up is constructed as something very literal (i.e., wearing of the blazer as a sort of cloak or armour) and something more subtle - the man looking down, not facing the world and others. This belief surpasses any kind of situation, meaning that a man is simply expected to protect himself from embarrassment.

"He wouldn't talk to his daughter, he talks to me, and I am not even that close to him, but it is because he likes me, and he understands I am a man" Siyanda, page 2

Thus, the importance of secrecy discussed in the theme before is now discussed specifically in relation to Xhosa men. On top of having to ensure that one's difficulties are not known outside of the family, when men do talk about these difficulties, they need to talk about them to other men. Meaning that, while they trust their family, it seems as though they trust other men more to protect their dignity and not result in them feeling embarrassed. Hoy also found that men preferred seeking support from other men, this gave them a sense of membership into groups of other men (2012). While not directed at men, in particular, Ruane (2010) found that her participants were reluctant to seek professional help from professionals that were not active in their community, as they would not be aware of the minor details in black communities. Although Ruane's study speaks to the general black population, what becomes similar to this mini-dissertation is the idea of membership. It seems as though differences in culture and gender may even influence help-seeking as individuals may be more inclined to seek help from those that they identify with. The participants in my study seem to suggest that although Xhosa men are not supposed to have difficulties, but when they do have

challenges their communication about the challenges should only be directed at other men. It further seems as though when Xhosa men are depressed, depression is constructed to mean different to that of women hence women would not understand it. This constructs a sense of shared understanding based on one belonging to a certain gender. It also means a "real" difference between men and women and this influences the ability to relate and understand closeness not as important but as just belonging to the gender of being male. In relation to depression and mental illness, this raises the question of help-seeking once more. It might suggest that when some Xhosa men seek help for depression symptoms, they are likely to rather speak to men who have undergone Xhosa traditional circumcision, as opposed to someone who hasn't. This may limit the avenues they approach for help. More so because despite the fact that the HPCSA stipulates that 50% of psychology trainees should be black students, Black psychologists are still a minority in the list of registered psychologists (Pillay, Ahmed, & Bawa. 2013).

The picture gets complicated: Religion, class, and age.

The following theme speaks to the exception to the rule placed by cultural expectations. Participants spoke about how while they acknowledge some of the values and beliefs held in the Xhosa culture they don't always adhere to these values and beliefs. This indicates a discourse of resistance to traditional values and beliefs. Each participant mentioned how people could be Xhosa but not necessarily have the same belief as the rest of the cultural group. This theme speaks to the complex nature of social identities, and the diversities within even the same cultural group. Watkins and Jefferson (2013) emphasize the importance of noting the nuances that are found even within the same cultural groups. What is also interesting to note is that Laher's study which was conducted on a Xhosa population found that spiritual illnesses which she considered to be equivalent to mental illnesses, may not always have a negative connotation to them (2014). She found that when spiritual possession happens for a positive purpose and the person is not harmed, then that person would not be diagnosed as spiritually ill (Laher, 2014). Therefore, while for the participants of this study, mental illness, particularly depression is constructed as negative and weak, in a different context amongst the amaXhosa the opposite may be true. This theme also speaks to the influence of industrialization and globalization.

"I'm making an example a man, my mind was opened to a lot of things, as when you are in the Lord most things are no longer determined by the Xhosa culture because there are certain things that no longer benefit me as a man. . . With us Christians we are always

reminded of the fact that whether you are a man or not, that doesn't mean anything, what matters is that you are now a new creation" Sakhumzi, page 4

"When I think about it. My sister, I see depression, I think about it in terms of my worldview. I view it as sin" Sakhumzi, page 5

From the two extracts by Sakhumzi what comes to the fore is that people hold multiple social identities. While Sakhumzi is a Xhosa man, he is also a Christian man which plays into his beliefs and values and how he thus constructs notions such as depression. Sakhumzi speaks of some of the values in his Christian identity that suggest that his manhood means nothing when put before his Christian identity. This seems to suggest that there is a power differential in terms of which discourse holds the biggest influence in defining him as a man. Here, the religious discourse of Christianity seems to have greater power than the cultural discourse of being a Xhosa man. Thus, while in the Xhosa culture manhood is an integral part of men for him it is not. With that in mind, Sakhumzi holds the belief that depression is a sin while other Xhosa men may construct depression symptoms as ancestral displease or weakness. What is interesting to note though is that both his Christian identity and Xhosa culture construct depression negatively and supernatural. He beautifully captures his personal construction when he says, *"I think about it in terms of my worldview".*

"I'm sure that before I even found salvation, I would have given you answers which are similar to those of other Xhosa people" Abongile, page 8

"But for me, I'm saying it's prayer. . . You will even find a verse in Philippians which says, 'be anxious about nothing but in everything, through prayer and supplication address your request to God' and then after doing so, there is this promise now that 'the peace that surpasses all knowledge shall rest upon you'" Abongile, page 8 and 9

Similarly, Abongile brings to the fore the role of one's religious affiliations and beliefs and how they construct the world around them as well as how they influence help-seeking. For Abongile his understanding of things has changed ever since he became affiliated with Christianity. Therefore, while he is a Xhosa man and identifies as one, he also identifies as Christian and thus his beliefs on depression have changed from how they were before. Abongile also speaks of what – as a Xhosa man - he considers as a suitable treatment for depression. He again considers suitable treatment in relation to his Christian belief. Therefore, while the majority Xhosa men would rather speak to family or other Xhosa men, he would rather pray and hold onto God's promise of peace. In his second extract, his Christian belief makes it

acceptable to suffer, to be in need and have trouble. This is in contrast to the traditional cultural notion that suffering means weakness or that it means the ancestors are not pleased with you. Abongile believes even though he also identifies as a Xhosa man that it is acceptable/fine to be suffering due to the promise of God.

"Depression is when you just can't cope anymore; whether its family, its relationships, its career or whatever. That's how I understand depression" Siyanda, page 1

"It's not something I learnt from culture its things I've watched and read on" Siyanda, page 1

Like the other two participants, Siyanda identifies as a Xhosa man, however, there are some of the beliefs that he does not necessarily adhere to. Siyanda attributes his difference in perception to exposure to alternative information. He explicitly shares that he didn't learn these from the Xhosa culture but rather from reading and watching. The idea of exposure to alternative information might speak to class difference, and possibly age differences as well. Therefore, Siyanda identifies as Xhosa, he considers himself to belong to the middle class as he has tertiary education. Holding those identities in society and a tertiary education exposes him to different discourses about depression such as those by the Western society. Siyanda acknowledges depression and reports the knowledge he has is from reading. When talking about other Xhosa people earlier in the discussion, he mentioned how the idea of depression does not exist in the Xhosa culture. Thus, even though he belongs to the Xhosa cultural group he holds an alternative belief to depression and mental health.

"But also, me, I don't have educational background about depression but, since I make it my habit to read about things I don't know; maybe I'm visiting a hospital and I see a poster or disclaimer on the board and then I get to know or maybe watch about it in a movie or something" Nceba, page 2

"I understand that it's something that you get diagnosed with, you are treated for and it can happen to anyone, no one is immune to it and ja" Nceba, page 1

Similar to the other participants, Nceba shares how his beliefs about depression are different from those of other Xhosa people, although he identifies as a Xhosa man. He explains how his exposure to reading and alternative sources about depression, he consequently has a different perception of the illness. Although his extracts do not explicitly speak to an alternative social identity such as a religious identity, they seem to imply class differences. Class

differences may allow people exposure to different kinds of information, for example, more traditional and rural Xhosa individuals may not be exposed to posters about depression due to their environmental exposures. Nceba describes depression as an illness that requires a diagnosis and may be experienced by anyone. Nceba's exposure to other discourses (in this case the dominant medical discourse) - e.g., those found in "Western hospitals and clinics" which would typically also construct depression as an illness, has led to his construction of depression in terms of a disease discourse. This is clearly different from how it might be viewed in the traditional Xhosa culture due to the cultural beliefs and values about suffering. Thus, like the other participants, Nceba is a Xhosa man and acknowledges some of these cultural beliefs but he notes how his ideas regarding depression are different due to what he is exposed to.

In summary, the best way to conclude this theme is through the use of Sakhumzi's utterance *"I mean that I am Xhosa, but my understanding is different" Sakhumzi, page 7.* Similar to what Sakhumzi is saying in this study is an argument made by Lehti, Hammarstrom and Mattsson (2009) who reasons that just because individuals belong to the same culture, it does not mean that their experience and expression of depression will be the same. Culture and gender are said to be fluid, changing and responding to other influences (Johnson & Repta, 2012; Korbin, 2002). This is a worldwide phenomenon. This is also important in terms of intersectionality - that if conducting research within this theory, one should be very cautious not to reify social identities - especially gender and culture in this case. It is important to acknowledge the relative nature of them and to be mindful of the impact (intersection and interaction) of various social identities on each other in how they shape the way discourses (e.g., about depression) are constructed. The participants in my study acknowledge the traditional discourses of depression that has no word and does not exist, but they also construct realities about alternative views. These alternative views are influenced by contexts such as hospital visits, posters, reading and religion and they cause them to understand depression differently from the culture. It thus seems that due to their affiliation to various social identities (defining self as religious or educated), as well as the contexts (e.g., local clinic) they find themselves in, the participants are challenging indigenous knowledges (epistemologies).

The influence of gender on Xhosa men's constructions of depression

From the data, it became apparent that there are certain socially constructed gender roles (i.e., masculinities) in the Xhosa culture that influence how Xhosa men construct and understand depression. These gender roles not only influence how they construct depression,

for they also impact how Xhosa men respond to depressive symptomology. The most common gender role assigned to Xhosa men seems to be "we are providers and representatives of our families". In addition, the themes also address issues about how to deal with difficulties as a Xhosa man. However, not all Xhosa men adhere to culturally prescribed roles, therefore, participants discussed some of these exceptions, and some of the factors influencing the exception.

We are providers and representatives of our families

"I mean I'm a man I've been to the mountain, so I feel a sense of responsibility to ensure that there is food you see" Sakhumzi, page 1

"You even hear sayings like 'you have to sweat in order to eat, a man is a man through their own hard work, so you're supposed to work for yourself'" Nceba, page 8

This theme relates to the need to carry the world despite any difficulties that the man might be experiencing. This idea is similar to the previous discussion on how a man is supposed to cope under all circumstances, which then leads to the conclusion that depression cannot exist. Nceba's extract seems to suggest that a man's identity is defined by works. This theme speaks to the role to provide for the family and to represent the family to the world no matter what it takes. These roles might result in men neglecting or hiding their depressive symptoms with the aim to avoid embarrassing their families. Therefore, emotional difficulties and time spent trying to cope with them may be constructed as an embarrassment to the family.

One of the things that cause that, you know when a man is unemployed; when a man is unemployed, he has no joy. . . So, a man usually feels that they have no role to play as a father because my family is my responsibility as a man" Sakhumzi, page 1

One of the most important roles assigned and accepted by men is the role of providing for the family. Sakhumzi highlights the effects of the inability to fulfil this role due to unemployment. From this extract, it seems as though, the inability to fulfil this role in a specific way may result in depression. These findings are in agreement with literature which found that men attributed the cause of depression to the inability to provide for their families, one study went more specifically explain that the ability to provide is a "masculine signifier" (Aliston & Kent, 2008; Hoy, 2012; Ritchie, 1999). Also, untreated depression can cause unemployment, which may further exacerbate feelings of depression. Sakhumzi reports that "*He has no joy"* suggesting that one of the possible causes of depression in men is from being unable to provide

or fulfil one of the fundamental/important roles. Sakhumzi furthermore seems to suggest that it is caused by the pressures placed on them to fulfil this role without any exceptions.

"Because we are providers it doesn't matter how educated and wealthy the woman is. I am a provider; I'm building a home and a comfortable life for her" Siyanda, page 7

Like Sakhumzi's extract, what stands out from this extract is the compelling need to fulfil the assigned role of the provider. The discourse here seems to be about how the role of the provider is so embedded that even if the role of women became more "equivalent" or similar to that of men in terms of earning power and education, he is still seen as the principal provider for her. If this role is deemed so important that it is seen as unchangeable, then one may speculate what happens to a man committed to the "provider discourse" who experiences depression. The prioritising of this role and the importance attached to it might mean neglecting his own mental health. The literature shares the same sentiments, that some men attribute depression to the inability to provide for their families, but literature also notes that men may overcompensate for depression by overworking themselves (Alliston & Kent, 2008; Hoy, 2012; Ritchie, 1999). In the context of my study, it means that if a Xhosa man who must be the provider at all costs also suffers from depression and copes with it through over-working this may compromise his mental health even further. It thus seems that there is no space for the experience of difficulties and the acknowledgement of such difficulties. Therefore, the Xhosa culture and masculinity intersect and interact in such a way that it may compromise mental health.

"As a man, you will be seen as a person who is going to have a say in the family. Meaning now you have this social status that you have to have" Abongile, page 3

"We are just told to know our priorities so that we don't embarrass our families because we are representatives of our families" Siyanda, page 4

Failure to provide for the family in a way that is expected seems to be interpreted as shame, not only to the man but to the family as well. The extracts above seem to suggest that the assigned role to provide surpasses all other aspects of one's life. Thus, while one may be suffering from depressive symptoms from life's challenges or even from not being able to provide for their family, they still need to find ways to ensure that they provide. Therefore, the symptoms might be ignored so as to ensure focus on the role, as well as to ensure to represent the family as a "strong" man. As I argued above, Xhosa men seem to be constructed as having to be strong despite the severity of their difficulties.

Men are never defeated

Siyanda spoke about the role of a man which is to be able to handle everything and not let it defeat you. This expectation is treated as though it is an inherent ability that is found in men. The participant makes mention of the need to ensure that nothing defeats you as a man. While this means dealing with your difficulties however way you can, there are limitations to how one deals with them. It is important to keep in mind the themes discussed above, about not embarrassing your family and involving or disclosing to strangers. Bearing this in mind, it seems that when dealing with the difficulty, men might not seek professional help or even admit to having any challenges because of the concerns of embarrassing and putting their families to shame.

"so, if there are things eating at me, I must make a way doesn't matter who I talk to, I must find a way and get over it. It shouldn't get to a point where this thing defeats me" Siyanda, page 3

"You must always understand that you can do it" Siyanda, page 3

"When you go for initiation and you're declared a man that's the gist of it. Nothing is supposed to break you, even if you lose a loved one, even if your baby dies, even if your mother or your father dies, or whatever it is, you are taught there you are a man you are supposed to take it, and you're not supposed to cry about it. You are a man, you're supposed to take it" Nceba, page 6

What becomes apparent from Siyanda's extracts is the discourse around expectations about men in situations that are associated with depression, loss bereavement, that men should accept it without negative emotion. Because men need to conquer all and make sure not to be defeated and at the same time not show their weakness, they may search within themselves for a solution. In the second extract by Siyanda, he seems to suggest is that there is an expectation that men should be able to handle anything because it is inherent to them to manage with any difficulty. A study on black African American also found that these men experience the pressure to be "tough" and "put together" in the face of difficulties (Watkins & Neighbors, 2007). The discourse is thus that after initiation men are naturally able to cope and handle any difficulties. Nceba lists a few instances that he might think of as stressful events, he highlights how even in these difficult instances men who have undergone initiation are not permitted to express any "soft" emotion. He shares that what men may be taught during the initiation process is that they are men and that they can handle anything. This again speaks to the expectation

that it is inherent to men to be able to handle any difficult situation. He reports that men cannot cry about things. Crying is one of the reactions people might expect to see in a depressed person, therefore, one might wonder how then some Xhosa men who adhere to this expectation might express, label and recognise their experience of depression. Like depression, it is typically "female" expression of emotion - which is a challenge to more traditional masculinity of strong and never-to-be-defeated men.

"The first that is a remedy for depression is alcohol because at least you can use a couple of hours away from your thought line. . . But the second thing is like you know this human contact thing. They will just say you know; they'll be thinking maybe a few moments of fun maybe sleeping with a person" Abongile, page 8

Abongile mentions some of the ways in which men may remedy depressive symptoms. Similarly, Hoy (2012) found that in most of the studies she reviewed, men used alcohol, risky sexual behaviour and work distraction as a means to cope with emotional difficulties. Considering that they have the need to ensure they are not defeated, these ways of dealing with difficulties may be used. These ways of coping may be used especially considering that men may seek solutions within themselves in order to avoid embarrassing their families and at all costs to avoid defeat.

Big boys don't cry

In this theme, participants made a clear distinction between the female assigned role and the male-assigned role. What is interesting to note about the distinction is how emotional difficulties seem to be readily acknowledged by women and that these women take the time to deal with them as something internal rather than a sign of weakness or ancestral displease. Literature suggests that it is more acceptable for women to express "soft and sad" emotions while it is unacceptable for men (Brownhill et al., 2002; Hoy, 2012). This is interesting because it highlights how culture specifically interacts and intersects with masculinity in constructing emotional difficulties as weakness and cultural displeasure. While when culture interacts with femininity it constructs emotional difficulties differently. For Xhosa men and some men in the studies that Hoy (2012) reviewed the acknowledgement of such feelings or rather emotional difficulties is made equivalent to femininity. While for women acknowledging emotions is not seen as weakness, but rather seen as feminine, what is seen as feminine, when it is performed by a man it is seen as weakness. In agreeance with these findings are findings in Brownhill et

al. (2002), they found that depression is associated with femininity and femininity is considered as defiance to masculinity. Femininity seems to be associated with irrationality. Participants thus made clear distinctions between the roles, ensuring to make clear that men need to be stern and less emotional. Therefore, with that expectation, one might find men shying away from internal or mental difficulties, or difficulties that may be termed as emotional difficulties as these are feminine. And femininity, when performed by men, seems to be a sign of weakness.

"Women see depression as it is, they see it as it is. . . Women are gonna see it as, okay she's depressed let's encompass her, let's cover her let's support her in this thing" Abongile, page 4 and 5

"The fathers have this, this sternness you know" Abongile, page 11

This participant was asked about what he thinks the acceptable treatment options are for depression in the Xhosa culture. He mentioned how fathers and mothers respond differently to their depressed children, and he attributed this to gender roles. He notes that the nurturing role that is assigned to women allows them to acknowledge depression and its symptoms. From what he says it seems like women are attuned to each other's mental health and are protective of each other. This thus constructs women as caring, perceptive, and supportive concerning depression specifically. Therefore, because they are assigned and in turn accept and enact the role of nurturers, they are allowed to be in touch with their emotional world. He further speaks about how fathers have a sternness to them. Additionally, he suggests that the role to be stern results in it becoming challenging to access their feelings and empathy towards emotional difficulties.

"And now that people are treating you differently because you are a man, and that means now I have to take a stand and become more like my father. And now that will also be accompanied with you seeing things that have to do with women as being uhm, a sign of weakness" Abongile, page 3

"And that person who is a leader is also engineered biologically to not show any, to just show this sternness and also this balance in things that's why we tend to internalize things" Abongile, page 2

In these two extracts, Abongile talks about the expectation for him to be like his father and how attached to that expectation is the covert teaching that anything to do with women is a weakness. This extract also speaks to the association between roles assigned to women and

weakness when they are performed by men. Previously the findings suggested that social identities related to class, education and religion challenge existing notions of depression for the participants. However, it seems when it comes to being a man and being a woman, the discourses surrounding the gendered Xhosa men seem more resistant to change through challenges. In the last extract, Abongile assigns the sternness to a man's biology, further constructing male roles as roles that are inherent to a man, thus constructed as something that is inescapable and unchangeable. Furthermore, Abongile suggests that this is the reason why men internalize their problems. This seems to mean that these men actually do have problems that they experience but they are experienced internally and acted out through behaviours such as substance abuse, sex and working hard. This is done to be able to provide and to be a stern male like their fathers.

The exception to the rule: Alternative priorities and responses to expectation

In this theme, participants speak about instances in which some men do not abide by these roles which in turn impacts on their construction of depression. What is important to note from this theme is the intersectionality of different social identities; that while a man might be a Xhosa man, he may also be a Christian man which in its own has its own expectations of him. The expectations might not always be the same, and individuals might prioritise expectations differently; either prioritising their religious expectations or cultural expectations. However, the expectations might be similar, for example, a Christian man - just as a Xhosa man - may not be encouraged to embrace aspects of femininity. Therefore, there are gendered expectations that seem to appear across their social identities.

"But for me, my view compared to Xhosa people on depression, I'd say really since we are people in general, we are like, depression is inevitable if you are in a certain situation. . . So, for me, I know that we all subjected to having that state of mind, that you are what you are stressed to the point that you are getting close to depression" Abongile, 2

In the previous theme Abongile spoke about how men are biologically engineered to have a certain kind of balance, and how he is expected to be like his father, he also mentions in this theme that he feels everyone could have depression. He particularly reports that we are all subjected to the state of mind, and he makes no exceptions to men or people with certain assigned roles.

The intersection between the Xhosa culture and male gender in the construction of depression

The assumption of this study is that gender, culture and mental health do not exist in isolation. Rather, they intersect and inform or influence each other reciprocally. The data strongly suggests an interplay between both the construction of the Xhosa culture and the male gender. Furthermore, it seems to suggest an intersection between the Xhosa culture and male gender in the construction of depressed. What was evident was that when participants spoke about their gender roles as men, they were mostly speaking in the context of the Xhosa culture. Therefore, the idea of the intersection of the social identities of the participants in this study is already discussed in the previous themes. The following two themes also speak to the intersection and interaction of masculinity and the Xhosa culture. This discussion is brief because as mentioned before, the previous themes also spoke to the intersection of the social identities in this study. The first theme speaks to the male gender particularly in the Xhosa culture and how this may affect the constructions of depression. The theme on "membership into ubudoda" speaks to the nature of gender in the Xhosa culture.

Membership into ubudoda

The following theme speaks to the male gender in the Xhosa culture, it particularly highlights the complexity involved in the construction of the notion of a Xhosa man. In this theme, it becomes evident that manhood in the Xhosa culture is not only gender with gender roles from the time of birth, but rather that there is a time where a boy is exempted from the cultural expectations associated with being a man. This seems true even in Mfecane (2016) where he found that the enactment of the gender roles expected from “indoda” does not make a boy a man, because these gender roles have to be preceded by traditional circumcision in order for them to qualify a male as a man (i.e. indoda). This highlights a particular point of transition from being a boy to being a man and the expectations of a man, particular to the Xhosa culture. After having addressed some of the above-mentioned ideas, this theme focuses on the impact of the transition on the construction of depression amongst these men and how these men may respond to depressive symptoms.

“ubudoda is about the ability to carry the world on your shoulders. So, I need to understand from the get go that I can conquer it no matter what it is. I’m given a way of thinking that ‘I can always come up with a plan’ so if there are things eating at me personally, I must make a way doesn’t matter who I talk to” Siyanda, page 3

"Because even before you became a man, you didn't care much, in fact even before you reached puberty you were still having times when you play with girls and so on. When you are acting like a boy, you are being associated to acting like a child. Now when you are coming into manhood that's when you start having that shift in your mindset" Abongile, page 3 and 4

The two extracts by Siyanda and Abongile speak to the transition from being a boy to becoming a man in the Xhosa culture. They seem to highlight the nature of this change as a transition and not just a change in one's physical body in terms of the removal of the foreskin. Abongile speaks about how a boy's behaviour is interpreted as simply behaving like a child, whereas once he undergoes traditional circumcision his mindset changes from that of a child to that of a man. Siyanda describes ubudoda (manhood) as being about carrying those around you, particularly your family, and having responsibility for them.

When you wear your blazer, you are said to be covering up your problems and embarrassments especially those of your household. Usually, they have their heads looking down right, so that means you are covering up, it means no matter what might be stressing you or eating at you, it is not something that you can go around talking about" Siyanda, page 1 and 2

Following coming back from the mountain the ikrwala is required to wear certain attire, and when they wear this attire, they are expected to uphold a certain demeanour. Ikrwala is a word used to refer to a Xhosa man who has recently come back from the mountain for traditional circumcision. Before discussing what Siyanda says in the extract above, it is important to consider the significance of the attire in terms of membership. The expectation for certain roles, as well as a different attire to everyone else, seems to suggest that the person is entering into a membership. Siyanda further speaks about the significance of the attire, which is to teach the new man the responsibility to hide embarrassment and to cover up their problems. As it was mentioned in themes above, the need to hide difficulties might influence the construction of depression as a secret, as a family matter. This might influence how these men seek help, as well as where they allow their families to seek help. Similarly, Ruane (2010) found that cultural beliefs act as a major barrier in help-seeking for some South Africans.

"So, when you are moving from being a boy to manhood, anything that shows a sign of weakness, as you are this new man because you have to prove yourself in a way according to how society views it. So, anything that distorts that mission of yours or disturbs it in those

early stages of transitioning from being a man, you try to run away from it because you know it's gonna affect you at some point" Abongile, page 4

"And there is an element of peer pressure, there's an element of peer pressure there and you know sometimes people would find ease at who they are when they're amongst their peers and get approval from their peers" Nceba, page 6

"So, men see it as something that isolates you from the flock that isolates you from the group" Abongile, page 5

In this extract, Abongile seems to highlight again the idea of membership and the need to prove that one is worthy to be a member of manhood in the Xhosa culture. Similarly, Nceba seems to suggest the idea of membership and that there is a need to find approval and validation of one's valid identity as a man from this group. Therefore, manhood is not just a set of gender roles, it is a membership which one needs to prove their commitment to it. Mfecane (2016) argues that once a man is reintegrated into their community his manhood status is judged less by having a circumcised penis and more by his conduct in society. Abongile speaks of the need to maintain one's attention to proving their worth in the membership, so much that they need to guard against anything that might sway them from that mission. He highlights that a man proves himself in the way that society expects, this means that anything that might make the man appear weak is avoided to ensure that their membership is secured and maintained. In the last extract Abongile shares that some Xhosa men see depression as something that isolates them from membership into manhood. Thus, it seems to be constructed as a threat to one's social belonging. In another question, Abongile is asked what he thinks Xhosa people might think causes depression, he responds *"I've noticed this like, people value being part of a social group but not social groups as friends. If there are events taking place around and then you're always excluded because maybe you've been to hospital (surgical circumcision) it even goes down to your manhood. Uhm ja its exclusion from social gatherings which can also lead things to like uhm. ." page 13.* He seems to suggest that being excluded from social gatherings, particularly those of a group you identify as a member of, can lead men to depression.

"Really you have to be strong whether you can or not so from there that will be how you approach life in all challenges even nice ones. Culture in my understanding of depression, the problem is, it is not something that was spoken of in all the things I have learnt there (at the mountain)" Siyanda, page 3

Central to the male gender in the Xhosa culture is traditional circumcision as is evident above. One participant noted how teaching on mental health issues was not mentioned at the mountain. Thus, this raises questions about whether some Xhosa men are likely to consider it as important if it is not given any considerations their teachings during the initiation process.

The need to be the alpha male

Participants spoke about the patriarchal nature of the Xhosa culture and how that, in turn, influences some of the constructions of masculinity. Common amongst the participants was the idea of the man being the leader or occupying the alpha position in the family, and the need to maintain that status even amongst other men. This theme speaks to the patriarchal nature of the Xhosa culture and how that translates into how Xhosa men are and are expected to be. It further highlights how Xhosa culture constructs a hierarchical structure between genders and this impacts on how men relate to women and vice versa. The patriarchal nature of the Xhosa culture constructs the male position in a specific way, particularly as the leader or the alpha position. The culture is then in turn influenced by these gender roles in their beliefs and values about men and mental illness.

"I mean to us as men, they always stress the fact that one should not be controlled by a female. If a man is controlled by his wife, there is nothing they can say, what I'm trying to say is that in our Xhosa culture a man is even shy to hang clothes on the washing line" Sakhumzi, page 4

"Coming to the Xhosa culture, it's like we, Xhosa men at first are seen as being people who are arrogant, and that arrogance is also linked to dominance over women or any female figure of any culture especially now those who are within our culture. So, if now you are deep, if you go on now to this level of depression, especially in such a culture, that's where now you show a sign of weakness. And even other men now outside, not only females, other men can use that to prey on you" Abongile, page 1

The two extracts above speak to the hierarchical nature of the Xhosa culture which translates into hierarchies in the gender positionings. The two participants explicitly talk about the position of men in relationship to that of females in the culture. They seem to suggest that men are seen as leaders, while women are below or dominated by men. Sakhumzi in his extract suggests that men in the Xhosa culture are even embarrassed to perform tasks that are typically considered feminine. Abongile speaks of how depressive symptoms would be interpreted by

some men in the Xhosa culture, he speaks of it being associated with weakness. He further highlights that depressive symptoms may be seen as a threat to a man's desired position to be the alpha, to lead. Therefore, this might suggest that due to the need to remain the leader, men in this culture may hide their symptoms or even disregard them because of its explicit association with weakness and femininity as opposed to mental illness that requires help.

"We honour dignity and respect as Xhosa men, so losing the respect and dignity can be fatal. Like if you are unemployed as a man, you're still living with your parents; you would see that you will not receive the respect of the person who is employed. Because there is that belief that a man has to be responsible for themselves. If you can't provide for yourself, you're not 100% regarded as a man and that can be fatal" Nceba, page 9 and 10

From the extract above it seems as if in the Xhosa culture dignity and respect are highly regarded and they may be associated with the validation of a man's identity. This is especially linked to employment. Nceba suggests here that men in the Xhosa culture perceive that it is important to be respected by others, to be seen as a real man which might speak to the hierarchical nature of the culture. The structure of the culture seems to influence the construction of a man as needing to maintain that hierarchy by fulfilling those roles that maintain him as a leader. Failure to live up to the expectations of manhood seems to mean the loss of respect and dignity which seems to be an integral part of manhood in the Xhosa culture. These expectations and ideas of manhood, as mentioned multiple times above, may result in men hiding anything that might pose a threat to their ability to live up to the expectations placed on them. This is because the failure to live up to these expectations seems to invalidate the man's identity. Furthermore, Nceba uses the term "fatal" which seems to construct the loss of a man's identity as equivalent to death or damage.

The figure below serves as a demonstration of the overall findings of this study in a diagram format. This diagram demonstrates a continuous field of interaction between the different social identities and depression (as discussed in *Chapter 1*). It suggests an influence *on* gender/Xhosa culture/ depression, while an influence *by* gender/Xhosa culture/depression is also suggested. This idea was discussed briefly in *Chapter 1* in the synergy between research approach, method, methodology and theory.

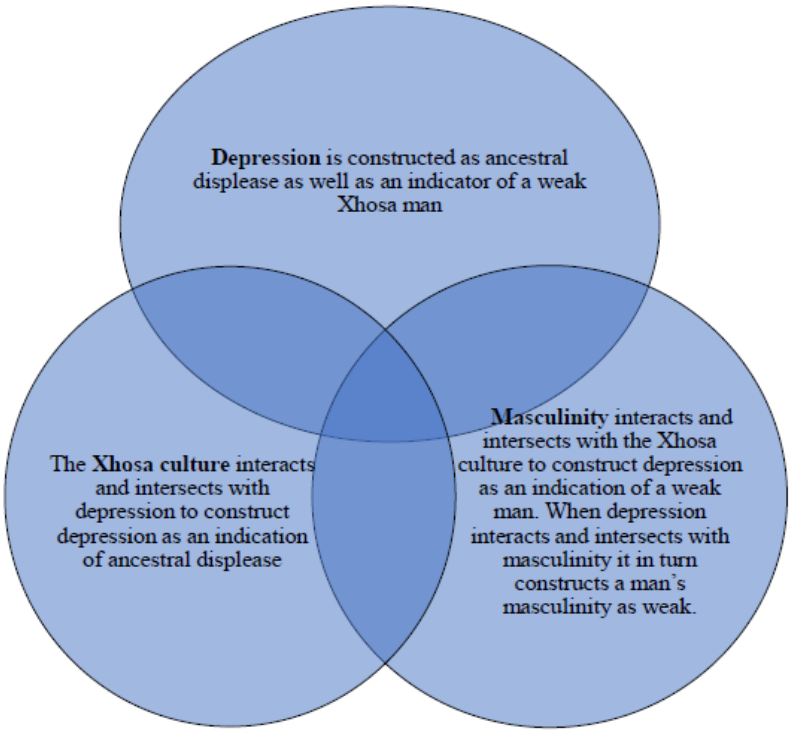

Figure 1: Demonstration of findings

Summary of chapter

This chapter presented a detailed analysis of the four participants that were interviewed. Following the thematic analysis method, each transcript was analysed. The steps that were followed are described in *Chapter 3* under the "thematic analysis as a method of analysis" section. The way in which the themes were presented in the mini-dissertation was such that they corresponded which each of the objectives of the study. Each participant was given a pseudonym to maintain confidentiality. Direct quotations from the interviews were used throughout the chapter in order to better capture what they meant as well as to support the findings.

All four participants were able to speak of the influences of culture and gender on their constructions of depression. The findings appeared to be in concordance with some of the literature regarding the intersection of culture, gender and depression. Furthermore, the findings also suggested that the processes of knowledge construction involve co-construction between individuals and socio-cultural structures.

CHAPTER 5: CONCLUDING REMARKS

Introduction

This chapter presents a brief discussion of the main findings in relation to the assumptions of the study, and how these findings answered the research question. To acknowledge my capacity to shape and influence the research processes, this chapter will also present a section on my reflexivity processes. The suggestions and recommendations for further research will be briefly discussed. Finally, the strengths and weaknesses of the research study are considered.

Summary of study

As a social constructionist research, this study holds that reality is co-created and that there is no single fixed truth to be discovered. In the context of my study, this means that the findings and discussions are not to be seen in absolutist terms. My study does not proclaim to tell the ultimate truth about Xhosa men's constructions of depression but rather it tried to remain cognisant of the relative nature of truth. In addition, it remained cognisant of the fact that the presented constructions of their discourses are possible ways of understanding, that these ways may change over time (for them) and that they may have been understood differently by another researcher. Research conducted from a social constructionism theoretical approach furthermore subscribes to the idea that knowledge, values, and social institutions are the products of social interactions and they are not separate to human influence (Gergen, 1985).

In the context of this study, the participants clearly illustrated how it is interaction with different discourses in different contexts and alignment with different social identities that influenced their constructions. Furthermore, Gergen's argument is also true in relation to this study in that it is only through interactions with the participants and my own set of values and social identities that I could make meaning of the participants' understanding. Thus, nothing is taken for granted in a study such as this one, as knowledge is considered to not be universal (Edley, 2001). Which means that this study does not claim that these constructions are true for all Xhosa men. The fundamental premise of social constructionism includes the importance of language in constructing reality (Cresskill, 2009). This study found that the participants struggled to find a term in isiXhosa that is an equivalent for depression. The findings emphasized the non-existence of depression as a result of not only gender norms (i.e., depression cannot exist for Xhosa men) but also because of a lack of a term for depression.

Furthermore, the influence of language on the participants' constructions was not limited to spoken language but written language as well. Posters on depression constructed a different reality about depression to the reality constructed by the Xhosa culture and male gender. According to social constructionism individuals not only construct reality, but they are beneficiaries and victims of the reality (Cresskill, 2009). In the context of this study the construction of "Xhosa men are strong men" and the accompanying pride of this type of masculinity may be positive or beneficial in that it may be good for Xhosa men's self-esteem. However, similarly, such a construction may deter a depressed man from seeking help, thus making him a victim, or at least not a beneficiary of reality.

The assumption of this study is that gender, culture and mental health do not exist in isolation. Rather, they intersect and inform or influence each other reciprocally. Throughout the analysis chapter, a pattern was found in which participants report on instances where their construction of depression is influenced by their culture and gender. They further report on how depression constructs a depressed man (gender) as weak and a Xhosa person (culture) as not pleasing to the ancestors.

This study complements the findings of other studies although the contexts are different. For example, both my study and other studies (such as Ellis (2003) and Tomlinson et al. (2007)) conducted in different cultural groups in South Africa found that depression can be understood and constructed as a sign of ancestral communication to the individual. Furthermore, literature from different continents found that men may conceal their depression symptoms to avoid stigmatization and being labelled as un-masculine (Cabassa, 2007; Hoy, 2012; Watkins & Neighbors, 2007). These similarities between my findings and other studies are found in the major themes; however, the nuances of these themes are different.

For example, while Laher (2014) found that depression may be a sign that an individual is called to be a traditional healer (i.e. making it a positive sign), my study found that depression may be seen as a sign of ancestral displease (i.e. making it a negative sign). In addition, some literature suggested that depression is located internal to the person (i.e. headache, fatigue) (Ellis, 2003; Tomlinson et al., 2007), while my study found that participants located it external to the individual (i.e. from a supernatural force).

An interesting contribution of my study is that it indicates how identities other than being male and Xhosa influence, and at times challenge traditional cultural discourses. The men in this study did not only draw their constructions from being Xhosa and male, but they

also drew from their religious identities, their class identity, and level of education. In these cases, these other identities challenged traditional discourses. For example, one participant understood depression as a mental illness instead of ancestral displease. He attributed this difference in construction to his level of education. This speaks to two of the major tenets of intersectionality (discussed in *chapter 2*) one being that social identities are multiple and dependent on each other. The second tenet emphasizes the intersection of different social identities in yielding disparities and advantages. The participants in my study clearly showed that there are similarities in how Xhosa men construct depression and masculinity. But they also showed differences in how Xhosa men construct depression, which speaks directly to the notion of a relative stance to culture.

In conclusion, my study does agree with existing literature and it also adds to what is already known. Furthermore, this study also contributes to indigenous knowledge within the domain of psychology. The findings of this study highlight the nuances in how depression may be reported on and understood in the Xhosa culture, as one of the indigenous cultures in South Africa. While studies may be conducted in South Africa, the culturally diverse nature of the country requires studies on specific populations to capture between-culture differences.

Reflexivity

Researchers are encouraged to talk about their presumptions, their choices, actions and experiences during the research process (Ortlipp, 2008). In a social constructionist study such as this (as discussed in *chapter 3 and chapter 5*) knowledge is co-created between the researcher and participants (Morrows, 2005). The findings are not "pure" representations of the participants' reality, but a product of a co-constructed discourse between me and the participants. This underscores the importance of reflexivity as a means to ensure the research is credible and that the researcher is aware of their role in knowledge production, as well as the power dynamics at play in that process. This reflection aims to consciously acknowledge my assumptions. I am a Xhosa female who is currently an intern clinical psychologist.

Personal dimension

From the beginning of my master's in clinical psychology degree, I went into the programme with the interest in understanding and reconciling African culture and psychology. I grew up in an environment where there were people who suffered from what I now know to

be mental illness. Although I now acknowledge that they were suffering from mental illness I still leave room for the cultural and spiritual aspects of the experience and understanding. Thus, my assumption is that there is a cultural and spiritual aspect to mental health.

Riding on this inspiration I went into the data collection process curious of what others think, particularly other black Africans. I also had the need to allow black Africans the opportunity to think and reflect on mental illness and what it means to them. My presumption here was that Africans are neglected in the conversation around mental illness, instead, they have diagnosis and labels given to them without the opportunity to share what the symptoms and the diagnosis mean to them. Interestingly, this was encouraging for me and gave me an inclination to allowing open interviews as I was also aware of my status as an intern clinical psychologist and the power dynamics that result from this status. Because I was aware of this status and it worried me, I noticed myself interact with the participants in isiXhosa our home language in order to relate with them as a Xhosa person instead of as a clinical psychologist.

In the Xhosa culture, the details regarding manhood and ulwaluko are exclusive to men and women are not allowed to know such details. This cultural dynamic possibly had an impact on the degree of openness from the participants and certainly impacted on the way I approached the research process. For instance, during the recruitment of participants and the interviews I was cautious - perhaps overly cautious - that asking these men about manhood and asking them to think about the concept with me as a Xhosa woman in their presence, that I would be met with resistance. I was concerned that the participants would find me disrespectful and that they would assume that I have abandoned my culture for my studies. This makes me aware of the possibility that the depth of the information I received may have been limited by their need to conceal and keep sacred the tradition. This is because of my position as both insider (Xhosa) and outsider (woman and researcher). Thus, they constructed their accounts based on what they may have thought would be acceptable to me whilst still honouring their construction of tradition of masculinity within the Xhosa culture. I was not an “objective” observer but an active agent and participant in what discourse were revealed and acceptable and which were hidden and thus unspoken.

However, I found that participants were quite comfortable speaking to me. I was also surprised that the participants took on a critical stance to their reflections. The participants were able to for example share that they think the Xhosa culture contributes to depression in men. This made it more comfortable for me to probe and ask for examples and more detail, without

feeling as though they will think I am crossing the line of respect for the sacred practice of ulwaluko (traditional male circumcision). This thus allowed for in-depth interviews.

Reflection on research process and approach

Before pursuing this research study, I had conducted research interviews for a research project that I conducted in my honours year. Going into this research study I already thought to myself that I have an internal model of how to conduct interviews in a qualitative study. In addition, my supervisor and I had supervision on how to conduct research interviews. These two experiences somewhat prepared me for the interviews. Also, as an intern psychologist, one is encouraged to approach patients with empathy, to ask open-ended questions and to probe without assuming that you know what they mean. Therefore, this knowledge, and having had practical experience of it I approach the participants with a curiosity to know their thoughts. Despite knowing the Xhosa culture as a Xhosa woman, and despite feeling as though I could relate with the participants due to our ethnicity, I think that I was able to let them explain things in their own terms. As I discussed in the data collection section of *Chapter 3*, semi-structured interviews allow participants to elaborate and explore outside of the listed questions, which is enriching to the data. Furthermore, although the structure of the interviews was helpful to me, the fact that it allowed me explorative space meant that other interesting avenues could be pursued. For example, participants were allowed to further elaborate things such as the involvement of religion in their constructions.

The participants of the study were Xhosa men who were not at the time diagnosed with depression. This is why the study was social constructionist, however, had the participants been diagnosed with depression then the methodology of the study would have been phenomenology and focussed on their lived experiences of the phenomenon of depression. Furthermore, considering my sample number, the semi-structured interviews, and the participants' openness, the study seems to have achieved its purpose which was to explore meaningfully. Considering that I am a female, and the participants are male, as discussed in the personal reflection, I was worried that they would not share openly with me. However, I found that they were willing to share, although they may have concealed some information. I think that the quality of the information they gave me was enough for me to write a meaningful discussion of the findings. Furthermore, the data was transcribed and translated by myself which allowed me to be more exposed to the data even before the process of analysis.

Furthermore, three of the participants were from an urban area while one was from a rural area. I approached the interviews expecting to see a significant difference in the way that

the participant from the rural area interacts with me compared to the ones from the urban area. However, the interactions did not seem too different. The one difference that I noted though, was that the participant from the rural area seemed more grateful for the opportunity. I thought that this was an indication that they might think highly of this research and the opportunity to be a part of an academic research. My interview with him lasted longer than my interviews with the other participants which made me think that maybe he wanted to give me as much information as possible. The participants were given the option to speak in isiXhosa or English if they wished too. Although this decision was made because both the participants and myself are isiXhosa speaking, the implication of this may have also that it helped to build rapport. The participants may have felt that they could relate better with me as we were speaking in our native language.

Implications of findings

This study raises awareness on men's mental health in general, and particularly their constructions of depression. The literature discussed in the background section (*Chapter 1*) highlighted the high prevalence of suicide amongst men and how this might speak to underdiagnosis of men with depression (Kilmartin, 2005; Lepine & Briley, 2011). Thus, this study as stated above sheds light on mental health in men, which in turn might help inform mental health practices around men. Further, this explorative study provided a limited yet meaningful perspective on how Xhosa men in general construct depression. In light of these findings, health care professionals may have to be aware of how some patient's depression may not fit neatly into categories such as the DSM (Philips et al., 2012). They may thus have to have a different perspective to the findings of their consultation and investigate more into patient's (men) symptoms.

In addition, the findings of this study suggest that men prefer practical solutions to emotional difficulties and that men in this study are socialised into believing that they need to have practical solutions to their problems. In light of these findings, health care professional may have to integrate more practical interventions (such as Cognitive Behavioural Therapy) when working with men.

This study found that in the Xhosa culture emotional difficulties may be thought of as related to ancestral displease, and the findings also suggest that men's emotions are not paid much attention to. This is because men are thought of to have the inherent ability to handle any

challenges without them having an emotional impact on them. Diagnostic criteria such as the DSM for depression is thought of to have typically feminine symptoms resulting in the underdiagnosis of men (Kilmartin, 2005). Such findings encourage more researchers to seek to understand and research men's emotional experiences and constructions as well as those of Africans. More so because research has called for the development of an indigenous psychology, especially in Africa (Bodibe, 1993; Dawes, 1985).

Strengths and Limitations of study

This study presented with the following limitations:

- The study included a small sample size, although meaningful information was obtained for the purposes of this study, having more participants may have provided more information and nuances on Xhosa men's constructions of depression.
- As it was mentioned in the reflexivity section, the difference in my occupation as both a researcher and intern clinical psychology and that of the participants may have resulted in the play of power dynamics. Participants may have felt the need to provide me with information that they thought I wanted to hear. Thus, resulting in findings that are not entirely true to the participants. In addition, the idea of the sacredness of traditional circumcision in the Xhosa culture, and the importance of ensuring that women (even Xhosa women) do not access information regarding traditional circumcision was discussed. This may have meant that participants concealed certain information which could have provided the study with better insight.

This study presented with the following strengths:

- The approach used to conduct this study was a qualitative research approach. This approach manages data in such a way that it maintains the data complexity and context. Although one may argue that the study is not generalizable Larsson (2009) argues that each specific case has a role to play in the bigger picture. Therefore, this study allows us to understand the specifics as part of a larger picture, which is men's mental health.

Recommendations for future research

Future research in this area is greatly needed as the focus on literature has been on mental health and women. More insight is needed in regard to men and mental health.

- This study sampled participants from Grahamstown. The Xhosa culture including the Eastern Cape contains a great deal of diversity. Within the Xhosa culture, there are tribes such as *amahlubi, amamfengu,* and *amabhaca* amongst others. Research may benefit from specifying which tribes participants come from to obtain a more nuanced set of data.
- As seen in the literature review, South Africa is a diverse country, thus, research on depression with men in other ethnic groups in South Africa is necessary.
- The discipline of psychology would benefit from research focussed on psychotherapists and their experiences with patients who come from a different ethnic group to them. This would possibly inform help-seeking.

Summary of chapter

Social constructionism emphasizes co-construction, suggesting that the researcher is also involved in the process of knowledge production. This chapter presents my reflections as an active member in the generation for the knowledge produced by this study.

This study provided valuable information concerning the general constructions of depression amongst Xhosa men. The information provided by this study corresponded and added to the already existing literature on men and mental health. This study contributes to indigenous knowledge and the indigenization of psychology. In addition to that, this study contributes to knowledge around the intersection and interaction of masculinity, the Xhosa culture and depression. The strengths and limitations of this study are also discussed in this chapter.

REFERENCES

Addis, M. E., & Cohane, G. H. (2005). Social scientific paradigms of masculinity and their implications for research and practice in men's mental health. *Journal of Clinical Psychology, 61*(6), 633-647. doi: 10.1002/jclp.20099

Alston, M., & Kent, J. (2008). The big dry: The link between rural masculinities and poor health outcomes for farming men. *Journal of Sociology, 44*(2), 133-147. doi: 10.1177/1440782308089166

Ally, Y., & Laher, S. (2008). South African Muslim faith healers' perceptions of mental illness: Understanding, aetiology and treatment. *Journal of Religion and Health, 47*(1), 45-56. doi: 10.1007/s10943-007-9133-2

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.) Washington, DC: American Psychiatric Association.

Anderson, K. K., & Mukherjee, S. D. (2007). The need for additional safeguards in the informed consent process in schizophrenia research. *Journal of Medical Ethics*, *33*(11), 647-650. doi: 10.1136/jme.2006.017376

Anderson, H. (2012). Reflections on Kenneth Gergen´s contributions to Family Therapy. *Psychological Studies, 57*(2), 142 – 149. doi: 10.007/s12646-011-0121-y

Anike, U., Govender, I., Ndimande, J. V., & Tumbo, J. (2013). Complications of traditional circumcision amongst young Xhosa males seen at St Lucy's Hospital, Tsolo, Eastern Cape, South Africa. *African Journal of Primary Health Care & Family Medicine*, *5*(1), 1-5. doi: 10.4102/ phcfm.v5i1.488

Aarseth, H. (2009). From modernized masculinity to degendered lifestyle projects: Changes in men's narratives on domestic participation 1990–2005. *Men and Masculinities, 11*, 424–440. doi:10.1177/1097184X06298779

Banks, K. H., & Kohn-Wood, L. P. (2002). Gender, ethnicity and depression: Intersectionality in mental health research with African American women. *African American Research Perspectives, 8*(1), 173-184

Bhugra, D. (2008). Cultural aspects of mood disorders. *Psychiatry, 8*(3), 87-90. doi: 10.1016/j.mppsy.2008.11.002

Blaikie, N. (2000). *Designing social research*. Cambridge, MA: Polity.

Bodibe, R. C. (1993). What is the truth? Being more than just a jesting Pilate in South African psychology. *South African Journal of Psychology*, *23*(2), 53-58. doi: 10.1177/088124839302300201

Bowleg, L. (2012). The problem with the phrase women and minorities: intersectionality - An important theoretical framework for public health. *American Journal of Public Health*, *102*(7), 1267-1273.

Braathen, S. H., Vergunst, R., Mji, G., Mannan, H., & Swartz, L. (2013). Understanding the local context for the application of global mental health: A rural South African experience. *International Health, 5*(1), 38-42. doi: 10.1093/inthealth/ihs016

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

Brocki, J. M., & Wearden, A. J. (2006). A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology. *Psychology and Health*, *21*(1), 87-108. doi: 10.1080/14768320500230185

Brownhill, S., Wilhelm, K., Barclay, L., & Parker, G. (2002). Detecting depression in men: A matter of guesswork. *International Journal of Men's Health, 1*(3), 259-280. doi: 10.3149/jmh.0103.259

Brownhill, S., Wilhelm, K., Barclay, L., & Schmied, V. (2005). "Big build": Hidden depression in men. *Australian & New Zealand Journal of Psychiatry, 39*(10), 921-931. doi: 10.1111/j.1440-1614.2005.01665.x

Bryant-Bedell, K., & Waite, R. (2010). Understanding major depressive disorder among middle-aged African American men. *Journal of Advanced Nursing, 66*(9), 2050-2060. doi: 10.111/j.1365-2648.2010.05345.x

Bryman, A. (2012). *Social research methods*. Oxford: Oxford University Press

Budgeon, S. (2014). The dynamics of gender hegemony: Femininities, masculinities and social change. *Sociology*, *48*(2), 317-334. doi: 10.1177/0038038513490358

Burr, V. (2004). *Social constructionism* (3rd ed.). East Sussex, United Kingdom: Routledge.

Burrows, S., & Laflamme, L. (2006). Suicide mortality in South Africa. *Social Psychiatry and Psychiatric Epidemiology, 41*(2), 108-114. doi: 10.1007/500127-005-0004-4

Butler, J. (2002). *Gender trouble*. New York, NY: Routledge.

Cabassa, L. J. (2007). Latino immigrant men's perceptions of depression and attitudes toward help seeking. *Hispanic Journal of Behavioural Sciences, 29*(4), 492-509. doi: 10.1177/0739986307307157

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316-1328. doi: 10.1177/1049732307306927

Chantler, K. (2005). From disconnection to connection: 'Race', gender and the politics of therapy. *British Journal of Guidance and Counselling 33*(2), 239-56. doi: 10.1080/03069880500132813

Christensen, A. D., & Jensen, S. Q. (2014). Combining hegemonic masculinity and intersectionality. *NORMA: International Journal for Masculinity Studies, 9*(1), 60-75. doi: 10.1080/18902138.2014.892289

Connell, R. W. (1995) *Masculinities.* Cambridge: Polity Press.

Connell, R. W. (2000) *The men and the boys*. Cambridge: Polity Press.

Connell, R. W., & Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society, 19*(6), 829-859. doi: 10.1177/0891243205278639

Connell, R. W. (2005). Change among the gatekeepers: Men, masculinities, and gender equality in the global arena. *Signs: Journal of Women in Culture and Society, 30*(3), 1801-1825. doi: 10.1086/427525

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

De la Rey, C., & Ipser, J. (2004). The call for relevance: South African psychology ten years into democracy. *South African Journal of Psychology, 34*(4), 544-552. doi: 10.1177/008124630403400403

Dawes, A. (1985). Politics and mental health: The position of clinical psychology in South Africa. *South African Journal of Psychology*, *15*, 55–61. doi: 10.1177/008124638501500202

Draguns, J. G., & Tanaka-Matsumi, J. (2003). Assessment of psychopathology across and within cultures: Issues and findings. *Behaviour Research and Therapy, 41*(7), 755-776. doi: 10.1016/s005-7967(02)00190-0

Edley, N. (2001). Unravelling social constructionism. *Theory & Psychology*, *11*(3), 433-441. doi: 10.1177%2F0959354301113008

Ellis, C. (2003). Cross-cultural aspects of depression in general practice: Clinical practice. *SAMJ forum*, *93*(5), 342-345.

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

Field, P.A., & Morse, J.M. (1992). *Nursing research: The application of qualitative approaches.* London: Chapman & Hall.

Flick, U. (2018). *An introduction to qualitative research*. London: Sage Publications Limited.

Forsberg, L. (2007). Negotiating involved fatherhood: Housework, childcare and spending time with children. *NORMA: Nordic Journal for Masculinity Studies, 2*, 109–126.

Garfield, C. F., Isacco, A., & Rogers, T. E. (2008). A review of men's health and masculinity. *American Journal of Lifestyle Medicine, 2*(6), 474-487. doi: 10.117

Gelo, O. C. G., (2012). On research methods and their philosophical assumptions: "Raising the consciousness of researchers" again. *Psychotherapie und Sozialwissenschaft*, *14*(2), 111-130. doi: 7/1559827608323213.

Gergen, K. J. (1973). Social psychology as history. *Journal of Personality and Social Psychology*, *26*(2), 309-320. doi: /10.1037/h0034436

Gergen, K. J. (1985). The social constructionist movement in modern psychology. *American Psychologist, 40*(3), 266-275. doi: 0003-066X/85/500.75

Gergen, K. J., & Gergen, M. (2007). Social construction and research methodology. *The SAGE Handbook of Social Science Methodology*, 461-478.

Gläser, J. (2004). Why are the most influential books in Australian sociology not necessarily the most highly cited ones?. *Journal of Sociology*, *40*(3), 261-282. doi: org/10.1177%2F1440783304046370

Gonzalez, V. M. (2008). Recognition of mental illness and suicidality among individuals with serious mental illness. *The Journal of Nervous and Mental Disease, 196*(10), 727-734. doi:10.1097/NMD.0b013e3181879deb

Griffith, D. M. (2012). An intersectional approach to men's health. *Journal of Men's Health, 9*(2), 106-112. doi: 10.1016/j.jomh.2012.03.003

Grix, J. (2002). Introducing students to the generic terminology of social research. *Politics*, *22*(3), 175–186.

Groes-Green, C. (2011). Philogynous masculinities: Contextualizing alternative manhood in Mozambique. *Men and Masculinities, 15*, 91–111. doi:10.1177/1097184X11427021

Gwata, F. (2009). Traditional male circumcision: What is its socio-cultural significance among young Xhosa men? (Working Paper No. 264). Retrieved May 19, 2018, from http://hdl.handle.net/11427/19824

Health Professions Act of 1974, 10 (2006).

Hoy, S. (2012). Beyond men behaving badly: A meta-ethnography of men's perspectives on psychological distress and help seeking. *International Journal of Men's Health, 11*(3), 202-227. doi: 10.3149/jmh.1103.202

Hunting, G. (2014). Intersectionality-informed qualitative research: A primer. *Criminology*, *4*(1), 32-56.

Iwamoto, D. K., Liao, L., & Liu, W. M. (2010). Masculine norms, avoidant coping, Asian values, and depression among Asian American men. *Psychology of Men & Masculinity, 11*(1), 15-24. doi: 10.1037/a0017874

Jackson, Y. (Ed.). (2006). Encyclopedia of multicultural psychology. Thousand Oaks, CA: SAGE. doi:10.4135/9781412952668

Joffe, H. (2012). Thematic analysis. *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners*, *1*, 210-223.

Johnston, E. R. (2015). South African clinical psychology's response to cultural diversity, globalisation and multiculturalism: A review. *South African Journal of Psychology*, *45*(3), 374-385. doi: org/10.1177%2F0081246315575648

Johnson, J. L., & Repta, R. (2012). Sex and gender. In J. L. Oliffe., & L. Greaves (Ed.), *Designing and conducting gender, sex, and health research* (pp.17-37). London: SAGE Publication.

Kalabamu, F. (2006). Patriarchy and women's land rights in Botswana. *Land Use Policy*, *23*(3), 237-246. doi: org/10.1016/j.landusepol.2004.11.001

Kepe, T. (2010). 'Secrets' that kill: Crisis, custodianship and responsibility in ritual male circumcision in the Eastern Cape Province, South Africa. *Social Science & Medicine*, *70*(5), 729-735. doi: org/10.1016/j.socscimed.2009.11.016

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *The Journal of Men's Health & Gender*, *2*(1), 95-99. doi: 10.1.1.543.5455

Korbin, J. E. (2002). Culture and child maltreatment: Cultural competence and beyond. *Child Abuse & Neglect*, *26*(6-7), 637-644. doi: org/10.1016/S0145-2134(02)00338-1

Korner, H., Newman, C., Limin, M., Kidd, M. R., Saltman, D., & Kippax, S. (2011). 'The black dog just came and sat on my face and built a kennel': Gay men making sense of 'depression'. *Health London, England*, *15*(4), 417-436. doi:10.1177/1363459310372511

Kvale, S. (1996). *Interviews: An introduction to qualitative research interviewing*. California, CA: Sage

Laher, S. (2014). An overview of illness conceptualizations in African, Hindu, and Islamic traditions: Towards cultural competence. *South African Journal of Psychology*, *44*(2), 191-204. doi: 10.1177/0081246314528149

Larsson, S. (2009). A pluralist view of generalization in qualitative research. *International Journal of Research & Method in Education*, *32*(1), 25-38. doi: org/10.1080/17437270902759931

Lepine, J. P., & Briley, M. (2011). The increasing burden of depression. *Neuropsychiatric Disease and Treatment*, *7*(1), 3-7. doi:10.2147/NDT.S19617

Lehti, A., Hammarström, A., & Mattsson, B. (2009). Recognition of depression in people of different cultures: A qualitative study. *BMC Family Practice*, *10*(1), 1-9. doi:10.1186/1471-2296-10-53

Lincoln, K. D., Taylor, R. J., Watkins, D. C., & Chatters, L. M. (2011). Correlates of psychological distress and major depressive disorder among African American men. *Research on Social Work Practice, 21*(3), 278-288. doi: 10.1177/1049731510386122

Loest, V., Britz, R., & Pauw, H. (1997). The acquisition of Xhosa: An ethnolinguistic study. *South African Journal of Ethnology, 10*(4), 180-190.

Losantos, M., Montoya, T., Exeni, S., Santa Cruz, M., & Loots, G. (2016). Applying social constructionist epistemology to research in psychology. *International Journal of Collaborative Practice*, *6*(1), 29-42.

Mansfield, A. K., Addis, M. E., & Mahalik, J. R. (2003). " Why won't he go to the doctor?": The psychology of men's help seeking. *International Journal of Men's Health, 2*(2), 93.

McLoed, J. (2009). *An introduction to counselling* (4th ed.). Glasgow, United Kingdom: McGraw Hill.

McNamee, S. (2012). From social construction to relational construction: Practices from the edge. *Psychological Studies, 57*(2), 150-156. doi: org/1007/s12646-011-0125-7

Meel, B. L. (2005). Community perception of traditional circumcision in a sub-region of the Transkei, Eastern Cape, South Africa. *South African Family Practice*, *47*(6), 58-59. doi: org/10.1080/20786204.2005.10873248

Messerschmidt, J., (2000). *Nine lives: Adolescent masculinities, the body, and violence*. Boulder, CO: Westview Press.

Mfecane, S. (2016). “Ndiyindoda” [I am a man]: Theorising Xhosa masculinity. *Anthropology Southern Africa, 39*(3), 204-214. doi: 10.1080/23323256.2016.1208535

Miglietta, A., & Maran, D. (2017). Gender, sexism and the social representation of stalking: What makes the difference? *Psychology of Violence*, *7*(4), 563-573. doi:10.1037/vio0000070

Morrell, R. (1998). ‘‘Of boys and men: Masculinity and gender in Southern African studies.’’ *Journal of Southern African Studies 24*, 605–30. doi: org/10.1080/03057079808708593

Morrell, R., Jewkes, R., & Lindegger, G. (2012). Hegemonic masculinity/masculinities in South Africa: Culture, power, and gender politics. *Men and Masculinities*, *15*(1), 11-30. doi: org/10.1177%2F1097184X12438001

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counselling psychology. *Journal of Counselling Psychology*, *52*(2), 250-260. doi: 10.1037/0022-0167.52.2.250

Murphy, G. E. (1998). Why women are less likely than men to commit suicide. *Comprehensive Psychiatry, 39*(4), 165-175. doi: org/10.1016/S0010-440X(98)90057-8

Murry, V. M., Kotchick, B. A., Wallace, S., Ketchen, B., Eddings, K., Heller, L., & Collier, I. (2004). Race, culture, and ethnicity: Implications for a community intervention. *Journal of Child and Family Studies*, *13*(1), 81-99. doi: org/10.1023/B:JCFS.0000010492.70526.7d

Ndangam, L. N. (2008). ‘Lifting the cloak on manhood’: Coverage of Xhosa male circumcision in the South African press. *Masculinities in Contemporary Africa, 2008*, 209-228.

Neff, D. F. (2007). Subjective well-being, poverty and ethnicity in South Africa: Insights from an exploratory analysis. *Social Indicators Research*, *80*(2), 313-341. doi: org/10.1007/s11205-005-5920-x

Newburn, T., & Stanko, E. A. (1994). *When men are victims: Men, masculinities and crime*. London: Routledge

Nieuwenhuis, J. (2007). Introducing qualitative research. In Maree, K. (Ed.), *First steps in research.* Pretoria: Van Schaik Publishers.

Nock, M. K., Hwang, I., Sampson, N., Kessler, R. C., Angermeyer, M., Beautrais, A., & Borges, G., et al. (2009). Cross-national analysis of the associations among mental disorders and suicidal behaviour: Findings from the WHO World Mental Health Survey. *PLos Medicine, 6*(8), 1-17. doi: 10.1371/journal.pmed.1000123

Noy, C. (2008). Sampling knowledge: The hermeneutics of snowball sampling in qualitative research. *International Journal of Social Research Methodology, 11*(4), 327-344. doi.org/10.1080/13645570701401305

Nyman, A., Josephsson, S., & Isaksson, G. (2012). Being part of an enacted togetherness: Narratives of elderly people with depression. *Journal of Aging Studies*, *26*(4), 410-418. doi: org/10.1016/j.jaging.2012.05.003

Ofori-Atta, A., Cooper, S., Akpalu, B., Osei, A., Doku, V., Lund, C., Fisher, A., & The MHapp Research Programme Consortium. (2010). Common understandings of women's mental illness in Ghana: Results from a qualitative study. *International Review of Psychiatry, 22*(6), 589-598. doi: 10. 3109/09540261.2010.536150

Ojeda, V. D., & McGuire, T. G. (2006). Gender and racial/ethnic differences in the use of outpatient mental health and substance use services by depressed adults. *Psychiatric Quarterly, 77*(3), 211-222. doi: org/10.1007/s11126-006-9008-9

Orb, A., Eisenhauer, L., & Wynaden, D. (2001). Ethics in qualitative research. *Journal of Nursing Scholarship*, *33*(1), 93-96. doi: org/10.1111/j.1547-5069.2001.00093.x

Payne, J. S. (2014). Social determinants affecting major depressive disorder: Diagnostic accuracy for African American men. *Best Practices in Mental Health*, *10*(2), 78-95.

Pearce, B. W. (2009). Communication and social construction: Claiming our birth right. In Leeds-Hurwitz, W., & Galanes, G. (Eds.), *Socially Constructing Communication* (pp. 33-56). Cresskill: Hampton Press.

Phillips, J., et al (2012). The six most essential questions in psychiatric diagnosis: A pluralogue Part 1: Conceptual and definitional issues in psychiatric diagnosis. *Philosophy, Ethics, and Humanities in Medicine*, *7*(1), 1-29. doi: org/10.1186/1747-5341-7-3

Pillay, A. L., Ahmed, R., & Bawa, U. (2013). Clinical psychology training in South Africa: A call to action. *South African Journal of Psychology*, *43*(1), 46-58. doi: org/10.1177/0081246312474411

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology*, *52*(2), 126-136. doi: 10.1037/022-0167.52.2.126.

Quale, A. (2007). Radical constructivism, and the sin of relativism. *Science & Education*, *16*(3-5), 231-266. doi: 10.1007/s11191-006-9038-6

Ramgoon, S., Dalasile, N. Q., Paruk, Z., & Patel, C. J. (2011). An exploratory study of trainee and registered psychologist's perceptions about indigenous healing systems. *South African Journal of Psychology, 41*, 90–100. doi: org/10.1177%2F008124631104100110

Ratele, K. (2014). Hegemonic African masculinities and men's heterosexual lives: Some uses for homophobia. *African Studies Review, 57*(2), 115-130. doi: /10.1017/asr.2014.50

Ritchie, D. (1999). Young men's perception of emotional health: Research and practice. *Health Education, 2,* 70-75. doi: org/10.1108/09654289910256932

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

Robertson, A., Venter, C., & Botha, K. (2005). Narratives of depression. *South African Journal of Psychology, 35*(2), 331-345. doi: org/10.1177%2F008124630503500210

Rogers, B. K., Sperry, H. A., & Levant, R. F. (2015). Masculinities among African American men: An intersectional perspective. *Psychology of Men & Masculinity*, *16*(4), 416-425. doi: 10.1037/a0039082

Rosenfield, S., & Mouzon, D. (2013). Gender and mental health. In Aneshensel, C. S., Phelan, J. C., & Bierman, A. (Eds.), *Handbook of the sociology of mental health* (pp. 277-296). Springer, Dordrecht.

Ruane, I. (2006). Challenging the frontiers of community psychology: A South African experience. *Journal of Psychology in Africa, 16,* 283-292. doi: org/10.1080/14330237.2006.10820132

Ruane, I. (2010). Obstacles to the utilisation of psychological resources in a South African township community. *South African Journal of Psychology*, *40*(2), 214-225. doi: org/10.1177%2F008124631004000211

Schippers, M. (2007). Recovering the feminine other: Masculinity, femininity, and gender hegemony. *Theory and Society*, *36*(1), 85-102.

Seidel, E., Habel, U., Finkelmeyer, A., Schneider, F., Gur, R. C., & Derntl, B. (2010). Implicit and explicit behavioural tendencies in male and female depression. *Psychiatry Research, 177*(1), 124-130. doi: 10.1016/j.psychres.2010.02.001

Seidler, Z. E., Dawes, A. J., Rice, A. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychology Review, 46*(2016), 106-118. doi: 10.1016/j.cpr.2016.09.00

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75. doi: 10.3233/EFI-2004-22201

Shields, S. A. (2008). Gender: An intersectionality perspective. *Sex Roles, 59*(5-6), 301-311. doi: 10.1007/s11199-008-9501-8

Snyder, C. R., & Pulvers, K. M. (2001). Dr. Seuss, the coping machine, and "oh the places you'll go". In Snyder, C. R. (Eds.), *Coping with stress: Effective people and processes* (pp. 3-29). New York, NY: Oxford University Press

Stein, D. J., Seedat, S., Herman, A., Moomal, H., Heeringa, S. G., Kessler, R. C., & Williams, D. R. (2008). Lifetime prevalence of psychiatric disorders in South Africa. *The British Journal of Psychiatry: The Journal of Mental Science, 192*(2), 112-117. doi:10.1192/bjp.bp.106.029280

Suffla, S., & Seedat, M. (2004). How has psychology fared over ten years of democracy? Achievements, challenges and questions. *South African Journal of Psychology*, *34*(4), 513-519. doi: rg/10.1177%2F008124630403400401

Swarr, A. (2012). Paradoxes of butchness: Lesbian masculinities and sexual violence in contemporary South Africa. *Signs: Journal of Women in Culture and Society*, *37*(4), 961-986.

Tomlinson, M., Grimsrud, A. T., Stein, D. J., Williams, D. R., & Myer, L. (2009). The epidemiology of major depression in South Africa: Results from the South African stress and health study. *SAMJ: South African Medical Journal, 99*(5), 368-373.

Tomlinson, M., Swartz, L., Kruger, L., & Gureje, O. (2007). Manifestations of affective disturbance in Sub-Saharan Africa: Key themes. *Journal of Affective Disorders, 102*(1), 191-198. doi: 10.1016/j.jad.2006.09.029

Thompson, V.L.S, Akbar, M.D., & Bazile, A. (2002). African Americans' perceptions of psychotherapy and psychotherapists. Poster presented at the 110th Annual Convention of the American Psychological Association. Chicago, Illinois, August 22-25. Retrieved from ERIC database.

Van Der Merwe, W. L. (1996). Philosophy and the multicultural context of (post) Apartheid South Africa. *Ethical Perspectives, 3*(2), 76-90. doi: 10.2143/EP.3.2.563038

Van de Velde, S., Bracke, P., & Levecque, K. (2010). Gender differences in depression in 23 European countries: Cross-national variation in the gender gap in depression. *Social Science & Medicine, 71*(2), 305-313. doi: 16/j.socscimed.2010.03.035

Van Mens-Verhulst, J., & Radtke, L. (2008). Intersectionality and mental health: A case study. Retrieved from http://www.vanmens.info/verhulst/en/?page_id=9

Van Mens-Verhulst, J., Bernadez, T., Goudswaard, H., Jacobs, G., Steketee, M., Williams, J., & Watson, G. (1999). Dilemmas as solutions: The development of feminist mental health care. *Manuscript Submitted for Publication*.

Van Wyk, S., & Naidoo, A. V. (2006). Broadening mental health services to disadvantaged communities in South Africa: Reflections on establishing a community-based internship. *Journal of Psychology in Africa*, *16*(2), 273-281. doi: org/10.1080/14330237.2006.10820131

Vincent, L. (2008). 'Boys will be boys': Traditional Xhosa male circumcision, HIV and sexual socialisation in contemporary South Africa. *Culture, Health & Sexuality*, *10*(5), 431-446. doi: org/10.1080/13691050701861447

Watkins, D.C., & Neighbors, H.W. (2007). An initial exploration of what 'mental health' means to young black men. *Journal of Men's Health and Gender, 4*(3), 271-282. doi: org/10.1016/j.jmhg.2007.06.006

Watkins, D. C., Abelson, J. M., & Jefferson, S. O. (2013). "Their depression is something different... it would have to be": Findings from a qualitative study of Black women's perceptions of depression in Black men. *American Journal of Men's Health*, *7*(4_suppl), 45S-57S. doi: 10.1177/1557988313493697

Whitehead, D.C. (2003). Rehabilitation counselors' perceived multicultural competence: working with African American and other culturally diverse clients with severe mental illness. Unpublished doctoral thesis, University of Maryland

Willig, C. (2009). *Introducing qualitative research in psychology* (2nd ed.). New York: Open University Press.

Willig, C. (2013). *Introducing qualitative research in psychology*. Berkshire, England: Open University Press.

World Health Organisation (2017, March 30). Depressions news release. Retrieved from http://www.who.int/news-room/detail/30-03-2017--depression-let-s-talk-says-who-as-depression-tops-list-of-causes-of-ill-health

APPENDIXES

Appendix 1 - Poster

CALL FOR RESEARCH PARTICIPANTS

WHAT IS THE RESEARCH ABOUT?

- The study is a master's mini dissertation, about exploring Xhosa men's constructions/understanding of depression and seeking help for it

WHAT DOES IT INVOLVE?

- One 1-hour interview which involves questions around how you understand depression, how you think Xhosa culture plays an influence in your understanding, and how you think being a Xhosa man influences this understanding.

WHERE DOES IT TAKE PLACE?

- At a safe and comfortable place, convenient for you and the researcher.

HOW DO I FIND OUT MORE?

- Contact Sinazo Williams on 076 783 6391 or email her on sinazo.williams94@gmail.com

Study has been approved by the Humanities' Faculty Ethics Committee at the University of Pretoria.

Appendix 2 – Information leaflet

Title of study

Xhosa men's constructions of depression.

Invitation

We invite you to participate in a research study. This leaflet is meant to help you decide if you would like to participate and help inform you about the procedure and what is involved. If there is anything further you would like to know, please do not hesitate to ask the researcher, Sinazo Williams.

Purpose of study

This study seeks to understand how Xhosa men construct depression, and how culture and gender have influenced these constructions. Approximately 4-6 self-identified Xhosa men will participate in the study. Your participation will be greatly appreciated.

Procedures

The study involves conducting interviews, each approximately an hour long. The researcher, Sinazo Williams, will ask you questions during the interview about your understanding of depression, cultural influences concerning this understanding and the role of gender as a possible consideration. There will also be questions regarding your perceptions of treatment and the causes of depression. Because the study is interested in your unique understandings, there are no right and wrong answers. This study is not about how you have experienced depression, rather, it is about thoughts of depression in your culture in general.

Risk and discomfort involved

There are no immediate risks in participating in this study. If there are any questions that make you uncomfortable, you do not need to answer them. If you feel that after the interview, you require further support regarding any uncomfortable content that the interview may have brought up, contact details for a non-profit organization that offers counselling services is provided below.

Families South Africa (FAMSA)

Tel: 046 622 2580

Address: Ground Floor, Settlers Day Hospital, Cobden Street, Grahamstown, Eastern Cape, 6139

Possible benefits of the study

There are no incentives or direct benefits to you, for your participation in this study. Your participation in this study will help inform mental health professionals, and researchers better understand the influence of culture and gender in the understanding of depression. This may in turn help us to develop more effective treatment strategies cross-culturally.

What are your rights as participants?

Your participation in this study is voluntary. You can refuse to answer questions, participate and withdraw participation during the interview at any point, without giving any reason. Your withdrawal will not negatively affect you in any way.

Ethical approval

This study has received written approval from the Research Ethics Committee of the Faculty of Humanities at the University of Pretoria. Copies of the approval letter is available to you, should you request one.

Information and contact person

The contact person for this study is Sinazo Williams. If you have any queries about the study, please contact her at 076 783 6391. Alternatively, you may contact the supervisor, Adri Prinsloo, at 012 420 2918

Compensation

Your participation in this study is done so on a voluntary basis. There will be no compensation for your participation.

Confidentiality

All information that you provide will be kept strictly confidential. Once the researcher and her supervisor have analysed the information, no one will be able to identify you. The information will then be archived for future research and stored in the Humanities building at the University of Pretoria, in HSB 11-24. Research reports and articles in psychology journals will not include any information that may identify you. Pseudonyms will be used when reporting on the results and findings in the journal article in which the results are to be published.

Appendix 3 – Informed Consent Form

CONSENT TO PARTICIPATE IN THIS STUDY

I confirm that the researcher conducting this study has told me about the nature, process, risks, discomforts and benefits of the study. I have been informed that FAMSA knows about the study and have agreed to counsel me should I need any counselling services. I have also received, read and understood the above written information (Information Leaflet and Informed Consent) regarding the study. I am aware that the results of the study, including personal details, will be anonymously processed into research reports. I am participating willingly. I have had time to ask questions and have no objection to participate in the study. I understand that there is no penalty should I wish to discontinue with the study and my withdrawal will not have any negative consequence for me.

I have received a signed copy of this informed consent agreement.

Participant's name

Date Place

Participant's signature

Researcher's name

Date Place

Researcher's signature

Appendix 4 – Interview schedule

Interview Schedule

1. Do you have any prior Psychological knowledge attained from tertiary education?
2. What role do you think culture plays in how you understand depression?

Prompt: As a Xhosa man, what do you understand depressions to be, and how is this understanding different or similar to the Xhosa cultural understanding?

3. What role do you think "ubu doda" (manhood) plays in how you understand depression?
4. From your point of view, do Xhosa men and women perceive depression in the same way?
5. What are the cultural ideas around the cause/s of depression?
6. How do your understandings about the causes of depression differ from these cultural ones?
7. What are the cultural ideas around acceptable treatment for depression?
8. How do your understandings about acceptable treatment of depression differ from these cultural ones?
9. How do you think older and younger generations' understandings of depression differ or agree?

Prompt: How does the older generation perceived depression, its causes, and what do they consider acceptable treatment to be

Prompt: How does the younger generation perceived depression, its causes, and what do they consider acceptable treatment to be

Appendix 5 – Letter of Approval from FAMSA

Families South Africa Grahamstown

(Known as FAMSA Grahamstown)

Settlers Day Hospital Grounds

Cobden street,Grahamstown

GRAHAMSTOWN

Tel (046)6222580

Email Address famsa@imaginet.co.za

The Manager

Dear Sinazo

Famsa will offer psychological support for the participants should they need it. They will have to book in advance for the sessions via telephone or come in office to make the booking.

Kind Regards

Sylvia Dyonase
Acting Director/ Social Worker

……

Appendix 6 – Translated transcript of Siyanda's interview

R: Researcher P: Participant

R: **Do you have any prior psychological knowledge?**

P: Industrial psychology

R: What role do you think culture plays in how you understand depression? What role do you think it plays in how you understand depression?

P: Yho How can I put it? This is where I'd prefer speaking isiXhosa.

R: No that's okay you may speak Xhosa

P: I think culture in this matter of depression, I can't really think now what role does it exactly play. But there's just expectation, it's not a subject that is found to be real. So I can't really say what role it plays because it's almost like it doesn't even exist.

R: So there's no role that it plays?

P: How I understand depression? No, culture? No.

R: So what do you understand depression to be?

P: You see there are people that are stressed, I think that is pretty much general. Depression is when you just can't cope anymore; whether its family, its relationships, its career or whatever. It is when all these combined, weigh you down. Like they weigh you down and break you, you see? Like you can't keep your head above the water. And the way that you feel it's almost like you walking on a treadmill, you have no way forward and no way out. That I how I understand depression

R: How is your understanding of depression similar or different to that of majority Xhosa culture? Do you think it's similar or different to that of the Xhosa culture?

P: No I won't know if it's because I'm curious or because I read a lot. But there is a thing that says, you know when a man (In the cultural sense) wears the blazer that thing is symbolic. When you wear your blazer you are said to be covering up your problems and embarrassments especially those of your household. Usually they have their heads looking down right, so that means you are covering up, it means no matter what might be stressing you or eating at you, it is not something that you can now go around talking about. It's got to be contained, so I feel

that that aspect is what leads them to die on their own inside. I, I can't, it's not something I learnt from culture its things I've watched and read on; that when there is something you struggle with just talk to someone even if it's one person. That is not in the cultural aspect, unless it's a family member. Family wise it's other men, there is no way I can talk to you about something that I am struggling with, even if you are my significant other. I don't know I am not married yet so I don't know if it's that deep but so far that's what I know. It was hectic at home and most of the things my dad would talk to me about you see. Even my uncle lost his wife to deal for now it was if we just relaxing drinking alcohol and listen to good music and have fun. Momentarily but not deal with it, until at least everyone has left, the he would talk to me about what exactly is bothering him. He wouldn't talk to his daughter, he talk to me, and I am not even that close to him but it is because he likes me and he understands I am a man. See, so they don't talk, that's the number one thing I have noticed they don't talk.

R: But do you think that depression exists to Xhosa people?

P: Yes

R: And what do you think they explain it as? In their minds when they think about do they think there is something like depression and what do they think about it?

P: Eish, on this point of its existence, it does exist yes. I don't know how they think about it but there is that thing of saying it's just hard times but the will never identify it as I have depression. Even me I would not really know that I am depressed, someone would have to tell me that no Siyanda you are depressed. I have a friend I go to school with last year he almost dropped out of school he was taken to a Clinical Psychologist and he was told that he is depressed. He was told that school has been good to him so he should go back to school and try make life as normal as possible, than to just sit around. So definitely it is there.

R: So I understand that you saying it does exist. But from your interactions with Xhosa people do you think they know about depression, do they identify that there is a thing called depression?

P: No they don't I don't want to say it doesn't it has different terms but it's not a thing where people will admit that I am depressed. No, that it does not exist. It's denial more than anything because you can't be at a position where you can't deal with things; you're brought up to be able to deal. It doesn't matter how old you are the moment you a men you have to find a way to deal with it. Say no I'm not coping I need help, no

R: So you said it is referred to using different terms, let me know what these terms are?

P: Most of the time you find that someone is found having already committed suicide and people will say that "no this person had mentioned there is something eating at him" So this thing has sugar coating to it. That no man they said kunento emtyayo (something eating him up). "No man he just stopped eating" hardly ever that if the relationship has communication between father and son the father will see it. But I'm not sure if I'd be able to talk to my dad that something is eating at me, but he would see it and give me his best version of advice. Not necessarily directed at my situation so that is our way of communicating and dealing and healing. Going beyond that hardly ever where I heard of a case whether a person saw a professional for help.

R: So what role do you think "ubudoda" plays in how you understand depression? How you see and think about depression.

P: Yho wow. I don't know how to reply directly. But more than anything ubudoda is about the ability to carry the world on your shoulders. So I need to understand from the get go that I can conquer it no matter what it is. I'm given a way of thinking that "I can always come up with a plan" so if there are things eating at me personally I must make a way doesn't matter who I talk to I must find a way and get over it. It shouldn't get to a point where this thing defeats me. It depends how open a person is if they can they can find people. If they can't then they find solutions in themselves, but that defeats them because they not open enough to do that alone. That's how I see it. Really you have to be strong whether you can or not so from there that will be how you approach life in all challenges even nice ones. You must always understand that you can do it. Culture in my understanding of depression, the problem is, it is not something that was spoken off in all the things I have learnt there (in the mountain). I've only learnt what I was taught; build a life for yourself, do this and that. They don't tell us not to drink or to drink we just told to know our priorities so that we don't embarrass our families because we are representatives of our families.

R: From your point of view do you think Xhosa women and Xhosa men see depression the same way? Do they perceive it the same way, think about it the same way?

P: No. You see now. No Xhosa women they know I don't know how but they know they can tell when someone is depressed and when they are going through something they know. Women know and they can deal I have watched this with multiple families. Women have

coping strategies, Xhosa women specifically when I say women. They know to talking, when to be silent, when to ask directly. They know

R: So what is depression to Xhosa women and what is it to Xhosa men

P: This is a difficult question. Something of depression on its own man like. . . Xhosa women there is a case I heard of where my grandfather died and I think a week after the funeral one of my father's brothers hung himself. When I analyze this this could have been avoided if that was a women that person could have been alive today. This person had no understanding and coping mechanism and that was a rural setting so they not even aware of depression. What can I say, I feel that could have been avoided if it was a woman, women even in families they have at least one other woman that knows you and understands you and that you talk to. Usually less than 5. Me as a guy I can find myself relating more to people who aren't families than those who are family. So if something defeats me in the families then I won't know how to cope. Women hardly ever resort to alcohol, we men want to numb the pain and then talk about it. We don't have the ability to just speak like this. You have to be on special person or something even then if I show you where I'm struggling I feel you have been exposed to my weakness. Let's say I get along with you and you the person I'm most intimate with. Even then I'll go to a pub first then talk to you, but if you raise it the following day I will not entertain that I will avoid the conversation and continue with life as normal. Women do, women form networks in the same street. It's always the women that interact. So when they have any problems women are always there for each other. They sacrifice their money to help each other up. Its ways that type of support system. I think we bring more problems to them in fact. Because they know how to do certain things up until we just quiet. But for us men, if we get along let's not go into the intimate details of my life up until I decide to tell you.

R: And in your perspective what do you think makes it hard for you guys to talk about your problems with each other?

P: I don't know. What can I say uhm, as a guy there is that things of wanting to be the Alfa, that's one of the things. The problem is there's always that thing that someone out to get you. It's safer to just not reveal any weaknesses. Like there are my friends that id hat with for hours, at the end only then someone will say that all the things they've just told you – on a casual basis- they have not told them to anyone else. Mind you the last time you saw this person was three months ago. I mean a person has a life they live. Some things aren't the same, let's say I was a student and I had financial issues, which is common with students. Everyone has their

own thing going on, and I on the other hand am really struggling. So I can't just tell the guys I chill with that hey so I'm struggling and I can't do this and that. But when I come across a guy that really knows me I'll then tell him. So I'll talk to someone I grew up with. You see with us, pressure, money, women, and the inability to sustain those around us really gets to us. And we can't communicate; we are just not built to facilitate platforms of communication. This is why there are programs like brotherhood, which focused on how men don't always having their lives figured out, that men don't deal they suppress and move on. Something as futile as a relationship, a guy will have three girlfriends and to all tell them that "we have something going on". He will not move forward from this no matter how much a girl loves him, because once upon a time he was once hurt by a woman. Its women who learn how to love a person, men don't; because he has told himself, emotions aside. Even I was glad for my friend that he was seen by a professional because it happened he had not dealt with the death of a siblings and this was manifesting in ways by ways. At home they'd never get a professional to help me unless if they open minded.

R: On the note of treatment, what are the cultural ideas about acceptable ways of treatment? So as Xhosa people

P: If I can come up with a suggestion, in the mountain this subject must not be missed. There you don't really get taught much, it's about what people that visits you say to you. So you sift from what they chat about to see what lesson to get. A person should not leave the mountain before getting told that "hey if you feel you are struggling here are some options and ways to deal with"

R: What options do they give? What options do they find acceptable to deal with depression?

P: As long as the neighbors don't know as long as this is not embarrassing you then its fine whatever you do.

R: And what would they find embarrassing?

P: People don't want to know what the problems are internally. If a car would be repossessed at home, I'd have to lie and say its just in the garage. This actually happened with me where my father's car got repossessed I would just say "my dad used to have this car, I don't know what happened to it". We have pride, a strong poisonous pride

R: So then an acceptable thing to do is then to hide things? Is it? When a person is hurt what do they do?

P: If we friends, there's me, there's your cousins, then you parents. It basically depends on whom you most close with. A way forward depends on whether you able to make these people understand what is going on with you

R: For you, what's an acceptable way of dealing with depression?

P: Talk, talk bra

R: Talk with whom?

P: Talk to someone, some things are much easier than we make them out to be.

R: And how is this different to what culture believes or thinks?

P: People aren't as judgmental as we think. You see, there's that thing in the states that black people don't go to psychologists they have barbare shops. We also have closed groups. Whereas there are professionals for these things, I have never been to one it would be a last resort, but don't suffer alone.

R: And how come it would be the last resort to see a professional?

P: Hayi I don't know. I don't know

R: Do you think that's a culturally informed thing? Do you think as a Xhosa man that's what is expected?

P: Amongst my friends I'm a bit older, in family I'm the youngest. With these people I know they have my best interests so when I talk to them really, like when I go wrong they'll let me know. They are my first go to. There's this show called please step I, you see that is a no-no. You can't have family and extended family and tell me they've all failed to resolve this for you. You can't go on television.

R: So the most acceptable thing is to speak to a family member and not let it get out of the family

P: Yes it can't leave the family. Culture or custom no

R: Explain to me the difference between culture and custom

P: Like for example as the Dlamini's you might do things this way so that's customarily. Xhosa is broad.

R: So each clan?

P: Yes, but not really that much difference to the general culture of Xhosa, with just those little differences.

R: What are the cultural beliefs around the causes of depression?

P: Death of a loved one, inability to support your family as a man; that is like the number one.

R: Why do you think that's such a big thing?

P: It is a big thing. Because we are providers it doesn't matter how educated and wealth the woman is. I am a provider; I'm building a home and a comfortable like for her.

R: And when you are unable to build it?

P: I feel incompetent. Nothing beats a man more than incompetence.

R: And what do you understand depression is caused by and how is this different or similar to that of the Xhosa culture?

P: Depression for me is caused by a number of things, there are a lot. Like, you can't ignore social media. There is a perceive lifestyle and the inability to live up to it is one of the causes. If I struggle compared to other students, that can affect me. That is something that seems small but to someone else is it. Peer pressure is another cause for young people. And then when your life feels stagnant. There is a period between age 21 and 26 where you feel life should be moving but it doesn't, that causes depression. If it happens that you still being supported by parents beyond 26

R: Is that for both genders?

P: Mostly I'm answering from a male's perspective. And when your . . . there's when everything else for your friends looks like it's going on while for you it seems stagnant/. And then internal conflicts in the family, potential separations of the parents. I don't know, Xhosa wise and culturally if you've reached the age of adolescence and you haven't gone to the bush, this really gets to some.

R: Which age specifically?

P: From 18 to 22. A guy I went to the bush with, he was 22 due to circumstances. Like at times before he went through initiation hen he would spend time with a group of men, everyone would assume his a man already. But he knew and so he had to avoid certain things and places because he wouldn't know how to talk or to engage in such settings. When I spoke to him he really struggled with his. And for a time and a period this got to him so much that he lost weight.

R: And then how do you think older and younger generations understand depression? Do you think they understand it the same way or are there differences?

P: No I think there's hope for younger. It differs. You see I can go to a Xhosa lady and just go and tell her whatever I'm stressed about. She'd advise me and she won't later embarrass me. A man on the other hand he'll bring it up. Older people re all about known protocols, it's what they've been told. You can't . . . like another cause is pursuits of careers, if your parents don't understand what you talking about they could cut you out. A lot of students study things they didn't want from the beginning. Old people are all about what is known, what is rule what is the law.

R: So older people, what do you think depression is to them, and what is it to young people?

P: With us I think we overdo it. We've already understood we don't want to be depressed, so whether I am depressed or not I'll go to the doctor to know it doesn't develop into a depression. We don't take too long to seek help. If we notice we sneezing we deal with it quickly. Older people won't to see how bad it could get first

R: Oh okay and when it gets bad what do they do?

P: Family meeting. Everything goes through a family meeting. And you find that two people can get a lot done than 20 people. So if you go to a family meeting, there are 20 different opinions. And pride, pride in older people is something. I try my best to speak to my dad; he has ways in which he lies by which aren't the best. So I learn from him and how their generation does things.

Older generations think they can do it all, and pride. Like even if I can know my dad's friend this side if I'd bump into him, regardless of whether I might be in need of money I can't ask him. I can't ask him to help me out. Everything must just seem okay. Yes if you bump into each other fine, but it mustn't happen that they know you struggle because you need to ensure

they don’t think your dad is struggling. And plus your dad’s friend has his own family to provide for.

R: Alright, that’s about it. Thank you so much for your time.