

**The Perception of Clinical Depression amongst Black Male University
Students in Durban, KwaZulu-Natal**

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To everyone who helped and encouraged me. Thank you all.

Thank You Lord, Ngoya'Bonga Dlozi Lami!

Declaration.

I, Thabile Mthethwa (209524541) declare that

1. The research reported in this thesis, except where otherwise indicated, and is my original research.
2. This thesis has not been submitted for any degree or examination at any other university.
3. This thesis does not contain other persons' data, pictures, graphs or other information, unless specifically acknowledged as being sourced from other persons.
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Signed: _____

Date: _____

Dedication.

To my Father Bhekizizwe Remember Mthethwa (1960-2018)

Thank You for instilling in me the importance of education, for always encouraging me even through your illness!

I am forever indebted to you for all the opportunities you afforded me!

Rest Well Nyambose! Dingiswayo, Khubase!

Acronyms.

AIDS	Acquired Immuno-Deficiency Syndrome
APA	American Psychological Association
DSM	Diagnostic Statistical Manual
HIV	Human Immune Virus
WHO	World Health Organisation
DALYs	Disability Adjusted Life Years
NIMH	National Institute of Mental Health
HIMM	Health Illness Men and Masculinities
UKZN	University of Kwa-Zulu Natal
SRC	Student Representative Council
USA	United States of America
SADAG	South African Depression and Anxiety Group

Abstract

The global and local prevalence of depression and suicide is increasing, particularly among men. However, in South Africa, particularly in black males in tertiary institutions there still remains a paucity of information in the area of depression and experiences of hegemonic masculinities.

The research design adopted in this study is qualitative in nature and draws from 12 semi-structured in-depth interviews conducted with male students at the University of Kwa-Zulu Natal. The data was thematically analysed and coded to present a comprehensive analysis.

Results: Participants articulated their personal identity as strongly influenced by hegemonic norms of masculinity such as strength, success, dominance and control. This identity was shaped by parents, particularly fathers, family members and peers. This hegemonic masculine identity, alongside the typical belief that clinical depression was a predominantly feeling of sadness that could be overcome by the individual on their own, meant that there was little recognition of the importance of professional help in overcoming the condition. Participants discussed externalising behaviours such as substance use and sexual activity to reduce these feelings. Positive coping mechanisms were creative recreational activities and seeking solace in religious or spiritual practices.

Conclusion: There is a need to increase awareness around depression and address attitudes and externalising behaviours that circumvent seeking professional help.

KEY WORDS: Mental Health, Mental illness, Clinical Depression, Masculinity, Suicide, Substance abuse, Sexual risky behaviour, Academic difficulties.

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CHAPTER ONE: INTRODUCTION

1.1. Background

“Depression is as old as the human race and rare is the person who has not felt its touch. Sometimes, suddenly without apparent reason we feel unbearably sad. The world turns grey, and we taste bitterness in our mouth. We hear a bell that tolls our passing, and we reach out for a comforting hand, but find ourselves alone. For some of us this moment is no more than a fleeting moment, or something we can dispel with common-sense thoughts and practical actions, but for some of us this experience becomes a ghost whose unbidden presence mars every feast, or, worse, a prison whose walls, though invisible, are quite impenetrable” (Rowe, 1996, p.3).

Major depressive disorder also known as clinical depression has been identified as a major public health concern as the condition contributes to the burden of disease in all regions of the world in terms of the years of life lost to disability (Ferrari, Somerville, Baxter, Norman, Patten, Vos, and Whiteford, 2013). Malhi and Mann (2018) noted that clinical depression is different from unhappiness or typical feelings of sadness, as individuals diagnosed with clinical depression present with five or more symptoms nearly every day during a 2-week period, and the symptoms are clearly different from the individual’s previous general functioning. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, 2005), these symptoms are: “ Feeling sad or having a depressed mood, loss of interest or pleasure in activities once enjoyed, changes in appetite — weight loss or gain unrelated to dieting, trouble sleeping or sleeping too much, loss of energy or increased fatigue, increase in purposeless physical activity (e.g., hand-wringing or pacing) or slowed movements and speech (actions observable by others), feeling worthless or guilty, difficulty thinking, concentrating or making decisions, thoughts of death or suicide” (American Psychiatric Association, 2000, p. 327).

Lopez, Mathers, Ezzati, Jamison, and Murray (2006) noted that in addition to the aforementioned symptoms of the condition, many with untreated depression find alternative means of coping or reducing their distress such as alcohol and substance use and these may be problematic in themselves. Addis (2008) explored how gender and depression intersect, and found that strategies to cope with depression vary considerably across genders, with men resorting to informal strategies of alleviating emotional distress and the impact of such behaviours impacts on the morbidity of individuals. In addition to the impact on morbidity,

mortality as a result of suicide or self-harm has most commonly been associated with the experience of clinical depression such that Lopez *et al.*, (2006) notes that suicide and depression are serious, inter-related public health problems, accounting for a significant proportion of the overall global burden of disease. According to Lozano, Giacobbe, Hamani, Rizvi, Kennedy, Kolivakis, and Ilcewicz-Klimek (2012) suicide cases following a persistent depressed mood have been reported to be on the rise globally, further ascertaining that the most vulnerable individuals are those aged 15-29 years. Suicidal thoughts and suicidal behaviour also seem to be common among college students (Nam, Hilimire, MJahn, Lehmann, and DeVlyder, 2018).

“It has been estimated that South Africans commit suicide every hour with 20 more attempting to take their lives daily. According to Caruso of the Suicide Organisation, suicide is on the rise in South Africa and children as young as 10 are dying by suicide.” (National Institute of Mental Health, 2015). According to the Eyewitness News (2018) “Reports indicate South Africa has a suicide rate of 14 per 100,000 people, which is higher than other African countries”. It has been established that the prevalence of major depressive disorder among 18 to 29-year-old individuals is several times higher than that for older people (American Psychiatric Association, 2013). Similarly, in South Africa while it has been noted that prevalence rates of major depression continue to increase in the general population, there has been a significant increase in the condition amongst young adults (Tomlinson, Grimsrud, Stein, Williams, and Myer, 2009). It is important to note that, as much as some depression cases end in suicide this is not the case for all individuals who are depressed.

Young people are those who are aged between 12 and 24 years (Rutter and Smith, 1995). Developmentally, they are emerging adults, sexually mature, in the final stages of their educational career or in the early stages of their employment career and embarking on several socially accepted adult pursuits including finding and keeping a job, romantic relationships (Rutter and Smith, 1995). The confluence of these experiences helps us contextualize the mental-health needs of young people as they give us an insight of the pressures that these young people face. Developmental pathways towards depression may differ by gender, with females suffering from pre-existing anxiety disorders and males experiencing more externalizing disorders, such as alcoholism, antisocial personality and drug misuse (Kendler, Gardner, and Prescott, 2006). A gendered analysis of young men must take into account the plurality of masculinities in Africa (Burrows and Laflamme, 2006). Versions of manhood in Africa are socially constructed, fluid over time and in different settings, and plural. The key requirement

to attain manhood in Africa is obtaining a certain level of financial independence, employment or income, and subsequently starting a family and these can be attained through academic achievements in tertiary students (Archer, 1984).

There is much reason for concern about depressive symptoms in university students, especially in view of the numerous sources of stress facing them. The vulnerability of this group to depressive illness has been noted in different parts of the world (Lester, 2014; Naushad et al., 2014; Williams et al., 2014). In the National Comorbidity Survey, 12.1% of USA adolescents experienced lifetime suicide ideation, 4.0% developed a suicide plan and 4.1% committed suicide attempt (Gili, Castellví, Vives, de la Torre-Luque, Almenara, Blasco, and Parés-Badell, 2018). Similar prevalence rates of suicidal attempts were found in Europe: 4.2% of more than 12,000 European adolescents reported attempting suicide during their lifetime (Gili *et al.*, 2013). Blanco, Okuda, Wright, Hasin, Grant, Liu, and Olfson, (2008) asserted that stress is an inevitable part of life. According to Mackenzie, Wiegel, Mundt, Brown, Saewyc, Heiligenstein, and Fleming (2011) stress is becoming more prevalent among tertiary students. Wolfram (2010) asserts that findings in the mental health domain project that was done in the United States of America, there is a considerable rise in depression cases, noting however that majority of people diagnosed with the syndrome are left untreated. The pressures and demands that emerge in the developmental stages of young people, their educational, career, familial and social contexts, it is understandable that tertiary level students are likely to experience stress. According to Da Silva (2016) obtaining a tertiary degree is perceived to be a gateway to a 'better' life. Students that are in these settings anticipate a better future, which is mainly the reason why they pursue tertiary education resulting in many of them leaving their homes and this transition itself can result in stress, anxiety and depression. Thurber and Walton (2014) further ascertains that the transition from high school to a tertiary institution as well as academic pressures can be a source of stress amongst individuals. Many other aspects of life can be linked to depression in tertiary level students, poor self-esteem and financial difficulties have been highlighted as sources of stress amongst university students (Orzech *et al.*, 2011)

Depression has been linked with a variety of detrimental behaviour such as smoking and negligence of one's overall well-being (Doom and Haeffel, 2013). Therefore these negative side effects of depression, shows a need for the treatment of mental disorders in university students. According to Kilmartin (2005, p. 95) "Women are diagnosed with depressive disorders twice as frequently as men, and yet evidence from differential rates of substance abuse, incarceration, and especially suicide calls into question the assumption that men are less

susceptible than women to depression. It is possible that there is a ‘masculine’ form of depression that is under-diagnosed and under-treated”. Moreover, this discrepancy in depression cases may be understood by paying close attention to help seeking behaviours in males. A study conducted in the USA found that only 62% of women and 38% of men in adult ages showed a willingness to divulge depressive symptoms to health care professionals (Meyer, Morrison, Lombardero, Swingle, and Campbell, 2014). According to Seidler, Rice, Oliffe, Fogarty, and Dhillon, (2017) Men are most likely to commit suicide due to untreated depression compared to their female counterparts. Furthermore, studies have shown that men have a higher rate of completed suicides compared to women who have a higher suicide attempt rate (Freeman, Mergl, Kohls, Székely, Gusmao, Arensman, and Rummel-Kluge, (2017). It is therefore critical to understand why men are more prone to depression leading to suicide to better deal with depression on a wider scale. The aim of this thesis is to explore the perception of clinical depression in black male tertiary students in Kwa-Zulu Natal

1.2. Gender and Depression

According to Evans *et al.*, (2011), gender is the combination of both complex facets of the social aspects of individuals lives, practices attached to individuals biological sex. Courtenay (2000) has suggested that gender may be one of the most important factor to review when trying to understand men’s behaviour and choices related to health patterns. Various research studies propose that fewer men than women are diagnosed with depression and in developed countries the ratio is 2:1 (Murphy, 1998). However, some researchers in men’s mental health argue that the lower reported rates may be due to the widespread use of generic diagnostic criteria that are not sensitive to depression in men (Blair-West, and Mellso, 2001). More so importantly, men’s reluctance to express concerns about their mental health and access professional health care services may be the reason why women are perceived to be the group that suffers greatly from depression (Seidler *et al.*, 2017).

Major depression is identified to considerably increase the risk for suicide, however suicide rates related to severe depression are four times higher in men than women (Möller-Leimkühler, 2003). According to Maris (2000) suicidal behaviour is gender normative. Suicide rates are usually found to be higher in men than in women (Butchart, 2000; Flisher and Parry, 1994) with males accounting for 82.4% of reported suicides in South Africa in 2001 (Donson & van Niekerk, 2002). Generally, females display higher rates of suicidal ideation, but males have higher mortality rates from suicide (Canetto, 2000). A study of attitudes toward suicide in the Northern Province of South Africa indicated a higher rate of parasuicide for boys than

for girls (Peltzer, and Cherian, 1998). Men may find acknowledging and pursuing help for depressive symptoms problematic; indeed, Warren (1983) has argued that depression is not compatible with masculinity. She lists three main reasons. First, showing emotion and crying which are prominent features of a depressed mood are perceived to fall in line with femininity; thus a “man may find depression an intolerable condition because it makes him feel like a woman” (Warren, 1983, p.151). Secondly, masculinity is linked with achievement and competence, while at the other end of the spectrum depression is often accompanied by feelings of hopelessness and lack of control. Thirdly, masculinity requires men to be resilient and self-reliant, whereas the experience of depression often leaves people feeling vulnerable and weak (Warren, p.1983).

Langhinrichsen-Rohling, Lewinsohn, Rohde, Seeley, Monson, Meyer, and Langford, (1998) suggest that gender differences in depression exist, as females are socialized to express their frustrations and unhappiness whilst young men are conditioned to assert autonomy and prove their manhood by engaging in risk taking behaviours and displaying their physical prowess. According to Courtenay (2000) emotional regulation and the denial of vulnerability form aspects of the hegemonic masculinity, therefore the “denial of depression is one of the means men use to demonstrate masculinities and to avoid assignment to a lower-status position relative to women and other men” (p.1397). According to Seidler *et al.*, (2017) the male mind is idealized as decisive and logical, and withstanding when ill fortune prevails, reinforced by perceptions that only fragile men respond to stress. Oliffe and Phillips, (2008) quoting Bartlett (2005), asserted that men’s denial of depression and their unwillingness to seek help for depression is directly influenced by masculine norms which places much emphasis on toughness, independence and strength. Dominant ideologies of masculinity suggest that depression is a female affliction, therefore help seeking is also perceived to be an acceptable response in females (Oliffe and Phillips, 2008), and for many men depression indicates some level of weakness and attracts significant stigma by going against what is perceived and known about masculinity (Link, Struening, Rahav, Phelan, and Nuttbrock, 1997). Moreover, some research studies advocate that diagnostic tools may ignore men’s depression because men express depression in different ways as they are most likely than females to conceal it (Kilmartin 2005; Oliffe *et al.*, 2011). Therefore, against this backdrop, it seems that there is a need to study the perceptions of men’s depression.

A plethora of studies on men and mental illness have suggested that men’s experiences and symptoms of depression are different from those of women, and men often deal with distress

in masculine ways (Cochran and Rabinowitz 2003; Kilmartin 2005). The studies of Oliffe *et al.*, regarding college men's depression (Oliffe, *et al.*, 2011; Krumm, Checchia, Koesters, Kilian, and Becker, 2017) reveal that the dominant discourse of masculinity is heavily aligned with the expectation that a man should build a successful career and this forms part of the male students' distress. Emslie, Ridge, Ziebland, and Hunt (2006) analysis of men's narratives of their depression discloses how depression endangered a man's masculine identity, according to this analysis depression could be connected to masculinity in various ways. Depression in men was experienced as a threat to masculinity and it was also perceived as a result of men's inability to embody hegemonic ideals of masculinity.

According to Vogel, Wade and Hackler (2008), the decision to pursue therapy in the case of distress is aligned with the tendency to express emotions and women are the group that's most likely to recognize and label feelings of distress as emotional problems (Addis and Mahalik, 2003; Möller-Leimkühler, 2002). According to Cramer (2005) levels of self-concealment directly impact help seeking, such as denial of distress results in a more pronounced hesitation to seek professional help. In addition, Ciarrochi and Deane (2003) found that men who reported feeling less equipped at regulating their emotions were less eager to seek help from friends and family for emotional problems and suicide ideation, and also less eager to seek help from professionals for suicide ideation. The concept of emotional proficiency is important for managing distress and pursuing support from others, however even in early childhood, male children are less likely to share their emotions compared to their female counterparts. A study by Rose and Espelage (2012) found that male children and teens hesitated to express their emotions because it would feel "peculiar" to do so or it would be a waste of time. The hypothesis then follows that males are conditioned at an early age, to be less expressive with their feelings and emotions and therefore are less likely to seek help for emotional distress. Recent figures confirm this hypothesis; of those who sought help in general practice in Britain 3% of them were men and 7% of them were women (ISD Scotland, 2004; ONS, 2000). However, as mentioned previously this could be because depressive symptoms in men are often undiagnosed and untreated (Royal College of Psychiatrists, 1998), and the fact that men generally express emotional distress in adverse ways (Cramer, 2005). This is evident in many parts of the world, notably suicide rates in the United Kingdom are currently three times higher for men than women and are generally higher for men than women in every country except for China (Cramer, 2005). Irrespective of the fact that suicide is not classified as a mental disorder,

severe depression unequivocally underlies more than half of the suicides that occur globally (MollerLeimkuhler, 2003).

1.3.Research Statement

Depression is the most common mental illness globally and affects millions of people each year. Black men are just as likely as anyone to have depression but less likely to get help for it. Left untreated depression can lead to chronic conditions such as diabetes, high blood pressure, sexual dysfunction, substance abuse and even death. According to the Centre for disease control, suicide is the third leading cause of death for African American males age 15-24. Because of gender-based notions, black men usually live in the shadow and avoid getting medical assistance although depression is treatable. There is a myriad of research that have been conducted pertinent to depression but there is quite a handful that took cognizant of the fact that black men suffer from depression disproportionately and yet the result of being depressed can lead to catastrophic outcomes if depression is left untreated. A growing body of evidence suggests that there is a high prevalence of mental health problems among students in institutions of higher education, which the majority of young adults attend (U.S. Department of Education, National Center for Education Statistics, 2005). Mental health has been shown to vary across several characteristics in the general population (Kessler, Chiu, Demler, and Walters, 2005; U.S. Department of Health & Human Services, 1999), but less is known about potential risk factors within young adults in African tertiary students, and student populations relatively.

According to Lopez and Mathers (2006), depression disrupts lives worldwide, posing significant threats to people's productivity and well-being. Indeed, depression is projected to become a leading contributor to the global burden of disease by 2030. A collaborative report between the World Health Organization, World Bank, and Harvard School of Public Health measured the global burden of disease using DALYs (disability adjusted life years). A study reported by the (National Institute of Mental Health, 2015) showed that while not typically fatal, depression is the current and rising leader in silently stealing years of productivity, health, and life from the world's population, other triggers of depression in developing nations are disease, poverty, and the struggle of difficult daily lives. In developing countries, particularly in South Africa there is an existing lack of mental health resources and treatment opportunities (World Health Organization, 2005).

Like many other low- and middle-income countries, mental health services in South Africa have been chronically under-resourced. There is currently evidence of widespread unmet need for services, with only 28% of people with moderate to severe CMDs receiving mental health care (Lund, Kleintjes, Kakuma, Flisher, and MHaPP Research Programme Consortium., 2010)

In the year 2001, the World Health Organization issued a report documenting the accessible mental health resources by country in all its member states, covering 98% of the world population. Their report, the Mental Health Atlas, discovered the disparity in facilities, resource accessibility, human resources, access to medication, and documented records for mental health across the globe. The report also showed severe mental health resource scarcity in developing countries compared to the rest of the world (Patel and Kleinman, 2007). Youth is the stage at which most mental disorders manifest (Skowrya, and Coccozza, 2006). Young people have a high rate of self-harm, and suicide is a leading cause of death in young people worldwide (Patel *et al*, 2007). A strong relation exists between poor mental health and many other health and development concerns for young people, notably with educational achievements, substance use and abuse, violence, and sexual health (Verhulst, Achenbach, and van der Ende, 2003). The risk factors for mental disorders are well established; however, in South Africa there still seems to be a growing number of untreated mental health cases and this is both a result of limited health care services as well as the unwillingness of males to speak about mental illness.

Prior (1999) attested that men with mental health problems have received relatively little attention in the social science literature. Men with depression have been unfortunately under-researched, because anxiety disorders and depression are conditions that are generally perceived to be problems associated with women. Despite the abundant research on depression and suicidal behaviour in youth within the general (predominantly white) population, there is a dearth of literature on suicidal behaviour in African youth, especially African college students. As a result, little is really known about the true incidence of depression among African youth. This is because most studies of suicidal behaviour generally make no mention of the racial composition of their sample (i.e., Connell and Meyer, 1991), Meneese and Yutrzenka. Jorm (2005) emphasized the significance of cross-cultural research on depression and the need to examine whether Western-defined depressive symptoms are recognized in non-Western cultural contexts, as context plays an important role in the understanding of depression and

exploring the general propositions in different historical and socio-political contexts rather than assuming a global experience.

This study will take into consideration the South African social context. South Africa in the Post-Apartheid era is a country marked by a plethora of social ills, great levels of inequalities even more so. Depression is therefore, better understood if we take into account the role the social environment, as well as factors that are positively associated with depression (Patel, and Kleinman, 2003). Although there are general predisposing and precipitating factors, we also have to take the uniqueness of each person and his circumstances into account. The complexities of South African society, for example, differ from those of American and European society and factors associated with our rapid socio-political changes, unemployment, inadequate educational and health facilities, growing urbanisation and westernization, poverty, or housing shortages, play different roles in individual depression cases (Campion, Bhugra, Bailey, and Marmot, 2013). Most lifetime mental disorders have first onset during or shortly before the typical college age (Kessler *et al*, 2005), and these problems may be precipitated or exacerbated by the variety of stressors in college life, including irregular sleep patterns, flux in personal relationships, and academic pressures (Kadison, 2004). According to Yu and Williams (1999), lower socioeconomic status is a known risk factor in the general population for mental health problems, but much less is known about students from lower socioeconomic backgrounds in the university setting. A British study found that students with greater financial strains had poorer mental health (Roberts, 1999).

1.4. Research Problem and Objectives

The aim of this study is to explore the perceptions of clinical depression amongst Black African male students, between the ages of 18- 30. “Women seek help, men die”, this supposition was drawn from a research study of suicide prevention in Switzerland, Angst and Ernst (1990) found that “75% of those who pursued mental health care in an institution for suicide prevention were female, and 75% of those who committed suicide in the same year were males”. Plumridge and Chetwynd (1999, p.333) assert that “what an individual believes about risk reflects on him or her as a person and what an individual is prepared to endorse as an acceptable personal risk inevitably carries connotations of personal characteristics like responsibility, maturity, courage or weakness”. Therefore, this study will seek to understand the full impact of psychosocial stressors on developing young men, and how they internalize external factors with respect to the social construction of the male identity; as well as the impact that psychosocial stressors have on their lives and the lives of those around them. The study

then questions if perhaps psychosocial stressors exacerbate depression in young men with the developmental demands of the social world respectively.

The objectives are to:

- Explore how masculinity is defined by black male university students
- Explore how individuals relate their identity to the concept of masculinity
- Explore awareness of clinical depression among black male university students
- Explore attitudes towards clinical depression among black male university students
- Explore acceptability of the various treatment options for clinical depression among black male university students

1.5.Theoretical Framework

This study will majorly draw reference from the Health, Illness, Men and Masculinities (HIMM) framework as proposed by Evans, Frank *et al.*, (2011). The study will also draw reference to the social constructionist theory (Burr, 2006). The HIMM framework acknowledges that gender, is one of the socio-cultural factors influencing health and health related behaviour. Therefore, the HIMM framework aims to help us understand ways in which masculinities intersect with other social determinants of health creating disparities amongst men. Schofield (2000) proposed that men's poor health could be generalized as a combination of social disadvantages and an ill-defined state of what it means to be a "man". Ideally the principal idea of the HIMM framework is to understand health behaviour within the context of gender, and how gender influences the health determinants for individuals provided that the social construction of masculinity shape men's perceptions of health and illness and their subsequent health care practices, hegemonic masculinities and traditional beliefs about the concept of manhood are the strongest predictors of individual risk behaviour over the life course of males. The HIMM framework looks at the notion of the construction of hegemonic masculinities therefore this framework will be supported by the social constructionist theory in theorising gender.

The social constructionist theory explores ways in which people construct their will as human beings, how they perceive themselves in relation to others. The social constructionist theory of identity construction can be interrelated with the HIMM framework as this framework looks at how men construct manhood and illness. The works of Cooley and Mead first introduced the study of identity. The study of identity is a critical foundation stone within the modern sociology (Cerulo 1997, p.386). Identity is a concept that can be understood and defined in

various ways. According to Howard (2000, p.367), “Identity, in current times, carries the full weight of the need for a sense of who one is, together with an often-overwhelming pace of change in surrounding social contexts”. Davis (1991, p.105) indicates that identity is a concept that neither imprisons nor detaches persons from their social and symbolic spaces. Bhabha (1994, p.51) suggests that identity is never a priori, nor a finished product; it is a continuous process of attaining an image of entirety. In other words, to understand the social construction of identity, one must not ignore the social context or influencing factors of which the identity is constructed around, as Elder-Vass (2012, p.2) suggests that any attempt to make sense of our social world must explain the roles that culture, language, discourse, and knowledge play in it.

1.6. Structure of Dissertation

The structure of the dissertation will be as follows: Chapter 1 introduced the focus and provided the background of the study. This chapter also explored the construct clinical depression. Furthermore, it highlighted the importance and the benefits of the study as well as the objectives that this study hopes to achieve. In addition, hereto it provides a glimpse into the theoretical framework used in this study.

Chapter 2 provides the background and the literature that this study draws on. The chapter also discusses the key concepts of this research which are: mental health, mental illness, clinical depression, emotional distress, and suicide. Additionally, the chapter explores the reviewed challenges that young male university students face both in their personal and academic lives as well as the coping strategies they adopt, also the implications of untreated depression cases. The HIMM theory is introduced and briefly discussed.

Chapter 3 discusses and unpacks the methodological paradigm of the study. This study adopted the qualitative means of inquiry thus this chapter looks at the research design of the study; in other words, how the participants were gathered, the type of sampling technique adopted, and the system used for the process of analysing the empirical data. It provides a brief background of the study population and location of where the participants were gathered. It also provides ethical considerations that were implemented to ensure the safety and protection of the participants for the study. Lastly, it outlines how validity and reliability was established and maintained

Chapter 4 presents and discusses the findings and the analysis of the data, by unpacking perceptions of masculinities and linking these phenomenological perceptions to the social constructionism theory. The study also presents an analysis of how depression is perceived by

participants in this study, relating these findings to the HIMM framework and further exploring help-seeking behaviours as well as attitudes regarding depression.

Chapter 5 concludes, summarises and presents the main findings of the study. In addition, the chapter concludes with an examination of the objectives of the study. This chapter will also include limitations pertinent to this study.

CHAPTER TWO: LITERATURE REVIEW

2.1. Introduction

The scholarship review for this study will focus on gender differences in depression. The review will majorly focus on perceptions of depression in men as well as men's perceived barriers to help seeking for depression. The literature review will focus on the study of masculinities and how they interest with the construction of identities in men. The review will also explore the constructs mental health and illness. Also reflecting on who the young adult is. Depression in this study is not reviewed in isolation, it will be discussed in relation to suicide and 'other' externalising behaviours, as well as coping strategies adopted by men when facing multiple stressors as well as depression in relation to race. Sources of stress will be explored within the university context and social contexts of young men, also paying attention to perceived barriers to health care. Journal articles, books, dissertations and online resources have been utilised to compile this scholarship review.

2.2. Mental Health

Mental health is conceptualized to be a state of well-being in which a person realizes his or her own abilities, is able to cope with the normal stresses of life, is able to work productively and fruitfully, and with capacity to make an impact to his or her community (WHO, 2005). Mental health encompasses the emotional resilience that enables people to be fully engrossed in the human experience and to survive pain, disappointment and sadness, and an underlying belief in our own, and others' worth and dignity. Mental health permits us to engage productively in, and contribute to, communities and societies (WHO, 2005). A positive sense of mental wellbeing is just as important to be conscious of all of the time, as we might be conscious of our physical, social and spiritual wellbeing. Mental health difficulties are often a result of major life events such as the end of a relationship, academic and financial difficulties, close bereavement, food insecurity, leaving home, all these factors can impact considerably on how young male students feel about themselves and how they engage with the transitions of student life and life in general (Heikkinen Aro, and Lönnqvist, 1993). Misfortune or what a person espouses as misfortune may beset anyone at any time of their lives, giving rise to stress that could interfere with the student's university experience and have implications for their mental health.

2.3. Clinical Depression

Depressive disorders also referred to as mood disorders, because the leading feature in this syndrome is mood disturbances. They are classified into "major depressive disorder, dysthymic

disorder, depressive disorder not otherwise specified, bipolar disorders I and II, cyclothymic disorder, bipolar disorder not otherwise specified, mood disorder due to a general medical condition, substance-induced mood disorder and mood disorder not otherwise specified” (DSM, 2005, p.155). According to the National Institute of Mental Health (NIMH) statistics (2016), an estimated 16.2 million (6.7%) of adults amongst ages 18 or older in the United States developed at least on major depressive episode, the institute further reported that the prevalence rate of depression was much higher in individuals aged 18-25 (10.9%). Likewise, South Africa, portrays worrisome finding regarding mental health in the country. The South African Stress and Health (SASH) revealed that anxiety, substance abuse and mood disorders are common among in all race groups as well as in all provinces major depressive disorder were documented to have a prevalence rate of at 4.9 per cent. Provinces affected most by anxiety and mood disorders are the Free State, Mpumalanga, KwaZulu-Natal and Gauteng (Herman *et al.*, 2009 and Stein, Seedat and Herman, 2007). According to Gupta, Dandu, Packel, Rutherford, Leiter, Phaladze, and Weiser (2010) depression has been deemed a significant contributor to disease and disability especially in developing countries, further claiming that the World Health Organization (WHO) ranked depression as the third leading contributor to the burden of disease internationally it will become the primary contributor to the burden of disease in the year 2030, especially in developing countries. Wampold, Budge, Laska, Del, Baardseth, Fluckiger and Gunn, (2011) also attest to the fact that depression is a major health problem that entails serious clinical and social consequences.

2.3.1 Prevalence of Clinical Depression in Younger People

In the little population-based studies that have been published on depression in Sub-Saharan Africa (Uganda Nigeria, Ethiopia, and South Africa), incidence rates vary greatly, lifetime prevalence is proposed to 3.1–9.7% (Gureje *et al.*, 2010; Herman *et al.*, 2009; Kebede and Alem, 1999; Stein *et al.*, 2008; Tomlinson *et al.*, 2009), this is clear indication of a need for mental health strategies that are inclusive to the broader population. According to Ibrahim *et al.*, (2013) clinical depression is the most prevalent mental illness among university students within several countries, including Australia, the United Kingdom, Spain and the United States.

“The prevalence of depression among first year female students in Canada and United States was double that of their male counterparts: 14% and 7% respectively” (Rockett, *et al.*, 2007: 311). However, Vaez and Laflamme (2003) found that female university students accessed mental health care facilities in higher proportions compared to their male counterparts. It was then postulated that “of those who had sought care, the proportion of females was significantly

higher than that of males (64.8% compared with 35.2%)” (p. 74). Vaez and Laflamme (2003), established that male students often denied or failed to express whether they had accessed mental health care services during their tertiary careers. This finding was consistent with a study conducted by Burris *et al.*, (2009) that advocated that female students had perceived poorer mental health status compared to male students and were at a larger risk for severe depression during tertiary.

Major depression in South Africa is unequivocally on the rise, and this rise in major depression results in high prevalence of suicidal acts, a profile of fatal injuries in South Africa showed that suicide is the third leading cause of death (8%) after accidents and homicides (Matzopoulos, Norman, and Bradshaw, 2004). According to Butchart (2000) most victims of suicide are between the ages of 20 and 30 and are predominantly males. Thus, suicide in South Africa, which was formerly known to be disproportionately high amongst the White population, is gradually increasing amongst other population groups, especially the Black population (79.2%) and it has been recounted that suicidal behaviour among black South Africans showed an increase of 58.10% over a period of 10 years (Schlebusch, 2000). Field, Diego, Pelaez, Deeds, and Delgado (2012) advocated the need for mental health care in tertiary settings because depression incidences seem to be higher in this population in most countries, suggesting that “depressive symptoms led to poorer academic performances among affected students and increased their vulnerability for experiencing additional mental health problems, including “anxiety, intrusive thoughts, controlling intrusive thoughts and sleep disturbances” (p. 194). Additionally, according to the WHO (2015), worldwide depression figures are a wake-up call for all countries to rethink their approaches to mental health and to treat it with urgency. According to SADAG (2016), a fifth of all South Africans will experience a depressive disorder at least once during their lifetime. Even scarier is that more than sixty percent will not get the necessary help. The biggest danger of anxiety and depression risk of suicide. The incidence of suicide in South Africa has soared to 23 a day- and for everyone person who completes a suicide, 10 attempt it SADAG (2016).

2.4. Factors Leading to Mental Health Disorders among University Students

An important area of stress research focuses on life events as sources of depression that may ultimately impact psychological well-being. Life events are typically defined as discrete occurrences that require major life readjustment (Wheaton 1999). There is growing evidence of the positive association between undesirable life events and psychological distress across a variety of countries including some in Asia (Tafarodi and Smith, 2001). Williams *et al.*, (1997)

attested that, “The higher the number of undesirable life events, the greater the levels of psychological distress”, this magnifies the relationship between perceived structural deprivation and depression. When members of disenfranchised racial groups in South Africa report unfair treatment perpetrated by both individuals and institutions, it has a similar effect on their mental health as it does adults in the United States (Kessler, Mickelson, and Williams 1999). Moreover, the higher the number of experiences of unfair treatment, the greater the levels of psychological distress (Williams *et al.*, 1997). Additionally, Flatt (2013) has provided a comprehensive discussion of several factors identified that supposedly lead to mental health disorders among university students.

In a study done in America, Flatt (2013) stated that academic pressures to achieve increase stress levels amongst tertiary students and thus exacerbates mental health problems, especially depression and anxiety. Financial burdens are the second influence which Flatt (2013) identifies as leading to depression, anxiety, and academic failure amongst students. Financial burden is a result of increased tuition fees, decreased governmental funding, the inability to obtain bursaries, increased students loans with extraordinary interest rates and related causes. Flatt (2013) also suggested that additional challenges in access higher education for many minority group students from different cultural, social, and economic backgrounds, also increase stress and depression amongst youth in those disadvantaged groups. Flatt (2013) postulates that the use of the internet and cell phones is a double-edged weapon, the harmful effect of the misuse of technology is another factor that has been found to create mental health issues among tertiary students. According to Flatt (2013, p.28), “the harmful effects of technology overuse include internet addiction or problematic internet use, mobile phone use, and overuse of internet pornography leads to depression, anxiety, social isolation, shyness, low self-esteem, and lack of social and emotional skills.”

2.5. Gender and Masculinity

“... Hegemonic masculinities can be constructed yet sometimes do not correspond closely to the lives of any actual men. Yet these models do, in various ways, express widespread ideals, fantasies, and desires. They provide models of relations with women and solutions to problems of gender relations. Furthermore, they articulate loosely with the practical constitution of masculinities as ways of living in everyday local circumstances.” - Connell and Messerschmidt (2005, p. 838)

The concept of hegemonic masculinities has been widely contested, this study however does not aim to unpack the criticism waged against this concept. Hegemonic masculinity in this study is conceptualised as the dominant practices in society relating to the behaviour of boys and men (Connell, 1995). It is important to note that masculinity is better understood in relation to gender, therefore gender is an important starting point in trying to uncover what is meant by masculinity (Connell, 2000). Gender itself has widely been contested however this study has aligned itself with a social constructionist understanding of gender and masculinity (Connell, 2000). The social constructionist paradigm views gender as a “human invention” that exists and operates at a social level and individual level (Barret, 2001, p.78). Social constructionist theorists claim that there is a difference between the construction of gender and sex (Barret, 2001). The latter is understood in the context of biological differences that exist between men and women, whereas the former is a result of human construction. Connell (2000, p.71) ascertain that, “gender is a social practice that constantly refers to bodies and what bodies do, it is not a social practice reduced to bodies.”

Hegemonic masculinities are related to all the standards and norms that are perceived to reflect ‘normal’ behaviour in men (Chadwick, 2007). According to Connell and Messerschmidt (2005) hegemonic masculinity depict patterns of practice and should not be conceptualised as just a set of role or as part of a fixed identity. Connell and Messerschmidt (2005) further ascertain that hegemonic masculinities fall within the paradigm of normative behaviours and they encapsulate acceptable ways of experiencing manhood and require all men to position themselves in relation to these ideals of normative behaviour. Connell (2005) outlines the importance of understanding masculinity as a concept with many variations and the possibility that it is embedded with a social context. Connell (2003, p.5) further ascertains that masculinity should be understood as concept that is self-constructed, however also noting that it is constructed within societies. Masculinity like any other societal construct is fluid, therefore constructed through social interactions by use of language. This understanding permits the notion that masculinity is not a fixed concept, it varies across actors and time, and therefore men depict different masculinities depending on context (Connell, 2005).

Masculinity is context specific, therefore this study notes the important of unpacking this construct relating to the South African context. Morrell (2001) attests that since gender relations in this country have begun to shift since the first democratic elections in South Africa in 1994. Morrell (2001, p.140) ascertains that the state of gender relations and masculinities in South Africa are “powerfully bound up with the history of this country”. In this study

masculinity will be considered collectively as the participants in this study belong to one ethnic group, however by considering South African masculinity collectively, this is not to suggest that masculinity in this space is not complex, as there are variations in the constructions and practices of masculinities in individuals. According to Atwell (2002), the ideological and socio-political changes that have occurred in South Africa since 1994, have impacted the way in which boys and men within this context understand the meaning of manhood. Research has noted that many boys living in South Africa across all ethnic groups feel “displaced and uncertain as to their role and status within a changing society” (Atwell, 2002, p.85). Kriel (2003, p.86) in a study conducted at the University of KwaZulu-Natal, highlighted that among boys “hegemonic masculinity is a dominant and pervasive form of masculinity”. Additionally, hegemony was associated with constructions of the “ideal man”, and was seen to be used by participants as a benchmark for curating and measuring their masculinities and those of their male counterparts (Kriel, 2003)

2.5.1. Gender and help-seeking

Many studies have shown that young adult males, are less likely to seek help when in need. There are varying reasons as to why men do not pursue help when they are faced with difficulties and this behaviour is exhibited from an early age. The concept of hegemonic masculinity has been used in attempts to understand men’s expressions and experiences of mental illness and depression (Emslie *et al.*, 2006). Hegemonic masculinity refers to the dominant practices and structures in society and in its institutions, which outline the values and norms according to which a man is expected to behave and experience life (Connell 1995). According to Valkonen and Hänninen (2013) positioning oneself in relation to hegemonic masculinity can be seen as a prevalent aspect of a man’s experiences and actions. According to Addis and Mahalik (2003) and Courtenay (2000) for men to be accepted as men in society, they must embody certain characteristics such as emotional endurance, fearlessness, toughness and engage in high risk behaviours. Roberts and Ryan (2002) attests that men generally exhibit behaviours such as but not limited to high risk sexual behaviours, substance abuse and aggressiveness. This is consistent with the findings from a study done by Chadwick (2007), where young men enrolled in a tertiary institution indicated that identification with the dominant hegemonic norms and practices requires them to engage in risky behaviours, thus making it harder for men to pursue help where their health is compromised (Courtenay, 2000). Eaton, Driffin, Kegler, Smith, Conway-Washington, White, and Cherr, (2015) highlighted numerous health-seeking barriers in men when suffering from health related difficulties, “lack

of time, poor access to opportunities, having to state the reason for a visit, and the lack of a male care provider” are reason that have been said to hinder help-seeking in men (Eaton *et al.*, 2006, p. 82). These are however not the only factors leading to men not pursuing help-seeking when their health is threatened, constructions of masculinity have also been argued to deter help-seeking behaviours and health respectively (Mansfield, Addis and Courtney, 2005). It has been argued that common ideals of masculinity have resulted in a lower incidences of help seeking in boy and men, including cases were the ‘problem’ presented might have detrimental outcomes (Lane and Addis, 2005). In a research study conducted in the United States of America, Mahalik, Burns and Syzdek (2007) postulated that masculinity negatively impacted on the health behaviours of men, including the use of appropriate help sources. The results of this study further suggested that men were heavily influenced by “traditional masculine ideals”, thus were more susceptible to other health risks (Mahalik *et al.*, 2007, p. 2208). Lane and Addis (1995, p.155) roles or ideals of masculinity typically include characteristics such as, “success and achievement, emotional stoicism, avoidance of the feminine, independence and reliance”. These traits are therefore, reasons as to why men may not seek help when faced with difficulties because doing so would result in them feeling they will be perceived as ‘unmasculine’, thus these traits foster masculinity. Furthermore, in so far as help-seeking and masculinity are concerned, social constructionist theory suggest that men in certain instances resort to denying needing or pursuing help with the intention of embodying masculine practices and beliefs, this is done as an attempt to maintain certain positions of power and status within society (Mansfield *et al.*, 2005).

2.6. Masculinity and depression

Depression is known to be more common among women than among men, it is often seen as a women’s affliction (Nolen-Hoeksema, 2001). Consequently, women have often been the target of studies of depression (Stoppard 1999; Lafrance 2009). However, men’s depression also deserves research, since it may have serious adverse consequences, which can be seen in the high suicide rates in men (Mo’ller-Leimku’hler 2002; Rochlen, Whilde, and Hoyer 2005). Addis (2008) proposed four conceptual frameworks aiming to explore how gender intersects with ways men experience, express and respond to depression. Addis (2008) proposes the following frameworks; the sex difference framework, the masked depression framework, the masculine depression framework and the gendered responding framework. This study does not explore the sex differences framework as there is absence of relevant theory to guide research pertaining to this framework. The masked depression framework, suggest that within the

context of physical health, a growing body of findings suggests that many men deny illness, self-monitor and treat symptoms, and avoid professional health care providers and services as a means to enact and preserve their masculinity (Addis and Mahalik, 2003; Sabo, 2005). For instances in their study by Lynch, Brouard and Visser (2010) on the constructions of masculinity in men living with HIV in South Africa, they found that men constructed their manhood in relation to societal expectations of invulnerability and expressed how these expectations discouraged attempts to protect themselves from potential infection, to seek health care if illness befalls them and therefore this led to the denial of their risk. Similarly, patterns of denial can be identified in depression cases among men, indicating the subscription to hegemonic masculine roles. Moreover, Findings from a study of rural-based Canadian men who experienced depression revealed that participants concerns about being known within their community as having depression was also a major barrier for soliciting professional help (Coen, Oliffe, Johnson, and Kelly, 2013).

Commonly outlined traits of Western masculine norms include emphasis on competitiveness, emotional invulnerability, toughness, independence, financial prosperity, and authority over women (Hanlon, 2012). These gendered masculine norms are said to shape how men react to complications such as depression (Addis and Cohane, 2005). Individuals who abide by norms such as emotional invulnerability, generally experience difficulties identifying sadness, grief as well as a depressed mood (Fischer and Good, 1997; Levant *et al*, 2003; Pollack, 1998; Real, 1997). Following men's tendency to conceal depression, Cochran and Rabinowitz (2000) proposed that men therefore experience a 'masked depression' and such a depression manifests in externalising behaviours. "Hidden depression drives several of the problems we think of as typically male: physical illness, alcohol and drug abuse, domestic violence, failures in intimacy, self-sabotage in careers" (Real 1997, p. 22). Depression can therefore be induced by masculinity, thus depression in individuals who identify themselves as falling into the social category 'man' cannot be easily diagnosed with this affliction because they cannot articulate their emotions or expressive depressive affect. According to Valkonen, and Hänninen, (2013) there are ways in which men's depression can be related to masculinity. Depression can be perceived as a consequence of both realized and unattained hegemonic masculinity, such as the practices they believe to be consistent with their ideas of manhood and values they ascribe to. At the other end of the spectrum according to Valkonen, and Hänninen, (2013) some men challenged the hegemonic masculinity and located the cause of their depression within the sociocultural gender order, reflecting on the fact that society pressures men into this category

of masculinity and that in itself creates distress. Cochran and Rabinowitz (2000) ascertained that sociocultural factors can account for the appearance of masked depression in men and masked depression may be a result of the inability to identify affective moods amongst individuals, as men rarely introspect.

Pleck (1995) developed a gender-strain model which suggested that the link between socialization of men through restrictive norms leads to developmental and intrapsychic strain amongst this population group leading to depression, consequently also inhibiting help seeking behaviours as masculine gender norms inhibit progressive ways to cope with mood disorders, resulting in men exhibiting more externalizing symptoms, Addis (2008) likens this trajectory to a 'masculine' depression. The gendered responding framework is based on the supposition that in addition to men responding in masculine ways when facing depression, they also respond to sadness and grief in masculine ways Addis (2008). Previous research has also noted the perceptions regarding the intensity of a problem directly affects decisions in men to adopt help-seeking behaviours (Kgole, 2004). Boldero and Fallon (1995) proposed that help-seeking in men is generally lower if there is a perception that the illness is intimate and if the illness has negative connotation attached to it, of which in the case of depression would translate to feelings of inadequacy. Smith *et al.* (2006) patterns of self-defeating behaviours are prominent in cases of depression, where the illness is perceived as having feminine features, thus inhibiting the pursuit of well-being as men find it threatening to their masculinity (Addis, 2005). Men also think it more acceptable to present with somatic symptoms rather than with emotional problems or that they should be strong enough to cope with emotional problems without professional help (Brownhill, Wilhelm, Barclay, and Parker, 2002).

2.6.1. Men, depression and suicide

According to Schlebusch (2005, p. 61), the highest fatal suicide rates are more pronounced in the younger population compared to the elderly population. Presently 53% of suicides are committed by people between the ages of 5-44 years and most fall in the 35-44-year age group and this is applicable to both females and males, this unreeling "phenomenon has resulted in suicide being among the top five causes of death in the younger age groups, globally speaking. Male to female suicide rates range from about 3:1 to almost 4:1". Schneidman (1999) attested that suicide is an attempt to solve a problem by which the individual hopes to end consciousness and sees this as the way to end their psychological distress. He stated that suicidal individuals

are not just depressed but are also hopeless and helpless about change and have frustrated basic psychological needs. Although they are uncertain about their conflicting longing to both die and live, suicide is an attempt to escape their current situation. Schneidman (1999) claims that those with suicidal ideations will verbalise their intentions to commit suicide and these communications are not always explicit and mostly have chronic self-destructive coping patterns, known as a suicidal career.

Research into the aetiology of suicide has proposed it to be related to depression, interpersonal problems (Cassimjee and Pillay, 2000), intrapersonal factors (Greydanus, and Patel, 2003) and the influence of stressful events. Other correlates include physical health problems, food insecurity for those residing in residences, academic pressure, substance abuse, genetics and unemployment (Greydanus, and Patel, 2003). Risk factors for depression and suicide relatively may include age, gender and the presence of physical and general mental suffering (Naidoo *et al.*, 2015.). Young people are plagued by various life stresses, and those in tertiary education have been found to be especially affected by academic concerns and family related stresses such as illness, death and finances (Pillay and Bundhoo, 2011). Recent research in the United States of America has established that academic stress and general life stress together predict depressive symptoms in tertiary students (Lester, 2014), hence the amplified concern over depression in this group, on the contrary “mental health is still a taboo subject among South African men, which has caused many to feel that the only way out is suicide” (NGOpulse, 2017). According to the Men’s Foundation of South Africa (2017), “South Africa has the eighth highest suicide rate in the world, with 450 men taking their lives a month and four out of five deaths being the result of suicide”. Suicide Statistics noted that, University students, predominately males are the highest group of people who commit suicide and gender differences in mental health have long been noted. A study done in 2006 and 2007 on individuals in Durban, South Africa, shown in the table below, depicts that the majority of suicide victims are black males. The study also showed that more men committed suicide compared to women (Naidoo and Schlebusch, 2014).

Cultural psychology recognizes that depression and suicide may be conceptualized as a "*cultural phenomenon within a post-Apartheid context*" (Laubscher, 2003, p.33) and must be "*situated in sociohistorical space and time*" (p. 141). It may also be highly associated with economic constraints and social factors (Meel, 2006). The increasing prevalence of suicide amongst black people may be indicative of the increasing levels of stress in South African society due to acculturation processes and the adoption of western life styles by traditional

communities within a rapidly changing socio-political environment. Some studies suggest that suicide may be increasing in relation to the urbanization of young Black youth post-apartheid. Bateman (2001) ascribes this to a loss of family cohesion and the lack of black role models within a rapidly changing culture. In addition, it may be a result of the sudden increase in pressure to achieve amongst Black South Africans and resulting stress (Laubscher, 2003). Similarly, Madu and Matla (2003) found rates of attempted suicide to be highest in the urban areas of South Africa. They attribute this to acculturation; the breaking of family ties and increases in social misconduct due to the erosion of cultural and traditional values in such areas.

Table 1: Suicide variations by gender and racial composition

Gender & Year	Black	Mixed Race	Indian	White	Gender Total	Gender %	Year Total
Men 2006	202	7	91	53	353	75.9%	465
Women 2006	63	3	32	14	112	24.1%	
Men 2007	239	10	103	40	392	78.9%	497
Women 2007	51	5	34	15	105	21.1%	
Total	555	25	260	122	962	—	—
%of Total	58.0%	2.0%	27.0%	13.0%	100.0%		

Source: (Naidoo and Schlebusch, 2014)

2.7. Depression within the South African sociocultural context

According to the World Health Report on Depression and Other Common Mental Disorders (2017), 4, 3% of the South African population as a whole suffer from depression. The report also found that 20 men per 100 000 of the South African population committed suicide due to depression and other mental disorders like anxiety. These men were found in low, middle and high-income individuals. The report also found that 6% of woman in the African Region, compared to 5% of men, had a prevalence of depressive disorders. It is necessary to understand the sociocultural context in which men live. Some studies have shown that political and socio-economic transitions impact on health (Rancans *et al*, 2001). The urban and most economically developed areas may be most affected because, by virtue of their relative affluence and good

communications, they are most susceptible and open to change (Burrows, and Laflamme, 2006). Following its transition to democracy in 1994, South Africa has undergone massive socio-economic changes and thus represents a country that will show varying health outcomes. Apartheid policies left their mark on the size and shape of urban populations by distorting where people lived. Further, although much progress has been made in ensuring more equitable access to the benefits of living in cities, in other respects, some of the largest cities are more unequal today than they were 10 years ago.

Durban is one of four major urban industrial centres in South Africa and is located in the province of Kwa-Zulu-Natal (KZN), one of the most densely populated regions in the country. Durban typifies many of the socioeconomic problems confronting the country, the most crucial of which are the delivery of housing and employment creation (Massey, 1996). The relationships between social determinants such as poverty, inequality, lack of education and unemployment; high concentrated areas also increase competition for public resources, which reduces the capacity of people within societies to coexist (Massey, 1996). As competition for scarce resources arises, the poor then face increased exposure to crime (Massey, 1996), thereby resulting in exposure to disease, family disruption, violence and community disruption and these outcomes can be linked to depression.

Many Africans continue to live on the outskirts of urban areas, the least developed sections of the city. Apartheid officially ended in 1994, but its legacy is evident in the marked racial stratification in South African occupational (Statistics South Africa, 2004) and educational systems (Buchmann and Hannum, 2001). In fact, until 1994, non-white South Africans could neither hold prestigious jobs nor reside in certain urban neighbourhoods unless they were domestic servants (Buchmann and Hannum, 2001). These provisions excluded many from full participation in the labour market. There still exists a deeply segmented work force with whites at one extreme, Africans at the other, and all other groups in the middle (Jackson *et al*, 2010). The unemployment rate in South Africa also falls along a colour continuum. In 2001, 50 percent of Africans, 20 percent of Coloured's, 17 percent of Indians, and 6 percent of whites were unemployed (Statistics South Africa 2004). The structural resource of education is also unequally distributed across the population, with Africans having less access to formal schooling than any other racial group (Buchmann and Hannum 2001). Socioeconomic status (SES) soon became confounded with race in South Africa. For example, the informal settlements in urban areas where many Africans were confined typically lacked electricity and running water. Kagee and Price (1995) argued that psychological suffering among South

Africans has social, economic, and political roots. Thus, the most disadvantaged racial groups in any society are expected to report higher distress levels than those from the majority groups (or those along the continuum of race) primarily due to a lack of socioeconomic resources. Ross and Mirowsky (2013) propose that race differences in psychological distress may actually be explained by socio-economic status disparities as well as exposure to prejudice and discrimination; they refer to this view as the minority status perspective.

Research indicates that across cultural contexts, depression is reliably linked to environmental factors such as demanding climatic conditions, stress, unemployment and poverty, and lack of social support (Chentsova-Dutton and Tsai, 2009). Different cultural groups have different suicide patterns. NIMS has reported 4.6 male' suicides for every female one (Lewis, Meehan, Cain, Wong, Clemence, Stevens, and Tillman, 2016). The findings also highlighted coping strategies for family problems, drug abuse and alcohol problems, lower in males than in females. Females have a more positive outlook on life and therefore manage to cope internally better with stress and emotions than men.

Depression is distinct from many other medical conditions because it is not only a neurological phenomenon, but also a psychological and cultural one (Ryder, Ban, and Chentsova-Dutton, 2011). Such findings demonstrate how the study of culture and depression requires attention to the cultural context and to the interaction of biological and sociocultural factors. According to Driscoll, Reynolds, and Todman, (2015) most people's general experiences of life stress, is perceived to be due to unfair treatment, and this arises from the racial order of South Africa. That is, these stressful experiences can be drawn back to surrounding social structures and people's locations within these structures. Generally, people exist in social environments that are shaped by political, cultural and social forces, of which Swanson *et al.*, (2003) argues that the nature of the challenges and experience resulting from the complex interaction of these social forces are significantly influenced by gender, socioeconomics position and ethnic group membership. As such, there is quite a lot of social environmental factors that affects young black men which triggers depression at alarming rates. These social determinants may include primarily education and employment, there is a great extent to which these social determinants affect the young black man because of the legacy of racism that has laid the unfortunate context that most black people within the general population are faced with currently. One can argue that it is the lack of economic opportunities coupled with poor educational preparation that result in many young black men not being able to forecast a positive future for themselves

Research have indicated that there is lot of hopelessness in black males and since that is a problem on its own, hopelessness is by the way another indicator of depression.

Various authors (Goldberg, 1976; Nathanson, 1977 and Harrison *et al.*, 1992) have previously studied masculinity and men's health in relation to the "male sex role" influence. Levant *et al.*, (2008) refers to masculinity as shared cultural expectations about appropriate male behaviour. Age being an important cultural dynamic, men in late adolescent stage often experience a stressful time of conversion as they try to gain emotional independence (Caldwell, 1999). Kendricks *et al.*, (2007) report that the ages between 18 and 25 years represent the final transition from childhood to adulthood, encompassing the end of adolescence and the achievement of full adult status. In these critical years, people's perceptions about themselves and their world are shaped and reshaped. Included in these perceptions are cultural values and beliefs regarding health and mental health, particularly among African American young men (Kendricks *et al.*, 2007). Furthermore, previous research indicates that men and boys experience comparatively greater social pressure than women and girls to endorse gendered societal prescriptions such as the strongly endorsed health-related beliefs that men are independent, self-reliant, strong, robust and tough (Williams and Best, 1990; Golombok and Fivush, 1994; Martin, 1995). These health beliefs do not only give explanation to the great incidence of serious health problems and early age mortality in men but also explain other sex-linked congenital abnormalities i.e. High rate of behaviour disorders that comprise of criminal acts, gangsterism, promiscuity, substance abuse, violence etc.

Young black men who are on the role to create a new life for themselves and emerge in the middle class social status are said to have perceived burdensome as a result of their gender role expectations, hence they possess the mentality that involves mandate for achievement and recognition deriving from outcome-driven performance. According to Chadwick (2007) the hegemonic masculine norms of being successful are aspirational features of masculinity, in his study participants indicated that having a good job and achieving financial success were all important aspects of masculinity. In South Africa most of us have come to terms with concept of "black tax" but some are still baffled by what it means. The concept refers to an obligation that an individual has to abide by, to support their extended family. This has been said to be the financial burden affecting emerging middle class, but specifically young black men who are disproportionately suffering from depression as a result of this traditional family obligation. Below are expressions from young men extracted from social media and reads as follow:

'Black tax kills the aspiration of the youth', #pursestrings #financialwisdom.

'Black tax is holding every black child down and there's nothing we can do, we need to accept it' #blacktax

'Black children are always under pressure to perform but no one really cares about what it takes & what they go through... Unfortunately, that's our burden in life' #blacktax

'What can one do for a young man who's fighting the age clock+ #blacktax, whilst failing to live his dream? Depression is killing me'

(Twitter, 2017)

The above quotes form part of the radio discourse that was extended on social media platforms including twitter, which was addressing the dilemma that black youth in the South African black middle class are facing. The notion of black tax as a family responsibility or traditional financial obligation that has created resentment in the lives of South African black or emerging middle class as it comes with too much expectation and results in delayed self-progress in one's upward social mobility journey. Because of this sharing and redistribution of the disposable income, Sen (1997) argues that the relationship between income, and individual achievement and freedom is not constant. In relation to this sharing and distribution of disposable income, Di Falco and Bulte (2015) argue that this form of social capital discourages investment and savings and may result to a poverty trap. Gerstel (2011) state that black people rarely have the economic resources that allow the kind of privatization that the nuclear family entails, which in turn, makes kinship a survival strategy in the face of economic difficulties.

The study aim is to investigate sources of depression among young black university students who are an emerging middle class on the role to obtain social mobility. Hence, understanding the origin of the middle class family is quite pivotal as Sullenberger *et al.* (2015) refers to the core factors that shape social mobility as including, family origin, motivation, educational attainment, and structural inequalities. The majority of black South Africans originated from low social class. As aforementioned, the system resulted in broken family structures, poor quality education and highly unequal societies and made close to impossible for the rest of the black South African to obtain upward social mobility. This is important to address particularly when one examines the sources of perceived hopelessness in young black men, as Hurd *et al.*, (2013) state that kinship support becomes an important aspect of coping, and resource of social capital. Gerstel (2011) also support this as he states that experiencing relative economic

deprivation leads to higher levels of extended family involvement, having limited money and education makes one more likely to give and receive help from kin. Di Falco & Bulte (2015) adds to this as they state that moral obligations towards sharing and redistribution are supported by custom and norms that enables kinship members to claim assistance from their relative when faced with difficulties. The concept of Ubuntu, well translated as “I am what I am because of who we all are”, means that my humanity is caught up, is inextricably bound up, in theirs (Dreyer, 2015). Dreyer (2015) state that the concept of Ubuntu speaks to the very essence of being human, it represents kindness, hospitality, friendliness, caring and compassion. While some have accepted this expectation of which anthropologist refer to as the ‘moral economy’ but some have not and refer to it as ‘force solidarity’ and if they do not comply upon to this traditional obligation they sense failure to live up to kin and extended family’s expectations. This usually results to long term depression because of emotional inexpressiveness that is coupled by men’s difficulties in expressing emotions of pain due to him protecting his status in masculinity hierarchy and does not want to be perceived as shifting power relations with women around him.

Given the nature of our globalized world, African people are subjected to western norms and these norms shape their identity as identity is not a fixed concept, therefore in as much as they belong to specific African cultures they are still heavily influenced by Western cultures. Through mass media, African countries and other developing countries have been exposed to the lifestyles of people in western countries and many people want to emulate these affluent lifestyles. This brings rise to different consumption patterns, patterns that are unequivocally detrimental to one’s psychological well-being. According to Üstüner and Holt (2009) the emergence of a global class in low income countries, such as those in Africa has led to the rise of discretionary purchasing power approaching Western levels, therefore low-income countries are able to now pursue a consumption-focused lifestyle, which is not necessarily easy to be a part of, because the majority of black households live below the poverty line in South Africa, thus this deepens the perception of deprivation amongst the African race group. Cultural imperialism according to Guang (2003) is a culture that not only considers itself superior to other cultures, but also practices this superiority; imposing its values and norms upon other cultures i.e. ‘Americanisation’. Americanisation, in Africa has led to the widespread familiarity with the notion of “The American Dream”, which is a phenomenon that heavily places great value in extrinsic goals such as wealth attainment and image as opposed to intrinsic goals such as personal growth, relatedness, and community (Ryan, Chirkov, Little, Sheldon, Timoshina,

and Deci, 1999). According to Ryan, Chirkov, Little, Sheldon, Timoshina, and Deci (1999), being wealthy, attaining an elite image and being famous as well as possessing a certain level of power is portrayed as the means to “the good life”. This view of the good life is referred to as the American Dream, mainly because the USA seems to be at the forefront of the market economic systems and it is a nation often described as exemplifying an individualistic, materialistic orientation. When African countries conform to Western/American culture, Nozick (1993) noted that cultural diversity is eroded as well as African traditions as a large proportion of population seeks to emulate the values of a mass consumer society (Nozick, 1993).

2.7.1 Externalising Behaviours, Lack of Treatment and the Effects of Depression on Population Health

Many men embody distinctive health and illness behaviours. Specifically, men are known to risk rather than promote their health, rely on performance-based models to confirm health, self-monitor and treat symptoms, deny illness, and avoid health care professionals and services (Sabo, 2005). According to Courtenay (2000) men’s health risk-taking and performance of heroic feats are linked to their need to have other men and women acknowledge their manhood. Cochran and Rabinowitz (2003) confirmed how men’s depression can manifest as anger, impulse control difficulties, anxiety and irritability, aggression, substance abuse, risk taking (e.g., drunk driving, binge drinking), escaping behaviours (e.g., over involvement in work and/or sports), emotional numbness, inability or unwillingness to express emotion, impoverished relationships, and suicide. Mirroring global patterns, Australian women report higher rates of distress, but men report more than twice the rate of substance use problems (Australian Bureau of Statistics, 2012), and account for 75% of suicides (Australian Bureau of Statistics, 2014). Men’s ineffective coping strategies unfortunately contribute to prolonged depression, lower detection, and treatment delays (Brownhill *et al.*, 2005; Hausmann *et al.*, 2008)

Courtenay (2004) predicted that college men who experience depression are likely to rely on themselves, withdraw socially, and/or try to talk themselves out of it. A secondary analysis of U.K.-based men’s interviews, derived from a study that focused on depression-related issues, indicated that longstanding feelings of isolation and difference, in addition to sadness, guilt, detachment, anger, and fear, were strongly represented in men’s accounts of their depression (Emslie *et al.*, 2006). Additionally, O’Brien and colleagues (2005) found that many men in their study emphasised the importance of remaining ‘strong and silent’ about emotional

difficulties. They conducted 14 focus groups with a diverse sample of men in order to explore help-seeking behaviour. The authors relayed that they experienced resistance, and even hostility from some younger men, when respondents were asked to discuss mental health issues. A number of social psychologist's view anger as an emotional reaction rather than a mood state. Hostility is the label generally adopted by stress investigators interested in this type of emotional state (Rosenfield 1980). Rosenfield (1980) stated that the term anger/hostility is adopted to represent both the emotion and the hostile behaviours that this emotion can evoke. Anger is especially important to consider in this study of young adults living in post-Apartheid South Africa, since such feelings may be the critical link between perceived structural inequalities, stress, depression and deviant behaviour, including aggressive and hostile acts (Agnew, 1995).

There is undoubtedly a strong relationship between depression and high-risk behaviours. Clinical depression if not treated has various negative implications on our overall well-being. suicide has been widely discussed in the study of depression along with other health implications such as using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high comorbidity rates between depression, anxiety and substance use disorders (Bolton *et al.*, 2009). In addition to being highly prevalent, depression and substance use disorders frequently co-occur in individuals (Conway *et al.*, 2006; Grant *et al.*, 2004; Kessler *et al.*, 2005; Sbrana *et al.*, 2005). In the National Epidemiologic Survey on Alcohol and Related Conditions (NESARC), 20.1% of people with an alcohol or drug use disorder clinical depression (Grant *et al.*, 2004). Various research has proposed a direct causal relationship between depression and substance use; this postulates that the presence of one disorder may result in the development of a second disorder. This explanation is often used to account for the comorbidity seen in depression and substance use disorders and has been described as the "*self-medication hypothesis*" (McGrath, Nunes, and Quitkin, (2015) whereby depressed people misuse alcohol or drugs to ease distressing symptoms.

Depression is a modifiable factor associated with high-risk sexual behaviours and STI among youth in the United States (Ramrakha, Caspi, Dickson, Moffitt, and Paul, 2000). While sexual risk behaviours and STI are risk factors for depression (Shrier *et al.*, 2001). Depression also may increase susceptibility to risk behaviours and infection (Lehrer *et al.*, 2006). Depression may impair cognitive function and memory as well decrease impulse control (Lejoyeux *et al.*, 2002). According to Aseltine *et al.*, (1994), the presence of depression in young adults

contribute to psychosocial impairment, including emotional reactivity in peer relationship reduce motivation and increase fatalism. These depression-related effects may inhibit clear perception of STI risk and the ability to prevent risk behaviour. Furthermore, if depression is not treated it may increase the spread of infectious diseases, such as HIV and sexually transmitted infections through risky behaviour such as alcohol and substance abuse and unprotected sex (Khan *et al.*, 2009). The prevalence rate of HIV/AIDS in South Africa is as high as 17.8% among adults aged 15–49 (UNAIDS, 2012) and untreated depression among such people may be a risk for low adherence to antiretroviral treatment (Nel and Kagee, 2011). A recent review study from Sub-Saharan Africa found that the likelihood of good adherence to ART was 55% lower among persons with depressive symptoms compared to persons with no sign of depression (Nakimuli-Mpungu *et al.*, 2012).

A community-based cross-sectional study from South Africa confirmed the associations between depression and having concurrent partnerships, previous treatment for a sexually transmitted infection, and sex with someone known for less than one day, sex while using alcohol or drugs, transactional sex and forced sex (Smit *et al.*, 2006). In their study Nduna *et al.*, (2010) postulated that in men depressive symptoms at baseline were associated with having had transactional sex, not using a condom or doing so incorrectly at last intercourse and having sexually assaulted a stranger or acquaintance. According to Nduna *et al.*, (2010) there was some evidence suggesting that they were also associated with having perpetrated more than one episode of physical or sexual intimate partner violence. Moreover, these findings suggested that men who reported baseline depressive symptoms were at greater likelihood of not using a condom or doing so incorrectly at last intercourse 12 months later.

Depression leads to the deterioration of abilities in daily activities, especially those in the occupational domain. Academic achievement is an important dimension for students, so the effect of emotional disturbance on academic achievement is an important subject. According to Turner *et al.* (2012), depression negatively affects cognitive functioning and, consequently, academic performance. Several studies have shown a relationship between academic performance and depression in college populations, (Birmaher *et al.*, 1996) noted that depression impairs psychosocial development and academic success. Depressed students were more likely to identify Attention Deficit Hyperactivity Disorder (ADHD), chronic pain, depression/anxiety/seasonal affective disorder, drug use, eating disorders, learning disabilities and relationship difficulties, and stress as sources of academic impairment than non-depressed students (Lindsey, Fabiano, and Stark, 2009). The common ages for most tertiary students is

age 17-26, these ages signify the stages of late adolescence and early adulthood. In these stages, emotional wellbeing is an important motivator (Baker and Siryk, 1984). Academic achievement is undoubtedly affected in students who suffer from depression, moreover learning problems also worsen emotional difficulties, therefore academic performance and personal emotional adaptations are two important dimensions of adaptive function in the college life period (Baker and Siryk, 1984). Moreover, emotional distress and depression become a burden to public health and in society in general as it interferes with the production of human capital.

2.7.2. Perceived Barriers to Health Care and Help Seeking

Some studies done in Africa have listed reasons as to why people do not seek health care when they suffer from a mental illness such as not being able to identify that the illness is a treatable disorder and beliefs that they would recover without treatment (Trump and Hugo, 2006) and the latter is predominantly why males do not seek mental health care facilities in the face of adversity, as well as not knowing where to go or feeling embarrassed about the perceived problem results in men not seeking mental health care (Seedat *et al.*, 2002) and beliefs that the mental illness is a somatic illness (Okello and Neema, 2007). Stigma and misconceptions about the cause and severity of mental illness (Corrigan, 2004; Sartorius, 2007) are common barriers especially in poor resource settings where local culture and religion have a profound impact on people's lives (Crawford and Lipsedge, 2004; Ae-Ngibise *et al.*, 2010). Crawford and Lipsedge (2004) highlighted that Zulu people in South Africa found Western medicine useful for treating physical illness, but not mental illness since many mental health problems were understood only by traditional healers from their own culture. Generally, men within this context would rather self-medicate rather than seek professional help.

Stigma plays a significant role in influencing individual's choices and perceptions about accessing professional psychological services. Stigma is defined as the perceptions society hold regarding individuals who are mentally ill (Vogel *et al.*, 2006). Bathje and Pryor (2011) stated that there are different forms of stigma and they include public and self-stigma. Public stigma pertains to the perceptions society holds regarding mentally ill people and self-stigma is imposed Pryor (2011), both these forms of stigma can intersect with masculinity and consequently affect help-seeking behaviours. Individuals may fear being stigmatised by 'others' if they divulge their emotional afflictions, moreover individuals may internalise the stigma thus resulting feelings of inadequacy and shame. Vogel *et al.*, (2006) attested that most people may refuse to access psychological services, not adhere to treatment, prematurely

terminate treatment and conceal their psychological concerns in an attempt to protect themselves from societal backlash.

Arguably the strongest barrier to treatment in the South African population involves the knowledge and beliefs about mental illness that aid recognition, management, or prevention. Studies investigating explanatory models of mental illness in Africa have revealed that depression, for example, is not seen as an illness but rather a result of psychological difficulties resulting from several external factors, such as poverty, alcoholism, or poor marital relations, which are highly prevalent in the developing world (Patel, 1995). This explanatory model of depression when coupled with the ideals associated with hegemonic masculinity suggest that the prevalence of depression in African men is much higher than estimated.

2.8. Summary

This review of literature has shown that depression is the leading cause of disability in the USA, highlighting the devastating effects of the subjective experience of the illness. It also explored how depression cases and suicide cases are on the rise in South Africa. Clinical depression has been widely researched by various studies due to its chronic nature, and its effects on the individual's physical, emotional and spiritual wellbeing and the suicide patterns seen in men. Considering these incapacitating effects, this literature search has aimed to explore how men construct their identities and how hegemonic masculinities are constructed socially. The review also considered the various perceived ways of coping with mental illness in men against the backdrop of masculinities when men are faced with stressful life events. Strategies conveyed by numerous other studies on topic about depression in men highlight externalising behaviours such as substance dependence, sexual risk behaviour and suicide (Addis, 2008). Men going experiencing emotional pandemonium tend to use distractions to obtain solace and comfort as these strategies help them conceal such emotions as they are viewed as female afflictions. Mental illnesses in this study were conveyed as illness that present themselves through clusters of symptoms. When such symptoms are associated with significant distress and impairment in one or more domains of human functioning, they are defined as clinically significant mental disorders (Lund *et al.*, 2009).

CHAPTER THREE: METHODOLOGY

3.1. Introduction

This chapter of the dissertation focuses on the methodological approach governing this research. The researcher will deliberate the research methodology and the research design adopted in conducting this study, which includes the sampling method used in the selection of participants, the data collection method and the system used for analysing the raw data that was collected during the twelve interviews. This chapter will also discuss the research experience in its totality, particularly looking into the challenges of field research of this nature. This chapter will also include the ethical considerations borne in mind for the participants' involvement in the study.

3.2. Qualitative Research Design

This study used the qualitative research approach. Qualitative research is conducted with the intention to study human action from the standpoint of the people being studied, and it relies heavily on thick descriptions and permits for the collection of valuable data in narrative form (Silverman, 2016). Qualitative research is conducted with the intent to give comprehensive descriptions about the behaviour of a certain people and not to predict and make assumptions about the participants in the study. The participants in this study are interviewed in their social academic space - a familiar space, around campus and resident rooms. According to Creswell, "a qualitative research design essentially collects and interprets non-numerical data, focusing on the meaning of sample participants' beliefs, experiences and perceptions of a particular phenomenon" (2003, p. 20). Qualitative research methods position the researcher central to the world of those being studied, such that the researcher is said to be a part of the research participants' world temporarily. This proximity permits the researcher to unfold the meaning and experiences that the participants ascribe to their lives with great detail.

In an attempt to explore and understand how African male university students perceive depression and the masculine identity, data gathered from participants focused on the meaning and understanding of the study participants, their lived experiences and perception of their experiences as young African males in a tertiary institution. A phenomenological approach to understanding the above-mentioned constructs was employed. According to Giorgi (1985) phenomenology, emerged in the 20th century, it has its roots in the philosophical movement based on the scholarly work of the philosopher Edmund Husserl (Giorgi, 1985). As a research instrument, phenomenology is grounded on the academic disciplines of psychology and philosophy and has come to be an extensively accepted method for describing human

experiences (Giorgi, 1985). Phenomenology is therefore the scholarship of structures that govern consciousness as experienced by an individual within their own frame of reference. Phenomenology is a qualitative research method that affords the researcher to have a descriptive understanding of how human beings experience a certain phenomenon, therefore the researcher in this study aimed to explore and understand how African Male University students in UKZN experienced masculinity and their social positions collectively. In adopting the phenomenological approach, the researcher consciously set aside biases and preconceived assumptions about the concept of masculinity in African males, their experiences, feelings, and responses to a particular situation, such as distress. This method allowed the researcher to probe into the perceptions, perspectives, understandings, and feelings of African males regarding the phenomena masculinity and depression. Because of the nature of this study, and its intention to explore how masculinity is defined by African male students, it is of paramount importance that the researcher fully explores the construction of the male identity and this can be done by completely exploring the social constructionist theory.

At the other end of the spectrum, this study also explored the construction of an identity, which is evidently the construction of the male identity. According to Berger and Luckmann (1991) social constructionism examines the development of mutually constructed understandings of the world that form the basis for shared assumptions about reality. Berger and Luckmann (1967) further attest that social construction is an on-going process that is reproduced by people acting on their interpretations and their knowledge of it. Therefore, social groups impact on the psychology of individuals through their capacity to be internalised as part of a person's social identity (Cerulo, 1997; p388). Masculine identities place individuals in a social space by virtue of the relationships that these identities imply, and are, themselves, symbols whose meanings vary across actors and situations. In essence gender is a social construct that is embedded in social identities. The study of the masculine identity is important to understand in order for us to fully grasp the extent at which these identities interlink with mental health, especially clinical depression. To further get a full understanding of the social construction of the masculine identity the researcher was not oblivious to the role social contexts play in influencing a great part of how identities are constructed.

Burr (1995) argued that any attempt to make sense of the social world social scientist must seek to explain the roles that language, culture, knowledge play in it, precisely because humans are social beings. Haslam *et al.*, (2009, p.2), attest that the paramount expression of this sociality is that humans live, and they have evolved to live, in social groups. This fact has

orchestrated not only the things humans do but also the evolution of their minds and ways of living. Being a male in society you have to act in a certain way that fits the category of being a male. The difference physically between males and females lies in biological make up, however this difference is not just a “mere” difference because from ancient time it has played a huge role in how humans perceive others and how people in general perceive themselves, in essence this biological difference has been part of people’s social cognition and it has influenced how they think about things and the manner in which they act. Therefore with this knowledge The researcher was able to gain a better understanding of who the participants were, how they ascribe meaning to their lived experiences as emerging adults and how they experience the concept of masculinity in congruence with their identity in great detail using the interviews, additionally also aiming to understand how they perceive depression.

According to Babbie (1995, p. 83) “research design addresses the planning of scientific inquiry designing a strategy for finding out something”. A research design entails the collective plan that explicates the process to be used in pursuing an answer that is proposed by the research question. According to Babbie (1995, p. 84-85) exploratory research is conducted to explore a certain topic; moreover, it is also used for examining a new area of interest in research. The persistent phenomenon of masculinity and depression is recurrent in international studies. However, depression in African males is an under researched area within the South African context and it has rarely been explored. Mouton (2001, p. 109) advances the idea that “an exploratory research has a basic research goal, and researchers frequently use qualitative data”. This research study will be governed by exploratory research, a research design that will include the implementation of in-depth interviews to illicit the data required by the researcher from the participants, this design is of greater preference because it is best suited for this study as this investigation seeks to understand the perception of depression in tertiary male students in relation to masculinity and the coping strategies that these young men perceive as feasible in an attempt to find a balance between distress and the masculine identity.

The researcher experienced some difficulty gathering participants because a relatively high number of males found it difficult to discuss “depression”. One of the challenges that the researcher faced was getting consent from the participants. The issue at hand was that of an unwillingness to delve in the topic of depression. The researcher did not act like a psychologist, therefore most participants felt uneasy speaking about clinical depression. However, being a student like the participants served as an advantage as some people are more comfortable and open to talking to a student rather than a trained professional for fear of being diagnosed or

rather misdiagnosed with clinical depression, because many were under the impression that the researcher approached them because they had symptoms of clinical depression. As a researcher, it becomes of paramount importance that one develops a relationship with the participants. This was achieved by disclosing ones identity at the onset of the encounter with participants, good rapport therefore entails informing the targeted population the reason for the research and how the data would be used. This enables the researcher to gain the trust of the participants, because good rapport was established with participants it was at this stage that they felt comfortable opening up to the researcher.

3.3. Study Area

The study was conducted at the University of Kwa-Zulu Natal, Howard College Campus which is located at the port city of Durban in Kwa-Zulu Natal. Durban has is one of the cities that has quite a number of higher education institutions. The study focus area was Glenwood where University of Kwa-Zulu Natal located. Most students enrolled in this institution fall into the age range of young people which is 23 Years -30 Years, this stage is important as it is during the developmental period of young adulthood that individuals learn to monitor their own health, make decisions about health service use (Rickwood, Deane, Wilson, and Ciarrochi, 2005). These men face a dilemma, however, between discourses circulated in western society regarding how 'masculine' men behave (i.e. showing that they do not care about their health) and realising that in everyday practice, men should care about their health. Most of the individuals attending this institution, come from neighbouring townships where there are great level of inequalities, proposed to have negative effects on an individual's mental health.



Figure 1: Map of UKZN, Howard College

3.4. Sampling Method

The researcher made use of the non-probability sampling method; namely the convenient sampling method. While convenient sampling is not always an ideal choice, the nature of this study required the use of this method since access to participants who showed willingness to participate in this type of study is unpredictable. According to Davies (2007, p.55-56) “in convenience sampling the researcher simply takes on what they can get where they can get it and interview the first eighty people they meet who agree to cooperate with the researcher”. The willingness of people to engage with another student provides a series of challenges for both the researcher and the participants. The researcher has established a relationship with the participants, as she is also a student in this campus, therefore some of the participants in this study were familiar with the researcher as they share the same public spaces, and the participants were selected using the convenient sampling method.

Convenient sampling is one of the methods that was used to recruit participants into the study. Permission was granted from the SRC to put out posters in the library as well as in the residences, informing students about this research. Word of mouth was also employed, where students were approached and briefed about the study leaving room for them to volunteer to be a part of the study. Some of the participants who were approached in the briefing showed a keen interest on the research and as a result were keen to partake in the interview process.

Davies (2007, p. 56) found that the researcher has no control over who falls into the sample in terms of age, and nationality and consequently the researcher had no means of knowing the extent of the information the researcher was going to get or the opinions that are expressed do or do not reflect the total 'population'- or even what that 'population' might consist of. It is therefore important to indicate that the findings are based on this particular small sample of African male tertiary students in Howard College and therefore the findings cannot be generalized to the broader male population.

3.4.1. Sample Size

The participants of this study comprised of twelve black males between the ages 23-30. The participants were required to be registered UKZN student in any faculty/school. These research participants were identified as they were conveniently available and at the appropriate stage of development for the study, that is at the transition to young adulthood (Ronnestad *et al.*, 2003). It is important to realise that the aim of this study was not to generalise the findings to the broader population of black male tertiary students, but to rather begin exploratory research into a relatively unexplored area. There was no selection criteria in terms of participant's place of origin. However, participants all came from similar social, cultural and economic backgrounds. Only one participant was Xhosa all were IsiZulu speakers. The participant were all above 20 years of age. The participants include 12 Black men, 11 of whom hail from urban townships around Kwa-Zulu Natal, they identified themselves as falling into the category of middle class. *Participant 6* identified as coming from an upper middle class background and resides in a suburban area.

Table 2: Participants Demographic Information

Participant number	Age	Level of study	Date of interview	time of interview	Venue of interview
1	24	Postgraduate	9/10/2017	1 hour	Residence
2	24	Undergraduate	11/10/2017	30 mins	Residence
3	23	Undergraduate	19/10/2017	47 mins	Residence
4	30	Postgraduate	23/10/2017	49 mins	Residence
5	25	Postgraduate	30/10/2017	40 mins	Residence
6	25	Postgraduate	31/10/2017	53 mins	Residence
7	25	Undergraduate	13/03/2018	1 hour	Residence
8	26	Postgraduate	27/03/2018	39 mins	Residence
9	26	Postgraduate	20/06/2018	35 mins	Residence
10	26	Undergraduate	27/06/2018	44 mins	Residence
11	28	Postgraduate	13/08/2018	42 mins	Residence
12	24	Postgraduate	14/082018	30 mins	Residence

3.5. Data Collection

3.5.1. The Interview Process

The data for this study was collected through one-on-one interviews using the interview schedule (*Appendix 4*). The interviews were conducted at the University of Kwa-Zulu Natal Howard College campus. Before the interviews were conducted, the researcher outlined the goals of the study and went through the consent form (*Appendix 3*) with the participants. Participants had to sign the consent form then only were the interviews conducted. All interviews were digitally recorded with the consent of the participants. In-depth interviews were conducted for this study. The interviews were conducted in English with little insertions in IsiZulu.

3.5.2. Procedure

All participants in this study lived in the student residential accommodations in the (UKZN) Howard College Campus, permission to put up notices in the residential accommodation and Howard College was granted by the Students Representative Council (SRC). Those who showed an interest in the study contacted the researcher via text, they were then informed verbally about the aim of the study before the interview commenced. Some participants in the study were approached by the researcher herself, as they were no referrals from other participants. Participants that were approached by the researcher, were approached in the corridors of the residence and told about the study, as such some agreed to be interviewed and others volunteered. Before the interviews were conducted participants were informed about the purpose and the aim of the study. The researcher perused the consent form with each participant before they signed it to acknowledge that their participation was voluntarily. There were informed of their rights to withdraw from the study at any time should they wish to do so. Permission to use a digital voice recorder during the interview process was obtained from each participant. The participants were interviewed individually for 30-60 minutes and the interview processes was carried out in one session per participant. All participants were interviewed in their student accommodations situated at the Howard college campus, in the evening as all participants were only available at that time. Participants who were personally approached by the researcher initially had their reservations about partaking in the study, of those who had their reservations the assumption was that the researcher assumed they were depressed. The researcher then intervened by going through the objectives of the study with them, that is when they felt comfortable with partaking in the study. The researcher had to establish rapport with participants and they all felt comfortable narrating their stories and perceptions to the researcher.

The interview schedule (*Appendix 4*) for this study was written in English and the researcher used English when asking questions during interviews. When answering questions, some participants used both English and IsiZulu to convey their answers. The researcher did not experience challenges with the use of both languages while transcribing as she is fluent in both languages. In the analysis chapter participant's responses were transcribed as translated to English with the exception of ethnic sayings. Furthermore, to maintain consistency and reliability in terms of the translation process, the researchers interpretations were verified by participants as answers in IsiZulu were reviewed with participants. According to Deumert (2010) language is a tool used in the social construction of reality and speakers use it to express

and relate their experiences. Expression through the use of their mother tongue allowed participants to express their emotions and associate them with their experiences. Expecting participants to respond only in English would have restricted them from expressing their true feelings, being in touch with their experiences or even distort their responses.

3.5.3. Semi-Structured One-to-One in-depth Interviews

According to Halgin and Whitebourne (2009) a semi-structured interview is a method of research used in social sciences. It comprises of standardised series of questions and because of its flexibility it allows the researcher to ask follow up questions based on the response given. Roy, Zvonkovic, Goldberg, Sharp, and LaRossa, (2015) argued that twelve to fifteen is the smallest acceptable sample size in qualitative research. According to (Morse 1994, p.225) six participants are recommended for phenomenological studies, hence why the researcher saw it feasible to conduct twelve in-depth interviews. Qualitative method is designed to meet rigour and trustworthiness, thick, saturated data is of paramount importance. To achieve these principles the researcher conducted twelve in-depth interviews, ensuring that the participants remain central to the study and they remain the holders of knowledge as per their own personal experiences in this research.

In this study, the researcher used semi-structured one-on-one interviews as a tool to gather data. Individual interviews are useful to determine individual African male ` perceptions, opinions, and information about their lived experiences in their general life, how they find balance under difficult and strenuous situations looking specifically at the general attitude towards clinical depression and health seeking behaviours in contrast with risky behaviours . This research tool enabled the participants to be more relaxed since it was more of a conversation between two people rather than a formal interview. However, the researcher was guided by a list of broad questions and themes that related to the key area of investigation around depression and masculinity. The unstructured one-on-one interviews afforded the researcher the opportunity to obtain greater understanding of how masculinity is constructed in African males, what it entails and the impact it might have in exacerbating depression.

The interviews carried out were all tape recorded and later transcribed verbatim. In general, the interviews lasted 30 minutes to an hour. It depended on the willingness of the participant to open up and share information. The interview process was very interesting. It afforded the researcher the opportunity to better understand how masculinity is dominant in the identity of males, and how life is like for them as black males who are transitioning from and to young

adulthood. It awarded the researcher the opportunity to have a better insight on the literature that the researcher had engaged in with for the purpose of this study and as a result, the researcher was able to relate theory to experience. The researcher is a female IsiZulu speaker, therefore language was not a barrier and the researcher was able to understand the expressions used by the participants to convey their messages. For instance, one participant said “*Indoda ayikhali, ikhalela ngaphakthi*” the literal meaning of this phrase from IsiZulu to English meaning “A man doesn’t he cry, he cries on the inside” which was a dominant theme in this study. Some participants felt more comfortable answering certain questions in isiZulu to emphasize the teachings of the African culture on masculinity.

3.6. Ethical Considerations

According to Blaikie (2000, p. 19) “most social research involves intervention in some aspects of social life. There is always a risk that even asking someone quite innocent questions could be disturbing or traumatic to that person. It has therefore become normal practice for the ethical implications of a social research project to be made explicit, together with the procedures to be used to deal with them”. Outlining the objects of the study helped prevent conflict that could have arisen between the researcher and the participants. Some of the ethical considerations are outlined below. All the 12 participants were notified that their participation was voluntary and they could withdraw from the study at any time if they wished to do so.

3.6.1. Informed Consent

Transparency is an important tool in qualitative interviews, it is important for the participants to be fully informed about the goal of the study, how the goal will be achieved and also the negatives and positives of taking part in the study. This approach ensures that the participants are aware of everything that will transpire or unfold from the interview process, and enables them to make an informed decision about being part of the study. However, it is important for the researcher not to indulge the participants with too much information as this might pose a challenge for the researcher. One of the challenges would be that the participants may hold back information which in turn may affect the outcome of the study in the sense that the researcher did not divulge a comprehensive understanding of the authentic experiences of black males in tertiary settings. The researcher informed the participants about the aim of the research study and the nature of the research study. Participants were informed on how data was to be collected. The researcher gave the participants an opportunity to ask questions before they took part in the study and after completion of the interviews. A sample of the consent form is attached as Appendix 3.

3.6.2. Confidentiality and Anonymity

The confidentiality of the participants was ensured and guaranteed. The participants were assured that no one else besides the researcher and the supervisor would have access to the recordings and that, after transcription, the recordings would be deleted and the transcribed material would be kept in a safe at the university after use. Participants were informed that they had the right to not answer questions that they did not feel comfortable answering. Anonymity was emphasised and promised to the participants. Pseudonyms (*Participant 1-12*) will be used instead of participants' real names.

3.7. Data Analysis

According to Terre Blanche and Kelly (in Terre Blanche and Durrheim 2002, p. 123), the *interpretive approach* presumes that people's subjective experiences are real, that we can understand others' experiences by interacting with them and listening to what they tell us, and that qualitative research techniques are best suited to this task. During the interview process, the researcher listened attentively to the narratives given by participants, in doing so the participants were fully encouraged to express themselves how they saw it fit to do so. The theoretical approaches that were adopted by the researcher to support the HImm framework are phenomenology and Social Constructionism, how African youth construct their identity and how they perceive depression as a phenomenon that is experienced by young men. Phenomenology defined initially as the study of structures of experience, or consciousness (Moran, 2000). Phenomenology is the study of "phenomena"; appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meaning certain objects have in our experience (Fricke and Fluidal, 2012). Therefore, this study will explore the meaning ascribed to depression, depression correlates, the experience of emotional well-being and identity in African males. According to Merleau-Ponty (2012) phenomenology studies conscious experience as experienced from the subjective or first-person point of view. Phenomenology studies the structure of various types of experience ranging from perception, thought, memory, imagination, emotion, desire, and volition to bodily awareness, embodied action, and social activity, including linguistic activity (Moran, 2000). Phenomenology develops a complex account of temporal awareness notably in perception, attention, awareness of one's own experience, the self in different roles (as thinking, acting, etc.), embodied action, purpose or intention in action, awareness of other persons and linguistic activity, social interaction (Moran, 2000). Identity will help us understand the developmental transitions of

black males, how black males construct their identities and how they perceive manhood in relation to illness using the social constructionist paradigm.

Thematic analysis was the strategy used to analyse the data in this study. According to Rugg and Petre (2007, p. 154), thematic analysis is based on what is said in a text, how it is said, and how often it is said. Thematic analysis in this study was performed through the process of coding in six phases to create meaningful patterns. These phases include: familiarization with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes, and producing the final report. The six phases upon which the analysis is based draws on Fereday and Muir-Cochrane's (2006) work. These six phases are detailed below;

- Phase 1: Becoming Familiar with the Data

The initial phase in thematic analysis once the audio had been transcribed verbatim required the researcher to read the transcriptions thoroughly to familiarize herself with the raw data. Before reading the interview transcripts, the researcher created a list of potential codes that were taken down as point notes during each interview. The data was read and re-read in order for the researcher to familiarize herself with what the data entailed. This was done while paying attention to patterns that occurred and taking notes. After this process the researcher had preliminary starting codes and detailed notes.

- Phase 2: Generating Initial Codes

The second step in thematic analysis was to generate an initial list of items from the data set that had a reoccurring pattern. This systematic way of organizing and gaining meaningful parts of data as it relates to the research question is called coding. Data was collapsed into labels to create categories for more efficient analysis. At this point meaning could be deduced from the codes. After this phase the researcher was left with comprehensive codes of how the data could potentially meet the objectives. During this phase initial codes that were identified were academic pressures, social pressure, romantic relationships as well as strength and success.

- Phase 3: Searching For Themes

Codes were then combined into over-arching themes that accurately depict the data. At this point the meaning of themes was described. Anything missing from the analysis became clear at this point. At this point a thorough examination of the codes was employed, leading to the

researcher omitting codes that appeared to have little relevance to the study. At this stage the researcher had a list of potential themes which required further analysis.

- Phase 4: Reviewing Themes

In this stage the researcher examined how themes supported the data and if themes had relevance to the theoretical framework governing this study. This allowed for further expansion on and revision of themes as they developed. During this phase the researcher had gathered potential themes, some themes were then presented as individual themes whilst others were constricted to sub-themes. The way in which the themes were coupled together began to narrate a bigger picture pertaining to the data.

- Phase 5: Defining and naming themes

Analysis at this stage included capturing interesting aspects of the themes and reasons as to why the researcher found them to be of interest. Existing themes were defined and refined because they were set to be presented in the final analysis. The researcher examined how each specific theme affected the entire data. By the end of this phase, the researcher was able to define what current themes consist of as well as explain each theme thus providing a comprehensive analysis of what the themes contribute to understanding the data.

- Phase 6: Producing the Report

After final themes were reviewed, the researcher began the process of writing the final report. It was important for the researcher to select themes that had the greatest potential to answer research questions and meet the research objectives. In order to increase dependability through thick description of the results, the researcher added dialogue amongst one of the questions asked to participants to ensure participants' answers were portrayed in the manner in which the message was conveyed. This sub theme is presented in the 'violence' section.

3.8. Reflexivity

3.8.1. Validity and Reliability

Qualitative studies aim to discover, understand and explore certain phenomena as opposed to measuring constructs to predict and describe empirical data. However qualitative studies according to Ulin, Robinson, and Tolley, (2005, p.31) have inborn threats in terms of validity and reliability of the data. Different criteria's are used to evaluate the quality of the data presented in both studies. In qualitative studies validity and reliability are concepts that are intertwined for the evaluation of quality. Lincoln and Guba, 1985 in Ulin *et al.*, (2005) attests

that essential criteria for the evaluation of data is credibility, dependability, confirmability and transferability. Reliability and Validity of in study will be evaluated as per its own paradigm. The trustworthiness in participants and the findings of the study are important. Consistency will be verified through raw data. Confirmability, consistency, neutrality and credibility are key concepts widely used in qualitative studies (Golafshani, 2003). The interview process took place in participant's natural environments to allow for the results to unfold authentically without manipulations. Due to the sensitive nature of this topic, the research questions were verified with the supervisor and a second opinion from an expert psychologist was gathered to guide the interview process with empathy and integrity. The interviews for data collection were collected through the use of semi-structured interview questions, the researcher trusted that answers given by participants were genuine. The data collected from participants was informed by secondary sources. The audio recordings will be handed over to the supervisor for verification and safe-keeping of the data.

3.8.2. Credibility

Credibility refers to the validity of the study which in qualitative methods focuses on confidence in the accuracy of the findings and understanding of the context (Ulin *et al.*, 2005). The researcher in this study aimed to achieve credibility by making use of Ulin, *et al.*, (2005) strategies of measuring for credibility, these strategies required researcher to ascertain whether a logical relationship developed between explanations from participants and whether these explanations were grounded in theory. To ensure the credibility of this study, semi-structured interviews were employed, participants were all asked uniform questions. The uniformity in questions asked participants allowed the researcher the ability to elicit information from participants while the open-ended questions allowed an in-depth exploration of the phenomena and understanding of the individual context. A thematic analysis method was also used to ensure consistency in the findings by observing all themes within the data and coding them consistently. Individual extracts were coded into themes and various themes were grouped together in terms of how they were related to the aims of the study and the research question.

3.8.3. Dependability

Dependability in qualitative research is the methodological parallel to reliability in quantitative research. Reliability of data in quantitative studies is concerned with the consistency of results if the research was to be conducted again. (Ulin *et al.*, 2002). Qualitative research compels the researcher to pay special attention to the consistency of the research process and also carefully follow the principles of qualitative methodology (Shenton, 2004). In this study the researcher

was guided by the principles highlighted by Shenton (2004) to ensure for dependability of results. To ensure dependability of the research process, questions to be asked participants were clear and concise and they were related to the research objectives and design. Therefore consistency of the research process addresses the dependability of the data. The data was collected by the researcher avoiding the employing of 'others' collecting the data without employing the necessary qualitative data collection principles Shenton (2004). The interview questions are connected to the purpose of the research.

3.8.4. Confirmability

In terms of the confirmability of the study, the researcher had to ensure that objectivity was maintained throughout the research process. The researcher had to constantly reflect on the interview process so as to not allow personal values held by the researcher interfere with the interview process and research process as a whole. If the researcher allowed her personal values to intersect with the research processes this would have undoubtedly threatened the validity of the study, therefore reflexivity was adopted by the researcher during the course of the interview processes and the analysis of data. The researcher aimed to continuously monitor objectivity therefore, ensuring that the research data was confirmable.

3.8.5. Transferability

Transferability can be seen as a degree to which findings of a specific research study conducted in a specific context can be transferred to other contexts (Miles and Huberman, 1994 in Ulin, 2002). It is the "qualitative analogue to the concept of generalizability" (Ulin, 2002, p. 32). This study adopted convenience sampling methods, this method has implications in terms of transferability. The results of the study will therefore not be taken as a true reflection of reality because this study was conducted amongst a group of males who are relatively in the same age group, who also form part of a university institution. The results in this study need to be interpreted with caution, as research findings are a reflection of the views of a small sample of black males. The implication is that the research findings can only be utilized to explore and understand the perceptions of depression and experiences of masculinity in a small group of males. Furthermore, the research findings cannot be utilized to address transferability in other contexts (i.e. race and gender).

3.9. Summary

In this chapter, the research methodology that was adopted to conduct the empirical component of the study is described in detail. Careful consideration is given to all aspects of the research

and is narrated as clearly as possible. The research design, sampling method, participants, ethical considerations, data collection, analysis procedures and validity of the study are explained in detail. Each of these components provides important insight and detail for the study that is important for the creation and generation of new knowledge.

CHAPTER FOUR: FINDINGS AND ANALYSIS

4.1. Introduction

This chapter discusses the findings and analysis of the data. The factors that are reviewed in the analysis include exploring themes that emerge from the data relating to ideals of masculinity, both hegemonic and individual concepts of masculinity. It further explores the way in which individuals relate their identities to the concept of masculinity. This chapter also explores the perceived contextual challenges facing black male university tertiary students that are seen as triggers of depression and the coping strategies that are perceived to be dominant in cases of health threatening challenges. The chapter also explores how individuals perceive clinical depression and further explores the general acceptability of various treatment options for clinical depression amongst individuals. This chapter reflects on the findings from the 12 in-depth interviews that were conducted with black male university students from the University of Kwa-Zulu Natal (*see table 2*). Due to their academic commitments individuals who were interviewed were interviewed as per their own availability, and as such interviews were typically carried out in the evening. The themes that will be discussed in this chapter have been identified through the process of transcribing and analysing verbatim the data gathered from the interviews. To extend the research findings, direct quotes are used from the transcriptions.

In an attempt to explore and understand how African male university students perceive depression and masculinity, data gathered from participants focused on the meaning and understanding of the study participants, their lived experiences and perceptions of their experiences as young African males in a tertiary institution. A phenomenological approach to understanding the above-mentioned constructs was employed. Understanding of men's perception of depression depicts the relations between experiences of life as chronological and here the dynamic interplay embedded in cultural constructions, and social interaction becomes evident, therefore this chapter is embedded in both the phenomenological and social constructionist approaches majorly drawing reference to the HMM framework.

4.2. Definitions of Masculinity

This theme provides an analysis of the general perception of masculinity amongst participants, how they relate their identity to the concept of masculinity. In all the interviews that were conducted, when participants were asked to give their own definition or rather their perspective of what masculinity entails, the definitions were interlaced with how they construct their identities, and what it means to be a man. The response reflect that the cultural view of

hegemonic masculinities typically impacted on the construction of the individual identity of males. Hegemonic masculinity highlights the dominant practices and structures in society which outline the values and norms according to which a man is expected to behave and experience life (Connell, 1995). The definitions that were given by participants relating to masculinity placed them central to the concept of both hegemonic masculinity and their individual identities, these definition determined the discourse at which they related to their experiences and actions.

Typically masculinity was perceived and described in terms of dominant hegemonic roles, the following are extracts from participants' statements reflecting the uniformity of the definition of hegemonic masculinities:

"I think it's associated with the gender of being a male person and then once the person who hears this notion of masculinity, they sort of like expect a person to behave in a certain way"
– (Participant 1)

"I think those are just traits that make you what we call a man in society. What everyone perceives to be a man, the roles that you fill in society, I would describe masculinity in that manner. I believe that a man should provide just by the mere fact that he's a man, look after his family. So I still believe in patriarchal roles" – (Participant 2)

"I think masculinity has to do with the attitudes and behaviours associated with how males are supposed to behave in society, they have to be strong, we have to be strong"- (Participant 5)

4.2.1. Strength

The first important finding is that numerous constructions of masculinity are perceived to be in relation with strength. *Participants (9, &11)* suggest that masculinity is associated with strength and this strength can be expressed in a multitude of ways. Although strength is not only perceived to be related to physical aspects of these young men, strength in participants was viewed in relation to being a survivor of challenges brought by life and conquering abject situations. Strength in participants was constructed in relation to possessing character, bravery, tenacity, mental strength, and courage. The narratives given by participants paint a picture of young men who stand tall in the face of adversity and coming up victorious in any situation, ruling out any emotions related to fear and hopelessness, as these are perceived not to be masculine norms. Courage and tenacity in young men is perceived to epitomize ideal masculine strength, following are extracts from participants narrating the importance of possessing mental strength.

“I think masculinity stems from the concept of what it means to be a man, all the traits that constitute a man. As a man you must have the ability to solve your own problems, you have to have the mental strength to fight emotional distress” - (Participant 9)

“I think ideally masculinity involves all the traits that curate a man, the ability to be in control of every situation that you encounter” - (Participant 11)

On the extreme end, one participant mentioned the need to control his emotions in relationships, *Participant 11* constructs a version of masculinity that opposes the investment of emotional feelings even in romantic relationships. His personal history provides various clues as to the reasons for inhabiting such a position, especially his experience of abusing his partner after feeling like he could not control her. In the interview, he also refers to an unpleasant experience in his relationship where he feels he loved his partner ‘too much’, thus his love for his partner may have resulted in him developing insecurities and therefore projecting those insecurities through the need to control her. He narrated that he constantly had to check up on her and know her whereabouts. It is against this backdrop that *participant 11* decided to choose to detach himself emotionally, and found it more ‘masculine’ to do so, but he still sees the need to be in control of women rather than being controlled by his emotions particularly in relationships. Such a narrative may be viewed as a defence against *Participant 11*’s feeling of vulnerability, but *participant 11*’s narrative also slightly indicates unconscious constructions of women as very powerful beings who have the ability to disarm his control over his emotions, therefore leading to his need for control as a way to protect himself. Narrative proceeds as follow:

“In the past, I have lost control over my emotions during times when I was in love, I really don’t like investing my feeling where the other gender is concerned because that is how I eventually lose control over emotions. Generally, the more I invest myself and my feelings in a relationship, that’s basically how I end up feeling like I have to control every aspect of the relationship, and my partner. When I couldn’t control my girlfriend, our relationship just started to get physical, I started abusing her physically and emotionally” - (Participant 11)

4.2.2. Success

The hegemonic masculine norms of being successful and, thus, of having the respect of one’s peers are aspirational features of the hegemonic masculinity. Success was perceived by participants as part of an extension of material wealth, but most importantly having money and

therefore being able to buy desired materials. *Participant 4* captures this form of success as follows:

“For me, masculinity typically has to do with strength, it just has to do with power possession, the ability to buy whatever you want to buy”- (Participant, 4)

Participant 10, believes that even society expects men, especially those who are pursuing tertiary studies to graduate and thereafter obtain material wealth and he further ascertains that if things do not progress in this manner, it poses a threat to ones wellbeing, as one will be perceived as not performing within the hegemonic identity. Ownership of material wealth therefore signifies an acceptable future masculine identity (Chadwick, 2007).

“There’s even this perception in the township that when you graduate you will get a job and buy a car, so if your life doesn’t progress in that manner you become really stressed because you feel like a failure”- (Participant, 10)

4.2.3. Protection of ‘others’

Strength in participants was framed as an aspirational standards of the masculine identity, where individuals see themselves as having a duty to provide and protect their families from situational happenings, poverty and crime. Protecting subordinate others, i.e. women and children is perceived as a hegemonic norm (Chadwick, 2007).

“I did mention that I provide for my family, and I do provide emotional support to my friends. I do provide love and protection to my woman and um, those are my values. Those are things that I think make me a man; as an individual”-(Participant10)

“As man you have to be strong and protective of your family and kids. A man also has to possess a great level of mental strength” - (Participant 9)

4.2.4. Masculinity and emotional composure

A study done by Blackbeard (2005, p.107) shows that many young men living in South Africa, perceive themselves has having pressures to act in certain ways; “invulnerability” and/or “toughness”. Emphasis on the dominant heterosexual traditional hegemonic constructions of masculinity have embodied the denial of weakness or vulnerability, emphasis on emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, (and) the display of aggressive behaviour and physical dominance” (Courtenay, 2000, p.1387). Participants highlighted that they have a duty to not show emotions

and in more extreme cases the need to not even feel emotion because this will solidify their masculinities, as this behaviour is endorsed by society. Following are extracts from participants.

“Masculinity for me, has to do with all the elements that pertain to courage, mastery, and being strong... being told that you as a man, you are inherently strong, so you shouldn't cry, you shouldn't show any emotions” - (Participant 6)

“I'd say masculinity is linked with the concept of being a man. It's linked with all the stereotypes that govern how a man should carry himself, how he behaves. Essentially being a man, you have to be hard, you have to be strong, you tend not to show your weak side, your emotional side” - (Participant 7)

4.2.5. Dominance and Control

Participants in this study constructed masculinity suggesting a strong alignment with the hegemonic masculine norms of control and domination. The belief in participants is that it is in the nature of men to be in positions of dominance and control within one's future family or immediate families, especially if they perceive (d) themselves in relation to a father a figure if they grew up being raised by single mothers. Extract from *participant 8* follows, he perceives himself as having a duty to provide for his mother as a man. This will in turn allow him to fit into a masculine role.

“I can define masculinity as the acknowledgement of my dominance over things that I can control. I believe in equality but a man and woman can come together and raise kids but it's important for the man to provide. Seeing my mother struggle to raise my siblings and I in the absence of my father, made me want to be able to be in a position where I am able to make her happy by providing for her and to see her not having to struggle anymore” - (Participant 8)

Participant 1 speaks about the lengths that men have to go through for them to feel as if they fit into the category of masculinity, for them to be perceived as having the rightful traits, such as being able to provide and the ability to even control things that are seemingly out of their control.

“Being a man comes with a lot of burden, because you want to be seen as a man, you have to try hard to prove this and this is why a lot of men turn to crime, this is why a lot of men are in prison, because now they're trying to the extreme of the limits because now they have to sort of provide for their families just because they're men, they have to control situations that are

sometimes beyond their control, what happens if you really can't get a job? Or start a business?" – (Participant 1)

4.3. Social and cultural influences

Below are extractions of participants perceptions of masculinity, dominant here are social and cultural influences in the development of the masculine identity. According to Cerulo (1997) social group's impact on the psychology of individuals through their capacity to be internalised as part of a person's social identity. Masculine identities place individuals in a social space by virtue of the relationships that these identities involve. Following here are quotes from participants openly expressing their thoughts relating to the masculine identity construction, majority of them openly indicating that the male identity is constructed through social influences and as a result manifest as learned behaviour because of its capacity to be internalised. The statements highlight how masculinity is defined, the views of masculinity are intertwined with what participants perceive as traits a man should have, the participants reflect on what it means to be a man, within society.

4.3.1. Parents

According to Mansfield *et al.*, (2005, p.95), "gender role socialization theories hold that environments from the level of culture down to individual and family and peer relationships, teach men and women to display distinct sex-types behaviours and attitudes.". Many of the participants attributed their socialisation into the category of hegemonic masculinity through social processes and interacting with other males within the family domain, placing their father central to the emulation of these roles and *participant 1* reflecting on what his teacher had said to him as a young boy, insinuating that men compose their emotions. Quotes are as follow:

" I think for the most part it's also stems from the concept of parental modelling, how your father behaves in front of you" - (Participant 5)

"I would venture to say, and I hope I'm not coming of as being sexist, but from the time you're born, it's like I said, it's almost as if you're inherently masculine by virtue of being a male, because from the time you are born, um, now that I think about it even as a boy, the toys, for example, you were exposed to playing with, how your father would instil these values in you of how a man behaves" - (Participant 6)

"I think most of our masculine traits, if not all are accentuated by our experiences, how we were raised. I think I picked up those traits from my father, my father is a very stern man, he

exhibits the principles of a typical Zulu man and he's very patriarchal and I believe I picked up most of my behaviours from him, he's been a reference point in my life.” - (Participant 11)

*“Being a man comes with a lot of responsibility at the same time because once you get a title, that title comes with responsibility and even in the primary school I went to before I went to a mixed school, our teacher used to tell us that **“tigers don't cry”**, And she meant that like if you're a boy you don't cry” – (Participant 1)*

4.3.2. Culture

Culture plays a fundamental role in understanding how men construct their identities in relation to masculinity. One of the participants was a Xhosa male he ascertained that by him being a Xhosa man and having had to go through initiation school, he embodies the ideals of a man as per his culture. “Constructions of masculinity among amaXhosa of South Africa relating to the notions of masculinity centre on the practice of ulwaluko, the customary rite of passage from boyhood to manhood” (Ntombana 2011). Ntombana (2011) ascertains that a Xhosa male, after having gone through initiation, he is regarded as a man/‘indoda’. This allows him to marry, build a homestead and actively participate in community discussions and rituals (Ntombana 2011). His quote reads as follow:

“I am a Xhosa man, with Xhosa men the concept of masculinity is everything. We are taught about masculinity, the whole idea of how a man should carry himself even in the mountains/bush during the initiation period. They teach us ways in which men should behave even when we come back from the mountain because that's part of Xhosa tradition, a man has to know his role, as a man you have to exist within that frame of masculinity” - (Participant 7)

Participant 1 also shares insight on the construction of the male identity in Xhosa culture, also making reference to other ‘black’ traditions and how marriage is also an important hegemonic masculine performance, therefore men who are not in matrimonial unions are perceived as occupying lower statuses in society. He attests that:

“Being a man comes with a lot especially within black communities, for example Xhosa tradition, you're not man enough until you are circumcised, or rather until you go through initiation. With black people you're not man enough until you get married, even when there are traditional ceremonies, you will not sit and eat meat with married men because you are not man enough” – (Participant 1)

4.3.3. Friends

Frosh *et al.*, (2002), attests that young men experience the male peer group as a space in which they are expected to prove their manliness, participants in this study identified the male peer group as a powerful normative influence on their concepts of themselves as masculine. Participants attested that the way in which men dress serves as an inclusion criteria in these peer groups and this is reflected in *participant 1's* narrative. *Participant 3* also ascertains that being in a serious relationship deviates away from hegemonic masculine norms within peer groups, therefore these peer groups are accepting of hyper-masculine displays. Chadwick (2007) ascertains that amongst black males, peer group notions of masculinity include the exhibition of material wealth and having multiple partners as opposed to one partner. Narratives demonstrating this behaviour are as follow:

“As a male, you're expected to dress in a certain way. Like you're expected to dress in certain brands. Now you're expected to wear certain brands. See, because now if you don't have certain brands you don't fit in and if you don't fit in now you become a loner”- (Participant 1)”

“If you're a guy in my age group and you are in a serious relationship, you buy your girlfriend flowers in as much as it is a beautiful gesture, the belief is that you cannot give your heart too much, we are told to protect our hearts. Some guys when they see you do nice things for your girlfriend they call you 'boyfriend' just to mock you. So even if you experience heartbreak and you have friends who have masculinity heavily engraved onto their minds, then you're most likely going to commit suicide because if you go and approach that person, they'll tell you you're weak. You're crying because of a girl come on, come on, come on!” – (Participant 3)

4.3.4. Religion

Christianity is heavily embedded in a traditional patriarchal system, supporting a hegemonic ideal of masculine dominance and feminine submission (Collins, 2010). *Participant 1 & 12* strongly believe that religion accentuates hegemonic masculine roles, they both ascertain that the role of leader and provider are dominant features of Christianity, and many other religions worldwide. Quotes from participants are as follow:

“I think it's associated with the gender of being a male person and then once the person who hears this notion of masculinity, they sort of like expect a person to behave in a certain way... as a man, you are expected to be like the head of the household. And even the Bible supports this notion” – (Participant 1)

“My father is a pastor, I grew up under the church, as a boy I went to bible studies and I was taught about the importance of prayer. As I got older I was taught about respect and the importance of having goals, the importance of providing and guiding my family and protecting women” - (Participant 12)

4.4. Individual Identities

The following extracts highlight how individuals relate their identities with the concept of masculinity, acknowledging how masculinities are socially orchestrated but also the knowledge that within these masculinities exists individual identities and notions of masculinities respectively. Burr (2006) attests that society should take a stand towards taken for granted knowledge, by doing so we oppose the idea that suggests that what exists is what we perceive, the following accounts of individual identities as per participants perceptions acknowledge the fluidity of masculinity, and the existence of individual identities. Extracts are as follow:

4.4.1. Individual identity congruent with hegemonic masculinity

Connell (1995) suggests that individuals are able to invest in contradictory identity positions in relation to hegemonic masculinities. *Participant 1* experiences a somewhat contradictory version of masculinity, where he contests hegemonic masculinities but however negotiates his identity in response to the hegemonic norm of responsibility. *Participant 8* also speaks of responsibility, as an alternative masculine norm however this responsibility is located within the household. Notions of masculinities pertaining to responsibility are contradictory and ambiguous, Wetherell and Edley (1997) ascertain that such norms are modern versions of patriarchy, such that most of these young men invoke the notion of responsibility in the context of assuming the envisaged 'responsible' role of provider, protector, and head of a future family where 'others' are perceived as occupying subordinate positions. Therefore, such constructions of masculinity draw upon the dominant hegemonic norm of dominance and control. Extracts follow:

“When I speak of responsibility, I speak of it in the sense that you understand yourself as a male person, but then you also realize that what comes with the word is mostly what society expects of you by virtue of you being a man. So by being responsible you also then realize that the concept of masculinity doesn't necessarily mean that as a male person I have to behave in a certain way. Responsibility is me also understanding that I'm not going to be defined by these

societal concepts because they are just concepts you see, responsibility is me taking care of my family” - (Participant 1)

“For me, I grew up in a family where my examples of masculinity were modelled by my mother instead of my father. My mother, had to do a lot of things which I feel like, should have been done by a man, like leadership, like providing, like the control, all the factors that I talked about, that is why for me responsibility takes precedence over my masculinity” – (Participant 8)

4.4.2. Individual identity incongruent with hegemonic masculinity

Morrell (2005) attests that the expression of a masculine identity is not only dependent on cultures, but a man’s identity takes on a different forms depending on the time, the place and the audience. In the following extracts participants showed a different view of masculinity, therefore prominent here is the uniqueness of every man’s identity as men adopt different positions of masculinity and perform these differently in different contexts. The Dialogical Self-Theory proposed by Hermans (2003) argues that identity changes across a time and space continuum granted the self is performed in relation to the perception of ‘I’ and ‘them’. It is the researchers percept that the performance of an ‘I’ identity manifests through consciousness of one’s identity and the idea that society is seen as an external feature. *Participant 4* acknowledges that masculinity is a system that is embedded within society, therefore as man he falls into this system, however through self-reflection he is beginning to find ways to conjure his own identity. *Participant 6* through self-reflection questions taken for granted knowledge, and believes in unlearning all the behaviours associated with hegemonic masculinity. *Participant 8* is similarly on a quest of redefining his manhood. Quotes from participants follow.

“Falling into the category of masculinity, it’s not by choice, but it’s a system that’s hard to do away with. I end up falling into that system because I am a man but lately I have been questioning it and lately I’ve been mostly neutral. There’s a different view that you tend to adopt as you grow older, you start questioning a lot of things basically and seeing that perhaps somethings are not meant to be as they are set out to be. It’s a system and it’s really hard to do away with because it began within the paradigm of privilege but lately I just don’t appreciate it” – (Participant 4)

“I think the more you learn, the more you grow, your definition changes. my definition of masculinity now as opposed to a few years back is very different, I have abandoned some ways of doing things as per societal expectations where masculinity is concerned because I am aware of the toxicity of these expectations” - (Participant 6)

“For me personally, I don't really take so much from the general perceptions of how men should be. I really feel like I need to find my own identity and have my own definition of what I think should make a man. I do acknowledge the fact that men according to society should behave in certain ways but personally I do not abide by those standards” - (Participant 8)

For the researcher, it was important to acknowledge that some participants have opted to adopt different views of masculinity. What is mostly common amongst the definitions that are given by participants is the fact that they agree that masculinity is derived from social interactions and practices, with this knowledge some participants still feel masculinity must be experienced as per their subjective capacities.

4.5. Perceptions of Depression (Symptomatology)

“Depression manifests itself in persistent feeling of sadness or loss of interest that characterises major depression. Depression can lead to a range of behavioural and physical symptoms. These may include changes in sleep, appetite, energy level, concentration, daily behaviour or self-esteem. Depression can also be associated with thoughts of suicide” (Calles, 2016).

Masculinity does not only hamper with the expression of distress and related help-seeking behaviour but it is in many ways present in men’s perception of clinical depression, accounts from the participants geared towards a considerably fair understanding of the symptomatology of depression. Participants described their perceptions of depression in various ways which led to the three themes emerging which are: *being in a dark phase, hopelessness & loneliness* and *anxiety*. These themes will each be reported and described below.

4.5.1. Being in a dark phase

Some of the participants described their perceptions of depression using words that likened depression to being in a dark place and being trapped. Collectively these metaphors advocate that depression is an insufferable experience of darkness, to the extent that the said depressed individual does not perceive nor anticipate a better tomorrow nor future. Other participants associated depression with a state of being trapped and hopeless. Following are statement from participant narrating their perceptions of depression.

“I can define it as a big dark cloud over a particular person's life where they are just filled with so much heaviness in their life that it triggers a particular mind-set or feeling less worthy and feeling hopeless, you know, where everything just seems less important. Especially life itself” (Participant 4)

“I think depression is a mental problem where you feel emotionally broken and you think there's no way out or you can't find help. So you're just stressed to the core. I can describe it as a state of feeling like you're stuck in limbo, it resembles a place of darkness where you feel like there is no way out and your emotions and mental health are in absolute turmoil.” (Participant 9)

4.5.2. Hopelessness and Loneliness

Abramson, Metalsky and Alloy's (1989) have proposed the hopelessness theory of depression as the predisposition to attribute negative events to stable and global causes which is also coined as a negative attributional style. 'Hopelessness Depression' has been proposed as the lack of voluntary responses in situations where one is faced with a predicament that requires cognitive effort to solve and the will power to do so, included here are feelings of apathy, lack of energy and psychomotor retardation, among others. Following are quotes from participants that highlight the theme of perpetual hopelessness and loneliness. It appears as though depression is perceived as not only intensifying self-defeating thoughts but it is perceived to thwart the said person's efforts to get out of the depressed state because of feelings of helplessness and isolation.

“Being hopeless and helpless and not being able to talk to people, I feel like that's kind of like being depressed because you sort of can't even think straight. Maybe you are thinking but you're only thinking about one thing and that's the only thing that's stressing you. So you can't really think about other things because you are just stressed and not having another person to talk to at that time, apart from that a person would be present but you don't know how to really start the conversation because you already feel alone” - (Participant 1)

“I think depression is an intense emotional break down. It's beyond a state of being stressed. Depression destroys you mentally, but also physically and emotionally. I think it's a real intense state to be in because it affects your mental, physical and your emotions respectively.... It is a state of constant hopelessness and loneliness” - (Participant 10)

Participant 1 & 10 describe being depressed as being in a state where you are only thinking about the perceived dilemma, the source of your stress and depression respectively, resulting

in the inability to seek help because the severity of the problem is perceived as being hard to solve or hard to get out of. In contrast participant ten relates depression to a state that amputates ones mental capabilities and accentuates feeling of loneliness and hopelessness.

4.5.3. Depression and Anxiety

Depression and Anxiety are notably two different clinical conditions; however their symptoms and causes can sometimes overlap. This is because many people with anxiety also develop depression and vice versa (Raes, 2010). Some participants attributed chronic worry to clinical depression. Extracts of this theme are as follows:

“I'd say depression is a state of worry. It's a state of worry about a permanent issue or a situation that takes a period to pass.....When you are depressed, your spirit is crushed. You can't get yourself up, they are so many things in a day that knock you and you're able to just bounce back but with depression you really can't”- (Participant 3)

“Before it touches on people around you, it really cripples you as person. You'd feel hopeless about the present and the future, it makes one ravel in self-doubt and makes one dwell only on the negative aspects of one's life, it makes you worry a lot about the present and the future, and you just generally have a poor locus of control” (Participant 7)

The above themes suggest that participants can recognize symptoms of clinical depression as most had believed they had encountered such states during the course of their lives. This study does not aim to prove nor dispel such convictions, provided the fact that this study does not seek to uncover such findings and the researcher is not a professional mental health care worker. Participants were also unsure if what they had ‘felt’ during the times they had thought they had been depressed was indeed depression. Further, showing the researcher why such statements cannot be taken at face value.

4.5.4. Beliefs and attitudes regarding mental health

The occurrence of clinical depression is more intricate then what participants in this study seemed to present it to be, depression does in fact manifest itself as per the aforementioned symptomology but for an individual to be diagnosed with depression, the criteria is far more complicated than what is presented here. A diagnoses for depression requires the presence of five or more symptoms and symptoms must last up to two weeks (APA, 2013, p.160-161). Malhi and Mann (2018) also attest that clinical depression is different from unhappiness or typical feelings of sadness, and depression impairs functioning as some symptoms manifest in somatic forms. Participants in this study had their own individual understanding of the illness,

and it has been noted that cultural stereotypes about mental illness determine help seeking behaviours (Choudhry *et al.*, 2016). All participants made no mention of the biological aetiology of the illness. Depression was therefore perceived as an illness that can be regulated through decision making. The masculine hegemonic norms of control and emotional invulnerability were dominant in participant's accounts regarding perceptions of depression, this can therefore in turn be used to determine patterns of health seeking behaviours and lack of such strategies. *Participant 7* suggests that men should mask their depression and this was consistent with Addis (2008) masked depression framework. *Participant 8* reported depression as an illness that lessens in symptomatology as times passes and he believes that it is a state of mind that the affected person can deviate away from, therefore the magnitude or rather the seriousness of the illness is undermined. If individuals believe they can 'get over' an illness, there is a greater chance that such individual will opt not to pursue psychological help, therefore denial of threat, diagnosis or prognosis, results in lower pursuits of help and higher risk behaviours (Ditto *et al.*, 1988). *Participant 11* also associates depression with mentally unfit men, who are perceived to be 'subordinate others' and therefore who are not aligned with hegemonic masculinities.

"The problem is in your mind, within yourself and it just builds up but ultimately, I feel like this is when you should adopt a change of mind. Anything that presents itself as an emotional deficit, a man has to deal with it by putting it somewhere and locking it deep within himself where it has no chance to be conveyed in its truest form" - (Participant 7)

"I'd also say depression is a lack of psychological control over your mind. I think sometimes we choose to be depressed over things. I think emotions are interwoven with thoughts and I really feel like I can be depressed today and I can sleep it off and ultimately wake up NOT depressed, but I'd feel much better than yesterday. I feel like ultimately depression is something that has to eventually subside on its own, because as a person you cannot be dwelling too much on situations" - (Participant 8)

"I think depression arises in situations when you are mentally unfit, that's mainly the reason why I cannot even take seriously any male person who says they are depressed. Because part of being a man you have to be mentally fit and when you are mentally fit you can avoid depression but you perhaps cannot control it if you have lost someone you love through a death etc. but even with that you can still heal in time" - (Participant 11)

One participant in this study believed that mental illness is influenced by witchcraft. Ethnic groups have been documented to perceive themselves as vulnerable to mental illness, due to witchcraft or misfortunes due to the ancestors' withdrawal of their protection towards them Bojuwoye and Edwards (2011), Therefore opting to consult traditional healers as proposed by *participant 11* in the section on spiritual healing. *Participant 5* attests:

“Black people in general whenever mental illness strikes, we look to external sources, we tend not to want to be held accountable for our actions, and for me specifically I blame it on witchcraft. You think maybe someone in your family is cursing you and that’s the reason why things aren’t working out how you want them to work out. I think it’s not only me. so when illness strikes, the general perception is that it is always a matter of someone is performing witchcraft on me or my family or maybe ancestors are displeased with me”-(Participant 5)

4.6. Attitudes towards Hegemonic Masculinity on Depression

Morrell (2001) used “hegemonic masculinity” to explain the nature, form, and dynamics of male power. He proposed not just one masculinity that was hegemonic, but at least three, a “white” masculinity, an “African” rurally based masculinity and finally a “black” masculinity. Dominant features of these masculinities as they appear to be integrated in the identities of black male tertiary students were power, competitiveness, financial success and control. Socialization according to restrictive masculine norms creates several forms of developmental and intrapsychic strain, as boys and men struggle to meet unattainable and contradictory standards of masculinity (Pleck, 1995). Evident from the following extracts is the undeniable fact that these strains are assumed to place boys and men at risk for emotional difficulties, especially depression. The tensions between hegemonic masculinity and individual identities in relation to the perceived impact of masculinity as having a negative influence on mental health was discussed by participants and the following themes emerged: *Financial Success, Family pressure, societal pressure, academic pressure, and relationship pressure*. It is important, however to note that these concepts have varying degrees of perceived impact on individual persons and they are other underlying sources that may lead to depression.

4.6.1. Financial Success

Masculinity defined in terms of success, respect and status is common amongst black men and across socio-economic statuses (Chadwick, 2007). Therefore, financial success is an aspirational feature of masculinity. Participant in this study all seemed to agree that money is an important aspect of the masculine identity, as having money allows them to exercise their

power in terms of being able to do all the things they deem necessary, such as providing, being able to take care of the women in their lives, the ability to act into accordance with the hegemonic role of 'responsibility'. This is consistent with findings from a study done in Nigeria among Nigerian youth where Uchendu (2007) reflected on the findings stating that material acquisitions in these young men was perceived as affording them a comfortable existence with little anxiety and greater self-confidence. As a result participants in this study all advocated for financial freedom to alleviate the perceived burden believed to be placed upon men by society. Participant's quotes follow. *Participant 1* narrates that money is power and if one has no one money they therefore do not possess power, being 'broke', is a slang term meaning 'being without money'. *Participant 4* narrates reasons as to why he had to terminate his relationship with his partner because he felt like he was unable to fulfil his role as a 'provider' and *Participant 11* speaks of the inability to pay ones fees..

*"I have this one uncle, when he has financial quandaries, he is not going to talk to anyone. I believe not having money leads to depression in its own way. So when he has money he's going to tell you why he wasn't talking to anyone. *becomes animated and imitates uncle* he would ask, "Have you ever heard a broke man speak?", money is power - (Participant 1)*

"I'm pretty sure money is what triggers a lot of anxiety that leading to depression. This reminds me of the time when I had just graduated from my undergraduate studies, I'd like to think that was a very dark period in my life because I had absolutely nothing, I was basically struggling so much financially that I ended up having to break up with my girlfriend because at that time I felt like I couldn't even provide minor things like maybe buying her food and going on dates" - (Participant 4)

"Not having money can be a source of depression for a person who is in a tertiary institution because of the inability to maybe pay ones fees, or the debt incurred from student loans, maybe not even having money to buy textbooks, not having money to do things you would like to" - (Participant 11)

4.6.2. Family pressure

Masculinity defined in terms of success, respect and status is common amongst black men and across socio-economic statuses (Chadwick, 2007). In a study done by Adinkrah (2012) in Ghana, men who engaged in suicidal behaviour were confined to such positions following perceptions of inadequacy as they felt shame regarding the inability to fulfil their socially prescribed economic roles as providers. Participants in this study opined that black tax as

discussed in chapter two brings rise to financial strain leading to stress however the notion of black tax stems from a place of Ubuntu in black communities. “Ubuntu is the capacity in African culture to express compassion, reciprocity, dignity, harmony and humanity in the interests of building and maintaining community with justice and mutual caring” (Nussbaum, 2003, p.2). The understanding in participants is that they perceive themselves as not being autonomous beings rather they perceive themselves to be aspects of more complex social networks, such as the family network. This heightens their need for provision, however this need to provide coupled with structural inequalities results in stress often times, following the inability to live up to such an obligation and the judgement from society. *Participant 5* speaks more on judgement. *Participant 2* speaks on helping the family regain financial stability. Quotes follow.

“You see your father and the things he has done for his family. So being a black child, especially in South Africa, coming from disadvantaged backgrounds, I can understand how from that tender age a boy picking up those traits about what he needs to do, he needs to provide, to keep your family safe. Also understanding at that time that his family isn’t economically okay, we struggle financially, every boy child will be speaking of wanting to buy their mom a house, they want to buy them cars, they’re going to be rich one day - (Participant 2)

“Black tax in a way pushes us backwards instead of making us progress in our lives because now we have to think of people at home and when you ignore that people react to that negatively, you are deemed as less of a man if you show any sign of being unable to provide but there's nothing we can do because it embedded in our culture and its comes from a good place, but the context that we live in now makes it hard for us to thrive, the economy, the scarcity of jobs so it becomes really hard. I feel like it’s even harder for someone who's not even working, it's even worse because now you have to think of two things, getting a job and providing. When you are not working even your own family treats you differently, that's what I have observed even in my own family” - (Participant 5)

4.6.3. Social pressure

The social pressure that participants in this study speak about is related to the pressure of fitting in social groups, being accepted into peer groups as embodying typical masculine traits. Participants in this study spoke about the importance of owning branded items of clothing to fit in. When one wears branded clothing, they are afforded acceptance and respect within social groups therefore status amongst peers is elevated. These findings are consistent with a claim

proposed by Alexander (2003, p.550) stating that 'branded masculinity indicates a transformation of men's understanding of masculinity'. This transformation reflect images of a transition, relating to the appearance of men, where men were not particularly known to take care of their appearances. Moreover, this transition in African societies can be linked to the diffusion of western hegemonic norms. *Participant 4* speaks about the struggle to fit into social groups and how burdensome this is because it creates a loss of values and identity confusion in actors. *Participant 6* speaks about the pressure of wanting to attain a certain level of success in order to be at the same level as is his peers. Social comparison becomes a tool that allows men to measure their manhood in relation to other men. Additionally, *Participant 6* speaks about the ownership of cars and cars have historically served as items which men use to position themselves in terms of masculinity, enabling an elaborated performance of the masculine identity and providing a ground for competition. Best (2006) reported that young men attest that men with cars use such items as symbols of success, therefore positioning themselves in higher statuses within the masculinity hierarchy.

"Life in general in varsity, it has a lot of standards that people are trying to keep up with and trying to live according to. In varsity you find people trying to fit in social groups, they end losing their sense of self, their values because they want to be accepted in this environment. Wanting to fit in comes with a lot of burden and stress because the end goal is, you are trying to be something or rather someone you are not. It's like living a lie" -(Participant 4)

"You could be exposed to friends who are more affluent than you, maybe amongst your group of friends you are the only one who doesn't have a car, you don't have money, and you don't wear certain clothes. You don't come from a well off home... to make this interview personal for me I've suffered a lot emotionally from not being where I want to be as we speak right now, you look at your life, you start looking at other people around you, your peers, you know, especially at the stage where people start getting jobs, buying cars. It can be a lot to handle" - (Participant 6)

Social pressure was also aligned with pressure from social media in terms of relative deprivation Nayyar (2003). Nayyar (2003) notes that exclusion has cultivated a new mechanism in developing countries such as South Africa, where urbanisation seems to be growing rapidly. Exclusion is not only experienced when individuals cannot satisfy basic needs, relative deprivation also comprises of the exclusion from consumption patterns and lifestyles. Relative poverty is the notion of being able to satisfy basic needs but not the luxuries

standards of living that are set by society (Chambers, 2006). Electronic media platforms such as Instagram, showcases lifestyles of the rich affluent members of society which Iqani, and Schroeder, (2016) attest accentuates a consumerist message that the rest want to emulate. When such lifestyles are unattainable for common people, they are alienated and some frustrated to the point where their mental health is compromised. The participants from this study identified social media as a threat to mental health, extracts are as follow:

“Social media definitely yes! Especially Instagram. Generally people’s portrayal of themselves on social media only reflects the good that is happening in their lives, people show their expensive designer clothes, going to clubs and buying expensive alcohol, traveling to overseas destinations and riding in fast cars. Social media induces depression because now you think to yourself, okay, this is how people in my age group live outside, then you say to yourself I should also find ways that will allow me to fit into that system because now this is how people live” (Participant 5)

“I think the most influential source of depression for people in our age group especially if you are in a tertiary institution is social media, social media puts a lot of pressure on us and it comes from people who generally don’t even have feasible sources of income, but they are on social media showing the lavish lives they live”- (Participant 9)

4.6.4. Academic pressure

Studies have reported that university students of any age have higher levels of anxiety and depression than the general population, academic pressures are reported to be the main sources of stress (Tanaka, 2006). Moreover, obtaining a college degree is seen as a key to success (Thurber and Walton, 2012). Participants in the study all collectively seemed to agree that academic pressure can result in stress and that stress can lead to depression and this likelihood is higher in men as success is an aspirational masculine feature. Accounts from participants follow:

“Academic pressure but academic pressure isn’t about marks only, the marks are only a reflection of what we perceive we might earn in future, and the perception is that good marks give you a better chance to thrive in the job market. The main goal really is to make money. So the marks you look upon as a reflection of how you are doing right now and how you are going to do in future” - (Participant 8)

*“*Laughs* right now I'm doing my masters and I haven’t studied the whole day I have been sitting on this table, I can feel the anxiety surreptitiously making its way into my psyche. I'm*

anxious right now. Academics poses a serious threat on the mental health of students, in fact all students essentially run the risk of being somehow engulfed by depression because of their academics...” - (Participant 8)

4.6.5. Relationship pressure

The desire to be in a committed relationship in young adults stems from an intrinsic need of requiring affection, men in this study from their quotes it is apparent that relationships are seen as a threat to one's well-being if there is love and intimacy involved. Men are socialised to take care and provide for their female counterparts, therefore when in a relationship men view their partners as people they need to take care of. According to a national survey conducted by Emmet, Richter, Makiwane, du Toit, Brookes, Potgieter, Altman and Makura (2004), 70% of young people aged between 18 and 32 years of age in South Africa ranked supporting one's family, keeping one's family safe, running a household and caring for children. Therefore, intimate partners are generally afforded the same level of care as family members, and when men feel as though they cannot take care of their partners it takes away from their perceived masculinities, following the cultural notion that a man without responsibilities is not yet a fully-fledged man, therefore he cannot be afforded the same respect as married men. This claim is supported by the following participants.

“Romantic relationship in their own respect are also a source of depression, it depends on the dynamics of the relationship but I can safely say that if you truly love someone and you anticipate a future with them, when they perhaps stray away from the relationship, maybe have an affair; that's going to really hurt you and also when you feel like you really can't maintain or provide for your girlfriend that in itself is a source of stress that could lead to depression because the perception is that what makes a man a man, is his ability to provide for the people he loves” – (Participant 7)

“let's say for instance you are in a relationship with a girl that you genuinely love and hope to have a future with; when that girl decides to leave you for another man who has more money and material things than you, that's going to hurt because it's going to make you feel like you have failed as a man because majority of women want to be maintained and we have been taught that as a man we have to provide, so when she leaves you, you will start questioning your manhood”– (Participant 9)

From the above discussed themes it is clear that the perception of underlying sources of mental illness differ from one individual to another and as a result it is also feasible to say that these conditions affect individuals, or rather their impact on the psychology of individuals differ considerably. However, the most prominent feature that is apparent within these perceived triggers of depression is that of structural inequalities and the impact this condition has on males in society. Williams *et al.*, (1997) attested that, “The higher the number of undesirable life events, the greater the levels of psychological distress”, this magnifies the relationship between perceived structural deprivation and depression. Moreover, pathways of these conditions somehow intersect, leading to catastrophic results especially in males as hegemonic masculine norms require men to attain financial success and the achievement of various other goals.

4.7. African Masculinities and Externalising Behaviours

Depression can be connected to masculinity in different ways. A dominant theme that emerged from the interviews conducted highlighted the fact that depression is generally perceived to be a threat to masculinity and is seen as *a consequence of men’s inability to live according to the hegemonic ideals of masculinity*. According to Möller-Leimkühler (2002) help seeking behaviours in men are inhibited by the fact that there are mediating factors of normative male gender-role expectations. “Together with gender-related health concepts contribute to a non-perception, undervaluation and denial of symptoms, thus producing barriers to help-seeking” Möller-Leimkühler (2002, p 5). The following are extracts from participants narrating concepts of traditional masculinity as per their own conscious experiences, highlighting traits such as control, dominance and invulnerability. *Participant 1*, speaks of being indoctrinated from an early age, reflecting back to his boyish years where metaphors such as the one he gives “tigers don’t cry” shaped how he saw emotions in relation to being a male person, additionally such teachings were instilled by his teacher, this shows how society shapes thinking in individuals. *Participant 2* acknowledges the fact that by virtue of him being a man around other men, he is unable to divulge his emotions because that goes against masculinity and *participant 7* blatantly states that he cannot in any event admit to being depressed because depression alone is in direct contrast with what it means to be a male in society. *Participant 9* reflects on being a Zulu man and the principles a Zulu men should uphold, which entails not showing emotions and having such principles instilled in him from a young age. *Participant 10* also attests that he cannot fathom experiencing depression or rather emotional difficulties because his manhood does not permit such ‘abnormalities’ and he further substantiates this with the notion that the men before

him have always been able to regulate their emotions, thus even the generations that come after his generation will most likely subscribe to these ideals of masculinity.

*“Being a man comes with a lot of responsibility at the same time because once you get a title, that title comes with responsibility and even in the primary school I went to before I went to a mixed school, our teacher used to tell us that **“tigers don’t cry”**, And she meant that like if you're a boy you don't cry” – (Participant 1)*

“I'm unable to open myself up emotionally because by the mere fact that I have been a man for so many years; and most parts of what being a man in society is actually very toxic...” - (Participant 2)

“The thing is... I can never associate depression with myself because admitting to being depressed would take away from my masculinity, it would make me feel weak so I commend any male who can come out and say they are depressed” - (Participant 7)

*“Being a Zulu man or an African man in fact, we are taught to behave in certain ways, which brings me to the silly teaching concerning crying. In our language, Zulu language we are taught that **“indoda ayikhali, ikhalelela ngaphakhathi”** a literal meaning in English stating that a man is not allowed to cry, if he must cry it be on the inside” - (Participant 9)*

*“I really don’t believe men should be emotional, I don’t believe we were created to be that way, God made us like this for a reason. We didn’t choose this way, we are this way. I think it’s just awkward even when a guy cries, when it so happens that a man cries; what should I do? Should I comfort him? *laughs* we don’t even have a reference point for how to act in those kind of situations..... maybe if we witnessed our fathers going through the same maybe then it would be easier to accept. We are mirroring the actions of men that came before us and the generation that follows after us will possibly be the same” - (Participant 10)*

Drawing reference from the above extracts of men’s lived experiences concerning masculinity it is evident that depression in men is underreported because of a myriad of reason, Addis and Mahalik (2003) frameworks of depression in men help us understand this confluence. The dominant themes that will be discussed next draw reference from the masked depression framework, Cochran (2000) asserts that men have a greater tendency to express depression in ways that do not correspond to the symptoms that are outlined by the diagnostic statistic manual of mental disorders. Participants perceived these behaviours as being the general coping strategies adopted by men as it is evident that men distract themselves when they are faced

with emotional challenges. Following are quotes that support the theory of masked depression in men.

“This whole concept of being a man, it comes with a lot of pride to a lot of people. Now people pride themselves with this thing of being men and they don’t want to talk just because they’re men. They sort of like feel like once you start talking, it’s sort of going to present you in a different way. Now you’re not going to be man enough, because you started talking” - (Participant 1)

“If you’re a male, masculinity is inherently indoctrinated in you from the time you grow up. Growing up our parents and everyone around us would say “umfana akakhali” meaning in English: “boys don’t cry” So that’s how you grow up. You avoid coming off as less masculine, you avoid coming off as weak. So you avoid things like being a bit feminine or being sensitive. You avoid crying, you avoid losing. Um, yeah. Anything that makes you come off as weak you try to avoid” - (Participant 6)

“In Xhosa there is a saying that “indoda ifela ngaphakthi” a literal translation to English meaning “A man dies on the inside”, which basically instils the idea that a man must control his emotions at all times and this is true because men really do die on the inside because they do not share their problems . As men we are taught to deal with our problems as per own personal capacities, to find solutions on our own because should you take it upon yourself to speak up you are seen as someone who complains, you are therefore perceived as being weak” - (Participant 7)

“My father was never a vocal man, I remember vaguely this one time when I was a little younger, there was a time where I went to him and I was crying, all he said to me was “indoda ayikhali” / “a man doesn’t cry”. So from that point onwards, I think that shaped how I saw myself because till this day I still do believe a man doesn’t cry, a man doesn’t talk about his problems and a man solves his own problems” - (Participant 10)

Following are quotes from participants expressing ways in which masked depression manifests in men. Cochran and Rabinowitz (2003) in Oliffe and Phillips (2008, p.197) confirmed how men’s depression can manifest as “anger, impulse control difficulties, anxiety and irritability, aggression, substance abuse, risk taking (e.g., drunk driving, binge drinking), escaping behaviours (e.g., over involvement in work and/or sports), emotional numbness, inability or unwillingness to express emotion, impoverished relationships, and suicide”, these behaviours

in men can account for the presence of depression. *Participant 2* eloquently captures this in simple terms.

“Men find distractions, they don't face their depression and sadness” - (Participant 2)

4.7.1. Suicide

The risk of suicide is prevalent in individuals with depressive illness, therefore this trajectory is of great concern within the mental health domain. Several studies have documented that people with affective illness have a greater incidence of suicide, and people who commit suicide have a high rate of depressive symptoms. A plethora of studies have also documented that suicide ideation is more prevalent in men because of the tendency to conceal emotions (Oliffe, *et al.*, 2012). *Participant 2* narrates how he believes that men commit suicide as opposed to seeking help, stating that his close friend committed suicide when he could have contacted a friend and expressed how he felt at that time. Quotes follow:

“I definitely think men commit suicide as opposed to seeking mental health care. I have a friend who committed suicide, who bought a rope at the market and hung himself on Christmas day last year, he bought a rope, he could have bought airtime and called anyone of us” - (Participant 2)

“Not talking.... It never worked because truth is you need to speak to someone, truth is it hurts. You read newspapers, and read insert that narrate stories of violence, for instance men shooting their wives and children, also committing suicide. That generally happens because men never fully allow themselves to feel emotional pain and when something happens, something that takes away from their perceived emotional resilience, it triggers violence and suicide” - (Participant 3)

4.7.2. Multiple Sex Partners

When life is altered and shadowed by chronic illness, such as depression, sex can become a source of support, comfort, pleasure, affirmation of endangered identity, intimacy, a medium for connecting with significant others, and a way of feeling “normal” (McInnes, 2003). Sex can be a “powerful medicine,” and human touch can be a “great healer” that may relieve the depressive symptoms (Berdychevsky, *et al.*, 2013). One of the symptoms of the symptoms of depression as highlighted by the DSM-IV (2013) is anhedonia, typically described as a loss of pleasure and the loss of libido, men may however try to consciously try to foster ways that will allow them to engage in this act. Several studies have explored the relationship between sexual risky behaviour in men who present with depressive moods and studies have shown a link

between depressive moods and engaging in sexual intercourse (Lehrer, *et al.*, 2006). Similarly in a study done by Chadwick (2007) young men in were said to consistently construct masculinity in terms of actively engaging in one or more risky behaviours. *Participant 10* expresses his belief that having multiple partners as a man also stems from cultural hegemonic ideals of masculinity, thus hyper-masculine displays are interwoven in culture. Accounts from participants in this study follow:

*“I would say they also engage in risky sexual behaviour as a tactic of releasing their depression or stress whatsoever because *Pauses and laughs* men do that actually... I just know for myself like no matter what’s stressing me, give me a woman my problems are going to go away”*
- (*Participant 1*)

“Men in general, the men that I know cheat (have multiple sexual partners/ more than one relationship). Depends on the person really, and I’m not saying depression leads to cheating, but some people do it for that reason just to distract themselves...” - (*Participant 2*)

*“ ...I think the idea of having multiple sex partners has its roots in masculinity because in African culture, a man who has multiple partners is praised, this is something that has always been prevalent in our culture, it is seen as normal and it is embedded in our Zulu culture, where even polygamy is endorsed and is seen as a norm, however presently polygamy or rather having multiple partners is not practiced with the same cultural intent as before but I think having multiple partners is a coping mechanism I would adopt this strategy as opposed to taking drugs.... I know it’s bad but I would rather that than committing suicide. - (*Participant 10*)*

4.7.3. Self-medication/Substance Abuse

Health implications such as using alcohol or drugs to reduce emotional distress (self-medication) has been proposed as an explanation for the high comorbidity rates between depression, anxiety and substance use disorders (Bolton, Robinson, and Sareen, 2009). In addition to being highly prevalent, depression and substance use disorders frequently co-occur in men with who present with depressive symptomology (Conway *et al.*, 2013). Moreover, the consumption of alcohol, and smoking are said to be important features of the emphasised masculinity that men generally engage in (Chadwick, 2007). Therefore such hyper masculine displays, was to gain the respect of one’s male peers. Social learning theories can also be used to explain such behaviours (Bandura, 2014)

“Substance abuse is common within the black community, as black men we have this tendency of using drugs to comfort our emotions to try to make ourselves feel better. We feel like we can go drink our problems away, but obviously drinking doesn’t solve problems but even with that knowledge we still drink because in that moment when you are drunk you feel as though you forget about everything that is happening” – (Participant 5)

“Alcohol and drug abuse, those are common tactics that men use to cope with stressful life events, I think also that’s depends on the kind of person you are, I am not much of a drinker but if marijuana is considered a drug than that’s what I use” – (Participant 7)

“I think I’m guilty of using alcohol as a distraction as well, and I think that’s really bad because that’s how we men think we can solve our problems because we hold this belief that we can’t talk about our problems because it reveals a lack of immunity.” - (Participant 10)

4.7.4. Violence

Research suggests that stress may contribute to domestic violence (Williams, and Anderson, 2002). Moreover, masked depression has been linked to aggressive behaviour in men, particularly intimate partner violence (Addis, 2008). Domestic violence scholars contend that some men may use violence to regain a sense of control when they feel a loss of control, especially given the fact that control is a dominant hegemonic norm (Umberson, Anderson, Williams, and Chen 2003). A study done by Jakupcak, Lisak, and Roemer (2002) exploring the role of masculine gender role stress in men's perpetration of relationship violence found that masculine gender role and the experience of stress accounted for the emergence of stress as a significant predictor of aggression and violence. *Participant 5* in his response shows how violence manifests as a learned behaviour especially in cases where this behaviour was exhibited by a male parent, this line of thinking is linked with theoretical principles underpinning the intergenerational transmission of violence that appear in social learning theories (Bandura, 2014). According to these theories, violence is transmitted through vicarious observations or direct experiences (Bandura, 2014). *Participant 7*, reflects back to a time where bereavement resulted in him committing intimate partner violence. The narratives follow:

Researcher: You mentioned that men respond aggressively to emotional afflictions, can you please elaborate on that part?

“I think with violence it becomes a vicious cycle, and it is also interlinked with how a person was raised, the environment that the person grew up in, if for instances your father or any other male figure in your family used violence to deal with situations, you are most likely going to internalise that behaviour and engage in that same behaviour because that is your main point of reference, that is basically what you know. Violence becomes the thing that enslaves you if your emotional well-being is somewhat lacking.” - (Participant 5)

“Depression really has dangerous elements to it, because when I lost my dad, I think I fell into a depression but because I lacked the understanding on the subject I wouldn’t have known but reflecting back on that time I remember there was a time where I got into a fight with my girlfriend and it became physical... I couldn’t understand, no one understood because by nature I’m not a violent person and I have never been a violent person so it raised a lot of question for me” – (Participant 7)

4.8. Gendered Sociocultural Symbols of Self-Defeating Behaviours and Socialisation

The aforementioned practices are thought to create restrictive norms defining how men should think, feel, and behave (Addis, and Mahalik, 2003). Participants also vocalized that substance abuse is very prominent in black communities, so much so that they believe that substance abuse has been exhibited by the older generation and they believe that this dependency to alcohol is brought on by depression and the uncomfortable state of having to mask it, hence the prevalence of this behaviour in younger adults and teenagers respectively. Extracts are as follow:

“So it can be drugs and alcohol and womanizing. Usually for some people it's a source of escaping your depression state. That becomes evident when you start abusing alcohol and drugs because you're constantly trying to escape depression. It's unfortunate that within the black society you are exposed to drugs even before you are familiar with depression, it's what you see all around you even from a young age” - (Participant 5)

“I think it's easier sometimes to end up abusing alcohol if it's something you have seen happening around you especially if your father has been exhibiting that kind of behaviour, I think that kind of influence is really powerful”- (Participant 10)

4.9. Treatment for Depression

Studies done in Africa have listed reasons as to why people do not seek health care when they suffer from a mental illness such as, stigma, not being able to identify that the illness is a treatable disorder and beliefs that they would recover without treatment (Trump and Hugo,

2006) and the latter is predominantly why males do not seek mental health care in the face of adversity, as well as not knowing where to go or feeling embarrassed about the perceived problem results in men not seeking mental health care (Seedat *et al.*, 2002). Most participants spoke about lack of understanding for depression as a mental illness, extracts are as follow:

“I don't think most men know they're depressed. They just think they are unhappy. So I don't think there's a general consensus on the treatment of depression when you don't want to face something or even agree that you are depressed, then you won't have a perception of it” (Participant 2)

“Although they say it's medical sometimes, I just don't know how though. I don't know, just my thinking it's hard for me to believe that somebody is born to have depression just like somebody would have diabetes. I don't believe it's hereditary at all, to me that just doesn't make any sense” - (Participant 4)

“Black people and black men in particular we're not educated on these topics on how to overcome depression” - (Participant 6)

Participant 10 vehemently opposes the idea of seeing a professional psychologist as he believes the act itself would dispel his masculinity, he ascertains:

*“Truthfully speaking I would never go see a psychologist *laughs* I honestly don't think I ever will it just goes against my masculinity... I just can't imagine myself in that space. Even if we do a survey, it would prove me right, most black men in our communities don't see psychologists and therapists because that's not manly”* – (Participant 10)

4.9.1. Stigma

Stigma plays a significant role in influencing men's choices and perceptions about accessing professional psychological services. According to Bathje and Pryor (2011) public stigma can be conceptualized as prejudice, comprised of cognitive, effective and behavioural reactions from society and may result in adverse attitudes towards accessing psychological services (Vogel et al., 2006). Participant 6 describes stereotypical attitudes projected by society on mentally ill people attesting that these attitudes heavily laden with stereotypes induce feelings of fear, shame and inferiority in individuals because they bring rise to what Bathje and Pryor (2011) coin as 'self-stigma'.

“People start questioning your mental capacity, people start calling you crazy. And for black people, once you label someone as crazy. You know, you could end their involvement in society

because anything I say or do starts being labelled as crazy. Black people are very dismissive when it comes to people who are labelled as crazy. It's one of those things you have to avoid being, it makes it even harder to admit you have a problem especially if you are a man” – (Participant 6)

Following is *Participant 1*'s quote, he speaks of a stigma related to masculinity where if an individual accesses psychological services this construes images of weakness (Bathje & Pryor, 2011). He ascertain that individuals generally don't seek help because in doing so, there is risk that you may be viewed as 'less than'. Chadwick (2007) attests that heterosexuality emerges as a defining feature of masculinity, Furthermore, Frosh et al., (2002) ascertain that masculine identities are largely constructed through performances of homophobia.

“A lot of people don't talk, because they're not going to be man enough now. All of a sudden the perception is that you are gay and people associate being gay with not being manly enough. It doesn't make sense” – (Participant 1)

4.10. Implementation of Models outside Hegemonic Masculinity & Health Seeking Behaviours

Following perceptions of barriers to health care and help seeking behaviours, are the implication of untreated depression that poses a threat to public health. There was a general agreement among participant's geared towards constructive ways of dealing with depression. The majority of participants had advocated models to perform outside the dominant cultural constructs and finding alternative constructive ways of coping with depression. Extracts are as follows:

“When dealing with young men we need to stop this thing of whenever they have a problem or they're going through something, we just ignore them and think they'll be fine.” - (Participant 6)

“I think people should ultimately talk about their problems because sometimes you can bottle up a problem because you feel like it threatens your masculinity whereas your neighbour has a solution to your problem. So sometimes it's not necessarily about showing emotions to other people, it's about exploring solutions together with other people because you're living in a social context” - (Participant 9)

4.10.1. Recreational Activities

Naidoo and Mahabeer (2006) conducted a study at the University of Kwa-Zulu Natal Westville campus where they sampled Indians and black South African students both males and females. The aim of the study was to explore the “pattern of acculturation and integration attitudes of university educated students of Asian Indian and African ethno-cultural origins” (p. 121). One question aimed to inquire on the mode of acculturation preferred by black South Africans and Indians. The outcome of the study showed that both racial groups have been absorbed into acculturation, into western culture, which had both benefits and disadvantages. Both racial groups in Naidoo and Mahabeer (2006) indicated an adoption of western cultures in their home environment. However, black Africans indicated the use of their artistic expression in a form of music, poetry, painting and dance. Quote’s extracted from participants are as follow.

“Okay. I think I’m one of the lucky people when I’m really stressed, um, I don’t drink or anything. I think I just write poetry or write music or write a lot of songs. I sing, uh, I sing really well. People enjoy my singing. I play soccer and sing, singing is like some sort of cure”
– (Participant 1)

“I try to find constructive ways to deal with whatever is bothering me, I enjoy art, music, my piano, and I write songs. I’ve written songs that have actually pulled me up in dark times in my life. I’ve written songs that helped me to cope” - (Participant 4)

4.10.2. Religion, Ancestral and Spiritual realms

It has been established that religion plays a major role in aiding people make sense of what they are going through especially in times of distress, it has been also noted that it promotes mental health (Pargament *et al.*, 1992). Religion has been said to impact on the mental health of people by providing a sense of meaning and purpose in life; a certain level of hope that the illness is going is working towards the person’s good (Alcock, 1990). Extracts from participants pertaining to religion and the spiritual realm are as follow:

*“I seek refuge in the bible as well, I think people should do the same. I’m a Christian, and so the bible has many verses that restore hope and faith in times of distress for example **Jeremiah 29 Verse 11**. Faith gives hope and hope doesn’t kill. We always say hope doesn’t kill and hope is character in a person. The word of God has helped me shape my character”* - (Participant 4)

From *participant 4’s* extract faith and hope are a fundamental basis of healing through religion, according to Ellison *et al.*, (2009) individuals who view life through a religious lens may

experience feelings of optimism, intrinsic self-worth and hopefulness. The intrinsic self-worth is reflected in this young man's view of himself, acknowledging his character and how God's teachings have allowed him to curate his character by meditating through bible scriptures, thus making him optimistic about life, irrespective of challenges he may face.

"I think people should pray about it.... I think people should meditate"- (Participant 8)

"The treatment for depression, for me to understand the treatment for depression, I would have to confine myself to that space, but then I would never feel depressed... Unless it's induced by loss then maybe it could happen and in the case it does, I'd seek spiritual healing, because we are spiritual beings..." - (Participant 11)

However, contrary to the above narratives regarding religion as a source of healing, a study by Hood (1992) found that more fundamentalist religious outlooks may lead to a greater sense of isolation and depression. Several other studies (Hodges 2002; Pieper, 2004) also found higher levels of depressive symptoms among people of a religious faith. Pieper (2004) ascertained that religious coping can be linked to an increase in the experience of depressive symptoms, indicating that individuals who make use of negative religious coping methods experienced more feelings of hopelessness, feelings of being forsaken by God, fears about the future, loneliness and despair, anger towards God. This claim was supported by Participant 11 in this study, he further attested that he stopped ascribing to Christianity and religious belief. His quote follows.

"I think religion to a certain degree can induce suicide in some people, I think when certain situations happen in your life and you start questions Gods presence in your life and Gods existence and you feel like God has forsaken you it's easy for you to choose the suicide root, because that belief system in as much as it has its pros it is also problematic, I grew up a Christian but I have abandoned that belief system" - (Participant 11)

Participant 11 following his account pertaining to religion and its ability to affect people negatively, in terms of it inducing depression, suggested that he would pursue spiritual guidance from his ancestors/'amadlozi' following his lack of enthusiasm regarding seeing a 'psychologist' or taking the route of western medicine. Spiritual or traditional healers are commonly preferred by indigenous communities as these individuals hold the belief that mental ill-health triggered by misfortunes, witchcraft and lack of ancestral guidance, therefore opting to perform rituals to appease ancestors (Bojuwoye, 2013; Bojuwoye and Edwards, 2011; Edwards, Makunga, Thwala and Mbele, 2009). Following is *Participants 11* quote.

“I have been in situations where I felt like prayer didn’t work for me, but I came out of those situations when I decided to abandon religion and find my purpose, so if anything unsettling were to happen to be I would seek for guidance from spiritual healers and my ancestors” - (Participant 11)

4.10.3. Talking to Friends

Help-seeking in males vary, in terms of channels preferred by individuals. Some of the participants in this study had attested that with the acknowledgment that expressing emotions assists in fostering better mental health, friends were seen as people with whom individuals can confide in. This is somewhat consistent with findings in a study done by Bushell (2008), where a friend in males was seen as a source of help, resulting in 35 % of participants reporting that they were very likely to seek help from a friend in the future, however 24% still reported an unlikelihood of this happening. *Participant 7* is more accepting of speaking to close friends, however still acknowledges the difficulty in doing so often times because masculinity interferes with such pursuits, this evident in *Participant 3*’s reflection where he ascertains that speaking to female friends is easier than speaking to his male counterparts as women are perceived to be ‘care givers’. *Participant 6* narrates the difficulties of communicating ones feelings in ones male counterparts, as doing so results in being labelled negatively.

“I think having a support system of two to three close friends can help you communicate your problems because of the comfort of knowing that you have someone to confide in but even that proves to be hard sometimes because of our masculine identities, you struggle to present yourself in a vulnerable manner but talking to a friend I feel is certainly better than going to a therapists” - (Participant 7)

“I have female friends having female friends has taught the importance of speaking out. It’s more of a safe ground for you to speak it’s easier to talk to women they give us sober responses” - (Participant 3)

“It’s very hard to convey this to your friends because you are going to be perceived as weak. People will then assume that you are weak, even if you do confide in your friends, there a certain limits to it because you will just end up being seen as annoying” – (Participant 6)

4.11. Summary

The analysis provides an understanding of the perceptions and attitudes towards masculinity and clinical depression respectively and the challenges perceived be to triggers of clinical depression by black male students academically and socially as well as the acceptability of

various treatment options. There appears to be similarities in men's perspective of what is perceived as hegemonic masculinities and how these masculinities are socially orchestrated. At their development stage, and level of education men in this study tend to advocate for the adoption of individual identities as these are perceived to be liberating of the burdens of societal expectations, however individual identities seem to be presented as intricately bound up in hegemonic masculine norms. The participants had a fair understanding of the symptomatology of depression, however they lacked comprehensive knowledge on the subject matter, especially where the biology of this illness is concerned. Participants seemed to all agree that masculinity as it appears, constitute to the challenges that men face in society especially drawing reference from the South African contexts that is engulfed by inequality and economic firestorms. Many of the participants agreed on strategies that geared towards combating mental illness within black communities, however different factors were noted as resulting in hindrances in doing so, one being the notion of masculinity itself, also the lack of information and the knowledge of what psychological services offers seem to take precedence. Therefore the findings indicated that masculinity is a concept that influences mental health in a bidirectional manner, Participants assert that males seem to be living up to the cultural standard and expectations set by the society which induces depression and also prohibits help seeking behaviours resulting in men adopting externalising and self-defeating behaviours to alleviate emotional distress. Participants reported the need for reconstructions of the male identity, as well as mental health education especially within black communities and males themselves. In addition alternative ways of coping with depression such as religion and the arts were proposed by participants.

CHAPTER FIVE: Summary of Findings and conclusion.

5.1. Introduction

This chapter presents a summary of this study's findings, and discusses these findings in relation to other studies and the HMM framework proposed in chapter three. The limitations of the study and the conclusion are presented in this chapter. The aim and objectives of this study were met and the following conclusions are drawn with regards to the findings.

5.2. Discussion

5.2.1. Definitions of masculinity

According to the data collected there was an indication from the participants in this study that masculinity is socially constructed. The data supports the notion that current images of masculinity are embedded in culture and therefore the manifestation of masculine traits in men is a result of socialization. According to Frosh et al., (2002) a dominant discourse of hegemonic masculinity impacts on the psychology of men, because men's understanding of the category of masculinity and what it entails directly affects how men act in order to feel accepted socially, or rather have their actions aligned with what is perceived as ways men should behave in society. From the participants' accounts, the researcher gathered that participant's believed that hegemonic masculine traits are entrenched in social environments such as the family setting, neighbourhoods, church and the tertiary institution by merely being in contact with other men. Peer groups were also perceived as places in which masculinity can be enacted.

Within the South African context, the construction of the male identity is closely linked with anti-femininity, strength, power and authority (Barret, 2001). The data from interviews conducted with participants is consistent with the knowledge that masculinity is typically defined in terms of power, leadership, domination and strength. Participants in this study attested that they identify with and embody typical masculine traits themselves. Emotional imperturbability appeared to be the most common trait of perceived cultural masculinity. Therefore from this study it was noted that strength in participants is not majorly concerned with physical strength but it reflects bravery and courage, immunity to feelings and mastery. The narratives of the participants explicitly indicate the fact that young men are conditioned to enact masculinity by possessing mental strength, character and bravery in any situation. This finding is consistent with the health, illness, men and masculinities framework proposed by Evans et al., (2011), attesting that gender is one of the most important socio-cultural factors

influencing health and health-related behaviours, because men are socialised to cultivate intellectual competence which will allow them to thrive as men in society and therefore not face emotional challenges, therefore the inability of one to solve ones problems inseminates emotional disharmony in men and the inability to regulate negative emotions contradicts hegemonic masculine norms. At one end of the spectrum the, ability to solve problems is perceived to be aligned with hegemonic norms of power and control (Frosh et al., 2002).

Participants in this study identified friends and peer groups as great influencers of normative masculine behaviour, therefore men place themselves in relation to a variety of dominant hegemonic norms and practices, because these practices are perceived to be gateways of inclusion within peer groups. Scholarly work done by Frosh et al. (2002), ascertains that hegemonic ideals become yardsticks of measurement of the concept of masculinity, resulting in the development of in groups and out groups, where men position themselves and others in relation to hegemonic ideals of masculinity (Kriel, 2003). Being of a certain 'gender' in society one has to behave in ways that are consistent with ones perceived gender. Clarke (2008) attests that identities are constructed through the ideas of 'them', 'us' , 'belonging and not belonging', 'in-groups and 'out-groups', therefore "masculinity achieves meaning within patterns of differences" (Barret, 2001, p.82).

This perception of masculinity perpetuates gendered stereotypes of dealing with stress, and constrains expressions of emotions such anxiety and hopelessness because such emotions are perceived to be feminine (Frosh et al., 2002). In this study masculine ideals of strength are epitomized by the willingness to rise above adversity and the ability, as well as the mental capacity to solve ones problems without showing signs of weakness, these ideals are conclusive with those proposed by Barret (2001). Other versions of strength and power that emerged from the data entailed the ability for a man to protect and provide for his family and loved ones respectively.

5.2.2. Individual identity and masculinity

According to Connell and Messerschmitt (2005) within any society there is a possibility of the existence of a hierarchy of masculinities with an idealized version being dominant or hegemonic. Masculinities are therefore also understood to be performed differently in different societies. Ouzgane and Morrell (2005) argued that within perceived socially and culturally constructed masculinities lie individual identities that take on different forms depending on the actors, the time, the place and audience. In essence masculinity can be enacted in subjective

ways. Among participants in this study they appeared to be individual masculinities that were congruent with hegemonic masculinities and those that were incongruent with hegemonic masculinities. Masculinities that showed congruency to hegemonic norms, they also appeared to have different elements to them and they appeared to be contradictory, and they also consisted of characteristics that were performed differently in different settings.

From this study, it was gathered that some participants opted for the construction of different masculinities where emotional difficulties arose, however all the participants constructed individual identities that still unequivocally had features of the traditional hegemonic masculine traits. Responsibility being one of the roles that was adopted by all men in this study, therefore extracts from interviews compelled the researcher to draw on Butler's (1990) view that masculinity is a concept that differs across contexts, giving rise to multiple masculinities rather than conceptualising men's masculinity as being stagnant. It is important however to note that even with the aforementioned claim by Butler (1990), the participant's narratives suggested that identities as per individual perceptions are relational and they involve complex processes. According to Renold (2004, p.249) "masculinities are derived through social interaction in relation to and opposition against an 'other', which can include women and alternate masculinities". The participants in this study who deviated away from traditional masculine traits such as emotional invulnerability, saw women as people they need to provide for and protect, therefore women were perceived as being part of the subordinate gender. Men in this study therefore still held views of power and authority and the responsibility to be a protector and provider, further placing them at risk of experiencing masculine depression where such roles were unattainable. Furthermore, masculine identities seem to be paradoxical in nature, given the fact that participants in this study expressed aspirational masculine traits such as having a wife whilst also ascertaining that promiscuity is endorsed in this social group.

From this study it was gathered that hegemonic masculinities are heavily laden with obscurity and they appeared to be unattainable. Wetherell and Edley (2014) explored this element of masculinity and coined it the 'troubled' masculine identity position. The obscurity of masculinities appeared in the construction of 'alternative' masculine identities in this study as these masculinities still subordinated other genders and proposed subordinated masculinities and such a discourse appears to be consistent with hegemonic masculine norms. According to Burr (2006) in his social constructionist theory reality is not given it is constructed everyday through the use of language and how certain things are defined, therefore identities are constructed linguistically. This trajectory purports that irrespective of the fact that participants

in this study had considerable amounts of self-knowledge and agency however the construction of their identities are undoubtedly controlled by the local cultural discourses and cultural resources respectively accessible to them surrounding gender and sexuality. Thus existing masculine identities, or subject positions, that young men can adopt are contradictory and uncertain.

A young man's masculine identity is an ongoing process of creation and recreation. Connell (1995) supports the assertion that constructions of masculinity are by-products of interpersonal relationships that draw reference from cultural ideologies and beliefs in different societies. Frosh et al. (2002) acknowledges the fluidity of masculinity and how language plays a role in the construction of such a concept. The participants in this study, with their varying views of their individual identities draw on a wide range of traditional means available to him within his direct social network and society as a whole. Notably, the resources available to these young men are heavily reliant on gendered norms therefore constraining males, however the existence of alternate masculinities exist, given the fact that masculinity was not perceived as an unchanging concept amongst participants. Individual masculinities were perceived to exist within hegemonic masculine norms, the degree to which this confluence exists is dependent on the individual as noted from the participant's narratives of individual identities.

5.2.3. Awareness of Clinical Depression

Participants in this study had satisfactory knowledge regarding the symptomology of depression, likening it to a state of darkness, helplessness and hopelessness and anxiety. What participants perceived to be depression, can be regarded as subthreshold depressive symptoms as the diagnosis of depression is more complex than the perceived symptoms presented by participants in this study. In this study depression was typically perceived to be a result of stressful life events, the aetiology of this syndrome was thus not comprehensive in males as it was perceived to be a result of external stressors neglecting the biomedical aetiology of this illness. Explanations from participants failed to be inclusive of the biological aetiology of depression. Depression was perceived in relation to external stressors and prolonged sadness therefore sidelining other symptoms that are outlined in the diagnostic statistical manual for mental illness. Depression manifests in a large variety of symptoms and is associated with many factors including chemical imbalances in the brain. The DSM –IV-TR (American Psychiatric Association, 2000, p. 327). Depression also manifests in somatic forms, not only as a psychological syndrome as presented by participants in this study. Addis (2008) has argued that the perceived severity of the illness would result in men not pursuing mental health

platforms to alleviate symptoms especially if these symptoms are perceived as mild and temporary such as feeling 'sad, hopeless and lonely' because men are conditioned to self-regulate emotions no matter their severity as part of masculine traits. This was evident in participants in this study as most believe that depression was a syndrome that subsides steadily as time passes and if men are emotionally strong enough to overcome it.

Thompson, Hunt and Issakidis (2004) stated that individuals only resort to seeking psychological services if symptoms are perceived to be worsening, however this proves to be problematic in men because they hardly introspect, therefore adopting externalising behaviours (Addis, 2008). Lack of knowledge about mental health and mental illness may therefore delay help seeking behaviour in men. Moreover, participants in this study had attested that depression in black men is perceived as sadness, irrespective of the fact that the sadness may be prolonged but essentially it was viewed as a condition that will pass if one desires it to pass. Emmott and Darley (1988) ascertained that if individuals feel as though they can 'get over' an illness, there is a greater chance that such individual will not seek psychological help, therefore denial of threat, diagnosis or prognosis, results in lower pursuits of help and higher risk behaviours because of cognitive discrepancies where individuals recognise the severity of the problem but refuse to admit as this because it is inconsistent with beliefs about themselves (Ditto, Jemmott and Darley, 1988). One participant believed that mental illness manifested because of witchcraft and this belief is common among ethnic groups, however most participants in this study believe that depression cripples individuals and interferes with their daily functioning if individuals 'allow' it to do so, because men are should always rise above emotional afflictions.

5.2.4. Attitudes towards clinical depression

The most commonly cited constituents of hegemonic western norms stresses the possession of traits such as competitiveness, power, financial success and emotional fortitude (Connell, 1995), such traits are dominant within the South African context and many other ethnic groups. The work of Mac and Ghail (1994) exploring "the lives of black students in the context of the British schooling system" were examined, it was found that Caribbean youth belonging to the black ethnic group constructed 'a black masculinity' as a source of power against the prevailing gender order. The manifestation of this masculinity was a result of a culture for survival coupled with anxieties about the future (Mac and Ghail, 1994). The construction of masculinities for black men appears to be a complex task, especially because of previous subordination from white racial groups and South Africa bears no exception to this truth as

South African black youth in tertiary settings are faced with acculturation which sees them steadily assimilating to 'white' culture and also trying to forge their own 'black' identities.

According to Luyt (2005) restrictive western hegemonic norms such as the ones aforementioned poses threats to the emotional well-being of men especially in cases where these norms appear to be unattainable. Donaldson (1993) attests that hegemonic masculinity is anxiety-provoking for individuals and for any society. Globalized ideals of hegemonic masculinities are defined in terms of success, relational to success is power. By virtue of being in a tertiary institution participants expressed that they are taking advantage of this platform to better their lives and the lives of their families and loved ones. Participants ventured to express that prosperity to them will be measured by the ability to obtain good employment opportunities, thereby being financially successful, taking care of their families and owning expensive possessions. The aspirational features of masculinities that young men aim to achieve, are associated with the achievement of a certain status amongst peers and society as a whole. When such aspirations are not met this places men at a predicament where they become susceptible to experiencing masculine depression (Addis, 2008).

According to Evans *et al.*, (2011), the theoretical framework underpinning this research men who form part of subgroups categorized by marginalized masculinities based on ethnicity and race are at a greater risk of experiencing poorer health outcomes than other groups of men. A study done by Xanthos *et al.*, (2010) supports this claim, reviewing social determinants of health for African-American men in the USA, it was found that lower socio-economic class and other inequalities can account for poor mental health in individuals. Courtenay (2000) attests that age has a significant impact on health in light of age-related constructions of masculinity, because is constructed and reconstructed in relation to an individual's life events and the social context of their experiences throughout the life course. During this phase of their life, men in this study attested that for a typical young man between the ages of 20-30 years, given the fact that are pursuing a tertiary education experience multiple sources of pressure that results in stress often times. Socio-economic stress, forms part of the themes that was discussed in chapter four, where men's narratives gave accounts of the pressure that young men face coming from family, society as a whole and relationships. The most prevalent concept that arose from the interviews was that of structural inequalities. A plethora of studies have investigated the relationship between low socio-economic status and depression, attesting that this correlation is indeed a positive one (Baum, and Yali, 1999).

Participants in this study perceived stressed in men as deriving from external societal pressures and individual pressure respectively. The pressure related to external sources is perceived to be a result of wanting to fit in, and comparison to other men where success becomes an important attribute, and attaining such an attribute solidifies one's masculinity. Blackbeard's (2005) study captures well the concept of success in black youth, where a relatively expensive car was perceived to validate one's status amongst peers and ensured the respect of one's peers and indicated an adequate future masculine identity. Noted in this study was participant's beliefs that financial difficulties are a major stressor in University male students given the fact most black students come from socio-economically disadvantaged backgrounds Cebekhulu and Mantzaris (2006), therefore increasing the susceptibility to financial stressors. Additionally, relationship stresses and academic pressures were perceived by participants in this study as resulting in depression. Success as a hegemonic gender norm if not attained is perceived to be an instigator for masculine depression.

5.2.5. Awareness of treatment options

Health seeking and promoting behaviours are perceived to be affiliated with constructs associated with traditional femininity, such as caring. This caring in men is misinterpreted as weakness therefore resulting in men opting to mask their emotional affliction because this affliction has been perceived to be inconsistent with their gender. In a nutshell, health promoting behaviours are associated with femininity (Courtenay, 2000). According to Mahalik et al. (2003) masculinity impacts how men experience, express, and respond to depression. It has been noted in this study that hegemonic masculine gender norms inspire action and deject self-examination. Men who embody such norms when faced with depression most likely exhibit more externalising symptoms and self-defeating behaviours respectively. Evans et al (2011) ascertain that some men experience what they coin as a 'masculine depression', this claim was consistent with the data collected from the interviews in this study because some men expressed that men generally engage in sexual risk behaviours, substance dependence and anti-social behaviour when distressed.

Courtenay (2000) ascertains that men who experience difficulties fitting into the category of hegemonic masculine roles feel somewhat marginalized and stigmatizing therefore resulting in them pursuing socio-culturally defined compensating behaviours that increases their vulnerability to greater health risks. Courtenay (2000) further states that by virtue of being a man, men facing emotional difficulties would rather opt to engage in risky behaviour because they do not want to be associated with feminine traits such as weakness and vulnerability. From

this study it was gathered that depression itself was perceived by some men as an illness that befalls weak men, and men who are generally perceived as not possessing intellectual competence which is aligned with masculine trait. A quantitative study done by Bushell (2010), “Looking at the relationship between ideas and practices of masculinity and help-seeking behaviour amongst young South African men”, hypothesized that young men were less likely to adopt help seeking strategies from several help sources, as seen in both intended and actual help-seeking, the results that were generated from this study confirmed the researchers hypothesis, as help-seeking behaviours were presented to be relatively low.

Addis and Mahalik (2003) attested that the socialisation of young boys is of great concern as these young individuals are indoctrinated to embody hegemonic masculinity and ‘take it like a man’ at an early age, and are discouraged from showing feelings of vulnerability or weakness. Participants from this study also expressed this from of socialisation, further expressing that the social expectation of toughness and independence results in men ideally resorting to the suppression of emotions and deflecting from seeking mental health where difficulties arise. Some of the participants in this study reported that irrespective of the fact that they are aware of psychological services that are accessible to them they strongly believe that they would opt for other sources when dealing with emotional problems. Dialogue with family members and friends and prayer/the spiritual realm were methods of choice and seeing a psychologist remained a last resort for participants, with many attesting with conviction that they would never consult with one because with take away from their masculinity. Seabi and Samouilhan’s (2010) study stated that although individuals may have considerable knowledge on psychological services available to them some may still opt to explore informal sources of help, particularly this study found that participants chose ‘other’ alternatives ways of dealing with emotional distress.

Some participants in this study expressed negative attitudes towards help seeking behaviour in both friends and mental health professionals, because they had a problem with disclosing their emotions because for them disclosing of emotions was perceived as an ‘unmanly’ thing to do. Vogel and Wester (2003) in their study found that expectations of having to express emotions, and thoughts to mental health professionals affects individuals’ help-seeking attitudes and intentions. A study exploring emotional expression found that the unwillingness to seek psychological help was higher for persons who were not transparent with their emotions (Komiya, Good & Sherrod, 2000). Additionally, the social environment where an individual resides influence the attitudes and beliefs held by men regarding help seeking, some men in

this study suggested that within black communities, the stigma placed on mentally ill people is relatively high because the assumption is that if one is experiencing mental difficulties one is therefore 'crazy'. Therefore, the tendency to provide negative descriptions of individuals who experience mental illnesses disheartens individuals from accepting their illness, seeking help, and also remaining in treatment which prolongs the suffering and healing process (Corrigan, 2004).

This research study also found that in addition to the hindrances perpetuated by masculine ideologies where help seeking behaviour is concerned, participants indicated that knowledge and the accessibility of psychological services is very much lower within the general black population, especially amongst males. According to Afolabi, Daropale, Irinoye and Adegoke (2013) the cost of prescribed medicines, poor access to services and delays in attending to patients are all issues that affect the support and utilisation psychosocial services especially those intended to be used by the public, one participant in this study further went to explain that the delivery of such services is also very poor. This study also found that participants because of their perceived masculinity, they relied on themselves to regulate the problems they encounter leading to distress. This finding is consistent with results from a study done by AlDarmaki (2011) on preferences for sources of help among United Arab Emirates university students, where it was found that students often times rely on themselves when faced with psycho-social challenges.

From this study it was noted that men who do not access psychological services were believed to be at a high risk of having prolonged distress coupled with risk averse behaviours as discussed in chapter four, however some participants reported that even though they recognise the need sometimes to consult with mental health professionals, alternative strategies of coping with distress were very much perceived to be as successful in alleviating symptoms of distress. Religion was perceived by participants as an effective strategy to combat mental illness, especially depressive symptoms. A plethora of studies have investigated this relationship, revealing that religion and the spiritual realm has been linked to reducing psychological illnesses such as depression and anxiety (Curlin, Lawrence, Odell, Chin, Lantos, Koenig & Meador, 2007). The fundamentals of religious faith healing as captured by Sandlana and Mtetwa (2008) relies on the usage of prayer, holy water, holy oil and other substances, faith is of paramount importance and it is regarded as the necessary prerequisite for healing. Sports and Arts, were also perceived as engines for healing. According to Archibald Dewar (2010) Indigenous societies have acknowledged the healing power of visual art, dance, music, drama,

and storytelling, in their survey attempting to explore this claim, 80% of the survey responses from participants mentioned benefits related to personal growth and well-being when using these platforms relating to mental health.

5.3. Limitations of Study

Conducting research is inevitably approached from a specific standpoint and qualitative research is subjective and thus making it difficult at times for the researcher to maintain objectivity throughout the research process. The researcher's priority in conducting the interviews was to ensure that participants were not subjected to any harm and a minimum of discomfort as they shared their thoughts about depression and mental health. The participants had the knowledge that in partaking in this study they will not be rewarded, however they still agreed to take part in it and the researcher knew that this topic due to it being of sensitive nature potential harm may arise during the interview process. The participants were issued with all details pertaining to psychological services offered if discomfort arises. The sensitivity of the research topic forced the researcher to constantly review any bias judgement in the analysis of data and this was done through consultations with the researcher's supervisor.

When researchers choose procedures for their study, they have to keep in mind some of the challenges that may surface in specific research settings, among certain research groups and in unique research circumstances (Berg, 1998). Thus it is important to take into account some of the limitations of this study when analysing the results of this study. When conducting the in-depth interviews, time proved quite challenging as participants had various other commitments to attend to. The age factor also proved to be a limitation, because ideally the study aimed to look at ages 18-30, however the researcher was unable to interview participants under the age of 22, such a shortfall proved to be a disadvantage as the younger age groups would have given a different perspective of perceptions regarding masculinity and attitudes pertaining to mental illness. The small convenience sample cannot be used to generalize the findings to the broader population of males. A small sample was used for convenience as handling large amounts of data would have proved to be time consuming.

Future research need to consider a bigger sample to address the concept of transferability of the data to other contexts. Secondly, participants' stories may have been influenced by social desirability in a sense that they may have consciously tried to deviate away from risky hegemonic norms, this was particularly evident in some participant's responses when asked about multiple sex partners. Participants generally laughed nervously when answering

questions pertaining to multiple sex partners, mainly giving answers that separated them from “other men”, stating that they don’t condone such behaviours from “others”, but later on insinuating that such a behaviour is more tolerable than using narcotics. Participants may have also experienced difficulties narrating intimate stories that would have helped the researcher gain a full picture of how masculinities hinder help-seeking behaviours whilst also promoting risk behaviours. Participants could only give the subjective experience as individuals who have never been diagnosed with a mental illness. In future studies it would be essential for researchers to explore perceptions of clinically depressed men to understand how masculinity is constructed in such individuals and pathways leading to health promoting behaviours.

5.4. Conclusion

This study aimed to explore the perceptions of clinical depression amongst Black African male university students. It further aimed to explore the concept of hegemonic masculinity in African males and how individuals experience individual identities. The study also aimed to explore prevalent attitudes towards clinical depression among black male university students and the general consensus pertaining to the various treatment options for clinical depression among this population group. The study found that common ideas and practices of hegemonic masculinities appeared to be uniform across participants, and individuals experienced individual identities as part of broader hegemonic masculinities. Clinical depression in participants was understood to be a result of stressful life events, thus only attributing external sources to the onset of this condition. Participants viewed mental illness as arising in individuals with lower self-efficacy and as not of biological aetiology, additionally depression was understood in relation to symptomatology that lacked comprehensiveness.

The HIMM framework by (Evans *et al.*, 2011) highlighted that social determinant of health that intersects with various determinants such as socio-economic status, race, ethnicity, sexuality, ability, geography, community, education, and employment plays a role in understanding the paradigm of health seeking behaviours in men. “Agreement with traditional conceptualisations of masculinity” (Luyt, 2005, p.212), was a dominant theme that determined help-seeking behaviours in men, where ideas and practices of masculinity indicated poor health related beliefs and practices amongst men, including help-seeking behaviour (Addis and Mahalik, 2003; Mansfield *et al.*, 2005). Although this research showed that masculinity influences health seeking behaviours in men and pronounces risky behaviours, men in this study also indicated informal ways of dealing with mental illness, naming religion, sports and the arts as alternative routes of alleviating psychological distress.

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Appendices

Appendix 1: Ethical Approval Letter



31 August 2017

Ms Thabile Mthethwa (209524541)
School of Built Environment & Development Studies
Howard College Campus

Dear Ms Mthethwa,

Protocol reference number: HSS/0856/017M

Project title: The perception of clinical depression amongst Black Male University students in Durban, KwaZulu-Natal

Full Approval Notification – Full Committee Reviewed Protocol

With regards to your response received in August 2017 to our letter of 04 August 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Dr Kerry Vermaak
Cc Academic Leader Research: Professor O Mtshali
Cc School Administrator: Ms Nolundi Mzolo

Humanities & Social Sciences Research Ethics Committee

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Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

Appendix 2: Gatekeepers Letter



11 May 2017

Miss Thabile Mthethwa (SN 209524541)
School of Built Environment and Development Studies
College of Humanities
Howard College Campus
UKZN
Email: 209524541@stu.ukzn.ac.za

Dear Sir/Madam

RE: PERMISSION TO CONDUCT RESEARCH

Gatekeeper's permission is hereby granted for you to conduct research at the University of KwaZulu-Natal (UKZN), towards your postgraduate degree, provided Ethical clearance has been obtained. We note the title of your research project is:

"The Perception of Clinical Depression amongst Black Male University Students in Durban KwaZulu-Natal".

It is noted that you will be constituting your sample by conducting interviews, and/or focus groups with African Male students on Westville campus.

Please ensure that the following appears on your notice/questionnaire:

- Ethical clearance number;
- Research title and details of the research, the researcher and the supervisor;
- Consent form is attached to the notice/questionnaire and to be signed by user before he/she fills in questionnaire;
- gatekeepers approval by the Registrar.

You are not authorized to contact staff and students using 'Microsoft Outlook' address book. Data collected must be treated with due confidentiality and anonymity.

Yours sincerely


MR SS MOKOENA
REGISTRAR

Office of the Registrar

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Appendix 3: Informed Consent

School of Built Environment and Development Studies, College of Humanities,

University of KwaZulu-Natal,

Howard Campus, Durban 4001

Ref Number: HSS/0856/017M

Dear Participant,

INFORMED CONSENT LETTER

My name is Thabile Mthethwa; I am a Masters student in Population Studies at the University of Kwa-Zulu Natal, Howard campus, South Africa. I am conducting a qualitative study with intention to explore: *The perception of clinical depression amongst black male university student at the University of Kwa-Zulu Natal*. The aim of the study is to develop an in-depth understanding of how masculinities are constructed by black males and attitudes pertaining to depression. To gather the information, I am interested in asking you some questions.

Please note that:

- Your confidentiality is guaranteed, as your inputs will not be attributed to you in person, but reported only as a population member opinion.
- The interview may last for about 1 hour and may be split depending on your preference.
- Any information given by you cannot be used against you, and the collected data will be used for purposes of this research only.
- Data will be stored in secure storage and destroyed after 5 years.
- You have a choice to participate, not participate or stop participating in the research. You will not be penalized for taking such an action.
- The research aims at knowing the challenges of your community relating to resource scarcity, peoples' movement, and effects on peace.
- Your involvement is purely for academic purposes only, and there are no financial benefits involved.
- If you are willing to be interviewed, please indicate (by ticking as applicable) whether or not you are willing to allow the interview to be recorded by the following equipment:

	Willing	Not willing
Audio equipment		

I can be contacted at:

Email: thabilenyambose@gmail.com

Cell: +27607918834

My supervisor is Dr. K Vermaak who is located at the School of Built Environment and Development Studies, Level 8 Shepstone Building, Howard Collage Campus of the University of KwaZulu-Natal.

Contact details: email: vermaak@ukzn.ac.za Phone number: +27 (0) 31 260 2285

Thank you for your contribution to this research.

DECLARATION

I..... (Full names of participant) hereby confirm that I understand the contents of this document and the nature of the research.

Participant Signature: _____

Date: _____

Researcher Signature: _____

Date: _____

Appendix 4: Interview Guide

The objectives are to:

Explore how masculinity is defined by black male university students

Explore how individuals relate their identity to the concept of masculinity

Explore perceptions of clinical depression among black male university students

Explore attitudes towards depression among black male university students

Explore acceptability of the various treatment options

Interview Schedule

How would you define masculinity?

Do you see yourself in relation of this definition? If yes/no, why?

What aspects of the masculine identity are congruent with your identity?

How would you define depression?

In your opinion what do you think are triggers of depression?

In your opinion what is the perceived impact of depression?

In your opinion what are the perceived ways of coping with depression?

What is your understanding of treatment for depression?