



Research article

Masculine norms and mental health of African men: what can psychology do?

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ARTICLE INFO

Keywords:

Psychology
Mental health
Masculine norms
Men
Africa

ABSTRACT

In Africa, internalisation of masculine norms among men has been reported to make them more susceptible to mental health problems. In this chapter, social construction and role theories are used to explore the relationships between masculine norms and mental health among men in Africa. The authors argued that due to traditional and institutionalised beliefs, men engage in restrictive emotionality through defence mechanisms by denying their mental health challenges and status. Hence, an inclusive model of remedy was suggested that targets men's traditional beliefs as a way of aiding help-seeking behaviour among them to make them less susceptible to mental health problems.

1. Introduction

"Boys don't cry, and men do not shed tears" (Goodey, 1997) is associated with the African culture about what society expects from men in typical chaotic or challenging situations. Consistent with this proverb is the reports about the likelihood that at every first year of life males are more likely to die than their female counterparts (Etienne, 2019; Williams, 2003). One of the reasons for this disparity is the mental health behaviours of men which have been a subject of debate in well-being research (Marcos-Marcos et al., 2019; Olanrewaju et al., 2019). Men are known to frequently negotiate social status and power with their health behaviours which in turn have dual effects (Courtenay, 2010; Leeds, 2009). Such health practises can either promote health within the scope of negotiation or undermine health when coping mechanisms are depleted (Courtenay, 2010; Kavanagh and Graham, 2019).

The social and cultural expectations make men think of themselves as risk-takers, thus, leading to the probability of engaging more in risky behaviours that could lead to injury and death than women (Apalkova et al., 2018; Smith, 2017). The supposed environmental pressures have been proposed to be one of the major cause of men's premature death and have predisposed them to engage in unhealthy behaviours (e.g. risky sexual behaviour, alcohol use and abuse, high-risk sports, reckless driving) detrimental to their mental health (Griffith et al., 2011, 2012). These challenges are visible within and across cultures and it calls for sensitivity within gendered health research especially to understanding

men's health and their relationship to masculine norms (Courtenay, 2002).

Masculine norms have been stated as a significant factor that encourages men to engage in restrictive emotionality, which is conceptualised as the state of being unable to express one's feelings or and difficulty in finding words to express one's emotional state due to fear (Gross and Levenson, 1997; Levant, 1996; Levant et al., 1992; Thompson and Bennett, 2017). Although this behaviour changes over time, it has been studied as a static factor and has been linked to the belief that economic opportunities, socio-cultural patterns, and marginalisation resulting from stress have a direct and indirect contribution to men's contact of preventable diseases and high rate of death (Williams, 2003).

Based on the conceptualization of masculine norms which is rooted in social and cultural underpinnings, we hope to shed light on the masculine norm discuss and debate from the African socio-cultural stand. The paucity of research in this area within the African context is aimed to be filled by this chapter. Thus, we organise this chapter by considering the theoretical underpinnings in the relationship between masculine norms and mental health in Africa. Our discussion also considered the African conceptualisation of mental health and how masculine norm affects men's health. We will build on literature to propose models of remedy with practical psycho-social intervention and conclude by focusing on the implications for policy and the need for possible interventions.

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2. Theoretical underpinnings

The concept of masculinity has received considerable attention in gendered research and is a subject of debate as a result of its definitions and conceptualisations. This is because there is no consensus on its operationalisations and definitions as a research term (Creighton and Oliffe, 2010; McDermott et al., 2019). Although researchers operationally define men's masculinity in relation to their health depending on what gender constructs they are interested in (Griffith et al., 2016), we rely on the definition by Griffith et al. (2016) that masculinity is defined as a relational term for what is not feminine. In this case, masculinity would be objectively considered in terms of social roles, behaviours, and cognitive construction of meanings that are peculiar to men, and this constitutes the masculine norms. This section will highlight the theoretical basis for this chapter in a bid to shed light on how internalisation of masculine norms impacts mental health. While many theories have tried to explain the concept of masculinity and masculine norms, we based our explanations on psychosocial theories of this construct which will be considered distinctively in relation to African men's health. These are social construction and social role theories.

2.1. Social construction theory

The social construction theory is centred on the assumptions that individuals' perceptions and world view are consequences of jointly developed shared meanings with significant others around them (Leeds-Hurwitz, 2009). Depending on what constructs are under scrutiny, the type of social explanations differs based on what characterised the society in which such a construct exists (Miller, 2017). Therefore, an individual in a society adopts beliefs, meanings, and perceptions about a construct based on the general view of the society in which they exist. This institutionalised meaning is what forms what the individual perceives as moral or immoral depending on the situation they find themselves.

2.2. Social construction and masculine norms

We argue in agreement with previous authors (e.g., Odimegwu and Okemgbo, 2008; Van Heerden et al., 2015) that masculine norms are socially constructed. This forms part of what a male adult individual believes is right depending on what expectation the society demands from them. This type of gender expectation(s) is like a psychological contract which is referred to as the perceived societal beliefs about the strength and characteristics of the male figure. In trying to confirm this expectation, the individual passively agrees and behaves in what the society considered normative.

In the ideal sense, the social constructivist argues that men are not naturally hegemonic and do not exhibit traits of confirming the masculinity norms, however, the way the society shaped the roles even though they are not written rules affects how men make their interpretation of social events (Leeds-Hurwitz, 2009). This interpretation which makes them hegemonic is also considered a function of their cultural beliefs and it is believed to be directly or indirectly passed down to their next generation (Lindemann, 2017; Seidler, 2013). Thus, in trying to understand how masculine norms and mental health among African men relate, one has to consider how it is culturally and societally shaped, which is the aim of this chapter.

Boahene (2013) argued that the African society values proverbs as the source of cultural and social wisdom socially construct gender roles which are cognitively fixed. The author while noting the patriarchy system also proposed that proverbs were used to elevate men and exacerbate women's dominance. Although the author did not consider other cofounds like personality, experience, and individualised meaning ascribed to such proverbs and narratives by the narrator, we argue that, the function of how moral norms are transmitted and upheld are dependent on what the society stipulates. Thus, a man would be and act

like a man within the confines of societal expectations whether the expected behaviour is healthy or not.

2.3. Role theory

Consistent with the social construction idea is role theory which deals with a set of duties, roles, norms, and behaviours that an individual must exhibit consistently as a result of socially defined hierarchies (Ritzer, 2007). Although the idea of attribution is related to social construction theory in terms of its conceptualisation, we argue that in the case of role theory, the individual not only perceives the societal expectation but takes a step to act them out as these become their daily behavioural or cognitive routines. For instance, even though there are changes in the fatherhood role in the new African dual-earner families, an adult male is still considered a husband (e.g. with one wife or more), a father (with or without children), an uncle (with responsibilities to others within the extended families), an employee or a manager who acts in fulfilling their job roles to the organisation, and also occupy a city or village chieftaincy position within their age grade (Kelly, 2018).

2.4. Masculine norm through role expectations

The social hierarchy created with the role expectation implied that everyone is structurally crafted to exhibit a corresponding behaviour fitting to their ascribed roles. In this case, society is conceived as a social playing ground in which all actors (male and female) consistently assume a role consciously or unconsciously (Smith, 2020; Yang, 2013). The challenge with the role play assumption is that it does not consider behavioural or emotional exhaustion of the actor which in turn leads to role conflict and decreased psychological wellbeing (Amarachi et al., 2020; Kaya et al., 2018). Role conflict within this context occurs when work or social role demands are incongruent with the family anticipated role (Amarachi et al., 2020).

An example would be mothers expecting their husband to punish their male child/ren whether or not they have a long day or understood the severity or mildness of the child's offense. Even though the mother is not exempted from exerting parental discipline, the assumption within the role theory is that fathers should take an active role in exerting proper disciplines within the family (Adkison-Johnson et al., 2016), and within the African family practise, this role can include corporal punishments or punitive which are all aimed to depict the father as the sole head of the family (Van den Berg et al., 2013).

It reasons that while men are trying to fulfil this expected roles, their mental health is undermined not only by the society that expects them to act in a prescribed capacity but also by the actor themselves (the male figure) who may be guilty of not acting in the expected role when called upon for an expected father or uncle duties. In harmony with Boahene (2013) narrative of the African proverbs and their role attribution is the assertion that men must be strong in the face of challenges and difficulties (Kila, 2019; Ogutu, 2019), irrespective of whether they have the mental capacity to do that or not. Role-play is not determined by the actor (husband/father/uncle/chief), but is predetermined and must be acted whether the actor is in good health or not. Failures to fulfil these roles may result in stress and health-related symptoms because of internalisation of the traditional role ascription. It is assumed that once the label of a strong man is applied to a male, then he is expected to fulfil certain roles, and he in turn act in ways to meet the societal expectations, a sort of self-fulfilling prophecy.

3. Conceptualisation of mental health in Africa

Mental issues in Africa receive little attention from policymakers (Okasha, 2002; Omigbodun, 2008; Rotich and Tugumisirize, 2017). This is due to the adverse effects of other infectious and communicable diseases, low incomes, and malnutrition (Rotich and Tugumisirize, 2017). The challenges are exacerbated by the poor status of peoples' general

health and the underfunded health sector which is considered mental health in the least of health hierarchy (Marangu, 2018; Rotich and Tugumisirize, 2017). Therefore, it is typical that every man irrespective of social or health status takes responsibility for their families which is an effect of the social value attached to their roles (father, husband, and uncle) within the society (Van Heerden et al., 2015).

While trying to meet societal expectations which present huge burden and stress, men access healthcare services less often than women (Zisette et al., 2016; Van Heerden et al., 2015), and then become prone to a destructive definition of manhood (e.g. risky behaviour, multiple sexual partnerships, sexual prowess, and hegemonic attitude) (Odimegwu and Okemgbo, 2008). Although early research (e.g., Fleming and Agnew-Brune, 2015; Odimegwu and Okemgbo, 2008; Odimegwu et al., 2013) have shifted the masculinity and health debate to understanding its implication to men's health, there are challenges regarding whether it is ethical to conduct masculine researches when participants (e.g. men) are unlikely to participate in such research and if the use of deception during such research could be justified (Affleck et al., 2020). There are also challenges in trying to define mental health within the Africa culture due to cultural complexities (Odimegwu et al., 2013).

The African culture characterised by traditional ideologies and masculine beliefs delineate men as brave, noble, emotionally intelligent, and strong, and thus, not be irrational or emotional in the face of challenges or overwhelming events (Odimegwu and Okemgbo, 2008; Van Heerden et al., 2015). Consistent with this belief is the idea that the African male or female does not get depressed (Alang, 2016; Cox, 1983) which is equivalent to the hypothesis that Africans do not experience mental health challenges. For instance, depression among blacks was considered a sign of emotional weakness, and those who exhibit helplessness, worthlessness, or hopelessness which are core symptoms of depression are considered cowards (Alang, 2016; Campbell, 2017; Odimegwu and Okemgbo, 2008; Van Heerden et al., 2015). Most Africans are likely not to report their mental health symptoms or seek professional help and are more likely to seek religious help when faced with mental health problems without guilt or self-blame (Cox, 1983; Read, 2019).

Due to stigmatisation, the tendencies to seek mental health help is reduced (Barke et al., 2011), and this is more pronounced for men who because of their hegemonic ideas and heterosexual ideal as they only report symptoms of psychosomatisation after a prolonged period of living with the mental discomfort (Abubakar et al., 2013; Lubega et al., 2015; Olanrewaju et al., 2019). Most reasons cited for this is hung on the assumptions that psychosomatic conditions are first explained supernaturally (Patel and Stein, 2015), and due to the perceived stigma common among men, such conditions are only reported when spiritual explanatory models have failed and this time, the condition may have become chronic (Campbell, 2017; Odimegwu and Okemgbo, 2008; Patel and Stein, 2015). While exploring how African men conceptualise mental health, we suppose that there could be explanations on how this conceptualisation relates to their actual mental health state and behaviours, thus, the next section will highlight these effects.

3.1. Masculinity and mental health

Mental health symptoms that arise from masculine norms internalised and self-represented by men predispose them to risky and unhealthy behaviours that heighten their premature mortality (Griffith et al., 2011; Griffith and Cornish, 2018). While men try to achieve societal respect as a consequence of expectation through attaining higher education and economic success, their stress level increases, and their mental health which most often is not checked dwindles (Griffith and Cornish, 2018; Griffith et al., 2011).

Among African men, mental health challenges may arise because of underlying loneliness, depression, anxiety, and stress which accumulate over time (Smith, 2017; Olanrewaju et al., 2019). This could occur after internalisation has taken place which may make the individual live in denial of the emotional symptoms. As stated by Garfield et al. (2008) and

reaffirmed in Barke et al. (2011), the chances that men will seek mental health when they feel discomfort is reduced because of their socialisation experiences. Men are often socialised through role-playing in such a way that they undermine help-seeking behaviour, and if at all they intend to seek help, the individual is faced with cognitive dissonance which is a consequence of contradictory beliefs of what they believe they are, and what action they intend to take.

As a result of traditional ideologies which may make men think that they are emotionally intelligent, self-reliant, and competent, they exhibit denials when a mental issue arises, may avoid engaging in emotional discussions, and instead of disclosing problems, they may engage in premature termination of such discussions (Seidler et al., 2018). This may increase their likelihood to engage in substance use and abuse which may strengthen addictive behaviour (Garfield et al., 2008; Levant and Wimer, 2014). Garfield et al. (2008) noted that men also engage in poor eating habits, physical inactivities, and steroid use to cope with subtle mental health challenges.

These aforementioned are consistent with the reports of Fast et al. (2020) that men in East Africa (e.g., Tanzania and Kenya) often engage and are overwhelmed with thinking and often gone "crazy" from confusion resulting from between and within psychological warfare which is entrenched and deepened by economic, political, and social uncertainty. Fast et al. further state that when men are unable to fulfil their expected fantasies designed by the society (e.g. to provide for the family and pay all the bills including but not limited to rents and fees), the sense of failure overwhelm them and they result to drug and alcohol use and abuse which bolster their depressive symptoms and suicidal ideation. In their report, Fast et al. (2020) posited that some of the men decided to commit actual suicide after a prolonged depression, anxiety, and stress which they termed "unhealed psychological wounds".

Although the severity of men's health is not well documented in the literature that considers gendered psychological well-being in Africa, this chapter argues that psychological and psychiatric mental health symptoms surface on daily basis as men engage often in impulsive drinking which most times are seen as an opportunity to prove their manhood (Fast et al., 2020; Garfield et al., 2008). While engaging in avoidance behaviour, men also drink heavily with the idea that intoxication takes away problems or stressful experience at least for a short-term, this is also visible among young college male students who also partake in this ritual with the believe that drinking and intoxication allow them to discuss men affairs (Dumbili and Onyima, 2018). This type of ideologies and believes that are perceived as social norms as argued earlier, forces men to a helplessness zone when they cannot met societal expectations. The authors propose that these behaviours are traumatic for males starting from younger age and may have a prolonged effect of making them dysfunctional adults (Ezeugwu and Oluwatelure, 2016).

While examining the associations between traumatic experiences and HIV-risk taking behaviours among young men in South Africa, Gibbs et al. (2019) found that the structural system of poverty and gender inequalities that supports gender role culminates to traumatic experiences that eventually predispose young men to engage in HIV-risk taking behaviour. Gibbs et al. then advocate that eradication of poverty is a way of reducing risky behaviour and mental health challenges among men, but noted that this strategy would significantly reduce mental health challenges only if there is a conscious effort to transform gender norms which place too much burden on men. Gibbs et al. report indicated the extent to which men suffer both cognitive and behavioural dysfunctions which most times go unreported as a result of masculine norms that stigmatise them as weak when mental health supports are sought.

This section puts forward the severity of mental health challenges common among African men as reported in the literature. Due to space constraints, we decided not to highlight a case these psychosocial pathologies distinctively, but merge them in our discussions with the hope that we could show their inter-relationships. For instance, we highlighted that denial may first occur when these symptoms surface mildly, followed by acute presentations of the symptoms in the form of depression,

anxiety, and stress. This is then followed by the worthlessness feelings which then form the basis for suicidal ideation and possible actual suicide. Having established the relationship between men's masculine norms and mental health, we will discuss the models of remedy in the next section.

3.2. Models of remedy

Developing a working mental health model for African men with a masculine norm would involve incorporating and taking cognizance of the Africanism characteristics. Africa is a diverse society with a varying culture that elevates masculine norms with a negative perception of mental health challenges that would benefit from policies or models that is concise and clear. However, while taking into account the fact that most Africa countries do not have functional mental health policies and often operate dated ones (Gureje and Alem, 2000; Marais et al., 2020), it is expected that the proposed model in this chapter will take an inclusive standpoint as argued by Hall et al. (2020), and can be built on to bolster positive wellbeing among African men. Below is the proposed inclusive model with four levels.

3.2.1. Awareness

In Figure 1, cognizance is taken of the individual who is the focus of discussion and we posited that there must be an awareness that must go through three phases (i.e., individual, community, and governmental). The first sub-stage of the awareness phase is the individual conscious view of problem which motivates the person to or not to seek help (Seidler et al., 2016). This will then be followed by the community or societal awareness level that provides emotional support for the individual. The last sub-stage of the awareness is the governmental which comes into play in the form of policies and institutionalised assistance. This awareness can be motivated through advertisements and campaigns such as the Real men Real Depression campaign by Rochlen et al. (2005) with emphasis on targeting at-risk subgroups first and then the general community.

3.2.2. Psychological referral

When awareness has been well established, psychological referral which is intrinsically motivated within the individual and extrinsically motivated by the society and government policies sets in. At the level of referral, the individual seeks help from mental health experts. For an effective treatment to take place, the authors suggest a person-focused therapy which focuses on building on the client's strength of accepting the plights with a genuine and empathetic understanding from the therapist (River, 2016; Rogers Carl, 1942). As posited by Seidler et al.

(2017), a clear and concise structured therapeutic plan will be more efficacious and facilitates trust from the client about the treatment and the therapist. In this chapter, it is suggested that with a well-structured person-focused approach to therapy, the individual can proceed to the third stage of the remedy.

3.2.3. Bias reduction

The third level is the bias reduction. This level proposes that every therapeutic process should acknowledge individual and cultural differences of the client. In other words, emphasis should be centred on bias reduction at all levels of client engagement. The client's belief that men cannot have mental health challenges could pose a threat to treatment acceptance and could reduce the effectiveness of the therapy. Thus a consideration of this cultural belief will help to checkmate the biases that may arise from the therapist. The authors propose that the therapist should consider the different levels of biases ranging from individual, cultural, and therapist, depending on the need of the client (Ogrodniczuk et al., 2016; Redley, 2009). This is because having pass-through levels one and two which may be anchored on the masculine norms may not be sufficient in the therapeutic process.

3.2.4. Psychoneuroimmunosomal

The successes achievable at the levels of awareness, psychological referral, and bias reduction would propel the fourth level which proposes an integration of different approaches towards bringing out the whole individual in the client's healing process. This is called *psychoneuroimmunosomal*. This is because the integration of psychological, neurological, immunological, and social therapeutic processes are expected to bring total healing to the individual in need of therapy. The fourth level is considered the last resort if there are no failures at the levels of awareness, psychological referral, and bias reduction, but if these levels are robust there will be an effective remedy. If the cost of masculine norms and mental health are significantly and positively skewed (Greenberg et al., 2015), we believe that investing in this model will yield a better outcome.

3.3. The implication for policy and practice

The model of remedy in this study has implications for both policy and practise. As highlighted above, the male individual is disintegrating in their mental health and therefore needs urgent attention from policymakers. Efforts from policymakers could focus on driving campaigns to demystify some of the age-long myths that "men don't cry" and "big boys don't shed tears". This type of targeted campaigns will help men to be able to seek mental health advice from professionals rather than dying in

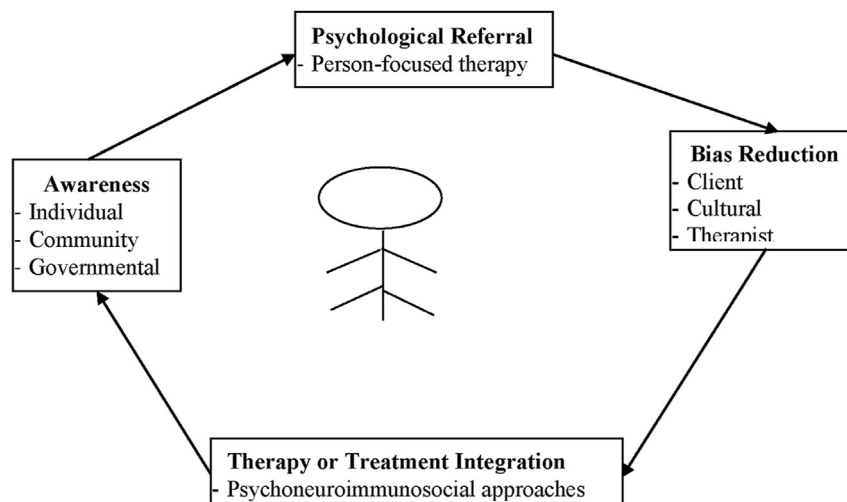


Figure 1. An inclusive model of psychosocial remedy for masculine norms.

silence. These campaigns can be extended to religious houses (churches, mosques, shrines, and different places of worship) in order to help men understand that mental health challenges are real irrespective of your religious beliefs and affiliations. This could serve as a bridge to help men feel comfortable discussing their mental health challenges.

In practice, we hope that the therapist and counsellor will take cues from our model to drive a holistic treatment plan. We believe that the individual (man) alone is not the cause of their mental state, which implied that the therapist needs to look beyond the individual surface to the ethnic, cultural, and linguistic differences that may have bolstered such discomfort. This should be acknowledged in order to reduce biases that may occur when therapies are offered.

4. Conclusion

This chapter conceptualised the relationships between mental health challenges and masculine norms among African men. We argued that the unquestionable internalization of social masculinity norms as defined by the social-cultural milieu makes African men more susceptible to poor mental health. We proposed an inclusive model of addressing the social construction of manly and modulating societal defined roles for men to help the African man less susceptible to poor mental health and also to heal those at the bridge of mental health collapse.

Our view in writing this chapter is that it will contribute to the literature on mental health and masculine norm in Africa which in turn will stimulate further researches that will empirically or qualitatively investigate these phenomena in order to highlight the contributory power of the variables highlighted in this chapter and other future researches. To this end, we are aware that some limitations exist in this regard. Thus, we encourage future research to take holistic approaches towards conceptualising mental health depending on their context and population of interest, and take cues from other theories that may best fit their conceptualisations.

Declarations

Author contribution statement

All authors listed have significantly contributed to the development and the writing of this article.

Funding statement

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Data availability statement

No data was used for the research described in the article.

Declaration of interests statement

The authors declare no conflict of interest.

Additional information

No additional information is available for this paper.

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