

# **Men and Distress: Experiences of Help Seeking, Coping and Self-Management**

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# Abstract

This thesis explores men's mental distress, attempting to move away from narratives that have consistently focused on problems to do with men and masculinity. Using a mixed methods approach, this research examines men's formal and informal help-seeking practices as well as effective daily coping and management strategies. In the first empirical chapter I begin by examining the contextual factors that predict men's formal mental health help seeking from the GP using a secondary analysis of the Adult Psychiatric Morbidity Study (2007). The main empirical component of the thesis is based on a series of semi-structured interviews, with a diverse range of men from the general public ( $n=19$ ) and men who have accessed support groups for emotional difficulties ( $n=19$ ), all living in Wales. Using a thematic analysis of the interviews I continue the exploration of formal help-seeking practices (chapter seven) and then move to focus specifically on men's experiences of support groups (chapter eight). In chapter nine, the focus turns to the more informal, everyday practices of coping and managing of distress. The findings of this research highlight the different things men do in their help seeking for distress, observing at times, the flexible use of masculinities, and, challenging the dominant discourse about help-seeking. In their everyday lives, men engage with their mental health and adopt a range of positive coping strategies in attempts to manage any difficulties faced. This thesis provides only a snapshot of men's experiences and many men today may still find it difficult to open up and seek help for distress for a number of reasons. However, this thesis attempts to acknowledge and commend men when they do positively engage with their mental health and wellbeing. Through doing this we can learn how to best support men in need.

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# List of tables and figures

**Table 1** – Type of support group and number of men recruited from that group

**Table 2** – Participants recruited from support groups and services

**Table 3** – Participants recruited from the general population

**Table 4** - Frequencies for variable 'DocPsys': GP: Spoke with about a mental, nervous or emotional complaint in past 12 months

**Table 5** – Frequencies for original socio-economic class variable and for recoded socio-economic variable

**Table 6** – Cross-tabulation for 'socio-economic status' by 'GP: Spoke with about a mental, nervous or emotional complaint in past 12 months'

**Table 7** – Variables included in binary logistic regression model

**Table 8** – Binary logistic regression for: Spoke to the GP about a mental, nervous or emotional complaint in the past 12 months.

**Figure 1** – How the two methodological components were carried out in this thesis



## Contents

Abstract.....	iii
Acknowledgements .....	iv
List of tables and figures .....	vi
Chapter One - Introduction .....	1
Structure of the thesis .....	3
Chapter Two - Literature Review: Why focus on men? Conceptualising masculinities and men's health .....	6
Introduction .....	6
Mental Distress .....	6
Gender and mental health .....	8
<i>Why focus on men and their mental health?</i> .....	9
"Being a man". Conceptualising Masculinities .....	12
<i>Hegemonic masculinity</i> .....	14
<i>Multiple Masculinities</i> .....	17
<i>A 'crisis' in masculinity</i> .....	21
Masculinities in the context of health and illness.....	23
<i>Men, masculinities and the relation to health beliefs and behaviours</i> .....	23
Conclusion .....	28
Chapter Three - Literature Review: Men's mental health experiences .....	29
Introduction .....	29
What do we know about men's experiences of mental health distress? .....	29
<i>Men express distress 'differently'</i> .....	30
Men and help seeking.....	33
<i>Masculinity, help seeking and social class</i> .....	36
<i>Masculinity and help-seeking: no longer a fixed relationship</i> .....	37
<i>Help-seeking enablers</i> .....	42
Men's use of support groups.....	43
Men's coping and self-management of distress .....	47
Conclusion .....	50
Chapter Four – Methodology .....	52
Introduction .....	52
Design and debates .....	53
<i>Making mixed methods work</i> .....	56
<i>Integrating the two components</i> .....	57
The Qualitative Component .....	60
<i>Why interviews?</i> .....	60
Sampling .....	63
<i>Inclusion criteria</i> .....	63
<i>Negotiating access</i> .....	64

<i>Recruitment of men who have accessed support groups .....</i>	<i>67</i>
<i>Recruitment of men from the general population .....</i>	<i>72</i>
<b>Ethical considerations .....</b>	<b>76</b>
<i>Using potentially vulnerable participants – was NHS research ethics committee approval needed?.....</i>	<i>76</i>
<i>Informed consent .....</i>	<i>77</i>
<i>Anonymity and confidentiality .....</i>	<i>78</i>
<i>Potential harm to participants:.....</i>	<i>79</i>
<i>Potential harm to the researcher .....</i>	<i>81</i>
<b>Data Analysis .....</b>	<b>82</b>
<b>Conclusion .....</b>	<b>86</b>
<b>Chapter Five - Reflections of a female researcher interested in men and their mental health.....</b>	<b>87</b>
<b>Introduction.....</b>	<b>87</b>
<b>Being a young woman in research.....</b>	<b>88</b>
<i>The challenges of gender in gaining access and recruiting male participants .....</i>	<i>90</i>
<i>Doing gender in the interview context .....</i>	<i>95</i>
<b>Interplay of gender with other attributes.....</b>	<b>100</b>
<b>Conclusion .....</b>	<b>101</b>
<b>Chapter Six - Secondary data analysis: Contextual factors that predict men seeking help from the GP .....</b>	<b>103</b>
<b>Introduction and overview .....</b>	<b>103</b>
<b>Background.....</b>	<b>104</b>
<b>Dataset selection.....</b>	<b>106</b>
<i>Data set information .....</i>	<i>107</i>
<b>Identifying the dependent variable .....</b>	<b>109</b>
<b>Question One – Can a significant relationship be identified between socio-economic status and whether a man had spoken to a GP about any emotional or mental difficulties? .....</b>	<b>111</b>
<i>Identifying a social class independent variable.....</i>	<i>112</i>
<i>How do we know what is going on? .....</i>	<i>118</i>
<b>Question two: What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional problem? .....</b>	<b>119</b>
<i>Identifying variables for analysis .....</i>	<i>119</i>
<i>Summary of variable selection and statistical test choice .....</i>	<i>127</i>
<i>Binary logistic regression results.....</i>	<i>128</i>
<i>Life and mental health factors .....</i>	<i>135</i>
<b>Conclusion .....</b>	<b>137</b>
<i>Limitations of the data and secondary analysis model.....</i>	<i>138</i>
<b>Chapter Seven - Men’s experiences of formal help-seeking .....</b>	<b>141</b>
<b>Introduction.....</b>	<b>141</b>
<b>Initial hurdles to help seeking.....</b>	<b>143</b>
<i>Recognising and communicating distress .....</i>	<i>143</i>
<i>Availability and access to formal support: men’s ambivalence to help seeking .....</i>	<i>148</i>

<b>External influences to help seeking .....</b>	<b>152</b>
<i>The importance of significant others .....</i>	<i>152</i>
<i>Social norms .....</i>	<i>155</i>
<i>Reframing help-seeking as ‘normal’ .....</i>	<i>157</i>
<i>Metaphors for formal help seeking.....</i>	<i>159</i>
<b>Support preference .....</b>	<b>161</b>
<i>The benefits of counselling and talk-based therapy .....</i>	<i>162</i>
<i>Dislike of prescribed medication .....</i>	<i>164</i>
<b>Conclusion .....</b>	<b>167</b>
<b>Chapter Eight- Men’s experiences of using support groups.....</b>	<b>170</b>
<b>Introduction.....</b>	<b>170</b>
<b>“They’ve walked in my shoes”: Shared understanding and experience.....</b>	<b>171</b>
<b>A safe space to offload .....</b>	<b>177</b>
<b>Tailored support offered and received .....</b>	<b>179</b>
<b>Reducing isolation and social benefits of groups: Socialising, meeting new people, discovering new hobbies and interests.....</b>	<b>183</b>
<b>Other experiences to do with using support groups.....</b>	<b>187</b>
<i>Preference for mixed groups .....</i>	<i>187</i>
<i>Frist attending the group: Access and availability .....</i>	<i>190</i>
<b>Conclusion .....</b>	<b>192</b>
<b>Chapter Nine - How do men manage and cope with distress?.....</b>	<b>195</b>
<b>Introduction.....</b>	<b>195</b>
<b>Being self-aware and having a sense of perspective.....</b>	<b>197</b>
<b>A range of flexible and proactive strategies combined .....</b>	<b>204</b>
<i>Exercise and taking care of physical health .....</i>	<i>205</i>
<i>Different ways to keep busy.....</i>	<i>206</i>
<i>Focusing on the positives in life and practicing gratitude.....</i>	<i>210</i>
<i>Combining typically ‘maladaptive’ strategies with useful ways of coping .....</i>	<i>211</i>
<b>Being open and talking about it .....</b>	<b>212</b>
<i>The benefits of talking.....</i>	<i>213</i>
<i>The importance of talking to the right person .....</i>	<i>217</i>
<i>Men and the disclosure of emotions .....</i>	<i>222</i>
<b>Conclusion .....</b>	<b>223</b>
<b>Chapter Ten – Conclusion .....</b>	<b>225</b>
<b>Introduction .....</b>	<b>225</b>
<b>Experiences of formal help-seeking.....</b>	<b>227</b>
<b>Coping and management.....</b>	<b>235</b>
<b>What does this tell us about men, masculinities and their experiences of mental health?.....</b>	<b>237</b>
<i>Is masculinity still an issue in relation to men’s help seeking, coping and management? .....</i>	<i>237</i>
<b>Limitations of the research .....</b>	<b>242</b>
<b>Research Implications.....</b>	<b>244</b>
<i>Further research .....</i>	<i>244</i>
<i>Policy and practice implications.....</i>	<i>247</i>

Concluding words.....	250
Bibliography .....	251
Appendices .....	276
Appendix 1 .....	277
Appendix 2 .....	278
Appendix 3 .....	279
Appendix 4 .....	281
Appendix 5 .....	283
Appendix 6 .....	285
Appendix 7 .....	287

# Chapter One - Introduction

In recent years, the long-neglected problem of men's mental health has started to receive more of the attention, academically and within popular culture, that it deserves. Suicide is the leading cause of death for men under 50. Despite there being a significant decrease in male suicides in the UK in 2016, with male suicide at its lowest in over 30 years, men in the UK are still three times more likely to take their own lives than women (ONS, 2017). Many voluntary sector organisations (such as Movember, CALM, Men's Health Forum, MIND, Samaritans and Time to Change) are continually developing new campaigns concerning men's mental health, urging men to speak out about issues they may be facing, as well as encouraging others to recognise symptoms of distress in men. High profile men in the media such as; male members of The Royal Family, sports stars, TV presenters, comedians and authors, have also opened up about their struggles with mental health difficulties. This has further increased awareness and pushed the issue forward onto public agendas.

Despite this increasingly valuable awareness and attention, there is undeniably still a way to go in understanding and tackling male mental health problems. According to The Adult Psychiatric Morbidity Survey (2014), women are still more likely to experience a common mental disorder (different types of depression and anxiety) than men. One in five women have common mental disorder symptoms (self-reported symptoms assessed using the revised Clinical Interview Schedule) compared to one in eight men (McManus *et al.*, 2016). However, it is likely that such data may not reveal the true extent of male mental health problems. Distress may manifest itself differently in men and their expression of emotional difficulties differs from that of women (Brownhill *et al.*, 2005). Men are traditionally less likely to seek help or treatment for mental health problems from a health professional (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005; Mansfield *et al.*, 2005; O'Brien *et al.*, 2005). As a result, large statistical data sets that explore prevalence of disorders may not reflect the true level of common mental health disorders in men. Besides, men's experiences of distress are much more complex than such noted gender differences described above. We need to begin to understand men's own lived experiences of distress, to get a full picture of what is going on with male mental health today and to move forward to reduce that heart-breaking suicide statistic.

There is still undoubtedly a need to continue to explore and understand men's experiences of distress, particularly; their help-seeking behaviour, the coping and management strategies they employ, and the support services they engage with. Social factors and influences of masculinities on men's experiences of distress and help-seeking behaviours have become an increasingly important topic of sociological interest. Previous academic work exploring male mental health has consistently suggested that men's unwillingness to seek help is based on the perceived threat to performing 'hegemonic' masculinity (Connell, 1995, 2005), which limits emotional expression and vulnerability. Studies have also put forward that men use fewer and more ineffective coping strategies than women to manage their mental health (Whittle *et al.*, 2015; Spendelow, 2015). Some authors have argued that much previous research has tended to focus on the 'men as deficient' narrative, what men *do not do* in relation to health and illness (Kiselica and Englar-Carlson, 2010; Siedler *et al.*, 2016), rather than exploring how men *can* and *will* engage with their own mental distress and wellbeing. Furthermore, previous research has often failed to include a broader population of men, often including primarily single, heterosexual, White, employed and well-educated men in their samples. Middle-aged, working class men, a social group of men who have received relatively little attention in research, policy or public discourse, and who also might be particularly vulnerable to emotional difficulties and suicide (Wyllie *et al.*, 2012), have often been left out of studies' sample groups.

Accordingly, there is a need to move away from exploring traditional masculinity as a problem and examine the positive things that men *do differently* to seek help and cope with any adversity they may experience in life. Although social science research on men's help seeking has increased in recent years, there is currently limited work on the positive and effective coping and management strategies that men adopt during times of emotional distress. Additionally, we know little about men's use of support services, more specifically the use of support groups for when experiencing distress. The purpose of this study was, therefore, to explore further these aspects to do with men's mental health and to carry out research that explores a diverse range of men's experiences of distress, specifically in South Wales. I aim to focus on what men *do* and *what they deemed effective* for them in relation to their experiences of help seeking, coping and use of support groups.

The study will therefore attempt to address the overarching research question:

- **When men experience distress and difficulties with their mental health, what do they do to manage this?**

To meet the different aims outlined above, the study will involve two separate methodological components and specifically attempt to address the following more specific research questions:

**RQ1 – What are the social contexts that predict help seeking from a GP for a mental, nervous or emotional problem?**

- a. Can a significant relationship be identified between socio-economic status and whether a man had spoken to the GP about a mental, nervous or emotional complaint?
- b. What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional complaint?

**RQ2 - What are men's experiences of help seeking for distress?**

- a. As a type of formal support, what are the men's experiences of using support groups?
- b. What is it that these groups are doing that works for them?

**RQ3 - How do men cope with distress and emotional difficulties they have been faced with on a daily basis?**

- a. What do they do to manage distress that works for them?

## **Structure of the thesis**

In order to answer the above research questions and address the aims, the thesis is structured in the following way. Chapters two and three review the current literature on masculinity and male mental health. In chapter two I will consider the importance of understanding male mental health. In this part of the literature review, I examine theories of masculinities, in order to better understand my research questions in the context of masculinities more broadly. Specifically, I consider Connell's (1995, 2005) relational framework model of masculinities in the current Western gender order. It is important to

consider the extent to which ideas of masculinity impacts on men's lives and behaviours in today's society. I therefore draw brief attention to considering whether masculinity is in crisis (Clare, 2000) and the relation of this to male mental health. I end chapter two by focusing specifically on masculinity in the context of health. Here, I highlight how the fluidity of the concept of masculinities can affect health generally (Robertson, 2007), and more specifically mental health. Chapter three moves to contextualise this thesis amongst the existing research that has been carried out in the field of men's mental health experiences. The existing literature has paid much attention to the role of masculinity on men's experiences of distress, their help seeking and their coping behaviours. In this chapter I review studies that have focused on men's help seeking in the context of depression, research on men's coping and finally men's use of support services, specifically support groups.

Having reviewed the literature, I set out my research approach in chapter four. In order to answer my separate research questions effectively, the study employed a mixed methods approach. Two methods were used in the research (statistical secondary analysis and qualitative interviews) and within chapter four I provide a rationale for this, as well as, examining the debates in using mixed methods in social science research. The rest of the chapter describes in detail the primary qualitative data collection of interviews with two different sample groups of men. Being a young woman interested in the lives of men and their experiences of distress required a particularly reflexive approach. In chapter five I reflect on issues, challenges and benefits to do with my position as a young woman, and its relation to the research participants and topic.

Chapter six presents a secondary statistical analysis of the Adult Psychiatric Morbidity Survey for England 2007, using a chi-square test and binary logistic regression to answer RQ1. The latter analysis explores the contextual factors that influence a man speaking to the GP about a mental or emotional problem, as well as specifically exploring whether there is a relationship between socio-economic status and help seeking through the GP.

In chapters seven, eight and nine I explore the findings from my primary qualitative research. Interviews with two different groups of men were carried out; men recruited from the general population ( $n=19$ ) and men recruited from support groups ( $n=19$ ). In Chapter seven I begin the empirical findings by exploring men's experiences of formal help



seeking. In chapter eight I focus specifically on men's attendance at support groups for formal help and support, whilst also considering the informal social organisations such as community peer-support. Here I explore the perceived effectiveness of support groups and, identify ways in which support groups can be beneficial in providing emotional support to men in distress. Chapter nine then moves to examine the informal, everyday coping and management strategies for distress that men engage in. Chapters seven and nine include findings from the interviews across both sample groups of men whilst chapter eight includes data only from interviews with men recruited through support groups.

Finally, in chapter ten, I conclude by bringing together the findings from the different analysis chapters in attempt to address the research aims and provide some understanding of men's experiences of distress in relation to their help-seeking, coping and management. Here I outline the limitations of the study and the main implications for further research and policy.

# Chapter Two - Literature Review:

## Why focus on men? Conceptualising masculinities and men's health

### **Introduction**

The following two literature review chapters will review with theoretical perspectives and debates exploring previous research on men, masculinities and mental distress. This chapter begins by briefly outlining how I contextualise 'mental health' within the thesis. This follows with an overview of gender differences in mental health, presenting why I chose to focus on men and their mental health. In order to appropriately focus on men, I spend time engaging with theories of masculinities. In this section, I draw on the notion of 'hegemonic masculinity' and now the preferred concept of 'multiple masculinities'. It is imperative that such theoretical perspectives of masculinities are examined in order to gain understanding of the impact masculinity can have on men's health and illness behaviours. The chapter will therefore conclude by considering the influence of masculinity in the context of men's health and illness.

### **Mental Distress**

Firstly, I contextualise mental health within the thesis. The World Health Organization (WHO) defines mental health as:

A state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contribution to her or his community.

(WHO, 2014)

Evidently, different issues constitute mental health. Mental health problems are a growing public health concern. The Mental Health Foundation (2016) outlines information regarding mental health today:

- Mental health problems are one of the main causes of the burden of disease worldwide (Vos *et al.*, 2013)
- The predominant mental health problem worldwide is depression.
- In the UK in 2013, depression was the second leading cause of years lived with disability. Mental health problems are responsible for the largest burden of disease (28% of the total burden, compared to 16% for each cancer and heart disease) (Ferrari *et al.*, 2013).
- One in six people in the UK (England specifically) will experience a common mental health problem (McManus *et al.*, 2016). This is a decrease from one in four since 2007 (McManus *et al.*, 2009).
- Mental health services in the UK are overstretched, have long waiting times and in some regions lack specialist services (Davies, 2013).

This thesis will discuss mental health and distress as broadly defined. 'Mental illness' is a multifaceted concept that requires the understanding of several disciplines, each with their own distinctive viewpoint, in order to recognise it fully. Defining 'mental health' can be controversial as well as problematic because there are markedly different ways of speaking about mental normality and abnormality in today's society (Rogers and Pilgrim, 2010). Here I acknowledge that there are many different terms used today, for example; 'mental health', 'mental illness', 'mental disorder', 'mental ill-health', 'mental well-being', 'mental health problems', 'mental distress' and 'emotional difficulties'. The 'Key Concepts' project (European Commission, 2004) concluded that mental health is best conceptualised by including 'positive mental wellbeing' and 'negative mental ill-health'. White (2010) explains further that positive mental wellbeing is not only the absence of mental ill-health but also the ability to cope with adversity, whereas negative mental health can be split into psychological distress and psychiatric disorders (White, 2010: 1-2).

Busfield (2000) argues that social processes are crucial to the understanding of mental health because: they shape the very concepts of mental health and the categories that are used to distinguish one disorder from another, and they play an important part in the aetiology of mental disorders and; they are vital in influencing mental health practice (Busfield, 2000: 544). It is therefore important to recognise the role that environmental and societal factors play in increasing health inequalities, particularly within mental health. In order to understand the mental health of men, we need to recognise the influence that

gendered social processes have. This thesis is not structured around diagnoses of a particular psychiatric disorder, however, it does focus on common mental disorders and so I do not want to ignore the impact diagnoses and medical models of mental illness might have on people's experiences. Given this, I also believe a bio-psycho-social model (Engel, 1977) of mental illness is the most appropriate model to understand how men experience and cope with mental distress in everyday life. I accept the biomedical model as a way to categorise mental disorders. However, with acknowledgement of the contribution of sociology to the understanding of mental illness, I regard it necessary that social constructions such as gender should not be left out and so believe that the understanding of 'mental distress' should be a flexible interaction of biological, psychological and social factors. Considering this, I use the term distress, defining it as a challenging emotional experience (e.g. anxiety, low moods, stress, isolation). According to Holland and Blutz (2007) distress can happen in a range of severities, which may not lead to a clinical diagnosis of mental health problems. Thus, this research explores men's experience of mental 'distress' broadly, using the above definitions.

## **Gender and mental health**

Careful attention needs to be given to the complex psycho-social phenomenon that is gendered mental illness (Featherstone *et al.*, 2007). Gender differences in mental health are of great psycho-social and medical interest, especially differences in prevalence rates, symptom profile, severity, distress/suffering, impairment, coping, help-seeking and prescribed treatments (Angst *et al.*, 2002). I should start by briefly summarising some of the key gender differences in the prevalence of mental health problems. The Adult Psychiatric Morbidity Study 2014 (APMS14) surveyed adults living in private households in England. As well as a key finding being that 1 in 6 people in England will experience a mental health problem in any given year, they also found the following key sex differences:

- Women are more likely than men to have a common mental disorder (CMD)<sup>1</sup> (19.1% and 12.2% respectively). Women are also more likely to have a severe CMD (McManus *et al.*, 2016: 10).
- Since 2007, people with CMD had more likely used community services and were more likely to speak to their GP about mental health (McManus *et al.*, 2016: 8).
- Rates of common mental disorder varied by age and gender. There were higher rates of CMD in women aged 16-24 years old, with a quarter (26%) of this group meeting the criteria for at least one CMD. For men, rates of severe CMD have increased for those aged 55-64 since 2007 (McManus *et al.*, 2016: 44-46).
- Anti-social personality disorder is more prevalent in men (4.9% of men and 1.8% of women) (McManus *et al.*, 2016: 175).
- Men were more likely to drink at hazardous levels and above and the highest levels of alcohol dependence were identified in those men between the ages of 25 and 34 (McManus *et al.*, 2016: 239).

Notably, women are more likely than men to have a common mental health problem. However, it is important to recognise that this survey is a self-report of symptoms and so does not reflect the population who may not recognise or report their symptoms of distress. Some men may not recognise their current experiences as symptoms of mental distress (see chapter three) and so may not report this in a survey. It is also important not to ignore such statistics and the types of problems that women face. It must also be acknowledged that mental distress is a phenomenon that people of all genders, ages and social backgrounds might still struggle to talk about. The above statistics point to the complexity of the intersection between gender and mental health.

### *Why focus on men and their mental health?*

This thesis is interested in the lives of men and their lived experiences of distress. It has been said that the way that men present with mental health difficulties is different from women and this can cause problems in the effective diagnosis of the problem and the

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<sup>1</sup> Common mental disorders (CMD) include different types of anxiety and depression. Does not include severe mental illnesses such as schizophrenia and bipolar.

referral on for effective treatment (Emslie *et al.*, 2006; Branney and White, 2010). I now turn to summarise some of the issues around men and their health and wellbeing:

- Men's health generally continues to be poorer than women's (Baker *et al.*, 2014). For example, men are more likely to die from circulatory disease and cancer overall and are twice as likely to die prematurely from diabetes (Men's Health Forum, 2014).
- In 2009, 2.7 million men in England had a mental health problem like depression, anxiety and stress (McManus *et al.*, 2009), and such difficulties have in recent years been exacerbated by the tough economic climate (Wilkins and Kemple, 2011).
- Three-quarters of all suicides in 2016 in the UK are male (ONS, 2017).
- The highest UK suicide rate in 2016 was in men aged 40 to 44 at 24.1 per 100,000 (ONS, 2017).

The alarming male suicide rate and the generally poorer health of men highlights the importance of understanding men and their mental health. As previously noted in the introduction, various mental health charities' campaigns now aim to reach out to men. Following on from their campaign 'Men and mental health, get it off your chest' (2009), the leading mental health charity Mind, collaborated with the Men's Health Forum (MHF) to launch the first ever set of guidelines addressing the mental health needs of men and boys, with the aim to improve mental health care and services for the male population in England. This report entitled *Delivering Male* (2011), attempted to resolve the fact that there had been no national men's strategy to mirror the one established for women. The report found that:

- Men self-stigmatize and many are embarrassed to admit to themselves and others that they have a mental health problem;
- This makes it harder for them to ask for help from the GP or friends and family;
- Men often do not display the traditional symptoms of depression and are more likely to act out meaning that their problems could be overlooked or misdiagnosed;
- There is a need for male friendly treatments and mental health awareness advertising direct to men (Wilkins and Kemple, 2011).

Additionally, charities such as the Samaritans and CALM (Campaign Against Living Miserably) have further attempted to highlight the needs of men. CALM conducted a

survey and subsequently released the report titled '*A crisis in modern masculinity: Understanding the causes of male suicide*' (2014). The report painted a bleak picture for men with the findings showing that when experiencing depression men often get into a cycle of frustration and unhealthy behaviours that are hard to break (Welford and Powell, 2014: 3). CALM highlight how thousands of men and boys in the UK may be struggling. CALM'S aim is to reach out to those men that may be entering this cycle, through their website and campaigns. Their most recent campaign called '#Project84' (2018), shared the statistic that 84 men take their own lives a week, providing the personal stories behind the statistics, thus raising the issue of male suicide to public consciousness. As well as this, a research report by leading academics in the field commissioned by the Samaritans (2012), aimed to examine why men of low socio-economic position in their mid-years (35-55 years) may be particularly vulnerable to suicide. The report found that the number of significant changes in society can present challenges to men in mid-life from low socio-economic backgrounds, and as a result this group may face increased risks to suicide (Wylie *et al.*, 2012). Such campaigns and reports raise awareness of the need for further understanding of men's complex experiences of distress.

Previously, men had not featured much in sociological writings on mental illness (Prior, 1999), however, this has significantly changed, and the problems men experience have increasingly gained a central focus in much psychological and sociological literature. Sociological studies are essential for the understanding of men's health, from their initial experiences right through to diagnosis, treatment and recovery. White (2001) found four key areas that were significant in understanding men's mental health problems and that need to be explored: men's access to health services; men's lack of awareness of their health needs; men's inability to express emotions; and men's lack of social networks. Recent and growing research has attempted to explore such areas but still, more attention is needed.

To explore men's mental health from a sociological perspective, first, we need to understand current conceptualisations of men and masculinities need to firstly be addressed.

## **“Being a man”. Conceptualising Masculinities**

Definitions in men’s health literature have defined men’s health as related to masculinity, that is, the social processes of being or becoming a man can have negative influence on men’s health practices and outcomes. If we want to explore men’s mental health experiences, it is important to first explicitly understand how masculinity/masculinities are conceptualised. The literature and theory on masculinities are diverse and complex. The term ‘masculinities’ is now more likely to be employed in the field to highlight how many multiple and diverse ways of ‘being a man’ there are. Firstly, I start by using the singular term to provide context. It is important here to acknowledge how ‘masculinity’ is never to be set in concrete and it always has the capacity for rapid modification (Beynon, 2002: 10).

In order to understand ‘men’ or ‘masculinity’, it is crucial to first have an understanding of gender. According to Butler (1990), gender is constructed through a repetition of acts, an imitation of miming of dominant performances of being a man or woman. For Butler, gender is performative. Gender is a way in which social practice is ordered (Connell, 1995), it is a specific form of social embodiment. Gender is not fixed it is rather ‘done’ by both men and women and can be understood ‘as a routine, methodical and recurring accomplishment’ (West and Zimmerman, 1987: 126). West and Zimmerman (1987) further argue that gender emerges from social situations. Masculinity can therefore be seen as a configuration of gender practice and necessarily a social construction (Connell, 2000: 29). According to Morgan (1992) gender and masculinity may be understood as part of a Goffmanesque presentation of self, something which is negotiated either implicitly or explicitly, over a whole range of situations, and so he suggests that we should think of ‘*doing masculinities*’ rather than of ‘*being masculine*’ (Morgan, 1992: 47)

Influential theory on masculinities came from the work of Raewyn Connell (1987; 1995; 2000; 2005), though this work is not alone, and many social scientists have contributed further to this expanding and evolving theory. Regarding ‘masculinity’ as a gendered practice and social construction, Connell argued:



Rather than attempting to define masculinity as an object (a natural character type, a behavioural average, a norm), we need to focus on the processes and relationships through which men and women conduct gendered lives. 'Masculinity', to the extent the term can be briefly defined at all, is simultaneously a place in gender relations, the practices through which men and women engage that place in gender, and the effects of these practices in bodily experience, personality and culture

(Connell, 1995: 71)

According to Connell (1995; 2000), in any given social setting there is never just one kind of masculinity. Thus, it is also important to consider intersectionality in the study of men, masculinities and men's health and in doing so it is imperative to understand that masculinity is vastly diverse, not homogenous, unchanging, fixed or undifferentiated (Coston and Kimmel, 2012). Intersectionality "moves beyond single or typically favoured categories of analysis (e.g. sex, gender, race and class) to consider simultaneous interactions between different aspects of social identity" (Hankivsky and Cormier, 2009: 3). The underpinning principles of intersectionality is the idea that people cannot be reduced to single characteristics and social categories such as gender, race, ethnicity, class and sexuality are socially constructed, fluid and changeable (Hankivsky, 2012). The construction of multiple masculinities is therefore a key theory to understanding gender. Connell (1995) developed a relational model of plural and hierarchically arranged 'masculinities' arguing that:

To recognise more than one kind of masculinity is only a first step. We have to examine the relations between them.

(Connell, 1995: 76)

For Connell, gender is sets of relations between men and women but also between men themselves. Connell terms these larger systems of the 'gender order' and viewing masculinities in this way "gives us a way of understanding the different dimensions or structures of gender, the relation between bodies and society, and the patterning or configuration of gender" (Connell, 2000: 24). Gender then, is both constructed and embedded in social, economic and political contexts and institutions. Connell's (1995) arguments became influential in the increasing recognition of the complexities of masculinities (Connell, 2000; Beynon, 2002; Brod and Kaufman, 1994; Mac an Ghail, 1996; Whitehead and Barrett, 2001; Haywood and Mac an Ghail, 2003). Such arguments highlight how social structures like class, race or global inequality cannot be understood without

incorporating gender, and so because of this interplay between them, it is now best to recognise 'multiple masculinities'. There are multiple versions of masculinity that coexist within different groups over historical periods. It is this diversity that can create marginalisation amongst and within different groups of men. Furthermore, different cultures and subcultures can influence how men develop their masculinities and in specific relation to the thesis, this can have an influence on how men respond to health issues and the health practices they engage in (Griffith, 2018). In the social hierarchy and within the Western gender order, Connell (1995) argued that individual men embodied different types of masculinity or 'multiple masculinities'. These multiple masculinities developed in Connell's framework were termed hegemonic, complicit, subordinated and marginalised.

### *Hegemonic masculinity*

At any given time in society, one particular form of masculinity is more culturally dominant. Connell (1995) refers to this as *hegemonic masculinity*, and negotiating this hegemonic form defines successful ways of 'being a man' in particular places at a specific time (Kimmel 1994; Connell, 1995). Hegemonic masculine 'code' is a set of ideals and practices, for example in today's society these codes still identify with being strong, competitive, self-reliant, autonomous, independent and a rational decision maker and problem-solver. Connell maintains that in its formation, hegemonic masculinity allows for more equitable relations between dominant and subordinate groups (Connell, 2005: 1818, Connell and Messerschmidt, 2005: 853). This 'hegemonic masculinity' can be understood as the pattern of practices that embodies the currently most honoured way of being a man, that requires all other men to position themselves in relation to it, and ideologically legitimises men's dominance over women (Connell and Messerschmidt, 2005: 832). 'Being male' can be interpreted differently in different circumstances (Cornwall and Lindisfarne, 1994: 37) and here it must be noted that hegemonic masculinity can be challenged by new groups and changes in a society at a particular time, so relates to that specific cultural context. Hegemony then, is a 'historically mobile relation' (Connell, 1995:77), it is active and socially constructed. Some have suggested that men today still aspire to live up to this masculine 'gold standard' (Chandler, 2012) in order to maintain power and dominance. Many agree that Connell's (1995) influential notion of hegemonic masculinity has been particularly

successful in highlighting the connections between power and masculinity, and the way in which some men dominate both women and other men (Hearn, 2004; Moller, 2007).

The concept of hegemonic masculinity however is not without critique and various authors question who, if anyone, actually embodies hegemonic masculinity (Donaldson, 1993; Wetherell and Edley, 1999; Demetriou, 2001; Hearn, 2004; Moller, 2007). Edley and Wetherell (1995) believe the concept is somewhat ambiguous with it not being clear what actually counts as hegemonic masculinity (Edley and Wetherell, 1995: 129). Wetherell and Edley (1999) added to this, arguing that it fails to describe what the negotiation of this hegemonic masculinity and hegemonic identities actually look like in practice in real life, suggesting instead that in order to understand men we need to attempt to understand their social and economic activities. Taking a discursive psychology standpoint, Wetherell and Edley interviewed men about a range of current topics in order to explore participants' negotiation of hegemonic masculinity. They found that through psycho-discursive practices, men strategically take up hegemonic norms in particular circumstances in order to define their subject position. Connell and Messerschmidt (2005) attempted to respond to such criticism as Wetherell and Edley's by reworking the concept. They argued that structured relations among masculinities remain in all local settings and motivation toward a specific hegemonic form varies by local context (Connell and Messerschmidt, 2005: 847). Therefore, a form of masculinity that is associated with power and authority will exist in any given setting.

Rather than concluding that the notion of hegemonic masculinity is not useful in critically analysing men, Hearn (2004) argued that the concept is too restricted and the focus on masculinity is too narrow (Hearn, 2004: 59). In his view, there is a need to look at the formation of the social category of men and men's presumed domination and control. Hearn (2004) prefers to use the term 'hegemony of men' rather than 'hegemonic masculinity'. Hearn believes the latter has been employed too restrictively and claims that the 'hegemony of men' views men as a social category formed by the gender system as well as dominant agents of social practices (Hearn, 2004: 59). Similarly, Jefferson (2002) suggested that hegemonic masculinity has been used too attributionally, by simply just referring to a list of 'manly' attributes e.g. competitive, strong, assertive, independent, unemotional etc. Moller (2007) believed that we should question what the effects of the

concept of hegemonic masculinity are on the way that researchers interpret men's (and women's) practices. He suggests that the concept of hegemonic masculinity conditions researchers to think about masculinity and power in a specific and limited way (Moller, 2007: 268), and because the concept is so prominent researchers only seem to use power to explain patterns and practices of masculinity.

I think it is important to consider the use of the concept hegemonic masculinity, particularly when applying it men's mental health experiences. Different groups of men may face different types of difficulties and so as Connell notes, hegemonic masculinity is not applicable to all men at all times, hence the notion of other multiple masculinities (subordinated and marginalised, for example) that are taken up at different times. Yet, I agree with Hearn that when the concept is being used, the focus can sometimes be too narrow. A more flexible approach has been to view masculinities as complex and multifaceted (Connell, 1995; Robertson, 2007). Masculinity is relational and so is constantly in a flux, sometimes co-constructed and reliant on context (Connell and Messerschmidt, 2005). This, however, does not mean that men can choose from a range of masculine identities as they are always restricted and influenced by a range of social factors that impact on how they are able to embody and perform masculinity. This will be considered further in the following sections.

Despite the criticisms above, I still consider the concept of hegemonic masculinity as a useful concept. In relation to men's experiences of health and mental distress, it has been found that many men still attempt to conform to traditional gendered views and practices. This will be explored in chapter three, where I examine research on men's mental health practices and research that has investigated the relations between traditional masculine norms and men's health attitudes and behaviours. In the analysis of the data, I draw upon Connell's ideas regarding hegemonic masculinity and multiple masculinities when exploring men's lived experiences of mental distress, help seeking and coping. In doing so however, I bear in mind the criticisms examined above. I agree that at times hegemonic masculinity can too often be described as a list of 'manly' attributes and it is therefore important to recognise the different ways such attributes can be used, in the context of men's mental health.

## *Multiple Masculinities*

Having discussed the dominant 'hegemonic form' of masculinity, there are also specific gender relations of dominance and subordination between groups of men that need to be identified. Men must navigate their identities through political, economic, gender, sexuality, power differential, race and cultural factors. Connell outlined how masculinities are developed in what may be referred to as 'configurations of gender practice'. Such configurations of gender practice are 'generated in particular situations in a changing structure of relationships' (Connell, 1995: 81) and will inevitably include health practices, or practices that influence health status (Robertson, 2007). Connell's gender relation's framework highlights the plurality of masculinities but also how they are constrained by the wider social order. For Connell (1995) "dominant, subordinated and marginalised masculinities are in constant interaction, changing the conditions for each other's existence and transforming themselves as they do" (Connell, 1995: 198). I will now briefly consider these different masculinities outlined by Connell.

*Subordinated masculinity* is most often based on sexuality, referring to the dominance of heterosexual men and the subordination of homosexual men. By oppressing homosexuality in society, homosexual masculinities are subsequently positioned at the bottom of the gender hierarchy among men. The intersectionality of privilege (Coston and Kimmel, 2012) is useful here in examining subordinated masculinity because homosexual men are not one single group. While men might be subordinated in one aspect of their lives, for example, homosexual men, they may have access to alternate sites of privilege through other aspects of their demographics. For example, white middle class, homosexual men are arguably higher up the gender hierarchy than heterosexual, working class men of Afro-Caribbean heritage. Furthermore, in society men are always going to be privileged in one sense by virtue of their gender (Coston and Kimmel, 2012). Homosexual masculinities do not always mean the abandonment of masculine standards. In examining how gay men respond to their masculinity being subordinated, Coston and Kimmel (2012) found that gay men relied on three coping strategies. They either reformulated their ideas of masculinity, relied on and promoted certain aspects of hegemonic masculine ideals or rejected the mass societal norms instead creating another set of standards for themselves (Gerschick and

Miller, 1995; Coston and Kimmel. 2012). This highlights the fluidity and changing of masculine standards.

Anderson (2009) criticised this hierarchical positioning of homosexual men by Connell, suggesting that such views have changed, with masculinities now being much more open around aspects of sexuality. He terms this '*inclusive masculinity*' and through his ethnographic work of university students in the U.S and UK suggests a decrease in the levels of homophobia and that this has in turn challenged hegemonic patterns of masculinity. This 'inclusivity' is the process of incorporating performances that are culturally viewed as 'Other' or 'subordinated'. Anderson further argued that cultural homophobia has further diminished, and it has become increasingly socially unacceptable to be homophobic (Anderson, 2009; McCormack, 2010, 2012). This model of 'inclusive masculinity' maintains that multiple forms of masculinity can exist in a horizontal not hierarchical arrangement (Anderson and McGuire, 2010). However, both Anderson's (2009) and McCormack's (2010, 2012) studies that explore inclusive masculinity used white, educated middle-class men, social factors that might make it more socially acceptable to engage in these 'Other' or 'subordinated' behaviours.

Connell claimed that although the number of men who actually practise hegemonic masculinity completely may be minimal, if at all, the majority of men still gain from it, benefiting from the patriarchal dividend (Connell, 1995: 79). *Complicit masculinity* then, refers to these men who benefit from the patriarchal dividend but may not actually enact hegemonic masculinity. Connell and Messerschmidt (2005) suggested that the concept of hegemony is at its most powerful when it is in relation to this group of men who feel the benefits of it but do not enact the strong version of masculine dominance. Furthermore, in their interviews with young men, Wetherell and Edley (1999) found in the men's talk that what initially looked like resistance to hegemonic masculinity turned out to be another form of complicity to it. Demetriou (2001) attempted to deconstruct the distinct difference between hegemonic masculinity and non-hegemonic masculinity as a way of portraying the mutual influence of different masculinities on each other, suggesting that hegemonic masculine patterns may change by incorporating elements of other forms of masculinities (Connell and Messerschmidt, 2005). This can be seen in the emergence of the term '*hybrid masculinities*' (Bridges and Pascoe, 2014), which has been used to account for the recent

transformations in men's behaviours, appearances and opinions. The term 'hybrid masculinities' refers to privileged men incorporating elements of marginalised and subordinated masculine identity and even sometimes femininities, into their own gendered identity (Bridges and Pascoe, 2014: 246). For example, Demetriou (2001) illustrated an example of hybridity showing how heterosexual men incorporate gay culture that produces new, hybrid configurations of gender practice that enable them to reproduce their dominance over women (Demetriou, 2001: 350-351). Thus, he argued that subordinated and marginalised masculinities could affect the formation, style and appearance of hegemonic masculinity.

Having outlined hegemony, subordination and complicity, this section turns to the interaction between gender and structures, such as social class. This creates a form of masculinity Connell (1995) termed *marginalized masculinity*, which refers to the relations between the masculinities in dominant and subordinated classes or ethnic groups (Connell, 1995: 81). Marginalized masculinity aspires to the hegemonic norm but is unable to fulfil it due to structures such as class and race. Men from different class, ethnic and religious groups may practice masculinity in various different ways. Phillips (2005) found that marginalized masculinities or 'outcasts' from the norm are often constructed in the wake of the ideal (Phillips, 2005: 220). Within discussion of marginalized masculinities, I turn attention to class, in particular *working-class masculinity*, as the intersection of class and gender on mental health practices is important to consider. Working class masculinity has been well documented across the social science literature (Hargreaves, 1967; Willis, 1977). When it comes to stereotypical images about masculinity, it is often still the view that middle class men can exert institutional power whereas working class men attempt to gain power physically through fighting, sports, drinking, machismo and displays of sexual prowess (Beynon, 2002: 20). There are different ways of 'doing masculinity' and these are recognised within the different constructions of social class, for example collective versus individual, oppositional versus rational, hands versus brains (Morgan, 2006). Working class men can be seen as very masculine, for example, strong, stoic, hard-workers, and their day-to-day lives are embodied as something particularly masculine (Coston and Kimmel, 2012). When referring to class masculinities it is clear that work and employment are central to men's lives. Morgan (1992) noted how workplaces forge male identities, giving them shape and meaning through role and environment (Morgan, 1992: 77). Paid work and the type of

work itself are notably an important part in the construction of masculine identities and of hegemonic masculinity (Fletcher, 2010; Dolan, 2011). Dolan (2011) found that paid employment was one of the domains through which the men he interviewed were keen to present a positive image of themselves as 'proper men' (Dolan, 2011: 599).

Many have noted that there has been crucial transformation in the relationship between waged work, gender and class (Sennett, 1998; Skeggs, 1997), which has caused new class-based inequalities in which working-class men feel their standards of living are threatened. Chandler (2012) suggests that men in middle age who are more economically disadvantaged may be more unable to live up to the ideal hegemonic masculinity. This may be due to what Nixon (2006) found, that low-skilled, unemployed men are continuing to seek traditional and familiar forms of male-dominated, low-skill manual employment that are now in further decline (Nixon, 2006: 201). Men's reactions and experiences to these changes in industry and the labour market have resulted in what many have termed a 'crisis in masculinity', which I turn to discuss in the next section. The key material resources that were once used to produce masculine identities have arguably become limited (Willis, 2000) and working-class men's position in society may be changing (Haywood and Mac an Ghail, 2003). If work is a way to produce masculinity then unemployment threatens the identity of men, disturbing the hegemonic ideal (Willott and Griffin, 1997). In relation to health, the mental health impact of unemployment has been found to be greatest among those in the manual labour work groups (Artazcoz *et al.*, 2004). Middle class masculinities are also profoundly based on work, but rather than establishing masculinity through physicality and risk, it is achieved through a successful career, power and money. For men, being a manager can enable them to exert power and control over both men and women beneath them, thus producing 'management masculinities' (Collinson and Hearn, 1994). In the face of redundancy this masculine identity is threatened, leaving men to feel like a failure, and perceive themselves as less of a person or 'man' (Parris and Vickers, 2010). This loss of role and status is one of the ways in which men may begin to experience a crisis in their masculinity.



## *A 'crisis' in masculinity*

In recent years, there has been a growth in an apparent 'crisis' discourse relating directly to the supposed increase in men's mental health problems and especially not forgetting the increase in male suicide rates. This notion of 'crisis' can be seen as a backlash (Fauldi, 1991) to wider structural social and economic changes in the wake of second wave feminism. Morgan (2006) suggested that possible roots to this crisis are seen to come from the collapse of 'traditional' men's work, the growth of a technological culture that cannot be passed on from generation to generation, the rise of feminism and certain challenges to dominant forms of rationality (Morgan, 2006: 111). Clare (2000) views the crisis as demonstrated across the whole landscape of social life, including crime, family breakdown, ill-health, suicide, domestic violence, education and work, including unemployment, redundancy and early retirement. Clare (2000) argued that men are in this crisis because they are constantly trying to confirm to rigid, now out-of-date, practices of traditional manhood and masculinity. Previous hegemonic masculine traits that were once highly regarded and accepted in Western society are no longer viewed in this way. MacInnes, (1998) claimed:

What were once claimed to be manly virtues (heroism, independence, courage, strength, rationality, will, backbone, virility) have become masculine vices (abuse, destructive aggression, coldness, emotional inarticulacy, detachment, isolation, an inability to be flexible, to communicate, to empathise, to be soft, supportive or life-affirming).

(MacInnes 1998: 47)

Stereotypical female qualities (such as empathy and gentleness) have now become widely accepted as superior to stereotypical male qualities (Beynon, 2002: 84). As noted above, social and economic changes have left men facing uncertainty and constant changes in their job roles, as well as the threat of unemployment and daily job-related stress. Due to these changes, men may find it difficult to establish their own masculine identity and place in society.

Masculinity and particular sets of masculine values and beliefs are frequently cited as potential reason for men's decrease in health with certain conditions (Sabo and Gordon, 1995) and also why men are more likely than women to take their own life (Chandler, 2012;

ONS, 2017; CALM, 2014; Men's Health Forum, 2016). Could this be a result of this so-called crisis in masculinity? Coyle and Morgan-Sykes' (1998) work highlights how increasingly accounts (in newspaper articles and the media) claim that patriarchal demands for the continued enactment of hegemonic masculinity have started to take their toll on men's wellbeing (Coyle and Morgan-Sykes, 1998: 264). Furthermore, masculinity and the 'failure' of hegemonic masculinity (losing control, authority, independence, assertiveness etc.) might be related to the higher suicide rates in men (Scourfield, 2005). In terms of the mental wellbeing of men, this 'crisis' is illustrated in men's emotional self-denial (Coyle and Morgan-Sykes, 1998) and their 'emotional illiteracy' (Goleman, 1995), with their inability to open up about their feelings and issues.

The notion of a 'crisis in masculinity' must however be viewed with certain scepticism and it is not without its criticism. McDowell (2000) suggested that rather than a crisis of masculinity, it is something far more complicated than a gender-based issue in Western societies and instead has more to do with the fundamental transformation of waged work, class and gender (McDowell, 2000: 201). Heartfield (2002) claimed that it is the working class that is in crisis not masculinity. Beynon (2002) further questions whether such crisis actually exists. This crisis discourse is documented largely across the public and media, especially in relation to men's mental health (Coyle and Morgan-Sykes, 1998) and suicide (Samaritans Report, 2012), but whether this 'crisis of masculinity' is actually a real issue, in the real world of people's everyday lives, is to be questioned. There is no doubt that more men are currently experiencing difficulties in various aspects of life, yet this 'crisis' may be an out-dated discourse. Newer studies on men's health behaviours (considered in more detail in the next section) suggest that rather than masculinity being at threat or in crisis, men are instead able to reconstruct their masculinity and use it more positively to overcome problems and difficulties in living (Kiselica and Englar-Carlson, 2010; Evans *et al.*, 2011).

More men today are starting to have a flexible view of traditional masculine traits, abandoning more rigid conventional roles and also engaging in more 'traditionally feminine' characteristics. In the context of men and their mental health, I suggest that the concept of a crisis of masculinity is somewhat useful in portraying some of the changes, struggles and adversity that men face today. I am, however, not convinced that this so-called crisis applies to just the working class as many privileged men are also feeling the stresses of the changing economy combined with traditional gender roles and pressures.

Furthermore, I suggest the word crisis may not be an appropriate word to describe such changes in gender relations, practices and identities.

It is also important that caution is taken in order to avoid making simplistic judgments about men, masculinities and their mental health. Within policy debates men are often either regarded purely as victims or purely as perpetrators (Featherstone *et al.*, 2007: 134). They are placed in either one discourse, never in between. Thus, when considering men and their mental health it is important that both the diversity of men and the diversity of mental health problems are acknowledged.

## **Masculinities in the context of health and illness**

Having conceptualised masculinities, where I explored Connell's gender relation's framework and work on multiple masculinities that are dependent on social and economic context, I will now consider work that explores theories of masculinities in relation to health and illness. The social construction of gender can often be understood as one of the most important sociocultural factors associated with, and influencing, men's health-related behaviour (Courtenay, 2000). Robertson (2007) suggests that understanding masculinities as hierarchical 'configurations of practice' that men move within and between provides a framework for exploring how and why men 'do' health differently in differing social contexts (Robertson, 2007: 35). Theories of masculinity have to therefore recognise the diversity of identity and difference among men and their health (Robertson, 2007). I will now briefly explore some work that has examined the influence of masculinities on men's health practices and the following chapter will further explore this in relation to the experience of mental health difficulties.

### ***Men, masculinities and the relation to health beliefs and behaviours***

There has recently been an increase in qualitative research that explores men's ill-health experiences, specifically how masculinity facilitates and inhibits behaviours and practices in health contexts (Robertson, 2007: 21). Such work has used a range of qualitative methodologies to account for the connections between masculinities and men's health

practices and illness experiences, focusing on the hierarchical and plural nature of masculinities (as described above), using hegemonic masculinity as a focal point (Gough, 2006; Oliffe, 2005; Robertson, 2006a). Much previous work around men and health has suggested that men use health beliefs and behaviours to demonstrate their own masculinity. Will Courtenay's (2000, 2003) influential work on masculinity and men's health adapted Connell's (1995) social constructionist masculinities framework and demonstrated how by dismissing health care needs and health promoting behaviours such as asking for help and avoiding unnecessary risk, men are in fact constructing masculinity. Courtenay (2000) outlines some of men's explicit health related behaviours and beliefs:

- Men are more likely to engage in risky behaviours
- Men are less likely to seek support in situations in which they need help.
- They do not see themselves as being at risk for health problems.
- Men do not view health information as important and so do not attempt to obtain it.
- Men who endorse dominant norms of masculinity adopt poorer health behaviours and engage in greater health risks.

(Courtenay, 2000)

Courtenay refers back to Connell's (1995) theory of hegemonic masculinity and claims that the health related behaviours and beliefs that are often used in the demonstration of hegemonic masculinity include "the denial of weakness and vulnerability, emotional and physical control, the appearance of being strong and robust, dismissal of any need for help, a ceaseless interest in sex, the display of aggressive behaviour and physical dominance" (Courtenay, 2000: 1389). These behaviours and beliefs can be specifically applied to mental illness and Courtenay (2000) claimed that the denial of depression is a way for men to ensure they are not perceived in the same position as women. This further supports Charmaz's (1995) claims that illness can threaten and reduce a man's status in masculine hierarchies and further cause self-doubt about masculinity (Charmaz, 1995: 268).

Research has suggested that men's perceptions of social norms of how masculinity is 'done' as well as other men's health behaviours may have an influence on how men feel they should act. Mahalik, Burns and Syzdek (2007) examined the contribution that masculinity and men's perceptions of normative male and female health behaviours make in predicting men's own health behaviour. One hundred and forty male participants

completed measures online assessing dominant notions of masculinity (using The Conformity to Masculinity Norms Inventory), their perceptions of normative health behaviours (for both men and women), and eight health behaviours (e.g. alcohol abuse, tobacco use, use of social support, diet, physical fighting etc.). They found a significant relationship between masculinity and the perceived normativeness of other men's health behaviours and participants' own health behaviours. This supports previous research that suggested perceptions of other men's health behaviours act as 'social proof' and also a guide for their own behaviours (Mahalik *et al.*, 2007: 2207). This study highlights the influence that social constructions of masculinity have on men's behaviours and how masculinity plays a part in the way their illnesses can be constructed.

As noted, there has been a shift towards a more variable range of masculinities that has been defined in terms of ideologies and practices, and this acknowledges the varying ways in which different groups of men experience health (Robertson, 2007; Noone and Stephens, 2008). Creighton and Oliffe (2010) maintain that Courtenay's (2000) work on masculinity and health has missed out the nuanced ways in which men experience masculine roles and gender relations in the context of a variety of intersecting identities. In this respect, it is also important to link concepts of masculinities and health to the broader social and economic context of men's lives. As discussed in the previous section regarding various forms of masculinities, for working class men who are denied the social power and resources that are often necessary to construct hegemonic masculinity, they may seek to adopt other strategies to construct gender identities and validate themselves as men. Health related behaviours such as taking risks with one's health and body or delaying professional help seeking for illness or problems in living, are means by which working class men attempt to demonstrate and articulate aspects of hegemonic working-class masculinity (O'Brien *et al.*, 2005; Dolan, 2014). Cornwell (1984) identified the duty to keep working and not seek help until there is no choice as key components of working-class culture. Working class men have also been assumed to be less concerned with or knowledgeable about health than middle class men, with them traditionally placing significance on physical toughness and emotional invulnerability (Dolan, 2011). The prescriptive definitions of working-class masculinity can inhibit men from building supportive health-enhancing relationships with others (Dolan, 2007) that can lead to men concealing or disguising any practical or emotional health problems.

In contrast to this, it has been found that some men do however choose an alternative set of social prescriptions of masculinity and adopt healthy lifestyle behaviours such as eating healthy and taking care of their body. Crawshaw (2007) found that magazines such as Men's Health promote individual choice, determinism and the opportunity to improve the body and mind, and so constructs their male reader in this way, inviting them to consume new ways of being healthy (Crawshaw, 2007: 1616). This idea that men do not care about health matters and attempt to incorporate hegemonic masculine ideals can lead to negative health behaviours is too simplistic and has been challenged in research on men's narratives that suggest a diverse and complex relationship between masculinity and health in everyday life (Robertson, 2006a: 452). Cameron and Bernardes (1998) claimed that men's traditional gender roles do not always have to amount to disadvantage but masculinity can be a resource in dealing with serious health problems. Newer research is beginning to shed light on how the use of masculine ideals, norms and values do not always lead to negative health practices. Research in positive psychology has noted that masculinity can instead be associated with positive strengths in men (Hammer and Good, 2010; Kiselica and Englar-Carlson, 2010), such as making choices dedicated to preserving a healthy body. Through doing this, men are able to situate themselves as rational, decisive and autonomous manly men, actively demoting illness and promoting self-health (Oliffe *et al.*, 2010).

Very recently, Oliffe *et al.*, (2018) carried out a mixed-methods study which was qualitatively led with a quantitative follow-up to explore young Canadian men's health-related masculine values, focusing on the potential positive strengths for men. Through their interviews with thirty young men (ages 15-29), they identified five health-related masculine values: selflessness, openness, wellbeing, strength and autonomy. Some of these values are more traditional, for example strength and autonomy, and these masculine values identified highlight how masculinity can be used more positively in men's health practices and behaviours. Furthermore, Oliffe *et al.*'s (2018) work points to complexities in how men and masculinities are conceptualised and also marks a shift in masculinity amongst young men. It is important to note that given the relatively small sample of young, Canadian men, these values may not be transferable to subgroups of young men in other Western countries, or men of different generations and age groups.

In theories of the social construction of masculinity and health, the variation between men has often not been recognised, as well as the complexities that relate to

'masculine identities'. Gough (2006) argued much more needs to be done to depict the meanings and practices which men present in health-related contexts (Gough, 2006: 2486). Considering social class, Griffith (2018) calls for the need to examine intersectionality in men's health research and also how men navigate class-based aspects of manhood in relation to their health problems and patterns. To do this there is the need to recognise the ways that race, class, sexual orientation, disability and other structures influence how men develop their masculinities and respond to health issues. It is therefore important, especially when considering social class, to be aware of how the intersection of such structures described shape men's health and their practices. As Evans *et al.*, (2011) acknowledge through their health, illness, men and masculinities framework, masculinities act as a social determinant of health that intersect other determinants such as socio-economic status, race, ethnicity, sexuality, ability, geography, community, education and employment (Evans *et al.*, 2011: 10). More specifically to mental health, Seidler *et al.*, (2017) argue that for the treatment of mental health problems in men, a person-centred framework and treatment approaches that cater to the diversity within and across men and masculinities is needed. This research points to the need for further investigation into new and varied health-related masculine values and what men these values work for.

Applying concepts of masculinities in relation to men's health and illness has however faced some critique (Hearn, 1996; Clatterbaugh, 1990). Criticism of using masculinities in men's health research has suggested that such an approach presents a deficit view of men in relation to their health practices, often promoting a "blame" discourse to explain men's poor health outcomes (Macdonald, 2006; 2011). Robertson, Williams and Oliffe (2016) developed an argument as to why it is still important to retain a focus on masculinities in studies on men's health. Robertson *et al.*, (2016) however, claim instead that appropriate conceptualisations of masculinities and gender relations are key to understanding the impact of wider social determinants of health inequalities (Robertson *et al.*, 2016: 58). Thus, there remains a need to consider masculinities and masculine practices when examining men's experiences of distress and emotional difficulties.

## Conclusion

Examining mental health problems and how social practices influence them has gained increasingly more academic focus in the sociology of health and illness. Gender and mental health is thus complex to study. As the focus of the thesis is men, in this chapter I have engaged theoretically with work on masculinities. Hegemonic masculinity is still considered as the dominant form in society that men typically strive towards achieving. Yet the term 'masculinities' (Connell, 1995; 2000; 2005) is now preferred to demonstrate the varying ways there are of 'being a man'. Connell emphasised that terms such as 'hegemonic masculinity' and 'marginalized masculinities' do not label fixed character types but rather configurations of practice that are developed in particular situations throughout a changing structure of relationships (Connell, 1995: 81). By considering work on these different masculinities I provide context for which men's experiences of distress can be explored. In viewing masculinities as 'configurations of social practice', they can be understood as dynamic practices in the gender order that vary and change throughout time and are diverse but also hierarchical. Individual experiences, circumstances, context and settings, as well as changing times, need to be considered in examining the way men enact masculinity. Understanding configurations of gender practice as open to change allows masculinities to be understood as fluid and used with more flexibility. As Beynon (2002) suggested, there is a need for more research on men's actual lived experiences of masculinities before applying 'masculinities' to all.

It would be impossible to address men's mental health experiences without examining and considering the influence masculinity practices, or certain ways of 'doing masculinity' can have. By examining theories of masculinity or rather 'masculinities' I have provided context in which to begin to understand men's mental health experiences. The next chapter will follow on from this by first considering the influence masculinity and masculine practices have on the manifestation of distress and mental health problems in men. Instead of broadly considering how notions of masculinity influence men's health behaviours I specifically focus on research that explores the experiences of mental distress in men. In relation to men's lived mental health experiences, I examine literature that has focused on men's expression of distress, their help seeking, coping and management and use of services.



# Chapter Three - Literature Review: Men's mental health experiences

## **Introduction**

In chapter two, the first part of the literature review, I focused on conceptualising masculinities as well as considering masculinities in relation to men's health research. It is necessary that such theoretical perspectives of masculinities be considered, in order to fully understand the impact masculinity might have on men's health and illness behaviours. Now I will examine empirical research that has focused on men's experiences of living with distress and mental health problems. The review considers studies that have explored men's help seeking generally but then also more specifically help seeking for distress, as well as how men cope with mental distress, the main priorities of the thesis. Studies in the area of coping for distress are relatively limited and have tended not to focus on men's positive coping strategies. As my research also explores men who use support groups, I then turn to examine the limited literature that has focused on men's use of support groups.

## **What do we know about men's experiences of mental health distress?**

Men with mental health problems have in the past received somewhat little attention in the social science literature. To be able to understand men's engagement with their mental health, then their everyday lived experiences of mental distress need to be explored. For the purpose of this section of the literature review I am going to focus on research that has explored all aspects of daily distress (see previous chapter for how distress is defined in the thesis) but also more specifically what has been called 'common mental disorders'. Common mental disorders (CMDs) comprise of different types of depression and anxiety, what much qualitative work on men's mental health experiences has previously focused on. Also known as neurotic disorders, they are mental conditions that "cause marked

emotional distress and interfere with daily function, although they do not usually affect insight or cognition” (McManus *et al.*, 2016: 41). Thus, I am interested in men’s everyday experiences of everyday emotional distress. Firstly, I begin by considering research that has explored how distress manifests in men.

### *Men express distress ‘differently’*

Some have suggested that mental illness, in particular depression, has been associated more often with women than men (Warren, 1983; Prior, 1999). Warren (1983) suggested that this has led to an emphasis on treating depression in women and viewing men as ‘intolerant’ of depression, arguing that the depressive experience is incompatible with the male sex role and male socialisation (Warren, 1983: 147). Beliefs about being male are thus challenged by mental health difficulties such as depression (Heifner, 1997). Ridge, Emslie and White (2011) argue that we still only have a one-dimensional understanding of how men experience, express and cope with distress and this might be because men may narrate distress in ways that are either hidden or difficult to interpret (Ridge *et al.*, 2011: 152). Some have argued that men express distress in ways that are different from women, referring to ‘male depression’ (Brownhill *et al.*, 2005). Brownhill *et al.*, (2005) conducted focus groups with both men and women and found that important gender differences were in the expression of depression rather than the experience of it. Their findings refer to the complex interaction between men’s experiences of depression (internalised feelings) and their responses to it (externalised feelings) as the ‘*big build*’ model. This ‘*big build*’ theory developed by Brownhill *et al.*, (2005) explained how masculine practices in relation to depression could result in a path of destructive behaviours and further emotional distress. The big build model shows how the practices and processes of depression in men start with “avoiding, numbing and escaping it” and then may further result in violence and hate towards themselves and others, even escalating to suicide. This model can be used to highlight how men’s experience of depression remains hidden and misunderstood, because masculine practices in relation to depression are often linked to risk-taking and aggressive behaviour. So rather than experiencing depression differently to women, men may express depression in masculine ways. Their study thus points to how depression is ‘done’ by men

and to the idea of 'male depression', portraying the enactment of masculinities through the depression experience.

Similar to Brownhill *et al.*, (2005) and Warren (1983), Chuick *et al.*, (2009) have also suggested that depression is not a socially accepted issue for men. During their in-depth interviews that attempted to explore men's experiences of depression, they found that men reported both typical symptoms (e.g. traditional diagnostic symptoms) and atypical symptoms (e.g. alcohol and substance misuse, interpersonal conflict and anger problems). The men tended to display the latter and perceived the former more diagnostic symptoms (e.g. despair, crying etc.) as 'unmanly'. These symptoms represented what Chuick *et al.*, (2009) developed as the *cycle of maladaptive coping* that enabled men to conceal emotions and often led to destructive behaviours. Their participants also identified the restrictions of masculinity and in their accounts, they portrayed the sense that it was inappropriate for men to seek help and men who were depressed were often seen as weak. Similarly, Cochran and Rabinowitz (2003) highlighted how depression can manifest in anger. Ramirez and Badger (2014) also found that the men they interviewed exhibited atypical symptoms of depression that have been associated with men and previously described by Chuick *et al.*, (2009). However, Ramirez and Badger's (2014) participants did not present masculinity ideals. Despite this, the researchers themselves share the social constructionist view that what it means to be a man does play a role in how men manage their depression (Ramirez and Badger, 2014).

Continuing the exploration into gendered differences in the expression of depression, Danielsson *et al.*, (2009) examined how primary care patients experience, understand and explain their depression. The ways in which the research participants told their story showed how they understood their own depression and the symbolic illness narratives described by them demonstrated prominent gendered patterns. The men's stories implied that when experiencing depression, they were 'struck' by some external force outside of their control, with sudden onset and dramatic physical symptoms (Danielsson *et al.*, 2009). For the women in their study, the stories were much more diverse, and women often thought that depression emerged from internal factors, their own personality or ways of handling life. These gendered narratives found by Danielsson *et al.*, (2009) proposed why it might often be more difficult to recognise and diagnose depression in men and also how different men's 'expression' of depression can be to women's, for example, comparing it to physical pain and being 'struck by lightning'.

Moreover, this equally highlights that many men may be unaware that their externalised behaviours are associated with depression (Lynch and Kilmartin, 2013). Similarly, Oliffe *et al.*, (2010) found that the ways in which men embody depression in their everyday lives, for example through anger, isolation and risk-taking, can lead to symptoms of depression being interpreted as expressions of masculine ideals instead (Oliffe *et al.*, 2010).

Focusing exclusively on men's accounts of depression, Emslie, Ridge, Ziebland and Hunt (2006) explored how depression influences men's gender identities and constructions. Emslie *et al.*, (2006) noted that during the recovery process from depression, it was important for the participants to reconstruct a valued sense of themselves and their own masculinity (Emslie *et al.*, 2006). They found that values associated with hegemonic masculinity (such as re-establishing control, being "one of the boys" and having a responsibility to others) were frequently incorporated into the men's narratives of depression, consistent with previous research that has discussed the practice of masculinities and health (Wetherell and Edley, 1999; Courtenay, 2000, 2003; O'Brien *et al.*, 2005; Lohan, 2007; Mahalik *et al.*, 2007). However, Emslie *et al.*, (2006) also found alternative patterns of expression that challenged dominant forms of masculinity, such as being creative, understanding and compassionate. In addition, some masculine ideals, such as self-control, actually aided recovery through fostering a positive sense of self (Emslie *et al.*, 2006). The men they interviewed could be seen redefining their 'difference' from other men as a positive rather than a negative feature of their masculinity. This highlights how some men are able to successfully renegotiate their masculinity in the face of adversity and viewing depression as 'difference' may actually instead reaffirm their masculine role. Valkonen and Hanninen's (2012) study parallels with that of Emslie *et al.*, (2006) by considering the relation between depression and masculinity as a question of how a man positions himself with regard to (hegemonic) masculinity. In line with what Emslie and colleagues (2006) found, masculine ways of thinking and acting were used as a way to help participants cope with mental distress.

Emslie *et al.*, 's (2006) study however, used a relatively small sample of participants as well as an unusual group of men willing to volunteer to discuss their experiences of mental illness. It has been argued that much of the research studies on men, masculinity and mental health described here are limited because of their restrictive and unrepresentative sample groups due to age and social class for example, sometimes only

inclusive of one age group of men or mostly exploring white, well-educated men. Danielsson and Johansson (2005) found in their qualitative study that the experience of depression was similar for both men and women, but the outward manifestations differed by gender as well as socio-economic status. Danielsson and Johansson (2005) argued, however, that these expressions are not just a concern of traditional gender roles, but they also reveal the impact of social position, status and options (Danielsson and Johansson, 2005: 176). This relationship between common mental disorders and social class and gender is one that many studies have failed to explore. Evidently, in order to begin to understand men's experience and expression of mental distress then we must consider the interaction of other social circumstances with gender. Having considered the relationship between social class and masculinities in the previous chapter (chapter two), it is notably important that when exploring men's health and mental health experiences, that the intersection between class and gender is considered. Social position and status, as well as gender can impact on the expression of depression and distress, as well as the health practices engaged in (for example, seeking help and positive self-management). The impact of social circumstances such as social class on men's mental health help seeking is further explored and discussed in chapter six that will examine specifically whether there is a relationship between social class and mental health help seeking, as well as what other social factors predict help seeking from the GP.

## **Men and help seeking**

Before I examine empirical studies that have explored men's help seeking for health problems and difficulties in living, I begin by briefly considering what actually constitutes help and help seeking, in the context of this thesis. Help seeking can be described as part of a process, with the action of help seeking being intentional. Cornally and McCarthy (2011) used concept analysis to define help seeking as a complex decision-making process instigated by a problem that challenges personal abilities. Furthermore, Rickwood *et al.*, (2005) describe help seeking in response to mental health difficulties as "the behaviours of actively seeking help from other people. It is about communicating with other people to obtain help in terms of advice, information, treatment and general support in response to a problem or distressing experience" (Rickwood *et al.*, 2005: 4). In this thesis, I use Rickwood

*et al's.*, definition of help seeking as I am interested in the processes and various pathways in which men may go about seeking out support for emotional difficulties and troubles in living. These authors go on to describe the diverse sources through which help can be sought, which I also consider when examining men's help seeking throughout the analysis chapters. These sources include informal help seeking from personal social relationships and networks such as family and friends, and also formal help seeking from professional sources of help such as mental health and health professionals. I will explore both the use of informal and formal support throughout this research study.

In relation to men's experiences of mental distress being examined in this thesis, help seeking is not naturally an individual and rational decision nor is it always a necessity for all men in their experiences of everyday emotional distress. It is important to recognise diversity in the behaviours of different men across various mental health difficulties, context and time. In the context of the thesis, the purpose of help and support is to aid coping in the everyday in response to a problem that cannot be solved or improved alone, so interacting with a third party is thus needed. For men and their mental health, help seeking is much more than just a case of seeking help or not seeking help, using services or not using services. It should be viewed as an interactive, ongoing process of formal and informal support seeking (Wenger, 2011: 495). In this respect, it should also be considered in a more nuanced way that acknowledges the process of help seeking as being influenced by perceptions, interactions, skills and strategies, and changeable approaches and outcomes. The overall thesis and findings across the analysis chapters aim to explore this process and the varying ways in which men go about seeking out both informal and formal help, focusing on the above influences, in relation to how men navigate help seeking specifically through their everyday coping, formal support seeking and use of support group services.

Not all previous research on male help seeking for health difficulties has adopted this approach of exploring the process of help seeking, instead exploring the single decision point and the impact of masculinity on this. I will now turn to examine studies that have explored masculinity and men's help seeking.

In the context of illness, particularly mental health, there is a dominant discourse about masculinity acknowledged throughout popular beliefs, stereotypes, media and academic literature, that men are more reluctant to seek help for health concerns and distress than women (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005; Mansfield *et al.*, 2005; O'Brien *et al.*, 2005). Various studies have shown that health behaviours such as help seeking contribute to the active construction of gendered identities (Johnson *et al.*, 2012). For example, not asking for help can demonstrate manly self-reliance, control and autonomy whilst seeking out support can also be perceived as the masculine identity of taking action and problem-solving (see below for further discussion on this). Much research has found that men do not seek help on a perceived threat to hegemonic masculinity that has traditionally limited emotional expression and vulnerability (Courtenay, 2000). In this section I will consider research that has examined men and their help-behaviours, firstly reviewing men's help seeking in general and then focusing specifically on studies that have explored men's help seeking for mental health distress.

Addis and Mahalik (2003) suggest that for men, basic social-psychological processes moderate both the effects of gender socialisation and the process of constructing masculinity, in particular help-seeking contexts (Addis and Mahalik, 2003: 10). This framework of processes includes: (1) perceptions of normativeness of problems, (2) the centrality of the problem to their identity, (3) available opportunities to reciprocate help and the characteristics of potential helpers, (4) characteristics of the social group that the individual men belong and how these others would react when or if they seek help, and (5) perceived loss of control. So according to the framework, men are less likely to seek help for a problem they see as unusual, for example mental health difficulties, and when they see it as a central part to their identity, for example having emotional control is perceived as an element of masculine identity. Also, if there is a risk of rejection from an important social group or if other men close to them endorse norms such as self-reliance and strength, then they are more likely to resist seeking help. This coincides with studies that have found that embarrassment amongst men is related to help seeking (Coles *et al.*, 2010; Doherty and Kartalova-O'Doherty, 2010; Jeffries and Grogan, 2012). Doherty and Kartalova-O'Doherty (2010) found that embarrassment was the strongest predictor of non-help-seeking in men. This embarrassment experienced links to a sense of threatened masculinity.

### *Masculinity, help seeking and social class*

Scholars have identified the need for further research that examines the determinants of men's help-seeking behaviours, in particular socio-economic variations and different types of health care seeking (Addis and Mahalik, 2003; Galdas *et al.*, 2005). As discussed in chapter two in regards to the relation between masculinities and health, delaying help seeking for health issues can be a way for men to construct gender identities and validate themselves as men, particularly for those men in subordinated and marginalised positions. For example, there is a general consensus amongst working class men that men are less likely to visit the doctors regarding a health problem than women, and this is mostly to do with an attempt at preserving strongly aligned hegemonic masculine identities (Dolan, 2011). Working class men in Dolan's (2007; 2011) study generally defined asking for help as a sign of weakness and instead would resort to behaviours considered more appropriate outlets for masculine expression to relieve stress (such as excessive smoking, drinking, drug use etc.) (Dolan, 2011). Moreover, it has been claimed that men in higher social classes have access to better emotional and social capital because higher levels of wealth and education open up knowledge about and access to health and health care (Seale and Charteris-Black, 2003). It is also expected that middle-class professional men might take up ideals and practices associated with both hegemonic masculine codes and the value of healthy living (Farrimond, 2011) yet these men of higher socio-economic status may also still delay help seeking for problems in living (Springer and Mouzon, 2011). Courtenay (2000) suggested that men in higher socio-economic status and the upper classes may resist healthcare and help seeking to prevent being positioned into a lower status position by others and risk losing their hegemonic masculine status.

Using logistic regression of the Wisconsin Longitudinal Study (a large, longitudinal study of ageing, careers and health), Springer and Mouzon (2011) examined whether socio-economic status interacts with masculinity to influence older men's help seeking for health issues. Their results demonstrated that strong endorsement of hegemonic masculinity influenced help seeking in different ways, depending on socio-economic status, specifically masculinity weakened the health promoting effect of higher socio-economic status and having higher socio-economic status increased the negative health effect of traditional



masculinity. Their analysis found that when exploring lower help seeking in older men both the main effects of masculinity and socio-economic status need to be observed together. Furthermore, they found that masculinity is not harmful for all men and higher socio-economic status is not always beneficial for all men either.

In order to understand how masculinities connect to men's health then theoretical work that accounts for the agency of an individual in making health choices, and the social structures that shape these choices is required. Considering elements of social class as well as men's meaning making and relationships with others is thus important in exploring men's mental health help seeking. It is important to be aware of the diversity amongst men and within different groups and social structures. Men's help seeking is thus complex and this points to the importance of examining the impact of socio-economic status variations, as well as masculine beliefs, on men's different types of help seeking practices.

### *Masculinity and help-seeking: no longer a fixed relationship*

O'Brien, Hunt and Hart (2005) explored men's experiences of help-seeking for various illnesses and the relation it has with 'practices' of masculinity. Through conducting 14 focus groups with fifty-five men that varied in age, occupational status, socio-economic background and current health status including men who have experienced mental health problems, they found a general reluctance to seek help amongst participants because of the belief that it was challenging to traditional norms of masculinity. They found that the men who were most vulnerable were those with emotional or mental health problems, which they often interpreted as 'stress' rather than acknowledge and admit to the 'unmanly' diagnosis of depression (O'Brien *et al.*, 2005: 515). Despite this widespread reluctance to seek help across their participants, there were also instances where some men sought help as a way to preserve masculinity rather than dismantle it. This could be seen in fire fighters for example, who were open in their health discussion because their job depended on sustaining good health and wellbeing and so they redefined masculine norms in a more positive way comparable to some of Emslie *et al.*'s (2006) participants.

Additionally, Farrimond (2011) attempted to rethink masculinity in relation to men's help seeking, with her analysis of men's 'interpretive repertoires' from interviews

with 14 higher socio-economic status men. In her data, she found that her participants engaged with newer help-seeking practices that were orientated around 'taking action'. In identifying themselves as someone who 'takes action' of their illness symptoms, they identified themselves as healthy members of society (Farrimond, 2011: 13-14). Farrimond (2011) calls for hegemonic masculinity to be viewed with greater flexibility in relation to men's health help-seeking practices, as her participants reformulated dominant masculinities in their accounts of help seeking.

I now turn to consider studies that have examined help seeking specifically for mental distress. In a qualitative study, Sierra Hernandez, Han, Oliffe and Ogrodniczuk (2014) sought to understand help seeking among depressed men. They took Addis and Mahalik's (2003) conceptual framework of five social-psychological processes (outlined above p.34) and sought to investigate the correspondence between it and the self-reported help-seeking experiences of depressed men. Their study hoped to test how robust the framework is and how useful it could be to promote help seeking by men who suffer from depression. Sierra Hernandez *et al.*, (2014) recruited thirteen men who had previously been diagnosed with depression and were currently receiving treatment to take part in qualitative in-depth, semi-structured interviews. Three of Addis and Mahalik's (2003) social-psychological processes (normativeness of depression, the centrality of depression, and the ability to maintain sense of control) were represented in all participants' discourses of their depression-related help-seeking experiences and the other two were reported in most cases. Consistent with much of the current social science literature, the role of gender socialisation and traditional notions of masculinity were very much present in the men's discussion of help seeking among men. Their study reinforced the view that masculine attitudes and expectations of being strong and in control can increase men's vulnerability (men's depression) through perceptions of further potential impacts to men's masculinity, for example, in the case of help-seeking (Sierra Hernandez *et al.*, 2014). However, similar to O'Brien *et al.*, (2005), Emslie *et al.*, (2006) and Farrimond (2011), when Sierra Hernandez *et al.*, 's participants did seek treatment for depression, they redefined their masculine identity and assessed their treatment seeking as retaining control, being strong, responsible and actively dealing with their issues. This finding shows that men are able to adopt "a flexible, individually defined and contextually based masculinity" (Sierra

Hernandez *et al.*, 2014: 352) that allows men to pursue formal support and further illustrates the plurality of masculinities (Connell, 1995) discussed in chapter two.

Sierra Hernandez *et al.*, 's (2014) study is generally consistent with Addis and Mahalik 's (2003) framework for help-seeking behaviour among depressed men, however, as with much of the research that has explored men's help seeking behaviour for mental health problems, the sample population is a limitation. Their sample group was primarily single, heterosexual, white, employed and well-educated men who had already sought help for their depression. Thus, causality and generalizability cannot be implied. As noted earlier, it is important to consider class and occupational status in exploring men's help seeking practices to point to how different contexts and social structures might influence men's experiences of help seeking. Moreover, the views of men who have experienced distress but have not sought help also need to be explored.

As I have begun to identify, masculinity does not necessarily have to be a barrier to health help seeking and some studies have begun to highlight just how diverse masculinities are and the influence this can have on help-seeking behaviour. Greenland *et al.*, (2009) examined distress disclosure amongst a community sample of young people. They found that the men with higher levels of femininity (as scored on a sex role inventory) were more likely to disclose distress. Branney *et al.*, (2012) explored how male frequent attenders of GP services construct their decisions to use or not use health-care services. They found that most male frequent attenders constructed themselves as embodied and health conscious. Supporting O'Brien *et al.*, (2005) their findings showed men talking about being health consumers and challenged the notions of health as a domain that is only feminine (Branney *et al.*, 2012: 876).

Johnson, Oliffe, Kelly, Galdas and Ogrodniczuk (2012) examined how their male participants reproduced and reconstructed the dominant discourse of help seeking for depression. They conducted in-depth, semi-structured interviews with 38 men who self-diagnosed as depressed and through discourse analysis found that the gendered construction of help seeking discourses took the shape of five discursive frames: manly self-reliance; treatment seeking as responsible, independent action; guarded vulnerability; desperation and a genuine connection to help seeking (Johnson *et al.*, 2012). Four of these discursive frames are variations on the dominant social discourse of men's help seeking and masculinity (i.e. men are often resistant to seeking help on the basis of masculine ideals)

and one, genuine connection, suggests an alternative account of help seeking. The men in Johnson *et al.*,’s study did not want to talk about their emotions because of masculine discourses, however similar to findings from O’Brien *et al.*, ’s (2005) study, a lot of the men did actually get help and treatment from services for their depression, despite reproducing the dominant social discourses that often restrain men from seeking professional help. Instead, ways of reproducing and enacting masculinity are reconstructed through help seeking in the frame of ‘treatment seeking as responsible and independent action’ and this highlights how help seeking can be reframed in a way to depict ‘independence’ and ‘individualism’ (Connell, 1995; Gill, Henwood and Mclean, 2005; Crawshaw, 2007). The fifth discursive frame of genuine connection (reflecting men’s willingness to talk openly and at length about depression) illustrates the varying alternative ways masculinity can be enacted to manage depression. However, such alternative masculinity constructions and men seemingly constructing themselves as active, empowered agents in healthcare settings can also be interpreted as “an attempt to preserve traditional masculine ideals” (Johnson *et al.*, 2012: 357). Similar to Sierra Hernandez *et al.*, (2014) this finding points to the adoption of a more flexible masculinity in the context of treatment seeking and how certain elements of hegemonic masculinity can be used positively in certain ways at certain times.

Some have argued that work by Johnson *et al.*, and O’Brien *et al.*, are limited because their samples consisted of an unusual group of men who have experienced depression and were willing to talk about their experiences to a researcher. Therefore, qualitative studies concerning help seeking and men miss out the experiences of the ‘silent’ men reluctant to volunteer to retell experiences. This is something I aim to address through a quantitative method using a large, national sample in chapter six. Johnson *et al.*, (2012) suggest though that the men’s willingness to participate in the study reflects their attempts at being active agents in their own care (Johnson *et al.*, 2012: 359). Johnson *et al.*,’s work asserts that there are men who endorse traditional roles and are willing to talk. The ‘silent’ men are difficult to access but new ways to approach and talk to men in their everyday local settings need to be considered in order to explore their everyday experiences. The thesis attempts to address this further using qualitative methodology in the empirical chapters seven, eight and nine.

More recently, Siedler and colleagues (2016) conducted a systematic review on both quantitative and qualitative studies to explore the role of masculinity on men's help seeking for depression. Consistent with much previous research and reinforcing the dominant notion, their findings suggest that conformity to traditional masculine gender norms impact on men's attitudes, intentions and behaviours related to help seeking. However, similar to Johnson *et al.*, (2012) and in contrast to popular assumption that men are less likely to engage in help-seeking behaviours, Siedler *et al.*, 's (2016) found that men will seek help if it is available and appropriately engaging for men (Siedler *et al.*, 2016: 115). This is consistent with Johnson *et al.*, 's (2012) discursive frame of genuine connection and highlights that men's experiences and behaviours are complex as well as vary depending on situational context.

In relation to seeking help from the GP specifically, Cheshire *et al.*, (2016) carried out an evaluation of the Atlas men's well-being pilot programme for stressed/distressed men in attempt to explore how men's mental health can be improved via primary care. The Atlas men's well-being programme provided two different options (counselling/acupuncture) that men could use to address their problems. Using these two options highlights that one size does not fit all for men in terms of their help seeking and primary care service use. They examined patient characteristics, service use, outcomes and cost implications of the Atlas programme and found that a service provided in this way (using two approaches, including acupuncture which does necessarily involve talking about emotions) can engage a diverse sample of men and can provide positive outcomes for well-being. They found that both acupuncture and counselling treatments were well utilised by men, which suggests that men adopt varying treatment preferences to address their problems (Cheshire *et al.*, 2016). Furthermore, and supporting work such as Johnson *et al.*, (2012), Siedler *et al.*, (2016) and Sierra Hernandez *et al.*, (2014), their evaluation challenged the stereotype that men do not talk, as counselling was in fact more often used than acupuncture. Another key finding from Cheshire *et al.*, (2016) that resonates with the context of this thesis was the important role of the GP in encouraging men to use the Atlas well-being programme. This is consistent with Harding and Fox's (2014) work on help-seeking enablers that is discussed in more detail in the section below.

The studies presented so far have explored the complex relationship between masculinity and men's help seeking. Here I must also acknowledge contextual and structural factors other than masculinity associated with delays in help seeking among men. Yousaf *et al.*, (2015) found that socio-demographic factors such as low educational status, young age and never-married status were all identified as factors that were negatively correlated with help-seeking frequency. Similarly, Mackenzie *et al.*, (2006) suggested that low educational status might be associated with low rates of help-seeking because educated individuals may be more informed and knowledgeable about symptoms of illnesses and the healthcare system. In addition, they noted that older people were more likely than younger people to seek psychological formal help (Mackenzie *et al.*, 2006), though this is not specific to men. The lower rate of help-seeking noted in single men/those never married highlights the influence partners, especially female, have on the help-seeking process, with them often supporting and encouraging men to seek professional help (Doherty and Kartalova-O'Doherty, 2010; Oliffe *et al.*, 2011; Harding and Fox, 2014). I discuss help-seeking enablers in more detail in the following section. Socio-demographic factors such as age, marital status and education and help seeking is what I intend to examine further through quantitative secondary analysis in chapter six.

### *Help-seeking enablers*

In order to move away from the focus on men's reluctance to help seeking and focus on positives to do with men's help-seeking, help-seeking enablers need to be considered. Research into the influences of help seeking is sparse with little known about men's access to and engagement in mental health support and care. Harding and Fox (2014) aimed to identify the factors that influenced and enabled men to seek mental health help in their interviews with men who are receiving counselling or have received counselling in the past 12 months. To be included in the study they have to have voluntarily attended counselling. Consistent with past studies (Mahalik *et al.*, 2007), they identified peer group social norms about help seeking and reciprocity as enablers of help seeking. The role of a significant other (mainly female), was reported by all men in the study (nine) as an influence to seeking professional help. This study is distinct in its focus on enabling and positive influences and exploring such factors can contribute to a better understanding of what encourages men to seek help. However, a limitation of this study is that they only

interviewed nine men, all of who were well educated so like many other previous studies on men's help-seeking behaviour, it lacks representativeness and generalizability, and would benefit from more exploration of diversity.

Other research has also found that significant others play an important role in encouraging men's help-seeking decisions (Jarrett, Bellamy and Adeyemi, 2007; Vogel *et al.*, 2007), particularly a female significant other such as a wife, partner, mother or close friend (Cusack *et al.*, 2004; Seymour-Smith *et al.*, 2002). Cusack *et al.*, (2004) analysed questionnaires given to 73 men who were either currently accessing or had recently accessed a mental health service and found that 96 percent reported their decision to seek help was influenced by others, particularly intimate partners. Thirty-seven of these men said that without this influence they would not have sought help at all.

It would be useful to use such evidence from research that explores enablers in targeting and providing services aimed at men. Service providers could work with significant others in the encouragement and engagement of men in services. Such research highlights how secure support networks play a vital part in men's experiences mental health help seeking.

## **Men's use of support groups**

Having examined research to do with men's mental health help seeking, I will now turn to explore men's use of support services, specifically support groups. Another main focus of the thesis is to focus on men's use of support groups as a type of formal help seeking. It is not well understood how to best support men suffering with depression or anxiety following initial consultation and help seeking, as men may not always accept particular interventions. This thesis specifically explores the experiences of a sample of men who have attended support groups for distress. Peer support, which is often done through the use of groups, "is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (Mead, 2003). Here, I briefly consider research that has highlighted the effectiveness of peer support and how it can facilitate coping with mental distress.

Cramer *et al.*, (2014) aimed to establish if men do attend and use therapeutic/support groups for depression, exploring what types of groups they attend and why, as well as the advantages and disadvantages of groups. Similar to the sample this thesis aimed to recruit, Cramer *et al.*, (2014) aimed for a broad representation of men who are at different points in their experience of depression and help-seeking. This included some men who had attended mental health groups, some who had not attended mental health groups but had spoken to their GP about depression or anxiety, and some men who had not attended groups nor spoken to their GP about feelings of depression or anxiety. The latter is a particularly difficult subgroup of men to access because these men are the ones who typically do not speak about their experiences of mental illness and/or may not even be aware that they have experienced depression or anxiety. Using qualitative mixed methods, they interviewed 17 men who had experienced depression and anxiety and then conducted a further 12 interviews with staff who had worked with depressed men. Their study shows that some men do in fact attend groups for support with depression and anxiety. These men who attended support groups highlighted a preference for mental health support outside their immediate family and friends. Despite use of support groups, barriers to help-seeking relating to common conceptions about masculinity were often reported across the interviews from the men.

The main strength of Cramer *et al.*,’s (2014) study is that they managed to recruit, interview and include the views of some men who have not been in contact with services. As such a hard to reach sample group of men who are not in contact with services and do not speak to their GP about depression, little research has been done with them and so Cramer *et al.*,’s study has attempted to explore these unknown experiences of these men. However, the sample used is also relatively small and therefore not representative of the depressed male population or of the males who use support groups. Although this study can be praised for attempting to recruit the men who have not been in contact with services, the final sample from this subgroup was only three men.

Additionally, Cramer *et al.*, (2014) found that their research participants also frequently mentioned feeling lonely, isolated or bored as motivation for attending groups. In men’s isolated situations, support groups were not always the first choice in immediate crises but more of an on-going social option (Cramer *et al.*, 2014: 295). There is research that highlights the social benefits of groups, specifically to older men, in decreasing social isolation and managing emotional difficulties. There is now a growing number of



community-based organisations that run groups specifically aimed to tackle loneliness and social isolation in older men. Research has highlighted how effective such groups can be because of the social support, relationships, social engagement and connectedness that they can provide to men who may be retired, widowed or living alone (Hoglund *et al.*, 2009; Wilson and Cordier, 2013; Agahi *et al.*, 2013; Broughton, Payne and Liechty, 2017). In Milligan and colleagues' review of gendered interventions for older men, they found that in these men's community groups, men valued the sense of contributing rather than being clients (Milligan *et al.*, 2016). Such support groups then, can foster identity and belonging for men in specific times of distress.

Simpson and Richards (2019) explored ways in which working class men involved in self-help groups can develop emotional reflexivity in relation to their health and wellbeing. Similar to research mentioned above (Cramer *et al.*, 2014; Milligan *et al.*, 2016), participants' accounts indicated how positive mental health was aided by support from men sharing experiences in an informal and non-clinical way. This highlights the power of 'informal' support from others for working class men and they found that these groups provided emotional resources that helped to normalise discomforting, emotional talk as well as present opportunities for supporting other men which further functioned as on-going therapy. Likewise, Mackenzie *et al.*, (2017) explored attendees' discussions of men's only groups and whether these discussions were complicit or counter to traditional, hegemonic views of masculinity. One of the themes they found discussed by men was the need for male focused spaces. The main benefits of such spaces were the opportunity for personal discussions often to do with health and mental health issues, encouraging diversity amongst men, connection through male friendly-banter and interests and activities that were unique to men. They identified this as a counter narrative to men's previous discussions of how they and other men have difficulty opening up about emotional problems.

The above work aligns with the concept of 'communities of practice' (Lave and Wenger, 1991) that refers to how identities are learned and produced within various subgroups and locales. Creighton and Oliffe (2010) argue for the inclusion of this 'communities of practice' framework in men's health research. A community can be broadly defined as groups or networks of people with shared understandings of norms, identity and social practices (Creighton and Oliffe, 2010) and so for example, health

support groups can be described as a community of practice. A community of practice builds identity through an individual's participation in social practices.

Through using the communities of practice framework, Simpson and Richards (2019) point to how the norms that underpinned the self-help support groups enabled the men in their study to express emotions that might in other contexts compromise masculine status, particularly for working class men. Thus, such communities of practice like support groups can restructure masculinity in more health promoting ways. Although not representative of all working-class men, the accounts produced in Simpson and Richards' (2019) study drew on discourses that could be common within men's self-help groups. Similarly, McKeown *et al.*, (2015) emphasised men's greater satisfaction with such projects as self-help groups that were experienced as empowering compared to traditional mental health services. Creighton and Oliffe (2010) suggest that linking the communities of practice framework with Connell's (1995) configurations of practices enables connections between the patterns and diversity that exist between and within men's health illness and practices (Connell and Messerschmidt, 2005).

Evidently, support groups can provide specific social relationships and unique social support to men in times of distress. Although not specific to mental health distress, there is theoretical literature that provides argument for how social relationships and social support improve psychological wellbeing and Thoits (1995; 2011a; 2011b) claims there are seven mechanisms through which this is done. In Thoits' (2011a; 2011b) work, she considers the effects of social support and the pathways through which social ties affect emotional wellbeing, including: social influence/social comparison, social control, behavioural guidance, purpose and meaning, self-esteem, sense of control or mastery, belonging and companionship and perceived support availability. Thoits' (2011a) theoretical argument demonstrates how support groups produce strong social relationships, ties and support, because they can provide a safe space to be around similar others, who have had similar experiences and can offer specific advice and support. Other research has also found similar benefits of support groups for example Seeborn (2013) found that self-help groups made a strong contribution to members' mental wellbeing by enhancing a sense of self-esteem and control and decreasing isolation through participation. Ussher *et al.*, (2005) identified support groups as being positioned as providing strong feelings of belonging, acceptance and a sense of community. This relates to the notion of communities of practice as particularly beneficial to men's healthcare and

support. The research described here however, is not specific to men, and does not consider constructions of masculinity. In addition, a number of these studies (Seebomh, 2013; Ussher *et al.*, 2005) refer to support groups for health problems other than mental distress.

There is evidently a need for more exploration of men's engagement in services, more specifically men's use of support groups for mental distress. From the literature reviewed, it can be suggested that support groups could be beneficial to men in times of distress and they also initiate influential social support and social relationships which in turn facilitates men's coping and management of challenging emotional difficulties. It also highlights how further exploration into the different types of services and support that may benefit men in distress would be valuable in order to develop and provide such support groups to specifically target men. This thesis is particularly interested in the different types of formal support men engage in, with it specifically exploring support groups and how they have potential to work positively for men in distress.

## **Men's coping and self-management of distress**

So far, I have considered research that examines how men communicate distress differently, help-seeking practices and use of support groups as a type of formal support. Exploring how men cope and manage with distress on a daily basis is a significant aim of the overall thesis. Much of the previous literature on men's self-management and coping strategies for mental distress has focused on men's lack of self-management and their different coping styles for distress than women (Tamres, Janicki and Helgeson, 2002) mostly including the maladaptive coping they engage in (Whittle *et al.*, 2015). It is therefore crucial to consider how men positively manage depression on their own or cope without clinical intervention, in their everyday lives. In their narrative review, Whittle *et al.*, (2015) found that discussion of positive or adaptive coping behaviours tends not to be the main focus of studies, arguing that further research into men's perspectives on positive coping behaviours and the mechanisms they deem effective is particularly necessary (Whittle *et al.*, 2015: 436). Such research would further reveal the different kinds of self-help strategies endorsed by men and what men do to cope in the face of adversity.

There have been some fairly recent studies that have attempted to explore the things men do to cope. Spendelow's (2015) systematic review of qualitative studies of men's self-reported coping strategies for depression identified themes that were consistently reported in relation to men's coping strategies; 'promote traditional masculinity' referring to coping responses that exhibited traditional masculine traits such as independence, concealing negative emotions and engaging in risky behaviours; 'promote flexibility' referring to coping strategies intended to broaden traditional traits to accommodate depression; and 'social concealment and minimization' which reflected men's attempts to conceal or distract themselves from depressive symptoms. The review highlights how when used flexibly, masculinity can be used as an advantage to men in coping and managing emotional difficulties. An example of this would be to reframe coping and managing strategies of distress such as help seeking and seeking out social support as being a responsible, health conscious man who takes action to control of the problem. This theme that was found in most of the studies reviewed confirms the presence of multiple masculinities (Connell and Messerschmidt, 2005). They noted how some men view masculinity as an adaptable construct that can be reframed to accommodate various coping strategies. Spendelow's (2015) findings suggest that coping in men's depression need not involve the abandonment of traditional masculine norms, but rather a more flexible view of them (Spendelow, 2015: 445). In addition to these themes mentioned above, there were two additional themes of 'seek support' and 'seek new perspectives'. 'Seek support' describes where participants referred to coping through the use of social support, which included relying on family and friends to talk to (Skarsater *et al.*, 2003), engaging in religious and moral beliefs (Oliffe *et al.*, 2012) and actually obtaining formal mental health treatment (Chuick *et al.*, 2009) as a means of coping. 'Seek new perspectives' refers to the way in which experience can lead to changes in men's life perspectives and general life-style changes which work to manage low mood.

In a recent study, that has particularly influenced the design and exploration in this thesis, Fogarty *et al.*, (2015) aimed to examine positive strategies identified by men as effective for preventing and managing depression. They conducted 21 focus groups and 24 in-depth, semi-structured interviews with men recruited through various organisations and digital networks. It is worth noting here that their recruitment flyers asked, "What do you do when things get tough?" avoiding the words "depression" or "suicide", in an attempt to attract men both with and without previous experience of depression. The majority of the

men (63%) reported no current depression and they actively engaged in attempts to prevent depressed moods through positive strategies. One of the main themes Fogarty *et al.*, (2015) identified was that men had recurrent ideas about 'manliness' and used strategies to prevent depression that were 'typically masculine'. However, they found that not all men in the study identified with this ideal. The men acknowledged that conforming to stereotypical male behaviours could be detrimental to their health. Rather than simply reacting to problems that arose, as seen in Brownhill *et al.*, 's (2005) study, the men in Fogarty *et al.*, 's (2015) study actively engaged in attempts to prevent depressed moods. For example, routines, plans and structure were part of the men's effective self-help strategies. Here, it could be argued that these positive strategies reported by the men in this study are a way of self-control and so performed traditional masculinity in some way, yet still manage moods effectively (Emslie *et al.*, 2006; Spendelow, 2015). The study provides important information on how men monitor their mental health in the absence of being depressed, through using such strategies. This illustrates flexible masculinities, reconfirming Spendelow's findings and supporting much of the literature previously discussed on viewing masculinities as multiple and with greater flexibility.

The majority of the male sample in Fogarty *et al.*, 's (2015) study were aged 55 years or over and were highly educated relative to the general population. It therefore cannot fully represent the male population, thus highlighting the essential need for a broader sample group of men to examine differences in the use of positive strategies between men who vary by age, education level and social class. In addition, as Whittle (2015) suggest, further research with men who are experiencing mild to moderate depression and distress is needed. Attempting to explore the coping and management strategies that men use on their own and in their everyday lives could help to shape service options aimed men. Spendelow's and Fogarty *et al.*, 's research reviewed here are of particular influence to this thesis and I will build on ideas from this work to further investigate men's coping and self-management.

## Conclusion

In this chapter I have reviewed relevant literature to examine the main areas around male mental health that the thesis aims to address. I have outlined work that has focused on men's experiences of distress with particular focus on their mental health help seeking, use of support groups and coping and management practices. From the literature reviewed, we know that men are less likely to seek help from health professionals for distress difficulties or engage in mental health services than women (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003). However, much of this research has consistently focused on men's reluctance to seek help and barriers that are notably to do with masculinity. Little research has focused on what facilitates men to seek help, the routes they take to seeking help and the types of services and support that works well for them. There is also limited work that has explored men's use of support groups for managing emotional difficulties and distress, a type of formal support that could potentially benefit many men. The review has highlighted some of the social benefits of support groups through Thoits' (1995; 2011a; 2011b) work and such work could be expanded on and used when focusing on men and support group use, as well as the idea of viewing support groups as a community of practice (Creighton and Oliffe, 2010) through which masculine identity can be reframed.

Furthermore, little research has explored men's informal and positive coping and management strategies for distress, and the previous work that has examined men's coping behaviour tends to focus on men's use of fewer and more ineffective coping strategies (Whittle *et al.*, 2015). Evidently more work like Fogarty *et al.*, (2015) is necessary to explore the positive ways men cope and manage distress. The studies I have examined here are somewhat limited in that they mostly fail to explore a broader population of men with their samples often limited to a sub-group of white, well-educated men so failing to address the experiences of a more diverse range of men of different ages and social backgrounds. The next chapter will indicate how this study will attempt to address this limitation.

Hoy (2012) also pointed out that most qualitative studies on men's mental health focus on problems in their behaviour and he highlights the need to move beyond the usual focus on the negative impact of hegemonic masculinities on mental health. As noted in this review, the relationship between masculinity and help seeking is not fixed, and masculinity

does not always have to lead to resistance to help seeking. Studies have started to acknowledge the different ways hegemonic masculinity can be used, as well as the flexible and alternative masculinities that are adopted by men in their mental health help-seeking and coping. Having highlighted studies that have begun to explore this, further research is required in the exploration of men's positive mental health behaviour and to recognise the multiple and fluid ways in which masculinity can be used to benefit men.

In reviewing the existing literature from the fields of masculinities, men's health and illness, it can be established that additional research on the different things that men do to manage mental distress effectively would be beneficial. Thus, reviewing the literature ensued the development of my research questions and aims of the study. Additionally, nearly of the literature reviewed in this chapter is qualitative in nature. The next chapter will explore how quantitative methods such as secondary analysis could be combined with qualitative methods to address the following research questions:

RQ1 – What are the social contexts that predict help seeking from a GP for a mental, nervous or emotional problem?

- a. Can a significant relationship be identified between socio-economic status and whether a man had spoken to the GP about a mental, nervous or emotional complaint?
- b. What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional complaint?

RQ2 - What are men's experiences of help seeking for distress?

- a. As a type of formal support, what are the men's experiences of using support groups?
- b. What is it that these groups are doing that works for them?

RQ3 - How do men cope with distress and emotional difficulties they have been faced with on a daily basis?

- a. What do they do to manage distress that works for them?

# Chapter Four – Methodology

## Introduction

This chapter describes in detail the methods used in this study, referring to epistemological and ontological debates around mixed methods, sampling and access for the qualitative component, explanation of ethical issues and procedures, and a description of the data analysis. Chapter five will then provide methodological reflections of my positionality within the research. Within the first section here, I justify my decision to use two different research methods, exploring the debates and contradictions in doing so. The rest of the chapter then focuses specifically on the qualitative method component and I discuss the reason for purposely recruiting two different sample groups of men. The overarching research question and aim of the project initially stated was:

- When men experience distress and difficulties with their mental health, what do they do to manage this?

This research used a mixed methods approach to explore men's experiences of emotional difficulties and more specifically their help-seeking and coping behaviour. To begin, I conducted quantitative secondary analysis of the Adult Psychiatric Morbidity Survey (2007) to explore formal help seeking and what contextual factors predict men seeking help from a GP for emotional difficulties. This was done to set the wider context for the more detailed small-sample qualitative study by exploring population trends through analysing a large and representative data set. Details of this dataset, the variables and statistical analysis used combined with the findings are outlined and discussed in chapter six. Here, in chapter four, I will discuss my rationale for using quantitative secondary analysis as well as such issues that arise with its application.

Following the quantitative analysis, I undertook a series of semi-structured interviews with men. I employed a combination of purposive and snowball sampling in order to recruit men from the general population and men who had attended support groups. Through these interviews I wanted to explore help seeking, both informal and



formal types of help, and also men's everyday coping and management for distress and emotional difficulties. The qualitative method, sampling strategy and approach to analysis are discussed in detail within this current chapter (four).

## **Design and debates**

As stated above, this research adopts a mixed methods approach, combining secondary analysis of a large quantitative dataset with qualitative interviews. In this section, I will start by considering the debates and contradictions that come with combining quantitative and qualitative methods. It is important to do this first to justify the decision to use mixed methods in this research.

My first subset of research questions focused on formal help seeking, specifically speaking to a GP about distress and any emotional difficulties that they might have experienced. I was particularly interested in the situational and social contexts under which men are more likely to seek this kind of formal help: contextual variables (e.g. socio-demographic) and situational contexts (e.g. age, marital status, social class and how close they are to family members). The qualitative interviews that follow will then provide a further in-depth exploration into men's lived experience of mental health help-seeking behaviour as well as explore informal support and coping. I wanted to set the context of men's help-seeking practices and it seemed the best way to accomplish this was through quantitative secondary analysis of a large sample population survey that records key demographic and situational variables (such as age and marital status, for example). Hakim (1982: 1) defines secondary analysis as "any further analysis of an existing dataset which presents interpretations, conclusions or knowledge additional to, or different from, those presented in the first report on the inquiry as a whole and its main results". My first subset of research questions that explored help-seeking can therefore be best understood through an objectivist ontology that employs quantitative methods through statistical secondary data analysis of an existing dataset. Chapter six will discuss this quantitative component in full, describing the chosen dataset, methods, analysis and findings of the statistical analysis in detail. In the next section I consider the underpinnings of combining this quantitative method of statistical secondary analysis with qualitative interviews.

I also wanted to explore men's accounts of their subjective experiences of mental health as articulated in their own terms. Thus, conducting statistical analysis on survey data

would not provide a means of exploring thoroughly how men experience and cope with emotional difficulties because it does not offer the space for them to discuss their experiences openly and at length. The qualitative methodology of semi-structured interviews was employed to explore these experiences. This formed the main part of the research data and overall thesis. Reasons for choosing interviews over other qualitative methods as well as the sampling and recruitment strategies that were employed are described in detail later in this chapter.

As the data is predominantly qualitative, it would seem appropriate to assume a social constructionist ontology approach that uses qualitative methodology. This is because I am mostly interested in understanding the complex world of lived experience from the point of view of my participants (Schwandt in Denzin and Lincoln, 1998: 221). However, given the subject of mental distress, the specific focus on men as well as the combination of quantitative and qualitative methods, I make the tentative claim that the research is operating in dual paradigms. In chapter two, I mentioned that I do not want to ignore the impact diagnoses and medical models of mental illness can have on people's experience and so I acknowledge the categories of mental distress as well as the social structures that influence experience of mental distress. It therefore seems more appropriate to take a critical realist approach to the research, methods and data.

Critical realism claims that reality does exist independently of our thoughts, impressions and descriptions. Bhaskar (1978) proposes that this ontology can be differentiated on three levels: the empirical level which consists of people's experiences; the actual level, which involves all events (experienced or not); and the causal level, which adopts the 'mechanisms' or social structures and agencies that generate events. It is these 'mechanisms' that produce tendencies and thus critical realism redirects attention to focus on an understanding and explanation of these tendencies (Houston, 2001). In this research, it can be argued that mental health (and the mind), as well as sex (e.g. biological characteristics of male and female) do exist, as some people do experience worse mental health that can affect their daily function. However, the meanings that are ascribed to these mental health categories and also gender categories are socially constructed (Oliver, 2011), contested and debatable. I recognise that there is a significant social problem (e.g. certain groups of men may be less likely to seek help for mental distress) and through an objectivist approach using secondary data analysis, I aimed to identify evidence of categories such as age, marital status and social class, that in turn produce patterns

associated with social structures (e.g. men speaking to the GP about an emotional problem). As noted in chapter three, there is a lack of quantitative research that has addressed men's mental health practices. Using quantitative secondary data analysis, I was able to identify these gendered social population trends but through the use of qualitative methods, I can further explore these trends or patterns generated by underlying social factors.

I have taken what Mason (2006) calls 'the rhetorical logic' approach, whereby the primary focus of the research has a qualitative direction that explores social processes and participants' experiences in rich and in-depth detail. The inclusion of some background material and statistics can provide context and help make the research part of a bigger set of observations (Mason, 2006: 4). Some critical realists want to preserve inquiry as a pragmatic process which is determined by the question under study and so in terms of what critical realism means for the way research is actually done, using mixed methodologies can fit well for investigation into how men cope and manage distress.

As with any mixed methods research, there was initial concern with combining the two methods effectively and where the two would interact. Given the way in which a critical realist approach can be applied, I argue that the use of secondary data analysis in this research acknowledges the effects of structure on action, which I could then build on during the interviews where participants further define their actions and experiences. Critical realism then, can connect the divide (Sheppard, 1998; Taylor and White, 2001) between positivism and constructionism, and quantitative and qualitative. I acknowledge the constructivist insight that the male participants in this study can actively transform and produce their everyday lived experiences, but through taking a critical realist approach, I am using statistical knowledge to infer a context of social structures that are equivalent in the qualitative sample. Both samples from the quantitative and qualitative component are derived from the same UK National context, perhaps therefore comprising of similar cultural values about masculinity and help-seeking behaviour. I recognise that I, as the social researcher, can never fully gain an accurate picture of the participants' social world, rather I can only gain a 'transitive view' (Bhaskar, 1978) that is influenced by socially structured constraints, culture and experiences. I also do not ignore the extent to which my participants' accounts are constructs of the interactions taking place between the two of us within the interview setting and additionally recognise the influence of potential power structures that come into play here. It is therefore necessary that when adopting a critical

realist approach using mixed methodologies that I engage in reflexivity throughout all stages of the research process (researcher reflexivity is discussed in detail in chapter five).

### *Making mixed methods work*

Researchers have previously worried that mixing methods with no clear aims and objectives could result in unfocused research being produced. However, some advocate that researchers should appreciate and utilize both qualitative and quantitative methods in order to take a pragmatic stance (Onweugbuzie and Leech, 2005). This echoes the point made above regarding critical realist's goal of inquiry to remain pragmatic, something this study aims to achieve. For Johnson and Onweugbuzie (2004), a key feature of mixed methods research is its methodological pluralism and its ability to produce pragmatic and more advanced results than mono-methods. According to Denzin (1978), triangulation is studying the same phenomenon using a combination of methodologies (Denzin, 1978: 291) and he argues that in order for triangulation of methods to be effective then researcher reflexivity in relation to the methods used is needed. As outlined, I wanted to explore a range of topics relating to men's mental health experiences including their help seeking and coping behaviours. Through the use of secondary analysis, I was able to begin the study with establishing some of the social patterns of help-seeking that exist amongst men.

Dale *et al.*, (1988) outlined many advantages for the use of secondary analysis. One obvious advantage is the minimal time and expense of access to large-scale data. Dale *et al.*, argued that secondary analysis can do much more than minimise time and expense and can provide the researcher with a unique opportunity. The datasets often employed for secondary analysis from the UK Data Archive are of very high quality, with careful questionnaire design, fieldwork and methodological development (Dale *et al.*, 1988: 45). Using these data sets allows concentration on subgroups of the study population, which is true for my data analysis that focuses on men and their mental health. The secondary analysis was completed before the qualitative data collection began. I was then able to use the findings from the secondary data analysis to inform the construction of my interview schedule and further explore and probe these important factors during the interviews. For example, age was a contextual predictor of help seeking found in the secondary analysis,

and so this led me to ensure the context of age was further explored during the interview content.

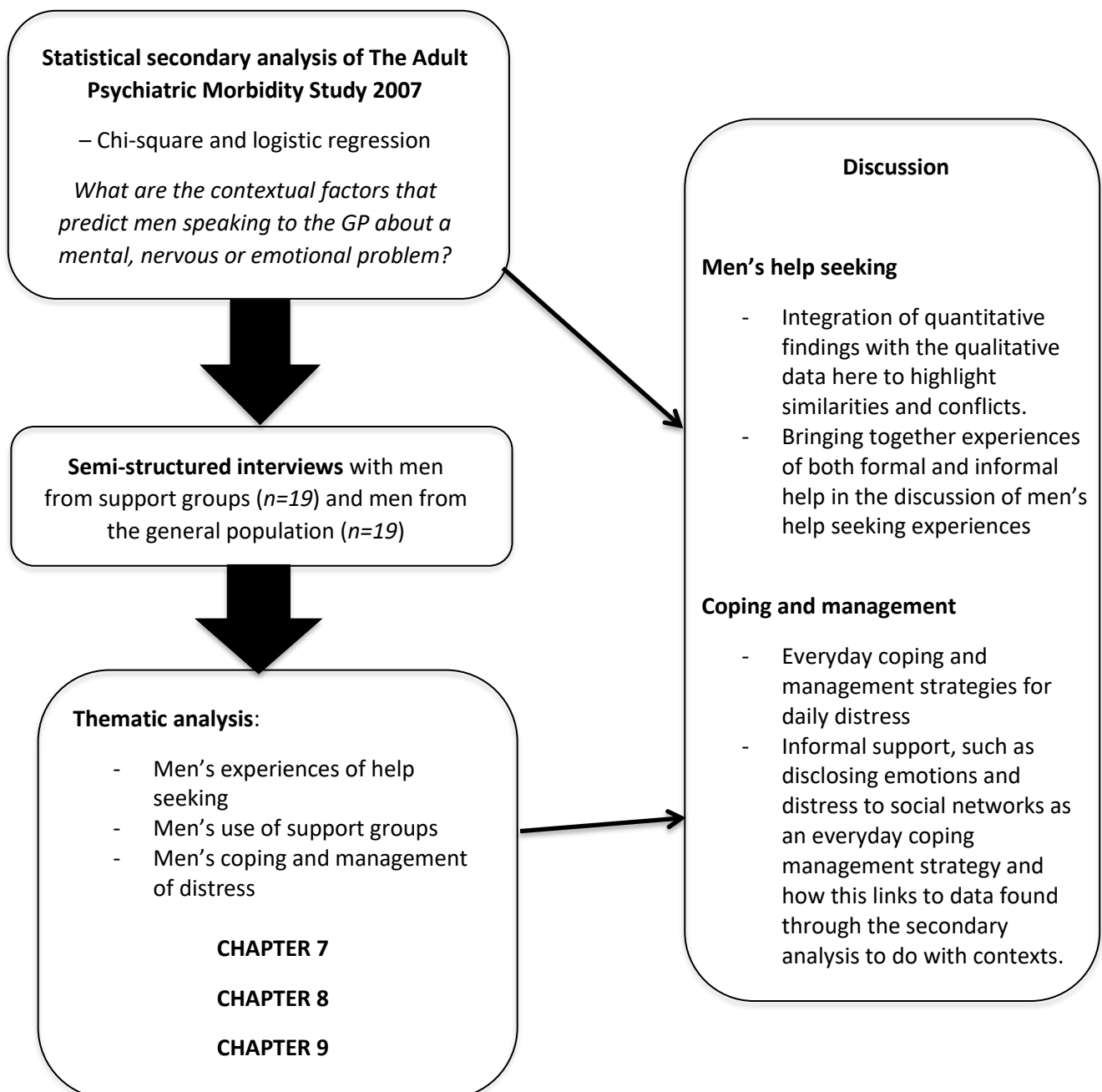
### *Integrating the two components*

As noted above, the statistical secondary analysis was undertaken first as part of phase one of the research design. This was purposeful owing to the design of the research. To reiterate, I wanted to initially explore contexts under which men might seek help and whether there were any social structures that predicted men attending the GP for emotional difficulties. During the reviewing of literature and the organising and arranging of the qualitative fieldwork, I had time within the first year to undertake statistical analysis to begin to investigate such contexts associated with men's help seeking. As a result, the secondary analysis methods and results write up happened together, early on in the research process. I felt it was appropriate and logical to keep this section of secondary analysis separate as one distinct section that discusses the precise steps I took, describing the background, rationale, methods, results and discussion of the statistical secondary analysis together. As the primary method of this project is qualitative, the quantitative secondary analysis chapter (chapter six) acts as a contextual starting point - with both methods and findings - for the following primary data.

As this is the principal methodological chapter underpinning the thesis, it was important for me to address the design and debates when utilising two different methods to answer the same the overarching research question. I believed that this main methods chapter should give focus to the primary qualitative research focus, specifically as the quantitative analysis was distinct in the write up and structure. I realise that because I am attempting to combine these two methods as part of the design, it could be argued that the methods for the quantitative secondary analysis should be included in this principle methodology chapter. However, due to the reasons outlined above and in the previous section concerning debates and mixing methods, I kept the detail of the quantitative secondary analysis methods separate. Instead the two datasets will be integrated in the discussion chapter (chapter 10) to examine men's help seeking in terms of contextual factors and participants' lived experiences. In the discussion (chapter 10) I will examine

similarities in the data found from both the method components, where the data sources meet and can be compared, as well as any conflicts and contradictions in the data. The diagram below shows how the research design takes shape within the structure of this thesis.

**Figure 1 – How the two methodological components were carried out in this thesis**



As I have noted earlier, using a quantitative method can identify patterns and associations that might otherwise be masked and so pull out unexpected causal mechanisms. The qualitative method is then open ended, which is a key strength from a critical realist perspective and so allows for themes to emerge that could not have been anticipated (McEvoy and Richards, 2006).

According to Bryman and Bell (2003: 291), “triangulation entails using more than one method or source of data in the study of social phenomena”. In research inquiry, triangulation is usually employed for reasons such as confirmation, completeness or ‘abductive inspiration’, or retroduction. My research has employed triangulation for the reason of completeness, so the reason being to obtain a greater level of detail regarding men’s help seeking than could be obtained from using just one of the data sources. I acknowledge that my use of triangulation is not triangulation in the sense of using more than one type of method on the same set of research participants, as my samples for each component were different. Using the combined methods of triangulation therefore enabled me to develop a more extensive picture of the patterns and processes of men’s help seeking for emotional difficulties. Using triangulation for this purpose allowed the methods to reveal different aspects of help seeking as well as provide a wider range of perspectives. However, I am aware that because of the way I have structured and utilised the combination of both quantitative and qualitative methods (having a separate quantitative chapter that discusses the method and results together), it could be argued that it is difficult to ‘genuinely integrate’ (Bryman, 2007) findings when writing up the research. Integration of the statistical results with the in-depth qualitative accounts was not paramount or the intended purpose of using a mixing methods design and I purposefully used two components to address distinct research questions. Nevertheless, I acknowledge that there is value in exploring connections between the quantitative and qualitative findings as well as in considering interesting contrasts, even though the research may not have been set up that way (Bryman, 2006, 2007; Hammond, 2005).

It has been found in previous mixed method research that a significant difficulty is that of merging analyses of quantitative and qualitative data to provide an integrated analysis (Bryman, 2007). Bearing in mind the purpose of triangulation in this study was for completeness rather than just testing findings against each other. The discussion chapter

therefore attempts to forge an overall, negotiated account of findings that bring together different elements of the discourse around men's help seeking. Remembering this reason for triangulation and combining two methods in the exploration of men's help seeking for distress, assisted me in dealing with conflicting data from the separate findings.

## **The Qualitative Component**

The rest of the chapter will now discuss the qualitative component of the research, which composed the main part of the thesis. Details of the quantitative secondary analysis method will be described in chapter six, including statistical findings and discussion. Here I firstly discuss the reason for choosing to conduct semi-structured interviews over other qualitative research methods. I then describe sampling, negotiating access, the recruitment process and the interview procedure for both the two different sample groups of men. Ethical considerations and data analysis are then discussed towards the end of the chapter.

### *Why interviews?*

The main component of the thesis is interested in men's personal and subjective mental health experiences. Using statistical analysis of survey data would therefore not provide means of exploring men's lived experiences of help seeking and coping with emotional difficulties. As Denzin and Lincoln (2013) outline, qualitative research involves an interpretive, naturalistic approach to the world, whereby the researcher attempts to make sense of or interpret social phenomena and the meanings people bring to them through use of a wide-range of interconnected interpretative practices (Denzin and Lincoln, 2013: 6-7). This contrasts to the quantitative component of my study that aimed to explore patterns and trends, using pre-set measures. I considered other qualitative practices before deciding on the qualitative methodology to be used in this research.

Focus groups were considered, particularly when deciding to access men from support groups, given that they would have already been in a group setting. Previous research on men however has suggested that focus groups provide a site for the



performance of masculinity itself (Salle and Harris III, 2001; Allen, 2005; Robertson, 2006b). Furthermore, discussing experiences of distress and emotional difficulties in a group setting may be particularly difficult, particularly for men from different ages and backgrounds who do not know each other. Given the sensitive nature of the topic, it might be that participants would not feel comfortable fully expressing themselves and their experiences, especially if they already knew other group members, as there would not be guaranteed confidentiality. It would therefore not be ethical to carry out focus groups because confidentiality and anonymity could not be achieved, two elements essential for research in such a sensitive area. On a practical level, getting all participants together at one time and location could be difficult, given my aim of recruiting a broad cross-section of men. Even in the support groups where they were already in a group situation, conducting focus groups in such a setting would not be appropriate due to the aims of the support group to be a safe and confidential space. People attending a support group do so for a time and space to open up about difficulties and receive support and so I would not want to disrupt this setting or cause any distress to others by attempting to turn this space into a research setting.

After considering focus groups, I felt that interviews were arguably the most fitting method to this research, both practically and theoretically. Miller and Glassner (1997) argued that information about social worlds is achievable through in-depth qualitative interviewing. Needing to access hard to reach populations, such as men who have experienced distress, is often a particular reason for doing qualitative research (Flick, 2014). Men and in particular men who have experienced distress and have accessed support services for such distress, are a 'hard to reach' group for several reasons. As noted in the literature review, there is this dominant narrative that men do not want to talk about their emotional experiences and subsequently do not seek out help. Therefore, they may fall out of general population studies, be less likely to complete survey questionnaires (Moore and Tarnai, 2002) or may say they do not have time to take part in any research. Interviews allowed participants to provide me with deeper insight into their personal stories and experiences, delving deeper into their subjective worlds. Practically, conducting individual interviews offered a safe, one-to-one space for men to open up and talk about issues and experiences to do with mental health. Given that the interview only involved

two of us, I was able to work around what was convenient to my participants in terms of the timings and locations of the interviews.

Qualitative interviewing is based on a form of conversation (Kvale, 1996; Kvale and Brinkman, 2009), but rather than just any conversation, interviews are instead a “conversation with a purpose” (Burgess 1984: 102). The qualitative interview is an “active” (Holstein and Gubrium in Silverman, 2004) conversation in which knowledge is constructed between the researcher and interviewee, whereby both participants are actively participating and interpreting (Yeo *et al.*, in Ritche *et al.*, 2014). The interviewer and interviewee therefore enter into a relationship and develop a “conversational partnership” (Rubin and Rubin, 2005). Interviewers guide the conversation and respond to the interviewees’ answers appropriately. Rubin and Rubin (2005) outline that:

In order to achieve richness and depth of understanding, those engaged in qualitative interviews listen for and then explore key words, ideas, and themes using follow-up questions to encourage the interviewee to expand on what he or she has said that the researcher feels is important to the research.

(Rubin and Rubin, 2005: 13)

When using a responsive interviewing model, it is essential that the researcher scrutinizes their own understandings and reactions and how they themselves can affect the relationship or partnership through their personality and emotions. Such interactions are affected differently because of age, gender, social class, ethnicity and other identities. Researcher reflexivity and the implications of this within my research are discussed in detail in chapter five.

I used a semi-structured approach to interviewing. This allowed flexibility within the interview, providing the interviewees with a chance to expand on any information they felt necessary but also attempted to prevent interviewees going off topic by guiding them back to structured topics. I used an interview schedule that outlined the topics to be included in the conversation (content of the interview schedule will be discussed in a later section in this chapter). During the interview this was used as a prompt for me rather than a script to follow. I will now turn to discuss my sampling strategy.

## Sampling

A combination of purposive and snowball sampling was employed in my research to access and reach two diverse groups of men:

1. Men who have voluntarily accessed some kind of support group.
2. Men from the general population – these men may or may not have experienced difficulties and may or may not have accessed support/sought help before.

Both of these groups of men were accessed within the South Wales region: some groups were located within small towns and valley communities, whilst others were located within the main cities of South Wales. In chapters seven, eight and nine, I explore the commonalities across the two sample groups of men and also focus on the use of support groups independently.

Identifying these two different groups of men was purposive in nature. Purposive sampling is a form of non-probability sampling whereby units of analysis are selected by their relevance to the research questions, with the aim of developing ‘insight and in-depth understanding’ (Patton, 2002: 230). It typically defines a narrow set specific of cases (Morgan, 2008) and so being a man and also being a man with some experience of distress was defined as my inclusion criteria from the start.

### *Inclusion criteria*

For both sample groups characterised above, I was interested in the more ‘common mental disorders’ such as depression and anxiety, as well as everyday mental health difficulties and distress that men may face. I chose to recruit men from the general population, with the intention being to try to include a diverse range of men of different ages and social classes and groups, as well as to include men who have not experienced a diagnosed mental health problem in addition to those who have. The reasons for this were because the research was interested in the various coping mechanisms and different help-seeking strategies that ordinary men from different social backgrounds adopt within their everyday lives. It was important to recruit a diverse sample of men because of the interest in a range of experiences to do with mental health help seeking and coping. I chose to recruit men who

have accessed support groups because I was interested in a specific type of formal support and how groups might be effective for men in managing their mental health. In addition, as some of the men recruited from the general population might not have sought formal support, recruiting men from support groups ensured the inclusion of some participants that have had experience of seeking formal help for mental health difficulties. Men who have voluntarily accessed a support group for distress were included.

Information about the study was distributed mainly through a recruitment flyer (see appendices 2 and 3) and also word of mouth, and participants then chose to participate. In addition to purposive sampling, the selection of participants also took on a snowball sampling approach (Morgan, 2008). Snowball sampling involves identifying respondents who are then used to refer researchers on to other appropriate respondents and it can be a real benefit when trying to access difficult to reach groups (Atkinson and Flint, 2001). As the aim of my study was primarily explorative, qualitative and descriptive, snowball sampling offered practical advantages (Hendricks *et al.*, 1992) in the recruitment of men. This approach involved men that I had already interviewed passing on my information and putting me in touch with other men who would be interested in participation. During the recruitment stage, I found this snowball approach to be a great advantage to my project and through it I met some interviewees that I might not have come into contact with otherwise. However, despite its influence in my study, using a snowball sampling approach does come with its limitations and problems. There is the issue of representativeness and the quality of data that this approach produces which in turn limits the validity of the sample (Van Meter, 1990). Some people, of certain ages, class, occupations, for example, may be more aware of social research and also more willing than others to participate in studies. For example, one participant said he had completed a masters and worked in consultancy and so knew what was involved in research which is why he wanted to participate.

### *Negotiating access*

Identifying research populations and then attempting to gain access is often one of the first and most difficult challenges that researchers face. Access to men who would be willing to talk to me was a particular challenge and this became obvious to me from the outset. As a

young female researcher interested in the emotional lives of men, where do I begin to start locating my research population of interest? After deciding on the two sample groups I wanted to access, deciding where and how I was going to recruit these men was the next step.

After identifying the purposive/theoretical sampling strategy as men of different ages and social classes, I had to plan how I was going to locate and access the two different sample groups of men. To begin, I designed a recruitment flyer to hand out at the various support group sites and local institutions such as pubs, coffee shops, betting shops, gyms, workplaces etc. as a way to attempt to recruit men. I chose these locations on the basis of them being perceived as typically male institutions where men might be found. The recruitment flyers differed slightly for the two different sample groups of men. The caption on the flyer recruiting men who have accessed support groups said “Would you be interested in taking part in an interview?” and the flyer aimed at the men from the general population was slightly more informal, “Interested in taking part in an interview?”. The slight difference between these two questions was because the locations chosen to recruit men from the general population from were more informal, everyday settings. This will be outlined in more detail in the following section that focuses on access and recruitment for each separate sample group of men.

As well as the caption, further thought and consideration went into the designing of the recruitment flyer, regarding the phrasing and the picture of myself that I chose. I decided to use a small photo of myself on the recruitment flyers to portray a friendly and warm approach in order to make potential respondents feel more at ease and willing to participate in an interview. I was conscious when choosing this photo of how I came across as a young female wanting to interview men. I wanted to make sure that I did not appear too feminised but wanted to look welcoming and friendly too. The fact that I was so conscious and aware of my image and appearance as a female researcher looking for a male participant highlights how important gendered image and the effects appearance still has today. I had to consider the various risks that would come with putting my face on these recruitment flyers, which would be handed out to numerous men. In addition to the choice of photograph, I had to be mindful of the way in which I worded expressions on the flyer, particularly with the flyer to be used to recruit men from the general population. Initially, I used the term ‘distress’ explaining that I am interested in talking to them about their experiences of distress. After careful consideration, piloting and discussions with my

supervisors, it was decided that this term might be slightly off-putting for some men. The term was changed to 'emotional difficulties' and 'challenging emotional experiences' as this felt more neutral. Furthermore, this opened up the topic more widely to include various difficult distress experiences and I felt it would attract more men and get a better response rate.

Another issue that was considered was whether or not I would advertise and offer payment for participation in my project. In qualitative social research the practice of paying for participation has become increasingly common. However, often the implications for paying have been neglected and ethical guidelines on payment provide a lack of guidance (Head, 2009). Motives for paying participants would be the incentive to encourage participation and gratitude for their time. Some researchers have said that making payments can be a way of 'beginning to equalise' the uneven power that exists between interviewer and interviewee (Thompson, 1996). This power dynamic was actually one of the reasons I decided not to pay my participants. For both sample groups of men, a young female paying a man for something in return may be seen as disrupting the power balance that might have been established during the interview. Especially given that the topic of conversation was the sensitive subject of their mental health, I felt that it would not be appropriate for me to pay the participants. In addition, there was the concern that paying interviewees might mean that men 'tell me what they feel I want to know', rather than giving an authentic account of their experiences, attitudes and views (McKeganey, 2001). Having said this, qualitative data obtained through interviews are only partial accounts of events, with experiences being constructed and described by the participant. I decided however, that I would not pay participants in my study and so payment was not advertised on the recruitment flyer.

After completing the recruitment flyer, the next step was to hand this out to men in my two diverse sample groups. I will now in turn, explain how I located and accessed men from the two different sample groups as well as describe the interview procedure for each group.

### *Recruitment of men who have accessed support groups*

Attempting to gain access to men who use support groups meant that I would first need to establish what groups are available out there. Due to not needing to apply for ethical approval from an NHS research ethics committee (NHS REC) (discussed later in the chapter on ethical considerations), the main criterion when searching for local groups was that they could not be run by an NHS organisation. Through Google searches and word of mouth I found various types of groups within travelling distance for people (men and women) who might be experiencing different kinds of emotional difficulties. Initially, I sent out emails to the people who facilitate and co-ordinate these groups who acted as gatekeepers for me to access and recruit men. The groups did not have to be exclusively men's only groups and they also included mixed gender groups. Some of the groups were large well known third sector organisations and others were small, local peer-support groups. I had a high response rate from nearly all the facilitators of groups that I approached, with many seeming very interested in the topic and happy for me to attend the groups to introduce myself and attempt to recruit from their groups. In most instances, I initially met with the facilitators to discuss my research, what I planned to do and how I planned to recruit from the groups. I explained how I would introduce myself and the research at the start of the group, handing out the recruitment flyers, and that I would then leave and be around at the end of the group should anyone be interested or have any questions. I felt that being around when the group finished would produce a better response rate and that way, I could ask the men myself, without pressure, whether taking part in an interview would be something that they would be interested in. Where I did not meet the facilitators first, I included what I planned to do when I attended in an initial email.

Going along to some of the groups and introducing myself at the beginning of the session proved a successful approach and I was often warmly welcomed into the groups and my research met with great interest. In some instances, I was faced with questions such as 'why just men?' and I had to negotiate this question carefully when in the mixed groups. Other similar issues and reflection on attending the support groups are discussed further in chapter five relating to reflexivity within the process. Nonetheless, during these times when I went along to groups, I received a good response rate and many men came forward straightaway and said yes, they would be happy to be interviewed. In this case, I took their contact details and explained I would follow-up to arrange a suitable time for the

interview. In some cases, the facilitator of the group thought it would be best if they spoke to the group/men first. In these cases, I emailed over my recruitment flyer to the facilitator who would then hand them out and speak to the men individually. Having facilitators speak to the group about the research first was also successful and resulted in five men contacting me and agreeing to take part.

I was pleased with the success of the approach used and the response that I had when recruiting men who had attended/were attending support groups. Warren (2001) claimed that this is often the case with qualitative interviewing with eagerness to talk about oneself in interviews the most commonly reported reason for participation. As Rubin and Rubin (2005) noted “most people like to talk about themselves: they enjoy the sociability and sense of accomplishment and are pleased that somebody is interested in what they have to say” (Rubin and Rubin, 2005). I found this was the case with the majority of respondents I recruited through the support group sites; the men were interested in sharing their story and distress experience. Particularly for the support group sample, I found that a central motivation for participation in the interviews was altruism (Warburton and Dyer, 2004) with many of the men saying things such as:

*"Well if you can help more people like us then I am happy to help with that".*

The typology of the different groups and descriptions of the final sample of men who have accessed support groups and services ( $n=19$ ) are outlined in the table below:



**Table 1 – Type of support group and number of men recruited from that group**

Type of support group	Number of interviewees and ages of men
User-led, self-help group for adults who suffer from depression and anxiety. Meet twice a week, one day time and one evening. Mixed group	n= 6 Age ranges = 44-74
A group for men to meet and do things together. To tackle isolation, loneliness and other difficulties. Men only	n= 5 Age ranges = 24-68.
Service that provides information, peer support groups, one-to one counselling and training that promote the development of skills and strategies. Mixed services.	n= 2 Ages = 34, 29.
A social informal peer-support group for people suffering mental ill health, particularly depression and anxiety. Mixed service and activities	n= 1 Age = 57
User-led open access support service that provides a drop-in service. Mixed service.	n= 3 Ages = 54, 52
National charity that provides a men's group for those experiencing mental health problems	n=1 Age = 38
Football training session set up for people experiencing mental health problems	n=1 Age=54

As mentioned, one of the main aims was to gain a diverse sample of men from different ages and social backgrounds. For both sample groups, I have classified the men using The National Statistics Socio-economic classification (NS-SEC), to provide an overview of my participants' characteristics. During the opening section of the interview, I asked participants what their current or most recent job was and used this to classify them using the NS-SEC. The NS-SEC has been developed as a sociological classification that has been constructed to measure the employment relations and conditions of occupations

(Goldthorpe, 2007). In classifying participants, I have used the three-class version of the NS-SEC. I am aware that measuring and classifying a person's social class is much more complicated than just using occupation and I found this during the interviews with the men. For example, one man (from the general population sample) whose current occupation placed him in analytic class one, higher managerial and administrative occupations, described himself as a "working class boy". However, for the purpose of this methods chapter, I am assessing my sample groups against the nationally used benchmark for socio-economic classification.

Table 2 on the next page shows the socio-economic status of the men recruited from support groups. Where men were retired, I classified them based on their most recent employment. Six of the men from the sample group were retired, with two of these men having taken early retirement due to ill health. Four men from the support group sample were long-term unemployed due to mental health reasons. The majority of men (eleven) fell into class two, intermediate occupations, two were in class three which were routine and manual occupations, four were currently long-term unemployed and only one man from the support group sample was in class one, in a higher managerial, administrative or professional occupation.

**Table 2 – Participants recruited from support groups/services**

<b>NS-SEC Analytic Class</b> <b>(Classified using the NSSEC three class version measurement)</b>	
<b>Analytic Class</b>	<b>Participants (Pseudonyms)</b>
1. Higher managerial, administrative and professional occupations	Thomas (62)
2. Intermediate occupations	Kyle (34), Richard (24), Peter (retired, 62), Joseph (retired, 68), Andrew (retired, 68), Mark (retired, 64), Jim (retired, 74), James (retired, 61), Rhys (57), Samuel (29), Patrick (54),
3. Routine and manual occupations	Albert (51), Ben (52)
* Never worked and long term unemployed	Barry (38), William (44), Matthew (54), Adam (48)
* Student	Rick (21)

### *The interview procedure*

When interviewing men recruited from support groups, I offered participants a choice of venues for the interview to take place. In most instances I was able to use a room in the facility where the group was held. In this instance I usually arranged times and dates with the facilitator of the group of when was best for me to return to the group and then subsequently arranged this with the men. All of the men interviewed at the location of the support group were happy to be interviewed at the time of the support group meeting. Two men from the support group sample were met outside of group locations: one in a local café and another in a room hired at a University building.

The interviews varied in length but most lasted around one hour. I opened the interview up by asking the men to begin by telling me a little about themselves for example age, family, occupation etc. I began the interview in this way because I wanted to get some background information and demographics of the participants, and also wanted them to feel relaxed and comfortable with me to be able talk about their experiences. It also

allowed them to take control of the direction of the conversation. This opening of the interview was successful: some men took this opportunity to begin to tell me the background to their emotional difficulties and how they came to attend the support groups. Following the opening questions, the rest of the interview schedule included questions about their experiences of distress, their sources of support and help seeking, how they came to attend the support group, what it was that worked for them in the support group, what they liked and found helpful and also what else they did to cope and manage any difficulties outside of the group. Although an interview schedule was used, in some instances throughout the interview, the more flexible, open-ended approach created some difficulties in regards to staying on topic. Some men talked in detail about their work, other hobbies and interests or their own personal relationships for example and it was sometimes a challenge during the interview process to guide them back to the research specific aims.

### *Recruitment of men from the general population*

Recruiting men from the general public was going to be much more of a challenge than with the support group sample. The approach I initially took was to distribute the recruitment flyers as widely as possible at various public places where men may be found. These public locations included local and city centre pubs, barber shops, cafes, betting shops, markets, rugby and football clubs, gyms, art centres and also some workplaces through people who worked there distributing them for me. I was essentially 'cold-calling' men in various public places, getting them interested in the research and then getting them to agree to spare some time for an interview. Spreading the flyers widely allowed them to be seen in the public, however, it did not necessarily equate to a good response rate. It was going to be unlikely that someone would phone to participate in the research off their own back, from a flyer they had been given in a pub. Especially as discussed previously, I decided not to offer my participants payment. My approach, then, involved me actively talking to people at these locations, explaining my research when handing them a flyer and then asking them if it might be something that they would be interested in taking part in. This was the best way to ensure some response rate. Following this, if the men said yes, I would take either their phone number or email address to arrange an interview.

I was met with mixed reaction from the public when distributing the recruitment flyers in this way (the reaction from men is discussed in more detail in chapter five). Some people, both men and women, appeared very interested in the research by asking more questions or even proceeding to talk about research degrees they have done or people they knew who had completed a doctorate. In addition, it sometimes sparked conversation about the topic of men and mental health itself. This did not necessarily result in them agreeing to participate though. Managers of such locations described above were happy to give out flyers, put them on noticeboards and one manager of a local Barber shop said they would hand them out with the receipts to male customers.

The mixed reactions described above were to an extent what I had expected from this recruitment procedure. I was, however, more surprised with the willingness of men that agreed to an interview. Given the topic of emotions and the consistent dominative narrative that “men do not talk” it was refreshing to be met with openness and willingness to engage. Especially considering what Blumer (1982) claimed “no-one gives anything away for nothing, especially the truth” (Blumer, 1982: 3). Such willingness has its reasons though and as mentioned before, people choose to take part in research for a number of personal reasons including altruism, seeing research as innocuous and the therapeutic aspects of interviewing (Peel *et al.*, 2006). With the general population sample group of men, it appeared to me that a key motivation for willingness to take part in an interview was both therapeutic and introspective interest (Clark, 2010). Some men saw the interview as an opportunity to talk about previous experiences and off load in confidence (this resonates with findings discussed in chapters seven, eight and nine). In addition, a number of the men who participated had subjective interest in the topic and research procedures themselves. These men said they had previously undertaken research or higher education degrees themselves and so were happy to help out and “understood” what was involved in research.

After the interviews had finished, I often asked if they knew any other men who may be willing to participate and proceeded to give them more flyers. This snowballing method subsequently resulted in more participants being recruited and interviewed. During the recruitment procedure there were only three men who contacted me first to enquire about the research after seeing my flyer, the rest of the men (n=16) were actively contacted by me after they had given me their contact details.

To reiterate, the aim was to recruit a range of men from different ages and social backgrounds, particularly aiming to get some from lower socio-economic positions, as previous qualitative research on men's mental health experiences has mostly failed to include such men (see chapter three). As can be seen in the table below, five out of the nineteen men interviewed were in lower socio-economic positions, having either never worked or who were currently long-term unemployed or in class three, routine and manual occupations. Six of the participants were in class two, intermediate occupations, with two of these now retired and seven of the participants were in class one, higher managerial, administrative and professional occupations. Similar to previous research, the reason for the recruitment of more men from the higher classes might be because men in these socio-economic positions might have more knowledge and insight of research and so may be more likely to take part. Table 3 below shows the social characteristics of the men interviewed from the general population, as classified using the NS-SEC measurement.

**Table 3 – Participants recruited from the general population**

NS-SEC Analytic Class (Classified using the NSSEC three class version measurement)	
Analytic Class	Participants (Pseudonyms)
1. Higher managerial, administrative and professional occupations	John (41), Simon (42), Oliver (36), George (45), Jake (29), Daniel (34), Harry (65)
2. Intermediate occupations	Dave (27), Nick (56), Shaun (48), Colin (retired, 74), Nathan (49), Kevin (retired, 65),
3. Routine and manual occupations	Geoff (54), Jason (55),
* Never worked and long term unemployed	Adrian (59), Steven (52), Joel (33)
* Student	Mike (25)

### *The interview procedure*

Interviews with men recruited from the general population were arranged via text message, email or over the phone. During this arrangement I offered the men to choose a public place to meet at their convenience. All interviews took place in local cafes, pubs or arts centres. As with the support group sample, the interviews varied in length but most lasted around one hour. Similarly, I opened the interview up by asking the men to begin by telling me a little about themselves so that I could find out more about them. For the general population sample, I had considered using pictures or probes to 'break the ice' and facilitate a conversation around men's mental health. I had also considered using images of famous men and a current trending male mental health campaign in attempt to elicit mutual conversation. Harper (1998) claimed that understanding the meaning images hold for interviewees within the interview process reformulates the relationship between the researcher and the participant into a mutual recognition. On reflection however, I felt that by using such images would lead conversations a particular way and about particular narratives, whereas I wanted the men to take the conversation where they wanted to, about their own experience, constructing their own accounts. I decided not to use the images and adopted the same approach used with the support group sample whereby I opened up the interview with "tell me a little bit about yourself". During the interviews this worked well and although they did not initially offer to speak of any specific emotional experience like the men in the support group had, it gave me some background information and allowed the men to feel more at ease and in slightly more control of the conversation. Differing slightly to the interview schedule used with the support group sample, the rest of the interview schedule included questions about any day-to-day difficulties and problems they experience and what they do to manage and cope with this distress. There were questions about any specific times of distress or experiences with mental health difficulties and what their help-seeking routes and sources of support were.

## Ethical considerations

I will now turn to consider ethical issues faced during the research. Mental distress is a sensitive topic and so careful consideration was given to the ethics of my research strategy from the onset of the project. Given that I planned to speak with potentially vulnerable men about potentially highly emotional topics and experiences, I had to be sure I was following the right ethical route. In this section, I will outline the steps I took to ensure my research was ethically sound and how such ethical practices influenced my sample and recruitment of participants. Ethical considerations continue throughout the fieldwork process to after the writing up of findings has been completed and so new issues are constantly arising.

### *Using potentially vulnerable participants – was NHS research ethics committee approval needed?*

The research was interested in men's experiences of help seeking and coping with distress, also specifically focusing on accessing support groups. From the beginning it was decided that I would use third sector and voluntary organisations, as well as peer support groups that may be set up in the local community. These groups might be accessed by potentially vulnerable men, who might have been experiencing distress at that time and could have also been under the care of a community mental health team or psychiatrist, so whether or not I needed to apply for ethical approval from the National Health Service Research Committee (NHS REC) was uncertain. In the initial research plan, I made it clear that I only wanted to approach and recruit from non-NHS sites. Through seeking advice from the Research Governance Officer at Cardiff University, it was established that I did not need to gain NHS REC approval for these support groups as they were voluntary and third-sector run groups not including NHS based interventions or organisations. Thus, ethical approval for my project was gained through The School of Social Sciences Research Ethics Committee of Cardiff University. Following gaining ethical approval, the way I recruited and accessed my participants had to be appropriately managed. I ensured that individuals in crisis or attending the groups under referral or as part of a care plan were not included in the study. I was also not able to recruit men from NHS run programmes and support



groups. This could be seen as a limitation as during the search for groups I found NHS courses such as 'depression management', 'stress control' and 'anger management' groups, which could have been an interesting site to recruit from.

Despite recruitment sites being limited due to ethical approval, I was still able to access and explore various third sector and voluntary organisation groups that provided different services to people experiencing distress. Furthermore, as the men attending support groups could have been potentially vulnerable at the time of the research, I took the measure of securing Disclosure and Barring Service (DBS) clearance to reassure potential gatekeepers of my suitability to undertake the research. A DBS is used to check the suitability of people to work with vulnerable groups. Due to issues of vulnerability, great attention was continuously given to ethical issues concerning informed consent, confidentiality and anonymity, data protection, and harm to both participants and researcher. All of which will now be discussed.

### *Informed consent*

Informed consent should be considered as an on-going process that is negotiated throughout and during the research process (Miller and Bell, 2002; Nordentoft and Kappel, 2011). Informed consent suggests that participants know and understand the risks and benefits of participation in the research, and they must also understand that their participation is completely voluntary (Flynn and Goldsmith, 2013: 10). As noted, the men attending support groups could have potentially been experiencing distress at the time of the recruitment and interview, and so could be considered as vulnerable subjects. Nordentoft and Kappel (2011) proposed that it is not always possible to determine who is vulnerable prior to the research as it often emerges during the research process (Nordentoft and Kappel, 2011: 373). To overcome this potential ethical issue, I had to ensure participants were not currently experiencing distress or crisis and that the participants needed to have self-referred or voluntarily accessed these groups themselves.

For both sample groups, following expression of interest in participation from the recruitment flyer, an information sheet was provided that explained full details of the study. The content of the information sheet made it clear that their participation was

completely voluntary, and they could change their mind about taking part at any time, during or after the discussion, without giving a reason. It reassured participants that: any identifiable information such as their name would be changed and only my two supervisors and I would have access to listen to the recorded interview; it stated that data would be held securely on a secure server network at Cardiff University for five years in accordance with the Data Protection Act 1998 and; explained that the data would be used for the PhD thesis and potential academic publications and presentations. I informed participants that Cardiff University has a secure computer server that requires users to be registered and obtain a password from the University in order to gain access. After they had fully read the information sheet, I allowed them time to consider and ask any questions or queries they had regarding the research process.

If they wished to continue then before the interview commenced a consent form, which was a separate form to the information sheet, was signed, stating that they agreed to take part in the study and had fully read and understood the information sheet provided. I again reminded participants that they were able to stop the discussion at any time and that they did not have to answer or discuss anything that they felt would distress them. I also emphasised that they could withdraw from the research at any time.

### *Anonymity and confidentiality*

Anonymity and confidentiality of the participants must be respected at all times, from the onset and throughout the research process. Given the personal and sensitive topic of mental distress, it was imperative that I took the appropriate steps to safeguard the confidentiality of records and any identifiable information. The ESRC framework for research ethics states that all researchers should be aware that the processing of any information relating to an identifiable individual constitutes 'personal data processing' and is subject to the provisions of the Data Protection Act 1998 (<http://www.legislation.gov.uk/ukpga/1998/29/contents>) (ESRC, 2015: 23).

To ensure anonymity, all names have been changed to pseudonyms, which were assigned at the earliest point possible. Any other identifiable information was also changed when using quotations during the write up. Direct quotations were selected carefully to

ensure that participants could not be identified by their publication. Cardiff University's data retention policy states that both original files (including interview audio files) and transcripts must be retained for no less than five years or two years post-publication. The reasons for retaining the source data are to ensure that the records contain sufficient information to establish their authenticity and also to make them reliable evidence to support any final research outcomes. After this, any interview transcripts and participant information will be destroyed. Only I have access to the participants' contact details and they were securely stored as a manual record in a locked filing cabinet in a security-controlled building on Cardiff University premises. Contact details were kept in case participants need to be contacted for a follow up debrief and in case they wished to receive a summary of the research findings. Completed consent forms are also stored in the locked filing cabinet on Cardiff University premises and will be shredded once the PhD research project has been completed. The Dictaphone used during the interviews was wiped once the recordings and transcriptions were saved to a University computer, specifically the H drive.

In research on sensitive issues there are times when confidentiality has to be broken, for example, if a participant discloses risk to themselves or others. I informed the participant that should they disclose such risks then I would have a duty to inform the relevant people or institutions regarding such risks. During the fieldwork, participants did not disclose any risks or potential harm to themselves or others.

### *Potential harm to participants:*

#### *Men recruited from support groups/services*

The support group sample participants would have been using such services for support with their emotional difficulties and so as mentioned earlier, the study involved engaging potentially vulnerable individuals. The safety and wellbeing of participants was therefore of the utmost concern in the design and implementation of the research. The interviews involved asking participants questions regarding their recent experiences of distress, seeking help and attending the support services, as well as also other coping strategies they use. These questions had the potential to elicit emotional reactions from participants,

making them relive potentially painful experiences that may have been particularly distressing to recall. I previously worked for one of the leading mental health charities Rethink Mental Illness and so have experience in working with and talking to people suffering from mental health problems and experiencing mental distress. I completed training relevant to working safely with people suffering with enduring mental illness, including appropriate 'safeguarding vulnerable adults' training. All the appropriate measures to ensure the safety and confidentiality of the participants were taken, (described below) and I ensured that participants truly understood the nature of the study and what was required of them.

I ensured that a safety protocol was in place that acknowledged the potential for any risks or concerns and put plans in place to deal with such risks. I reminded participants that they could stop the discussion at any time and that they did not have to answer or discuss anything that they felt would distress them. Furthermore, I had to be aware of whether the discussion was visibly distressing participants, and so with a duty of care would check they were okay to continue or whether they would like to terminate the conversation. There were three men from the support group sample who became emotional when retelling past experiences of distress and they spoke of how when they discussed this experience, they could sometimes get emotional. I checked that they were happy to continue with the interview or if they would like to take a break. They all informed me that they would like to carry on with the interview. Following the interview, I checked if participants were affected in any way and if they wanted to say anything else that they felt relevant. At this stage, participants sometimes offered a concluding remark around the topic or about their own experiences of distress. There were no participants that were visibly distressed following the interview and some said they enjoyed the interview experience.

### *Men recruited from the general population*

Although the men recruited from the general population were not using support services for any mental health issues, it was quite likely that they might have experienced mental distress in the past given the stated interview topic of men's mental health and so exploring such issues may have led to the participants having to also relive painful

experiences. As with the support group sample, I ensured that participants fully understood the nature of the research and what it involved, emphasising that they could terminate the interview at any time should they start to feel distressed or uncomfortable. Additionally, at the end of the interview, participants were provided with details of organisations which could provide further support should they need it, e.g. from local organisations such as Cardiff MIND, Hafal, and national organisations such as Samaritans, Rethink etc.

Ethical considerations were also given to the location of where the interviews would take place. As a key consideration at this stage was my own risk, I decided that it would not be appropriate or safe for the interviews to take place in participants' homes. Using public places however could have resulted in issues regarding confidentiality and anonymity, as these men were talking about potentially very personal and sensitive issues in a public space. Others in the public might have overheard discussion that took place and men may not have felt comfortable opening up about their own mental health in a public location. On consideration however, conducting the interviews in public places such as cafes, pubs and local community centres was the most suitable option. To counterbalance any risks of confidentiality and anonymity or of men feeling apprehensive to discuss their experiences in a public place, when arranging the time and location of the interview I gave the participants the choice of where and when they would prefer to meet to ensure that they felt most comfortable. None of my participants from the general population had any issues with meeting in such public locations.

### *Potential harm to the researcher*

Qualitative interviewers can experience emotional turmoil as a result of the interviewing experience (Beale *et al.*, 2004), as listening to the distressing experiences of others can sometimes be challenging. During the interviews, I could have been potentially impacted emotionally by the study due to the nature of the topic. Particularly when accessing service users' views and experiences, serious difficulties can be presented for not only the participant but also for the researcher (Johnson and Macleod Clarke, 2003). Some things could have been distressing for both the participant to recall and for me to listen to, for example, if a participant recalls feeling suicidal and shows visible emotion, this can be a difficult situation for a researcher to negotiate. There were five men across the two sample

groups who spoke of previous experiences of self-harm and suicidal thoughts. Again, I ensured that I checked that they were okay to continue to talk about this during the interview. Self-care strategies (Rager, 2005) such as research diary keeping and off-loading to the supervisory team, were adopted throughout the research process and aided protection of emotional safety to myself as a researcher. Regular supervisions were held with my academic supervisors, enabling the discussion of any aspects of the study that were personally troubling or problematic. The counselling service at Cardiff University was also on hand to provide support if necessary.

In addition, there were situational risks and thus potential for harm as a lone female researcher interviewing men and knowing nothing about them beforehand. As outlined above, the interviews were therefore conducted at appropriate safe public environments, for example large cafes, pubs, local community centres etc. A separate research phone was also used instead of my own personal mobile number. I ensured that I followed Cardiff University's lone worker safety procedures correctly by putting in place a safety plan for myself for when I was in the field. When recruiting men from pubs and other such public locations I always took someone I knew with me, who would be around should any issues occur. When meeting men for interviews in public places I made sure that there were people aware of where I was at certain times. Any concerns that I came up against during the interview process or any potential risks posed were further discussed with my supervisors. Situational risks and potential for harm as a lone female researcher are reflected on further in chapter five, which explores researcher positionality and reflexivity in more depth.

## **Data Analysis**

Analysis of data is not an afterthought that takes place once the interview data have been collected and transcribed, but rather it is an iterative process that takes place from the onset of the design, right through to writing up.

I was interested in the subjective accounts of my participants and in order to gain such insight I adopted a thematic approach to the analysis. Thematic analysis is one of the most widely used, yet rarely acknowledged approaches to data analysis and there has been

recent debate about what thematic analysis is and how you actually go about doing it (Attride-Stirling, 2001; Boyatzis, 1998; Tuckett, 2005). According to Braun and Clarke (2006), “thematic analysis is a method for identifying, analysing and reporting patterns (themes) within the data and can minimally organise and describe the dataset in rich detail” (Braun and Clarke, 2006: 79). This approach was chosen because of its flexibility and theoretical freedom, however, it is because of this flexibility that much of the debate regarding the use of thematic analysis has arisen. Braun and Clarke (2006) have attempted to address such critique and the view that thematic analysis can create a kind of ‘anything goes’ (Antaki *et al.*, 2003) qualitative research. Instead they celebrate the flexibility of the method but still provide detailed guidelines of how to go about using it effectively. It was imperative then, that I was clear with the steps that I took in analysing the data.

All researchers need to be able to manage, organise and retrieve the most meaningful parts of the data they have collected (Coffey and Atkinson, 1996) and a means of doing this is through coding. A code can be described as a researcher-generated construct that symbolises or translates data (Saldana, 2009: 121) and is a word or short phrase that acts like a label that gets assigned to a particular attribute of the data. After transcribing the interview data myself, which achieved great familiarity with the data, a large coding frame was developed that effectively captured the main themes in the data and this was applied to both of the sample groups. The steps I took to developing this coding frame are described below.

To begin and to further assist me with the coding process, I imported all the interview transcriptions into NVivo 10.2 Computer Aided Qualitative Data Analysis Software (CAQDAS). CAQDAS allowed me to organise my data in a variety of useful ways, enabling me to search and retrieve at ease. Fielding and Lee (1998) provide justification for CAQDAS use, claiming that it allows effective data management, which in turn enables more time for the analysis itself. It also extends the capabilities of qualitative research such as replication, and it further enhances the acceptability and credibility of the research. Developing the latter, more recently Seale (2002) argued that using computer software can improve research rigour.

Once all data sources were imported into NVivo, I followed Braun and Clarke's (2006) suggestions for conducting thematic analysis. Firstly, I thoroughly immersed myself in the interview transcripts by reading both datasets repeatedly, making notes of any preliminary codes, themes and ideas. According to Strauss and Corbin (1990) identification of themes and coding can take both an inductive and deductive approach (Strauss and Corbin, 1990). Inductive coding is where themes emerge from the data themselves, whereas deductive coding is based on the predefined research question and theoretical constructs that the researcher wishes to explore. Fereday and Miur-Cochrane (2006) call this a hybrid approach to thematic analysis and utilised both approaches, adopting the data driven inductive approach of Boyatzis (1998) and the deductive template of codes approach of Crabtree and Miller (1999). I also decided to use both approaches to coding in my work because I wanted to let the data speak to me to, with the potential for new, emerging themes to develop but also wanted to explore themes found in the literature review regarding men's help seeking and coping.

In relation to research that takes a critical realist standpoint, another way of viewing the combination of both inductive and deductive coding in analysis is termed abductive and retroductive inference. Abduction and retroduction require the researcher to move between data and theory and acknowledge in the findings the significance of data that do not necessarily fit with initial theoretical frameworks. According to Meyer and Lunney (2013) it is recognised that some social researchers do in fact use abductive and/or retroductive inference unknowingly by analysing data that fall out of the initial theoretical framework. Both abduction and retroduction are analytical tools and logic that underpins critical realism (Danermark *et al.*, 1997; McEvoy and Richards, 2006). For critical realists, the underlying argument is the importance of the analysis of lay accounts which requires interpretative tools that are able to unpack the association of what people do and the individual and structural factors encountered in their environment that shape their behavioural responses. Abduction and retroduction have been claimed to be robust tools that can provide a more rigorous form of analysis through understanding the complex processes of research participants differentiating the actual and the real. As I have claimed at the beginning of this chapter, due to the mixing of methods and topic of mental distress, this thesis takes a critical realist standpoint and so it is appropriate for me to also consider abduction and retroduction in the discussion of data analysis.



Considering and using these approaches allowed me to formulate new ideas, think of things in different contexts and to further 'see something else' that might be going on with men's experiences of help seeking and coping for mental distress. This enabled me to further explore data beyond masculinities frameworks and to instead consider and develop other concepts and ideas that might explain men's experiences. Re-description and re-contextualization are key features of abductive and retroductive inference and these are something that took place during the coding of my data and it gave new meaning to already known phenomena. These approaches allowed for a more nuanced analysis of my participants' mental health experiences and further to this, Meyer and Lunay (2013) claim that they can be used to add clarity to methods of analysis.

After completely immersing myself in the data, I separated the sample groups and began with the general population sample dataset, coding it broadly. Nonetheless, with the research aims and theories of masculinity and previous research on men's mental health in mind, there were some codes that were already set in the coding frame that I subsequently searched for. For example, anything to do with coping and management strategies and data specific to speaking to a GP about difficulties developed into deductive codes. Numerous descriptive codes were used and some data segments had a number of different codes assigned to them. I then started to analyse the codes and considered how different codes could be combined to create themes. Essentially, I began searching for themes. Themes can be identified by, "bringing together components or fragments of ideas or experiences, which are often meaningless when viewed alone" (Leininger, 1985: 60). Thematic maps were sketched to explore connections and relationships within or between themes and also to aid my analytic thinking.

Before I then went any further with the analysis of the general population sample group, I began to work on coding the support group sample, using the same coding frame but with additional codes emerging distinct to the support group men. This was done because I was aware that there would be commonalities of themes across the datasets and I wanted to ensure I was consistent in coding. New codes for the support group sample for example included, what it was the men found effective about the support group. These new codes were added to the coding frame that was being developed. I compared the data within and across the interviews from both sample groups and continued to allocate

descriptive codes to data segments (Strauss and Corbin, 1998). Initial themes and thematic maps were then reviewed and refined to include the merging of the two sample groups. Theme definitions were produced and validated by returning to check on the coded data and re-read extracts. The aim was to interpret the meanings and significance underpinning each theme and move from a descriptive to an interpretative level. To do this, I sought both existing literature that had already been reviewed as well new literature to do with the new emerging themes, to make comparisons to my findings.

## Conclusion

In this chapter I have discussed how my research uses both quantitative and qualitative methods to explore men's experiences of distress in terms of coping, managing and help seeking behaviours. My research aimed to explore two different areas relating to men's mental health that included help seeking (both informal and formal support) and coping and management strategies. To explore these areas of men's experiences I used secondary analysis of an existing dataset (the Adult Psychiatric Morbidity Study 2007) and a series of semi-structured interviews with men from the general population ( $n=19$ ) and men who have attended support groups ( $n=19$ ).

Using both quantitative and qualitative methods in this research required reflection and consideration of the epistemological and ontological debates that surround mixing methods, something I have considered at the beginning of this chapter. How I carried out the qualitative component of the research was then described in detail, focusing on the sampling and recruitment of the male participants. Given the emotionally sensitive nature of mental distress, ethical considerations were an important element in the design and carrying out of the research. Potential harm to the participants and researcher were particularly important considerations and the next chapter follows on this reflexive discussion further. The findings from the qualitative interviews were analysed thematically to explore the main patterns of experiences that emerged from the men's accounts. In the next chapter I consider my position in the research, presenting experiences and challenges of being a young female researching men about their mental health, and the influence of this on the data that was collected and analysed.

# Chapter Five - Reflections of a female researcher interested in men and their mental health

## Introduction

Through qualitative research, researchers want to become involved in a different world or subculture in order to understand the individual's viewpoint. The researcher themselves however can always affect participants' responses in some way. Reflexivity throughout the research process is therefore crucial as a means to increase the integrity and trustworthiness of the research (Finlay, 2002), as the researcher needs to continuously consider how he or she belongs in relation to their research participant and topic. Reflexivity is 'ongoing self-awareness' (Finlay and Gough, 2003) whereby researchers need to "take stock of their actions and their role in the research process" (Mason, 1996). My position as a young female researcher interested in the lives of men and their emotional difficulties had the potential to create challenges throughout all stages of the research process. At every opportunity, right from the beginning of the design and planning of the study, throughout the recruitment process and interview interactions and also during the analysis of data, it was important to reflect on my positions as a young, female, PhD researcher.

To ensure reflexivity, I kept a research diary throughout and made field notes when approaching recruitment sites and gatekeepers, as well as after the interviews had taken place. This reflective diary allowed me to contemplate my own positions in the field. I was aware that within the field, both myself and my participants, were portraying multiple positionalities (McDowell 1998; Pini, 2005; Tarrant, 2014) (e.g. gender, age, class) and it was important that I reflected on the impact of this on the research. The multiple positionalities that were key to this study included gender, social class, age and the position of the academic researcher and the researched subject. At times I experienced shifts in positionality, for example, when adopting the position as academic researcher recruiting

men from pubs where I might also end up socialising outside of being a researcher. As a result, I have taken a reflexive approach from the onset and in this chapter, I consider the influence of my position, perspective and presence throughout all stages of the research process. This chapter is marginally smaller than a typical thesis chapter but acts as an extension of the previous methodology chapter, narrowing the focus to examine methodological reflections that I felt needed further attention. In this chapter I provide a reflexive commentary on the position of gender, from both myself and my participants, during the recruitment and data collection. I consider how I engaged with power dynamics and struggles and acknowledge the interplay of gender with other characteristics on the research process.

Broom *et al.*, (2009) state that in order to produce high quality analyses then it is crucial to understand the range of interpersonal dynamics that can shape the qualitative interview context. Such differences and intersections between gender, class, age and ethnicity make up these interpersonal dynamics and highlight the need for qualitative interviewing to be reflexive in nature. It is important that I first set out my multiple positions here. I am a young, white, Welsh woman in my mid-late twenties, carrying out an academic research PhD and studying men of various ages and social backgrounds. I have also previously worked as a Mental Health Recovery Support Worker for a mental health charity and so have experience with, and knowledge of, mental health issues. This chapter predominantly addresses gender reflexivity yet not losing sight of these other influential positions and identities that intersect.

## **Being a young woman in research**

During the research process, the need to be reflexive was especially important given the gendered incongruence of the researcher and the interviewee. Poulton (2012) suggests the need for researchers to think about their gender more critically and engage in such reflexive commentaries to disclose the complexities and messiness of qualitative work, particularly when women research men. Interview settings require a degree of rapport and trust from both the interviewee and the interviewer, however in the case of women interviewing men the interview can become burdened with gender performances and power struggles (McKee and O'Brien, 1983; Smart, 1984; Gurney, 1985; Williams and Heikes, 1993; Arendell, 1997; Horn, 1997; Lee, 1997; Campbell, 2003; Pini, 2005; Gailey and

Prohaska, 2011). In review of the literature of women interviewing men, noting such gender performances and power struggles, it has been found that men will try to exert control and dominance over the interview situation through emphasizing their heterosexuality, positioning themselves as knowledgeable and sexualising and testing the female interviewer (Schwalbe and Wolkimir, 2003; Pini, 2005; Arendell, 1997). Such power struggles can lead to an influence on the female researcher's actions and conversation.

I was conscious of my position as a young female researcher interested in the lives and experiences of men, and that in turn affected decisions that I made throughout the research process. Initially I was concerned that my gender might be a drawback or 'liability' (Ortiz, 2004: 266). I was worried that some men, particularly from different social backgrounds, might not want to talk to me about their personal experiences of being a man experiencing distress, because how could I as a young, educated woman understand their circumstances. I often worried about how the men I attempted to recruit perceived me and whether I would have been able to gain their trust. Such worries were unwarranted. In fact, the majority of men I approached did not question my position in the field or my interest in the area in this way, and if they did, it appeared to be out of interest for the topic rather than suspicion of my reasons for doing the research.

I did however face challenges with being a young woman during the recruitment of participants, which is discussed in detail in the following section. In her paper, Arendell (1997) considered and described the play of gender on the interviewing process and the interactions between researchers and male participants from her own experience. She questioned the gendered research interaction, asking:

Is a woman studying men a 'low status stranger' (Daniels, 1976), an outsider (Sway, 1981; Naples 1996) or an outlaw, positioned by the participants into subordinated status?

(Arendell, 1997: 343)

Despite feminist researchers acknowledging the hierarchical power relations that have been embedded in the traditional relationship between the research and the researched (Oakley, 1981), being a woman still positions you lower in status during interactions and relationships. My initial anxieties echoed that of Arendell's questions, highlighting notions

of power obviously still present in male-female interactions today. The following sections of this chapter will outline areas during the research process where my gendered position created challenges, such as the recruitment process and interview setting, as well as consider where my position actually became an advantage instead. I have already discussed in detail the recruitment and interview process in the previous chapter (four), here I will discuss these parts of the research in relation to my positionality.

### *The challenges of gender in gaining access and recruiting male participants*

The recruitment procedure was one gendered aspect of the research process that was particularly challenging. As described in chapter four, I firstly decided to contact and recruit men from support groups. Immersing oneself in a research setting allowed the opportunities to talk those in that setting comfortably and so I took the opportunity to visit a number of support groups. However, I also felt it was inappropriate for me to sit in on the whole duration of the group. This was due to two reasons, the first being that some of the groups were specifically targeted at men as a 'safe' space for men to come together. I felt as a woman, it was not appropriate for me to be there for the whole duration of the group. Secondly, and although not specific to gender, other groups I approached aimed to provide a supportive space for people who may have been struggling with mental and emotional difficulties, isolation and loneliness and so I did not want to make other users of the support group feel uncomfortable with my presence. During one of the support group meetings I attended, I was asked questions by the women at the group, to do with my career plans after the research and whether I, myself had suffered any mental health difficulties in the past. Answering the latter then placed me as an outsider in a support group for people experiencing depression and anxiety. Nevertheless, my previous role as a support worker for a mental health charity opened up familiarity with the support group situation, offering a way into that setting and a starting point for discussion with the group. This previous work experience meant that I had knowledge of the problems some of the people accessing the groups might have been experiencing, as well as better understanding of how third sector groups and supports work.

In accessing male participants from support groups, my gendered position was generally not a problem in influencing the interactions that took place between myself and potential participants. This, I believe, was due to gatekeepers through which I accessed and recruited these participants. As explained in chapter four, I contacted and met with facilitators of the support groups first before speaking to men alone and they often introduced my research beforehand or asked me to give a short presentation to the group in more of a professional capacity. The presence of a group facilitator acting as a gatekeeper seemed to mediate any potential power imbalances that may have been created through the gendered researcher dynamic and the men recruited this way were always respectful of my position. As well as this, I felt that I was perceived as more of a professional researcher, and the subject of the research was particularly valued in this setting, which influenced the way the male participants from the support groups interacted with me. This competing form of positioning as an academic researcher seemed to hold more power in the interaction within this field location.

My gendered position produced more challenges when it came to recruiting men from public spaces, in particular leisure spaces such as pubs, rugby clubs and bars for example. When trying to locate and recruit men for interviews, being a woman, I was aware of my position as 'outsider' (Mannay, 2010). As described in chapter four, I chose to recruit the general population sample men from what I perceived as 'typically male' environments and institutions. These sites included pubs, football and rugby clubs, gyms, cafes, barbers, betting shops, golf clubs, working men's clubs and also workplaces. During this process I was met with a mixed reaction from men within the general public. In some instances, I was met with no response, with the men blanking or ignoring me, whilst other times I was pleasantly surprised with the positive interest in the research. Generally, a lot of men who I approached made jokes about themselves, men or mental health after reading the flyer. For example, when in a traditional city centre pub one man said:

*"Oh, you'll find lots of men with problems in this place",*

and another:

*"Oh, you don't want to talk to me I'm bloody nuts"*

[Field-notes: February 2017 evening time, recruitment in City Centre locations].

My recruitment approach was also commented on by some men, for example:

*"This is a bit strange picking up men in pubs"*

*"You're brave, fair play to you"*

[Field-notes: February 2017 after work hours, recruitment in pub chain in the city centre].

I did feel at times and in certain locations that it was 'brave' of me to attempt to recruit men in a way that could potentially place me in a vulnerable position. Before the recruitment had begun, I had not comprehended exactly how emotionally draining it might have been. I found the recruitment of men from public spaces challenging as it involved adopting an element of false confidence in approaching complete strangers, the majority of which were in places of leisure, and there was also a sense of being an intruder to their leisure space. In addition, in some of these spaces, such as pubs, it did feel strange being a young woman essentially trying to obtain men's contact details in these locations. This was resonated in some of the strange looks I received, particularly when asking if they would be interested and could I take their contact details. I wanted to get the right balance of being friendly and approachable enough for them to consider taking part in an interview but also remain professional as a researcher, as well as dissuade any unwanted attention in these particular settings. However, given the typically masculine environments I chose to recruit from, unwanted sexual innuendos, jokes and attention was somewhat unavoidable and there were notable times where I had to negotiate such situations carefully. For example, when recruiting from a local pub I approached a mixed group of both men and women of different ages. One of the men asked questions about it and read the recruitment flyer so seemed interested, but often turned to others in the group to make jokes about himself and his mental health during the discussion with me about the research. When I asked when he might be free for an interview he replied in a joke-like manner and then turning to his friends to laugh:

*"Uh you can come over about eleven pm tonight"*

[Field-notes: February 2017, mid-afternoon, recruitment from local pub]



I chose to laugh this off, deciding that ignoring the comments was the best way to deal with this situation during the recruitment process, despite it making me feel somewhat vulnerable and uncomfortable. Sharp and Kremer (2006) noted how difficult it can be for female researchers to deal with such sexual advances because researchers feel that the subject is doing them a favour by participating. At times I too felt like this and was aware of the need for participants to take part in my research. On reflection, if I were faced with a similar comment outside of the research process then I may have acted differently towards such remarks. For example, I probably would have walked away from this man. During the research process however, I wanted to remain professional. The aim was to recruit participants and from the beginning I was aware of the potential challenges of recruiting male volunteers and so I struggled with the dilemma of the best way to respond to such inappropriate comments. Other examples of similar situations included two older men asking:

*"Are you going to ask me about sex?"*

*"Is this a chat up line?"*

[Field-notes: February 2017, evening time, recruitment from City Centre chain-bar]

As observed in the discussion of ethical issues in chapter four, as part of the safety strategy that I had put in place, I always took someone with me when recruiting men from public locations. A friend in the smoking area overheard a man saying, *"Does she want a shag"* whilst holding the recruitment flyer. Another situation involved a man texting me (via the research phone) inappropriately a number of times, not long after I had handed him a leaflet in a local pub, despite me not replying to any texts.

Such experiences are not uncommon when women research men and many female researchers have written about similar experiences to this (Green *et al.*, 1993; Arendell, 1997; Lee, 1997; Gailey & Prohaska, 2011). Gurney (1985) called this 'sexual hustling', which involves male participants making sexual advances and displaying suggestive behaviours. Many of the men that behaved in this way often did so in front of other men, so depicting stereotypical male behaviour (Courtenay, 2000) in such masculine environments as the pub or football club. Following these situations, I became quite exasperated with the recruitment process and also with men in general. I felt frustrated

that men made me feel uncomfortable in this way even though my research was interested in men's mental health experiences and was attempting to give them a voice. This brings attention to how gender performances and power assertions are very much still present within male cultures (Poulton, 2012), such as pubs and bars etc. In certain contexts, men are still trying to exert power and subordinate women into lower status, through sexualising and performing dominant heterosexuality.

I persevered with the recruitment of men in public spaces despite my reservations of the kinds of behaviours that I now anticipated from men. Not all the men I approached made sexual jokes or behaved inappropriately towards me. There were some men who were positively interested, discussing issues to do with men's mental health. The challenging situations initially experienced however created anxieties about further potential participants. For example, I recruited a man from a local pub and when we arranged the interview via text message, I felt uncertain and uneasy about his replies. When I took a while to reply back for example, he sent another message asking if I had received his message and then when a time and date was arranged, he replied with '*look forward to seeing you*'. I felt that such messages appeared too eager and had the potential to put me in a vulnerable situation. As it turned out, this man was currently unemployed and having experienced depression saw the interview as an opportunity to discuss his experiences and it gave him purpose to his day. He was in no way inappropriate towards me, highlighting the influence of my position on future recruitment of participants and the vulnerabilities and uncertainty that a female researcher feels in such a setting.

As Poulton (2012), who was a female researcher in a hyper-masculine subculture, argued that qualitative research is messy, and researchers are required to dig themselves out of a hole or deal with awkward and challenging situations. It was important throughout the recruitment stage that I was constantly reflecting upon the impact of these experiences and emotions as a female researcher and how they may have influenced future aspects of the research process. I ensured I followed the ethical code and safety protocol that I initially put in place. Throughout the recruitment process I always ensured someone accompanied me to these male sites to provide a safety net should I find myself in any particularly vulnerable situations. For example, when I received a number of texts off a man who was currently in the same pub, I was grateful to have friend with me who I could leave with. Challenging situations such as the ones I have described in this chapter highlight

the need for such ethical protocols to be established from the beginning of the research process. Female researchers like Arendel (1997), Green *et al.*, (1993) and Sharp and Kremer (2006) suggested the need for researchers to trust their instincts in the field. As a result, on two occasions where I did not feel comfortable pursuing a man's interest and willingness to take part in the research then I did not follow it up and arrange an interview. Although this therefore influenced the sample, which was based on who I approached and chose to interview, researcher safety was the fundamental goal.

### *Doing gender in the interview context*

I will now consider gendered positionality during the interview setting. My female identity was also potentially problematic in this context, as participants may have changed their behaviour because of my gendered status. The interview can act as a site for men to perform gender (Salle and Harris III, 2001; Robertson, 2006b) particularly as the interview situation itself can be seen as a threat to a man's control and autonomy (Schwalbe and Wolkomir, 2001). It is difficult to say whether the performance of masculinity would differ with a male interviewer compared to a female interviewer. Schwalbe and Wolkomir (2001) argued that the interview process puts a man's masculinity at risk as he opens himself up to interrogation potentially placing him in a vulnerable position. This risk may be higher if the interviewer is also a man, with the threat of vulnerability in front of another man. In addition, the research topic of mental distress could have caused men to feel even more vulnerable in this interview situation. Due to the semi-structured interview being flexible in nature, there were some instances when some of the men in my study took charge of the conversation, often going off topic and taking the conversation in a different direction. However unlike for other researchers, (Green *et al.*, 1993; Arendell, 1997; Gailey and Prohaska, 2011) this was not necessarily a problem in my research and the men never tried to control the actual interview situation itself. Given my interest in their experiences of distress, I wanted them to talk in depth about their personal experiences or a particular life event that they deemed important in their account. So as per the nature of semi-structured interviewing, flexibility was warranted during the interviews. Where this happened, men sometimes paused and asked, "*Is this okay? Is this where you want to go?*" and so negotiating the interview interaction with myself.

Doing gender (Butler, 1990; West and Zimmerman, 1987) noticeably occurred on both the part of the participants and myself. When I prepared for each interview, I found myself consciously considering how I portrayed my femininity, and I carefully chose how I dressed and how much make-up I wore. I developed a kind of uniform for interviews, usually consisting of black jeans or trousers, a smart-casual shirt and boots. Other female researchers have described doing this to avoid the likelihood of sexual advances (Pini, 2005; Sharp & Kremer, 2006; Gailey and Prohaska, 2011) and this too was a reason to dress more conservatively. Regardless of whether it was a man or woman I would still want to look professional, but on reflection would I have put so much consideration into the amount of makeup I wore had I been interviewing women? I felt that if I was interviewing women, I would not have been worried about looking like I had too much make-up on. Gill and Maclean (2002) claim that female researchers cannot simply “hide” their sexuality from public view. When talking to colleagues, someone suggested I could put a ring on my wedding finger to avoid any sexual advances during fieldwork. I did not feel this was appropriate and similar to Lee (1997), who also considered doing this in her study of lone fathers, I felt that it would be deception, as well as further creating a gendered construction.

In some instances where the participants were recruited via snowballing, I had had no prior contact with them before meeting for an interview, except for a few text messages. These “cold call” interviews have the highest level of risk (Sharp and Kremer, 2006) and so the location of the interview was an important factor in minimising any potential risk. As discussed in chapter four, safety strategies were put in place within the design of my project. Paterson *et al.*, (1999) suggested that whenever possible, researchers should meet participants in public places and during the day. I followed this and only met participants for interviews in public places that included mainly coffee shops or local pubs during the daytime. I always informed someone of where I was. Lee (1997) explored issues of interviewer vulnerability for women interviewing men and similarly, she interviewed her male participants in a public setting. However, Lee worried about the ethical responsibilities to interviewees. Lee (1997) acknowledged that while interviewing men in their own home could place women in potentially dangerous situations, conducting interviews in public places may also put men in difficult situations as they may not want their experiences to be overheard (Lee, 1977: 563). I considered such potential ethical dilemmas with meeting men in public spaces, particularly given the topic of mental distress

and as the interview would involve them potentially disclosing vulnerabilities and emotions. Nevertheless, neither my supervisors nor I felt comfortable with the interviews taking place in men's own homes and as noted previously, researcher safety was the utmost concern. I overcame this ethical dilemma by offering participants to choose a public space that they felt comfortable with for the interview to be held, and then I would find a quieter area of the location.

There were numerous occasions during the interviews where men offered to buy me a drink (usually a coffee) and I was faced with the dilemma of whether to accept this. In these cases, I usually replied that I would get one for myself or offered to buy them one as gratitude for taking part in the research. Often the men insisted that they would get the drink and so I felt rude not to accept this, as well as wanting to build rapport and make them feel comfortable within the interview setting. In the instances when men would not let me buy them a drink of gratitude, I accepted a coffee or soft drink off them. This sometimes made me feel awkward as a researcher because I felt that they were the ones doing me a favour by participating in the research. It could be suggested that this situation highlights that male respondents are conscious about fulfilling masculine expectations (Salle and Harris III, 2001: 425), such as being the provider and the one in financial power by offering a beverage. This exposes power struggles that play out during the interview situation, particularly with a young woman interviewing men. These situations were in cafes and so I did not ever accept an alcoholic drink off any participants.

It has been suggested that rapport and reciprocity is often more easily achieved through 'same-sex' interviews (Williams and Heikes, 1993; Broom *et al.*, 2009). Resisman (1987) found that her interviews were 'hindered by a lack of shared cultural and class assumptions' (1987: 190). Bearing this in mind, my interviews too could have potentially been hindered by lack of insider researcher status as I was not a man, nor was I of the same age to most participants and in some instances of the same social background as my participants. Some might argue then, that there should always be race, gender and class matching between respondents and researchers (Byrne, 2004: 213). This may have granted a better insight and understanding into the participants' lived world. However, the subject of the research must also be taken into consideration. Winchester (1996) suggested that during the interview men may use opportunities to exert power over the female researcher and so stereotypical gender discourses that suggest that women's role in conversation is to

be an empathetic listener are often reinforced. As discussed above, this was not a problem within my research. Despite challenges during the recruitment process because of my position as a young woman and holding outsider status, I actually found that being female and being located in the traditional femininity discourse by my male participants was instead advantageous for the research. I believe this was because of the subject of the research being mental and emotional health, a typically feminine domain, and so men felt more comfortable speaking to women about such issues.

Horn (1997) found that being assigned a 'traditional' female role, which is often perceived as harmless and unthreatening, might allow women to access research areas that may be barred to male researchers. When women interview men there has been the general view that men may actually feel more comfortable talking about intimate topics with women than with other men (Williams and Heikes, 1993; Arendell, 1997; Lohan, 2000). I found this to be true throughout the fieldwork as the men opened up to me in-depth regarding their personal stories and experiences, for example discussing personal life events that had led to distress and emotional difficulties. As McDowell (1998) claimed, it is the subject of the research not just the identities of the researcher and researched that shape the interview. The men in Lohan's (2000) research perceived women to be 'naturally' more interested in the personal and emotional and so found it easier to discuss personal matters with a female interviewer. One of the participants said that he had never spoken about his experience and feelings to anybody else before this interview. Many of the participants in this study, from both sample groups, reiterated this point and a key finding that emerged from the research (discussed in more detail in chapter nine), is that men explicitly talked about feeling more able to discuss emotions and difficulties with women rather than men. I observe here that such remarks could be an artefact of me being female in the construction of their accounts and I cannot know that what they say is truth. They may have just been saying this to please me. Additionally, though, some of the men from the general population sample said after the interview that it felt cathartic to open up about previous experiences, for example one man said after the recorder had stopped, *"wow didn't know all that was there"*. Such examples highlight that although my gender proved to be a challenge in the recruitment stages, during the actual interviews, being a young woman instead placed me in a position of advantage, to which the men felt they could share things that they might not have shared with others, due to the sensitive nature of the topic and the confidentiality of the research interview.

I refer back to Arendell's question mentioned earlier, "is a woman studying men a 'low status stranger' (Daniels, 1976), an outsider (Sway, 1981; Naples 1996) or an outlaw, positioned by the participants into subordinated status?" (Arendell, 1997: 343). During the interviews I had not felt that I was being positioned as subordinate or a low status stranger but positioned instead within the traditional feminine discourse of empathetic listener. During some interviews, both with men from support groups and men from the general population, the men would sometimes apologise to me if they had said something that they thought might be sexist for example, or inappropriate. Again, it could be that their apologies were because I was positioned as a young, empathetic woman in addition to the participants' renegotiation of their masculinity within the interview setting. The statement and the apology can both be interpreted as a performance of a gender binary. This also highlighted pressure to enact masculinity amongst other men and within masculine environments that were performed throughout the recruitment procedure.

Salle and Harris III (2011) found that in two different studies of male University students, the responses from their male respondents changed depending on whether they were interviewed by a male or female researcher. This highlights how cross-gender interactions can influence the research and I contemplate how different the interviews and the data collected would have been if I were a male researcher. Would my participants disclose such emotional experiences and events if I were male, or if they did, would their accounts of experiences be constructed differently? It is important to note that in my study however, I cannot say for certain whether my gender was an obstruction or advantage because the study has not been carried out a second time in exactly the same way by a male researcher.

Pini (2005) claimed that it is likely that male participants will engage in more pronounced identity work as their masculine selves may be viewed as central to the research. As this thesis is interested in men's mental health, they could have viewed their masculine selves as a central focus. Yet as the topic is mental health and emotional difficulties, it may be that they constructed their masculine identity as more flexible and fluid, one that involves helping others (through participating in this research) and being proactive and in control, through engagement with their health and research on men's mental health (Spendelow, 2015). When acknowledging and understanding the influence of gender and interviewing it is therefore important to critically reflect on the influence of the research question also.

## Interplay of gender with other attributes

In this chapter so far, I have discussed how the gender incongruence between participants and myself influenced the relationship and interactions that took place. It would be misrepresentative to talk of only gender as a thing by itself, as something not intersecting with other traits such as age, ethnicity, sexuality, faith and personal and professional relationships (Thomas, 2017). It is also important to acknowledge how gender becomes articulated with other interpersonal aspects of the researchers-self. Tarrant (2014) was concerned that when only examining gendered power relations between men and the female researcher, it does not include the complexity of those interactions. In my research, I was initially conscious that I look younger than my age, and that (combined with my gender) may influence the power dynamic with my participants.

As part of the criteria for my sample, I was particularly interested in middle-aged men but also aimed to recruit a broad cross-section of ages, so the age of my participants had the potential to influence the interaction during the interviews. The majority of the men recruited through the support groups were middle to old aged. One such support group was targeted for older men specifically. During the interviews with some of these older men I noticed some age-based subjectivities. For example, when those men who had been in the army talked about war some said things like *“you are too young to remember that”* or *“of course, you wouldn’t know that”*. Here, my outsider status meant that they had to explain things to me, changing the interview power dynamic slightly. Another example is when men recalled particular songs or TV programmes there would be comments such as *“that’s way before your time”*. Despite such comments, and some of the male participants explicitly referencing my age, I felt that it did not hinder the data collection. I believe my status, as a relatively young research student was instead valuable, as it seemed my participants felt comfortable talking at length with me about an emotional subject. Similarly, Gurney (1985) found in her study that her gender, youthful appearance and student status created an impression of being non-threatening and so easing her participants’ initial anxieties regarding the research. Moreover, Dingwall (1980) referred to ‘personable young women’ (Dingwall, 1980: 881) in research, and how it is the combination of gender, age and personality that makes for empathetic interviewers. Dingwall (1980)



also suggested that such researchers should be used in studies of 'powerful older men' (Dingwall, 1980) as they might be again observed as unthreatening.

Status relations and subject matter are also key influences on the interview process (Brown, 2001). My status as a doctoral student researcher was also potentially influential to interactions that took place, in both the recruitment and interview stages of the research, and as noted, intersected with other positions such as gender and age. Researchers conducting interviews hold some power in the research situation over their research participants yet as noted throughout this chapter, being a young woman intersects with this position and creates certain power struggles. Being a woman had the potential to position me as lower status, but being a researcher also elevated my status. As I have discussed, during the interviews being a researcher and a woman seemed to become an asset instead. My participants respected my position as a female, PhD research student, exploring what they appreciated was an important topic of men's mental health experiences. With my participants valuing the subject matter and perceiving my status as a non-threatening, female research student, the potential for power struggles to influence the interactions during the interviews was minimised.

## Conclusion

This chapter has explored my experiences as a young female researcher researching men about their mental health experiences and how this position and my identity influenced various aspects of the research process. Being a young woman recruiting, interviewing and writing about men's distress had the potential to create problematic and challenging situations throughout the research process. During the recruitment of participants, I experienced feelings of vulnerability, and had to endure sexist remarks and inappropriate behaviours from men. Following this, I then had to negotiate the interview setting carefully in order to facilitate the interviews and ensure researcher safety. Despite issues I faced at times, being a young woman actually became an advantage within data production rather than an obstruction. Participants seemed to position me as understanding and empathetic and were able to discuss at length their mental health and experiences of distress. Essentially, my gender became a 'useful tool' (Poulton, 2012). It is important to note that throughout the research process, gender performances were not unique to the male

participants, and I also notably performed gender during both the recruitment and interview process. It is essential to reflect on the ways in which both my participants and I constructed and performed gender during the research process and how this can influence the data collected.

As noted in this chapter, my position was multi-dimensional. The interviewees and I during the interview situation occupied several different social locations, including intersections of gender, race, age, and social class. This chapter has reflected in more depth on gender and such challenges it brought with it. Reflecting on such interactions within the research process point to it being more complex than gender. Significantly, this chapter has highlighted the paramount importance of being reflexive throughout the research process and acknowledging contrasting positions from early on.

# Chapter Six - Secondary data analysis: Contextual factors that predict men seeking help from the GP

## Introduction and overview

This chapter begins the exploration into men's mental health help-seeking practices and sets out some context for the following qualitative interviews. I used secondary data analysis of The Adult Psychiatric Morbidity Study 2007 (APMS07) to explore the contextual factors (for example, age, marital status, social class and life events experienced) that affect the likelihood of a man speaking to a GP about emotional issues. Using a large sample with nationally representative context, I wanted to set out to explore the prevalence of men's help seeking for emotional difficulties and distress. A chi-square test and a binary logistic regression model was used to answer the following research questions:

**RQ1 – What are the social contexts that predict help seeking from a GP for a mental, nervous or emotional problem?**

- a. Can a significant relationship be identified between socio-economic status and whether a man had spoken to the GP about any emotional or mental difficulties?
- b. What are the other contextual factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional problem?

Firstly, I will provide background for this chapter within the wider thesis. I will then briefly discuss the chosen dataset. Following this, each research question will be addressed in turn, justifying choices for variables and method and then interpreting the results.

## Background

The influence of social, contextual factors (such as age, social class and marital status) on help seeking has often been overlooked by the focus on the substantial impact of psychological factors such as embarrassment, fear or shame, as well as masculine beliefs or attitudes (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005; Mansfield *et al.*, 2005; O'Brien *et al.*, 2005). Yousaf *et al.*, (2015) however, argue that there is a need for help-seeking theories to encompass both psychological factors such as attitudes and contextual factors such as socio-demographics (Yousaf *et al.*, 2015: 272). Although contextual factors (such as socio-demographics) and psychological factors (such as attitudes) are quite often related (e.g. attitudes and beliefs of older men may differ to those of younger ages), it would be useful to highlight the social contexts that might have an impact on asking for help when it comes to experiencing emotional distress. Much of the work on men's mental health and help-seeking behaviour often refers to help-seeking attitudes and beliefs in relation to attempting to live up to masculine practices, rather than structural and social contexts that might impact on help seeking. This is something that the thesis has attempted to explore and through the use of a quantitative method this chapter focuses specifically on the element of contextual factors in relation to help seeking.

Recently there has been a growing concern about whether men underutilise primary healthcare services (Robertson and Williams, 2009; Branney *et al.*, 2012). As previously discussed in chapter three the dominant narrative surrounding help seeking and men is that men typically do not seek help for emotional problems because of the construction of traditional masculine norms (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005; Mansfield *et al.*, 2005; O'Brien *et al.*, 2005). Stereotypical notions of masculinity that emphasise men's need for control and independence, have continuously been highlighted as the main barriers that men face in seeking help for mental health difficulties. In Yousaf *et al.*, 's (2015) systematic review and meta-analyses, they found a number of help-seeking factors with the four major ones being: embarrassment/ anxiety/ distress /fear related to using health-care services; need for emotional control/ guarded vulnerability; viewing symptoms as minor and insignificant; and poor communication with health professionals (Yousaf *et al.*, 2015: 271). In addition, logistic regression by Doherty and Kartalva-O'Doherty (2010) found that the strongest

predictor of help seeking from the GP for males was self-reported embarrassment associated with seeking help from the GP.

The factors outlined in the studies presented above could be viewed as 'psychological factors', referring to male attitudes, beliefs and behaviours. Specific contexts and structural factors (such as age, social class, marital status etc.) may also influence help seeking behaviour and should be taken into account when exploring the prevalence of men's help seeking. For example, factors such as marital status and education have been found to influence help-seeking behaviour (Parslow and Jorm, 2000; Simon, 2002). The benefits of education on wellbeing are also well known and further education can impact on attitudes to help seeking (Smith *et al.*, 2008). However, socioeconomic class has often been left unconsidered. In relation to social class and socio-economic status, it has been claimed that unemployment appears to be linked to both gender and class. Artazcoz *et al.*, (2004) found that the impact of unemployment is greater on the mental health of men than women. Yet unemployment as a factor that predicts help seeking for distress has rarely been explored. Dolan argues that when exploring health outcomes for men, studies have largely ignored social class, both as an independent influence and one that interacts with gender (Dolan, 2011). Springer and Mouzon (2011) however attempted to explore the interaction between socio-economic status and masculinity on older men's help seeking and found that the impact of hegemonic masculinity on help seeking behaviours varies depending on socio-economic status. Thus, socio-economic can have an influence on help seeking behaviours. However, Springer and Mouzon (2011) explored help seeking for a range of general health problems, not specifically mental health, and they also did not consider the effect of socio-economic status alone, only its interaction with masculinity.

This chapter therefore attempts to address and explore further some of the contextual factors that predict help seeking in men. Examining what contexts influence men to take the initial step to speaking to a doctor about emotional problems will act as good groundwork for the following qualitative interviews that explores routes of formal help-seeking, including accessing support groups. Findings from the quantitative secondary analysis in this chapter provide a starting point to develop an understanding of men's experiences of help seeking. Accordingly, this chapter will form as a contextual basis for the qualitative part of the thesis. I now turn to describe the chosen dataset used to explore men's help seeking for distress.

## Dataset selection

The Adult Psychiatric Study in England 2007 (APMS07) was selected after a search of all potentially suited data sets available in the Economic and Social Data Service, part of the UK Data Archive (search conducted in 2016). It was a requirement for potential studies to have variables on common mental health difficulties and emotional problems, as well as variables on help-seeking behaviour (for example help-seeking behaviour could include: visiting or talking to a GP; attending support groups or day services; counselling and; initially telling family or friends about the problem). The dataset search process is described below.

I decided first to search for data sets that addressed 'mental health'. This presented 906 results. Examples of some of the results are 'Mental Health Surveys 2004-2005', 'Mental Health Trusts: Community Mental Health Service User Survey', 'Mental Health Inpatient and Day Care' and 'Mental Health of Children and Adolescents in Great Britain'. On searching through these, it became apparent that the majority of the results were studies that had variables on people already in contact with mental health services. In addition, a lot of studies focused on adolescents and children. These did not meet the requirements of the research questions for my study because I was interested in adult men and also help seeking for distress more generally, rather than community mental health care and service use.

Also among these results there were potential options such as 'Welsh Health Survey 2014' and 'Health Survey for England'. The 'Welsh Health Survey' was of particular interest because it was carried out in Wales, which was consistent with where the qualitative component of the research was carried out. It included statistics on the health and health-related lifestyle of people living in Wales, including some mental health statistics. However, when exploring it further, I was concerned with how the variables focused on general health more than mental health. There was a question about diagnosis of depression or anxiety in the 'Welsh Health Survey' but no other mental health variables. This study also did not include any variables that related to mental health help seeking and only included variables that approached service use more generally. Although carried out in Wales, the study would not have provided any understanding into what would influence

men to seek help for emotional distress and so did not meet the criteria to answer the research questions.

After reviewing the available datasets that could have potentially been used, the Adult Psychiatric Morbidity Study 2007 was found to have key variables that I needed for my analysis. This study had relevant information on both mental and emotional problems and seeking out help for such issues. It is worth noting here that this study was carried out in England, so the data is of people living England, whereas the qualitative part of my research recruited men living in Wales. As discussed above, the decision to not use a Welsh dataset was due to there being no surveys that were carried out in Wales that held information relevant to address and answer my research questions.

### *Data set information*

The Adult Psychiatric Morbidity Survey 2007 dataset was selected as the most appropriate within the UK Data Archive because the series has had a huge impact on the understanding of mental illness, substance dependence and suicidal behaviour, and their causes and consequences, and so fully met the criteria of this thesis. The aim of the survey is to provide up-to-date information about the prevalence of psychiatric problems among adults in Great Britain, as well as use of services and associated disabilities. The Adult Psychiatric Morbidity survey is carried out every seven years, starting first in 1993. At the time of analysis and writing up, the most recent survey, APMS14 was being developed, with the results published by the Health and Social Care Information Centre late September 2016. The dataset was not made available on the UK Data Archive until June 2018. Due to the time frame and schedule of the thesis, I was not able to use the APMS14 and so chose the most recent survey that was available to me, APMS07.

The survey is part of a series entitled 'Surveys of Psychiatric Morbidity in Great Britain' which 'provides data on the prevalence of both treated and untreated psychiatric disorder in the English adult population' (NHS Digital, 2009). It is the primary source of information on psychiatric problems and their associations, and such data cannot be obtained from other sources. This survey is the third in the series and was conducted by

the National Centre for Social Research in collaboration with the University of Leicester for the NHS Information Centre for health and social care.

The main aim of the 2007 study focused on mental health among adults aged 16 and over living in private households in England. Fieldwork for the survey took place between October 2006 and December 2007. The survey adopted a multi-stage stratified probability sampling design with a total sample size of 7,403 adults that was designed to be representative of the population living in private households in England. The sampling frame was the small user Postcode Address File (PAF) and one adult aged 16 years or over was selected for interview in each household. The methods of data collection were a self-completion questionnaire and two phases of face-to-face interviews using computer-assisted interviewing software. The survey data was weighted to take into account non-response.

As with the previous surveys (1993 & 2000), a two-phase approach was used for the assessment of several disorders. The first phase, which was carried out by NatCen interviewers, included structured assessments, serving diagnostic criteria and screening instruments for mental disorders as well as questions about other topics such as general health, service use and risk factors and demographics. The second phase was carried out by clinically trained research interviewers employed by the University of Leicester: a sub-sample of phase one respondents were invited to take part in the second phase interview to allow assessment of psychosis, borderline and antisocial personality disorder and Asperger syndrome.

The survey aims included: to estimate psychiatric morbidity and examine trends in psychiatric disorders over the years, to identify the extent to which social disadvantage is associated with mental health issues, to determine the level of treatment and service use in relation to mental health problems with emphasis on primary, and to collect data on key lifetime factors that might be associated with mental health problems such as experience of stressful life events (including bereavement, crime, financial troubles), abusive relationships and work stress. Data from the survey can help doctors and other health professionals get a better picture of people's health and wellbeing in the UK. Specific to my thesis, the APMS07 provided detailed information on service use for mental health problems.



The APMS07 has a wide range of variables and so can be used to explore various issues relating to psychiatric problems. Issues and topics that have been previously explored using the APMS07 include the relationship between loneliness, common mental disorders and suicidal behaviour (Stickley and Koyanagi, 2016), mental health in non-heterosexual populations (Charkraborty *et al.*, 2011), the relationship between common mental disorders and employment (Ford *et al.*, 2010), and social work contact with suicidal individuals (Slater *et al.*, 2015).

Having provided information about the chosen dataset, I will now turn to discuss the choice of dependent variable used in the analyses. Following this, I will address the research questions. Before I chose variables and carried out any analyses, including descriptive statistics, I excluded women from the dataset sample as the research was only interested in men's experience of common mental disorders. The number of men in the sample was 3197 and this was the sample that was used throughout.

## Identifying the dependent variable

One dependent variable was used for both the quantitative analyses - chi-square and logistic regression - in order to answer the research questions. The choice of dependent variable is now discussed. The APMS07 has 1,754 variables (including some derived variables) ranging from basic demographic information to detailed information on mental health disorders. My thesis was interested in men, help seeking and coping with distress and as noted so far there has been limited work that has explored the contextual factors (such as socio-demographics) that predict help seeking in men for emotional distress.

Help seeking when experiencing mental and emotional distress can take many forms. There was a range of variables available in the APMS07 that could have been used to measure help seeking for mental health problems. These included: currently having counselling or therapy for mental, nervous or emotional problems; currently having psychotherapy, psychoanalysis, individual or group therapy; currently having behaviour or group therapy; spoke with GP about a mental, nervous or emotional complaint in past 12 months; spoke with GP about a mental, nervous or emotional complaint in past 2 weeks; community care – psychiatrist in last 12 months; community care – psychologist in last 12

months and; community care – self-help/support group in last 12 months. Given that the wider thesis was interested in men's help seeking experiences generally, I felt that focusing on men's first point of contact with a primary care health professional about emotional problems or mental distress would provide context for the qualitative analysis. The qualitative research in the subsequent chapters will then further explore this route of help seeking and also address other types of help seeking such as support groups. I could have used the variable 'community care – self-help/support group in last 12 months' in order for both the quantitative and qualitative components of the research to match up as I recruited men from support groups. However, the frequencies for this variable were much too low, with only .8% of men ( $n=25$ ) mentioning that they had been to self-help/support groups in the past 12 months, whilst 92.7% ( $n=2964$ ) of the men fell into the 'item not applicable' category of this variable. The frequencies were therefore too low for this variable to be used in any viable analysis.

The GP is usually one of the first routes to seeking formal help for people experiencing distress. It seems it would be useful to attempt to explore this through the use of quantitative methods using a secondary dataset. Unlike Doherty and Kartalava-O'Doherty (2010), I will not use psychological factors such as attitudes and embarrassment. This is partly due to the variables included in the dataset chosen but also because I felt it was necessary to begin by concentrating on the structural contexts and factors that may have played a part in men's help-seeking and talking to a GP about distress. I decided then to use responses to the APMS07 question 'In the past 12 months, have you spoken to a GP or family doctor on your own behalf, either in person or by telephone about being anxious or depressed or a mental, nervous or emotional problem?' (response: 'Yes' or 'No'). This was labelled DOCPSYC in the dataset. As this question asked about the last 12 months, it meant that the help seeking was more recent for the male respondents and not as restrictive as the variable that asked for the past two weeks. Furthermore, this variable was the one with the highest frequencies.

In order for the results of the logistic regression analysis in the following section to make sense, it was firstly important that the coding of responses for each of the variables was set up carefully. The value of 0 should be used for the response that indicated a lack or absence of the characteristic of interest. So therefore, I recoded the answer No to the question 'Have you spoke with a GP or family doctor about a mental, nervous or emotional

complaint in the past 12 months?’ to 0 and the value of 1 was used to indicate a Yes answer.

Only .0% ( $n=1$ ) of the sample population of men were missing from this variable. Table 4 shows that the distribution of data indicated that the vast majority 91.7% ( $n=2933$ ) of male respondents had not spoken to their GP or a family doctor about a mental, nervous or emotional problem in the last 12 months. Only 8.2% ( $n=263$ ) had spoken to a GP or family doctor about a mental, nervous or emotional complaint in the past 12 months.

**Table 4 – Frequencies for ‘DocPsysc’**

GP: Spoke with about a mental, nervous or emotional complaint in past 12 months	
	Frequency
No	$n=2933$ (91.7%)
Yes	$n=263$ (8.2%)
Missing	$n=1$ (.0%)
Total	3197 (100%)

The variable DocPsysc was used as the dependent variable for both statistical analyses that were conducted (a chi-square and binary logistic regression) and through using this variable I was able to highlight some of the contextual factors that predicted men seeking formal support and help for distress from the GP.

### **Question One – Can a significant relationship be identified between socio-economic status and whether a man had spoken to a GP about any emotional or mental difficulties?**

Firstly, I was interested in establishing if there was a relationship between socio-economic status and men’s help seeking. There have been limited studies on the mental health experiences of men of different social class positions and in particular relations between social class and mental health help seeking. It is important to consider social class in relation to men’s mental health help seeking because the intersection of social structures

and contexts other than just gender can influence how men respond to health issues (Griffith, 2018). I felt it was important then to consider social class when exploring men's help seeking. Furthermore, as presented in the literature review in chapter three, many social science studies on men and their mental health have often failed to examine a broader sample population of different men. One of the main aims of this research was to attempt to access a more diverse and heterogeneous sample population of men, so it was therefore appropriate to begin by investigating any relations between social class and men's help seeking. Through quantitative data analysis, I wanted to identify any possible associations so first set out to establish whether a significant relationship between social class and help seeking could be identified. As discussed in the section above, the dependent variable of interest identified was 'DocPsyc: In the past 12 months, have you spoken to a GP or family doctor on your own behalf, either in person or by telephone about being anxious or depressed or a mental, nervous or emotional problem?' and this was used as the dependent variable as it specifically addressed formal help seeking.

### *Identifying a social class independent variable*

In order to answer research question one, the second variable I was interested in was socio-economic status. There were several variables within the dataset that addressed 'social class' or 'socio-economic status' and it was important that I defined how I was planning to operationalise social class. The variables that I considered were: social class, nssecR (national statistics socio-economic classification) employment status, highest educational qualification, employment status and equivalised income quintiles. For the purpose of answering research question number one, one socio-economic class variable needed to be selected.

The APMS07 uses the national statistics socio-economic classification to operationalise socio-economic class in the survey. I decided to adopt the NS-SEC measure for the purpose of my analysis, instead of the other possible social class variables mentioned, because of its long-standing use as a measure within the UK. Occupational social class has long been used to measure social class in the UK and so the NS-SEC (National Statistics Socio-Economic Classification) was constructed to measure the employment relations and conditions of occupations (Goldthorpe, 2007). The NS-SEC

portrays the structure of socio-economic positions in modern societies. The categories within the NS-SEC distinguish different positions (not people) as defined by social relationships in the workplace, that is, by how employees are regulated by employers through employment contracts (ONS, 2010). Furthermore, the NS-SEC measure has been used frequently by other researchers in other studies. Mellitzer *et al.*, (2010) used the five-class version of the self-coded NS-SEC in their analysis that examined the relationship between job security and depression among workers and investigating whether this is mediated by their socio-economic circumstance. Research such as this shows how the NS-SEC can be applied when exploring it in relation to health-related outcomes.

Within the conceptual model, it is possible to have eight, five and three class category versions of the NS-SEC. In the APMS07, the researchers derived the variable into a five-class version. This derived variable 'nssecR (D) SOCIO DEMO RESP nssec 5 variable classification' has 7 values:

1 = "Managerial and professional occupations", 2 = "Intermediate occupations", 3 = "Small employers and own account workers", 4 = "Lower supervisory and technical occupations", 5 = "Semi-routine/routine occupations", 6 = "Never worked/not worked in last year", 7 = "Not classified for other reason".

Using the ONS (2010) guidelines and also due to my own research aims, I decided to recode their derived five class version variable into a four-classification version. Another reason I wanted to recode it down to less class categories was because of the statistical analysis that I wanted to undertake. In their classification 'never worked/not worked in last year' and 'not classified for other reason' was not included as a class category. However, in my variable 'never worked/not worked in last year' was included as class category four. The final recoded four categories were as shown in table 4: 'Higher managerial, administrative and professional occupations', 'Intermediate occupations', 'Routine and manual occupations' and 'Never worked and long-term unemployed'.

For complete coverage, the ONS (2010) guidelines state that in the analytic classes, the three categories: students; occupations not stated or inadequately described; and not classifiable for other reasons, are added as 'not classified'. No matter how many rules are devised, there will be some adults who cannot be allocated to an NS-SEC category. In this case, I recoded 7 = "Not classified for other reason" into "missing". The new variable was

labelled **"Socio\_economic\_status"** and the frequencies for this new variable as well as for the original variable can be seen on the next page in table 5.

**Table 5 – Frequencies for original socio-economic class variable and for recoded socio-economic variable**

Original APMS07 five class variable – 7 values ‘nssecR’		Recoded four class variable – 4 values ‘Socio-economic status’	
1. Higher managerial, administrative and professional occupations	<i>n</i> =886 (27.7%)	1. Higher managerial, administrative and professional occupations	<i>n</i> =886 (27.7%)
2. Intermediate occupations	<i>n</i> =112 (3.5%)	2. Intermediate occupations	<i>n</i> =382 (11.9%)
3. Small employers and own account workers	<i>n</i> =270 (8.4%)		
4. Lower supervisory and technical occupations	<i>n</i> =252 (7.9%)	3. Routine and manual occupations	<i>n</i> =760 (23.8%)
5. Semi-routine and routine occupations	<i>n</i> =508 (15.9%)		
6. Never worked and long-term unemployed	<i>n</i> =1049 (32.8%)	4. Never worked and long-term unemployed	<i>n</i> =1049 (32.8%)
7. Not classified for other reason	<i>n</i> =90 (2.8%)	Missing	<i>n</i> =120 (3.8%)
Missing	<i>n</i> =30 (.9%)		
Total	3197 (100%)	3197 (100%)	

Having identified an appropriate independent variable to do with social class, the next section will discuss the analysis that was used (chi-square test) to explore the relationship between this socio-economic status variable and help seeking from the GP.

## Statistical Analysis: Chi-Square results

To explore the relationship between socio-economic status and GP contact regarding a mental complaint, a Pearson's chi-squared test using the two variables was selected and performed.

**Table 6 - Cross-tabulation for 'Socio-economic Status' by 'GP: Spoke with about a mental, nervous or emotional complaint in past 12 months'.**

nssecR recoded\*GP: Spoke with about a mental, nervous or emotional complaint in the past 12 months

	GP: Spoke with about a mental, nervous or emotional complaint in past 12 months		
	No	Yes	Total
Higher managerial, administrative and professional occupations	836 (811.7)	50 (74.3)	886
Intermediate occupations	356 (350.0)	26 (32.0)	382
Routine and manual occupations	695 (696.3)	65 (63.7)	760
Never worked and long term unemployed	931 (960.1)	117 (87.9)	1048
Total	2818(2818)	258 (258)	3076
Chi-square test	$\chi^2 = 20.468$ $df = 3$ $p = .000$		

Observed frequencies out of brackets and the expected frequencies are in parenthesis e.g. 50 (74.3)

The Pearson's chi-square was used to compare the proportion of cases from a sample with those from a comparison population (Pallant, 2013). 'Expected' and 'observed' frequencies were therefore used to explore hypotheses: the expected frequencies indicated what would happen if the data was evenly distributed across the cells, whilst the observed frequencies indicated what has actually happened. From the Pearson's chi-squared test (Table 6) ( $\chi^2(3) = 20.468, p = .000$ ), we can see that a significant relationship can be



identified between socio-economic status and whether or not a man had spoken to a GP about a mental, nervous or emotional complaint in the past 12 months. In answer to the research question, there was an association between socio-economic status and help seeking from the GP.

Here I can start to explore where something might have been happening by looking at the difference between the observed and expected frequencies. For those in higher managerial, administrative and professional occupations, the observed count of men who said they had spoken to their GP was 50, but the expected count was actually 74.3. (Odds ratio =  $50/74.3 = 0.67$ ), so this means that men in those occupations were less likely to speak to their GP than would be expected. This was contrary to existing literature that suggests that those men in higher middle classes have more social and emotional capital and so may be better educated when it comes to their health, as well as having better access to support and therefore take steps to manage it and seek out help (Seale and Chariteris-Black, 2008; Farrimond, 2011). The actual observed frequencies presented here being lower supports the argument that men who have achieved one aspect of dominant masculinity (i.e. higher socio-economic status) might be particularly hesitant to losing this masculine status by asking for help (Courtenay, 2000). Or in relation to context, these men could have less time due to work commitments and so seek out of other ways to manage distress.

Conversely, there were 117 men who had never worked or were long term unemployed and have spoken to a GP about a mental, nervous or emotional complaint in the past twelve months, whereas the expected frequency was less, being 87.9 (Odds ratio =  $117/87.9 = 1.33$ ). This means that men who were out of work were nearly one and half times more likely to seek out help from the GP than was expected. This however is partly a function of the majority of the men in the sample falling into this socio-economic group. There are a number of possible interpretations of this effect though. One could be that those who have never worked or are long term unemployed have a higher prevalence of mental health complaints and distress, which studies have suggested in the past (Artazcoz *et al.*, 2004). An alternative interpretation is that this socio-economic group of men could be in touch with a GP more often because they had more free time to visit the doctor, and may be on long-term sick leave and so would be in frequent contact with the GP due to needing the paperwork to be signed off work.

## *How do we know what is going on?*

The significant result between speaking to the GP and socio-economic class differs to the some of the existing literature (chapter three). Previous research has in contrast suggested that working class men are less likely to speak to the doctor about such emotional problems, and middle class men are the ones who are supposedly more likely to have knowledge and access to health and healthcare (Courtenay, 2000; Seale and Charteris-Black, 2008) and so value being healthy and proactive in their health management practices (including help seeking). There are three explanations for this. Firstly, more research on social class and men's mental health help seeking is needed as it could be that the men in the lower classes in this study were aware of their mental health and did talk about mental health problems whereas the men in higher social classes are actually the ones who endorsed traditional masculine beliefs about asking for help and therefore did not speak to the GP. The second explanation, as discussed above, is that this group of men in the lower socio-economic classes could have actually been experiencing more mental health and emotional problems and it is this experience that meant that they were more likely to speak to the GP. The third explanation is institutional: that those men who were out of work had to work closely with their GPs in order to retain benefits and support. Whether this group of men were more willing to talk about emotional problems or whether they have had more mental health issues to begin with is a confounding theme that is present throughout the chapter. However, this does not have to be an either/or question and it is important to consider the possible explanations. To further explore such possible explanations and lived experiences of help seeking across different groups of men was a reason for using qualitative methods and analysis.

The significant relationship from the chi-squared test indicates that socio-economic status and help seeking is related. In answer to the first question, I was able to establish that a significant relationship existed between what socio-economic class category and whether a man had spoken to a GP about a mental, nervous or emotional problem. Following this, I also wanted to explore and consider what else it was that influences a man to speak to a GP about a mental problem.

## **Question two: What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional problem?**

The previous section answered research question 1(a) and established that a significant relationship did exist between socioeconomic status and contact with the GP regarding a mental or emotional problem. However, what socio-economic class a man belongs to cannot be the only factor that might influence whether he will speak to his GP about a mental or emotional problem. I also wanted to explore under what other circumstances men might have spoken to a GP about a mental or emotional problem. In order to answer this question, a binary logistic regression model was used. In the following sections I will explore how variables for the model were selected, why binary logistic regression was identified as the appropriate model, and the steps I took to build the model.

### *Identifying variables for analysis*

#### *The dependent variable*

I was interested in identifying the factors that were important in understanding men's help seeking and speaking to a GP. As stated in the introduction, the variable 'DocPsys' - 'GP: Spoke with about a mental, nervous or emotional complaint in past 12 months' (responses: yes or no) was used as the dependent variable for both analyses. In the literature reviews (chapters three and four) and at the beginning of this chapter, I outlined that one of the main aims of the thesis was to explore what it was that influenced and encouraged men to initially seek help by speaking to a doctor. It therefore seemed appropriate to explore such factors using the initial chosen variable 'DocPsys' - 'GP: Spoke with about a mental, nervous or emotional complaint in past 12 months' as the dependent variable.

Binary logistic regression was chosen as the most appropriate statistical model. Log-linear regression would not have been appropriate because I would not have been able to include as many independent variables (Yang, 2010). Logistic regression explores how well a set of predictor (independent) variables predicts or explains the categorical dependent variable (Pallant, 2013). Including more independent variables meant that I

could explore added potential factors and gain a better understanding of the circumstances under which men might have spoken to a GP about a mental, nervous or emotional complaint. In addition, it was more fitting to use binomial logistic regression because it is much more flexible in application than multinomial logistic regression (Howitt and Cramer, 2011).

Using a number of predictor variables, binary logistic regression analyses how independent variables affect the probability of a particular outcome in the dependent variable. The odds probability is made against a reference category. The reference category is normally the largest value in the dependent variable (DV), so in this case it will be: No (not spoken to a GP about a mental, nervous or emotional problem in the past twelve months).

### *Selecting independent/predictor variables*

The selection of independent variables to go into my binary logistic model went through a number of stages.

#### *1. Identifying and recoding variables*

The selection of independent variables was informed primarily by my literature review and what we already know about mental health and men's help seeking. Where previous research indicated that a particular variable might be related to men seeking help and talking to a doctor (for example age, social networks), they were chosen to be included. After identifying relevant variables, I then recoded if necessary. Recoding was done partly due to theoretical reasons and partly due to the nature of the data. Through the recoding process I attempted to make the variables with multiple values/categories as binary as possible (for example general health had five values so this variable was recoded into just two).

APMS07 there were sometimes multiple variables that exist on one topic and so it was necessary to merge and recode these variables into one. For example, eighteen variables explored various types of major life events that a person may have experienced. These life events included things like serious illness, death of an immediate family member, losing a

job, divorce etc. This was merged into a variable that totalled together the number of life events the respondent had experienced ranging from 0—15 life events. This then became a binary variable with two categories: 0-2 life events experienced, and 3-15 life events experienced and the process of doing this is explained in detail below (page 122).

## *2. Missing data*

Logistic regression is highly sensitive to missing data and will exclude cases where one or more of the independent variable values are missing. It was therefore important that I checked for missing data within all of the potential independent variables. In order to check for levels of missing data that might cause problems, I ran descriptive statistics on each of my potential predictor variables and examined the frequency distribution for each to establish levels of missing/invalid data.

Three variables were removed due to missing data. 'Equivalised income in quintiles' contained 20.1% ( $n=642$ ) missing data. 'Total work stress score', which was the variable that I derived from a number of work stress variables had 43.9% ( $n=1403$ )<sup>2</sup> missing data. 'Sexual orientation of the respondent' had a very small number of men reporting a sexual identity other than entirely heterosexual with 50.8% ( $n=1624$ ) missing data. It would have been particularly interesting to see whether the sexuality of the male respondent had an impact on speaking to the GP, particularly as previous research has indicated that sexuality influences help-seeking among gay men (Robertson, 1998). However, due to this high level of missing data it was not included in the model.

There was not a limit set on missing data but the increasing effect as well as the contribution of the variable to the model was considered. In the final model, the level of missing data was 5.9% ( $n=189$ ) and so this means that 94.1% ( $n=3008$ ) of the sample participants were included in the model.

## *3. Testing relationships*

To examine whether a significant relationship could be identified between the potential predictor variables and the dependent outcome variable, a series of Pearson chi-square tests were performed. The significance level was set at  $p \leq 0.05$  (Field, 2009).

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<sup>2</sup> The amount of missing data found in these two variables could be due to the amount of people who are not working and so these questions do not apply to them.

As a result of the Pearson's chi-squared tests, two variables were subsequently removed as predictors. Participants' ethnic origin ( $\chi^2(3) = 3.651, p = .302$ ) and religion ( $\chi^2(3) = 6.708, p = .082$ ) were not significantly related to the dependent variable. The removal of religion was a little surprising given that previous research has found that religion was a significant predictor of positive attitudes to seeking help (Sheikh and Furnham, 2000). However, it has also been suggested that belonging to a specific religious group can protect you from mental health distress and it can provide support and encouragement so therefore religious men might not need to speak to the GP about any such problems. In addition, another explanation for this could be the role of stigma and shame attached to seeking mental health help for those who belong to certain religions. The lack of relationship between the dependent variable and ethnicity is not that surprising given some studies have reported more negative attitudes toward mental health treatment in ethnic minority groups (Sanchez and King, 1986; Cooper *et al.*, 2003) whilst other studies have found no differences or more positive attitudes (Leaf *et al.*, 1987; Furnham and Andrew, 1996; Sheikh and Furnham, 2000). According to Courtenay (2003), ethnicity does not explain gender differences in health care utilization and the same gender-specific patterns of use can be found in most ethnic groups, which might further explains why there was no statistically significant relationship between ethnic origin of the male respondents and the dependent variable.

#### 4. Multicollinearity

Once a suitable set of independent variables had been identified it was important to test for multicollinearity. Multicollinearity checks that the correlation between each of the independent variables is not too high. If this is the case and each variable accounts for similar variance in the outcome, then it makes it difficult to assess the individual importance of a predictor.

To test multicollinearity a simple linear regression model was built and 'collinearity statistics and diagnostics' was run. The tolerance statistic is an indicator of how much of the variability of the specified independent variable is not explained by other independent variables in the model. This value needs to be above .2 (Field, 2009) to indicate no collinearity. The variance inflation factor (VIF) is also tested in regression analysis (any VIF values above 5 would cause concern). The collinearity diagnostics indicated that the VIF

values were all well below 5 and the tolerance statistics were all above 0.2, indicating that there were no collinearity issues within my set of predictor variables.

#### 5. *Backwards selection/elimination*

Following the four stages described, the set of independent variables were reviewed, and some were further removed because they were too similar to other more significant and theoretically driven variables, for example housing tenure was too similar to other socio-economic status variables included in the model. This was done because the best regression models are those that only contain a few variables, i.e., explain the most variation in the dependent variable with the fewest number of independent variables. This left twelve predictor variables: age in 20 year bands; marital status; socio-economic status; employment status; highest educational qualification; general health; whether the respondents had a drink problem; whether they had a drug dependency problem; the number of life events experienced; the number of family and friends they feel close to; whether they have ever made a suicide attempt and; whether or not they have a common mental health disorder present. The twelve variables added up to 17 values. This is a relatively high number of variables and it would make sense to be further taken down to be under 17 values. For example, 'Age in 20-year bands' was a variable that had four values. I therefore decided to perform manual model building for the prediction of help seeking.

Backwards selection was chosen in my analysis to further eliminate independent variables from the model. A first initial logistic regression model was employed including all twelve predictor variables. Following this, the worst predictor (least significant) was dropped. The model was then recalculated on the basis of the remaining predictors with the remaining worst predictor again being dropped (Howitt and Cramer, 2011). This was repeated until all the p-values of the predictor variables were significant. Backwards elimination is the simplest of all variable selection procedures and is often considered to be preferable to forward selection because through forward selection, important variables are more likely to be missed due to other variables entering the model first.

Socio-economic status was at one point during the running of the models, the least significant predictor ( $p = .571$ ), however I kept this variable in the final model because of theoretical reasons (Artazcoz *et al.*, 2004; Dolan, 2007, 2011; Seale and Charteris-Black, 2008) and the aims of the research questions.

Four variables were removed during the backwards elimination process. Variables not adding significantly to the model at .05 level were removed in the following order: whether the respondent had a drink problem ( $p = .751$ ), the respondents' educational status ( $p = .565$ ), their employment status ( $p = .399$ ), and finally whether the respondent was dependent on any drug ( $p = .053$ ). This left eight final predictor variables that went into the binary logistic model, as shown in Table 7.

The removal of the respondent's educational status was surprising, as previous research has found that low educational status was a significant predictor of help seeking for males (Yousaf *et al.*, 2015; Doherty and Kartolova O'Doherty, 2010). Mackenzie *et al.*, (2006) suggested that low educational status might be associated with lower rates of help-seeking because higher educated individuals may be more informed and knowledgeable about the healthcare system and illnesses (Mackenzie *et al.*, 2006).

Even though the Hosmer and Lemeshow tests showed that the previously built models with more independent variables explained slightly more variance and had better goodness of fit, the variables highlighted above (having a drink problem, educational and employment status and drug dependency) did not contribute significantly to the model and so it made sense to eliminate them from the model. Furthermore, as stated previously, the best logistic regression models are the ones that explain the most variance possible with the least number of variables, and so it was appropriate to adopt an elimination process.



**Table 7 – Variables included in the binary logistic regression model**

Original APMS07 variable name and label	Variable	Recoded from other variables?	Frequency (Missing Data)	Relationship with the DV. (Chi-squared)
<b>Age20yr</b> (D) Age in 20 year bands	<b>Age in 20 year bands</b>	Derived variable by study researchers	3197 (0%)	( $\chi^2 = (3) 19.359$ , $p < .05$ )
<b>ResMarDF</b> De facto marital status of selected respondent	<b>Marital Status</b>	I recoded from existing variable: 6 values to 3	3197 (0%)	( $\chi^2 = (2) 39.735$ , $p < .05$ )
<b>nssecR</b> (D) SOCIO DEMO RESP nssec 5 variable classification	<b>Socio-economic group of respondent</b>	Derived variable by study researchers. I recoded from 7 values to 4	3077 (120, 3.8%)	( $\chi^2 = (3) 20.468$ , $p < .05$ )
<b>TRAUMA11, TRAUMA12, TRAUMA13, TRAUMA14, TRAUMA15, TRAUMA16, TRAUMA21, TRAUMA22, TRAUMA23, TRAUMA24, TRAUMA25, TRAUMA31, TRAUMA32, TRAUMA33, TRAUMA34, TRAUMA35, TRAUMA36, TRAUMA37</b> (see description below for individual variable labels)	<b>Number of life events respondent has experienced</b>	I derived this variable from 18 existing life event variables	3175 (22, 0.7%)	( $\chi^2 = (1) 46.662$ , $p < .05$ )
<b>PrimGrp</b> (D) Number of family and friends the respondent feels close to	<b>Number of family/friends respondent feels close</b>	I recoded this continuous variable into 2 categorical values	3130 (67, 2.1%)	( $\chi^2 = (1) 31.708$ , $p < .05$ )
<b>SF1</b> SF: Health in general	<b>Self-reported general health of respondent</b>	I recoded from existing variable: 5 values to 2	3195 (2, 0.1%)	( $\chi^2 = (1) 123.530$ , $p < .05$ )
<b>DSHlife</b> Ever thought of taking own life	<b>Has respondent ever thought about suicide?</b>	N/A	3159 (38, 1.2%)	( $\chi^2 = (1) 246.284$ , $p < .05$ )
<b>CISRTWO</b> (D) CISR-R Score in two groups	<b>Does the respondent have a common mental disorder present?</b>	N/A	3197 (0%)	( $\chi^2 = (1) 565.329$ , $p < .05$ )

Table 7 shows the final version of independent variables, including derived and recoded variables, to be used in the logistic regression model. I will now talk through each variable that was derived and explain how and why I did this.

#### *6. Recoding of variables*

The age variable used in the model had previously been derived by the APMS07 researchers. The original age variable was a continuous variable that was collapsed into categorical groups. As the variable had been derived by the researchers, I did not have to do this myself and I chose to use the variable with four categorical values. Marital status originally had 6 values: married; cohabiting; single; divorced and; separated. I collapsed this into three categorical values: In a relationship (including married and cohabiting); single and; not in a relationship (including widowed/divorced/separated). I did this because of the unequal frequency distribution, where over 50% of the male respondents fell into the value married, and widowed and divorced had very similar frequencies, so I felt it made sense to merge these together.

The reasons for recoding and merging of the socio-economic status variable are explained previously in section 'research question 1(a)'.

I briefly touched upon why I derived a life events variable in the section 'identifying and recoding variables'. As I explained, I could not justify choosing just a few of these eighteen life event variables so I decided to compute a total. The eighteen life event variables included: serious illness/injury/assault to yourself; serious illness/injury/assault to close relative; death of immediate family member; death of a close family friend/other relative; separation due to marital difficulties/divorce etc; serious problem with close friend/neighbour/relative; being made redundant or sacked from job; looking for work without success for more than one month; major financial crisis; problem with police involving court appearance; something you valued being lost or stolen; bullying; violence at work; violence in the home; sexual abuse; being expelled from school; running away from home and; being homeless. I computed these to get a number of life events total for each respondent. I then wanted to divide the sample into equal groups according to the male's total life events score, making it into a binary variable. Thus, I created a median split, where I divided the sample into two groups, using the median cut off point. This left with me with the two value groups of 0-2 life events experienced and 3-15 life events experienced. These

will be referred to as either a high number of life events or a low number of life events throughout the analysis.

I also used a median split on the variable 'number of family and friends the respondent feels close to'. This variable was an already derived variable in the study which was derived from computing three social support variables together: number of adults live with and feel close to; number of adult relatives (do not live with) feels close to and; number of adult friends (do not live with) described as close or good friends. This derived into a continuous variable and I wanted it to be categorical so again, I used a median split to divide it into two groups using the median as a cut-off point. The two categorical values of my new derived variable 'number of family and friends feels close to' were 'less than 8 (<8)' and '9 or more family members and friends'.

The variable health in general originally had five categorical values: excellent; very good; good; fair and; or, poor. Once again, I felt that excellent, very good and good were too similar. Furthermore, these three values were where the majority of the male respondents fell-into. Subsequently, I decided to collapse and recode these five categories into two: good/fair and poor. This was because I was only interested in health generally as factor, so being good/fair or poor seemed the two most appropriate categories.

### *Summary of variable selection and statistical test choice*

The selection of independent variables was initially informed by the literature review and what has previously been suggested to affect mental health and help-seeking behaviour. The variables selected were appropriately recoded and then reviewed to check that they did not violate any of the regression assumptions including: frequency of missing data; significant relationships examined through Pearson chi-squared test results; and multicollinearity diagnostics. This left a total of twelve predictors, which were then subject to backwards elimination to leave a final eight-predictor variables to be entered into the final model.

As the dependent variable and all of the predictor variables selected are nominal variables, it was decided that binary logistic regression was the most appropriate statistical

analysis to test and explore factors that predicted men speaking to a GP about a mental, nervous or emotional problem in the past twelve months. The following section will discuss in detail the model findings and interpretation.

### *Binary logistic regression results*

Having identified variables to be included and excluded in the binary logistic regression model, the model was performed to assess the impact of a number of factors on the likelihood that respondents would report that they had spoken with their GP or family doctor about a mental, nervous or emotional problem in the past 12 months. The model contained eight independent variables: age in 20 year bands; marital status; socio-economic status; number of life events experienced; the number of family and friends the respondent feels close to; their self-reported health in general; if they have thought about suicide; and if they have a common mental disorder present.

The model was then evaluated in a number of ways. The full model containing all predictors was statistically significant ( $\chi^2(13) = 456.570, p < .05$ ) as portrayed in the Likelihood Ratio Tests, indicating that there was a significant difference between the 'intercept only' and the populated model. Therefore, I can use this model with confidence to distinguish between respondents who reported and did not report that they had spoken with a GP in the last 12 months about a mental, nervous or emotional problem. The results from the Hosmer and Lemeshow Test also support the model being worthwhile ( $\chi^2(8) = 456.570, p = .119$ ), because a poor fit is actually indicated by a significant value less than .05. The pseudo  $R^2$  suggested that between 14.1% (Cox and Snell  $R$  square) and 32% (Nagelkerke  $R$  square) of variance in the dependent variable was explained by the model.

**Table 8 – Binary logistic regression for: Spoke to the GP about a mental, nervous or emotional complaint in the past 12 months.**

	Direction of the relationship (B)	df	Significance (p)	Odds Ratio (O.R)
Age in 20 year bands (ref. group 16-34)		3	.003	
Age group 35-54	-.122	1	.561	.885
Age group 55-74	-.649	1	.011	.523
Age group 75+	-1.292	1	.001	.275
Marital Status (ref. group Married/In a relationship)		2	.032	
Marital status - Single	.230	1	.243	1.258
Marital status – Divorced/widowed/separated	.509	1	.010	1.664
Socio-economic Status (ref. group Higher managerial, administrative & professional occupations)		3	.053	
Socio-economic status - Intermediate occupations	.137	1	.616	1.147
Socio-economic status - Routine & manual occupations	.233	1	.285	1.263
Socio-economic status - Never worked & long term unemployed	.644	1	.007	1.904
General Health (ref. group good/fair)	.760	1	.001	2.137
Total number of life events experienced (ref. group 0-2)	.498	1	.013	1.645
Number of family and friends a respondent feels close to (ref. group <=8)	-.332	1	.032	.718
Ever thought about taking own life (ref. group No)	.941	1	.000	2.561
Has a common mental disorder (CMD) present – CISR score in two groups (ref. group No)	1.995	1	.000	7.351
Constant	-3.569	1	.000	.028
Nagelkerke R <sup>2</sup>	.32			

All of the independent variables except for one (socio-economic status) made a statistically significant contribution to the model. I can therefore establish the major factors that influenced whether or not a man had spoken to a GP about a mental, nervous or emotional problem in the past 12 months. These are: being in the age groups 16 to 34, 55 to 74 and 75+; being in relationship/married or being widowed/divorced/separated; never have worked or have been long term unemployed; how their general health is; the number of life events they have experienced; the number of family and friends they feel close to; whether they have ever thought about taking their own life; and if they have a common mental disorder present. The strongest predictor of reporting having spoken to a GP about mental, nervous or emotional problem in the past 12 months was their clinical interview schedule score (CISR) indicating whether or not they have a common mental disorder present, recording an odds ratio of 7.351. This indicated that male respondents who had a common mental disorder present were over seven times more likely to report that they had spoken to a GP about mental, nervous or emotional complaint in the last 12 months. This will be further discussed later in this section.

As outlined earlier, binary logistic regression analyses how the chosen independent variables affect the probability of a particular outcome in the dependent variable. The odds ratio refers to odds being made to a reference category. In the dependent variable, the largest value is designated the reference category and in this case it is 'No, have not spoken to a GP about mental, nervous or emotional problem'. Any effect on the dependent variable that the independent variables are having is made in relation to the reference category. So, any claims made about an independent variable increasing or decreasing the odds of a man answering 'yes he has spoken to the GP about a mental, nervous or emotional problem' is made in relation to the odds of a man answering no. An example would be, if we said those who answered 'yes they have spoken with a GP' were more likely to be single than the reference category (i.e. those who have not spoken with a GP). I will now in turn report the odds ratio for each independent variable. To explain and discuss the meanings of the results presented, I have split the discussion into two parts grouping 'socio-demographic factors' and 'life and health factors'. Within in these groups I will discuss each independent variable and its effect in turn. Firstly, I turn to discuss the socio-demographic factors and to what extent they predicted help seeking.

## *Socio-demographic factors*

### *Age*

Firstly, I am going to look at the socio-demographic factor age that as we can see from Table 8 presented above, was significant overall. Within this variable, the values age group 55-74 and age group 75+ were statistically significant. Men aged 55-74 were less likely to have spoken to a GP ( $b = -.641$ ,  $Odds Ratio = .523$ ,  $p = .011$ ) compared to the reference category age group 16-34, and those older men 75+ were even more less likely again ( $b = 1.292$ ,  $Odds Ratio = .275$ ,  $p = .001$ ) to report that they had spoken to the GP about a mental, nervous or emotional problem in the past 12 months than the reference category. This indicates that the older age category a man falls into then the less likely it is that he would have reported to have spoken to a GP about a mental, nervous or emotional problem in the last 12 months.

These results contrast with some studies that suggest that older adults' attitudes towards help seeking are actually generally positive (Robb *et al.*, 2003). However, results from such studies only portray attitudes that may be more positive and do not show actual attendance and visits to GPs and services. Contrary to previous research, my analysis has found that older men were less likely to speak to a GP than the younger age group of 16-34. Mackenzie *et al.*, (2006) found that older men were significantly more willing to seek psychological help than younger men and suggested reasons for this might be that younger men may have lower levels of illness and also partly due to the fact that their vitality and masculinity are important to them. In addition, previous studies have found that online information and support seeking is preferred among young people (Best *et al.*, 2014; Oh *et al.*, 2008; Burns *et al.*, 2009) and it has been argued that young men may be using the internet instead consulting the GP, whereas older men may only know means of support through the GP.

The results presented here seem to suggest something else and this could be interpreted in two ways. Firstly, it could be that the older men in the survey sample had not experienced any mental, emotional or nervous problems in the past year and therefore would not have spoken to the GP regarding them. This is consistent with Doherty and Kartalova-O'Doherty (2010) whose findings showed that older men actually reported fewer mental health problems than females. Young men today may be reporting more mental and emotional problems than older men and this could be due to a number of factors such

as increasing pressure in today's society, more awareness of illnesses and willingness to open up due to campaigns aimed at the younger generation. The men in the highest age category (75+) might have been experiencing more physical health problems and so may only consider the times they have been to the GP regarding these physical issues. Williamsom (2010) highlights how mental health problems among older men, such as depression, are less likely to be reported or diagnosed, or may be incorrectly seen by practitioners as an inevitable part of growing old and often not referred to specialist mental health services where appropriate. This is despite the fact that older people are much greater users of health and social care services than younger people. They visit the GP almost twice as much as younger people. Older men may just put their mental and emotional feelings down to growing old, loneliness and loss, and they may not even be aware of the help that would be available to them through their GP.

Secondly, it could be argued that the older generation of men typically endorse particularly strong beliefs in hegemonic masculine values such as autonomy and independence (Springer and Mouzon, 2011), and so would choose not to speak to a GP about a mental, nervous or emotional problem due to traditional notions of masculinity and ideas about mental health, including feelings of embarrassment, shame or fear of appearing weak. Age Concern (2006) conducted local and national research and found that traditional notions of gender emphasising the importance of independence and self-reliance deterred many older men from going to a local branch of age concern.

Here again we have the same confound issue that was discussed previously at the end of section one. With the data I have, I cannot know why it is that these older men had not spoken to the GP and there are therefore different ways to understand this effect. Whether it is because they were experiencing less mental health problems or mistaking them for old age and physical conditions, or whether it is because of their traditional masculine norms and behaviours, we cannot know. Although the latter would seem a more feasible explanation given what is known about mental health prevalence and old age.

Male respondents who were in the age group 35-54 were less likely ( $b = -.122$ , *Odds Ratio* = .885,  $p = .561$ ) to report that they had spoken to their GP about an emotional problem than those men aged between 16 and 34. However, this value was not statistically significant and so did not contribute significantly to the model.



### *Marital status*

I will now turn to explore the variable marital status. Marital status overall was significant so influenced the likelihood of seeking help from the GP. The category divorced/widowed/separated was significant within this variable. The odds of a man who is either widowed, divorced or separated reporting yes they have spoken to a GP about mental, nervous or emotional problem were 66.4% higher ( $b = .509$ ,  $Odds Ratio = 1.664$ ,  $p = .010$ ) compared to the reference group of men who were married or in a relationship. This contrasts with research that has previously found that men who were married or cohabiting were more likely to contact the GP regarding mental or emotional problems than males who were without a partner (Yousaf, 2015; Doherty and Kartalova-O'Doherty, 2010; Harding and Fox, 2014) arguing that the reason for this is that often female partners would support and encourage men to seek professional medical help. Conversely however, other research has found men who are married/cohabiting/in a relationship have both the social and emotional support of their partners (Rogler and Hollingshead, 1985; Vogel and Wade, 2009) and so speaking to a GP may not be needed, which supports my findings here. Again, as discussed previously, there are two different possible explanations that could explain this effect. For those men who have been divorced, widowed or separated, it may be that they had to be more open to seeking help for emotional problems because they did not have the emotional support of a spouse. They therefore may have been more willing to reach out and seek help from professionals. Contrarily, getting divorced or being widowed are often seen as a major life events that could result in much emotional distress and so it could be argued that those men might have been experiencing mental and emotional distress more than those who are in a relationship. This appears a more persuasive explanation and is supported by research such as Simon (2002) who found that marital loss increases emotional distress. However, these relationships were only statistically significant for certain types of people and certain types of emotional problems, and it is important to take this into account when considering help-seeking and marital status. The value being single did not contribute significantly to the model.

### *Socio-economic status*

Finally, I will turn to the last socio-demographic factor, socio-economic status. Socio-economic status was the only variable overall that was found not to be significant ( $p = .053$ ) in predicting the dependent variable. However, it was very close and because socio-

economic class was an important part of the empirical context of the wider thesis, I am going to look at the effect. The value never worked or long term unemployed did however contribute significantly to the model ( $b .644$ ,  $Odds Ratio= 1.904$ ,  $p=.007$ ). The odds of these men in this category reporting 'yes they had spoken to a GP about a mental, nervous or emotional problem in the last 12 months' was 90.4% higher than for those men in higher managerial, administrative and professional occupations. Furthermore, this value was the strongest predictor after the three health variables (CISR score, thought about suicide, and general health). Unemployment is consistently linked with a variety of negative health effects (Courtenay, 2003; Artazcoz *et al.*, 2004), which could account for why this value was significant within the model. Again I refer back to the two confounding explanations that I have discussed previously for research question one and throughout this analysis: is it because this group of men were more likely to be experiencing mental health issues or is it because they were more willing to seek help. The effect here is consistent with the chi-square results explored in research question one and supports Doherty and Kartalova-O'Doherty (2010) who suggested that it is possible that those men who are long-term unemployed or have never worked have more time or are prone to various physical health problems, as well as mental and emotional problems, and so have a greater opportunity of consulting with the GP for any mental or emotional problems they subsequently may be experiencing. Furthermore, those who were described as long-term unemployed or have never worked may have been off work due to sickness or disability, so again it would be more likely that they would have been in contact with a GP regarding various issues, and also even to retain sickness notes and maybe more compelled by the system to present illness to the GP in order to receive benefits.

The values intermediate occupations and routine or manual occupations were not statistically significant within this variable (intermediate occupations  $b .137$ ,  $Odds Ratio= 1.147$ ,  $p=.616$ , routine or manual occupations  $b .233$ ,  $Odds Ratio= 1.263$ ). The men in these groups were more likely to report that they had spoken to a GP about a mental, nervous or emotional problem compared to the reference category men in higher managerial, administrative and professional occupations. This coincides with previous research that has found that those men in a manual social class group were at higher risk of poor mental health than the non-manual group (Artazcoz *et al.*, 2004), so it would seem that subsequently experiencing poorer mental health would increase the likelihood of them speaking to a GP regarding these issues and is again consistent with the chi-square result in

question one. Even though it could be considered that men in higher occupational positions experience more stressful situations (Dolan, 2011), this group of men may also have access to resources that enable them to demonstrate control over certain situations and so in various ways manage any emotional problems before having to speak to a GP. In addition, those in higher professional full-time jobs may have difficulty setting time aside to speak to a GP due to their full-time work and so might seek out other forms of help. It must be reminded though that the socio-economic status variable as a whole was not statistically significant and was kept in the model due to the research's aims.

### *Life and mental health factors*

As we can see from Table 8, all of the 'life and mental health factors' contributed significantly to the binary logistic model. This suggests something about the nature of these factors and how they affect men's help-seeking behaviour.

#### *General health*

Men who reported that their health in general was poor were over two times more likely to have spoken to a GP about mental, nervous or emotional problem than those men whose general health was said to be fair or good ( $b = .760$ ,  $Odds Ratio = 2.137$ ,  $p = .001$ ). This is expected given that there is strong evidence presenting a relationship between mental illnesses – particularly depression and anxiety – and physical outcomes (Kolappa *et al.*, 2013). Not only that but poor physical and general health can result in poor mental health and the two should not be thought as separate. Additionally, if they have reported that their health in general is poor then it may be that those respondents are in more contact with the GP regarding other issues, and so subsequently may also talk to the GP about any mental or emotional problems they may additionally be experiencing.

#### *Life events experienced*

As we would predict, men who had experienced a higher number of life events were more likely to have spoken to a GP about a mental or emotional problem compared to the reference category, men who had only experienced a low number of life events ( $b = .498$ ,  $Odds Ratio = 1.645$ ,  $p = .013$ ). Research has shown that being exposed to such events can

trigger distressful moods and depression (Kessler, 1997) and so this suggests that experiencing more of such events may result in more emotional problems that in turn may increase the likelihood of speaking to the GP regarding such issues.

#### *Social support and relationships*

Men who had closer family relationships and friendships were less likely to have spoken to a GP. The odds of a man who reported that he felt close to a relatively high number of family and friends .718 (-28.2%) lower than for man who feels close to a relatively low number of family and friends ( $b$  -.332, *Odds Ratio*=.718,  $p$ =.031). Men may use families and friends as a means of support instead of going straight to doctor. Furthermore, there is much research that highlights that greater social support can protect one from stress and emotional experiences (Turner and Brown, 2010). Fewer closer relationships and social support have all been linked to depressive symptoms (Kawachi and Berkman 2001: 458). So subsequently this group of men who reported that they felt close to a relatively high number of family members and friends are likely to have less mental and emotional problems and therefore less likely to have spoken to a GP regarding these.

#### *Diagnosed with a common mental disorder and experience of suicidal thoughts*

As we would expect to see given that the dependent variable is speaking to a GP about a mental, nervous or emotional problem, having a common mental disorder present would seemingly be an obvious factor. Those men who did have a common mental disorder present were over 7 times more likely to have spoken to a GP about these issues than those men who did not have a common mental disorder present ( $b$  1.995, *Odds Ratio*= 7.351,  $p$ =0.000). This makes sense given that not having a common mental disorder present, for example anxiety, depression, stress, you would probably not speak to a doctor about any of these issues, unless things had changed from the time of speaking to the GP to when they participated in the APMS. Again, as you would predict, the odds of a man who had previously thought about taking his own life speaking to a GP about mental or emotional problems was 156.1% higher than those men who have never thought about suicide ( $b$  .941, *Odds Ratio*= 2.561,  $p$ =0.000).

## Conclusion

To conclude this chapter, I am going to return to the research questions set at the beginning of the chapter:

RQ1 – What are the social contexts that predict help seeking from a GP for a mental, nervous or emotional problem?

- a. Can a significant relationship be identified between socio-economic status and whether a man had spoken to the GP about any emotional or mental difficulties?
- b. What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional problem?

We have seen that, in answer to question one, a significant relationship can be identified between socio-economic status and speaking to the GP about a mental, nervous or emotional problem in the past twelve months for men ( $\chi^2 = (3) 20.468, p = .000$ ). The association found between socio-economic status and help seeking is not surprising given that we know that men of different social status may engage in varied masculine practices (Connell, 1995; Coston and Kimmel, 2012) and have different attitudes towards help seeking and distress (Dolan, 2007, 2011). Experience and prevalence of distress differs amongst men from different social backgrounds, so we would expect there to be some relationship between socio-economic status and help seeking for a mental or emotional problem. My analysis found an association that was in the opposite direction to what was expected however, as it has previously been assumed that men in lower socio-economic groups strive to live up to hegemonic masculine ideals that limits emotional expression and perceives asking for help as a sign of weakness (Dolan, 2007, 2011).

Question two explored whether socio-economic status and other contextual factors predicted men seeking help. Through binary logistic regression I was able to gain an added understanding of the contexts under which men speak to the GP about any mental, emotional or nervous issues. The main findings from the final model indicate that those men who had a common mental disorder present (according to their results from the CIS-R carried out as part of the survey), and those men who had previously thought about taking their own life, were the most likely to have spoken to a GP about mental complaint in the

last twelve months. Having a lower socio-economic status (never worked or long term unemployed) was found to significantly affect the likelihood of a man speaking with a GP about an emotional complaint. In addition to socio-economic status, the logistic regression model allowed an insight into how other contextual factors such as age, marital status, general health, and social support could affect the likelihood of a man having spoken to a GP in the past twelve months. Those men who were more likely to have sought help from a GP about an emotional problem were younger men (aged 16-34); men who were widowed, divorced or separated; men with poorer health; men who have experienced a number of significant life events; men with a relatively low number of close family and friends; men who have common mental disorder present; and men who have experienced suicidal thought previously. In the discussion of these results I have presented some interpretation of why these results might be. I will now turn to discuss limitations of the data and analysis.

### *Limitations of the data and secondary analysis model*

Important limitations restrict how far this piece of secondary analysis can be generalised and therefore limit the conclusions I can draw from it. Firstly, throughout the discussion section potential reasons why certain factors predicted (for example, being unemployed, being single, divorced or widowed, having poor general health and having experienced more life events) speaking to a GP were discussed. Often these reasons assumed that this is because the men in certain subgroups may have been experiencing more distress and mental problems and therefore were more likely to speak to a GP about a mental, nervous or emotional complaint in the past twelve months. For example, as suggested in the discussion around the relationship between socio-economic status and help seeking from the GP, it might be expected that lower socio-economic status men speak to a GP more because they have worse mental health. However, my multivariate logistic regression found that men with lower socio-economic status were more likely to report having spoken to the GP over and above the effect of having a common mental disorder present, as having a common mental disorder present was considered in the model. Nonetheless, the wider context of the thesis is to explore men's help seeking behaviour and coping strategies in challenging times of emotional distress and not what causes and influences the prevalence of these emotional problems. Further research is needed to explore the

factors that influence men's mental health as well as their help seeking and talking behaviour. Further secondary data analysis could be carried out using the newest version of the series, APMS14, in order to explore what effects and influences men's common mental health problems, as well as examine the nature of their treatment and service use for such problems.

Secondly, the age of the study could be seen as a potential limitation. The APMS07 was carried out in 2007 and is therefore over ten years old. This potentially affects the validity and representativeness of this secondary analysis. Using the newest version, APMS14, would have been beneficial in terms of any changes made and new questions added that differs from the coverage in the previous survey. The new questions and coverage may have been more beneficial to the topics covered in my secondary analysis. Mental health awareness in men is increasing and men's experiences may have changed in line with any economic and cultural changes over 10 years. It may include other contextual factors that might impact on seeking mental health help. It also would have demonstrated more current and up-to-date population trends on men's help seeking.

Thirdly, the dataset was not designed to explore the issue at hand (male help-seeking and speaking to the GP regarding mental health issues). Therefore, the way the survey was carried out, the kinds of questions asked, and the importance given to certain topics, would be different if I were carrying out the study myself. Questions on help seeking practices as well as questions specific to masculine practices might yield different data. Additionally, the sampling technique used within the APMS07 did not focus on the male population, in which I was specifically interested. Given this, a major limitation is the issue of non-response bias when investigating a potentially sensitive area (Charkraborty *et al.*, 2011). It is important to consider how many of the refusals in the survey response were men.

The way mental health and common mental disorders were measured within the survey also needs to be noted. The CIS-R is a structured validated instrument that enables clinically untrained interviewers to administer a verbal questionnaire to assess someone's mental wellbeing. It therefore needs to be considered whether the answers to this self-report survey are true to life, particularly given what we know about men talking honestly about their health and wellbeing. Men might have used socially desirable answers due to self-presentation concerns that may affect the reliability and the validity of the survey.

Furthermore, the interviewer's characteristics and the survey situation would determine the occurrence and extent of social desirability bias (Krumpal, 2013), which through secondary data analysis, I have no control over. However, within the APMS07 this potential limitation is overcome by the main strengths of the study that lie mainly in its large nationally representative population sample (Weich *et al.*, 2011).

Finally, another limitation of this secondary analysis is the time frame of the dependent variable (spoken to a GP about a mental, emotional or nervous complaint in the past 12 months). Experiencing mental, emotional or nervous problems might be an on-going issue, so the men in the sample may have spoken to a GP regarding such experiences previously, earlier than twelve months ago, and so therefore might answer no to this question. In response to this limitation, I argue that this variable was the only relevant variable that explored help-seeking particularly at the primary care level, and also with it being in the past twelve months then it was more of a current issue in the men's lives at the time of the survey.

Despite these limitations, I have aspired to make the best of the limited available data on this topic area and attempted to explore the contextual factors that predict men speaking to the GP about a mental or emotional problem. I have identified some of the contextual predictors of male help seeking from a GP and made suggestions as to why this might be the case. It is apparent through the findings presented in this chapter, that there is a need to explore contextual factors as well as psychological factors such as attitudes and beliefs, that may influence male help-seeking and talking about emotional problems. Further research is required to examine the specific situations and contexts that might play a part in men's mental health help seeking from the GP. This research should explore a combination of psychological factors, economic factors and social factors using a combination of both quantitative and qualitative methodology. This chapter has formed a contextual basis that can now be built upon and qualitatively explored further in the following empirical findings chapters of the thesis.



# Chapter Seven - Men's experiences of formal help-seeking

## Introduction

This chapter is the first of three chapters from the qualitative interviews and uses data from both sample groups of men. In this chapter, I continue the exploration of help seeking from chapter six (that examined contextual factors that predicted seeking help from the GP) by examining participants' accounts of their experiences and practices of formal help seeking for distress. Previous research on men's mental health has often focused on likely barriers to help seeking, mostly investigating gender differences, i.e. differences between men and women, rather than considering diversity of gendered identities and practices. As noted in the literature review (chapter three), the dominant narrative has been that men are reluctant to seek help from health professionals for emotional distress, in attempt to conform to and preserve traditional male gender roles, as well as due to the fear of being stigmatised or perceived as weak (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005; Mansfield *et al.*, 2005; O'Brien *et al.*, 2005). As well as exploring more informal and everyday coping and management strategies (chapter nine), I was interested in participants routes of formal help seeking, and what support they utilised and preferred. I define formal help seeking as including all types of help and support outside of immediate family and friends, for example, speaking to a GP (general practitioner) and attending counselling or other professional healthcare support services, including support groups. In the following chapter (chapter eight), I will specifically focus on men's attendance at support groups.

In chapter four I discussed the reason for recruiting two distinct sample groups of men – men from support groups and men from the general public - with the aim of accessing men of a diverse range of ages and social backgrounds. Specifically, I chose to recruit men who had accessed support groups in order to ensure that there were participants who had sought and received some type of professional help, as well as to explore the perceived effectiveness of those groups. In the event though, the majority of

the participants from the general population sample (16 out of 19 interviewees) had also sought and received formal support for distress or emotional difficulties. On methodological reflection, this could be expected, as it is most likely that research volunteers would be men with personal experience of the topic that is being explored. This points to the difficulty in getting a representative sample in this kind of qualitative research.

There were distinctions and overlaps in participants' formal help-seeking experiences across the two different sample groups. In this chapter (as well as in chapter nine that specifically explores coping and management), I will not focus on the two different sample groups of men as distinct groups. Instead I explore all participants' experiences of formal help seeking together. It is important to note here that I am not treating participants as one homogeneous category, especially considering that a main aim of my recruitment strategy was social diversity. Rather, I recognise that it would be difficult for me to discuss the two sample groups separately, given the potential overlaps in characteristics, perspectives and practices of help seeking. As indicated, I will then address more specifically the use of support groups in chapter eight, as using support groups was a formal help seeking route that was distinct to this sample group of men. In chapter nine, I move to focus on the everyday coping and management strategies that men engaged in both before and after professional support.

My participants' help-seeking practices were not straightforward. Participants' engaged in help seeking in various ways and their preferences for various help-seeking routes and types of treatments were complex and personal, depending on individual circumstances. Nevertheless, there were broad themes identified across the accounts from both sample groups around their experiences of formal help seeking. In the following sections I will draw on these themes in turn. Rather than focusing on the things that men do not do in relation to help seeking, this chapter will focus on the things that men do *differently* in their help seeking for distress.

## Initial hurdles to help seeking

As mentioned in the introduction, the majority of participants from both sample groups - support group sample and general population sample - had sought out some formal support. Despite this, participants often noted that in their experiences, formal help seeking had not always been immediate. Subsequently, I cannot ignore what I phrase here as hurdles (instead of barriers) to formal help seeking. I use the term hurdles to refer to particular concerns (both internal and external obstacles) that participants had to negotiate and 'get over' in their help-seeking practices. In this section I begin the exploration of men's accounts of help seeking by drawing attention to the discussion of such hurdles that men spoke of encountering.

### *Recognising and communicating distress*

In the discussion of seeking professional help for emotional distress some participants spoke of initially not identifying themselves as being 'depressed' or struggling emotionally. Previous research into what other authors have described as 'barriers' that men face to help seeking have suggested that men struggle to recognise the symptoms of mental health difficulties (Brownhill *et al.*, 2005; Ridge *et al.*, 2011). Men may interpret symptoms of distress (such as fatigue, low mood, restlessness and irritability) as something other than mental health issues (Chuick *et al.*, 2009; Oliffe *et al.*, 2013a; Seidler *et al.*, 2016). In addition, it has been previously understood that traditionally some men are socially conditioned not to engage in emotion-based communication (Seidler *et al.*, 2016) and so find it difficult to articulate their feelings and experiences of distress. With the general population participants, something that emerged that was particularly interesting was that there were a number of men who discussed initially consulting the GP about 'sleeping troubles', or other physical problems in which 'stress' manifests, rather than identifying it as depression or distress. This could suggest how men might have difficulty recognising symptoms of emotions difficulties or that it might be more acceptable for them to say that they sought help from the GP for a problem to do with sleeping, rather than emotional distress. Oliver interpreted his emotional difficulties as a physical issue:

Oliver, 34:  
(General population sample)

AV: *Did you go to the GP off your own back?*

Oliver: *Yeah it was just, it was sort of an on-going because I was becoming.... I wasn't really sleeping well. I was very, very restless and anxious all the time and it was sort of this, I perceived it as some kind of physical problem... and my GP was like no I don't think so.*

In the above extract, Oliver is talking about a specific period of distress that he experienced whilst at University. A common presentation of distress in men is somatic symptoms such as physical pain, sleep problems and anger (Montano, 1994; Roberston, 2006a). Oliver explicitly said that he thought what he felt and experienced at the time was physical in nature. It has also been suggested that men express distress differently (Brownhill *et al.*, 2005; Chuick *et al.*, 2009; Ramirez and Badger, 2014) and so might often present to the GP with something else such as interpersonal conflict, anger, alcohol misuse and sleeping problems. For Oliver, it could be that his distress was potentially confused or conflated with other complaints (Scholz, Crabb and Withert, 2017). This finding is also consistent with Scholz, Crabb and Withert's (2017) study which found that as a way to legitimise emotional distress, it may be easier for men to discuss it if it is explained through the presence of observable symptoms (Scholz, Crabb and Withert, 2017: 729). Traditionally, there is the view that physical illness has represented a legitimate reason for accessing health services yet seeking help for what can be perceived as coping with difficult aspects of daily life still carries stigma for men (Robertson, 2007: 115). This is because hegemonic masculine standards have traditionally perceived depression and sadness as revealing weakness and vulnerability. This suggests that men's indirect strategies of disclosure reveal symptoms that may lead to discussing the dis-preferred topic of 'depression'.

Another participant from the general population sample, Nick (56), said that he consulted the GP for "something different" but came away with anti-depressants, having been told that he was experiencing depression. Nick had previously experienced cancer and following this was out of work for a length of time as a result (although was working at the time of interview). I asked him about how that time affected him emotionally:

Nick, 56:  
(General population sample)

AV: *Did you go to the doctors about depression when you were feeling low or during those times?*

Nick: *No, no. I was probably more depressed when I split up with my son's mother, which was years before then. I did see a doctor then, not about it, he just knew.*

AV: *Oh really*

Nick: *Yeah*

AV: *Were you going for some other reason?*

Nick: *Yeah, I can't remember. He was a locum he was he wasn't a regular, he was just there for like a fortnight, and he said I think you're depressed, and he said are you and I told him, and he give me some tablets.*

Again, Nick said he did not attend the GP with the intention of talking about his break-up yet ended up discussing this with the doctor. He claimed that he initially went to the GP for something else, but he did not actually say what he went for, which could suggest the different ways in which men may understand their distress (Scholz, Crabb and Withert, 2017). Furthermore, Sierra Hernandez *et al.*, (2014) suggest that men can lack insight into their own depression (Sierra Hernandez *et al.*, 2014: 349). However, as well as lack of insight, it could be that Nick was just trying to legitimise his reasons for going to the doctor, without having to admit that he was struggling with difficult aspects of life.

When I asked Nick what he had replied to the GP after being asked if he thought he was depressed, he said:

Nick, 56:  
(General population sample)

*Yeah, I did say yeah. I can't remember why I went there. I think I was like low and like tired all the time and everything like that and he said he sort of just knew. He's the only one that's ever said it to me*

Despite him saying he went to the GP for "something else", he goes on to explain that he was "low and tired all the time", symptoms of mental distress that he perhaps interpreted as something else. Or it could be that he had difficulty in articulating such feelings as emotional distress. Having someone explicitly ask the question actually facilitated Nick to

talk about how he was feeling and disclose his emotional difficulties. Having a health professional point out problems rather than having to make the admission for himself may also be an attempt to preserve masculine ideals and limit any potential vulnerability or weakness. It could be suggested then that masculinity and hegemonic practices that limit emotional expression shape the initial help seeking process for some men as Nick attempted to resist vulnerability in the process of help seeking by tentatively seeking out support for distress through his admission to the GP. Specifically for Nick, who was in manual work and classified in the lower socio-economic status classification (see chapter four), physical issues such as not sleeping may provide more of a legitimate or 'manly' reason for initially visiting the GP for support. This also points to the importance of having skilled GPs that recognise anxiety and depression by looking beyond the physical symptoms (Cheshire *et al.*, 2016).

It is important to note that despite saying that they initially sought help for something other than distress, appearing somewhat passive in their accounts, both Oliver and Nick revealed that they do care about their health in their decisions to originally seek help from the GP. It could be interpreted that Nick and Oliver may have guarded their vulnerability by cautiously seeking mental health help. In minimising the severity of their distress experience and the magnitude of need for help they could protect masculine identity and any potential for loss of self-esteem in being given a psychiatric classification (Johnson *et al.*, 2012: 352). By initially presenting to the GP (albeit not explicitly for emotional distress) both Oliver and Nick are counteracting hegemonic standards that have traditionally inhibited men from seeking professional help. Nevertheless, in their process of help seeking that involved cautiously acknowledging and admitting emotional distress, it could be claimed they are carefully attempting to negotiate embodied masculinities. This also suggests that some men are not always reluctant to seek formal health support, but when it comes to mental health specific help, they may negotiate the ways in which they go about this.

In connection to legitimizing emotional distress through observable symptoms, two other participants from the general population sample explicitly noted how men tend to tie any kind of emotional difficulties under the expression of 'stress' instead. I asked participants whether their male friends spoke of any personal and emotional difficulties, as well as what they have heard men use in their talk to describe mental health difficulties. Despite Simon being classified in the higher socio-economic class and showing awareness

of his own mental health (see chapter nine), he observed that discussion of emotional difficulties was still uncommon amongst his male friends:

Simon, 42:  
(General population sample)

*Ah I don't know anybody that talks about it in those terms really. It's just like "ah you know I'm happy, a bit stressed"... Stressed is the classic catch all isn't it, lump everything under, under stress, yeah a bit low or you know or they'll talk about a particular issue like you know me and the missus are not getting on or you know I don't know what the future holds you know. Sometimes you will have a particular issue and lump all worries behind that issue and actually it may be only 30% about that issue and the rest of it is about something really different but of course you need an outlet. If you're having an emotional, relationship issue, you perhaps pile all those issues into one thing. Um but nah blokes, my friends at least, don't really talk in those terms*

Similarly, Mike said the same about men articulating and framing mental health difficulties as 'stress':

Mike, 25:  
(General population sample)

*I think one of the words that's kind of been normalised, which it shouldn't have been, particularly in men, is stressed. "Aw I'm really stressed about it, aw I'm stressed". Well that used to mean, stressed used to mean unhappy and nowadays if you said, "I'm actually really unhappy at the moment you know, works bad I'm really unhappy", that would be weird. To say "I'm stressed" it's kind of the norm, it's like oh yeah everyone's stressed aren't they and that gets used a lot. I think a lot of men in particular use that as a kind of guard, say "aw I'm pretty stressed at the moment", really they mean I'm anxious and I'm tired, I'm angry and sad. That's a word they use to deflect from mental health, I think...*

This is consistent with O'Brien *et al.*, (2005) who found that their participants often described stress rather than acknowledge the perceived 'unmanly' term of depression. Simon and Mike's discussion of men using stress to describe emotional difficulties suggests that amongst groups of males, the admission of depressive symptoms might still carry with it fears of shame, vulnerability and societal stigma which contradicts with masculine ideals of control, strength and success (O'Brien *et al.*, 2005; Emslie *et al.*, 2006; Ramirez and Badger, 2014). Previous research has found that diagnostic criteria and labels attached to the term depression can contradict with the influence of masculine ideals (Seidler *et al.*, 2016; Cleary, 2012). Using the term 'stress' might be a way to demonstrate manly self-reliance and success, or, like in Oliver and Nick's accounts, highlights the difficulty men

might have in interpreting distress as something other than physical (Siedler *et al.*, 2016). This points to the potential impact masculinity and traditional masculine ideals can have on distress symptoms and the ways in which distress can manifest in men (Seidler *et al.*, 2016). As a result of the notion that men identify as 'stressed', Cheshire *et al.*, (2016) carried out an evaluation of a programme that aimed to improve men's mental health via primary care. This programme used the idea that offering acupuncture as well as counselling to men was considered as a way to initially engage 'stressed' men in a treatment that is not grounded in talking about difficult emotions. Offering the two options of treatment facilitated men's engagement and the above extracts indicating men's use of the terms stress support the need for such programmes in engaging men in primary healthcare support as well as highlight some obstacles to men in seeking help for distress.

### *Availability and access to formal support: men's ambivalence to help seeking*

Cost, lack of time and availability of services, in particular waiting lists for counselling services, also emerged as initial practical hurdles faced in participants' accounts of seeking professional help. When discussing help seeking in men more generally, Adrian acknowledges a traditional difficulty that he believed men face in accessing formal support:

Adrian, 59:  
(General population sample)

*Well I think one of the big issues for men is that actually doctors' surgeries are not open at the time when men need to access them. Traditionally, if you're a bloke you're working, when can you go?*

The traditional idea of work and employment being central to men's lives is a long-standing view (Morgan, 1992). Adrian did not say that this was a reason for him not seeking help from the GP, yet he invokes generalisations of what other men might experience. Adrian himself was in touch with professional healthcare services for both physical and mental health difficulties, following a head injury. Although work and time can be seen as an external hurdle that is explicitly gendered, it may be slightly out-dated as many women today might also face this difficulty in balancing full-time work and finding time to visit the GP.



Daniel from the general population sample reiterates this point further when he explained that he tried to seek counselling from a professional. He had a friend who promoted talking to a counsellor and Daniel's response to this was "*but it's finding time*". Again, time to access services is perceived as an external obstacle to seeking professional support. However, this difficulty in access could be read instead as ambivalence to visiting the doctor, as some would say there is always time to see a doctor. Further to this though, the sense of not having time can in contrast also be a symptom and expression of anxiety. In his account, Daniel constructed himself as a busy man who does not have the time to access mental health support, regardless of whether he wants to or not. An account is employed when an action (not seeking formal support) is subjected to question and accounts are used to verbally bridge the gap between action and expectation (Scott and Lynman, 1968: 46). Accounting for not seeking out formal help by using lack of time as a specifically gendered issue attempts to justify the notion around men's lack of health care help seeking, positioning it as an impact of societal context that is out of men's control. For Daniel, when it came to a recent experience of distress, where he experienced what appeared to be a panic attack, his wife gave him a number for a psychologist she had used before:

Daniel, 34:  
(General population sample)

*It's quite ironic that I'm doing this because about three months ago I just woke up and I had a bit, not pan- I wouldn't call it a panic attack but bit like an anxiety attack. So, I tried to go to a psychiatrist, a psychologist. She wasn't able to fit me in, so I haven't gone.  
Yeah, I rung this woman up and um typical man, sort of you know, can you fit me in, and she was like no can't take anybody on. Oh, forget it.*

It seems Daniel's idea of a "typical man" is someone who would just leave things, showing that dominant discourses around men, masculinity and help seeking are still influential. Like Adrian, in his account, Daniel invokes generalisations of what "typical men" do as a way to seemingly affirm his reasons for not further seeking out professional help elsewhere. He justifies his ambivalence to help seeking using a 'normalised' fatalistic reasoning (Scott and Lyman, 1968) of men and their help-seeking practices, employing such cultural commonplaces as "men are like that". This also aligns with Robertson's (2007) 'should care/don't care' dichotomy that argues that because society values healthy practices and health as a moral responsibility, men have to balance the masculinity

requirement of showing that they do not care about health with the opposite belief that they should. It must be recognised however that Daniel did ring the psychologist (having been encouraged by his female partner) in the first place and so revealing that he was not completely reluctant to seeking formal help. This here points to the importance of informal support and supports the quantitative finding in chapter six that men who are married were less likely to seek help on the presumption that they had access to informal support through their marital relationship. This is further discussed in the next section and in chapter nine. It also highlights that some men do want to receive professional support. For Daniel, the obligation and responsibility to seek medical help was there, yet the prospect of a waiting list was an external hurdle that he said was apparently stopping him from continuing to seek this support.

Another participant also discussed his intention to seek formal help for emotional distress but again said he changed his mind due to the prospect of waiting lists:

Andrew, 69:  
(Support group sample)

*Andrew: But I did think once of asking the doctor if I could see a psychiatrist. Which would have to be a waiting list for it. The only service I had to have was to get myself going innit, to up service myself like. I couldn't ask anybody else to sort my problems out for me. I had to do it myself*

*AV: But you were thinking about asking?*

*Andrew: I was thinking about it at the time yeah. Psychiatrist was on the book see but alas a time went by and that's it*

Here in Andrew's account, it seems to be a combination of both availability of an appointment with a psychiatrist as well as the requirement for self-control of his own health (Robertson, 2007) that impacted on his change in decision in seeking out formal help. He mentioned the possibility of a waiting list, which was potentially off-putting to him, being the initial hurdle to mental health specific help. Andrew talked about how it was his job to sort himself out, to '*get himself going*' and not the job of somebody else. This highlights to some extent alignment with hegemonic masculine ideals, and portraying the traditional notions of self-sufficiency, independence and autonomy (Connell, 1995, 2005; Courtenay, 2000). A combination of both the prospect of a waiting list and masculine expectations seemed to deter Andrew from seeking out mental health help. It is worth

pointing out here that Andrew said he was in contact with the GP and through his own insight considered asking to see a psychiatrist. Here it is important to give my participants credit for seeing medical professionals as and when they do. Both Andrew and Daniel said they had considered speaking to a mental health professional. Despite deciding to not ask to see a psychiatrist, at the time of interview, Andrew was attending a support group aimed at older men to support them with elements of distress such as loneliness and social isolation. This suggests that men might have different strategies they prefer to take to seek mental health help, which might be more indirect than simply just directly confessing their mental health troubles in a medical setting. Men instead may seek out social conditions (for example, the support group Andrew attends) where disclosing distress may emerge more comfortably. Perhaps seeking help in this way is a particularly 'masculine' strategy because it allows men to maintain hegemonic masculine practices through a sense of self-control of their own health (Robertson, 2007), independence and self-sufficiency.

Both Daniel and Andrew's accounts indicate their intentions to seek professional mental health help so demonstrating insight, awareness and engagement in their mental wellbeing. However, these accounts of their intentions further highlight men's ambivalence regarding help seeking for distress, as they decided not to pursue formal help. Men may not be completely averse or reluctant to seek professional help but are conflicted in their decisions and actions to pursue formal support and so justify this using external hurdles outside of their control (such as lack of time or waiting lists for counsellors). My participants then, seemed to be somewhat ambivalent in their help-seeking decisions and actions. Nonetheless, it is still important to recognise that despite these hurdles that were discussed, these participants did engage, or at least attempted to engage, in some type of formal help seeking. We must therefore appreciate the things that men do differently in their help seeking rather than what is "wrong" with them in relation to why they do not seek help. The participants' nuanced accounts discussed in this section regarding external hurdles that men might face demonstrates complexities and tensions in relation to how my participants asked and accepted mental health help.

## External influences to help seeking

Having discussed some of the initial hurdles and ambivalence men conveyed in their pursue of formal support, I now turn to focus on what assisted and facilitated men to seek out help for distress. I was particularly interested in what participants did and how they went about seeking formal support. In participants' accounts of their experiences of help seeking for distress it emerged that they were often influenced and impacted to seek help by external contexts such as a significant other, certain environments and social norms. Such contexts were influential in participants' decisions to pursue formal help and support at times of distress. This theme and its subthemes will explore these external influences that participants talked about as being significant enablers in their help seeking decisions. Help-seeking enablers refers to the factors that enabled the decision to seek help.

### *The importance of significant others*

A majority of participants who had sought formal help for distress acknowledged the importance of a significant other in the decision to initially speak to the GP. Talking and opening up about distress in everyday life can be regarded as a more informal type of help-seeking action or coping strategy (discussed in chapter nine). Initially talking to someone close to them about emotional difficulties often led to seeking more formal support, usually from the GP. Having first spoken to partners, parents or close friends, participants were then encouraged and supported to seek professional help. Mike spoke to his girlfriend first:

Mike, 25:  
(General population sample, student)

*First person I told was my girlfriend at the time. I told her. She's the one I opened up to and she was a massive help to me, and she urged me to seek help, so I did. So that's when I started having counselling with the Uni and seeing my GP*

Middle aged men Steven and Nathan both spoke in the past about their emotional troubles to their mothers, who subsequently aided their help seeking:

Steven, 52:  
(General population sample)

*I spoke to mum about it and that and I realised you know it was the best thing to do, to explain*

Nathan, 48:  
(General population sample)

*I spoke to my mother I think, and I think it was mum who said you know just go and speak to somebody*

For the participants here, these significant others were influential help-seeking enablers, providing an impetus for seeking help (Harding and Fox, 2014). This is consistent with other research that has acknowledged the role that a significant other, particularly a woman, has in help-seeking decisions (Seymour-Smith *et al.*, 2002; Cusack *et al.*, 2004; Jarrett, Bellamy and Adeyemi, 2007; Vogel *et al.*, 2007).

My participants spoke of a preference to initially speak to women regarding their distress (this is covered in more detail in chapter nine in terms of everyday coping). Seymour-Smith *et al.*, (2002) reported that women played a pivotal role in facilitating men's access to professional help seeking. For James in the extract below, it was his wife who recognised that something was wrong without him speaking to her first:

James, 61:  
(Support group sample)

*And obviously my wife, who knows me better than myself really, she saw there was something up and she said you need help and uh... I'd always been the decision maker in work, I'd always been the one who says, "you do this, you do that, I'll take care of this". I didn't want to be told, but in that I couldn't help myself*

James later acknowledged his reluctance to seek out help until his wife forced a decision to go to the GP. He talked about how his wife actually physically took him to the doctors to ensure that he sought help:

*James: She told me to go to the doctors. Well she took me she did actually, she did actually take me, because if she hadn't taken me, I wouldn't have gone. I would have gone out and said I've been to the doctors you know*

*AV: Lied?*

*James: Yeah basically*

According to previous research, seeking help is acceptable under certain conditions (Addis and Mahalik, 2003) and for James, things had got to the point where he said he could not help himself and instead his wife had to intervene. On the verge of crisis, professional help seeking becomes acceptable (Johnson *et al.*, 2012). James discussed having always been the decision maker in work, portraying established hegemonic masculine roles and ideals through his work life and so this perceived loss of control (Addis and Mahalik, 2003) potentially created a barrier to seeking out professional help for his distress. Similar to what was described above, it could also be that he had difficulty recognising and articulating such distress (Sierra Hernandez *et al.*, 2014; Scholz, Crabb and Withert, 2017). Moreover, feeling helpless is a symptom of depression highlighting the complex reasons for initially delaying help seeking.

Some of the findings above coincide with previous research that has found that discussing one's symptoms with a close female other, typically mother or partner, was the most preferred forms of help-seeking (Lane and Addis, 2005). Although speaking to partners, family and friends is a more informal kind of help-seeking behaviour (or more explicitly, I frame it as an everyday coping and management strategy that may lead to more formal engagement in healthcare services, see chapter nine) it can evidently be an influential starting point that can promote and lead to formal help-seeking from healthcare professionals. Samuel articulated this in the extract below:

Samuel, 29:  
(Support group sample)

*It started off with friends then parents then GP and then who they referred me to. Whereas I don't think I could have gone straight to the GP or the services, I think I needed to make that admission to somebody else comfortable with first and then that would have given me time to sort of process that and say yeah, I do need help*

Having his distress confirmed through admission to people closest to him, Samuel was able to then seek formal help from the GP on his own terms. There are different pathways to

doctors, and people often use 'lay networks' of friends, families or other individuals to help them assess and respond to symptoms (Smith *et al.*, 2005). Samuel's account shows parallels with Johnson *et al.*'s., (2012) discourse of 'guarded vulnerability', whereby men spoke of the idea that initial disclosure of distress to family or friends might put them in a less vulnerable position than disclosure to a professional. Having one's distress validated first by close family and friends was important in the decision to embark on formal help-seeking and treatment, as noted in a number of my participants' accounts. Farrimond (2011) found this in her work regarding help-seeking and masculinity, with two of her participants who had mental health problems initially restricting help-seeking to an 'inner circle' of 'people who knew' (Farrimond, 2011: 12). One of her participants began relaying information about his depressive symptoms slowly to his mother, then a close friend and then visiting the doctor through their encouragement. This resonates with Samuel's account of help seeking (as well as Mike's, Steven's and Nathan's accounts above) and shows the gradual pathways to the doctor for distress. In addition, according to Sierra Hernandez *et al.*, (2014), if a man has a choice in the process of help seeking then he is able to maintain a sense of control over the situation (Sierra Hernandez *et al.*, 2014: 351). The data presented confirm what others have found: that significant others encourage the participants to pursue formal help and affirm that professional support is necessary.

### *Social norms*

Another external context that influenced participant's help-seeking behaviour was social norms, which included particular environments or cultural milieu. According to previous research, within their social context, men will ask themselves whether or not they perceive the emotional problem as normal (Addis and Mahalik, 2003; Seirra Hernandez *et al.*, 2014). Mahalik, Burns and Syzdek (2007) reported that men's health behaviours are influenced by what is perceived to be normative among men in general. This was notable in some of my participants' accounts, whereby having friends who had experience of help seeking for distress further motivated formal help seeking:

John 41:  
(General population sample)

AV: *Did you go to the doctors off your own back?*

John: *Yeah. It was funny because I was talking to another friend. He was having something similar and he described to me as he just didn't know what to do for help and this depression was like a big wall in front of him and he didn't know how to get over the wall. And he said he went to the GP and started just the talking therapies and he took medication... and he described it as the wall started to come down and he started to see how a way over it and how to move on and that's exactly how it felt to me. And I went to the GP and just, I was really surprised I just burst into tears and just sort of off-loaded everything which came as a, I didn't expect to do that, I expected to go have a much more calm conversation with him*

Although John did not get encouraged into seeking help by others, it was only after speaking to a friend that he decided to. Talking to others can help people in distress make sense of what they may be experiencing and feeling (this is further discussed in chapter nine regarding the benefits of talking about distress as a coping and management strategy). In the extract above, John started his story by describing the situation as a coincidence of similarity that is demonstrated in the mutual disclosure of depression within friendship networks. Sierra Hernandez *et al.*, (2014) demonstrate how men were better able to recognise depression in others through their own experience and this is evident here in John's friend's discussion of his own distress. John's account is consistent with Addis and Mahalik's (2003) social-psychological processes that moderate the construction of masculinity in the context of help seeking. This refers to the characteristics of the social group that men belong to and the influence of the social norms within that social group on help seeking decisions. Seeking help and divulging personal experiences is normalised within John's social group (Harding and Fox, 2014) and so impacted on his behaviour through social norms within that group. It is important to point out here that John is a well-educated, gay man, with a supportive friendship network of other males who are seemingly willing to talk in-depth about their emotional experiences. As a result, John and his similar male friends may have better knowledge of and access to healthcare as well as emotional and social capital (Seale and Charteris-Black, 2008), thus allowing them to be reflexive of their own emotions. The characteristics of his social group therefore influenced his perspective on help seeking and the ways in which his masculinity was constructed.



The social norms model (Sieverding *et al.*, 2010) suggests that seeking help is influenced by what is commonly approved by important others and what is commonly observed as done. When disclosing vulnerable emotions and feelings, men may hear important others say that it is important to get help for distress and they also may observe men they know get help. This can be seen specifically in John's account but also in the extracts above describing the influence of others in my participants' accounts of their pathways to support. Other men (and women) can broaden men's help-seeking actions (Sierra Hernandez *et al.*, 2014) and John's account highlights the importance of norms related to help seeking, dependent on their social context, as an influential factor in the help-seeking process. Specifically, John's account indicates the influence of descriptive masculine norms that are produced when a male observer sees what other men are doing in a situation (Addis and Mahalik, 2003: 10). The analysis regarding help-seeking influences illustrated here depicts men's disclosure of distress as an event within familial and friendship networks (more informal help-seeking) which then most often leads to seeking formal help. Perhaps men need confirmation and encouragement from others first before taking the direct route to the GP. Interestingly John did not expect to 'burst into tears', possibly unaware of the extent of his distress or perhaps he viewed himself as having emotional control as he expected to have a calmer conversation with the GP. Disclosing distress to a medical professional seemed to cross a certain emotional threshold in John and allowed for such sudden loss of emotional control and expression of emotions.

The importance of external cultural contexts in shaping whether men are likely to ask for help (Keohane and Richardson, 2017) is highlighted in the data and shows that men's decisions that lead to help-seeking in action are relational, depending on external contexts. A decision to seek formal help for distress emerges from conversations that may have involved disclosure, recognition and advice giving.

### *Reframing help-seeking as 'normal'*

It emerged throughout the interviews across both sample groups that those men who had had previous experience of formal help seeking and support had developed more positive attitudes towards help-seeking. Thus, the positive experience of help seeking is an influence itself. It appears that formal help seeking can lead to a change in attitude to help-

seeking practices, as well as recovery. James was particularly explicit in realising such a change within himself and his perception on seeking mental health support. He had previously sought help from the GP which led to one-to-one counselling, something that he identified as particularly effective. He recognised that having this counselling, this level of support, had changed something for him:

James, 61:  
(Support group sample)

*It sort of just changed something for me. Sort of said yeah if I break my leg, I go out to a doctor. It's the same thing. You need help, you need professional help, go see a doctor...*

Some participants who generally had more positive experiences and perspectives towards seeking professional help reframed the process of help seeking in an attempt to normalise it into the everyday. As mentioned previously, James' wife had to initially take him to the GP. Similar to participants in O'Brien *et al.*, 's (2005) study, James' previous practice to do with help seeking had shifted after his own experience. Following this positive experience of formal help seeking, including an attentive female GP, as well as successful engagement with support and counselling services, James reframed the help-seeking process in a more practical and logical way. In the extract above, James is comparing emotional distress to a physical problem such as breaking a leg, in the way that it should be treated, highlighting the potential way men privilege the physical over the emotional. For James now, mental distress is considered the same as a physical injury. Following his experience, James now instead constructed himself as an active participant in seeking mental health help (Johnson *et al.*, 2012). It can further be interpreted as an attempt to re-establish and preserve traditional masculine ideals through an active, positive and strength-based perception and approach to help seeking.

Such comparisons were seen within other men's narratives in an attempt to normalise mental health help seeking through metaphors.

### *Metaphors for formal help seeking*

As well as physical problems there were some participants who also compared seeking help for distress with external issues and activities, for example Daniel said:

Daniel, 34:  
(General population sample)

*You know, I have a golf lesson once a month just to tidy up my golf swing, it's exactly the same as probably going to see somebody. Just talking through your issues, which is life*

Here, in Daniel's comparison to golf, linkages to social class can evidently be made, as golf can be associated with those with higher economic status. Interestingly though, Daniel had not spoken to a professional about distress himself, yet as discussed in the previous section regarding hurdles to help seeking, he had tried to at one point. Similarly, Simon likens seeking help for mental distress to a practical fault with his house:

Simon, 42:  
(General population sample)

*If my pipes are leaking in the house, I don't just like shut the bathroom door and hope it's going to go away. You know, you phone a plumber and get an expert in... but you know we don't do that do we, well men don't do they?*

We can see that Simon is attempting to normalise the help-seeking process and shows awareness of how important seeking support and talking to someone about distress is. However, he suggests that men do not seek expert help. Simon starts by saying "*but you know we don't do that do we*" but then restructures his sentence by saying "*well men don't do they*". Using the homogeneous terms 'men' and 'they' in his narrative, Simon is distancing himself from engaging in such 'typically male' behaviour (resisting seeking help) and instead portraying his actions as exceptional and also praiseworthy. This shows that the dominant narrative around men's help seeking is still very much present, yet some men attempt to purposively position themselves outside of this discourse. This is similar to Fogarty *et al.*, (2015) who found that some participants acknowledged how stereotypical masculine behaviours and attitudes could be potentially detrimental to their health.

Moreover, James', Daniel's and Simon's accounts of mental health help-seeking show parallels with Johnson *et al.*'s (2012) discourse of treatment-seeking as a responsible independent action, whereby the participants are acknowledging a time and a place for rational and responsible approaches to help-seeking (Johnson *et al.*, 2012: 351). This 'taking action' discourse related to help-seeking practices (Farrimond, 2011) can be aligned with hegemonic masculine identities despite Simon distancing himself from 'other men'. This is also consistent with work (O'Brien *et al.*, 2005; Emslie *et al.*, 2006; Farrimond, 2011; Sierra Hernandez *et al.*, 2014) that indicated that some men attempt to redefine their masculine identity through assessing help seeking as retaining control, being responsible and actively dealing with problems. This is consistent with the positive masculinity paradigm (Kiselica and Englar-Carlson, 2010; Hammer and Good, 2010; Oliffe *et al.*, 2010) that points to the importance of emphasising the positive aspects of masculinity when it comes to health help seeking. Masculinities connected to the role of protector or provider can instead influence men to engage in self-care and support seeking (Robertson, Williams and Oliffe, 2016) to prevent such roles being threatened. My participants' new and redefined attitudes towards help seeking for distress redefined masculinity more positively in light of these roles. Thus it could be argued that my participants here were adopting a more culturally flexible, alternative masculinity, one which positions help-seeking as a necessity and as a way of actively dealing with any distress symptoms, for example when Daniel said about '*just talking through issues, which is life*'. Through this, participants are positioning and identifying themselves as healthy members of society. Conversely, in the previous section regarding hurdles to help seeking, Daniel spoke of a disinclination for being on a waiting list, as well as lacking time to engage in formal help. This demonstrates how men can be involved in changing and contradictory masculine practices in different times and places (Robertson *et al.*, 2016). However, it is important to note that both Daniel and Simon fall into a higher socio-economic classification and so may have better access to resources (Seale and Charteris-Black, 2008) that facilitate more flexible attitudes and use of masculinity than someone in a lower socio-economic class. Similarly, James had a supportive wife and also attended a support group, pointing to the importance of encouraging social networks and social norms on positive attitudes to help seeking.

In comparing and relating mental health to physical and other external problems, it could be argued that these men attempted to validate the experience of distress and their accounts of seeking help. They did this through constructing the problem as 'normal' and

so legitimising mental health help seeking. In doing this, it could be interpreted as an attempt preserve masculine ideals. This can be viewed as consistent with Addis and Mahalik's (2003) framework of social-psychological processes in how the participants perceived the normative nature of their problems and so addressed them and constructed their masculinity in this particular help-seeking context. Perceiving a problem as normative is expected to positively influence help-seeking behaviour (Sierra Hernandez *et al.*, 2014). However, having this perspective on mental health issues comes with experience as well as understanding. As noted, those in higher socio-economic classes, such as Daniel and Simon, may have a better understanding of distress and help seeking practices. This also relates to what will be discussed in chapter nine that considers how having a sense of perspective positively influences coping and management of distress.

## **Support preference**

Having explored participants' accounts of initial hurdles and influences to mental health help seeking, I now turn to examine the kind of support the men engaged in and what it was they found effective and had a preference for. Generally, as can be seen in the discussion so far, the participants' initial port of call was the GP, generally after conversations with immediate family and friends. It emerged that in general, the participants who said they had sought formal support from a therapist or counsellor, emphasised a preference for such help over antidepressants. Ten out of the nineteen men I interviewed from the general population and the majority (fifteen out of nineteen interviewees) of men from the support group sample had engaged in some form of talking therapy (including counselling, CBT or psychotherapy) in the past. Some of the participants had accessed counselling through their workplace or University, others had been referred to services through their GPs and a few had sought out private counselling themselves. What talking therapy they thought had worked varied and again points to individual complexities and preferences of support.

## *The benefits of counselling and talk-based therapy*

In participants' accounts of their experiences of counselling and other talking therapies, a number of participants constructed the desire to just have someone listen. Participants talked of how having had someone listen to them, helped to recognise the source of their emotional difficulties. In the extract below, Will discusses how counselling through the University was not quite person centred enough for him:

Will, 25:  
(General population sample)

*This is going to sound really awful but the counsellors yeah, they're lovely, they're really nice. It didn't have the depth I needed it was all kind of... "well let's just sit down and draw a quick kind of chart, colour this then you'll be fine". It wasn't anywhere near deep enough for me. I need someone to have like a good dig around my brain, figure out what the problem was, and they weren't up to that*

Will illustrated his perception of the difference between CBT and humanistic counselling, and it appears he preferred the latter. He evidently wanted professional help with his emotional troubles. There were other men in both sample groups who felt similar to this, preferred more in-depth talking therapies and counselling. Similar to Johnson *et al.*, 's (2012) participants, a number of my participants articulated the desire to have someone listen to their emotional problems as well as to be understood. Like Will, some participants spoke of wanting to talk more in-depth about past events and experiences that might have triggered distress, thus offloading was important and helpful in understanding their own distress. The data here contrasts with previous work that has suggested that men prefer more goal-orientated therapy (Emslie *et al.*, 2007; Seidler *et al.*, 2016), whereas my participants spoke of benefiting from "talk-based" therapy.

Cheshire *et al.*, (2016) have suggested that counselling could provide an effective talking-based intervention for men as an alternative to CBT, which is currently already available on the NHS, (Cheshire *et al.*, 2016). Other types of counselling options can often have limited availability as well as a higher cost. Since Will's initial counselling at University, he said he had been able to see a psychotherapist through the community mental health team. He felt psychotherapy was much more effective and gave him more to think about in terms of his own emotions. As will be discussed in chapter nine, it emerged that when men are willing to talk about distress, then it needs to be with the right person. As highlighted in

the data, some men do have preference for opening up, offloading and going 'deeper' to a stranger or someone in a professional position, in this case a psychotherapist (Berger *et al.*, 2013).

How effective particular types of counselling or talking therapies were to participants was also influenced by the relationship the participant had with the practitioner/counsellor. Thomas, from the support group sample said about counselling, "*I think it's very good, if you got the right person who's counselling*". This again supports Johnson *et al.*, 's (2012) discourse of genuine connection that emerged in men's accounts of help-seeking and refers to their willingness to talk openly and at length with health care providers whom they have established mutual trust and understanding. Genuine connection, which contrasts to traditional constructions of masculinity such as self-reliance and limited emotional expression, includes a desire to have someone listen and to be understood as a person and having one's distress validated within this context (Johnson *et al.*, 2012: 356). Linking back to Will's discussion above regarding his dislike for CBT type therapy, it is evident he was seeking out such genuine connection within the relationship with his counsellor, as well as a preference to be understood. This emerged in a number of participants' accounts of their reasons for preferring to speak at length with a counsellor or therapist over speaking to a relative or friend. For Shaun it was having someone else, someone independent of the situation, acknowledging the extent of his distress:

Shaun, 48:  
(General population sample)

*To have somebody else say yes that's a shed load of shit was cathartic enough for me to be able to contextual, probably stuff that went way back to when I was 16 so, that really helped me, just for somebody else to say, "yeah that was difficult it's no wonder you felt like that".*

Perhaps what is helpful for some men is having an independent, medical profession validate feelings of distress, as well as for a mutually respectful relationship to be developed. This relationship, whereby they are the ones choosing to disclose personal emotions, also allows participants to construct themselves as active and empowered agents in their relationships with formal support providers (Johnson *et al.*, 2012). The extracts above suggest that these participants did not completely abandon masculine ideals, as making the decision to seek out counselling therapies and knowing what they

want out of that relationship signifies independence and autonomy. It could also be interpreted that preference for such counselling demonstrates the negotiation of a more alternative and flexible masculinity, one that values the importance of emotional expression. This preference for speaking to a counsellor overlaps with the discussion in chapter nine regarding everyday coping strategies. In relation to how talking about problems can be a particularly helpful coping and management strategy, participants said they preferred talking to a third party and someone who “*won’t offer an opinion*” (Daniel, 34). Oliver, also felt similar about speaking to a counsellor:

Oliver, 34:  
(General population sample)

*I think you’re not feeling like you’re burdening someone. If you talk to a friend, it can feel very much like you’re giving someone else your problems to deal with whereas when you’re talking to a professional, I felt much less guilty.*

Again, as noted previously, this suggests that men may have different strategies for seeking professional help and talking at length about distress. These strategies may not be immediate and may take time to realise what works best for them. Feeling like a burden or wanting to talk to someone independent is not necessarily distinct to men’s gendered experiences of mental health support and this could also be true for women. Such factors for preferring to speak to a counsellor or therapist such as being able to offload and not feeling like a burden to those closest to them were also reasons for attending support groups and are considered in more detail in chapter eight that specifically focuses on the participants’ use of peer support groups.

### *Dislike of prescribed medication*

It emerged that use of prescribed medication was considered to be the least preferred and successful means of formal support for my participants. Most commonly, GPs offer medication in the form of antidepressants as an initial treatment regime. George from the general population sample claimed:



George, 45:  
(General population sample)

*So yeah, I decided you know, to go to the doctors and they dish antidepressants out like sweets don't they really*

A majority of my participants had taken or been given some form of antidepressants after consulting the GP. In general, it emerged that a majority of the men were opposed to the idea of medication and also reluctant to take antidepressants. For example, when Nick told the GP about his break-up, he was given medication:

Nick, 54:  
(General population sample)

*And he gave me tablets but when I read the side effects, I wouldn't take them. So, I took them for about a week and then I thought ah I'm not doing these, they'll make me more depressed.*

George also talked about side effects of antidepressants:

George, 45:  
(General population sample)

*They prescribed Citalopram. I took them for two weeks... they made me feel worse really. My god the side effects sexually. I thought the only thing good in my life was the sexual stuff going on and it killed the sexual side. I thought I'm not taking them.*

Previous research has found that people using antidepressants have reported having conflicting feelings about their own use of the medication (Garfield, Smith and Francis, 2003; Grime and Pollock, 2003; Karp, 2006). Gibson *et al.*'s (2016) work is a unique study in exploring men's experiences with antidepressants, examining how such experiences are shaped by constructions of masculinity and the use of such medication can present challenges to their own masculine identity. For George and Nick, it was the distinct side effects of antidepressants, such as a functioning sex life, that had the potential to threaten and conflict with masculinity, as well as decreased enjoyment of certain aspects of life. This is consistent with Gibson *et al.*'s (2016) findings that recognised how impotence has a strong association with the failure of masculinity (Gibson *et al.*, 2016: 7) and so is one of the reasons my participants said that they refused to take antidepressants.

In both Nick and George's discussions, this decision was often to do with side effects of the pharmaceutical itself. The material effects of the medication itself can also be one of the reasons that people struggle with using this medication (Pound *et al.*, 2005). Interestingly, later in the interview, George said that he now takes dietary supplement 5-HTP, which (he said) helps to raise serotonin levels in the brain. This indicates that he was not completely averse to medication in tablet form. It could be argued then that choice to not take this medication is not clearly gendered or distinct to men and issues to do with side effects could be true for women also. However, traditionally sexual desire has been tied in with masculine identity and behaviour and so George's reason for not taking the medication may be due to a masculine ideal. Moreover, we cannot say that women do not experience this side effect of antidepressants or that they choose not to take the medication for such reasons (Gibson *et al.*, 2016). Previous research has found that male participants interpreted medication as threatening to their masculinity and linked to a loss of control (Oliffe *et al.*, 2010), which can be seen in the participants' accounts above. In relation to this, Steven, from the general population sample, said he was still taking medication but voiced being reluctant to because he said he "*felt like he wanted to deal with it himself*". This depicts that he was trying to maintain some control and self-sufficiency in his management of distress that can be interpreted as an attempt to preserve masculine ideals.

As with Steven, the men that were still taking some form of antidepressant emphasised that it was more of a "*foundation to build on*" and to reiterate the point made above, talking about distress, whether that be professionally or informally, was the preferred type of support. Participants that had taken medication and engaged in talking therapy or counselling suggested that it was a combination of both these treatments that could often work well for them. This was particularly the case for many of the men from the support group sample. In general, the men from the support group sample were less negative towards the use of medication and those who were taking antidepressants (or other medication for mental distress) acknowledged the importance of them in recovery and daily coping. As will be mentioned in chapter eight, the support group offered them a chance to discuss different medications and any problems relating to these medications, so perhaps normalising the use of medication and limiting any potential for vulnerability or stigma that might be attached to anti-depressant use. However, these participants who attended support groups also recognised that effective treatment is a combination of

medication, talking more and being self-aware. Not only this, but there were some men who were taking antidepressants because they had not been able to get access to any other means of formal support. Unfortunately, some participants pointed out that GPs do not usually offer counselling straight away.

The participants' accounts of a general dislike of being "*fixed*" with medication instead of talking to a professional about the complexities of their lives again reiterates further the discourse of genuine connection (Johnson *et al.*, 2012). From these accounts regarding medication use, participants appear to be moving away from a traditionally masculine preference of a 'quick fix' and 'problem solving' treatments to a desire instead to be listened to, understood and not be judged. This reaffirms the claims that medical institutions have positioned help seeking as a feminised activity (Courtenay, 2000) and as Keohane and Richardson (2017) argue, this discourse of genuine connection raises certain questions about whether men are being offered the appropriate forms of help during times of emotional distress.

## Conclusion

This chapter has explored experiences of seeking formal support for mental distress of men from both sample groups. Specifically, this chapter aimed to answer the second main research question:

RQ2 - What are men's experiences of help seeking?

As the majority of participants had sought some type of formal help or had talked about intending to seek out help, I conclude that some men do seek out healthcare support for emotional problems and there are varied ways in which they go about doing this. Nor did participants hold particularly negative attitudes towards mental distress help seeking. On reflection though, men with experience of distress and more positive attitudes to help seeking were always going to be more likely to volunteer to take part in this research than those with negative views and experience of mental health help seeking. Despite this potential limitation, the data presented in this chapter sheds some light on the varied help seeking experiences and preferences of different types men.

In their experiences of formal help seeking, the majority of participants admitted that seeking help was not an immediate action. This was because of a number of hurdles they had to overcome first, including difficulty in recognising and articulating distress symptoms, and also the perception that they lacked time and access to GP and mental health services. These accounts seemed to reflect ambivalence towards help seeking, whereby they justified their reasons for not pursuing formal support through external social contexts. In the discussion of initial hurdles to help seeking mentioned by my participants, it is important to draw attention to the reality that most of my participants had sought or, at least, attempted to seek out some kind of professional help for distress. Much of the data here then, constructs an alternative to the dominant discourse that men are unwilling and reluctant to seek for distress.

Following the initial hurdles faced and consistent with much previous research, significant others such as immediate family and friends were influential formal help-seeking enablers (Harding and Fox, 2014; Seymour-smith *et al.*, 2002; Cusack *et al.*, 2004). Speaking to these significant others about their distress experiences can be perceived as more informal help (and is discussed further as a coping and management strategy in chapter nine), but this also led to and facilitated more formal help and support through encouragement and motivation by others. Participants often initially sought help from the GP in times of distress and then this often led to either being prescribed medication or referred to counselling or talk-based therapy. In some instances, participants had sought out counselling or talking therapy themselves, without the assistance of the GP. In this discussion of support preference, the data presented suggests a general dislike for prescribed medication (Siedler *et al.*, 2016) and a desire to have someone (independent of family and close friends) listen and to be understood (Johnson *et al.*, 2012).

Some participants' accounts used metaphors for help seeking to normalise and legitimise practices. This use of metaphors as well as their preference for counselling and talking therapies over 'quick fix' medication emphasises the complexity of gender in relation to help-seeking practices. This points to the different ways that masculinity can be enacted and constructed that go further than a one-dimensional construction that always emphasises stoicism and self-sufficiency. There is not only one best route of help seeking

nor is there one stable masculine identity that constructs help seeking in a particular way, at a certain time and across different groups of men. In this chapter I have only focused on professional healthcare help seeking, such as speaking to the GP or counselling, and it is important to acknowledge that there may be other sites of help for distress (for example, web resources, helplines) that other men may use when experiencing minimal distress. In chapter eight and nine I attempt to explore some of these other sites of help, including using peer support groups (chapter eight) and turning to spouses, partners and peers for informal support as everyday coping and management strategies (chapter nine).

# Chapter Eight- Men's experiences of using support groups

## Introduction

In this thesis, the aim of recruiting men who had accessed some kind of support group was to explore the effectiveness of that particular type of formal support for men in coping with and managing their mental health distress. This chapter will again continue the exploration into participants' articulated experiences of formal help seeking and examine their experiences of using support groups and what they deemed useful about such groups. The men I recruited and interviewed were attending or had attended a support group of some kind and I was interested in finding out what it was about the service that particularly worked for them, in an attempt to highlight the benefits of peer support for men in the absence of clinical treatment or one-to-one counselling, an area of research which is currently limited. It has been suggested that when men do initially seek help from the GP, treatment options are usually limited to medication or long waiting lists for counselling services (Cramer *et al.*, 2014). This was also portrayed in the findings presented in chapter seven. Groups are becoming increasingly popular as opposed to individual therapy as means of help for people who are struggling and also as a way to increase access to support. Previously in chapter four, I discussed the different types of support groups that men were recruited from and how these varied in their structure and attendees. To recap, these groups were not professionally run therapy groups but peer-groups that involved lay people offering support to each other. The groups included mixed gendered support groups run by third sector organisations, mixed gendered self-funded peer-support groups set up by individuals in a local community and also men's groups specifically targeted to older men.

From the analysis it emerged that the perceived effectiveness of the different groups varied, depending on the man and his circumstances, the kinds of distress experienced and the structure of the group. Although what works for each man is mostly

personal to them and therefore varied, through analysis, common themes around the groups' effectiveness emerged. The findings that I present here that reveal the perceived effectiveness of support groups, support and build on Thoits' (1995; 2011a; 2011b) theoretical argument that puts forward seven possible mechanisms through which social relationships and social support improve psychological wellbeing. These included: social influence/social comparison, social control, role-based purpose and meaning, self-esteem, sense of control, belonging and companionship, and perceived support availability (Thoits, 2011a). This chapter will use these mechanisms in the discussion of the developed themes to demonstrate the ways that social support through peer support groups can have a positive effect on emotional wellbeing and be effective in managing and reducing distress. I do not completely structure the chapter around Thoits' themes but integrate her concept of mechanisms throughout the themes, with noticeable overlaps within and throughout. The themes discuss the main aspects of the groups that benefited the participants and what was it about the groups that worked as a useful tool in coping and managing their distress.

## **“They’ve walked in my shoes”: Shared understanding and experience**

One of the main factors of the support group setting that was commonly constructed as useful to my participants was being able to be amongst and speaking to others who had similar experiences and so were *‘like them’*, which in turn lead to a particular level of understanding and empathy. What became apparent is that through attending and opening up within a group setting, the participants felt that what they had to say, and even more so what they experienced, was more relatable within that setting than it might have been outside of the group setting. During the interviews, I asked the participants what it was about the group that was beneficial to them and why talking within the group setting particularly worked:

Mark, 64:  
(Mixed gender, local community-led depression support group)

*.... because you're in a room with like-minded people. Who've either been there or are there, and they can relate to what you say*

Here we can see Mark constructed himself in the same position as others who have experienced mental health difficulties, claiming that the people within the group are like him, with similar thoughts, experiences and attitudes. For Mark, only those who have experienced what he has can relate and that is why talking within this setting works so well for him because he does not talk to anyone else. This is consistent with previous research that has found that in support group settings, the relationships established are based on a unique mutual understanding of experience, which cannot be developed with those who have not had that same experience (Gray *et al.*, 1997; Coreil *et al.*, 2004; Ussher *et al.*, 2005; Thoits, 2011a, 2011b; Gage, 2013). Thoits (2011a) calls these voluntary group members 'secondary groups', which are less personally invested in the individual, and so do not include immediate family and friends, as well as not needing to have the same social characteristics (e.g. age, gender, race/ethnicity and socioeconomic status). However, as Thoits (2011a) claims, direct experiential knowledge and in particular the experience-based support they can provide, is key to effective emotional sustenance and also active coping assistance (Thoits, 2011a: 154). Those who attended the support group therefore shared a common identity and the group itself becomes a kind of community of support.

For Mark and others, this 'shared ownership' created a sense of belonging (Seebomh *et al.*, 2013) in the face of mental health distress. Belonging and companionship is one of Thoits' (2011a) social psychological mechanisms that link social relationships to improved mental wellbeing. Belonging implies acceptance and inclusion by members of secondary groups, which was often described by participants in their discussion of perceived effectiveness of support groups. This can also be seen in Rhys' account in the extract below whereby he expands to describe the flexibility of understanding that support groups offer:



Rhys, 53:  
(Mixed gender group, meets in various areas)

*Rhys: And I'd just feel good speaking to people that sort of understood without me having to explain what was going on in my head, you know. And that was the thing with [name of counsellor]. I felt like I needed to explain my symptoms that I'd been going through sort of thing. Whereas when it's peer support, it didn't matter whether I did or not. If I wanted to it didn't matter, that was okay, but I didn't have to. I didn't feel like I had to, but I go to meetings, if I don't say anything that's fine and nobody is going to say what's wrong, you haven't spoken. Nobody has ever said that*

*AV: It's like being with someone who resonates with how you've felt?*

*Rhys: Yeah, they've walked in my shoes if you like. They might not have been to war but that doesn't matter you know. It's just like it doesn't matter what's happened because [name of the group] isn't there to fix anything, we're not medical, we're not professional, we can't fix anybody's problems and nobody in [name of the group] fixed my problems but they do just by being there*

Rhys reiterated this sense of shared understanding and experience that is present within support group settings. Group members may not have had the exact same experience of distress or trigger of distress, in Rhys' case having been part of the armed forces and experienced post-traumatic stress disorder, but they have on some level experienced emotional difficulty, and because of this he feels they have "*walked in his shoes*". From similar experience, similar others have an in-depth understanding of the many facets of distressful situations. For him, this shared understanding is unspoken, as if members of this group setting have this equal insight and awareness that others such as family members or counsellors cannot have. Rhys compared how he felt speaking to his counsellor to speaking to the group where there was less pressure to explain fully how he feels because they have that level of understanding. As well as that sense of belonging that support groups can encourage, for Rhys there appeared to also be a sense of 'knowing' without him having to actually explain anything. These people in the group are just like him. Mead (2003) says that people feel a connection with other people that they think are like them and this affiliation is a "deep, holistic understanding based on mutual experience where people are able to 'be' with each other without the constraints of traditional (expert/patient) relationships" (Mead, 2003: 1), which is evident in Rhys' description of his relationship with his counsellor.

For Rhys specifically, as well as other participants discussed in this theme, the unique mutual understanding of experience that could be encountered within support groups facilitates masculine practices such as retaining control and autonomy. For men, the constraints of an expert/patient relationship can threaten masculine power and have the potential to subordinate and marginalise masculine status. Choosing when to speak about their distress and emotions only when it is the right time and place for them allows men to hold on to some control and also to construct hegemonic masculine identity. This is further expanded on in the following themes. Notably, having the choice when or when not to talk about their mental health within groups was important to a number of my participants. It could be suggested then, that this 'not talking' itself is a coping mechanism for men, and particular settings (whether that be formal support group settings or more informal settings such as meeting with friends or family, in the local pub etc.) can help men by providing a space to be around others with, potentially with similar experiences, without having to articulate emotions or talk about themselves.

This assumption of an 'unspoken connection' may be especially advantageous to men who typically might not always want to talk to those closest to them or explain how they are feeling at any great level of depth. Just 'being' around those who have experienced similar adversity, and so have a particular level of understanding, ultimately made Rhys and other men who attend groups feel more comfortable with their own feelings, a situational experience that might not be as achievable through interaction with a professional counsellor for example. Interestingly, although it was found throughout the support group sample that one-to-one counselling was helpful and generally preferred to groups, the flexibility and informality of peer support groups was noted as a particularly effective and supportive aspect of groups that counselling did not possess. As Rhys discussed, there was no pressure on oneself to speak or behave in a certain way and those in the group will understand and respect this. Furthermore, the extract above reveals a certain level of acceptance and connectedness, something that people experiencing distress may often seek when the experience of distress itself can cause isolation and loss of self and identity. This may be particularly true for men who feel at loss with their masculine identity due to emotional troubles. Ussher *et al.*, (2005) position support groups as providing a strong and unique sense of community and non-judgemental acceptance and through this they facilitate coping (Ussher *et al.*, 2005: 2573).

Knowing that there were other people, particularly locally, who shared experiences similar to them provided comfort and acceptance to support group attendees at a time when distress and mental ill health could have the potential to isolate and segregate.

Joseph believed that no one else could possibly understand his feelings:

Joseph, 66:

(Mixed gender, local community-led depression support group)

*Well it's made me feel less isolated because you know there are other people who are experiencing the same or very similar to you. Cause' you can think you are the only one in the world experiencing these thoughts, doing these actions, but when you speak to the group you appreciate that other people have been there, maybe still are. So, you see yeah there's much more widespread than you first perceive.*

*[...] I meant you're talking to people, with empathy for your situation not just people with sympathy for your situation. You're talking to people who know, who've done that and wearing the t-shirt, that's what I mean by less isolation. I don't mean physical isolation from people I mean, understanding of different people*

Above, Joseph explicitly mentioned the shared empathy for a distressful situation. Thoits' (2011a) argues, through her concept of social mechanisms, that empathy from similar others is a factor that can reduce distress and emotional impacts. Again, similar to Rhys' discussion, by having "been there" themselves, similar others can tolerate expressions of distress and validate the normalcy of the person's emotions through this empathetic understanding (Thoits, 2011a: 154). Thomas from the same support group also explicitly acknowledged this:

Thomas, 62:

(Mixed gender, local community-led depression support group)

*So, I'm not just sympathetic I'm empathetic and I know what he's going through coz I've been there myself and once you talk to someone who has been there, and does really understand what you have been going through, I think it's much easier*

Empathy, which refers to the ability to understand and accurately acknowledge the feelings of others, was cited by participants as preferred to sympathy, which has been described as the emotional reaction of pity towards another (Post *et al.*, 2014).

Additionally, Joseph talks about how before he attended the group, he had not realised how many other people might have been experiencing the same thoughts and acting the same way as he did during times of distress. Lack of awareness of mental health issues is seemingly more common among men (Courtenay, 2000) and this combined with the isolation that distress can often create, led to Joseph feeling like “*the only one in the world*” experiencing that. Through speaking about problems to other people who understood and accepted them, all three men discussed spoke of feeling less isolated and more hopeful (Seebom, 2013). Similar to Rhys’ description about “*walking in his shoes*”, Joseph uses a metaphor, “*wearing the t-shirt*” to portray this level of mutuality that was present within the support group. Those who have shared experience and first-hand insight to coping with a particular distressful life event are therefore more empathetic and able to provide specialised emotional support (Sutor and Pillemer, 2000; Gage, 2013).

Jim, 74:

(Mixed gender, local community-led depression support group)

*Whether it’s because you’re hearing about different people, how different people feel. Like sometimes you look at yourself and you think to yourself I’m the only person who’s ill... but when you see other people and you think to yourself, I’m not that bad, or I don’t feel that bad*

Like Joseph, Jim’s comparison to others’ experiences gave him a different perspective on his own feelings of distress. Having an interaction with others’ feelings caused Jim to consider his situation differently. This can also connect with Thoits’ (2011a) mechanisms of social influence/social comparison, suggesting that through comparisons with similar others, people acquire norms about health behaviours, for example seeking a particular type of support or complying with medical regimes. Individuals may compare their emotional reactions and coping styles to others who have faced similar life stress (Thoits *et al.*, 2000; Gage, 2013) and then shift their own coping attitudes, beliefs and behaviours to match those of the support group. Furthermore, and observed in both Jim and Joseph’s discussions and behaviours, Taylor and Lobel (1989) suggest that individuals may also compare themselves against less fortunate similar others and so perceive their own distress differently.

Although this idea of shared understanding was commonly voiced amongst the support group sample, I recap here that it was not unique to only those who have attended

groups, as discussed in the previous chapter (seven) that explored who men preferred to talk to and seek help from at times of distress.

## **A safe space to offload**

Not only did support groups provide a space for experientially similar others to come together to share problems, but what emerged from the interviews was that the men also felt that the group provided a safe and trusting space to disclose difficulties, something they might not always feel able to do with friends and family. They often identified the confidentiality aspect of the group and how important that was in choosing to open up within the group:

Kyle, 34:

(Mixed gender, third sector organisation led depression support group)

*Its more just a chance for people to talk in confidence about, you know, what's stressing them, what's bothering them, stuff they feel they can't talk about elsewhere and obviously the idea that it is in confidence, so it doesn't go outside.*

Here, Kyle identified the importance of confidentiality within the group setting and this illustrates how the group setting might be the only space whereby people have the chance to open up and talk about their distress. Being around people with shared understanding and experience validates emotions and offers a safe outlet to ventilate feelings (Thoits, 2011a). The group setting was perceived as somewhere safe and for some men, the only space they feel as safe and acceptable to open up. This principle of confidentiality is found within support groups because of the mutuality present as discussed in the previous section. The influence of confidentiality was in some cases discussed as a reason for the choice to offload to the group over close family and friends.

Mark, 64:

(Mixed gender, local community-led depression support group)

*I find the chat, not so much helpful for me now because I'm feeling better but when I was poorly it was great because you could offload rubbish, and the nicest thing about it was it was in confidence [...] I don't offload anywhere else. I don't offload to my wife, my family, my friends and I certainly wouldn't offload in a pub environment, if I used one. I don't use them, but you know what I mean. I wouldn't offload there, so to answer your question this is the only place where I offload. I don't tell my wife no, she's got enough on her plate without me boring her to death*

As we can see in the above extract, Mark talked about “*dumping*” the “*rubbish*” feelings on the group and what made this easier to do is knowing that whatever he talks about within the group will not be discussed any further. Given that men may be reluctant to open up emotionally due to the fear of perceived vulnerability, the affirmation of confidentiality amongst similar others is able to facilitate the participants’ openness within support groups. There was a perceived unspoken knowing that there will be no judgements because everyone else in that setting is “*like them*”. This was the case for both Kyle and Mark, where the group had been the only place that they had felt able to offload. This provides some evidence of how useful such support group settings can be to men, who may feel that offloading anywhere else may lack confidentiality and so result in judgement.

In the data presented so far, it can be identified that a sense of community was articulated in the men’s accounts. Thus, the support group can be defined as a community of practice (Lave and Wenger, 1991; Creighton and Oliffe, 2010) through which masculine identity is contextually reframed through stories of shared experience, shared identity and social positioning. Social identity is developed through shared personal storytelling and community narratives in groups such as support groups. According to Mankowski and Rappaport (1995), masculine identity may be understood in terms of storytelling, guided by hegemonic masculinity or dominant cultural stories. Similar to Simpson and Richards’ (2009) study, this shared masculine identity that emerged in the support group setting allowed for the portrayal of a level of emotional vulnerability, something that they still may feel unacceptable to show outside of that setting. Furthermore, it highlights the importance of social context in the construction of gender identities and the embodiment of masculinity more flexibly. In the support group context, being around other men with shared experience facilitates norms that enable masculinity to be restructured into more

health positive ways. This demonstrates negotiation of a more flexible masculinity, whereby vulnerability is acceptable in certain situations and contexts.

Here, Mark is engaging in varied masculinity practices in his decision to “offload rubbish” to others at the support group he attends. He demonstrates complicity to hegemonic values of masculinity in choosing not to offload distress in the ‘typically masculine’ setting of the pub so sustaining an element of control, autonomy, choice and self-reliance in his choice (Connell, 1995, 2000; Courtenay, 2000). However, counter to hegemonic ideals he chooses to open up about distress, and benefits from doing so within the support groups setting, so similar to Rhys’ account in the previous section, makes the rational choice to disclose feelings of distress to others when there is the view that it is safe to do so amongst others with whom they have built up trust. Thus, my participants are breaking expectations of men’s reluctance to engage with, and benefit from, health services such as support groups. They are also breaking the assumption that men find it difficult to disclose and offload distressful experiences. Instead, there is evidence of negotiating hegemonic masculinity in different ways that allows them to gain from the support group interaction and experience.

Interestingly, in Mark’s discussion of how the group provided a safe space, he explained that he does not talk to his wife as it may “*bore her to death*”. Mark assumed that his problems could be a burden to his wife, echoing the point made in the previous chapter regarding help-seeking (seven) and what will also be noted in the following chapter (nine) to do with men preferring to talk to others who were detached from their situation. This is consistent with Cramer *et al.*, (2014) who found that men who utilised support groups had a preference for support outside of immediate friends and family, as is noted in Mark’s account.

## **Tailored support offered and received**

Those experiencing illness, especially mental health difficulties, often find it difficult to get the tailored support that they need or want. As described earlier in this chapter, through having that shared experience and knowledge, experientially similar others are able to offer as well as give specialised dimensions of support and authentic empathy. Being the

one to provide that specialised support can also have huge benefits to psychological wellbeing. It emerged throughout the interviews that giving support was also just as important as receiving help. Similar others offer active coping assistance by supplying information, advice, appraisal feedback and encouragement (Thoits, 2011a). Some men talked about how even after the group had helped them through to recovery, they still attended because they wanted to help others and felt as if they were an important part of the group's function.

Thomas, 62:

(Mixed gender, local community-led depression support group)

*And I've been coming ever since, and I got better, slowly got better. And anyway, every meeting you come in and they give you a chat and have you got something to say, I say well I'm fine. I been good for weeks and weeks I said but what I'm going to do is keep coming and if somebody want me to do a one-to-one with them up here - sometimes, I used to bring some men up here on a one-to one to talk to me like, about depression and I tried to explain to them, how I sort of beat it, what I do and listen to their problems and... so I just kept coming to help other people really*

Reciprocity is an integral part of the process of peer support group settings, which makes it distinct from 'expert worker support' (Repper and Carter, 2011: 395). According to Mead *et al.*, (2001), it is reciprocity that distinguishes peer-to-peer support group settings and relationships from the unequal relationships and power dynamics that are found between a patient or 'client' and professional. During distress, men may face some loss of power due to vulnerability and so could struggle with such an unequal relationship. This indicates the importance the role of peer support groups could play for men. It has been previously found that the chance to reciprocate help is an important help-seeking enabler for men (Harding and Fox, 2014) and evidently one of the reasons that support groups were effective for my participants. Reciprocal support in peer-group settings can 'preserve masculine status' and provide adherence to societal expectations of masculinity through ensuring strength and competence (Addis and Mahalik, 2003; Mansfield, Addis and Mahalik, 2003). Being able to provide support to others facilitates a defining role within a group as provider, problem solver and someone in control, aligning with masculine ideals (Courtenay, 2000; Addis and Mahalik, 2003). Furthermore, having the opportunity to support other men can act as on-going therapy for men (Simpson and Richards, 2019), as identified in Thomas' account.



Having said that, Thomas' account and the idea that reciprocity in support groups is useful to men highlights some tensions in masculinities. Thomas' willingness to disclose distress and receive support is countered by his reciprocity and actions of giving back support to others, particularly men, in the group. He has become 'expert' through his own experience of distress and support seeking and is able to maintain dominant forms of masculinity through this newly acquired role. At the same time he is also adopting an alternative and more flexible masculinity that allows for both the giving and receiving of emotional support. Providing empathetic support and help to others could be traditionally perceived as feminine, thus demonstrating alignment with more hybrid and newer forms of masculinity. As observed above, the support group setting can be viewed as a community of practice (Creighton and Oliffe, 2010) which offers legitimate opportunities to break from hegemonic masculinities. However, for my participants, giving back support to others is an alternative way to endorse hegemonic masculinity and masculine status rather than completely break away from it. It allowed them to further utilise and assert their masculine capital in a positive way to relate to others, in particular to other men. Interestingly, Thomas talks about providing emotional support to other men specifically, rather than to women. This is interesting as it suggests that since his experience of mental health difficulties and his recent recovery, he now perceives that he is able to relate better to other men struggling with emotional difficulties, through specific knowledge and experience of being a man who has experienced distress. Thomas uses hegemonic values such as being a provider (of support) and a strong man who "beat" depression, to not only enhance his sense of masculine self after experiencing distress, but also to relate to other men and retain a sense of masculine capital within these settings.

It emerged that for many of my participants, attending the groups provided them with the chance to influence others and gain a particularly valued role within the group, notably at a time where role loss may have happened. The data supports Seeborn *et al.*'s (2013) findings that found that participants wanted to give back the help that they had received within peer support groups, as a way to prevent others from other potentially poor clinical experiences that they might have had. Having been through that journey themselves, these participants had become 'experts' and wanted to pass knowledge on to others. This characterises the more implicit or indirect social psychological mechanism of behavioural guidance, purpose and meaning (Thoits, 2011a), whereby individuals accept social roles as identities. According to Thoits (2011a), knowing who we are to others

provides purpose and meaning in life that then shields against anxiety (Thoits, 2011a: 148) and so specific role identities, such as the role Thomas adopted within the group, and believing that they are important to another person, can have positive effects on mental wellbeing.

In Mark's discussion of such reciprocity described, he said that he brought in his prescription to talk through different types of medication to others in the group and explained how they appreciated his comments because he had first-hand experience and had *"been committed, I've seen the standard of care once been committed which is appalling"*. Most of my participants who attended support groups had had a diagnosis and so this had shaped their experiences of help seeking and support to some extent. Sharing these experiences and using their knowledge of their own diagnosis as well as of medical healthcare settings to potentially help others can have a positive effect on participants' own self-management and coping. In the extract below, Mark explicitly acknowledged how contributing to the group helped him and how it made him feel, having gone back to the group despite no longer attending following recovery:

Mark, 64:  
(Mixed gender, local community-led depression support group)

Mark: *I had a birthday card of the group and it said something like we "miss you at group, we need your guidance" or something like that. Which was very complimentary. So, I come now because I feel I can contribute rather than participate*

AV: *And help them?*

Mark: *Yeah and it makes you feel better doesn't it*

The act of 'giving' has been identified as a way of promoting wellbeing (Aked *et al.*, 2008). As we can see, Mark found the group's request for advice complimentary, which gave him a sense of appreciation where he was not only understood and accepted by others but also needed. This highlights how support group membership and attendance can increase self-esteem (Gray *et al.*, 1997), knowledge and confidence as well as a sense of agency, which Borkman (1999) suggests replaces previous passive and pathological attitudes (Borkman, 1999). Men, such as Mark and Thomas, may also benefit from this sense of control and being positioned as a valued member of the support group community, at times where

their valued sense of self and confidence as well as their masculinity, may have been threatened in the face of distress. Similar to the discussion above regarding reciprocation, adopting a particular role within the group setting could be a way of reconstructing masculine identity in that particular community (Creighton and Oliffe, 2010) and allowed participants to preserve or reconstruct traditional masculine status. Mark and Thomas attended a mixed-gender peer support group and so assuming a specific role that involved providing assistance to others, both men and women, facilitated them to gain a sense of masculine value and self-worth.

Also illustrated here within this theme are Thoits' (2011a) social psychological mechanisms of self-esteem and a sense of control or mastery. Both these mechanisms tie in with the above discussion regarding purpose and meaning and derive from role identities. Self-esteem and a sense of control or mastery can be viewed as ideals of masculinity (Courtenay, 2000). Through their roles within the support group, Mark and Thomas self-evaluated their performances, which has the potential to have a positive effect on self-esteem, which in turn is associated with lower levels of anxiety, depression and distress (Baumeister *et al.*, 2003; Thoits, 2003). Perceptions of control or mastery through being positioned into this valued role within a group can strengthen confidence in one's ability to cope with distress (Thoits, 2011a). In addition, similar others in a group setting giving and receiving support also serve as role models who can be observed and followed (Taylor and Lobel, 1989) by others experiencing challenging life stresses. This social comparison generates hope, encouragement, emotional support, health-related information and knowledge among the group setting as Mark and Thomas may have done in their support group. Participants further discussed continuing to use the support groups even when they were no longer needed because as described, the role identities, relationships and social ties developed within the setting had positive effects on maintaining and managing mental wellbeing.

## **Reducing isolation and social benefits of groups: Socialising, meeting new people, discovering new hobbies and interests**

In addition to providing much needed mental health benefits, it was found amongst my participants that support groups were helpful in providing support for other areas of life. It emerged that support group settings provided a space for social contact to build social and

friendship networks as well as being a place to discover new interests and engage in something new. This seemed to be a deciding factor for Kyle in attending a support group:

Kyle, 34:

(Mixed gender, third sector organisation led depression support group)

*You know, I didn't have what you call a support network. When you go to the doctor, they always ask, you know, have you got a support network, that kind of thing. So, I suppose for me the obvious thing was I didn't have a support network um, so [name of group] seemed like something to me that was worth trying*

For Kyle, the support group service provided an alternative social support network instead of immediate family and friends. A number of men, due to personal circumstances, work or family estrangements, could be in the same situation as Kyle, and do not have a close support network to utilise in times of distress. In general, for participants, whatever the structure of the support group, the setting also served as a means to meet new people, make new friends, keep busy and active and also learn new things as well as gain other hobbies and interests. Evidence for the benefits of support groups identifies the social benefits groups can have through the way in which they increase participants' social networks and reduce social isolation (Davidson *et al.*, 1999; Cramer *et al.*, 2014). This was found to be particularly true of the groups that were aimed at older men who may be retired, or for those people who could not work due to ill health. As noted earlier (in the introduction to this chapter and in chapter four), the structure of the groups and how they were run varied, including engaging in different activities or just meeting for a chat about personal struggles. Both these types of groups provided structure, routine and something to do for participants.

A number of the men (nine out of nineteen interviewees) I interviewed from the support group sample were either retired or unemployed and so attending a weekly support group provided structure to their week, something to look forward to and a chance to get out and interact with others.

Peter, 62:

(Men's only group)

*So, I find coming here is quite relaxing. It gets me out the house, it gets me socialising with people you know. I've met a lot more people here and with the legion than I would if I was sitting in the house all day*

Particularly in old age, living alone can be common for men. For Peter, presented in the extract above, as well as for Andrew demonstrated in the following extract below, getting out of the house, where he lived alone, was an important aspect to his day. It is the social element that the group provided that was particularly useful to Peter. For older men, adjusting to life following retirement may be challenging as many men focus on the importance of work throughout their adult lives and work has likely been a determinant of their identity as men and with retirement comes identity and role loss, reduced sense of purpose, and disconnection from others (Collinson and Hearn, 2004; Kleiber and Linde, 2014; Oliffe *et al.*, 2013b; Wilson and Cordier, 2013). Specifically, the transition into retirement has often been associated with a loss of work-related friendships that can impact on older men's social isolation. It is especially important then that they find and have access to other meaningful social activities and sources of leisure. For Andrew, the support group enabled him access to such social activities:

Andrew, 69:  
(Men's only group)

*Basically speaking, it gets you out of the house and it gives you an interest, doesn't it really. Which is good*

*It creates a kind of a balance really, you come here and all that and you take part in it. Well, it's better than roaming the streets of [location] now, nothing to do, know what I mean. All the pubs are full, oh god what a bloody environment innit, you know what I mean, and that's it. You've gotta have an interest in something. Because there's nothing worse than being bored. Boredom is devastating, boredom*

Both Peter and Andrew attended the same group that specifically aims to tackle social isolation in older men. Indeed, from the extracts we can see that the group is achieving this. Evaluations of such groups have identified how they can also have health benefits (Cordier and Wilson, 2013) and specifically cater to the social needs of older men who may be experiencing social isolation (Dave *et al.*, 2008; Milligan *et al.*, 2016). Broughton, Payne and Liechty (2017) found that meet-up groups for older men enabled social engagement and connectedness, provides friendship and social support to cope with stress and/or negative life events, and they are also a space to share health information (Broughton *et al.*, 2017: 268). One of their participants described such groups as '*continuing the camaraderie*' that they previously had within a workplace environment. This was also found throughout some of my interviews, whereby the men I spoke to had previously had

roles within the military and other typically male work environments such as manual or mechanic trades, and so they specifically spoke of the notion of camaraderie and how the group setting provided an extension of this following retirement or unemployment.

This fits with hegemonic norms such as the importance of work and how social identity has been established throughout their work life. Furthermore, both Peter and Andrew's accounts reveal the hegemonic masculine practice of independence, also underpinned by choice and self-reliance (Mackenzie *et al.*, 2017). They had the option and choice regarding their involvement in the men's only group that they attended. However, contrary to traditional beliefs about men and masculinity, Peter and Andrew instead valued social connection and engagement with others over self-reliance and independence. These discussions regarding the social benefits of groups present traditional narratives of hegemonic masculine norms but also counter narratives to these norms that exhibit flexible masculine practices.

Again, the extracts here support the social psychological mechanism of belonging and companionship. Feeling like they belong through inclusion and companionship and being part of a group whom they can share social activities with produces a positive effect on mental wellbeing and distress. Similar to Keohane and Richardson (2017), for my participants here, being part of this group and community provided routine, ritual and contact in the men's lives which can act as a buffer against disruption, isolation and disconnection as well as at the same time preserving masculine identity through a sense of belonging (Keohane and Richardson, 2017: 8). The findings presented here recognise and highlight the importance of the role of being in contact with others and of shared social activities such as attending groups in managing distress and promoting emotional and social wellbeing among older men (Agahi *et al.*, 2013; Hoglund *et al.*, 2009).

Meeting new people and social participation can have an influence on mental health and health behaviours (Kawachi and Berkman, 2001). Where isolation is felt, access and availability to support services may also be limited. John and Andrew may not have initially attended the group for specific mental health support but being surrounded by people in similar situations to them enabled them to informally seek help from a formal outlet and further facilitated them in managing any distress and future mental health difficulties they may face. In addition, support groups can also work to facilitate a greater participation in community life as well as a better interconnectedness with others as Rhys

suggests in the extract below:

Rhys, 53:  
(Mixed gender group, meets in various areas)

*To me [name of the group], is like we help people with their general life, you know, which is the other 90 percent outside of counselling and other therapy. Just how to get on with people, and we are just a vehicle for a lot of people to actually become more social and sociable.*

This again highlights the social psychological mechanisms of social control/social influence, belonging and companionship and perceived social support (Thoits, 2011a, 2011b).

## **Other experiences to do with using support groups**

So far, this chapter has discussed what works about the groups for participants and what they deemed as effective aspects of the group in helping them to cope and manage with distress difficulties. I now briefly explore other elements of the groups that were notably important and discussed by a number of interviewees.

### *Preference for mixed groups*

As described previously at the beginning of this chapter and in the methodology chapter (four) and to reiterate here, the support groups that I recruited and interviewed men from varied in being mixed or men's only groups. The majority of men discussed a preference for being involved in a mixed, male and female, support group.

Samuel, 29:

(Mixed gender, third sector organisation led depression support service)

*I think I would have found it more intimidating if it had all been men, which is strange because you'd think in that kind of situation it would almost be, not empowering but oh look these guys are in the same situation as me um... reassuring, that's the word I'm looking for, reassuring, but I think I would find it more intimidating. When I've recently been to the mindfulness course run by the primary mental health service it was a good mixture of men and women there as well and that made me feel more at ease as well*

There was explicit reference to gender differences in the men's discussions of preferring mixed groups. They noted that women have more of a compassionate voice in their attempt at support and also how they believed that men are not as comfortable to be as open within a group setting. This links to what will be discussed in the next chapter (nine) regarding men preferring to speak to a woman where anything emotional was concerned. In addition, it could be suggested that in group settings single sex is better for women than men and women being present in such groups can dilute the performance of dominant masculinities (Ivinson and Murphy, 2003).

The men's only group that I recruited from was not advertised as a mental health support group, but as a community men's group for men to connect with others through woodwork and other activities. Its aim was however, to reduce social isolation and loneliness amongst local men, arguably a mental wellbeing issue. All the men I spoke to from this group had themselves experienced some level of psychological distress regardless of whether that was the reason for attending and participating in the group. Had this group been labelled a group for 'men in distress', I question whether these men would have still attended. As this group had a practical element to it, whereby the men would build and fix things together, and as a result engage in more in-depth, supporting discussion, the men I interviewed were very much in favour of the group being men only. In addition, the success of these men's only groups in supporting older men across the UK provides a counter argument for the preference for mixed gender groups. Reasons for this may be because of older, more traditional masculine attitudes about physical work as well as their own reasons - feeling bored, lonely or isolated –for seeking support from such groups. In their narratives, the men that discussed the benefit of a men's only group found it to be a reassurance, in contrast to how Samuel in the extract above described it:



James, 61:  
(Men's only group)

*It's new, it has the potential to do some real good... by maybe guys initially coming. And it's a big thing for guys to come, on their own [...] but it's blokes chatting to blokes and eventually... I'm hoping that there will be some serious conversations, you know.*

In a time where they were experiencing some level of social isolation, and the group might be one of the only social engagements of their week, knowing that there are other men in their local area that were like them and may have had similar experiences to them, again provided comfort and acceptance to them. This is consistent with Mackenzie *et al.*'s (2017) study that explored such men's only groups similar to the ones I recruited from. Mackenzie *et al.*, found that these male only spaces provided a place where men could discuss personal topics, such as mental health topics relating to ex-military men, and where there was often a great deal of openness amongst members of the group. Some of my participants recruited from the men's only group spoke of this, and how the group enabled them to forge meaningful relationships with other men with whom they felt safe and comfortable being around. These male spaces therefore allowed a space for men to adopt less rigid and express alternative to traditional, hegemonic views of masculinity, which has previously deterred openness about sensitive issues. Furthermore, this again points to the idea of a community of practice (Lave and Wenger, 1991; Creighton and Oliffe, 2010) whereby this unique setting of a male support group allowed for a certain level of emotional vulnerability. Perhaps it is having a male-focused space that provides an opportunity for male friendships and male-friendly banter, diversity and activities that are traditionally masculine that enables men to feel comfortable opening up about distress to other men who may have experienced similar. In line with hegemonic masculine norms, men may approach sensitive topics differently, for example through the use of male-friendly banter, swearing and constructing their masculinity through their engagement in men's activities. Within the culture of a men's only group, it is understood that men talk differently to women and so it could be argued that such groups provide a better place for men to discuss emotionally sensitive issues as there is a developed sense of safety felt within the relationships with other men in the group. This can be a space for hegemonic norms to be inhibited but also a space for different masculinities to be adopted in more

flexible and health promoting ways. Thus, for my participants, hegemonic masculinity was initially used to relate to other men within the men's only group they attended but then it can be negotiated to be used in counterhegemonic ways that were still deemed acceptable within that particular setting.

However, this structure of a men's only group that involves masculine activities but also facilitates openness amongst men might not necessarily benefit all men, as noted in the discussion with Samuel above. It is important to consider the intersection of age and social class with gender, in relation to the preference of type of support group. The men I recruited from the men's only group were predominantly aged 60+ and mostly classified in the lower socio-economic classes. These men may have held more traditional masculine values and so engaging in activities with other men who were "like them", promotes group social norms, and so may have allowed for open group discussion with other men. Despite discussing how they previously struggled with opening up about difficulties (see chapters seven and nine) the response rate from this group showed that some of these men were eager to talk about their experiences of emotional problems and they wanted to share their story with me.

### *Frist attending the group: Access and availability*

Surprisingly, a majority of the men I spoke to had decided to attend the support groups by themselves with no encouragement or influence from others. These men had seen the group being advertised through posters or flyers around the local community, had been recommended the group or had searched for groups online themselves. In cases where they had searched themselves for the groups, they knew it was a peer support group type setting that they specifically wanted. Some may have also been recommended the group through professionals or others they knew in the local area. In choosing to attend the groups some men spoke of wanting 'do something about the problem', with the wish to offload and get better, some saying "well, what have I got to lose?". Within these narratives, it could be argued that masculinity is established to some extent, demonstrating autonomy and self-sufficiency in how they wanted to sort the issue out themselves. In a sense they were taking control and attempting to manage their emotional troubles. Others also discussed reasons for coming similar as described in the previous subtheme as

'something to do' and 'something to get me out of the house', as Peter in the extract below did:

Peter, 62:  
(Men's only group)

*I gotta admit at one point, I was considering not coming. But then I thought to myself, well don't be stupid it gets you out of the house, you get to meet people, you get to learn new things, you know and so I keep going.*

In addition, and again consistent with much previous research regarding men's help-seeking enablers (Vogel *et al.*, 2007; Harding and Fox, 2014), and as discussed in detail in the previous chapter (seven), there were also two men out of the support group sample whose wives had encouraged them to attend the support group, having found an advertisement and then convinced them to go along

These men recruited from the support group sample were distinct in that they had not only found and attended a formal peer support group, but they were also willing to speak to me about their experiences. There were men in the general population sample who had not been able to access or were even aware of support groups available. Access and availability of peer support groups in the local and surrounding areas were often touched upon in some of the participants' accounts. It was not surprising, given the effectiveness of the groups that I have outlined throughout this chapter, that the majority of participants held the view that there should be more support group services, like the ones that they attended, made more readily available and promoted further.

William, 44:  
(Mixed gendered, local community-led depression support group)

*But places like this are brill and the thing is, they don't get, they don't get thought of, they don't get the publicity they should be because they do a lot for people. They don't get appreciated. I think they don't get appreciated*

A number of the participants mentioned how support groups like the one they attend and others alike, were not well advertised or receiving enough funding. For my participants, groups acted as an alternative space where they could share unfortunate experiences with the healthcare system and instead offer and receive alternative support. Due to their

positive experiences of utilising support groups, the men felt strongly about the use of support groups and shared similar opinions on the need for more support groups to be more widely available. It could be argued from the findings here that participants wanted and needed more of an available outlet to support them through their distress.

## Conclusion

In this chapter I have addressed data that are distinct to the support group sample and have examined the perceived effectiveness of support groups for my participants in attempt to answer the sub-questions of the second main research question:

RQ2 - What are men's experiences of help seeking for distress?

- a. As a type of formal support, what are the men's experiences of using support groups?
- b. What is it that these groups are doing that works for them?

In doing so I have identified how support groups can provide a safe place for people in similar situations to offer and receive help. The most effective aspect of a support group setting for my participants was being amongst others with shared life experience of distress, which established mutual respect, understanding and empathy. The findings I have presented here build on Thoits' (2011a) theoretical argument that people who have experienced similar distress can offer specialised emotional sustenance and active coping assistance (Thoits, 2011a) and this is influential in shaping illness and the health care experience (Gage, 2013). I have in places drawn on Thoits' seven social psychological mechanisms to describe the ways in which support groups as social networks can positively influence mental wellbeing and distress. In some examples, I have also described how elements of masculinity are portrayed through these mechanisms, for example how for the male participants here, successful role performances within the group setting produce a general sense of control or mastery over life, which could be observed as a feature of masculinity.

Through exploration of these mechanisms I have drawn attention to the role of support groups in society and the potential influence they can have on individuals'

wellbeing. A support group setting is artificially creating a social network and community of practice and as I have shown throughout the themes, a social network of experiential similar others works well in providing support, specific healthcare information, purpose, routine and companionship. All this can contribute to lower levels of distress. A social network and community like a support group is useful in times where individuals may not feel comfortable or ready to speak to or seek support from significant others, as seen in some of my participants' discussions in the theme 'safe space to offload' and will also be noted in chapter nine, that discusses the benefits of talking to others in coping and managing distress. Research has suggested that when it comes to improving depressive symptoms, peer support groups have similar efficacy to group cognitive behaviour therapy (CBT) (Pfeiffer *et al.*, 2011). This is supported by the data and findings here that discuss the men's preference for familiarity and companionship. Participants also valued the confidentiality and reciprocity that a support group can offer. Having the chance to help others, further helped them preserve masculine status (Addis and Mahalik, 2003; Mansfield, Addis and Mahalik, 2003). For many single, older men, attending a support group was not only a means of support for emotional difficulties, but it was specifically a chance to socialise and partake in new social activities with others like them.

In using support groups for distress and emotional difficulties, including the use of both mixed gender and male only groups, my participants' accounts presented counter narratives to hegemonic norms that displayed varied and flexible uses of masculine practices. There were tensions in how masculinity was constructed as despite being able to adopt a more fluid approach to masculinity in their choice to attend groups, disclose distress and receive formal and informal help from others at the groups, my participants at times, also attempted to sustain hegemonic masculinity in their own rational choice to disclose distress at certain times and in certain places, and their emphasis on receiving and giving specific, tailored support. The findings here highlight the extent of the fluidity concerning conceptualisations of multiple masculinities. Similar to chapter seven, men's narratives surrounding their use of support groups and what they found useful shows that men (of various ages) are able and willing to have emotional discussions with others (including other men) given the right time and context.

The findings discussed in this chapter do not provide intervention research or outcome evaluation of successful peer support groups because it did not involve any measures of impact or any comparison with a similar group of people who have not

attended support groups. However, the aims of this research and reasons for recruiting men from support groups was not to establish whether support groups *do* actually work but rather *how* they might work for men. In addition, I was interested in highlighting the acceptability of support groups as a formal means of help seeking and support for this particular sample group of participants. Thus, I have attempted to provide a basis for an argument for the effectiveness of support groups for men putting forward that more support group settings should be established in place of other, more costly and inaccessible services.

# Chapter Nine - How do men manage and cope with distress?

## Introduction

The discussion of how men cope and manage any distress and emotional difficulties is a focal point of the overall project aims. During the interviews with men from the general population, as well as exploring formal help-seeking practices, I was particularly interested in how men cope with all kinds of distress in every-day life. With the men from support groups, the majority had had a specific experience of distress or diagnosis and attending the support service was one of the ways in which they managed such emotional difficulties. During these interviews with men who attended a support group, I also probed what else it is that the men do to cope and manage emotional difficulties outside of the support group setting. The analysis revealed similarities in the coping and management strategies that were adopted by men across both samples.

As with chapter seven, because of these overlaps, I recognise that it would be difficult for me to discuss the two sample groups separately and instead here I acknowledge thematic similarities in participants' accounts of coping and management strategies. I reiterate that I was interested in exploring all participants' different experiences together and address what it is that is effective for them in coping with emotional distress.

Initially, the analysis of men's distress coping and management highlighted some tensions revolving around what psychology literature would call 'adaptive' and 'maladaptive' coping strategies (Whittle *et al.*, 2015; Spindel, 2015). 'Adaptive' coping refers to "the effectiveness of coping in improving the adaptational outcome" (Lazarus, 1993: 237), so including positive and helpful behaviours that might address the problem. On the other hand, 'maladaptive' coping strategies are often seen as unhelpful strategies such as avoidance, drinking, emotional numbing and social withdrawal that may relieve symptoms only temporarily. I decided that this normative categorisation is too binary to analyse in this way and I should not split their discussion into these two different categories

of coping strategies, as their accounts of coping were much more complex than this. It would also be crude to assume what exactly is a positive coping strategy and what is a negative coping strategy, only identifying that through the limited previous literature exploring men's coping strategies. In the men's constructed accounts of how they coped and managed any emotional difficulties, it appeared that they adopted a range of various coping strategies in combination. Given the aims of the thesis and in particular the research questions that aimed to focus on the everyday practices of ordinary men, when analysing the interview transcripts, I prioritised the positive constructions of coping and management for distress. I was interested in what the *men said they do* in practice and what *they said was useful*.

'Coping' is key to the understanding of how people adapt to adverse situations (Melendez *et al.*, 2012) such as mental distress and I was interested in how men manage and cope with adversity in their lives. According to Tamres, Janicki and Helgeson (2002), men differ in their coping styles to women. Through exploration and interpretation of what the men said was effective for them, it emerged that their accounts were relatively complex, and the range of self-reported coping responses varied depending on the problem severity. Generally, there were parallels amongst the men from both sample groups in respect of what are useful ways to manage and cope with any adversity and distress in daily life. These different strategies that they used show that some men can and do actually consider and engage with their mental health, and actively work to manage any distress they may be faced with.

The main finding that has emerged, regarding coping and management strategies, was that in everyday life and practice, men adopted and combined a whole range of strategies to manage and prevent distress and emotional difficulties. These strategies can be identified as being flexible and adaptive in managing distress. The various strategies that have been identified were used in various ways. In the following section, I discuss the main coping strategies that the men in my samples adopted, exploring the ways in which these tools facilitated them to manage distress effectively.



## Being self-aware and having a sense of perspective

For a lot of the men across both sample groups, being self-aware and having a sense of perspective were important tools in managing distress. There was discussion about 'knowing yourself' and subsequently knowing how to cope. This was an especially prominent theme within the general population men's reflexive demonstration of self-awareness of their own emotions, moods, triggers and behaviours (15 out of 19 interviewees). In the conversations where self-awareness was identified, the men talked about recognising what they needed to cope and manage any adversity they may face. Being self-aware then, was a tool that enabled some men to proceed in adopting appropriate adaptive coping strategies:

Will, 25:  
(General population sample)

*So, I can feel it coming on in my mind now. I've learnt how to see the signs early on. Physical exercise is a big help, staying off the booze is a big help as well, that's a difficult one but it really is a huge help. Eating well, just general like clean living is what I need and being much more open about it. I wasn't, I always preached that talking about it would help but never actually did it myself until quite recently until last year or so. Which something in the brain just came out, had enough, I thought I can just talk about it and no one judges you. If they do then, fuck them.*

Above, Mike demonstrates self-awareness in that he can 'feel it coming', which arrives through past experience and knowing his own signs. Here, self-awareness led to proactive management, which included adopting positive coping strategies. The coping strategies that Mike described in his account were distinctively positive and this resonates with previous literature that outlines positive strategies, such as engaging in a healthy lifestyle and diet (Biringer *et al.*, 2015). Adopting healthy lifestyle behaviours such as eating well and going to the gym can also be an alternative way to construct masculine identity (Crawshaw, 2007). Yet at the same time, in the extract above, Mike is also demonstrating hegemonic masculinity in his account of taking action and 'doing something' about emotional difficulties. In being aware of his own emotions and learning to see the signs, he takes independent action and control (Connell, 1995; Johnson *et al.*, 2012), by adopting a number of coping strategies and mechanisms in his mental health management. Mike's account does not demonstrate the enacting of a particularly strong version of masculine

dominance, yet his account of managing his own moods and emotional difficulties still depicts a form of complicity to it. He is engaging in both typically masculine and non-masculine coping mechanisms so changing hegemonic masculine patterns by incorporating parts of other forms of masculinities, such as, looking after oneself, maintaining a healthy lifestyle and disclosing distress to others.

Mike clearly identified what it is that he needed in his management of distress. Interestingly here, being more open about how he was feeling was a way in which Mike now managed his depression, but here he also admitted that he did not always adopt this openness in practice. This implies that self-awareness may not always lead to dealing with distress in a positive way and it may come with a combination of self-awareness, experience and realisation. In addition, it highlights that the dominative discourse of men not being open is still present in men's constructions and accounts (Courtenay, 2000; Moller-Leimkuhler, 2002; Addis and Mahalik, 2003; Galdas *et al.*, 2005), particularly as a past action. Men and talking about distress will be discussed in more detail later in this chapter. The way in which Mike talked about what he did not do in the past and what he does do now, shows that experience and change can be a big influence in men's self-awareness as a coping strategy, and this can be seen within other participants' accounts also. Experience of distress and help seeking was also noted as influential to help-seeking practices too (chapter seven). Through experiencing mental health issues in the past and considering various way to prevent, manage and cope, as Mike said, he arrived at realisations of what it was that worked best for him, in terms of mood management (Forgarty *et al.*, 2015). This can further be seen throughout other men's discussions, emphasising how self-awareness through past experience better equips men to deal with difficulties in a more proactive way:

Shaun, 48:  
(General population sample)

*I do think I've addressed a lot of stuff. I mean it can crop up at any time because you can't, because stresses come from many a different place, like I say you know when layers of things have happened, or accumulation of things have happened, that can affect stress or your chemistry. Your body chemistry can chuck your brain chemistry all over the place so I mean, periodically, generally my backbone at the moment is, if I'm feeling flat or down, it is acknowledging that it will pass and it's periodical. And it's generally been an overview of what's led to it, in myself so it's kind of recognising and acknowledging what led to that issue or that feeling of depression or being low. Always kind of had that overview though but sometimes that overview isn't enough. It won't overcome that feeling, hence then going to a third party.*

The key words here in the discussion with Shaun, are *acknowledging* and *recognising* it at various stages of his experience. Having '*addressed a lot of stuff*', Shaun displayed reflexivity of his own self and emotions as well as a sense of knowing of the experience of distress. He discussed being conscious and aware of his own stresses and emotions and where they manifest, through past experiences he acknowledged that these feelings would pass as he attempted to manage them. Importantly however, here Shaun also acknowledged that insight into his own feelings will not always shift the feeling, and further management is needed and so he recognised the need to speak to someone independent such as a counsellor. This highlights the importance of self-awareness in enabling men to consciously think about ways in which to positively cope and manage any adversity they may face and therefore then be able to take further steps in help seeking and management. The data supports Liddon, Kinglerlee and Barry (2017) who found that for men, self-awareness of the problem as well as anonymity are important factors for help seeking. Additionally, both Shaun and Mike's accounts demonstrate that some men do actively consider their mental health and successful ways to manage emotions. As displayed through Shaun's own admission, self-awareness, acknowledgement of moods and emotions are not enough alone, however. It needs to lead to, enable and be combined with adopting positive strategies and activities, such as, like Shaun said, seeking help from talking therapies and professionals.

One man from the support group sample discussed how his mental health is something he has "*to keep working on*" and how he was "*working his best to try and do*

*things which are helpful*". Self-awareness is a very important tool for him in trying to continue working on his mental health and proceed in adapting positive management strategies:

Ben, 52:  
(Support group sample)

*Ben: I think the biggest thing I'd say about mental health, is awareness, and you've got to be self-aware as well about what you're going through. You gotta understand yourself, what you're going through, otherwise you're just going to end up being really unwell*

*AV: Were you self-aware at first?*

*Ben: No. No definitely not. When I was diagnosed with depression, I hardly knew what depression was, I didn't have a clue what the doctor was talking about.*

Having experienced a few crises during his distress, Ben valued the importance of self-awareness through experience, in preventing him from ending at crisis again. In his reply to me asking whether or not he was previously self-aware, Ben demonstrated a previous lack of insight into depressive symptoms (see chapter seven) and how he was not self-aware of his own emotions and distress in the past. Previous literature has noted men's lack of awareness relating to mental health issues and themselves (Courtenay, 2000). Conversely, had Ben not experienced crisis then he may not have developed the awareness that he now has. Ben's situation is in line with previous research and a number of the men's accounts presented in chapter seven, that suggests that for men, help-seeking and attempting to manage distress was often not immediate (Harding and Fox, 2014). The extracts presented so far suggest that men's self-assessments and self-awareness develop through having experienced a particular time of distress and so they learn to cope and manage personally through that experience.

It emerged that self-awareness was also characterised by a sense of perspective and viewing their own emotions, stresses and experiences of adversity in a particular way made it easier for them to adopt positive coping and management strategies. Again, past experience of distress, change in life circumstances, ageing and maturity are influential in their sense of perspective (Fogarty *et al.*, 2015) and attempting to change mind-set can again lead to embracing more positive coping strategies. Simon in the extract below portrayed how important perspective is:

Simon, 42:  
(General population sample)

*Exercise. Think it through. Try and put perspective on things and I know, I think now, I'm 42, so you kind of know your own patterns. So like if it's a really big issue, like clearly you got to do something about it. If it's like ah I'm just feeling down this week because I've been burning the candles at both ends and I don't know, I've got too much work on and it's the circumstances or your environment that's pissing you off. And I'll probably just work through it and say right come on, pull yourself together, go to the gym, have a few quiet nights um, you know ask for help, get some work done you know, get somebody to help you with your work. And I tend to deal with it myself so I'm kind- I do try and probably deal with it myself more than I should sometimes (...) Like you'll get down but then there will come a point when you will say, will kick back in and say sort yourself out, you will have your coping mechanism (...) I typically am an aware person that's why I think I can cope myself with most of it and then only if it gets, if something really bad happens, then you speak with your mates.*

*Yeah, perspective. Perspective is a big one. Like I'm just kind of a bit more chilled out now. I've chosen to be self-employed. I've chosen to be [job title] so I'm in control of my own diary (...) so that's a big choice. But in a way it's also a bit of a coping mechanism.*

Again, similar to the previous extracts, Simon talked about knowing himself and his own patterns and behaviours and he also made explicit reference to his own age, portraying how such self-awareness comes with maturity. It is evident here in Simon's extract that having a certain self-awareness as well as accepting a different perspective was an adaptive tool that enabled him to then engage in a range of different coping strategies to manage his mental health and stresses. Perspective for Simon was having a new perception about himself and his surrounding world and this new insight can lead to general lifestyle changes to adaptively manage low mood (Skarsater *et al.*, 2003; Spendelow, 2015). He discussed how through this perspective he attempted to change his mind-set and identified what was wrong and so proceeded to manage through going to the gym, having early nights and asking for help in work. Interestingly, Simon discussed how he deals with distress himself probably more than he should, so recognising that the more adaptive approach would be to involve others rather than deal with it alone using own self-management strategies. To some extent this characterises conformity to conventional masculine norms and behaviour, such as dealing with it alone, however recognition of this shows self-awareness that challenges the claim that men are not self-aware.

Furthermore, in his account Simon used expressions such as '*pull yourself together*' and '*sort yourself out*' which have previously been viewed as typical masculine language (Smith, 1999; Emslie *et al.*, 2006) and it could be argued that he was attempting to hold on to and re-establish masculine discourse at times of distress (Emslie *et al.*, 2006). Both Will and Simon, in the extracts above, demonstrated self-control in their coping, yet in their accounts this masculine notion appears to have facilitated their coping and self-management, consistent with Emslie *et al.*, (2006), Valkonen and Hanninen (2012) and Spendelow (2015). Albeit using this language and trying to deal with things alone, he incorporated this with a range of other adaptive and positive strategies, as described above. This highlights how traditional masculine language is still very much embedded, even in those men who actively work towards positively managing their mental health. Nonetheless, it also suggests that maintaining masculine patterns and language does not always have to be detrimental, and despite '*dealing with things alone*' he still continued to utilise seemingly positive management tools. Furthermore, the extract here demonstrates Simon's construction of multiple versions of masculinity in his coping and managing behaviour. For example, he demonstrates healthy masculinity as a man who engages in strategies such as visiting the gym, healthy living and talking to people to cope with distress but at the same time denotes a more traditional masculine ideal in trying to "*sort these problems out by himself*". These participants discussed here can be described as privileged men, being white and classified in the higher socio-economic classes and so they are able to gain from hegemonic masculine values without having to enact such strong versions of it in practice. It seems that Simon's alignment with hegemonic ideals helped him construct his masculine self in particularly health promoting ways (Krumm *et al.*, 2017).

It is also difficult for me to claim that 'knowing yourself' and using self-awareness and perspective in this way to manage difficulties is distinctive to men. I cannot say that women do not use self-awareness and perspective as a coping tool. However, it can be recognised that the way in which these accounts are articulated is typical of traditionally male language. In addition, in reviewing any problems, stresses or emotional issues they may be faced with, the extracts above show rationality, self-control and practicality, qualities typically associated with masculinity (Brownhill *et al.*, 2005; Tamres *et al.*, 2002; Addis *et al.*, 2010; Cleary 2012). This is consistent with the overall theme depicting that men may take up and combine a whole range of strategies when it comes to coping and managing distress. Previous research has found that where men adopt adaptive coping

strategies they use 'practical solutions' and 'problem solving' (Whittle *et al.*, 2015). The data also provide evidence for the use of a more flexible masculinity in the context of coping strategies as well as a strategic interpretation of traditional traits (Spendelow, 2015). The latter refers to where men focus on existing masculine traits to preserve masculinity and to emphasise positive characteristics (Coen *et al.*, 2013). The participants described above however, demonstrated reflexivity in recognising their own moods and emotions and the need for adaptive coping. This contrasts with claims that suggest that men are not (mental) health conscious or do not consider their own mental wellbeing. The extract above demonstrates use of masculine characteristics in more positive ways of coping and shows how complicated and personal the men's accounts of experiencing and coping and managing distress are.

So far, I have described above some of the ways in which the participants used self-awareness in a proactive way to manage their moods positively. In some instances though, self-awareness and gaining a different perspective did not always result in positive coping strategies. You can be self-aware or say you are self-aware but not actually do anything particularly positive with it in practice. This was evident in some participants' discussions and it was not clear whether their distress coping and management was particularly positive or helpful.

Daniel, 34:  
(General population sample)

*The way I rationalise it, I had a bad few months and led up to one incident and I just oof and I think it's just the way your body says, hang on now, time out. So, I think as long as you're aware of things and you know what your triggers are. My feelings are everyone's got mental health issues, but most people know how to deal with them. They don't actually know what they're doing but they cope with it themselves*

Daniel talked about being self-aware, particularly of his own emotions, behaviours and triggers and was also aware that sometimes he may need some time out to take stock of himself, presenting a kind of 'manly self-reliance' (Johnson *et al.*, 2012). He claimed that self-awareness leads to coping however there is no evidence that this actually facilitated positive coping and management for him. Daniel even later discussed how he would not go to the GP and would instead use the Internet to explore solutions to the problem. It could be argued that his talk portrays conventional masculine norms in his resistance to seeking

professional help yet at the same time he has noted that he would attempt to seek informal support through the Internet. Being autonomous is important to hegemonic masculinity (Connell, 2005) and tackling it alone, through developing his own personal coping and management strategies is an attempt to preserve such autonomy. Again, the attempt to rationalise, not seek help and cope with things alone characterises traditional masculinity. These behaviours do not resemble what would be defined as positive and adaptive coping strategies, and thus contrast with what I have discussed earlier, which argued that self-awareness and perspective leads to and makes it easier for men to adopt positive coping and management strategies. From this extract above, it is rather ambiguous as to whether the ways in which Daniel uses his own self-awareness to cope with adversity are positive or negative. It may be that he perceived his coping as positive because he believed that was coping. As described above, the value of insight can be important in self-managing distress. He did not follow up this self-awareness with any strategies in practice though, unlike the previous extracts shown.

## **A range of flexible and proactive strategies combined**

This chapter has so far identified the ways in which self-awareness and perspective engender a whole range of coping, management and prevention strategies. As mentioned at the beginning of the chapter, participants reported coping and management strategies for distress that were both proactive and adaptive. The common positive strategies disclosed throughout the data from both sample groups of men included: engaging in physical activities and exercise; having a positive outlook; keeping busy, whether that be through work, hobbies or interests; seeing and spending time with family and friends, and; talking and being more open about feelings of distress. Similar to Fogarty *et al.*, (2015), routines, plans and structures helped my participants effectively self-manage emotional difficulties. The strategies adopted here are in line with previous research that has explored self-management and coping in the context of mental health, including developing and maintaining a healthy lifestyle, engaging in sporting activities, finding meaning, changing their beliefs, and developing a positive self-image and outlook (Mezzina *et al.*, 2006; Murray *et al.*, 2011; Villagi *et al.*, 2015). Examples of some of these coping and management strategies and the ways in which the men used them will now be explored.



As mentioned earlier, the accounts of coping were complex and individual and the ways in which the men adopted these strategies depended on their own individual circumstances.

### *Exercise and taking care of physical health*

Notably prevalent across the men's accounts was looking after physical health as an approach to better mental health. Participants described a variety of physical activities (such as running, walking and participating in various sporting activities) that were viewed as significant in their experiences of managing distress.

Steven, 52:  
(General population sample)

*Walking oh yeah, it's great. That's one of my best coping strategies that to be honest, walking. If I feel down, I go for a long walk and just being out there in the fresh air, especially on a day like today and it's absolutely fantastic, and so uplifting kind of thing. So I tend to do a lot of walking myself*

Walking was mentioned as an especially positive management strategy that many of the men across both sample groups engaged in. This is consistent with research that has found that walking has a statistically significant, large effect on the symptoms of depression (Robertson *et al.*, 2012). While most of my participants were conscious that good physical health was important in managing and maintaining good mental health, engagement in physical activities was again combined with other strategies. This can be seen in the extracts in the previous section, where Simon talked about exercise and going to the gym amongst a variety of other coping strategies upon realisation of a distressful situation through his own self-awareness and perspective. In addition, the way in which they approached maintaining good physical health was flexible and diverse across the men's discussions.

Much research has previously found that engaging in physical activities and exercise is imperative in maintaining good mental wellbeing and coping with mental health problems, particularly depression (Mutrie, 2000; Biddle and Mutrie, 2001; Daley, 2002; Crone and Guy, 2008; Mammen and Faulkner, 2013). Callaghan (2004) argues that exercise improves mental health and wellbeing, reduces depression and anxiety and also enhances cognitive functioning. Furthermore, for men, it has been found that as well participating in

physical activities (such as running and walking), having an interest in sports and engaging in that sporting culture can be beneficial to their wellbeing. In discussion of exercise and sports, a number of participants discussed going out to watch games such as football, rugby and cricket. Pringle (2004) has argued that watching such sporting games has been shown to provide a sense of belonging, alters mood and enables a cathartic release of tension for men.

Physical activity and sport has often been associated with masculinity, as a central way to promote and maintain men's dominance over women (Connell, 1995) and whereby men can employ hegemonic masculine practices. Engaging in physical activity, whether that be just taking a long walk, working out at the gym, or playing football or rugby with a team of other men, no doubt has mental health benefits. For men, it could also be a particularly important coping mechanism as it allows them to retain and utilise hegemonic practices yet at the same time negotiate these practices enough to be able to use physical activity appropriately and so effectively engage in managing mental health and wellbeing.

### *Different ways to keep busy*

Keeping busy through engagement in meaningful and enjoyable activities was another very important and influential coping and management strategy for participants across both sample groups. Villagi *et al.*, (2015) described such a strategy as "fostering social recovery" and in line with their research, a lot of my participants communicated strategies aimed at escaping isolation and developing and maintaining social relationships (Villagi *et al.*, 2015: 4). This was particularly the case for those men who were out of work, either due to current unemployment, retirement or ill health. Again, similar to other participants described so far, when Steven (who was unemployed at the time of interview) discussed coping (in the extract below), he mentioned a whole range of strategies that he combines. He emphasises the importance of keeping busy:

Steven, 52:  
(General population sample)

*It's just keeping busy really, like I say I'm not one to sit. If I sit in my flat I'm my own worst enemy but I always like to be out and about and there's plenty of things you can do for free like, I use the library a lot and that and you know I just try to keep as active as I can. You know talking to people, going out, meeting people and what have you, it's a big part of it. What I've done if I'm feeling down, I think in myself what can I do to change it, I don't want to be like this. I look at things I can do and change it, whereas when I was younger I wouldn't. I would sit there just feeling depressed and people used to say to me oh "what's wrong", "oh nothing, nothing". And I used to spend days and days of just going down. It happens again and again because you're not dealing with it and that's why you know, when I get problems now, I don't sit on them, I try to deal with them straight away and as effectively as I can like. Cause' I realise once the problem is sorted you can get on with your life, everything's great, instead of just chucking them in the cupboard there and just leaving them like I used to do. Yeah that's been a big change in me that has*

Steven's utilisation of various coping strategies and the ways in which he managed his mental health has again been learnt through experience and age. He talked about how he previously did not manage his mental health in a suitable way and through maturity and experience came the realisation of what does and what does not work to cope. In the past he said that he would not have opened up or addressed any difficulties he faced, so endorsed traditional masculine values. Through lived experience of distress, he adapted his mind-set and attempted to renegotiate masculinity to being active in his self-care (Johnson *et al.*, 2012). By embracing a 'taking action' approach to work through any distress, he was depicting a 'strong and competent' (Addis and Mahalik, 2003) character and using hegemonic masculine ways of thinking and 'doing' as a way to help him cope with mental distress (Emslie *et al.*, 2006; Farrimond, 2011; Valkonen and Hanninen, 2012; Sierra Hernandez *et al.*, 2014). This demonstrates the multiple uses of masculinity and how hegemonic practices may change and be redefined As with other participants such as Will, who was previously discussed (p.189), this kind of 'fighting back' talk demonstrates taking control and it involves the adoption of proactive strategies such as keeping busy and having positive things to do. Seeking help or engaging in management of mental health was no longer perceived as a weakness to Steven, instead like Johnson *et al.*, 's (2011) respondents, the discourse of help and proactive management is now viewed as a responsible and independent action (Johnson *et al.*, 2011: 351). This again reiterates the idea that masculinity does not have to be negatively used when it comes to coping and managing

distress and coincides with Spendelow's (2015) coping strategy theme 'promote flexibility'. For Steven, his positive outlook on various adaptive activities (Biringer *et al.*, 2016) provided him with more opportunities to manage his mental health.

Notably, Steven was unemployed at the time of interview and so emphasised the importance of keeping busy, talking to others (see the end section of this chapter) and engaging in positive everyday coping and management strategies. As a result of this unemployment, Steven's masculinity had been marginalised as previous literature has noted how employment is central to the construction of men's identities and hegemonic masculinity (Fletcher, 2010; Dolan, 2011). Steven's masculinity was thus threatened by both unemployment and the experience of mental health difficulties. In the extract above, it could be suggested that in the absence of paid work, Steven attempts to re-establish hegemonic masculine practices through an action approach to coping with distress that involves seeking out formal and informal support and keeping busy through various means. It could be suggested then that marginalised, class-based masculinities, or more specifically unemployed masculinities, are associated with an increasing sense of flexible and more open gender roles, as Steven's account counters hegemonic discourses.

Interestingly, as we were concluding the interview, Steven said he would be very interested in attending some sort of group for support, and for something to do, as a way to keep busy during his unemployment. However, he said he was not aware of any such groups he could attend or know where to find information regarding this. As noted previously in chapter eight, this emphasizes the importance of groups being made more widely available, accessible and advertised to unemployed men, as noted previously in chapter eight. This also further points to the importance of paid work (Morgan, 1992; Dolan, 2011) and 'having something to do' for men and their mental health management, as echoed by Simon:

Simon, 42:  
(General population sample)

*Sometimes, maybe being busy is like a coping mechanism in itself, it's useful at least. Perhaps if you've got like lots of time on your hands, say if you didn't have a job or something, or you were ill and stuck at home, then maybe it would be harder to cope because you wouldn't have stuff to distract you*

Traditionally, work has been considered a 'male' domain (Morgan, 1992; Fletcher, 2010; Dolan, 2011; Emslie and Hunt, 2009) and it could be argued that in times of distress, in the perceived threat to hegemonic masculine identity, focusing on work or careers can be a central component to maintaining and reconfiguring this masculine identity (Cochran and Rabinowski, 2003). Not only does work act as a vehicle to re-establish this role but the routines and structure of work in men's lives can help them to manage distress by providing them with 'something to do' and a reason for getting out of bed in the morning (Olliffe *et al.*, 2013). Work therefore can provide therapeutic value to men as it can maintain structure and distraction. It is important then, to consider the impact of role loss on men's distress as well as on their self-management (Scholz *et al.*, 2014) and discussion of role loss was particularly evident in a number of my participants' accounts of distress. This contrasts with the dominant narrative that points to the detrimental impact hegemonic masculine values and behaviours can have on men's health and wellbeing. The above findings suggest instead that hegemonic and certain class-based masculine practices and values (e.g. valuing and placing emphasis on paid employment) could also be a useful tool for men when it comes to positively engaging in the management of their mental health. Thus, maintaining hegemonic masculinity through working and social position can also be a way to sustain good mental health and wellbeing.

Similar to Simon and Steven discussed so far, it emerged that keeping busy and/or finding new hobbies and interests was a very important coping and management strategy, aside from the group setting, for the men from the support group sample. Attending the group itself was as a way to keep busy and find new interests as discussed previously in chapter eight (p.177). Outside of the group, keeping busy and having other positive activities going on was also crucial to managing emotional difficulties, as Richard said:

Richard, 24:  
(Support group sample)

*Put it this way, once I started, once my life got busier, I think I was okay then. When I was out of a job and stuff, which happened for about a year, I was out of a job, that was really difficult. As I say I gained weight and I drank more, and I started to go downhill. But now that I do volunteer and I do different projects with different people and yeah, I'm just a lot more, happier now*

For Richard, being in work and keeping busy was a particularly important tool for managing distress and something he was aware of as a way to maintain emotional wellbeing.

Previously not having structure or focus led to particularly unhelpful coping behaviours (drinking alcohol and avoidance) and further distress, whereas work enabled him to manage his distress, perhaps through reconstruction of identity and purpose.

### *Focusing on the positives in life and practicing gratitude*

A majority of the men discussed, in some shape or form, how choosing to focus on particularly positive areas of their life was a means of coping with distress and emotional difficulties. Such a strategy instilled hope by having a positive outlook (Villagi *et al.*, 2015). The importance of concentrating on a significantly good thing enabled them to cope with everyday life and positively manage their mental wellbeing more effectively:

Kevin, 65:  
(General population sample)

*Be grateful for what I've got. Be grateful for my small little family, be grateful for my home and what I have got. Be grateful that I'm fit and well enough to play golf. Just enjoy it. The other thing now that is so different when you get older, is that your life is going so quickly, it only seems like yesterday I was maybe 40 or 45 and suddenly you're 65 and so mortality becomes really important, you know how long have you got? So, you got to make the most of everything and you except things a lot more*

Being grateful for various things in his life is how Kevin attempted to remain positive and combined with other strategies such as playing golf and socialising, was a way of coping for him on a daily basis. For Kevin here, and for a majority of other participants, practising gratitude was crucial to managing moods and moderate distress. As mentioned above, the ways in which such strategies were adopted depended on the individual and Kevin's endorsement of positive attitudes as a management strategy was a result of his age and experience. This is consistent with Spendelov's (2015) theme of 'seek new perspectives' that found that experience can lead to men's perspectives and lifestyle changing. This also points to the potential differences in attitudes between older and younger men towards their own mental health and wellbeing (Mackenzie *et al.*, 2006), as noted in chapter six. Such a positive outlook develops with age and relates to the first theme to do with gaining

perspective and self-awareness as discussed earlier. The discussion here regarding men adopting a more positive and proactive outlook supports research that has found that the ability to reframe problems and negative thoughts is helpful in managing depression (Kelly *et al.*, 2008).

### *Combining typically ‘maladaptive’ strategies with useful ways of coping*

It would be worth mentioning here that on occasions, coping strategies that could be interpreted as unhelpful were sometimes also mentioned in combination with the seemingly adaptive strategies described above. For the general population sample, turning to alcohol as a means to cope was in some cases (9 out of 19 interviewees) discussed casually in combination with positive strategies such as exercise, talking about problems and having a positive focus. Using alcohol to cope has been typically viewed as a maladaptive tool that is not helpful in managing emotional problems (Brownhill *et al.*, 2005; Cleary, 2012). However, in some participants’ accounts, alcohol was discussed as being used in conjunction with other more adaptive and useful strategies:

Simon, 42  
(General population sample)

AV: *What do you do then when things get tough?*

Simon: *Go to the gym, all the time. Have a drink. And then depending on I suppose how serious those issues, then you know, you’ll probably like push it a bit with certain friends*

As the extract above shows, Simon talks about ‘*having a drink*’, in combination with other more positive ways of coping such as going to the gym and potentially talking about issues with friends. If alcohol is used in moderation or in social situations with friends that might result in distress disclosure, then it may not necessarily be negative or ‘maladaptive’. This points to how scholarly language of ‘coping’ is gendered in such a way that men’s behaviour in relation to negative effect is often viewed as either ‘maladaptive coping’ or ‘not coping’ (Addis and Hoffman, 2017: 180). ‘Having a drink’ does not necessarily have to be detrimental in men’s everyday self-management of emotional troubles. Having a glass of wine with dinner to relax after a long day might be perceived as a more functional response to low mood, as well as something that women might do to manage difficulties. Yet we

often view such strategies as maladaptive when compared with the coping strategies typically employed by women. It is important to acknowledge that men may use alcohol in moderation, routinely and combined with other healthier strategies, so demonstrating their flexibility in positive distress management. We should therefore be careful in assuming that men typically turn to maladaptive strategies such as over-drinking, over-working and engaging in risky behaviours.

## **Being open and talking about it**

In the discussion around coping and management strategies as well as help-seeking practices, it became evident that for my participants from both sample groups, talking and being more open about distress was helpful in managing distress. Given the dominant narrative in gender that men conceal emotions and the tendency in previous research to focus on men's reluctance to open up on account of perceived masculine norms, men's experiences of talking about distress emerged as a notable subtheme yet also overlapped with the discussion of help-seeking practices (chapter seven). As explored in chapter seven, in their experiences of help seeking, a number of participants were often influenced and encouraged by a significant other (a partner, family member, close friend) to seek formal help for emotional difficulties. Initially disclosing emotions and symptoms of distress to close family members or friends acted as a starting point to more formal help and support services. In the discussion in chapter seven, I specifically focused on the practice of help seeking and how significant others were an influence and gateway to more professional support following disclosure of distress. Here in this chapter, I emphasise the everyday use of family support in coping and managing distress through being open about challenging emotional difficulties. I differentiate this section to chapter seven by exploring the importance of disclosing problems as an informal coping mechanism for my participants. Talking about emotions emerged as an important thing that my participants had to do in their everyday coping and management of difficulties. In their accounts, talking about distress used as an everyday coping and management strategy did not always lead to seeking out formal support and services but facilitated men to positively manage challenging emotions.



I reiterate here the thesis' main aim of focusing on the positive things that men do and what it is that men find effective when it comes to managing their mental health. Much literature and many campaigns have suggested that talking about problems and distress is a good thing. Findings here support this and the majority of participants discussed talking about distress as a positive and helpful thing for them in managing distress. Skarsater *et al.*, (2003) found that men referred to coping through the use of social support such as family and friends to talk to. This was particularly true for participants from the support group sample. One man from the support group sample, Adam, believed that talking is *"a lot better than the drugs you know"*, referring to prescribed anti-depressant medication and adding to the discussion in chapter seven about preference for counselling over medication. The importance and benefits of talking about distress for my participants will be considered in the rest of this chapter, in relation to their everyday coping and management of difficulties.

### *The benefits of talking*

For some participants and in line with the previous discussion around self-awareness and coping, talking about problems gave them perspective on the situations they found themselves in. Below Steven from the general population sample, discussed how he felt once he started opening up more about difficulties he experienced at the time:

Steven, 52:  
(General population sample)

Steven: (...) *but then as soon as I started opening up and talking about problems and that, it was so easy to solve the problem and get help and like I say, it just gave me strength and made me a better person like you know so*

AV: *And talking about things helps put things in perspective?*

Steven: *Yeah*

AV: *Has it helped, has it made you feel better?*

Steven: *It certainly does. I mean, I became a different person, just you know talking to people and I found when I've had problems in the past, it was so difficult for me to sort things out. But there were times when I just needed to speak to people and I wouldn't and now being able to do that is so beneficial to me, and yeah, I don't get as depressed as what I used to let me tell you. And like I say that's the thing, it's just talking to people it is, just talking to people*

Steven maintained that talking about any difficulties actually facilitated managing and solving the problem experienced and subsequently led to seeking formal help and effective self-management. For Steven, talking about distress and emotions, which has traditionally been perceived as feminine behaviour, instead gave him strength and he used it as a means to take back some control, as well as take independent action in the face of distress (Johnson *et al.*, 2011; Gill, Henwood and Mclean, 2005). Problem solving and rationality has typically been associated with men (Connell, 1995, 2005) and so if talking about emotional difficulties enabled the process of solving problems, then it would be misconstrued to continue to regard opening up and talking about emotional difficulties and distress as feminised.

Talking about distress could be instead recognised as a demonstration of strength and thus a portrayal of more flexible masculine practices. Strength and taking control have long been associated with masculinity (Connell, 1995, 2005; Courtenay, 2000) and reframing opening up about problems as a strength and a way to take back control and 'do' something to manage the problem highlights the use of masculinity in an alternative positive way (Spendelow, 2015). This corresponds with the Samaritans Campaign (2010) 'Men on the Ropes', where men said that talking to the Samaritans helped them find strength. There were other men in the general population sample who illustrated talking about emotions as a kind of strength, discussing it in a seemingly fighting tone as described previously through Mike's words "*I thought I can just talk about it and no one judges you, if*

*they do, then fuck them*" (p.189). Making the decision to talk about emotional difficulties, combined with the swear word discerns a particularly masculine, strong and powerful tone without explicitly saying it gave him strength. This is in line with Charteris-Black and Seale's (2009) study that found that in discussion of illness experience, men used 'on the record' styles such as swearing. Again, as discussed in previous sections in this chapter and within the previous empirical chapters (chapters seven and eight), the accounts presented here look like resistance to hegemonic norms such as the "big boys don't cry" discourse to do with men not talking about emotions. However, as Wetherell and Edley (1999) point out, rather than total resistance to such norms, what can be seen here is instead another form of complicity to it. In demonstrating a 'taking action' approach to the coping and management of mental distress and having a "*fuck them*" attitude towards seeking out support, these participants are emphasizing their strengths as men, thus aligning with hegemonic masculine norms. These attitudes and behaviours align with the positive masculinity paradigm (Kiselica and Englar-Carlson, 2011) that highlights the strengths of masculinity in facilitating men to manage their wellbeing effectively rather than the detrimental impact masculinity can have on health.

In most of the interviews however, talking about problems was not always discerned as an expression of masculinity, and not all of the men's accounts exhibited talking as strength but rather just part of their everyday, coping and management strategies. The men who did construct this strength narrative appeared to also be the ones who discussed having previously not opened up or talked about distress in the past.

Despite my attempt at focusing on the positive things that men do to cope with distress, during the analysis I could not ignore some of the discussion around reasons for not talking about emotional difficulties and distress. Not surprisingly, and consistent with chapter seven, for all my participants across both samples, being open about distress and problems was not immediate in their experience and had developed through realisation and practice. There was a general concurrence among the men in their accounts that embodied the widespread gendered discourse that "*we men are not very good at talking about emotions*". When recalling their own experiences of distress however, most of the discussions about being reluctant to open up were in relation to past actions and how they previously did not open up about difficulties, but they since advocated talking as much as possible, as can be seen above in Steven's account. Reasons for previously not opening up were often discussed in line with typically masculine ideals such as being self-efficient,

being avoidant, the belief that experiencing distress is a sign of weakness or shameful or also being unaware of the problem for example. For Joel, it was a number of these reasons that inhibited him speaking to others about his difficulties:

Joel, 33:  
(General population sample)

*Joel: I think it's something where I didn't really want to go and speak to people. Part of me didn't want to go speak to people because well you know, I don't want people thinking, why you bothering me now (...) I was almost ashamed, you know, people now have this dismissal attitude towards me saying, "everyone has problems in their life you know you're not the only one". I felt very guilty of that. I didn't want to burden other people with my own problems, you know. So, it's almost like I felt I should be trying to deal with these things by myself, which wasn't very successful.*

*AV: So do you find that offloading in that way kind of helps?*

*Joel: Yeah, I think it definitely did. I think the fact, if I'd been keeping it all bottled up, I think it probably wouldn't be very healthy and I think if it wasn't for my partner now (...) but I'm not really sure what my situation would be if I hadn't had someone to talk to but I definitely don't think it would have been a very good thing keeping all those emotions bottled up.*

*I would say find someone to talk to, absolutely... definitely and I wish I had done that sooner*

As noted previously, realisation, experience and maturity were important for my participants, particularly for Joel here, where he has since discovered how effective talking about problems is, only wishing he had done it sooner. This relates to the previously explored theme regarding self-awareness and a sense of perspective as crucial in the coping and management of distress. As well as this, during our discussion about being more open, Joel said that before his current partner, he was not aware of anywhere he could go to talk, and symptoms of his depression also led to him withdrawing from others. Joel discussed feelings of guilt, shame and the expectation that he should have been trying to deal with it alone, reproducing the dominant discourse on men's talking and help seeking. Feelings of shame may also affect men's ability to speak about emotions and further seek and receive help due to masculine weakness (Emslie *et al.*, 2006; Shepard and Rabinowitz, 2013; Vogel *et al.*, 2011). Joel considered how people might have had dismissive attitudes towards him as he said, "everyone has problems in their life you know you're not the only one". Kadam *et al.*, (2001) found that patients with anxiety and depression often expressed

the view that people were generally not sympathetic because of the invisible nature of emotional problems. Joel did not want to burden others with his own problems and so chose not to disclose his issues at the beginning. Not wanting to burden those close to them was a common reason for not wanting to always talk about distress and emotional difficulties and has been drawn on in all three empirical chapters. As noted in the previous chapter (eight), not having to worry about feeling a burden to others was one of the benefits of attending support groups. Symptoms of distress, such as depression and anxiety, can also make people feel like a burden to those closest to them and so I cannot attribute this experience just to men's discourses, as women too might feel themselves to be a burden to others at times of distress.

Through desperation (Johnson *et al.*, 2012) Joel eventually sought help and with the support from his partner he recognised the value of talking about distress as a way of managing it. As noted, his advice to others was to find someone to talk to about emotional troubles. Realising the benefits of talking through experience was common among a number of the participants.

### *The importance of talking to the right person*

I have so far considered how talking and opening up about distress was influential in how my participants coped and managed, and furthermore sought out help for distress. From this chapter and the proceeding two chapters (chapters seven and eight), it seems that some men do want to and are willing to talk about distress but only in appropriate circumstances and with the right person. Many of my participants recognised the impact of having someone to talk to with whom they felt comfortable with, trusted and felt they would not be judged by. These significant people included partners, family members, support group members, strangers and health professionals. Being selective of who they chose to open up to and discuss difficulties with was common across both sample groups of men.

Those men who were in a relationship all spoke of being able to turn to their partner to talk to when experiencing any distress. This was particularly the case if their partners also had experience of distress, as Joel discussed:

Joel, 33:  
(General population sample)

*Joel: Oh, definitely my partner. I think it's probably more understanding when I talk about things with my partner. We can relate to each other a bit more*

*AV: And you can open up more now?*

*Joel: Oh yeah, absolutely now, yeah. It's been such a big help and I think being in this relationship now. She's been so supportive of me, helping me to turn my life around and I know she's someone I can always open to, that can always talk about anything and she's got very good friends as well. I know I could even talk to them if I needed to. Everyone's so very transparent with the fact that they've got these sort of problems as well, like anxieties, and I think that really helps me because it reassures me that I'm not alone in dealing with these problems.*

Joel's partner was influential in his distress experience, through providing support and also encouraging help seeking and to be more open about difficulties. It is often considered that female partners or significant women in men's lives play an important role in men's self-management (see chapter seven). Being able to talk to others in similar situations can lead to feelings of acceptance and support and so enabled positive coping. As demonstrated in Joel's account in the abstract above, speaking to others who had experienced similar difficulties and distress, those who had a shared understanding, was important in the decision of whom to speak to (this connects with the discussion of the importance of shared understanding found in chapter eight). Oliver for example, could talk about stress and some emotions to his partner but when it came to talking about a specific emotional issue, he preferred to talk to his friend and also his friend's wife, who had also experienced something similar to him, in his case, losing his mother:

Oliver, 33:  
(General population sample)

*I'd say it to my other half, and you know I talk to [name of friend] my best mate, we do talk about everything and also my friend, his wife. She lost her mum, so we tend to have quite a lot of deep conversations because you don't need to really express the emotions because you're aware. I know it's different for everyone, but there is shared experience so you can sort of just go and talk about things again in a slightly bleak way but in a more meaningful way if that makes sense*

Oliver pointed out how important it is to have different people to talk to and open up regarding different emotional issues. This was often portrayed in the interviews,

highlighting that men may not open up to just anyone, but the right person and opportunity is needed. Oliver continued to explicitly communicate this:

*I think it depends on the person and what I'm talking about. So if it's something about my mum, I'll probably talk to [name of female friend, best friend's wife] and not [name of best friend], but again I think it's that shared experience thing. But if it's a specific work thing, I'd probably talk to [name of best friend] more because he understands [work], so I think it's really around who has the most shared experiences (...) Again I think it's quite nice to sort of share that responsibility out, you don't feel you are burdening that one person with everything*

Feeling more able and preferring to talk to those with shared experience was also a prominent theme that emerged from the support group sample as discussed in chapter eight. Interestingly, despite having a positive experience with talking about emotions and distress, as demonstrated in the extracts above, Oliver described talking as “burdening” and so he preferred to ‘offload’ to a counsellor because “that is what they’re there for”. Oliver’s preference for counselling and perception of talking about distress as a ‘burden’ to certain people was noted in chapter seven to do with formal help seeking, highlighting the overlaps between talking to others as an everyday coping strategy and as a gateway to formal support.

Others echoed this and there were a few men who said they spoke to their partners when experiencing emotional difficulties but said that they actually preferred a third party, whether that be a professional or stranger, when it came to disclosing a specific emotional issue. Shaun talked about a particularly low time he experienced in the past and I asked if he spoke to any family or friends during this time:

Shaun, 48:

(General population sample)

*Uh at that point no cause' I wanted a third party. Friends aren't always the best people to talk to and having somebody within a recognised position and a recognised... because when you're talking mental health issues and your talking depression, the person that you're talking to really needs to have a good experience of that (...) But I think professional counselling is probably one of the better ports of call because they should be trained in how to deal with that. But saying that I couldn't have gone to a counsellor that I didn't have an immediate rapport with. That's really important as well*

Shaun says that he could “*actually talk openly and confidently*” to his partner, but if he needed a certain level of counselling, if it was a much deeper issue, then he would speak to a professional. This again points to that level of shared understanding, which was significant in the disclosure of emotional difficulties to others. He also mentioned the importance of rapport in the counselling relationship, which is consistent with Johnson *et al.*,’s (2012) discourse of genuine connection that was further discussed in relation to help seeking in chapter seven (p.158). Furthermore, this supports what was discussed in chapter seven about the benefits of counselling and talking therapies for men experiencing distress. As well as an independent professional being able to offer a certain ‘level’ of advice that family and friends may not have been able to, Shaun’s extract also reiterates Oliver’s discussion about being able to completely offload at length to a counsellor without feeling guilty or having other social or personal factors influencing the conversation. Daniel also spoke of something similar:

Daniel, 34:  
(General population sample)

*Yeah, I like to talk to somebody, and I like somebody to listen but not necessarily offer an opinion. I think that’s where a psychiatrist is good because they are emotionally separated from the situation and I like talking to myself. I will, you know, not, role play is the wrong thing, but you go through the situation and think what could I have done differently and you end up talking to yourself. I’ve always done it, she [wife] thinks I’m mad but...*

When it comes to experiencing everyday distress, stress and worry, Daniel spoke of his wife offering an opinion on the situation, which was not what he wanted. Having someone *just listen* was preferred. Rhys from the support group sample echoed these three extracts (Oliver, Shaun and Daniel), claiming that “*it’s not always best to talk to a love one*” and how his wife would often ask too many questions, wanting a lengthier conversation that came with a lack of understanding. This suggests that some men may prefer to talk openly and at length where they will not be questioned or judged by someone close to them.

Despite some of these participants preferring to not always talk at length to their partners about distress difficulties, nearly all men across both sample groups specified that they mostly preferred to and found it easier to talk to women rather than other men. One man from the support group sample said this is because women have ‘*compassion*’ in their voices. Others mirrored this, explaining how they have always felt more comfortable with



women counsellors or GPs when discussing any personal mental distress. Andrew described this in relation to talking to a group of men at work:

Andrew, 69:  
(Support group sample)

*I think a woman is more understanding. I mean you couldn't be working on a building site now, talking to a load of blokes now, starting to say, "Well I dunno mind, I find it difficult to sleep at all now see like, I've got headaches and all that see". They'll be saying well there's a nutter amongst us (laughs loudly), what's he doing working here now he's a hypochondriac*

Perhaps due to Andrew's age and familiarity of a male dominated context of a building site, he constructed more traditional masculine ideals about talking about health to other men. Furthermore, this is consistent with research that has found that men felt pressure from other men, particularly in a work environment, in the disclosure of health issues out of the fear of other men defining their masculinity and exposing them as 'weak' (O'Brien *et al.*, 2005) or in Andrew's example, a 'nutter'. Mahalik and Dagirmanjian (2019) found that working class men preferred to talk to women about depression or sadness as it was a condition that reduces threat and stigma to men. Generally, women are seen to be more understanding of emotional issues and the female language style has been described as one of rapport, sympathy, intimacy and cooperation (Talbot, 2003: 475). As reflected on in chapter five, this was evident throughout the recruitment and research process and as I found that some of the men in this study said they felt more comfortable talking to me as a young, female researcher.

## *Men and the disclosure of emotions*

Recently there has been increasingly more research on masculinity and emotion that has questioned the wider assumption that men are less emotional (de Boise and Hearn, 2017; Galanski, 2004). The above analysis further supports this and points to the importance of speaking about distress to others as a coping and management strategy and means of informal support. My participants' emphasis on the benefits of disclosing emotions and talking to others about distress as a coping mechanism recognises that men have developed the capacity to express themselves emotionally and so are practising 'softer' or 'more emotional' masculinities (de Boise and Hearn, 2017: 779). It is important to note here that I am not claiming that all men are becoming more emotional (de Boise and Hearn, 2017) nor do all men find talking about distress an effective coping mechanism. My participants instead reported that the experience of having someone to talk to was a much better means of coping than holding feelings in, as they previously had done in the past. The variation in my participants' behaviours and opinions to do with seeking out informal support points to the endorsement of more hybridized masculinities and the flexible use of multiple masculinities in their everyday gendered identity. These hybridized masculinity perspectives recognise men's increasing willingness to talk about emotions today yet also note how these newer 'hybrid masculinities' can still also maintain gender inequalities. Men who are able to redefine masculinity into a more emotional form, change patterns of hegemonic masculinity to effectively manage health and thus demonstrate newer hybridized forms of masculinities, are men who embody privilege in some respect.

Although my aim was to recruit a broader cross section of men from a range of backgrounds, my participants were privileged in the sense that they were white and so might have had access to certain privileged social structures such as money (to be able to choose to access formal support like counselling), informal support networks such as family and friends and also previous positive experience of seeking out support for distress. Men of different ethnic backgrounds may not have access to the same conditions as discussed above that allow for emotional disclosure and expression and thus, they might also find it difficult to redefine and utilise masculinity in such a flexible and hybrid way.

## Conclusion

This chapter has explored findings from the interviews from both sample groups of men, exploring and examining what they said they did to cope and manage with everyday emotional difficulties and specific times of distress they have experienced. Specifically, this chapter aimed to answer one of the main research questions:

RQ3 - How do men cope with distress and emotional difficulties they have been faced with on a daily basis?

- a. What do they do to manage distress that works for them?

The support group sample were distinct in that attending a mental health peer support group was something that enabled them to effectively cope and manage emotional difficulties. However, this chapter also referred to the interviews with the general population sample and addressed what else was useful for men in coping with distress.

To summarise, it emerged that the men's coping and management strategies that they adopted in times of distress were complex in what they utilised and the way that they used them. The majority of men in the study talked about 'knowing themselves' or being self-aware of their own emotions in some way, and how important this was in further self-management and coping of emotional difficulties. This self-awareness allowed the men to engage in their mental wellbeing and then adopt appropriate coping and management strategies. In addition to being self-aware they talked about how having a particular sense of perspective on life can influence the way they coped and managed mental health difficulties.

This was followed by discussion of the range of adaptive coping and management strategies that the men adopted. It emerged that participants employed a range of flexible and adaptive strategies. These included engaging in physical exercise, spending time with family and friends, keeping busy, engaging in different interests, and having a positive outlook view towards things in life. Where strategies typically described as 'maladaptive' or unhelpful were mentioned (e.g. drinking alcohol), they were often used in combination with more effective and useful strategies. The different ways they adopted these coping and management strategies in combination highlights different versions of masculinity

being taken up by the participants, depending on context and circumstances. In participants' discussion of the importance of self-awareness and the range of different strategies used, some masculine ideals such as self-control, being health conscious, responsible and taking action assisted positive coping (Valkonen and Hanninen, 2012) and thus promoted flexibility in their broadening of traditional masculine traits (Spendelow, 2015). There evidently was not only one way of coping and managing daily emotional difficulties and we therefore cannot assume that men's strategies are always negative or 'maladaptive'.

As noted in the literature review (chapter three), Whittle *et al.*, (2015) found that previous literature has tended to only focus on maladaptive coping strategies discussed by men regarding their experiences of depression. They observed that most of the qualitative research reviewed tended to reinforce stereotypes that '*women talk*' and '*men don't speak*' and the second part of this chapter focused on the participants' accounts of '*talking about distress*'. I found that participants acknowledged the importance of talking to others about emotional difficulties in their coping and management of distress. Like recent studies (Johnson *et al.*, 2012; Cheshire *et al.*, 2016; Siedler *et al.*, 2016) the findings here highlight that some men are willing to talk, but not just to anybody and only under the right circumstances. My participants mostly found it easier to talk to women, mainly a partner, family member or close friend, and especially those who had shared similar experience. It is important to note though that some participants often explicitly noted how they would not have spoken about emotional difficulties in the past. Perhaps, traditional masculine discourses to do with not opening up emotionally are still present initially for men, but through experience and perspective, some men were able to recognise the value of emotional expression on managing distress. Not only this, but the research situation also presented these men with a 'safe' space in which to reveal 'healthy' or more 'flexible' masculinities in which positive coping strategies are important in their distress management on a daily basis.

# Chapter Ten – Conclusion

## Introduction

Throughout this thesis I have explored a diverse range of men's lived experiences and perspectives of mental health and distress, specifically relating to their coping and management of everyday distress, engagement in formal help seeking, and their use of support groups. The focus has been on the things that men say they do to positively engage in management of their mental health. In chapters two and three I explored relevant literature to do with men, masculinities and mental health and found that a majority of the qualitative studies on male mental health have tended to focus on men's reluctance to seek help, the barriers they face to help-seeking, their lack of attendance at services and the perceived maladaptive coping and management strategies they adopt. Much of the literature reviewed in these two chapters explores men's practices and behaviours in relation to masculinities, in particular dominant, hegemonic masculinities, and the impact masculinities can have not only on the development of mental health issues but also on men's effective management of them. Recent research has however begun to explore the ways in which masculinities can be used in a more flexible and fluid way.

As Ridge and colleagues (2011) argue, gender and mental health issues are complex areas to study, and so careful consideration was given to what methods should be employed for this research. In chapter four I outlined the methods I used in this study. Considering that the study used mixed methods, combining secondary statistical analysis with qualitative primary analysis, I provided an overview of the ontological and epistemological debates that can arise with mixing methods. In the same chapter I then discussed in detail the qualitative component methodology, including access, sampling, ethical issues and data analysis. The discussion of the methods used in the secondary analysis was provided in its own chapter (chapter six) that focused solely on this component with the findings. The reasons for this being a stand-alone chapter were explained in chapter 4. As the research has explored gender, my positionality within the thesis, as a young woman interested in the lives of men, at times created issues during the research process and this was critically reflected on in chapter five. Despite such challenges discussed, no major ethical issues were experienced during the primary data collection.

As observed, two methods were selected to allow me to address specific research questions and further explore men's mental health help seeking, coping and management. The overarching research question of the thesis asked:

- **When men experience distress and difficulties with their mental health, what do they do to manage this?**

To begin to explore help seeking specifically I firstly carried out secondary analysis of The Adult Psychiatric Morbidity Survey 2007, using a chi-square and multivariate logistic regression model to explore the following research question and two sub-research questions:

**RQ1 – What are the social contexts that predict help seeking from a GP for a mental, nervous or emotional problem?**

- a. Can a significant relationship be identified between socio-economic status and whether a man had spoken to the GP about a mental, nervous or emotional complaint?
- b. What are the factors that influence whether or not a man would have spoken to a GP about a mental, nervous or emotional complaint?

Following this, semi-structured interviews with men recruited from the general population (n=19) and men recruited from support groups (n=19) were carried out to explore the following research question and sub research questions regarding help seeking:

**RQ2 - What are men's experiences of help seeking for distress?**

- a. As a type of formal support, what are the men's experiences of using support groups?
- b. What is it that these groups are doing that works for them?

Finally, through the qualitative interviews, I also wanted to explore ways in which men coped and managed everyday distress and emotional difficulties:

**RQ3 - How do men cope with distress and emotional difficulties they have been faced with on a daily basis?**

- a. What do they do to manage distress that works for them?

The different components and areas of the thesis have so far been analysed and considered separately but here I will link them together to draw overall conclusions. This discussion chapter will be structured around the two main areas of men's mental health that have been priority within the thesis: formal help seeking (including the use of support groups) and coping and management (which includes informal help-seeking such as speaking to immediate friends and family). I begin by providing a summary of the main findings within these areas. The secondary analysis findings will be concluded within the discussion of interview participants' formal help-seeking experiences, as its focus was on exploring predictors of seeking help from the GP. The findings from the secondary analysis data will be integrated with the findings from the qualitative data here within the discussion of both these main areas that the thesis explored. Here I will consider to what extent the different data sources support each other and also where they conflict. Following this, I consider the extent to which the participants' accounts of their experiences represent distinct gendered characteristics as well as the application of the concept of masculinities in research on men's mental health. The chapter will then clearly identify and discuss the limitations of this study, finishing with the implications of my research for further research, policy and practice.

## **Experiences of formal help-seeking**

Firstly, the thesis began exploring formal help seeking. I reiterate here that within this thesis formal help seeking included all types of professional support outside of immediate family and friends. In chapter six, a secondary analysis of the Adult Psychiatric Morbidity Survey (2007) was conducted to identify the factors that predict whether or not a man will have spoken to a GP about a mental, nervous or emotional problem. The purpose behind this was to explore the contexts and circumstances that predicted men seeking help from a general practitioner, a type of formal help seeking. Given the limited previous research on social class, mental health and help seeking, I was particularly interested in examining whether conditions such as socioeconomic status were related to help seeking. The

statistical secondary analysis found a significant relationship between socio-economic status and help-seeking from the GP, yet interestingly there were fewer than expected men in higher socio-economic positions, and more than expected men who were unemployed (at the time the survey was carried out) that had spoken to a GP about a mental, emotional or nervous complaint in the last twelve months. Even though I purposefully attempted to recruit men from a range of different social backgrounds, it is difficult to confirm or refute this from the qualitative findings as the majority of the men I interviewed had sought some formal support (GP, counselling). Instead, the purpose of the qualitative interviews was to explore lived experiences in more depth and identify the things that different men in different situations did in seeking help for distress, focusing on routes they took to speak to a GP.

A binary logistic regression model was then used to establish which other variables were important in explaining the likelihood of a man speaking to a GP about a mental, emotional or nervous complaint. All of the chosen variables except for socio-economic status made a statistically significant contribution to the model. Socio-demographic factors that predicted the likelihood of a man speaking to a GP were age, marital status and being unemployed or out of work long term. Interestingly, education was eliminated through the backward elimination process, despite previous research finding it a significant predictor of male help seeking (Mackenzie *et al.*, 2006; Yousaf *et al.*, 2015; Doherty and Kartolova O'Doherty, 2010). Furthermore, ethnicity was also eliminated from the model through this process. Both ethnicity and educational level would have been particularly interesting to explore in the qualitative interviews given the attempt at a more diverse sample and would have enabled more specific integration of the qualitative and quantitative data here in the discussion. However, because of their elimination at this stage it was not something I specifically explored in the interviews with men and analysis of the data.

Data from the secondary analysis found that older men (age categories 75+ and 55-74) were less likely to report speaking to a GP about a mental or emotional problem than those men in the younger age groups (aged 16-34 and 35-54). The qualitative research participants and the data I obtained through the qualitative interviews does not explicitly support this because the majority of the participants (of all different ages) had sought some type of formal help and in most instances at some point in their experience, this help had involved speaking to the GP about distress. As well as this, I did not manage to recruit any men who were aged 75 or over, however, there were two participants who were aged 74,



both of which were from the support group sample. One participant in my sample who was aged 74 spoke explicitly about how he took himself straight to doctor because he did not know what else to do when experiencing depression. I found that middle aged and older men (from both sample groups) were particularly willing to speak to me about their experience of distress and at one point I had struggled to recruit men who were in their twenties or thirties, thus highlighting a tension with the quantitative data. However, the quantitative finding that older men were less likely to have spoken to a GP about distress could be interpreted in light of one of the main qualitative themes from chapter eight (men's use of support groups). Chapter eight highlighted that specifically for older men, support groups were especially beneficial as a place to meet and socialise with others, forge new relationships and prevent loneliness and isolation in old age, as well as support people with emotional struggles. It may not be that older men were less likely to seek help for mental health difficulties (as suggested in the quantitative data findings), but instead the qualitative findings suggest that older men might have different pathways to formal help seeking, as well as different ways of coping and managing distress such as seeking out informal support in the shape of support groups or male only groups instead of initially directly speaking to the GP. The qualitative findings suggest that men of all age categories embodied more varied and flexible masculinity practices when it came to their actions and views on mental health. However, it could also be suggested that these flexible masculine practices and attitudes towards mental health help seeking were a result of their own personal experience of help seeking for distress. Nevertheless, the qualitative findings suggested an alternative explanation as to why older men might not be speaking to the GP, as they might be seeking formal support from elsewhere. The strong association between marital status and contact with the GP was further explored during the interviews (see chapter seven). My participants often discussed the importance of a significant other, usually female and usually a partner, in their decision to seek formal help from a doctor. Through initial disclosure to those close to them participants sought out encouragement from others in their decisions to seek formal help from the GP. In the qualitative findings, being married or in a relationship was actually a help-seeking influencer, whereas the secondary analysis found that those in a relationship or married were less likely than those who were single, widowed, divorced or separated to speak to a GP about emotional difficulties. This is an important tension in my findings. It is likely that there were not enough men in my sample who were, at the time, single or not in a relationship and so I am

unable to shed much light on the relationship between marital status and formal help seeking. The findings from the quantitative data fits with the idea that family and friends are in some ways the most obvious source of initial informal support (see chapter nine also regarding talking to others as helpful in coping and managing distress). For those without a partner or close relationship, that level of immediate support is not available and so these men may have been more likely to initially turn to services such as the GP.

In addition, an explanation of the secondary analysis finding which indicates that single men are more likely to seek help from the GP is that those men may have experienced more emotional difficulties as a result of lack of social networks and social support or a relationship breakdown for example. In contrast, it could be that those men with poorer mental health may also find it difficult to hold down relationships. Again, this points to the value of the role of informal support for men and this was noted and discussed in chapter nine exploring everyday coping and management. However, the qualitative component explored being married or in a relationship as an influence rather than a predictor and is important to consider the difference here when comparing the qualitative and quantitative findings. Also, there were a number of single men in my qualitative sample who had sought out professional help from the GP without the influence and encouragement of a significant other.

The multivariate regression model also explored the life and mental health factors that predicted the likelihood of a man speaking to a GP about distress. These factors included health in general, higher number of major life events experienced, closer family and friend relationships, having a common mental disorder present as well as previously having thought of taking own life. These are all factors that you would expect to influence help seeking from a GP and they can also be reflected in the qualitative findings. The importance of closer family and friend relationships has already been briefly touched upon above in relation to the finding regarding marital status, but I will reiterate here how my qualitative data can support the finding that men with fewer close family and friend relationships were more likely to seek help from the GP. The role of informal support from family members and friends was notable in the qualitative data as for a number of participants this support acted as an everyday coping and management strategy and also a pathway to more formal support from the GP and other professionals (see chapters seven and nine). Findings from across the empirical chapters which include my interview participants' support preference being counselling or talking therapies, the positive

benefits of support groups and being able to talk to similar others, and the significance of opening up about distress to others as an important everyday coping and management strategy, support the quantitative finding that those men with less close family and friend relationships were more likely to seek help from the GP. This quantitative finding can be interpreted in light of these qualitative findings noted, as those with fewer close social networks do not have the opportunity to seek informal support and so may only have the option of initially seeking out formal support from the GP. Some of my participants from the qualitative sample who did not have friends to talk to or felt they did not want to speak to others close to them discussed how they initially spoke to the GP of their own accord and how the support group became a safe space to talk also. Having said that, a qualitative finding presented was that some men did not want to 'burden' family and friends or be judged by those close to them, and instead spoke of how a third party, usually a professional, was the best route of formal support for them (p. 158).

Interview participants who had current or previous physical illness or difficulties (for example, having had cancer or serious leg injuries) discussed already being in contact with the GP about these physical illness or difficulties and so were also able to also discuss with the GP feelings of distress. Previous research has acknowledged that stressful life events trigger depression and distressed mood (Kessler, 1997) and for most of my interview participants, major life events such as redundancy, loss of someone close, a relationship breakup, being in financial trouble etc. were a focal part of their accounts of distress, coping and management and formal help-seeking. For example, in chapter seven I discussed Nick who said that he was more depressed when he split up with his son's mother (p.141), highlighting the impact of stressful life events such as relationship breakdown on distress. Another example from my qualitative findings was when I discussed Rhys, from the support group sample (p.168), who experienced post-traumatic stress disorder as a result of triggers from previous events being in the armed forces. The accounts found in the qualitative data thus support the quantitative data regarding life events and help seeking.

The contextual factors that were found to influence men speaking to a GP about an emotional problem paint just a small picture regarding men's help seeking. In chapter seven I explored my interview participants' lived experiences of formal mental health help seeking. To reiterate, the majority of my participants had some experience of seeking formal help. Firstly, I considered how for a number of my participants seeking help was not

immediate and I examined the hurdles (both external and internal) to help seeking that participants discussed. It emerged that for some men, a reason for not initially seeking professional help was not being able to recognise symptoms of distress, seen in a number of my participants who had originally visited the GP for 'stress' or sleeping problems. This points to the important role GPs play in recognising and diagnosing distress, such as depression and anxiety, in men (Cheshire *et al.*, 2016). In addition, some participants talked of external obstacles such as timing, access to services and waiting lists. In the discussion of help-seeking behaviour, particularly hurdles, I noted the importance of the construction of accounts, and how these so-called hurdles described by the men could be instead interpreted as a kind of ambivalence towards help seeking for distress. They appeared to be neither resistant nor inclined to seek out mental health specific help. Given my attempt throughout the thesis at a positive focus on men's mental health practices, my participants' attempts to seek formal help must be acknowledged and supported.

The chapter then moved to focus on the external contexts that emerged as influential in participants' help seeking. These external influences included significant others (Harding and Fox, 2014), social norms of their social group (Addis and Mahalik, 2008) and the perception of a problem as normative (Sierra Hernandez *et al.*, 2014). The last section of this chapter then examined what kind of formal support participants utilised and preferred.

Overall, chapter seven demonstrated participants' help seeking experiences and highlighted how varied and complex they are. The findings presented support other studies that have found that some men do seek for help for distress under the right circumstances and if it is accessible and engaging (Cheshire, *et al.*, 2016; Seidler *et al.*, 2016; Spendelow, 2015; Galdas *et al.*, 2005). Nearly all of the participants across both sample groups had sought help or at least attempted to seek help for some distress, even if they had not pursued it or utilised continued mental health support. Keohane and Richardson (2017) argue that instead of examining men as resistant to mental health help-seeking, we should question their ambivalence depending on the type of help available and the context in which they seek formal help (Keohane and Richardson, 2017: 167). My study has to some extent attempted to explore such a question, but it has also suggested the need to address this issue further in future qualitative research.

In chapter eight I explored help seeking in the form of participants' use of support groups for distress and emotional difficulties. Throughout the chapter, I explored the mechanisms through which social support and social relationships in the form of support groups, improve psychological wellbeing. Being amongst others who shared experience and understanding was said to be the most effective element of the support group settings for my participants. Tailored support and relationships with others who have direct experiential knowledge seemed to enable group members to develop active coping and mutual understanding. In such group settings, Thoits (2011b) called these people outside immediate family and friends, 'voluntary' groups whom have a social influence over the behaviours of those within such groups. Overlaps are noted here between the support group participants' experiences and the participants from the general population, in emphasising the importance of being able to express emotions in the right circumstances and to appropriate persons. In chapter seven (that explored formal help-seeking), support preference was explored, and it emerged that counselling and talking therapies were useful in supporting interviewees to manage and cope with emotional difficulties. Participants had a general preference for such support (and support groups) because they felt they were able to talk at length about their own feelings of distress in a safe environment without being judged or burdening others close to them. This point was then further explored in chapter nine (that explored coping and management strategies) as participants spoke of the benefits of speaking to others and how this can be a particularly useful way to cope and manage everyday emotional difficulties.

The specific mental health related support that can be offered from others within a support group was also something participants perceived as effective. Within support groups they received what they appreciated as authentic empathy from others, as well as having the chance to reciprocate support. Participants also talked about developing a new role, identity and purpose within the support group setting and this combined with being able to provide specific knowledge and support can influence wellbeing and render benefits with respect to coping with distress. For some, new identity could be a chance to reconstruct their masculinity. Specific to men, and a reason for older men seeking group support, the final theme concerning support group effectiveness acknowledged the importance of support groups in providing social benefits that can alleviate social isolation and loneliness amongst older men (Dave *et al.*, 2008).

Fundamentally, the majority of men in the support group sample discussed how important the groups had been to them in helping them to cope and manage emotional difficulties. They identified positive ways in which the groups they attended were effective for them, in the absence of other types of formal support. As discussed earlier in this section, this finding from the qualitative data can be interpreted in light of the quantitative finding that older men were less likely to seek help from the GP than younger men. To reiterate from above, it may be that older men who are experiencing distress in the shape of social isolation and loneliness may prefer alternative types of formal support instead. This points to the importance of social interaction and social networks in the everyday coping and management of distress and how this can influence help seeking in different ways. My study has added to the field by addressing men's experiences and positive engagement in support groups, something that is limited in the literature. As noted in the discussion of formal help seeking routes (chapter seven) and coping and management strategies (chapter nine), I am not suggesting that support groups would work for all men, as what works for one man and his complex social circumstances may not necessarily be suitable for another. What these findings have acknowledged however is the positive influence of support groups for some men, and the potential for more group-based support to be developed to benefit and support men experiencing emotional difficulties.

Through exploring participants' formal help-seeking experiences in chapter seven and their use of support groups for mental health difficulties in chapter eight I have attempted to answer RQ2 and highlight the varied and complex experiences of men's mental health help-seeking. It can be suggested from the data that some men seek out a safe and confidential space to engage in formal support, talk about problems at length with others who may have shared experience and who would not offer a negative opinion. Some men seem to want an alternative to medication prescribed from the GP and prefer to talk at length with a professional with whom they have a genuine connection with yet still separated from their situation. Found through the support group sample, some men also wanted the chance to reciprocate help seeking and take the chance to use their experience of distress to do something positive and productive through helping others. This could lead to a new sense of purpose and re-establishing of masculinity identity. Although in some instances, participants exhibited ambivalence to seeking professional help, it needs to be acknowledged that these men had made attempts to seek support and they deserve credit for doing so. This is important in highlighting the positive things that men do differently in

their mental health help seeking and that some men can and will seek help under the right circumstances. Perhaps instead of consistently focusing on discourses to do with men's reluctance to seek help, and the detrimental impact this can have, the focus should instead be directed to the different approaches they take to seek help and engage with their mental health.

## Coping and management

Following on from exploring the formal help-seeking avenues men take, including social organisations such as support groups, the thesis then moved to examine the everyday coping and management of distress. In chapter nine I established that participants adopted a range of various coping strategies in combination to positively manage and cope with adversity and distress in daily life. Previous research identified in chapter three mostly related maladaptive coping strategies to men whereas my analysis prioritised positive constructions of coping and management: what the men *said was useful*, rather than splitting the discussion into a binary categorisation of maladaptive and adaptive coping behaviour. Being self-aware and having a certain sense of perspective were said to be particularly important coping tools in managing distress, often leading to proactive management strategies through realisation (Forgarty *et al.*, 2015). This included things like adopting a healthy lifestyle, engaging in exercise and sporting activities, finding meaning, changing their beliefs and developing a new outlook and positive self-image.

Traditionally “maladaptive” coping strategies (Whittle *et al.*, 2015; Spendelow, 2015) such as dealing with things themselves or turning to alcohol were occasionally mentioned within the participants' accounts. These, however, were used in combination with seemingly more positive and effective strategies. The range of coping strategies identified by the participants as effective suggests that some distress coping strategies should not be viewed as explicitly gendered and we should consider that individuals can often develop their own expertise to self-manage their health (Ridge *et al.*, 2011) finding what works effectively and personally for them.

Another self-management tool that was said to be particularly effective was talking to others about distress. This coping and management strategy can also be considered as informal help seeking and so provides explicit links to the discussion between the two main areas of the thesis. In addition and as discussed in the previous section, this qualitative

finding regarding talking about emotional difficulties as an important coping strategy supports the quantitative data that suggests that those men who have less close family and friend relationships (and so less people they feel able to open up to about difficulties) are more likely to have spoken to a GP about distress. The importance of talking and being more open about distress became evident across all three empirical analysis chapters, with it being an effective way to manage and cope with emotional difficulties, a tool that led to more formal help-seeking and a significant benefit of support groups. Participants spoke of the difficulties in previously being able to speak out about distress to others yet, during the interviews, some of these same men acknowledged the importance of talking and how helpful it can be in managing their mental health effectively.

Overall the thesis has indicated that some men are willing to talk when the setting is right and with an appropriate person whom they trust and feel comfortable with (O'Brien *et al.*, 2005; Emslie *et al.*, 2006). The findings highlight the complexities and individualities of men's coping and management and as Ridge *et al.*, (2011) point out, when men and women are faced with the complexity of their own distress then they have their own reasons for choosing to manage their problems in ways that do not always match professional frameworks (Ridge *et al.*, 2011: 151). This study therefore emphasises the importance of acknowledging the complexity, individuality and flexibility of men's mental health coping and management tools. Here I suggest that we move away from stereotypes that men's coping can often be maladaptive, and instead place emphasis on the positive things that men *do* and what *they say works* for them.



## **What does this tell us about men, masculinities and their experiences of mental health?**

Throughout the analysis I have in places applied theories of masculinities to the participants' accounts of their experiences of coping and management, help seeking and use of support groups. I have considered at times that it is important not to assume that the ways my participants engaged with their mental health were unique to only men. As this research has been conducted with men only, it is difficult to claim that women would not engage with their mental health in a similar way. For example, previous studies have found that women too perceive themselves as gaining control strength and control through recovery from depression (Maxwell, 2005). Nonetheless, masculinity, and the ways in which it was constructed throughout my participants' accounts of their lives and experiences, cannot be ignored in concluding the thesis.

Performances of masculinities are fundamental in the discussion of men's mental health help-seeking and coping. There are arguably elements of my participants' experiences of distress observed in the data that indicate distinct gendered characteristics. I have touched on some of these characteristics of masculinity throughout the empirical chapters, for example, the gendered nature of sport in men's engagement in physical activities to manage emotional difficulties and the gendered nature of the importance of work. In this section however, I briefly reflect on the use of masculinities within the thesis and consider the extent to which different types of masculinity shape and structure the experience of help seeking and everyday coping and also how this thesis might have challenged pathological views of men and masculinity in relation to mental health experiences.

### ***Is masculinity still an issue in relation to men's help seeking, coping and management?***

As noted in the literature reviews (chapters two and three) as well as consistently throughout the thesis, there has been a dominant, pathological narrative that "men do not talk about feelings" and "men do not seek help for distress". Men and masculinities have

previously been examined as a problem in men's mental health practices. Robertson and Williams (2009) argue that we should not assume that all men are always reluctant to engagement in healthcare. This study has highlighted this, with the aim having been to move away from this 'men as deficit' model. Instead I wanted to explore the positives of what men say they *do* to engage in and manage distress and what it is that facilitates them to seek help. There appears to be much more going on within my participants' accounts of their experiences of coping, help seeking and engagement in services, than unitary notions of masculinity allow. Consistent with other research, my participants' accounts suggest a diverse and complex relationship between masculinity and distress in daily life that was also negotiated through other aspects of identity (Robertson, 2006a). For example, different versions of masculinity were constructed and taken up in different ways during the experience of distress and help seeking. Observed throughout the analyses, participants often drew upon discourses and values associated with hegemonic masculinity (Emslie *et al.*, 2006; Jeffries and Grogan, 2012; Johnson *et al.*, 2012) when articulating their experiences. However, in the same conversations these participants at times also drew on discourses outside this hegemonic ideal, such as valuing the importance of talking about distress and advocating support groups, and through these accounts of their experiences employed different models of masculinity. Previous literature suggests that men in distress can negotiate hegemonic masculinity and they can use various culturally dependent strategies to perform masculinity and take up multiple positions (Jeffries and Grogan, 2012; Wetherell and Edley, 1999).

The findings across the qualitative chapters affirm the concept of multiple, multi-dimensional and flexible masculinities (Connell, 1987; Connell and Messerschmidt, 2005) in the way that the men constructed different identities in their engagement in different ways of coping and help seeking for distress. For example, in discussion of their coping and management strategies, some men reconstructed the disclosure of emotional difficulties to others as a portrayal of strength, control and doing something about the problem, so reforming hegemonic masculine ideals. In using support groups, some participants adopted an alternative to hegemonic masculinity that allowed for the sharing of distress openly in group settings but also at the same time demonstrated complicity to hegemonic masculinity in the way they adopted an active and responsible masculine 'provider' role in reciprocating support to others in that group. Although the support group as a 'community of practice' (Creighton and Oliffe, 2010) provided an opportunity to break away from

hegemonic masculine practices, my participants also at times renegotiated their masculine identity and drew on both hegemonic ideals and other forms of masculinity. These examples point to more hybridized models of masculinities where hegemonic patterns change through incorporating parts of other forms of masculinities, such as softer masculinities which allows for the expression of emotion. In some cases, participants across both sample groups were marginalised in their identity through conditions such as unemployment, illness (such as cancer) or distress and depression itself. These participants still attempted to negotiate hegemonic notions of masculinity into their accounts of help seeking and everyday coping and management of distress. This concept of multiple masculinities allows for variability within men and for a range of manageable ways men can live out their maleness. Examples of multi-dimensional masculinities can thus be seen in the ways my participants negotiated different versions of masculinity in adopting suitable coping strategies and formal support routes appropriate for their individual contexts and circumstances.

I return here to note criticisms of Connell's influential work on masculinities theory as discussed in chapter three. Having completed this research and drawn on the theory of hegemonic masculinity and fluid, multiple masculinities in places throughout the analysis, I still support Connell's relational framework and its application to men's experiences of mental health difficulties. I do agree that in some contexts, hegemonic masculinity can be too restricted in perceiving men as continually trying to live up to these 'hegemonic' masculine practices, that are often associated with a list of 'manly' attributes. However, I do believe that there is a form of masculinity that is associated with power in any given setting and that this will vary by local context but men will continue to attempt to locate themselves within this form of masculinity in some way or another. Previously, hegemonic masculinity has often been used to blame men for their lack of engagement with health difficulties. We should be cautious in assuming that hegemonic masculinity is a given and should proceed in showing awareness of the varied ways men can strategically take up hegemonic norms flexibly within different contexts. In the context of men's experiences of help seeking and coping for emotional difficulties, hegemonic masculinity and its characteristics are still an influential concept in understanding the varied pathways men take to seek out informal and formal support. As such, using Connell's gender relations framework and viewing masculinities more flexibly, and as multifaceted and complex (Connell, 1995; Robertson, 2007), is valuable in understanding the varied ways in which

men use, negotiate and reform different masculinities at different times and in different ways dependent on context and setting.

As indicated in chapter two, recent studies on masculinity and health have begun to note how traditional masculine values do not always have to be detrimental to men's health practices and behaviours and they can instead become a resource (Cameron and Bernardes, 1998; Robertson, 2006a; Hammer and Good, 2010; Kiselica and Englar-Carlson, 2010; Oliffe *et al.*, 2010; Oliffe *et al.*, 2018). Kilmartin (2005) suggested building on positive masculine qualities such as courage, e.g. being brave enough to express feelings, leadership, strength and independence, e.g. taking action to do something about issues and using responsibility to show other men more effective ways of dealing with their emotional lives. Similarly, Orgrodniczuk, Oliffe, Kuhl and Gross (2016) are trying to change men's perspectives about utilising health services by reframing help seeking as a show of strength and responding to men's desire of autonomy and independence. Such approaches, however, need to also caution not to reinforce negative traditional male views. There are examples of where my participants reframed help seeking and masculinity in this way, supporting previous qualitative research that has found similar (Emslie *et al.*, 2006; Johnson *et al.*, 2012; Sierra Hernandez *et al.*, 2014; Spendelow, 2015). In their accounts, they perceived help seeking, speaking about distress and having their own personal coping strategies as being responsible, independent and strong, thus emphasising and utilising hegemonic masculine practices positively. Similar to Sierra Hernandez *et al.*, (2014), in some instances my participants tended to redefine and adopt more flexible and contextually defined masculine identities that allowed them to 'do' hegemonic masculinity even when engaging in help-seeking and coping and management behaviours. For example, my participants' increasing capacity to express their emotional distress, and their valuing of this as a particularly effective coping mechanism and means of informal support, was essentially them redefining masculinity. As noted though, in redefining masculinity they did not abandon hegemonic masculine practices completely but often flexibly used them. The more positive aspects of masculinity thus shaped my participants experiences of help seeking. This can be seen in their accounts of normalising formal help seeking, holding choice and power in their decision of when to disclose distress in both counselling and talking therapies and also within support groups, and in them adopting a range of adaptive, positive coping strategies in combination (for example, being self-aware, engaging healthy living, exercise, and speaking to someone about feelings) and so 'taking action' to actively

attempt to manage their mental health. Their masculinity was one that was often based on their individuality that allowed them to engage in their mental health. It is important to consider here the context and subject matter of the interview, as well as my position as a young female researcher and its effect on the negotiation and construction of different masculine identities. In this research, participants may have adopted a particular masculine identity based on the subject of distress and how they wanted to be understood during the interview. This could be seen in Farrimond's (2011) study, whereby participants negotiated their masculine identities according to whom was present, the symptoms of the distress and the identity demands of that social context.

The presence of flexibly constructed masculinities that varied in certain contexts point to the need for researchers, practitioners and the media to resist focusing on masculinity, or more specifically hegemonic masculinity, as something negative and detrimental in men's mental health experiences. In order to maximise the likelihood of men engaging in positive practices of care, interventions and men's mental health promotion needs to recognise men's practices as contradictory, fluid and contextual (Robertson *et al.*, 2016). Although a lot of my participants reproduced traditional masculine discourses at times in their discussions of their coping strategies and potential hurdles to help-seeking, in actuality, most had sought out services for distress, and they spoke of their effective self-management and coping strategies.

This thesis contributes to the theory of multiple masculinities and the positive masculinity paradigm, specifically in relation to men's mental health and wellbeing management. It has highlighted that mental health help seeking experiences are still to some extent shaped by masculinity but not wholly defined by static notions of 'being a man'. This thesis has further exhibited just how contradictory, fluid and contextual (hegemonic) masculine practices are in the experiences of men's mental health help seeking and everyday coping and management. It is important to note though that in this thesis, masculinities were not the only influencing factor on the help seeking experience. External contexts and structural factors such as access to social networks (to provide informal support), socio-economic status and employment (that can impact mental health and access to certain masculine practices), age and also experience of certain life events/conditions, can influence not only the experience of distress (and help seeking and everyday coping) but also the negotiation of masculine identity. Health promotions and

interventions need to recognise all these factors and acknowledge men's multiple use of masculine practices, in engaging them in effective mental health management.

## Limitations of the research

The findings of this study help to provide an insight into men's experiences of distress in terms of help-seeking, coping and management, an area of research which is still to some extent largely limited, and non-existent in Wales. Before I consider the implications of these findings for further research, policy and practice I acknowledge the limitations of the study.

Firstly, a limitation is my qualitative sample. As I have noted during the empirical chapters, particularly in the discussions around talking to others about distress, the sample groups consisted of atypical groups of men who were willing and able to talk about their distress experiences in-depth, as well as being prepared to take part in a research study. The majority of the men in my study had personal experience of distress and help-seeking for distress and so that was potentially a reason for their willingness to take part. Although in this study I endeavoured to recruit a diverse and broader sample of men from different ages and social backgrounds, which much previous research has failed to do, it is still missing those 'strong and silent' men (O'Brien *et al.*, 2005) who are not able to recognise and open up about their distress experiences. I believe I have managed to capture some 'silent' types to an extent, as there were men who described to me how they had never opened up about their experiences until the research interview. This could be down to the confidentiality aspect of the research interview and due to circumstances where they may not have had the opportunity to talk previously. Still, men who are willing to talk are not representative of the typical male population, and it is important to recognise this.

The sample was obtained only within South Wales, which can be seen as a strength because to my knowledge a qualitative research study investigating men's experiences of distress, exploring elements of masculinity, help-seeking, coping and use of support groups has not been carried out within this part of the country. However, the participants were mostly recruited from city centre locations or other smaller areas around that city centre. It is important to consider the potential differences in men's experiences from city centre and

rural areas, as well as socio-economic differences throughout different towns and locations outside of the city centre. I chose 'typically' male spaces and institutions such as pubs, gyms, football and rugby clubs, workplaces, betting shops, cafes etc. to recruit from and so this may have led to some potential bias towards particular places within particular locations being selected by myself. As well as this, it only really captured those men who were socially active in that they used these social and public locations, so missing out socially isolated men.

Finally, in relation to the limitations of the sample, as I have emphasised, I sought to collect a diverse sample of men, yet the sample lacks ethnic diversity, as I did not manage to obtain men of different ethnic minorities or cultural or religious backgrounds. As well as this, the general population sample still included more men in the higher occupations/socio-economic classes than in other categories (see classification tables in chapter four).

In addition to issues with the sample, the men I recruited and interviewed knew that the study was interested in men, masculinity and their own personal experiences of distress *as a man* and so there was potential for self-conscious performances of masculinity to take place during the interview situation. I have discussed limitations of interview research in chapter four as well as issues with gender and my position as a young woman interviewing men potentially having had an influence on performances and constructions of masculinity during the interview setting in chapter five. Qualitative semi-structured interviewing involves participants constructing accounts of their experiences and so there is nothing to validate what the men retell as having actually happened in that way. The men may have told me what they thought I would like to hear regarding their experiences of being a man and mental distress, potentially accentuating or masking their masculinity in their discussions. The interview only provides a snapshot of experience, and the men may have behaved differently or construct a different version of events within a different context and at a different time or place.

There is also the issue of mixing methods and how the two different components of the study take place in different home nations within the United Kingdom. The Adult Psychiatric Morbidity Study 2007 was conducted with households in England, whilst my own primary qualitative data collection, was conducted in Wales. I have discussed this as a limitation in the conclusion of the secondary analysis chapter (six). The dataset from

England was used for the secondary analysis component in the study because there was no comparable source exploring people's mental wellbeing that included appropriate variables available at the time for Wales.

Findings from the study provide an interesting exploration and understanding into a predominantly heterogeneous sample of men and their accounts of their experiences of distress help seeking, coping and management. However, they also point to the complexity of men's experiences. Despite this complexity and difference highlighted, these findings can be of value to the developing and informing of policy, practice and future research, particularly in relation to examining men's formal help-seeking and their use of support groups. The following section will proceed in highlighting the ways in which the findings from this study could be used.

## **Research Implications**

### *Further research*

It was noted in the literature review that much male mental health research supports the notion that men are less likely than women to seek help. Nonetheless, more research has now attempted to further the exploration to investigate differences in men and not just between the genders, with Galdas *et al.*, (2005) arguing that men are not a 'homogeneous group that can be compared against women' (Galdas *et al.*, 2005: 620). This study sought to explore a more heterogeneous group of men and examine the various ways in which men cope, manage and seek-help for distress, emphasising positive aspects of what men perceived as effective for good mental wellbeing and management of their mental health. It can be seen in chapter four, (from the socio-economic status classification table) as well as throughout the analytical discussion in chapters seven, eight and nine, that the study was successful in obtaining a relatively broad range of participants, owing to my specific recruitment strategy. Achieving this diverse sample population has greatly helped to inform our understanding of the complexity of men's experiences of formal help-seeking for distress, their perceived effectiveness of support group services and their positive coping and managing strategies. However, in exploring the limitations of this study, it is clear that



there is still difficulty in obtaining a truly heterogeneous and diverse sample of men, despite my trying. Further research should attempt to obtain an even broader range of participants, such as those of different ethnicities, as well as a range of class backgrounds, in order to further investigate help-seeking and coping in men's distress. Although a reasonable number of interviews ( $n=38$ ) were carried out, given the diversity of men and the two different sample groups it is likely that only a partial understanding of men's perspectives and experiences are obtained.

Additionally, future research on those 'strong and silent' men (O'Brien *et al.*, 2005) who have not sought out any formal support instead of those who are willing to speak about their experiences in a research situation are still needed. Although my recruitment strategy was adopted in attempt to gain access to these types of men, it could be developed further in future research. Perhaps a way to do this would be to advertise the study differently on the recruitment flyer. Rather than explicitly saying the research is interested in "experiences of difficulties", it could be advertised as interested in "experiences of being a man" (although this would have the potential to only engage a more selected group of interviewees who are reflective about masculinity on some level), with the topic of coping with distress to be covered during the interviews. However, this study has also used a nationally representative sample in the secondary analysis in attempt to capture the widest possible population of English men.

Using the secondary analysis, the study aimed to take into account the influence of bounded social and structural circumstances and contexts on men's likeliness to visit a GP about an emotional problem, and such social circumstances have been drawn on where necessary throughout the qualitative analysis also. However, further research that focuses specifically on these social circumstances for specific groups of men and their influence on men's personal experiences of distress, as well as their help-seeking and coping behaviours, would be beneficial in identifying ways in which these specific groups of men can be supported. Perhaps because one of the study's main focuses was to strive for a broader sample, it may have missed out specific different groups of men in the recruitment. A number of studies in the future that focus solely on a specific group of men only could be valuable. For example, concentrating on groups of older men, gay men, younger men, students, ex-veterans, single middle-aged men, married middle-aged men, men in specific occupations etc. would potentially offer a more in-depth exploration of experiences distinct to that group and their social circumstances.

A study that focuses on the perspectives and experiences of healthcare professionals that work with and support men in distress, as well as immediate family and friends, might also help further identify the ways in which men cope and manage distress on a daily basis, in addition to their engagement in support services. If research included men and their partners, this would further validate my participants' self-reported accounts, as well as offer a different perspective in identifying what is effective in supporting men to further engage in and manage their mental health. Speaking to professionals could identify effective ways of working with, and supporting men, as well as any specific issues in engaging men from different groups bound by different social circumstances.

At the beginning of this section I referred to the literature review that highlighted the need for there to be more qualitative research that explores differences in help-seeking and mental health management within men rather than just between men and women. Throughout the findings chapters I have considered the extent to which I can claim that the participants' accounts of their experiences are explicitly gendered and distinct to men, resulting in this being a limitation of the study. It is difficult to discern to what extent different men's experiences are to do with the performance or construction of masculinities, or other dimensions that can influence subjective experience, such as personal circumstance or social class for example. Additional qualitative research that investigates coping strategies and formal help-seeking behaviours and routes for both men and women to offer comparison would draw attention to whether or not the strategies, avenues and issues identified by the men in this study are distinctly gendered. Nevertheless, there is some debate as to whether qualitative analysis can ever be truly comparative as the nature of qualitative methods is to provide exploratory findings that are indicative of personal and subjective stories and experiences.

Finally, much of the previous social research on men's mental health experiences has used qualitative methods to explore personal subjectivities, lacking studies that use quantitative and mixed methodologies. In this study I have used both approaches, quantitative and qualitative methods, to help further inform the exploration of men and distress. As noted in reviewing the limitations, there was no dataset exclusively conducted with men in Wales that included appropriate variables addressing distress help seeking and coping. Conducting a large-scale survey, specifically designed to explore this could support future qualitative research, as in the case of this study, and also aid healthcare service design and delivery. Examples of surveys that would ask questions not covered in the Adult

Psychiatric Morbidity Study could include exploration of men's formal help-seeking avenues and service use, including support group attendance (chapters seven and eight), particularly focusing on which areas within Wales have higher service attendance of males, as well as support group evaluation of those utilising support services. Also, a study that explores men's mental wellbeing in general could be helpful, with a survey focusing on the things that men do to cope and manage with distress on a daily basis (chapter nine).

### *Policy and practice implications*

Although I have highlighted the areas in need for further research, the conclusions from this research could also potentially have implications on policy and practice. One finding is the value of having others recognise distress in men and so influence the help seeking and support process. A number of mental health campaigns including the Time to Change 'Be in your mates corner' campaign (Time to Change, 2017), a number of CALM campaigns including the most recent '#Project84', and the Movember Foundation 'Unmute- Ask him' campaign, aim to encourage open conversations around men's mental health, urging others to ask how men are doing. Through such campaigns, the conversation around men's mental health seems to be improving. High profile men in mainstream popular culture, including those perceived as typically masculine such as footballers and grime musicians, are now talking more openly about mental health, in the hope of making it more acceptable and normal to do so. Nevertheless, as the findings presented in this thesis show, there is still a way to go in terms of men feeling more comfortable to be more open about their mental health. One finding presented is that some men can and do talk about their mental distress and experiences, but this was often following past experience and they point out the value of having a significant person to talk to in the right circumstances. Perhaps instead of focusing on how men still feel they should hide their feelings, campaigns should acknowledge that some men will talk under the right circumstances and provide a means for men to do so comfortably and when suitable to them. Additionally, the findings could further expand such campaigns described above in considering the language endorsed by men when engaging with their own mental health. Previous research (Cheshire *et al.*, 2016) has suggested that in marketing campaigns and specific services to men, the term 'stress' attracts a greater male audience and so men are able to resonate

with this term in their discussion of further emotional difficulties. This thesis adds to this insight in the discussion of men's attempts to normalise and articulate distress. In addition, the diverse sample explored in this study indicates the need for campaigns to consider the precise group of men from different backgrounds that they want to reach, as there is not 'one size that fits all' (Stein, 2018). Campaigns should be sensitive to language and contexts of different men from different social groups.

The point above leads on to consider the training that GPs and other primary care health professionals receive in being able to recognise and diagnose distress in men when they do initially seek some form of support. Throughout the literature reviews as well as within my research findings, the ways in which distress can manifest itself in men has been discussed. The importance of a skilled and empathetic GP in identifying emotional problems in men who present to them is identified in the thesis findings and this can influence the following route that men subsequently take to get help and maintain support. This study further supports the suggestion that GPs, nurses and other primary care professionals need to be provided with specific training to recognise the distinct gendered characteristics of distress and how it presents itself in a diverse range of different men with intersecting identities.

Another important and more specific, policy relevant finding to emerge from the study, is the value and significance of support groups for men who may be experiencing some kind of mental distress, whether that be depression or anxiety or loneliness and social isolation. It is important to emphasise that this study does not claim that support groups are suitable for all men. However, what is notable from my findings is the ability of such environments to provide a space in which some men may feel that their distress can be understood. Speaking to someone who had similar experiences of distress, whether that was a partner, friend or group member, was often discussed by participants as being helpful in the coping and management of distress. Those other people who understood how they were feeling, particularly within a group context which provided membership and belonging, further supported them in accepting and managing their distress. It emerged that support group environments and their activities provided men a chance to re-construct role identities and a sense of purpose. This is particularly important for men who may have felt a loss of masculinity in their experience of distress and being valued as a member within a support group can help them rebuild their sense of identity within a community of practice (Creighton and Oliffe, 2010). In addition, support groups can also be

a means in which to decrease loneliness and social isolation that a number of men, specifically older men, may be experiencing.

In aiming to engage more men in more services, mental health campaigns from both public health and third sector organisations should highlight the significance of support groups and their potential benefits in supporting men to cope and manage with distress. Perhaps support services for mental wellbeing and distress, both for men and women and for men only, are lacking in all regions, locally and nationally. Or perhaps it is the advertising and marketing of these support groups that is missing in engaging and encouraging men to access such services. The Welsh Government's 'Together for Mental Health' campaign sets out its commitment to prioritise mental health treatment. It supports and considers the importance and potential of social prescribing in preventing problems early on before they worsen. Social prescribing is a way of linking patients in primary care with sources of support in the community, including a range of activities and interventions such as meet up groups, volunteering, arts and sports. The importance and potential of support groups in the management of mental health should be acknowledged within the consideration of the social prescribing scheme. GPs, nurses and other primary care professionals need to be aware of the local and various types of support groups that are available and use them as a non-clinical referral option other than prescription medication. Findings from the study suggest that support groups can be helpful to men in managing their distress and so groups like the ones I recruited from could be offered and provided as a means of support where men may not have the access to support from significant others.

Finally, the findings have suggested men still initially lack awareness of mental health issues and are unsure of where to look for support alternative to the primary care route of the GP. The Welsh Government 'Together for Mental Health Campaign' (Welsh Government, 2012) emphasises the need to help people understand and manage mental health better through the right information and advice. They proposed that health boards should provide more low-level services, such as anxiety management and mindfulness, and to ensure that people have better information and knowledge about these services. This study highlights the importance of this Welsh Government campaign and the need to revisit and revise it to ensure important information and advice on managing distress is made better accessible and available to the general public.

## Concluding words

In conclusion, this thesis has intended to explore and prompt insights and understandings into a range of men's experiences of help-seeking and coping and daily management for distress. This research has found that some men are active in engaging in their mental wellbeing and adopt positive coping mechanisms to manage and prevent daily distress effectively. It has also shown that some men are *willing* to seek help for distress when it is needed and in ways that are most appropriate to their personal circumstances. Men's help seeking and coping may not be straightforward, but it is nonetheless not always as negative as previously perceived. It is important to recognise the varied things that men do differently and what facilitates help seeking and coping, to better provide support for men experiencing distress. We need to work with men to normalise mental health help seeking and encourage positive coping and open discussion around experiences of distress. Despite male suicide being at its lowest in 30 years (ONS, 2017), the overall heart-rendering male suicide figures still manifest that some men may still find it difficult to talk about distress and further demonstrates the need for continuous attention, promotion and support for male mental health.

# Bibliography

- Addis, M. E. and Hoffman, E. (2017). Men's depression and help-seeking through the lenses of gender. In Levant, R.F and Wong, W.J. (eds) *The psychology of men and masculinities* (pp. 171–196). Washington, DC: American Psychological Association
- Addis, M. E. and Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist*, 58(1), 5-14.
- Addis, M. E., Mansfield, A. K. and Syzdek, M. R. (2010). Is “masculinity” a problem?: Framing the effects of gendered social learning in men. *Psychology of Men & Masculinity*, 11(2), 77-90.
- Agahi, N., Silverstein, M. and Parker, M. (2011). Late-life and earlier participation in leisure activities: Their importance for survival among older persons. *Activities, Adaptation & Aging*, 35(3), 210–222.
- Age Concern (2006). *Investigation into the Social and Emotional Well-being of Lone Older Men*. London: Age Concern Surrey.
- Aked J., Marks N., Cordon C. and Thompson S. (2008). *Five Ways to Wellbeing: A Report Presented to the Foresight Project on Communicating the Evidence Base for Improving People's Well-Being*. Centre for Well-Being, New Economics Foundation (NEF), London.
- Allen, L. (2005). Managing Masculinity: Young men's identity work in focus groups. *Qualitative Research*, 5(1), 35-57.
- Anderson, E. (2009). *Inclusive Masculinity: The changing nature of masculinities*. London: Routledge.
- Anderson, E. and McGuire, R. (2010). Inclusive masculinity and the gendered politics of men's rugby. *Journal of gender studies*, 19(3), 249-261.
- Angst, J., Gamma, A., Gastpar, M., Lepine, J.P., Medlewicz, J. and Tylee, A (2002). Gender differences in depression. *European Archives of Psychiatry and Clinical Neuroscience*, 252(5), 201-209.
- Antaki, C., Billig, M., Edwards, D. and Potter, J. (2003). Discourse analysis means doing analysis: a critique of six analytic shortcomings. *Discourse Analysis Online* 1, Available at: [http:// www.shu.ac.uk/daol/previous/v1/n1/index.htm](http://www.shu.ac.uk/daol/previous/v1/n1/index.htm) [Accessed: 20<sup>th</sup> January 2018].
- Atkinson, R. and Flint, J. (2001). Accessing hidden and hard-to-reach populations: Snowball research strategies. *Social Research Update*, 33.
- Arendell, T. (1997). Reflections on the Researcher-Researched Relationship: A Woman Interviewing Men. *Qualitative Sociology*, 20(3), 341-368.
- Artazcoz, L., Benach, J., Borrell, C. and Cortes, I. (2004). Unemployment and mental health: Understanding the interactions among gender, family roles and social class. *American Journal of Public Health*, 94(1), 82-88.

- Attride-Stirling, J. (2001). Thematic networks: an analytic tool for qualitative research. *Qualitative Research*, 1(3), 385-405.
- Baker, P., S. L. Dworkin, S. Tong, I. Banks, T. Shand. and G. Yamey. (2014). "The Men's Health Gap: Men Must be Included in the Global Health Equity Agenda." *Bulletin of the World Health Organization*, 92 (8): 618– 620.
- Baumeister, R. F., Campbell, J. D., Krueger, J. I. and Vohs, K. D. (2003). Does High Self-Esteem Cause Better Performance, Interpersonal Success, Happiness, or Healthier Lifestyles? *Psychological Science in the Public Interest*, 4(1), 1-44.
- Beale, B., Cole, R., Hillege, S., McMaster, R. and Nagy, S. (2004). Impact of in-depth interviews on the interviewer: Roller coaster ride. *Nursing & Health Sciences*, 6(2), 141-147.
- Berger, J. L., Addis, M. E., Green, J. D., Mackowiak, C. and Goldberg, V. (2013). Men's reactions to mental health labels, forms of help-seeking, and sources of help-seeking advice. *Psychology of Men & Masculinity*, 14(4), 433-443.
- Best, P., Manktelow, R. and Taylor, B.J. (2014). Social work and social media: Online help-seeking and the mental well-being of adolescent males. *British Journal of Social Work*, 1-20.
- Beynon, J. (2002). *Masculinities and Culture*. Buckingham: Open University Press.
- Bhaskar, R. (1977). *A realist theory of science*. Brighton: Harvester
- Biddle, S. J. H. and Mutrie, N. (2001). *Psychology of Physical Activity Determinants, Well-Being and Interventions*. London: Routledge
- Biringer, E., Davidson, L., Sundfor, B., Lier, H. O. and Borg, M. (2016). Coping with mental health issues: subjective experiences of self-help and helpful contextual factors at the start of mental health treatment. *Journal of Mental Health*, 25(1), 23-27.
- Borkman T. (1999). *Understanding Self Help/Mutual Aid: Experiential Learning in the Commons*. Rutgers University Press, New Brunswick
- Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: SAGE
- Branney, P. and White, A. (2008). Big boys don't cry: depression and men, *Advances in Psychiatric Treatment*, 14, 256–62.
- Branney, P., Witty, K., Bagnall, A.M., South, J. and White, A. (2012). 'Straight to the GP: that would be where I would go': An analysis of male frequent attenders' constructions of their decisions to use of not use health-care services in the UK. *Psychology & Health*, 27(7), 865-880.
- Braun, V. and Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.



- Bridges, T. and Pascoe, C.J. (2014). Hybrid masculinities: New directions in the sociology of men and masculinities. *Sociology Compass*, 8(3), 246-258.
- Brod, M. and Kaufman, M. (1994). *Theorizing masculinities*. Thousand Oaks: Sage.
- Broom, A., Hand, K. and Tovey, P. (2009). The role of gender, environment and Individual biography in shaping qualitative interview data. *International Journal of Social Research Methodology*, 12(1), 51-65.
- Broughton, K. A., Payne, L. and Liechty, T. (2016). An exploration of older men's social lives and well-being in the context of a coffee group. *Leisure Sciences*, 39, 1–16.
- Brown, S.R. (2001). 'What makes men talk about health?', *Journal of Gender Studies*, 10(2), 187- 195.
- Brownhill, S., Wilhelm, K., Barclay, L. and Schmied, V. (2005). 'Big build': hidden depression in men, *Australian and New Zealand Journal of Psychiatry*, 39(10), 921–31.
- Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative Research*, 6, 97-113.
- Bryman, A. (2007). Barriers to integrating quantitative and qualitative research. *Journal of Mixed Methods Research*, 1(1), 8-22
- Bryman, A. and Bell, E. (2003) *Business Research Methods*. Oxford: Oxford University Press.
- Burgess, R.G. (1984). *In the field: An introduction to field research*. London: Allen and Unwin.
- Burns, J.M., Durkin, M.A. and Nicholas, J. (2009). Mental health of young people in the United States: What role can the internet play in reducing stigma and promoting help-seeking? *Journal of Adolescent Health*, 45(1), 95-97.
- Busfield, J. (2000). Introduction: Rethinking the sociology of mental health. *Sociology of health and illness*, 22(5), 543-548.
- Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity*. New York: Routledge
- Byrne, B. (2004). Qualitative interviewing. In Seale. C. (eds) *Researching society and culture*. London: Sage, pp. 179-192
- CALM (Campaign Against Living Miserably) (2014). *A crisis in modern masculinity: Understanding the causes of male suicide*. Available at: <https://www.thecalmzone.net/wp-content/uploads/2014/11/CALM-State-of-the-Nation-Audit-Summary.pdf> [Accessed: 15<sup>th</sup> March 2016]
- Callaghan, P. (2004). Exercise: a neglected intervention in mental health care? *Journal of psychiatric and mental health nursing*, 11, 476-483.
- Cameron, E. and Bernardes, J. (1998). Gender and disadvantage in health: men's health for a change, *Sociology of Health and Illness*, 20(5): 673-93.

- Campbell, E. (2003). Interviewing men in uniform: a feminist approach? *International Journal of Social Research Methodology*, 6(4), 285–304.
- Chandler, A. (2012). Exploring the role of masculinities in suicidal behaviour. In: Wyllie, C., Platt, S., Brownlie, J., Chandler, A., Connolly, S., Evans, R., Kennelly, B., Kirtley, O., Moore, G., O'Connor, R. and Scourfield, J. *Men suicide and society: why disadvantaged men in mid-life die by suicide*. Surrey, UK. Available at: <https://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf> [Accessed: August 2<sup>nd</sup> 2018]
- Chakraborty, A., McManus, S., Brugha, T. and Bebbington, P. (2011). Mental health of the non-heterosexual population of England. *The British Journal of Psychiatry*, 198(3), 143-148.
- Charteris-Black, J. and Seale, C. (2009). Men and emotion talk: Evidence from the experience of illness. *Gender and Language*, 3(1), 81-113.
- Charmaz, K. (1995). Identity dilemmas of chronically ill men. In: Sabo, D., Gordon, D.F. (eds) *Men's Health and Illness: Gender, Power and the Body*. Sage Publications, Thousand Oaks, CA. pp. 266-291.
- Cheshire, A., Peters, D. and Ridge, D. (2016). How do we improve men's mental health via primary care? An evaluation of the Atlas Men's Well-being Pilot Programme for stressed/distressed men. *BMC Family Practice*, 17(13)
- Chnick, C., Greenfield, J., Greenberg, S., Shepard, S., Cochran, S. and Haley, J. (2009). A qualitative investigation of depression in men. *Psychology of Men and Masculinity*, 10(4), 302-313.
- Clare, A. (2000). *On Men: Masculinity in crisis*. London: Chatto and Windus.
- Clark, T. (2010). On 'being researched': why do people engage with qualitative research? *Qualitative Research*, 10(4), 399-419
- Clatterbaugh, K. (1990). *Contemporary Perspective on masculinity: Men, Women, and politics in modern society*. Boulder, CO: Westview press.
- Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science of Medicine*, 74(4), 498-505
- Cochran, S.V. and Rabinowitz, F.E. (2003). Gender-sensitive recommendations for assessment and treatment of depression in men. *Professional Psychology: Research and Practice*, 34, 132–140.
- Coen, S.E., Oliffe, J.L., Johnson, J.L. and Kelly, M.T. (2013). Looking for Mr. PG: masculinities and men's depression in a northern resource-based Canadian community. *Health Place*, 21, 94-101.
- Coffey, A. and Atkinson, B. (1996). *Making Sense of Qualitative Data*, Sage Publications, Thousand Oaks, CA,
- Coles, R., Watkins, F., Swami, V., Ones, S., Woolf, S. and Stanistreet, D. (2010). What men really want: A qualitative investigation of men's health needs from the Halton and St

- Helens Primary Care Trust men's health promotion project. *British Journal of Health Psychology*, 15(4), 921-939.
- Collinson, D.L. and Hearn, J. (1994). 'Men' at 'work': multiple masculinities and multiple workplaces. In: Mac an Ghail, M. (eds) *Understanding Masculinities*. Buckingham: Open University Press.
- Collinson, D.L. and Hearn, J. (2004). Men and masculinities in work, organizations and management. In Kimmel, M., Hearn, J. and Connell, R.W. (eds) *Handbook of studies on men and masculinities*. Thousand Oaks, CA: Sage. pp. 289-310.
- Connell, R.W. (1987). *Gender and Power: Society, the person and sexual politics*. Stanford University Press.
- Connell, R.W. (1995). *Masculinities*, Cambridge, Polity Press.
- Connell, R.W. (2000). *The men and the boys*. Cambridge: Polity Press.
- Connell, R.W. (2005). *Masculinities*, Cambridge, Polity Press.
- Connell, R.W. and Messerschmidt, J. W. (2005). Hegemonic masculinity: Rethinking the concept. *Gender & Society*, 19(6), 829-859.
- Cooper, L.A., Gonzalez, J.J., Gallo, J.J., Rost, K.M., Meredith, L.S., Rubenstein, L.V., Wang, N.Y. and Ford, D.E. (2003) The acceptability of treatment for depression among African-American Hispanic, and white primary care patients. *Medical Care*, 41479- 489.
- Coreil, J., Wilke, J. and Pintado, I. (2004). Cultural models of illness and recovery in breast cancer support groups. *Qualitative Health Research*, 14(7), 905-923.
- Cornally, N., & McCarthy, G. (2011). Help-seeking behaviour: A concept analysis. *International Journal of Nursing Practice*, 17(3), 280-288.
- Cornwell, J. (1984). *Hard Earned Lives: Accounts of Health and Illness from East London*. London: Tavistock.
- Cornwall, A. and Linisfarne, N. (eds) (1994). *Dislocating Masculinity, comparative ethnography*. Oxon: Routledge.
- Coston, B.M. and Kimmel, M. (2012). Seeing Privilege Where It Isn't: Marginalized Masculinities and the Intersectionality of Privilege. *Journal of Social Issues*, 68(1), 97-111.
- Courtenay, W.H. (2000). Constructions of masculinity and their influence on men's wellbeing: a theory of gender and health. *Social Science and Medicine*, 50, 1385-1401.
- Courtenay, W.H. (2003). Key determinants of the health and well-being of men and boys. *International Journal of Men's Health*, 2, 1-30.
- Coyle, A. and Morgan-Sykes, C. (1998). Troubled men and threatening women: The construction of "crisis" in male mental health. *Feminism & Psychology*, 8, 263-284.
- Crabtree, B. and Miller, W. (1999). *A template approach to text analysis: Developing and using codebooks*. In Crabtree, B. and Miller, W. (eds) *Doing qualitative research*. Newbury Park, CA: Sage. pp. 163-177.

- Cramer, H., Howrood, J., Payne, S., Araya, R., Lester, H. and Salisbury, C. (2014). Do depressed and anxious men do groups? What works and what are the barriers to help seeking? *Primary Health Care Research & Development*, 15, 287-301.
- Crawshaw, P. (2007). Governing the male citizen: Men, masculinity and popular health in Men's Health magazine. *Social Science & Medicine*, 65, 1606-1618.
- Creighton, G. and Oliffe, J.L. (2010). Theorising masculinities and men's health: A brief history with a view to practice. *Health Sociology Review*, 19, 409-418.
- Crone, D. and Guy, H. (2008). 'I know it is only exercise, but to me it is something that keeps me going': a qualitative approach to understanding mental health service users' experiences of sports therapy. *International Journal of Mental Health Nursing*, 17(3), 197-207.
- Cusack, J., Deane, F., Wilson, C. and Ciarrochi, J. (2004). Who influences men to go to therapy? Reports from men attending psychological services. *International Journal for the Advancement of Counselling*, 26, 271-283.
- Dale, A., Arber, S. and Proctor, M. (1988). *Doing Secondary Analysis*. London, Allen and Unwin
- Daley, A.J. (2002). Exercise therapy and mental health in clinical populations: Is exercise therapy a worthwhile intervention? *Advances in psychiatric treatments*, 8, 262- 270
- Danermark, B., Erksom, M., Jakobsen, L. and Karlson, J.C. (1997) Generalization, scientific inference and models for an explanatory social science, in B. Danermark (eds) *Explaining Society: Critical realism in the social sciences*, Abingdon, Oxon: Routledge
- Daniels, A. K. (1967). The low-caste stranger in social research. In Sjoberg, G. (eds) *Ethics, politics, and social research*. Cambridge, MA: Schenkman. pp. 267-296.
- Danielsson, U. and Johansson, E. (2005). Beyond weeping and crying: a gender analysis of expressions of depression, *Scandinavian Journal of Primary Health Care*, 23, 171-7.
- Danielsson, U., Bengs, C., Lehti, A., Hammarstrom, A. and Johansson, E. (2009) Struck by lightning or slowly suffocating – gendered trajectories into depression, *BMC Family Practice*, 10,56.
- Dave, D., Rashad, R.I. and Spasojevic, J. (2008). The Effects of Retirement on Physical and Mental Health Outcomes. *Southern Economic Journal*, 75, 497-523.
- Davidson, L., Chinman, M., Kloos, B., Weingarten, R., Stayner, D. and Tebes, J.K. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology: Science and Practice*, 6, 165-187.
- Davies, S.C. (2013). Chief Medical Officer's summary. In: Metha, N. (eds) Annual Report of the Chief Medical Officer 2013, Public Mental Health Priorities: Investing in the Evidence [online]. London: Department of Health, pp.11-19. Available at:

<https://www.gov.uk/government/publications/chiefmedical-officer-cmo-annual-report-public-mental-health> [Accessed: November 18<sup>th</sup> 2015]

de Boise, S., & Hearn, J. (2017). Are men getting more emotional? Critical sociological perspectives on men, masculinities and emotions. *The Sociological Review*, 65, 779–796

Demetriou, D. (2001). Connell's concept of hegemonic masculinity: A critique. *Theory and Society*, 30(3), 337-361.

Denzin, N. K. (1978). *The research act: A theoretical introduction to sociological methods*. New York: Praeger.

Denzin, N.K. and Lincoln, Y.S. (2013). *Strategies of Qualitative Inquiry* (4e) Sage: Thousand Oaks, Californian

Dingwall, R. (1980). Ethics and ethnography, *Sociological Review*, 28(4), 871–891.

Doherty, D.T. and Kartalova-O'Doherty, Y. (2010). Gender and self-reported mental health, *Psychology*, 15(1), 213-228.

Dolan, A. (2007). 'Good luck to them if they can get it': exploring working class men's understandings and experiences of income inequality and material standards, *Sociology of Health and Illness*, 29(5), 711-29.

Dolan, A. (2011). You can't ask for a Dubonnet and lemonade!: Working class masculinity and men's health practices. *Sociology of Health and Illness*, 33(4), 586-601.

Dolan, A. (2014). 'Men give in to chips and beer too easily': How working-class men make sense of gender differences in health. *Health*, 18, 146–162.

Donaldson, M. (1993). What is hegemonic masculinity? *Theory and Society*, 22(5), 643-657.

Economic and Social Research Council. (2015). *ESRC Framework for research ethics*, Updated January 2015. Available online at: <http://www.esrc.ac.uk/files/funding/guidance-for-applicants/esrc-framework-for-research-ethics-2015> [Accessed: October 10<sup>th</sup> 2017]

Edley, N. and Wetherell, M. (1995). *Men in perspective: Practice, power and identity*. T.J. Press Ltd.

Emslie, C., Ridge, D., Ziebland, S. and Hunt, K. (2006). Men's accounts of depression: reconstructing or resisting hegemonic masculinity? *Social Science and Medicine*, 62, 2246–57.

Emslie, C. and Hunt, K. (2009). 'Live to work' or 'Work to live'? A Qualitative study of gender and work-life balance among men and women in mid-life. *Gender, Work and Organisation*, 16(1), 151-172.

Engel, G. L. (1977). The need for a new medical model: A challenge for biomedicine. *Science*, 196: 129- 136.

European Commission (EC). (2004). *Action for Mental Health: activities co-funded from European Community Public Health Programmes 1997- 2004*. Available at: [http://ec.europa.eu/health/ph\\_determinants/life\\_style/mental/docs/pact\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/pact_en.pdf) [Accessed: October 23<sup>rd</sup> 2015]

Evans J., Blye F., Oliffe J. and Gregory D. (2011). Health, Illness, Men and Masculinities (HIMM): a theoretical framework for understanding men and their health. *Journal of Men's Health*, 8(1), 7–15.

Farrimond, H. (2012). Beyond the caveman: rethinking masculinity in relation to men's help-seeking. *Health (London)*, 16(2), 208-225.

Fauldi, S. (1999). *Stiffled: The betrayal of the modern man*. London: Chatto and Windus.

Featherstone, B., Rivett, M. and Scourfield, J. (2007). *Working with men in health and social care*. London: SAGE.

Fereday, J. and Muir-Cochrane, E. (2006). Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development. *International Journal of Qualitative Methods*, 5(1), 80-92.

Ferrari, A., Charlson, F., Norman, R., Patten, S., Freedman, G., Murray, C., Vos, T. and Whiteford, H. (2013). Burden of Depressive Disorders by Country, Sex, Age, and Year: Findings from the Global Burden of Disease Study 2010. *PLoS Med*, 10(11).

Field, A. (2009). *Discovering Statistics Using SPSS (3e)* London: Sage.

Fielding, N.G. and Lee, R.M. (1998). *Computer Analysis and Qualitative Research*. London: Sage.

Finlay, L. (2002). 'Negotiating the swamp: the opportunity and challenge of reflexivity in research practice', *Qualitative Research*, 2(2), 209–30.

Finlay, L. and Gough, B. (2003). (eds) *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford: Blackwell Science Ltd

Fletcher, D.R. (2010). The workless class? Economic transformation, informal work and male working-class identity. *Social Policy & Society*, 9(3), 325-336.

Flick, U. (2014). *An Introduction to Qualitative Research*, (5e). London: Sage

Flynn, L. R. and Goldsmith, R. E. (2013). *Case studies for ethics in academic research in the social sciences*. London: SAGE Publications, Inc.

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

Ford, E., Clark, C. McManus, S. Harris, J., Jenkins, R., Bebbington, P., Brugha, T. Meltzer, H. and Stansfeld, S. A. (2010). Common mental disorders, unemployment and welfare benefits in England. *Public Health*, 124(12), 675-681

Furnham A. and Andrew, R. (1996). A cross-cultural study of attitudes towards seeking psychological help. *Psychological Reports*, 79, 289–290.

- Gage, E. A. (2013). Social networks of experientially similar others: formation, activation, and consequences of network ties on the health care experience. *Social Science Medicine*, 95, 43-51.
- Gailey, J.A. and Prohaska, A. (2011). Power and gender negotiations during interviews with men about sex and sexually degrading practices. *Qualitative Research*, 11(4), 365-380.
- Galdas, P., Cheater, F. and Marshall, P. (2005). Men and health help-seeking behaviour: literature review, *Journal of Advanced Nursing*, 49(6), 616-23.
- Garfield, S., Smith, F. and Francis, S.A. (2003). The paradoxical role of antidepressant medication: Returning to normal functioning while losing the sense of being normal. *Journal of Mental Health*, 12, 521-535.
- Gerschick, T. J. and Miller, A. S. (1995). Coming to terms: Masculinity and physical disability. In Sabo, D. and Gordon, D.F. (eds) *Men's health and illness: Gender, power, and the body, Research on men and masculinities series*. Thousand Oaks, CA: Sage Publications. Vol. 8, pp. 183 – 204.
- Gibson, K., Cartwright, C. and Read, J. (2016). Conflict in Men's Experiences with Antidepressants. *American Journal of Men's Health*, 12(1), 104-116.
- Gill, R., Henwood, K. and McLean, C. (2005). Body projects and the regulation of normative masculinity. *Body & Society*, 11(1), 37-62.
- Gill, F. and Maclean, C. (2002). Knowing your place: Gender and reflexivity in two ethnographies. *Sociological Research Online*, 7(2)
- Goldthorpe, J.H. (2007). *On Sociology*, (2e) Stanford: Stanford University Press
- Goleman, D. (1995). *Emotional Intelligence*. New York: Bantam.
- Gough, B. (2006). Try to be healthy, but don't forgo your masculinity: deconstructing men's health discourse in the media. *Social Science Medicine*, 63(9), 2476-2488.
- Gray R., Fitch M., Davis C. and Phillips C. (1997). A qualitative study of breast cancer self-help groups. *Psycho-Oncology* 6, 279-289.
- Green, G., Barbour, R.S., Barnard, M., and Kitinger, J. (1993). "Who wears the trousers?" Sexual harassment in research settings. *Women's Studies International Forum* 16, 627-37.
- Greenland, K., Scourfield, J., Maxwell, N., Prior, L. and Scourfield, J. (2009). Theoretical antecedents of distress disclosure in a community sample of young people. *Journal of Applied Social Psychology*, 39, 2045-2068.
- Griffith, D. M. (2018). "Centering the margins": Moving equity to the center of men's health research. *Health Promotion International*, 12, 1317-1327
- Grime, J. and Pollock, K. (2003). Patients' ambivalence about taking antidepressants: A qualitative study. *Pharmaceutical Journal*, 271, 516-519.
- Gurney, J.N. (1985). Not one of the guys: The female researcher in a male-dominated setting. *Qualitative Sociology*, 8(1), 42-62.
- Hakim, C. (1982). *Secondary Analysis in Social Research*. London: Allen and Unwin.

- Hammer, J. H. and Good, G. E. (2010). Positive psychology: An empirical examination of beneficial aspects of endorsement of masculine norms. *Psychology of Men & Masculinity*, 11, 303–318.
- Hammond, C. (2005). The wider benefits of adult learning: An illustration of the advantages of mixed methods research. *International Journal of Social Research Methodology*, 8, 239–255.
- Hankivsky, O. (2012). Women’s health, men’s health, and gender and health: Implications of intersectionality. *Social Science & Medicine*, 74, 1712–1720.
- Hankivsky, O. and Cormier, R. (2009). *Intersectionality: Moving women’s health research and policy forward*. Vancouver: Women’s Health Research Network.
- Harding, C. and Fox, C. (2014). It’s Not About “Freudian Couches and Personality Changing Drugs”: An Investigation into Men’s Mental Health Help-Seeking Enablers, *American Journal of Men’s Health*, 9(6), 451–463.
- Hargreaves, D.H. (1967). *Social Relations in a Secondary School*, London: Routledge & Kegan Paul.
- Hargreaves, D. (1987). *Sport, power and culture*. Cambridge: Polity.
- Harper, D. (1998). An argument for visual sociology. In: Prosser, J. (eds) *Image-based Research: A Sourcebook for Qualitative Researchers*. London: Falmer Press. pp. 24–41.
- Haywood, C. and Mac an Ghail, M. (2003). *Men and masculinities*. Buckingham: Open University Press.
- Head, E. (2009). The ethics and implications of paying participants in qualitative research. *International Journal of Social Research Methodology*, 12(4), 335–344.
- Hearn, J. (1996). Is masculinity dead? A critique of the concept of masculinity/masculinities. In: Mac an Ghail, M. *Understanding masculinities: Social relations and cultural arenas*. Buckingham, UK: Open University Press.
- Hearn, J. (2004). From hegemonic masculinity to the hegemony of men. *Feminist Theory* 5 (1), 49–72.
- Heartfield, J. (2002). There is no masculinity crisis. *Genders*, 35
- Heifner C. (1997). The male experience of depression. *Perspectives in Psychiatric Care*, 33, 10–18.
- Hendricks, V. M., Blanken, P. and Adriaans, N. (1992). *Snowball Sampling: A Pilot Study on Cocaine Use*, Rotterdam: IVO
- Hoglund, M.W., Sadovsky, R. and Classie, J. (2009). Engagement in life activities promotes healthy aging in men. *Journal of Men’s Health*, 6(4), 354–365.
- Holland, J.C. and Bultz, B.D. (2007). The NCCN guideline for distress management: a case for making distress the sixth vital sign. *Journal of the National Comprehensive Cancer Network*. 5(1), 1–5.



- Holstein, J.A. and Gubrium, J.F. (2004). The active interview. In: Silverman, D. (eds) *Qualitative Research: Theory, method and practice*. London: Sage.
- Horn, R. (1997). Not 'one of the boys': women researching the police. *Journal of Gender Studies* 6(3), 297–308.
- Houston, S. (2001). "Beyond Social Constructionism: Critical Realism and Social Work," *British Journal of Social Work*, 31(6), 845-861.
- Howitt, D. and Cramer, D. (2011). *Introduction to statistics in psychology*. Prentice Hall.
- Hoy, S. (2012). Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help-seeking. *International Journal of Men's health*, 11, 202.
- Ivinson, G. and Murphy, P. (2003). Boys don't write romance: the construction of knowledge and social gender identities in English classrooms. *Pedagogy, Culture & Society*, 11(1), 89-111.
- Jarrett, N., Bellamy, C. and Adeyemi, B. (2007). Men's health help-seeking and implications for practice. *American Journal of Health Studies*, 22(2), 88-95.
- Jeffries, M. and Grogan, S. (2012). 'Oh, I'm just, you know, a little bit weak because I'm going to the doctor's': Young men's talk of self-referral to primary healthcare services. *Psychology & Health*, 27(8), 898-915.
- Johnson, B. and Macleod Clarke, J. (2003). Collecting sensitive data: The impact on researchers. *Qualitative Health Research*, 13(3), 421-434.
- Johnson, R.B. and Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher*, 33(7), 14-26.
- Johnson J.L, Oliffe J.L, Kelly M.T, Galdas, P. and Ogrodniczuk, J.S. (2012). Men's discourses of help-seeking in the context of depression. *Sociology of Health Illness*. 34(3), 345–61.
- Jefferson, T. (2002). Subordinating hegemonic masculinity. *Theoretical Criminology*, 6(1), 63-88.
- Jeffries, M. and Grogan, S. (2012). 'Oh, I'm just, you know, a little bit weak because I'm going to the doctor's': young men's talk of self-referral to primary healthcare services. *Psychology of Health*, 27(8), 898-915.
- Kadam, U.T., Croft, P., McLeod, J. and Hutchinson, M. (2001). A qualitative study of patients' views on anxiety and depression. *British Journal of General Practice*, 51(466), 375-380.
- Karp, D. (2006). *Is it me or is it my meds? Living with antidepressants*. Cambridge, MA: Harvard University Press.
- Kawachi, I. and Berkman, L.F. (2001). Social Ties and Mental Health, *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, 78(3), 458-467.

- Keohane, A. and Richardson, N. (2017). Negotiating Gender Norms to Support Men in Psychological Distress. *American Journal of Men's Health*, 1-12.
- Kelly, M., Tyrka, A.R., Price, L.H. and Carpenter, L.L. (2008). Sex differences in the use of coping strategies: predictors of anxiety and depressive symptoms, *Depression and Anxiety*, 25(10), 839–846.
- Kessler, R.C. (1997). The effects of stressful life events on depression. *Annual Review Psychology*, 48, 191-214.
- Kilmartin, C. (2005). Depression in men: Community, diagnosis and therapy. *The Journal of Men's Health and Gender*, 2(1), 95-99.
- Kimmel, M.S. (1994). Masculinity as homophobia: fear, shame and silence in the construction of gender identity. In Brod, H. and Kaufman, M. (eds) *Theorizing masculinities*. Thousand Oaks, CA: Sage.
- Kiselica, M. S. and Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: the positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy (Chic)*, 47(3), 276-287.
- Kleiber, D.A. and Linde, B.D. (2014). The case for leisure education in preparation for the retirement transition. *Journal of Park and Recreation Administration*, 32(1), 111–128.
- Kolappa, K., Henderson, D.C. and Kishore, S.P. (2013). *No physical health without mental health: lessons unlearned?* WHO Bulletin, Available at: <http://www.who.int/bulletin/volumes/91/1/12-115063.pdf> [Accessed: June 16<sup>th</sup> 2016]
- Krumm, S., Checchia, C., Koesters, M., Kilian, R. and Becker, T. (2017). Men's views on depression: a systematic review and metasynthesis of qualitative research. *Psychopathology*, 50(2), 107-124.
- Kumpal, I. (2013). Determinants of social desirability bias in sensitive surveys: A literature review. *Quality and Quantity*, 47(4), 2025-2047.
- Kvale, S. (1996). *InterViews: An introduction to qualitative research interviewing*. Thousand Oaks, CA: Sage
- Kvale, S. and Brinkman, S. (2009). *InterViews: Learning the craft of qualitative research interviewing*. Thousand Oaks, CA: Sage
- Lane, J. M. and Addis, M. E. (2005). Male gender role conflict and patterns of help seeking in Costa Rica and the United States. *Psychology of Men & Masculinity*, 6(3), 155–168.
- Lave, J. and Wenger, E. (1991). *Situated Learning*. Cambridge: Cambridge University Press.
- Lazarus, R.S. (1993). Coping theory and research: Past, present and future. *Psychosomatic Medicine*, 55, 234-247.

Leaf, P.J., Bruce M.L., Tischler G.L. and Holzer, C.E III. (1987). The relationship between demographic factors and attitudes toward mental health services. *Journal of Community Psychology*, 15, 275–284.

Lee, D. (1997). Interviewing men: vulnerabilities and dilemmas. *Women's Studies International Forum* 20(4), 553–564.

Leininger, M. M. (1985). Ethnography and ethnonursing: Models and modes of qualitative data analysis. In: Leininger, M. M. (eds) *Qualitative research methods in nursing*. Orlando, FL: Grune & Stratton, pp. 33-72.

Liddon, L., Kingerlee, R. and Barry, J. A. (2017). Gender differences in preferences for psychological treatment, coping strategies, and triggers to help-seeking. *British Journal of Clinical Psychology*, 1-19.

Lohan, M. (2000). Extending Feminist Methodologies: Researching Masculinities and Technologies. In: Byrne, A. and Lentin, R. (eds) *(Re)searching Women: Feminist Research Methodologies in the Social Sciences in Ireland*. Dublin: Institute of Public Administration

Lohan, M. (2007). How might we understand men's health better? Integrating explanations from critical studies on men and inequalities in health, *Social Science and Medicine*, 65, 493–504.

Lynch, J.R. and Kilmartin, C.T. (2013). *Overcoming masculine depression: The pain behind the mask*. New York, NY: Routledge

Mahalik, R.J, Burns, M.S. and Syzdek, M. (2007). Masculinity and perceived normative health behaviors as predictors of health behaviors. *Social Science & Medicine*, 64, 2201 – 2209.

Mac an Ghail, M. (eds) (1996). *Understanding Masculinities*. Buckingham: Open University Press.

Macdonald, J. (2006). Shifting paradigms: A social determinants approach to solving problems in men's health policy and practice. *Medical Journal of Australia*. 185(8), 456-458.

MacInnes, J. (1998). *The end of masculinity*. Buckingham: Open University Press.

Mackenzie, C.S., Gekoski, W.L. and Knox, V.J. (2006). Age, gender, and the underutilization of mental health services: The influence of help-seeking attitudes. *Ageing and Mental Health*, 10(6), 574-582.

Mackenzie, C.S., Roger, K., Robertson, S., Oliffe, J.L., Nurmi, M.A. and Urquhart, B.S.W. (2017). Counter and complicit masculine discourse among Men's Sheds members. *American Journal of Men's Health*, 11(4), 1224-1236.

Mammen, G. and Faulkner, G. (2013). Physical activity and the prevention of depression: a systematic review of prospective studies. *American Journal of Preventative Medicine*, 45(5), 649-657

Mankowski, E., and Rappaport, J. (1995). Stories, identity and the psychological sense of community. In: Wyer Jr R.S (eds), *Knowledge and memory, the real story. Advances in social cognition*. Hillsdale, NJ: Erlbaum, pp. 211–226.

Mannay, D. (2010). Making the familiar strange: Can visual research methods render the familiar setting more perceptible? *Qualitative Research*, 10(1), 91-111.

Mansfield, A., Addis, M. and Courtenay, W. (2005). Measurement of men's help seeking: Development and evaluation of the barriers to help seeking scale. *Psychology of Men & Masculinity*, 6, 95-108.

Mansfield, A., Addis, M. and Mahalik, J. (2003). Why won't he go to the doctor? The psychology of men's help seeking. *International Journal of Men's Health*, 2, 93-109.

Mason, J. (1996). *Qualitative researching*. London: Sage

Mason, J. (2006). Six strategies for mixing methods and linking data in social science research. *Real Life Methods* working paper, University of Manchester.  
[www.manchester.ac.uk/realities/resources/Toolkits](http://www.manchester.ac.uk/realities/resources/Toolkits) [Accessed: May 10<sup>th</sup> 2017]

Maxwell, M. (2005). Women's and doctors' accounts of their experiences of depression in primary care: the influence of social and moral reasoning on patients' and doctors' decisions. *Chronic Illness*, 1(1), 61-71.

McCormack, M. (2010). The declining significance of homophobia for male students in three sixth forms in the south of England. *British Educational Research Journal*, 37(2), 337-353.

McCormack, M. (2012). *The Declining Significance of Homophobia, How Teenage Boys are Redefining Masculinity and Heterosexuality*. New York: Oxford University Press.

McDowell, L. (1998). Elites in the City of London: Some Methodological Considerations, *Environment and Planning A*, 30, 2133–46

McDowell, L. (2000). The trouble with men? Young people, gender transformation and the crisis of masculinity. *International Journal of Urban and Regional Research*, 24 (1), 201-209.

McEvoy, P. and Richards, D. (2006). A critical realist rationale for using a combination of quantitative and qualitative methods. *Journal of Research in Nursing*, 11:66–78

McKee L. and O'Brien, M. (1983). Interviewing men: taking gender seriously. In: Gamarnikow, E., Morgan, D., Purvis, J. and Taylorson, D. (eds) *The Public and the Private*. London: Heinemann. pp. 147–161.

McKeganey, N. (2001). To pay or not to pay: Respondents' motivation for participating in

research. *Addiction*, 96, 1237–1238.

McKeown, M., Roy, A. and Spandler, H. (2015). 'You'll Never Walk Alone': supportive social relations in a football and mental health project. *International Journal of Mental Health Nursing*, (24)4, 360–9.

McManus S, Meltzer H, Brugha T, Bebbington P. and Jenkins, R. (eds) (2009). *Adult psychiatric morbidity in England, 2007: Results of a household survey*. [online] NHS Information Centre for Health and Social Care, pp.1-274. Available at: <http://www.hscic.gov.uk/catalogue/PUB02931/adul-psyc-morbres-hou-sur-eng-2007-rep.pdf> [February 15<sup>th</sup> 2016]

McManus, S, Bebbington, P, Jenkins, R. and Beugha, T. (eds) (2016). *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital. Available at: [https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/556596/apms-2014-full-rpt.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/556596/apms-2014-full-rpt.pdf) [Accessed: November 20<sup>th</sup> 2018]

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134–141.

Mead, S. (2003). *Defining peer support*. Online. Available at: <http://www.mentalhealthpeers.com/pdfs/DefiningPeerSupport.pdf> [Accessed: January 20<sup>th</sup> 2018]

Meléndez, J. C., Mayordomo, T., Sancho, P. and Tomás, J. M. (2013). Coping Strategies: Gender Differences and Development throughout Life Span. *The Spanish journal of psychology*, 15(3), 1089-1098.

Meltzer, H., Bebbington, P., Brugha, T., Jenkins, R., McManus, S. and Stansfeld, S. (2010). Job insecurity, socio-economic circumstances and depression. *Psychological Medicine*, 40, 1401–1407.

Men's Health Forum. (2014). *Men's health manifesto*. Available online at: [https://www.menshealthforum.org.uk/sites/default/files/pdf/mens\\_health\\_manifesto\\_lr.pdf](https://www.menshealthforum.org.uk/sites/default/files/pdf/mens_health_manifesto_lr.pdf) [Accessed: November 23<sup>rd</sup> 2018]

Men's Health Forum. (2016). *Key data: Mental health: Statistics on mental health and men*. Available online at: <https://www.menshealthforum.org.uk/key-data-mental-health> [Accessed: November 23<sup>rd</sup> 2018]

Mental Health Foundation. (2016). *Fundamental Facts About Mental Health 2016*. Mental Health Foundation: London. Available at: <https://www.mentalhealth.org.uk/sites/default/files/fundamental-facts-about-mental-health-2016.pdf> [Accessed: November 23<sup>rd</sup> 2018]

Meyer, S.B. and Lunay B. (2013). 'The Application of Abductive and Retroductive Inference for the Design and Analysis of Theory-Driven Sociological Research.' *Sociological Research Online*, 18(1).

- Mezzina, R., Davidson, L., Borg, M., Marin, I., Topor, A. and Sells, D. (2006). The social nature of recovery: Discussion and implications for practice. *Archives of Andrology*, 9(1), 63–80.
- Miller, T. and Bell, L. (2002). Consenting to what? Issues of access, gate-keeping and 'informed' consent. In: Mauthner, M., Birch, M., Jessop, J. and Miller, T. (eds) *Ethics in Qualitative Research* London: Sage.
- Miller, J. and Glassner, B. (1997). The inside and outside: finding realities in interviews. In: Silverman, D. (eds) *Qualitative Research: Theory, Method and Practice*. London: Sage
- Milligan, C. Neary, D. Payne, S. Hanratty, B. Irwin, P. and Dowrick, C. (2016). Older men and social activity: a scoping review of Men's Sheds and other gendered interventions. *Ageing & Society*, 36, 895-923.
- Moller, M. (2007). Exploiting patterns: A critique of hegemonic masculinity, *Journal of Gender Studies*, 16(3), 263-276.
- Moller-Leimkuhler, A.M. (2002). Barriers to help-seeking by men: a review of sociocultural and clinical literature with particular reference to depression, *Journal of Affective Disorders*, 71, 1–9.
- Montana, C.B. (1994). Recognition and treatment of depression in a primary care setting. *Journal of Clinical Psychiatry*, 55(12), 18.
- Moore, D. L. and Tarnai, J. (2002). Evaluating nonresponse error in mail surveys. In: Groves, R.M., Dillman, D.A., Eltinge, J.L. and Little, R.J. A. (eds) *Survey Nonresponse*, John Wiley & Sons, New York. pp. 197–211.
- Morgan, D.H. (1992). *Discovering men*. London: Routledge.
- Morgan, D. (2006). The crisis in masculinity. In: David, K., Evans, M., Lorber, J. (eds) *The Handbook of gender and women's studies*. London: Sage. pp.109-124.
- Morgan, D. L. (2008). Snowball Sampling. In: Given, L.M. (eds) *The Sage Encyclopaedia of Qualitative Research Methods*, London: SAGE
- Murray, G., Suto, M., Hole, R., Hale, S., Amari, E. and Michalak, E. E. (2011). Self-management strategies used by “high functioning” individuals with bipolar disorder: From research to clinical practice. *Clinical Psychology & Psychotherapy*, 18, 95–109.
- Mutrie, N. (2000). The relationship between physical activity and clinically defined depression. In: Biddle, S.J.H., Fox, K.R. and Boutcher, B.H. (eds) *Physical Activity and Psychological Well-being*. London: Routledge.
- Naples, N. (1996). A feminist rethinking of the insider/outsider debate: The 'outsider phenomenon' in rural Iowa. *Qualitative Sociology*, 19(1), 83-106.
- NHS Digital (2009). *Adult Psychiatric Morbidity in England – 2007, Results of a household survey*. Available online at: <https://digital.nhs.uk/data-and->

[information/publications/statistical/adult-psychiatric-morbidity-survey/adult-psychiatric-morbidity-in-england-2007-results-of-a-household-survey](#) [Accessed: April 10<sup>th</sup> 2016]

Nixon, D. (2006). I just like working with my hands: Employment aspirations and the meaning of work for low-skilled unemployed men in Britain's service economy. *Journal of Education and Work*, 19(2), 201-217.

Noone J.H. and Stephens C. (2008). Men, masculine identities, and health care utilisation. *Sociology of Health & Illness* 30(5), 711-725.

Nordentoft, H. M. and Kappel, N. (2011). Vulnerable participants in health research: methodological and ethical challenges. *Journal of Social Work Practice*, 25(3), 365-376

Oakley, A. (1981). 'Interviewing Women: a Contradiction in Terms' in Roberts, H. (eds) *Doing Feminist Research*. London: Routledge, pp. 30-61.

O'Brien, R, Hunt, K. and Hart, G. (2005). 'It's caveman stuff, but that is to a certain extent how guys still operate': Men's accounts of masculinity and help seeking. *Social Science and Medicine*, 61, 503 – 516.

Oh E., Jorm A. and Wright A. (2008). Perceived helpfulness of websites for mental health information. *Social Psychiatry and Psychiatric Epidemiology*, 44, 293-299

Office for National Statistics (ONS). (2010). *Standard Occupational Classification Volume 3: the National Statistics Socio-economic Classification* (NS-SEC rebased on the SOC2010), Available online at <http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/guide-method/classifications/current-standard-classifications/soc2010/soc2010-volume-3-ns-sec--rebased-on-soc2010--user-manual/index.html> [Accessed: May 12<sup>th</sup> 2017]

Office for National Statistics (ONS). (2017). *Suicides in the UK: 2017 Registrations*, Statistical Bulletin, [Online] Available at:

<https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2017registrations> [Accessed: October 10<sup>th</sup> 2018]

Ogrodniczuk, J. S., Oliffe, J. L., Kuhl, D. and Gross, P. A. (2016). Men's mental health: Spaces and places that work for men. *Canadian Family Physician*, 62, 463-464.

Oliffe, J. (2005). Constructions of masculinity following prostatectomy-induced impotence. *Social Science & Medicine*, 60(10), 2249-2259.

Oliffe, J. L., Kelly, M. T., Johnson, J. L., Bottorff, J. L., Gray, R. E., Ogrodniczuk, J. S. and Galdas, P. M. (2010). Masculinities and college men's depression: Recursive relationships. *Health Sociology Review*, 19(4), 465-477.

Oliffe, J.L., Kelly, M.T., Bottorff, J.L., Johnson, J.L. and Wong, S.T. (2011). "He's typically more female because he's not afraid to cry": Connecting heterosexual gender relations and men's depression. *Social Science and Medicine*, 73, 775-782.

Oliffe, J. L., Ogrodniczuk, J. S., Bottorff, J. L., Johnson, J. L. and Hoyak, K. (2012). "You feel like you can't live anymore": suicide from the perspectives of Canadian men who experience depression. *Social Science Medicine*, 74(4), 506-514.

Oliffe, J. L., Galdas, P. M., Han, C. S. and Kelly, M. T. (2013a). Faux masculinities among college men who experience depression. *Health (London)*, 17(1), 75-92.

- Oliffe, J. L., Rasmussen, B., Bottorff, J. L., Kelly, M. T., Galdas, P. M., Phinney, A. and Ogrodniczuk, J. S. (2013b). Masculinities, work, and retirement among older men who experience depression. *Qualitative Health Research*, 23, 1626-1637.
- Oliffe, J. L., Rice, S., Kelly, M. T., Ogrodniczuk, J. S., Broom, A., Robert, S. and Black, N. (2018). A Mixed-Methods Study Of The Health-Related Masculine Values Among Young Canadian Men. *Psychology of Men & Masculinity*. Advance online publication
- Oliver, C. (2011). Critical Realist Grounded Theory: A New Approach for Social Work Research. *British Journal of Social Work*, 42(2), 371-387.
- Onwuegbuzie, A. J. and Leech, N. L. (2005). On Becoming a Pragmatic Researcher: The Importance of Combining Quantitative and Qualitative Research Methodologies. *International Journal of Social Research Methodology*, 8(5), 375-387.
- Ortiz, S.M. (2004) 'Leaving the private world of wives of professional athletes: A male sociologist's reflections', *Journal of Contemporary Ethnography*, (33)4, 466-487.
- Pallant, J. (2013). *SPSS Survival Manual* (5e) Open University Press. McGraw-Hill
- Parris, M. A. and Vickers, M. H. (2010). "Look at Him ... He's Failing": Male Executives' Experiences of Redundancy. *Employee Responsibilities and Rights Journal*, 22(4), 345-357.
- Parslow, R. and Jorm, A. (2000). Who uses mental health services in Australia? An analysis of data from the national survey of mental health and wellbeing. *Australian and New Zealand Journal of Psychiatry*, 39, 997-1008.
- Paterson, B. L., Gregory, D. and Thorne, S. (1999). A Protocol for Researcher Safety. *Qualitative Health Research*, 9(2), 259-269.
- Patton, M.Q. (2002). *Qualitative research and evaluation methods* (3e). Thousand Oaks, CA: Sage
- Peel, E., Parry, O., Douglas, M. and Lawton, J. (2006). "It's no skin off my nose": Why people take part in qualitative research. *Qualitative Health Research*, 16, 1335-1349.
- Pfeiffer, P. N., Heisler, M., Piette, J. D., Rogers, M. and Valenstein, M. (2011). Efficacy of peer support interventions for depression: A meta-analysis. *General Hospital Psychiatry*, 33, 29-36.
- Phillips, D. (2005). Reproducing normative and marginalized masculinities: Adolescent male popularity and the outcast. *Nursing Inquiry*, 12(3), 219-230.
- Pini, B. (2005). Interviewing men: gender and the collection and interpretation of qualitative data. *Journal of Sociology* 41(2), 201-216.
- Post, S. G. et al. (2014). Routine, empathic and compassionate patient care: definitions, development, obstacles, education and beneficiaries. *Journal of Evaluation in Clinical Practice*, 20(6), 872-880.
- Poulton, E. (2012). 'If You Had Balls, You'd Be One of Us!' Doing Gendered Research: Methodological Reflections on Being a Female Academic Researcher in the Hyper-Masculine Subculture of 'Football Hooliganism'. *Sociological Research Online*, 17(4), 4.



- Pound, P., Britten, N., Morgan, M., Yardley, L., Pope, C., Daker-White, G. and Campbell, R. (2005). Resisting medicines: A synthesis of qualitative studies of medicine taking. *Social Science & Medicine*, 61, 133-155.
- Pringle, A. (2004). Can watching football be a component of developing a state of mental health for men? *Journal of the royal society for the promotion of health*, 124 (3), 122–128.
- Prior, P. (1999). *Gender and Mental Health*. Macmillan Press Ltd.
- Rager, K. B. (2005). Self-care and the qualitative researcher: When data can break your heart. *Educational Researcher*, 34(4), 23-27.
- Ramirez, J.L. and Badger, T.A. (2014). Men navigating inward and outward through depression. *Archives of Psychiatric Nursing*, 28, 21-28.
- Ridge, D., Emslie, C. and White, A. (2011). Understanding how men experience, express and cope with mental distress: where next? *Sociology of Health & Illness*, 33(1), 145 - 159.
- Rickwood, D.J., Deane, F.P., Wilson, C.J. and Ciarrochi, J. (2005) Young people's help-seeking for mental health problems. *Australian E-Journal for the Advancement of Mental Health*, 4: 218–251.
- Riessman, C. (1987). When gender is not enough. *Gender & Society*, 1(2), 172-207.
- Repper, J. and Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392-411.
- Robb, C., Hayley, W.E., Becker, M.A., Polivka, L. A. and Chwa, H. (2003). Attitudes towards mental health care in younger and older adults: Similarities and differences. *Aging and Mental Health*, 7, 142-152.
- Robertson, A.E. (1998). The mental health experiences of gay men: a research study exploring gay men's health needs. *Journal of Psychiatric and Mental Health Nursing*, 5, 33-40.
- Robertson, R., Robertson, A., Jepson, R. and Maxwell, M. (2012). Walking for depression or depressive symptoms: A systematic review and meta-analysis. *Mental Health and Physical Activity*, 5(1), 66-75.
- Robertson, S. (2006a). 'I've been like a coiled spring this last week': embodied masculinity and health. *Sociology of Health and Illness*, 28(4), 433-456.
- Robertson, S. (2006b). 'Not living life in too much of an excess': Lay men understanding health and well-being, *Health*, 10, 175–89.
- Robertson, S. (2007). *Understanding Men and Health: Masculinities, Identity and Wellbeing*. Buckingham: Open University Press.
- Robertson, S. and Williams, R. (2009). Men: Showing willing. *Community Practitioner*, 82, 34–35.
- Robertson, S., Williams, B. and Oliffe, J. (2016). The case for retaining a focus on "Masculinities" in men's health research. *International Journal of Men's Health*, 15, 52–67.
- Rogers, A. and Pilgrim, D. (2010). *A Sociology of Mental Health and Illness* (4e). Open University Press.

- Rogler, L. H. and Hollingshead, A. B. (1985). *Trapped: Puerto Rican families and schizophrenia* (3e). Maplewood, NJ: Waterfront Press.
- Rubin, H.J. and Rubin, I. S. (2005). *Qualitative Interviewing: The art of hearing data* (2e). Sage: Thousand Oaks, California.
- Sabo, D., and D. F. Gordon. (1995). *Men's health and illness: Gender, power and the body*. eds. Thousand Oaks, CA: Sage.
- Saldaña, J. (2009). *The coding manual for qualitative researchers*. Thousand Oaks, CA: Sage.
- Salle, M.W. and Harris III, F. (2011). Gender performance in qualitative studies of masculinities. *Qualitative Research*, 11(4), 409-429.
- Sanchez, A.R. and King, M. (1986). Mexican Americans' use of counselling services: Cultural and institutional factors. *Journal of College and Student Personnel*, 27(4), 344-349.
- Samaritans. (2010). *Men on the Ropes Campaign*. Available online at: <https://www.samaritans.org/media-centre/samaritans-and-network-rail-campaign-2010/men-ropes-press-materials> [Accessed: May 20<sup>th</sup> 2016]
- Samaritans Research Report. (2012). *Men, Suicide and Society*. Available online at: <https://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf> [Accessed: May 20<sup>th</sup> 2016]
- Scholz, B., Crabb, S. and Wittert, G. A. (2014). "We've got to break down the shame": portrayals of men's depression. *Qualitative Health Research*, 24(12), 1648-1657.
- Scholz, B., Crabb, S. and Wittert, G. A. (2017). "Males don't wanna bring anything up to their doctor": Men's discourses of depression. *Qualitative Health Research*, 27(5), 727-737.
- Schwalbe M.L. and Wolkomir M. (2001). The masculine self as problem and resource in interview studies of men. *Men and Masculinities*. 4, 90–103.
- Schwalbe, M. L. and M. Wolkomir. (2003). Interviewing men. In: Holstein, J.A, and Gubrium, J.F. (eds) *Inside interviewing: New lenses, new concerns*. Thousand Oaks, CA, London, New Delhi: Sage. pp. 33-53.
- Schwandt, T.A. (1998). Constructivist, Interpretivist Approaches to Human Inquiry. In: Denzin, N.K. and Lincoln, Y.S. (eds) *The Landscape of Qualitative Research: Theories and Issues*. Sage: Thousand Oaks, California.
- Scott, M. B. and Lyman, S. M. (1968). Accounts. *American Sociological Review*, 33(1), 46-62.
- Scourfield, J. (2005). Suicidal masculinities. *Sociological Research Online*, 10(2), [www.socresonline.org.uk/10/2/.html](http://www.socresonline.org.uk/10/2/.html).
- Sennett, R. (1998). *The corrosion of character: The personal consequences of work in the new capitalism*. New York: W.W. Norton.
- Seale, C. (2002). Computer-assisted analysis of qualitative interview data. In: Gubrium, J.F. and J.A. Holstein, J.A. (eds) *Handbook of interview research: Context and method*. London: Sage. pp. 651–670.

- Seale, C. and Charteris-Black, J. (2008). The interaction of class and gender in illness narratives. *Sociology*, 42(3), 453-469.
- Seebohm, P., Chaudhary, S., Boyce, M., Elkan, R., Avis, M. and Munn-Giddings, C. (2013). The contribution of self-help/mutual aid groups to mental well-being. *Health Social Care Community*, 21(4), 391-401.
- Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L. and Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: A systematic review. *Clinical Psychological Review*, 49, 106-118.
- Seidler, Z. E., Rice, S. M., River, J., Oliffe, J. L. and Dhillon, H. M. (2017). Men's Mental Health Services: The Case for a Masculinities Model. *The Journal of Men's Studies*, 26(1), 92-104.
- Seymour-Smith, S., Wetherell, M. and Phoenix, A. (2002). My wife ordered me to come! A discursive analysis of doctors' and nurses' accounts of men's use of general practitioners. *Journal of Health Psychology*, 7, 253-267.
- Sharp, G. and Kremer, E. (2006). The safety dance: confronting harassment, intimidation, and violence in the field. *Sociological Methodology* 36(1), 317-327.
- Sheikh, S. and Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. *Social Psychiatry and Psychiatric Epidemiology*, 35, 326-334.
- Sheppard, M. (1998). 'Practice validity, reflexivity and knowledge for social work', *British Journal of Social Work*, 28, 763-81.
- Shepard, D.S. and Rabinowitz, E. (2013). The power of shame in men who are depressed: Implications for counsellors. *Journal of Counselling & Development*, 91, 451-457.
- Sierra Hernandez, C.A., Han, C., Oliffe, J.L. and Ogrodniczuk, J.S. (2014). Understanding help-seeking among depressed men. *Psychology of Men & Masculinity*, 15(3), 246-354.
- Sieverding, M., Mattered, U., & Ciccarello, L. (2010). What role do social norms play in the context of men's cancer screening intention and behavior? Application of an extended theory of planned behavior. *Health Psychology*, 29, 72-81.
- Simon, R.W. (2002). Revisiting the relationships among gender, marital status, and mental health. *American Journal of Sociology*, 107(4), 1065-1096.
- Simpson, P. and Richards, M. (2019). Reflexivity Denied? The Emotional and Health Seeking Resources of Men Facing Disadvantage, *Sociology of Health and Illness*. 41(5), 900-916.
- Skärsäter, I., Dencker, K., Bergbom, I., Häggström, L. and Fridlund, B. (2003). Women's Conceptions of Coping with Major Depression in Daily Life: A Qualitative, Salutogenic Approach. *Issues in Mental Health Nursing*, 24(4), 419-439.
- Skeggs, B. (1997). *Formations of Class and Gender: Becoming Respectable*. London: SAGE.

- Slater, T., Scourfield, J. and Greenland, K. (2015). Suicide attempts and social worker contact: A secondary analysis of a general population study. *British Journal of Social Work*, 45, 378-394.
- Smart, C. (1984). *The Ties that Bind*. London: RKP.
- Smith, B. (1999). The abyss: Exploring depression through a narrative of the self. *Qualitative Inquiry*, 5(2), 264–279.
- Smith L.K, Pope C and Botha J.L. (2005). Patients' help-seeking experiences and delay in cancer presentation: A qualitative synthesis. *The Lancet* 366(9488): 825–831.
- Smith, J. P., Tran, G. Q. and Thompson, R. D. (2008). Can the theory of planned behaviour help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men and Masculinity*, 9(3), 179–192.
- Spendelow, J. S. (2015). Men's self-reported coping strategies for depression: A systematic review of qualitative studies. *Psychology of Men & Masculinity*, 16(4), 439-447.
- Springer, K.W. and Mouzon, D.M. (2011) "Macho Men" and preventive health care: Implications for older men in different social classes. *Journal of Health and Social Behaviour*, 52(2), 212-227.
- Stein, C. (2018). *Mind your language: How men talk about mental health*. Men's Health Forum. Available online at: <https://www.nspa.org.uk/wp-content/uploads/2018/05/Mens-Health-Forum-Mind-Your-Language.pdf> [Accessed: July 10th 2018]
- Stickley, A. and Koyanagi, A. (2016). 'Loneliness, common mental disorders and suicidal behavior: findings from a general population survey', *Journal of Affective Disorders*. 197, 81-87.
- Strauss, A. and Corbin, J. (1990). Open coding. In: Strauss, A. and Corbin. J. (eds) *Basics of qualitative research: Grounded theory procedures and techniques*. Thousand Oaks, CA: Sage. pp. 101–121.
- Strauss, A. and Corbin, J. (1998). *Basics of qualitative research: techniques and procedures for developing grounded theory*. Sage.
- Suitor, J. J. and Pillemer, K. (2000). When experience counts most: effects of experiential similarity on men's and women's receipt of support during bereavement. *Social Networks*, 22, 299-312.
- Sway, M. (1981). Simmel's concept of the stranger and the gypsies. *The Social Science Journal*, 18(1), 41-50.
- Talbot, M.M. (2003). Gender stereotypes: reproduction and challenge. In: Holmes, J. and Meyerhoff, M. (eds) *The handbook of language and gender*. Oxford: Blackwell. pp. 468–486.
- Tamres, L.K., Janicki, D. and Helgeson, V.S. (2002). Sex differences in coping behaviour: A meta-analytic review and an examination of relative coping. *Personality and Social Psychology Review*, 6(1), 2-30.

- Tarrant, A. (2014). Negotiating Multiple Positionalities in the Interview Setting: Researching Across Gender and Generational Boundaries. *The Professional Geographer*, 66(3), 493-500.
- Taylor, S. E. and Lobel, M. (1989). Social comparison activity under threat: Downward evaluation and upward contacts. *Psychological Review*, 96(4), 569-575.
- Taylor, C. and White, S. (2001). 'Knowledge, truth and reflexivity', *Journal of Social Work*, 1(1), 37.
- Thoits, P.A. (1995). Stress, Coping, and Social Support Processes: Where Are We? What Next? *Journal of Health and Social Behavior*, 53-79.
- Thoits P.A. (2003). Personal Agency in the Accumulation of Multiple Role-Identities. In: Burke P.J., Owens T.J., Serpe R.T., Thoits P.A. (eds). *Advances in Identity Theory and Research*. Springer, Boston, MA
- Thoits, P.A. (2011a). Mechanisms linking social ties and support to physical and mental health. *Journal of Health Social Behaviour*, 52(2), 145-161.
- Thoits, P.A. (2011b). Perceived Social Support and the Voluntary, Mixed, or Pressured Use of Mental Health Services. *Society and Mental Health*, 1(1), 4-19.
- Thoits, P.A., Hohmann, A. A., Harvey, M. R. and Fletcher, B. (2000). Similar–other support for men undergoing coronary artery bypass surgery. *Health Psychology*, 19(3), 264-273.
- Thomas, G.M. (2017). Doing Gender in a Hospital Setting: Reflections of a Male Researcher. *Sociological Research Online*, 22(2), 1-14.
- Thompson, S. (1996). Paying respondents and informants. *Social Research Update*, Autumn, (14).
- Time to Change. (2017). Be in your mate's corner campaign. Available online at: <https://www.time-to-change.org.uk/news/be-in-your-mates-corner> [Accessed: May 14<sup>th</sup> 2018]
- Tuckett, A.G. (2005). Applying thematic analysis theory to practice: A researcher's experience. *Contemporary Nurse*, 19(1-2), 75-87.
- Turner, R.J. and Brown, R.L. (2010). *Social support and mental health*. In: Schied, T.L, and Brown, T.N. (eds) *A Handbook for the study of mental health: Social contexts, theories and systems*. Cambridge University Press.
- Ussher, J., Kirsten, L., Butow, P. and Scandovola, M. (2006). What do cancer support groups provide which other supportive relationships do not? The experience of peer support groups for people with cancer. *Social Science Medicine*, 6, 2565–76.
- Valkonen, J. and Hanninen, V. (2012). Narratives of masculinity and depression. *Men and Masculinities*, 16(2), 160-180.
- Van Meter, K. (1990). Methodological and Design Issues: Techniques for Assessing the Representatives of Snowball Samples, *NIDA Research Monograph*, 31-43.
- Villaggi, B., Provencher, H., Coulombe, S., Meunier, S., Radziszewski, S., Hudon, C., Roberge, P., Provencher, M. and Houle, J. (2015). Self-Management Strategies in Recovery From Mood and Anxiety Disorders. *Global Qualitative Nursing Research*, 2, 1-13

- Vogel, D.L., Heimerdinger-Edwards, S.R., Hammer, J.H. and Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counseling Psychology*, 58(3), 368-382.
- Vogel, D., Wade, N., Wester, S., Larson, L. and Hackler, A. (2007). Seeking help from a mental health professional: The influence of one's social network. *Journal of Clinical Psychology*, 63, 233-245.
- Vogel, D. L. and Wade, N. (2009). Stigma and help-seeking. *The Psychologist*, 22 (1), 20-23.
- Vos, T., et al. (2013). Global, regional, and national incidence, prevalence, and years lived with disability for 301 acute and chronic diseases and injuries in 188 countries, 1990–2013: a systematic analysis for the Global Burden of Disease Study. *The Lancet*. 386 (9995), 743-800.
- Warren, L. W. (1983). Male intolerance of depression: A review with implications for psychotherapy. *Clinical Psychology Review*, 3, 147–156.
- Warren, C.A.B. (2001). Qualitative interviewing. In Gubrium, J.F and Holstein, J.A. (eds) *Handbook of Interview Research: Context and Method*, Sage: Thousand Oaks, California.
- Warburton, J. and Dyer, M. (2004). Older volunteers participating in a university research registry: Helping others my age. *Educational Gerontology*, 30(5), 367-381.
- Weich, S., Brugha, T., King, M., McManus, S., Bebbington, P., Jenkins, R., Cooper, C., McBride, O. and Stewart-Brown, S. (2011). Mental well-being and mental illness: Findings from the Adult Psychiatric Morbidity Survey for England 2007. *The British Journal of Psychiatry*, 199(1), 23-28.
- Welford, J. and Powell, J. (2014). *A crisis in modern masculinity: Understanding the causes of male suicide*. London: CALM.
- Welsh Government (2012). *Together for Mental Health: A strategy for mental health and wellbeing in Wales*. Available online at: <https://gov.wales/docs/dhss/publications/121031tmhfinalen.pdf> [Accessed: November 10<sup>th</sup> 2018]
- Wenger, L. M. (2011). Beyond ballistics: Expanding our conceptualization of men's health-related help seeking. *American Journal of Men's Health*, 5(6), 488–499.
- West, C. and Zimmerman, D.H. (1987). Doing Gender. *Gender & Society*, 1 (2), 125-121.
- Wetherell, M. and Edley, N. (1999). Negotiating hegemonic masculinity: Imaginary positions and psycho-discursive practices. *Feminism & Psychology*, 9, 335–356.
- White, A.K (2001). *Report on the scoping study on men's health*. London: Department of Health
- White, A. (2010). 'Introduction' In. Conrad, D and White, A. (eds). *Promoting men's mental health*. Radcliffe Publishing Ltd.
- Whitehead, S.M., & Barrett, F.J. (2001) *The masculinities reader*, Cambridge: Polity.

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

Wilkins, D. and Kemple, M. (2011). *Delivering Male: Effective Practice in Male Mental Health*. London: Men's Health Forum, MIND, The National Mental Health Department Unit.

Williams, C. and Heikes, E.J. (1993). The importance of researcher's gender in the in-depth interview: evidence from two case studies of male nurses. *Gender & Society*, 7(2), 280-291

Williamsom. (2010). Grumpy old men? Older men's mental health and emotional well-being, In: Conrad, D., and White, A. (eds) *Promoting men's mental health*. Radcliffe Publishing.

Willis, P. (1977). *Learning to Labour: How working class kids get working class jobs*. Farnborough: Saxon House.

Willis, P. (2000). *The Ethnographic Imagination*. Cambridge: Polity Press.

Willott, S. and Griffin, C. (1997). 'Wham Bam, am I a Man?': Unemployed men talk about masculinities. *Feminism and Psychology*, 7(1), 107-28.

Wilson, N. J. and Cordier, R. (2013). A narrative review of men's sheds literature: Reducing social isolation and promoting men's health and well-being. *Health and Social Care in the Community*, 21(5), 451-463.

Winchester, H. P. M. (1996). Ethical issues in interviewing as a research method in human geography. *Australian Geographer*, 27(1), 117-131.

World Health Organization (WHO). (2014). Mental Health: A state of well-being, available at [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/) [Accessed: June 1<sup>st</sup> 2016]

Wyllie, C., Platt, S., Brownlie, J., Chandler, A., Connolly, S., Evans, R., Kennelly, B., Kirtley, O., Moore, G., O'Connor, R. and Scourfield, J. (2012). *Men suicide and society: why disadvantaged men in mid-life die by suicide*. Surrey, UK: Samaritans. Available at: <https://www.samaritans.org/sites/default/files/kcfinder/files/Men%20and%20Suicide%20Research%20Report%20210912.pdf> [Accessed: August 2<sup>nd</sup> 2018]

Yang, K. (2010). *Making sense of statistical methods in social research*. London: Sage

Yeo, A., Legard, R., Keegan, J., Ward, K., McNaughton Nicholls, C. and Lewis, J. (2014). In-depth Interviews. In Ritchie, J., Lewis, J., McNaughton Nicholls, C. and Ormston, R. (eds) *Qualitative Research Practice: A guide for social science students and researchers*. London: SAGE

Yousaf, O., Grunfield, E.A. and Hunter, M.S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*, 9(2), 264-276.

# Appendices

**Appendix 1** – Recruitment flyer for men recruited from support groups

**Appendix 2** – Recruitment flyer for men recruited from the general public

**Appendix 3** – Participant information sheet for men recruited from support groups

**Appendix 4** – Participant information sheet for men recruited from the general public

**Appendix 5** – Consent form for participants

**Appendix 6** – Interview schedule for men recruited from support groups

**Appendix 7** – Interview schedule for men recruited from the general public





# Would you be interested in taking part in an interview?



## About me

My name is Alex Vickery and I am a PhD research student at Cardiff University. I am interested in writing about the lives of men and their emotional experiences.

## About the research

I am particularly interested in men's experiences of help-seeking and accessing support services for emotional difficulties, and I would like to speak to men who have voluntarily attended support groups. I hope that by doing this research it will be possible to find out what more could be done to encourage other men experiencing difficulties to talk about it and seek help. I am happy to meet at the support service site you use or somewhere else public and convenient for you.

If you are a man who is attending or has attended a voluntary support service or group, and are interested in being interviewed then I would really like to hear from you!

## Confidentiality

I'd be delighted if you could help me with my research; anything you say to me would be confidential and anonymised.

If you have any questions and would like to take part then please get in touch with me through email, text or phone at the following:

Email: [VickeryAY@cf.ac.uk](mailto:VickeryAY@cf.ac.uk) Phone: 07496017299

I look forward to hearing from you!

# Interested in taking part in an interview?



## About me

My name is Alex Vickery and I am a PhD research student at Cardiff University. I am interested in writing about the lives of men and their emotional experiences.

## About the research

I am interested in talking to men of all ages about difficult and challenging emotional experiences. I would like to hear from you, whether you have had such an experience or not.

If you are a man and are interested in being interviewed then please get in touch!

## Confidentiality

I'd be delighted if you could help me with my research; anything you say to me would be confidential and anonymised.

If you have any questions and would like to take part then please get in touch with me at the following:

Email: [VickeryAY@cf.ac.uk](mailto:VickeryAY@cf.ac.uk) Phone: 07496017299

I look forward to hearing from you!



Cardiff University School of Social Sciences  
Glamorgan Building  
King Edward VII Avenue  
Cardiff, CF10 3WT  
Email: VickeryAY@cf.ac.uk

## **PARTICIPANT INFORMATION SHEET**

Research into men and coping with distress

### **Would you be interested in taking part in some research?**

My name is Alex Vickery and I am a PhD research student at Cardiff University. I am doing some research into the experiences of men who voluntarily access support services. I would like to invite you to take part. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and if you're interested then I'd really like to hear from you.

### **Why am I doing this research?**

I am interested in men's experience of help-seeking and attending support groups for emotional difficulties. I would like to speak to men who have voluntarily attended support groups. I hope that by doing this research it will be possible to find out what more could be done to encourage other men experiencing difficulties to seek help and even attend support groups.

### **Who can take part?**

I am looking for men who are attending or have attended voluntary support groups for mental and emotional difficulties.

### **What does it involve?**

If you chose to participate, I would like to talk to you about your experiences in accessing support. The interview should take no longer than an hour of your time. I am interested in what you have to say about:

- ❖ Deciding to access support
- ❖ What kind of support and coping strategies work best for you
- ❖ Your opinions on what more could be done for other men in similar positions.

**What will I do with the information you provide?**

With your permission I will record our discussion and then write it up into what is called a transcript. This will allow me to read what was said again. It will then be used to write up my PhD thesis. Quotations from the transcripts will be used in my thesis, other academic publications/presentations and some other public documents.

**Will the things you say be kept private?**

To help reduce the chances of anyone identifying you I will change your name and will remove, or amend, identifiable information. All data will be securely stored in accordance with the Data Protection Act 1998. It will not be used for any other purposes. Electronic data (audio recordings, etc.) will be saved on the secure servers at Cardiff University. Any paper documents will be locked in filing cabinets on properties that are security controlled at Cardiff University. Any identifiable data will be kept for five years after the completion of the research and then destroyed.

**What if you change your mind about taking part?**

Your participation is entirely voluntary and you can change your mind about taking part at any time, without giving a reason. It doesn't matter if it is before, during or after our discussion, all you have to do is let me know.

**How to get involved!**

Thank you for taking the time to read this sheet. If you are interested in taking part or would like more information about the study please do not hesitate to contact me at the following:

Alexandra Vickery  
Cardiff School of Social Sciences  
Cardiff University  
[VickeryAY@cf.ac.uk](mailto:VickeryAY@cf.ac.uk)  
07496017299

I'd be happy to answer any questions you have, and of course, look forward to meeting.



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Email: VickeryAY@cf.ac.uk

## **PARTICIPANT INFORMATION SHEET**

Research into men and coping with emotional difficulties

### **Would you be interested in taking part in some research?**

My name is Alex Vickery and I am a PhD research student at Cardiff University. I am doing some research into men's experiences of emotional difficulties, help-seeking and coping strategies. I would like to invite you to take part. Before you decide to take part it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and if you're interested then I'd really like to hear from you.

### **Why am I doing this research?**

I am interested in exploring men's experiences of difficult and challenging emotional experiences, and their attitudes and beliefs about help and talking about any issues. I hope that by doing this research it will be possible to find out what more could be done for men experiencing difficulties and how we can help them.

### **Who can take part?**

I am looking for a diverse range of men from any age group and any occupation.

### **What does it involve?**

If you chose to participate, I would like to talk to you about any emotional experiences. The interview should take no longer than an hour of your time. I am interested in what you have to say about:

- ❖ Any issues you have been faced with and how you cope with such difficulties in everyday life
- ❖ What kind of support and coping strategies work best for you
- ❖ Your opinions on what more could be done for men, what would encourage men to talk and seek help

### **What will I do with the information you provide?**

With your permission I will record our discussion and then write it up into what is called a transcript. This will allow me to read what was said again. It will then be used to write up my PhD thesis. Quotations from the transcripts will be used in my thesis, other academic publications/presentations and some other public documents.

**Will the things you say be kept private?**

To help reduce the chances of anyone identifying you I will change your name and will remove, or amend, identifiable information. All data will be securely stored in accordance with the Data Protection Act 1998. It will not be used for any other purposes. Electronic data (audio recordings, etc.) will be saved on the secure servers at Cardiff University. Any paper documents will be locked in filing cabinets on properties that are security controlled at Cardiff University. Any identifiable data will be kept for five years after the completion of the research and then destroyed.

**What if you change your mind about taking part?**

Your participation is entirely voluntary and you can change your mind about taking part at any time, without giving a reason. It doesn't matter if it is before, during or after our discussion, all you have to do is let me know.

**How to get involved!**

Thank you for taking the time to read this sheet. If you would like more information about the study please do not hesitate to contact me at the following:

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07496017299

I'd be happy to answer any questions you have, and of course, look forward to meeting.

Appendix 5  
Consent form for participants



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**CONSENT FORM – Interviews**

**Title of Project:** Men and coping with distress.

**Researcher:** Alexandra Vickery

	Please Initial
1. I confirm that I have read the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have these answered satisfactorily.	
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason.	
3. I understand that no one will have access to the recording beyond the researcher and her two supervisors.	
4. I understand that the data collected from this research will be used in: the researcher's PhD thesis; academic research papers and presentations and; a summary report to be circulated to all interested participants or interested parties.	
5. I agree to participate in the interview for this research and for the interview to be recorded.	

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Name of Participant

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Date

---

Signature

---

Name of Researcher

---

Date

---

Signature



## Appendix 6

### Interview schedule for men recruited from support groups

- Firstly, I just want to start by getting to know a bit more about you and your life.  
Can you tell me a little bit about yourself? (age, family, work, education, brief history, everyday life)

<b>To explore men's experiences of seeking help, engaging in services, using support groups for emotional difficulties.</b>	<b>Can you tell me about the support service you attend?</b>	<b>Experience of attending the service</b>  <b>Things they do</b>  <b>Things they like and dislike about it</b>  <b>Pressures for men</b>
	<b>Reasons for using the service</b>	<b>When started</b>  <b>Emotional difficulties they experienced – story</b>  <b>First point of help – (talk to, family, GP etc?)</b>  <b>Where first heard about service</b>  <b>Who encouraged?</b>  <b>Any things that discouraged?</b>  <b>How it felt first attending</b>
	<b>What works?</b>	<b>Has it helped/is it helping - how</b>  <b>What works/helps you/manage difficulties</b>  <b>How members support each other, and leaders</b>  <b>Works for other men?</b>  <b>Recommend or encourage</b>

		<p>other men?</p> <p>Advice you'd give</p> <p>What more could be done for men</p> <p>More services?</p>
	Other ways of coping	<p>Before groups, how did you cope and manage?</p> <p>As well as the groups, what else do you do to cope/manage</p> <p>What positively helps</p>
	Anything else you would like to comment on/say?	

## Appendix 7

### Interview schedule for men recruited from the general public

- First I just want to start to get to know a little bit more about you and your life. Can you tell me a little bit about yourself? (age, family, work, education, brief history, everyday life)

<b>To explore men's emotional experiences and how they cope. (emotional difficulties, challenges)</b>	<b>To start off with, just want to find out about you...</b>	<b>Pressure you think men feel in today's society</b>  <b>Talk generally about mental health – how can you tell a man is feeling down</b>  <b>What they think about men getting emotional</b>  <b>What sorts of words do you use or hear men use to describe mental health/distress</b>
	<b>What do you think discourages men from talking about difficulties?</b>	<b>How they feel at the moment...</b>  <b>Happy? Stressful? Challenging? Positive?</b>
	<b>Who do you turn to when you get stressed, lonely or feel down?</b>  <b>On a day-to-day, weekly basis how do you remain positive?</b>	<b>How do you cope/ deal with it/How do you manage feeling down?</b>  <b>Any particular positive things that work well for you?</b>  <b>Find it easy/difficult to talk to someone? Do you talk about your emotions often?</b>  <b>Friends ever talk about difficulties?</b>  <b>What kind of support works/worked (go through above also)</b>
	<b>Can you think of a particular time when you, or someone you know has experienced a very low period, or mental</b>	<b>Tell me more about this experience</b>  <b>What was affected (work, relationships etc)</b>  <b>Get help? Talking to someone about</b>

	<p><b>distress?</b></p>	<p><b>experience, taking initial first step.</b></p> <p><b>GP? Group/counselling/medication?</b></p> <p><b>Did it work? What else helped?</b></p>
	<p><b>What more could be done for men?</b></p>	<p><b>What else would help men face difficulties/talk about things/show emotions</b></p> <p><b>What advice would you give to other men?</b></p> <p><b>Best ways to target/reach out to men</b></p>