Leveraging concepts of masculinity for better mental health outcomes for men

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Table of Contents

Abstract

Masculinity is argued to impact negatively upon men's health and mental health with men half as likely to be diagnosed with depression, the disparity in diagnoses has been linked to masculinity and differing gendered expectations of behavior. Masculinity has been presented by the media and psychology as toxic, or maladaptive with research focusing on how masculinity is a barrier to accessing psychological help. Recent research has focused on how mental health providers can utilize concepts of masculinity and help individuals use these traits in adaptive ways. The study aims to expand on and explore how masculinity can be leveraged to create better mental health outcomes. A thematic analysis (Bruan and Clarke (2013)) was undertaken on a recording of the Australian Men's Health Forum workshop held in November 2018. The workshop was presented by three prominent researchers working within the men's health field. Key themes that emerged from the data is the need for gender competent practitioners and the importance of viewing masculinity as 'masculinities' and acknowledging the flexible and multi-faceted nature of men and their different experiences of masculinity.

Declaration

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Chapter 1: Introduction

1.1 Background

Masculinity has been argued to impact negatively upon men's health. On average male life spans are five years shorter than the female life expectancy; men are also more likely to turn to substance dependency and twice as likely to use A class drugs (Peate, 2010). Men who score higher on anti-femininity have been shown to be at higher risk of contracting HIV or other STIs through none safe sex practises (Rhead, Skovdal, Takaruza, Maswera, Nyamukapa &Gregson, 2019). The disparities are not just seen physiologically but also in the form of mental health with men 3 to 5 times more likely to die as a result of suicide than women (Jordan & Chandler, 2018; Seidler, Rice & Dhillon, 2019). Although suicide is a leading cause of death for men aged between 15-44 years, men are half as likely to be diagnosed with depression (Scholz, Crabb & Witert, 2016). The disparity in diagnosis is argued to be explained by the difference in gendered behaviour expectations (Seidler, Dawes, Rice, Oliffe & Dhillon, 2016). Men are argued to ignore and avoid feelings of depression or express their distress through anger (Scholz, Crabb & Wittert, 2014) and are less likely to take medication for their symptoms (Voelker, 2015). These behaviours are taught or enforced through traditional western masculinity which socialises boys to not express their emotions and discourages feelings of sadness while promoting men as aggressive. Gendered expectations of being aggressive, stoic and rational are argued to be factors which prevent men from talking about their mental health and engaging with the health care system (Englar-Carlson & Kiselica, 2013). Another factor preventing men from engaging with the mental health care system is stigma (Scholz, Crabb & Wittert, 2014). Receiving help for mental health concerns is considered predominantly a feminine behaviour within the western

world, potentially creating a stigma that men who do receive help are not as masculine, or not 'real men' (Scholz, Crabb & Wittert, 2014). Men who do engage with the health care system have been found to disengage from services prematurely (Seidler, Rice, Ogrodniczuk, Oliffe & Dhillon, 2018a) due to factors such as services not being appropriate for male clients, a perceived lack of accessibility, and a lack of flexibility from the service providers (Rice, Telford, Rickwood & Parker, 2017). Research demonstrates poorer health and mental health outcomes for men who strongly endorse hegemonic masculinity traits and ideals; a majority of current research has focused on the problems with masculinity and explored how adhering to rigid masculine ideals can have adverse effects (McDermott, Pietrantonio, Browning, McKelvey, Jones, Booth and Sevig, 2019) (Krumm, Checchia, Koestersm Killian and Becker, 2017).

Psychology has been argued to pathologize masculinity by focusing on the negative outcomes perceived to effect men who present in masculine ways (Englar-Carlson & Kiselica, 2013). Psychologists and clinicians may potentially be biased against men, perceiving them and masculinity as harmful. Viewing men as harmful and in need of fixing can be damaging and alienating to the client, clinician relationship and prevent men from receiving the psychological or medical support necessary (Rice et al, 2017). A new line of research has called for gender competent practice to help facilitate men's engagement with the mental health system. While a strong endorsement of hegemonic masculinity has been linked to worse health outcomes for men, there are plenty of men who are high functioning members of society. Based on this notion of functioning or beneficial masculinity, new research has begun to focus on the protective or positive factors of masculinity (Seidler et al, 2018). To explore the positive or protective aspects of masculinity, the construct of masculinity must be viewed in a flexible, adaptive way (Seidler,

Rice & Dhillon, 2019a). Currently mainstream media and professionals view masculinity as a stable, unchanging construct, limiting men, and their ability to express themselves.

Addressing and advancing understandings of men's mental and physical health not only aims to benefit men, but more broadly society. Current gender expectations and norms are shown to harm men and women (Etienne, 2018). Changing the discourse around the normal and acceptable behaviours and activities for men creates a wider discourse for men to operate in allowing for men's health to be addressed in a more male focused, productive manner (Jordan & Chandler, 2019). This does not mean changing men into something else, but rather capitalising on their experiences and expressions of masculinity and presenting activities like help seeking as positive and a strength rather than a threat to masculinity (Englar-Carlson & Kiselica, 2013).

Suicide and poor health outcomes are some significant problems men face, but it can be argued that just telling them to get help fails to address the problem. To better assist men, psychologists and practitioners need to understand what is causing men to commit suicide, and how it can be prevented. If men are not accessing health care or are disengaging prematurely it is important to understand how men can be better engaged, and how masculinity, which has been shown to be a significant barrier to accessing help can be leveraged to provide better, more effective services for men (Jordan & Chandler, 2019).

1.2 The plurality and flexibility of masculinities

Within the literature there is a division in the understanding of sex and gender. Sex is based on biology and is something people are born with, Sex is viewed as a male, female dichotomy with the exception of intersex. Gender is instead learned and preformed; it is a

spectrum of masculinity to femininity, and where an individual resides on the spectrum evolves and changes based on societal norms, cultural expectations and individual life experiences (Buchbinder, 2013; Englar-Carlson, 2006)). Currently within the medical and mental health fields masculinity is viewed as a single stable construct with hegemonic masculinity being privileged. Hegemonic masculinity is argued to be unobtainable to most men but rather an ideal masculinity that men endorse (Connell & Messerschmidt, 2005; Krumm, Checchia, Koesters & Kilian, 2017). Common traits prescribed to hegemonic masculinity are stoicism, strength, self-reliance (Seidler, Rice & Dhillon, 2019a) with some more negative traits being aggression and the willingness to endorse violence (Scott, 2015). Theorists suggest the more strongly men endorse these traits the more negative health outcomes they experience. This notion of traditional or hegemonic masculinity is viewed within Western culture as powerful and normative, upholding the patriarchal code and bringing about the subordination of femininity (Buchbinder, 2013; Scott, 2014). It is argued because health practitioners generally treat masculinity in the same manner as sex, they view all men as at risk of negative health outcomes due to being male without exploring the individual's masculinity in their own personal, social and cultural context. By viewing all men as at risk of negative health outcomes they become pathologized and therapy becomes about making men less masculine and more feminine. To work with men in a productive way more recent research is suggesting masculinity needs to be viewed as a fluid changing construct, with potentially positive or protective elements (Seidler, Rice & Dhillon, 2019a). Emphasising the flexible and multifaceted nature of masculinity is not about making men more feminine but giving them a way to position themselves within the world in a productive and constructive manner (Jordan & Chandler, 2019). The ability to work with men in a constructive way is needed within the health care field (Seidler, Rice & Dhillon, 2019a).

Professionals and researchers within the men's health industry are working to demonstrate the need for gender competent practitioners. Practitioners being able to recognise both the adaptive and maladaptive masculine behaviours are able to help the client achieve a more flexible, functionable and conscious enactment of their masculinity (Krumm et al, 2017).

1.3 Gender competency

One example of efforts to promote gender competency is that of The Sex and Gender Women's Health collaborative formed to promote the inclusion of sex and gender specific material within academic settings in the medical field. They argue for more effective and personalised care of patients, and suggest practitioners need to be aware of and competent in understanding the different health impacts of gender and sex and the way the two interact. While their focus is on women's health they argue it benefits men because it brings awareness to the differences in health issues suffered by men and women. The focus of the organisation is on educating physicians on the continuous relationship and impact of sex and gender on health (McGregor, Templeton, Kleinman & Jenkins, 2013). Gender competence is growingly being recognised as important within the medical field, but most mental health practitioners are considered to be gender blind. Being gender blind can be caused by viewing masculinity as a stable unchanging construct. Gender blind practice is argued to prevent practitioners from working with clients in a gender competent way (Seidler, Rice, Ogrodniczuk, Oliffe, Shaw, Dhillon, 2019). It is argued practitioners need to understand masculinity as a fluid and changing construct that can present in complex and sometimes contradictory ways to be able to work with men in a gender competent way. Gender competent practice is about meeting men where they are

at, working with men and leveraging their strengths to create a welcoming environment, rather than stigmatising and reinforcing negative stereotypes (Seidler et al., 2018).

1.4 Protective factors of masculinity

Understanding the plurality of masculinities and how masculinities and sex interact with health is argued to be the basis of working in a gender competent manner with clients who experience masculinity. When the concept of a stable, toxic masculinity is understood to be false, health practitioners can begin to consider the components of masculinity in different ways (McDermott et al., 2019) Viewing masculinity in its complexity allows for an understanding of how it can be used in a healthy productive way but also allows the practitioner to acknowledge and identify the damaging ways masculinity can be constructed (Krumm et al, 2016). Typical masculine traits like strength and courage can be damaging to a man's health when used in a maladaptive way, these same traits can be applied in productive ways. The concept of strength can be constructed in a maladaptive way wherein men feel they must be strong and not experience emotional distress or must carry on even though they are not well. A practitioner could instead bring attention to how asking for help when it is needed shows strength and courage (Scholz, Crabb, Wittert, 2016).

Deficit-based views of masculinity and male socialisation are contested with the emergence of positive masculinity or strengths-based approaches to treating men (Seidler et al, 2018). Positive masculinity therapies use a strengths-based approach and focus on what a client can do rather than what needs to be fixed. This line of psychology argues for the focus to not just be on the negative and disease but rather, on growth and development which can be more beneficial to the client. (Englar-Carlson & Kiselica, 2013).

1.5 Community initiatives

Media and social media have the ability to promote certain discourses and have previously been found to perpetuate false or misleading perceptions of mental illness'. Men are viewed as being stable and healthy within Western culture (Krumm et al., 2017). Western culture generally endorses the assumption that men do not want help and will not seek help even when it is necessary for their wellbeing. Media's presentation of discourses has been shown to impact how individuals see themselves and others. When men are continually exposed to a discourse which tells them they do not need help and they do not access help, it can perpetuate the stigma attached to men seeking help. This stigma can be internalised and impact how men feel about and respond to mental illness (Scholz, Crabb & Wittert, 2014). Addressing mental health and the stigma attached to men seeking help is important in progressing men's engagement with mental health services. Media and social media is being explored as a way of engaging men in mental health services (Schlichthorst, King, Turnure, Sukunesan, Phelps & Pirkis, 2018).

One program that has been shown to be associated with positive outcomes for older adults is Men's Sheds. Men's shed's engage men in a way that leverages masculinity to promote social engagement and better health and mental health among men with a primary focus on men of retirement age. It aims to engage men who may be facing isolation who are experiencing or may be at risk of poor physical and mental health. (Nurmi, Mackenzie, Roger, Reynolds & Urquhart, 2018). Older men have been found to be the least likely to seek help; this is argued to result from a more stringent endorsement of traditional masculine gender expectations (Labra, Wright, Tremblay, Maltais, Bustinza & Gingras-Lacroix, 2018).

1.6 Study's Aims

Current research exploring the concept of leveraging masculinity is in its early stages; there are a few notable researchers working within their respective fields working to promote a more adaptive and pro-social view of masculinity. This research aims to add to the evolving and developing field exploring how to leverage masculinity. It intends to add a unique perspective by analysing a recording of Australian Men's Health Forum workshop held in November 2018. The specific objective is to understand how three prominent practitioners/ researchers understand men's health and masculinity. The workshop was hosted by the Freemasons Foundation Centre for Men's Health and offers a unique opportunity to analyse three different researchers/practitioners' views on the current field of men's health care and how men's health care should progress. Using thematic analysis, the study aims to analyse and contrast the different concepts and ideas put forward by each speaker to explore how to best leverage masculinity and facilitate better health outcomes for men. The study aimed to expand on the growing strengths-based literature of masculinity and explore how masculinity can best be leveraged to facilitate better health outcomes for men.

Chapter 2: Methods

2.1 Procedure

The study used data from a recording of the Australian Men's Health Forum workshop held in November 2018 which is the property of the Freemason's Foundation Centre for Men's Health (FFCMH). Permission was acquired from FFCMH before using the recording data. The workshop's aim was to explore the relationship between masculinity and men's health, with the general theme of the 2-day event being 'Working Together to Improve Male Health and Wellbeing'.

The data were selected as the 1.5 hour workshop was presented by three prominent researchers working in the men's health field and thus offered a unique opportunity for examining the views of workers with deep experience in the field. The speakers provided a broad interdisciplinary set of rich data, each specialising in a different profession within the field of men's health care. The first presenter is a physician/researcher, the second a researcher/psychology practitioner and the third presenter is a professor working within a science and health department. The workshop allowed a number of health care providers and members of community organisations to come together and listen to the presentations, and then participants in the workshop were provided the opportunity to ask the speakers questions and expand on the topics discussed in the presentations.

An application to recruit and interview participants was submitted and approved by the University of Adelaide Human Research ethics committee approval number HREC - 19- 67.

The recorded data were transcribed by the researcher and the recording was returned to the owners. The complete transcript was stored on a password protected computer and a password protected USB. Confidentiality and anonymity were achieved by replacing speakers names with a number i.e speaker1 and removing any identifying information from the transcript and results. A thematic analysis framework was utilized to identify themes and patterns of meaning within the data.

2.2 Analysis

Thematic analysis (TA) was used to identify the themes and meaning present within the data. Thematic framework was chosen due to its ability to provide a richer understanding of the data. The data were analysed following Bruan and Clarke's (2013) six steps for TA. The six steps provided are 1) Transcription, 2) A complete reading of the transcripts and data familiarisation, 3) Complete coding- this is done across the entire data set, 4) Refining codes and searching for themes, 5) Reviewing the themes and exploring themes and sub-themes relationships through a thematic map, 6) Refining and defining the themes. These steps were used to ensure a thorough, high quality thematic analysis was conducted.

The recorded data were listened to on two separate occasions before transcription begun and then were transcribed by hand allowing for data familiarisation. Transcription was done using an Orthographic style of audio transcribing. The orthographic style focuses on what was said rather than how it was said, this was the most appropriate transcription style for TA as TA focuses on patterns of meaning. The transcription notation system outlined by Bruan and Clarke (2013) which was adapted from Jefferson, 2004 (see appendix) was used to ensure consistent

transcription across the data set. After the data were transcribed the transcript was read as a whole to ensure the researcher was familiar with the main ideas of the data; during this process the researcher made notes of potential themes and concepts. A complete coding of the text was completed to generate initial codes based on patterns within the data. The initial codes were reviewed and collated into broader themes relevant to the research question. The themes were reviewed, and a thematic map was developed to examine the relationships between themes, subthemes and codes. Throughout this process the data were continually reviewed and refined, and themes were defined, named and supported by extracts. The three speakers' transcripts were initially coded separately, but due to the similarity in the provisional themes, the data were analysed together.

Reflexivity is a critical part of qualitative research and instrumental in addressing cultural and power differences. The conference was hosted by the FFCMH and the presenters are all prominent researchers in men's health. Due to the organisation and the researchers positions the data may reflect a more positive view on masculinity. Although it should be noted all three researchers' presentations were based on their own published empirical studies within the field of men's health. Self-reflexivity is equally important in good qualitative research. The researcher has a background in gender studies which predominantly focuses on toxic masculinity, but it should be noted, this project was done in conjunction with the FFCMH who research and present a more productive view of masculinity (Bruan and Clarke, 2013; Grbich, 1999; Green & Thorogood, 2014).

Chapter 3: Results

Two superordinate themes were developed through the process of analysis to best represent the themes identified. The first of these was defined as the ‘current relationship between masculinity and the health care system’. It consists of two themes, ‘masculinity viewed as inherently harmful’ and ‘health care’s not meeting men’s needs’ with the sub-theme ‘research and policy level’. The second superordinate theme was ‘leveraging masculinity for better mental health outcomes’, and it directly addresses the aims presented in this study. This consists of three themes and two sub-themes. The first theme was the ‘plurality and depth of masculinity’. The second theme identified was ‘leveraging masculinity using a strengths-based approach’ with the sub-theme ‘conscious utilisation of masculinity’ and the third theme identified was ‘adapting the system’ with the sub-theme ‘gender competent practitioners’. In total five themes and three sub-themes were identified, these are discussed in detail below.

3.1 Current relationship between masculinity and the health care system

The concept of masculinity was discussed as an important aspect of men’s health. The researchers each discussed what they saw as a disparity in how the health care system viewed men and their masculinity and how their research suggested concepts of masculinity and men as patients should be interacted with. The first concern voiced was the way in which researchers and health care providers view men and masculinity. The second theme present within their discussions was how the current health care system is not meeting the often complex and multi-faceted needs of men. This was seen at both an individual and systematic level. The two themes were identified to explore the complex ways the researchers discussed the current interactions of men and the health care system.

3.1.1 Masculinity viewed as inherently harmful.

The three researchers discussed masculinity as represented in dominant research and practice. Masculinity was discussed as being "framed in a negative connotation" (sp1, lines 71-72). With one researcher describing the prevalent view in health care and research as being "the idea of toxic masculinity" (sp2, line 103). The health care system viewing masculinity as negative and toxic was attributed by one speaker to the dominant view being progressed by prominent researchers. Speaker 3 stated that;

> *Many of the central assumptions advanced by existing research on men and masculinity support the notion that males are defective and damaged, they need to be fixed and are at fault for the problems they bring to counselling (sp3, lines 501-503)*

Viewing men as defective and damaged "buys into that the problem of men's health is men" (sp3, lines 472-473). The implications of viewing masculinity as inherently harmful were discussed by one of the researchers who expressed that it distances men from accessing health care, for instance speaker 2 expressed;

> *We have uh uh mental health system especially where where I work … health system on the whole ah that pathologises and distances ah men, it it does that for the idea of masculinity on the whole, it says that masculinity is the thing killing you… it says that masculinity is dangerous (sp2, lines 109-112)*

This narrative of masculinity as inherently harmful was seen to filter from research into practice. All three speakers discussed concepts of masculinity at both a systemic and individual level prevalent within the field of research and health care. The main idea expressed was the

"fundamentally negative approach to masculinity" (sp3, lines 492-493). This was seen at the policy level with researchers arguing for masculinity being the cause of men's poorer health outcomes. It was also seen on an individual level with high disengagement rates of men from services. The notion of all masculinity being treated as negative or toxic in the current system was discussed as being unproductive and unhelpful. As seen in the lines above speaker 2 discussed how the system pathologies men, speaker 1 illustrates a similar discourse of negative masculinity not working, he stated;

> *That approach has not lead to improvements in men's health and is very unlikely to lead to improvements in men's health (sp1, lines 48-49)*

3.1.2 Health care's not meeting men's needs.

Men's relationship with the health care system was discussed by the speakers. The general view was the current system, as a majority, did not address the needs of men. The speakers addressed this issue from a number of perspectives. The first concern addressed was the discourse around men and seeking help. Men not seeking help was presented as the prevalent concept within the main stream western health care system. Men are discussed as being the issue, and not seeking help. Speaker 1 disagreed with the idea that men don't seek help and presented his research which found when taking out visits for reproductive reasons, men and women access health care to the same extent. He expressed this stating;

> *Men are very interested in their health, they use health services just as commonly as do women (sp1, lines 50-51)*

Speaker 1 went on to discuss that even though men use health services as commonly as women “men interact with health services in a very different way” (sp1, lines 53-54). This difference in interaction style was discussed as an important factor that needed to be addressed. Speaker 1 talked about his own research and how he found that men not seeking help wasn’t the problem, but rather, the interactions with the health practitioner were problematic. He stated;

> *The vast majority of men were unhappy or dissatisfied with the interaction with the general practitioner and the reason was because they weren’t asked about other issues that bothered them (sp1, lines 61-63)*

A similar discourse was presented by speaker 2. He also expressed that men access and use health services and it wasn’t the men but rather the health services that were the problem. He went further and discussed the high disengagement rate, which he attributed to something going wrong on a health care level. This sentiment can be seen here;

> *The idea that men do not seek help will not hold any longer we are getting all of these guys coming through the door and they leave and that is not okay. We can spend millions and billions of dollars trying to get more men in to seek help but if they leave we are done for and so when we have sixty-four percent of those who go to see a gp, a psychiatrist, or a psychologist and then suicide a month later that is not okay, and I will not sit with that (sp2, lines 239-244)*

All three speakers expressed their concern over the current health care system and how it interacts with and views men. They also identified a number of factors they felt contributed to the system not meeting men's needs. The first can be seen above in speaker 1's statement that men aren't being asked about the issues they are facing. A significant barrier to men experiencing better health was attributed by the speakers, to the negative discourse the health care system presented of men and masculinity. Clinicians were viewed as part of the problem which was expressed by speaker 2;

> *We need to train clinicians to understand gender a lot better and to stop being complicit in undermining men and to stop being complicit in narrowly reducing them to stereotypes (sp2, lines 293-295)*

The underlying discourse held by the health care system was not only talked about in regard to its impact on clinicians and how clinicians treat men. Speaker 3 also talked about how this negative discourse is internalised by men, impacting men's expectations of health care and practitioners. He stated;

> *The problems not men but the fact that they come with that culture, with that ideology behind them that th-the counselling world apart from some notable exceptions has in their mind there's something basically wrong with them. (sp3, Lines 505-507)*

This impacts how men engage with the health care system. If they internalise the inherently negative approach to masculinity seen within the health care industry it leaves the

question “what is masculinity supposed to look like, it’s all dangerous, it’s all you know bad news” (sp2, lines 151-152). Another concern discussed in regards to the health care system was individuals’ access to health care. The discussion was centred around what happens to men when they do ask for help; speaker 2 expressed how “We’re ending up with this idea of the missing middle” (sp2, lines 637-638). He went on to state;

> *We have the people who are not that severe who can get in who can pay for private um you know psychologist and psychiatrists who are very privileged and then we have all these other guys who are extremely critical and only come out at the spiky end and they have nowhere to go and so we’ve got all of these guys who we’re telling to seek help and then we push them through the system and they either come in to see somebody who’s not gender competent and who is unable to understand their masculinity and utilise it to their advantage and they disconnect and they disengage um or their just not able to to come in in the first place… we need more attention on what follows the problem is where they fall after (sp2, lines 639-646)*

Some of the main concerns expressed are the fact that the health care system is not equipped to deal with all the individuals who need assistance, either by not being available altogether or not having appropriately trained staff available. The speaker highlights his understanding of the importance of understanding and leveraging masculinity by the health care system. Speaker 2 expresses his concern that the system is gender blind as can be seen here;

> *When we have gender competence, gender competence is the idea that we see men for their complexity and their depth and their strengths. When we have that in comparison to being gender blind which is what is what is happening now, we are gender blind people come in you treat them in a one size fits all way and it stuffs up (sp2, lines 229-233)*

All three speakers expressed concerns with the health care system and men's health within Australia. The problems they expressed as most prevalent were the idea men do not seek help; the health care system's inherent view of men and masculinity as being negative; men internalising this negative view of themselves; the health care system not being gender competent and understanding men interact with the health care system differently; and the concept of the missing middle. Speaker 1 summed some of these up and stated;

> *So the problem with men's health is that the advice to men to talk or all the advice to men to behave differently doesn't address the nature of the problems that effect men nor does it provide health care practitioners with the needed that's required to manage problem (sp1, lines 746-9)*

3.1.2.1 Research and Policy level.

The health care system was not only discussed from a provider, clinician and individual level but concerns were also expressed at a policy research level. Research and policy guide practice, and so addressing the policy level of men's health was an important part of discussion for speaker 3. He discusses one current states men's health policy and how it fails to address the complexity of men's health barriers and needs. He states;

It's about four diseases so it was so we have a male health framework but it's about four diseases one of which of course is depression (sp3, lines 338-340)

Speaker 3 goes on to express how;

Academia having filtered into so called men's health policies presumes that masculinity is something negative something that needs to be fixed (sp3, lines 371-373)

This negative view of masculinity is used to form the basis of men's health policies which guides health services and practitioners. The policy was called "moving forward in men's health" (sp3, line 310). All three speakers discussed how the current negative views impact men, and how they felt the health care system was not able to understand or meet the complex and diverse needs presented by male clients. Speaker 3 highlighted how this begins at a policy and research level, with academia influencing policy and policy influencing practice. Speaker 3 goes on to say;

I think Australia is going backwards; the new men's health framework will talk of um disease; it won't talk about building on the strengths of Australian men. (sp3, lines 527-529)

3.2 Leveraging masculinity for better health outcomes

The three speakers all addressed significant issues within the men's health field, they also talked about their own view on how men's health could or should be addressed moving forward.

Each speaker presented on their own research and experiences of masculinity, men, and the health care system.

3.2.1 Plurality and depth of masculinity.

To leverage masculinity, and achieve the best health outcomes for men requires a reconsideration of masculinity. Speaker 1 addressed the fact masculinity is portrayed as wrong and put forward a counter opinion. This was based on his own findings that men do seek help, and that viewing masculinity as a negative or as dangerous was counterproductive. He stated;

> *It's okay to be a man and it's okay to be a masculine man and that does not confer a risk to health and does not make people violent and is not the cause of violence and it does not need to be remediated by education (sp1, lines 45-47)*

Speaker 2 also discussed how masculinity wasn't negative but went further to talk about the complexity and plurality of masculine traits and masculinity as a whole. Masculinity as a discourse was discussed using the plural form masculinities, this was suggested to better reflect men's experience of masculinity. Viewing masculinities in a plural sense provided a narrative that could account for the negative aspects of masculinity, but also allowed the strengths of masculinity. Speaker 2 stated;

> *When I talk about masculine strength I talk about a flexibility, I talk about the idea that rigid masculinity, everyone telling everyone that there is only one way of being, that there*

is only one way forward is the thing that is really not working well for us so I talk about multiple masculinities. (sp2, lines 183-186)

All three speakers agreed on the fact masculinity is a complex, multi-faceted construct which men experience differently "we need to start to realise it has great depth" (sp2, lines 145-147). Part of understanding the plurality of masculinities is not just exploring the negative aspects but also seeing the strengths men possess. Speaker 2 talked more explicitly about this concept, as his research predominantly focused on the strengths men possess, he discusses some of these strengths in this quote;

Here are all these traditional norms whether it be male ways of relating, self- reliance, respect for women, forms of service, humour, heroism all of this stuff… traditionally masculine ideas um that are really overlooked, these are strengths, these are positive prosocial ways of being… we need to be seeking these out. (sp2, lines 153-158)

He also goes on to specify that;

No traditional masculine norms and that's taking aside misogyny and homophobia which have sadly been placed in this group um needs to be unlearned, they do not need to be unlearned. (sp2, 196-198)

Identifying positive prosocial attributes of masculinity facilitates an understanding of the different ways masculinity can be experienced, and allows a better understanding of men and

their experiences. Although the strengths of masculinity were predominantly discussed in the presentation, it was acknowledged masculinity can also be maladaptive but focusing on the maladptive behaviour is non-constructive. Speaker 2 stated;

> *Some form of maladaptive behaviour whether it be violence or otherwise, telling them that they're wrong and that they're thick and they're stupid and pushing them away; we're done for; there's no way of adapting their behaviour to be more healthy and pro-social. (sp2, lines 118-121)*

3.2.2 Leveraging masculinity using a strengths-based approach.

Acknowledging the complexity of masculinity allows for a better understanding of how to work with men. Focusing on the strengths men bring allows for a connection to be made with the client. Understanding masculinity is the beginning to understanding how to leverage masculinity. Speaker 1 discusses this sentiment;

> *Intervening in ways that recognise and capitalise on their strengths, men can reasonably be viewed to construct their experiences of help seeking in terms of being responsible, problem solving and in control (sp1, lines 75-77)*

Leveraging masculinity is about focusing on "what masculinity can and should look like in a prosocial and health manner" (sp2, lines 141-142). The inherently negative view of masculinity that the health care system has was discussed as not meeting men's needs by all three speakers. A strengths-based approach to masculinity attempts to change the discourse

around masculinity and hopes to utilise masculinity to better men's health. All three speakers discussed the importance of acknowledging men as complex individuals, and that being a male or a masculine male was not wrong or negative. Strengths- based health care applies this discourse of a more positive view of masculinity, speaker 2 talks about how it works in practice;

> *Instead of a man coming in and you going these are all of your problems, they come in and you go this is what we can build on, this is what you are coming with, these are your strengths and this is what we need to prop up because the more of these positive behaviours that we have the better it's going to be for everyone (sp2, lines 160-163)*

The speakers discussed how a more positive discourse moving forward would potentially produce better engagement and retention in the health care system, and also provide health benefits. A more flexible approach to masculinity would also allow for men to experience the positive aspects of masculinity and the protective factors afforded by pro-social masculine traits. Speaker 2 discusses how men and the health care system are currently missing out on the benefits masculinity has to offer and expresses how a more open flexible masculinity is key to accessing the benefits. This is reflected in his statement;

> *They're missing out on all of the health, all of the benefits of masculinity and so let's start to look at how you can use that to your advantage… stop policing or becoming complicit with these traditional masculine norms and instead start to open it up and realise all of the differences that exist (sp2, lines 171-174)*

3.2.2.1 Conscious utilisation of masculinity.

The conscious utilisation of masculinity was a very important theme throughout the discussion of leveraging masculinity. It was predominantly presented throughout speaker 2's discussion of leveraging masculinity. Speaker 2 explained the conscious utilisation of masculinity as men making conscious choices about their masculinity and how they want to engage with and use their masculinity. Consciously using masculinity was also about understanding that when masculinity is not understood or engaged with purposefully, it can be negative or even potentially harmful. This can be seen in this collection of quotes;

> *They (men) need to be making choices about their masculinities and that means leveraging by choosing which ones you want to use and why and making a purposeful decision rather than life acting upon you… this is how we get from healthy to unhealthy to abusive is when people start to let all of those social pressures kind of act upon them (sp2, lines 192-196)*

> *We need to understand that not all traditional masculine behaviours are dangerous, we just need to be able to hone them, to explore them and to use them wisely (sp2, lines 295-297)*

To leverage masculinity and achieve the best outcomes for men and their health, it requires educating men on themselves, and their masculinity. Speaker 1 discusses how only presenting a negative framework of masculinity is creating a confusing discourse for men. They are not able to understand themselves or how to consciously utilise their own masculinities.

Speaker 1 presents this concept as to why masculinity might be increasingly seen as negative; he discusses it as a dysfunction of masculinity rather than the concept of masculinity being negative as a whole. He states;

> *I would argue that uh when there is a problem it's because masculinity has dyfunctioned and um and they are not functioning as normal men; so it's not masculinity that's the problem; it's a bunch of other things that have affected the ability of a man to function as a man; and I think one of the problems is that boys are becoming increasingly confused about who they are and who they should be. (sp1, lines 570-575)*

Masculine identities are presented as a choice, with men able to choose between adaptive and maladaptive ways of engaging with their masculinity. Speaker 2 discusses leveraging masculinity as an empowerment process, where men are supported and given the tools, to discover, explore, and use their masculinities in adaptive ways. He states;

> *It's an empowerment process and that knowledge is true strength here, that they can go from being adaptive to maladaptive to unhealthy very quickly and so it's a matter of really being in control of that… we need to start to explore and gain insight into their masculinity; it's something that's been avoided for a very long time. (sp2, lines 204-208)*

Leveraging masculinity in this way allows men to use their masculinities in a conscious and purposeful way and allows the health care system to support them; this is in contrast to pathologising men and telling them they are wrong and need to change.

3.2.3 Adapting the system.

A theme discussed by all three speakers was how to move the discourse forward. The health care system was seen to not be meeting men's needs, and leveraging masculinity was discussed as an important change to how the health care system can address men, masculinity and men's health. This sentiment of needing the system to progress the discourse was expressed by speaker 2: "Up to us to find a way to move the dialogue forward rather than backwards" (sp2, lines 105-106). He expressed what moving the dialogue forward would look like according to his research, as can be seen in this collection of quotes;

> *I think that the idea of aligning, empathising and adapting our system is going to be the best way forward. (Sp2, lines 116-117)*

> *The system needs to open up and understand and embrace masculinities.(Sp2, lines 125-126)*

> *Really to provide a pretty strong framework for what masculinity can and should look like in a prosocial and healthy manner rather than working on what it doesn't do you know, what it can't do, what you shouldn't be as a man. (sp2, lines 140-143)*

One of the first steps to moving the discourse forward and adapting the system to work with men in a more productive way was discussed as understanding when men talk. The notion men do not talk or seek help was discussed as the dominant view of the inherently negative

stance towards masculinity. To adapt the system, this notion needs to be changed according to two speakers as can be seen in these quotes;

> *They give the impression that they won't talk but in fact if you ask the right questions, men will talk and masculinity is not a barrier to even the most stereotypical man talking about his problems if you create the right environment and if you ask the right questions. (sp1, lines 66-69)*

> *They have to be given the context in which to feel free to talk in; in which they feel supported. (sp3, lines 411-412)*

Asking questions, using tailored language and creating a context which men feel supported in where all important factors highlighted by speaker 1 and speaker 3. Speaker 2 also discussed this, and through his research he presented four key ways the system could be adapted to leverage masculinity and achieve better health results for men. He stated;

> *I've got these four themes that came out of the literature which are very clear, everyone agrees on them and it says, we need to clarify structure, we need to tailor our language as clinicians as doctors, we need to understand gender socialisation and we need to look at building rapport. (sp2, lines 251-254)*

He went on to discuss what each theme meant in a practical sense. Clarifying structure was seen as important as "men do not understand this (therapy) process very well… It's quote

foreign" (sp2, lines 270-271). Talking men through the process was discussed as important to create a more supportive and welcoming environment. Tailoring language, was in part what speaker 1 and 3 discussed, with asking men questions being important. He also discussed the importance of "using metaphors… and using emotions focused vocabulary and dialogue" (sp2, lines 284-285). Speaker 1 expanded on this stating "men want direct communication, action orientated, how do I solve this problem" (sp1, line 808). In regards to gender socialisation speaker 2 stated;

> *We've got this idea of gender socialisation and that implies we need to train these clinicians to embrace and promote healthy positive masculinity. (sp2, lines 255-257)*

Gender socialisation was about understanding masculinities and promoting productive expressions of masculinities which can be achieved through equipping men with knowledge about masculinities. Rapport building was the final theme identified by speaker 2 as being relevant to adapting the system and moving the dialogue forward. He suggested this could best be achieved through;

> *Employing a strengths-based relational style, ensuring that the relationship is egalitarian and non-directive. (sp2, lines 278-279)*

Applying these themes of changing the language, asking questions, explaining how the health care system works, understanding the role masculinity plays and knowing how to work

with men are suggested to be important factors in changing the system so that it supports men. Speaker 2 stated;

> *We need to involve men in their health care and use their strengths to our advantage and to their advantage. (sp2, lines 292-293)*

3.2.3.1 Gender competent practitioners.

Gender competency and gender competent practitioners were discussed as embodying the themes for better health care and their practical application within the health care industry. Moving toward gender competency was discussed as being important to understanding how to work with men. Gender competent practitioners were seen to understand men and masculinity; they are able to leverage masculinity and promote adaptive masculine ideals. Gender competency was discussed as working with men in the way they need when they need; it is about understanding men's needs as an individual. Gender competency was described by speaker 2 who stated;

> *So that's kind of where I'm working towards, is getting clinicians to see that men have so many shades and when we do that we have gender competence; gender competence is the idea that we see men for their complexity and their depth and their strengths. (sp2, 228-231)*

> *We just need to open up to the fact lots of men like to be treated in a naturally feminine way, lots like to be treated in a naturally masculine way. Whatever it may be, lets open*

up and start to train in all of these shades and colours and start to go whatever the guy needs, the guy gets. (sp2, lines 820-823)

Chapter 4. Discussion

4.1 Overview

The study aimed to explore how masculinity can be leveraged and utilised to achieve better health outcomes for men from the perspective of three researchers/practitioners. Thematic analysis resulted in the identification of five themes and three subthemes. A thematic map was used to explore the relationship of these themes resulting in the themes being split into two super-ordinate themes. The first of these explored how masculinity relates to the health care system currently and consisted of two main themes and one sub-theme. These themes described how masculinity is currently perceived as negative, and how the health care system is currently seen as failing to meet men's needs at both a research/policy level and a practical level. The second super-ordinate theme explored the original aim of the study more directly, that of how masculinity could be leveraged for better mental health outcomes. It consisted of three major themes and two subthemes. These themes explored the complexity and depth of masculinities and how to leverage these to support men. It also explored how the concept of leveraging masculinity could be applied to the health care system and what this would look like. The findings were consistent with previous research on leveraging masculinity and adds to the research in support of changing the way masculinity is viewed and treated within the health care system.

4.1.1 Current health care system not meeting men's needs.

The present study did not originally intend on exploring how the health care system was not meeting men's needs. Throughout the analysis it became evident, to understand how to leverage masculinity and improve outcomes for men's health, it was vital to understand what

parts of the health care system were not working. While previous research has addressed the concerns of high suicide rates and the disparity in health outcomes for men, as in the introduction, this was generally attributed to masculinity (Peate, 2010; Scholz, Crabb, Wittert, 2014). This notion of negative masculinity being the predominant view was presented in this statement 'Many of the central assumptions advanced by existing research on men and masculinity support the notion that males are defective and damaged, they need to be fixed and are at fault for the problems they bring to counselling (sp3, lines 501-503)'. The results of the current study did not support the notion of masculinity being responsible for men's poorer health outcomes. Instead the results suggest it is the way the health system views and deals with masculinity that contributes to the negative health outcomes experienced by men (Englar-Carlson & Kiselica, 2013). The concerns found in the literature that masculinities were being seen as inherently negative (Mcdermott et al., 2019) was echoed within the analysis. This feeling of dissatisfaction can be seen in this quote 'The vast majority of men were unhappy or dissatisfied with the interaction with the general practitioner and the reason was because they weren't asked about other issues that bothered them (sp1, lines 61-63)'. Another theme presented in the introduction was the stigma mostly presented within the media of being considered feminine for seeking help. This was seen as a major barrier to men accessing health care (Scholz, Crabb & Wittert, 2014). The stigma of being perceived to be feminine was not discussed as an issue by the speakers, but rather they commented on the stigma men feel from health care providers. This was consistent with the findings that men are being pathologized by the health care system and health care providers may be biased against men. These findings do not discount the effect the stigma of being perceived as weak or feminine may have, but rather suggests that stigma is not all external to the health care system. The speakers also identified the notion of the "the missing middle";

this concept was not seen within the existing literature except in a newspaper article by McGorry (2019). The need to understand why men disengage from health care was discussed within the introduction. The results suggest where the health care system is failing men is in its view of masculinity as being inherently negative and men then internalising this negative representation. Other issues are the lack of gender competence and understanding how men interact with the system and finally the missing middle, which prevents or makes it difficult for men to access the care they need.

Chapter 4.1.2 Leveraging masculinity to adapt the health care system.

The second super-ordinate group of themes identified were in direct relation to the study's original aims. It was found a strengths-based approach to masculinity that aimed to leverage masculinities was considered controversial. This was based on the health care system's currently very negative views of masculinity. Changing the discourse of masculinity was considered an important step towards leveraging masculinity (Englar-Carlson & Kiselica, 2013). The results found to change the discourse of masculinity from negative, to a more productive discourse requires masculinity to be considered in a more flexible way, but it also requires the negatives of masculinity to be addressed (Seidler et al., 2016). Strengths-based approaches do not aim to discount the impact masculinity can have when used in a maladaptive way but rather work towards adapting the maladaptive behaviour (McDermott et al., 2019). This can be seen in the discussion of maladaptive masculinity in the results. Viewing negative behaviours as maladaptive rather than as stable traits of masculinity allows for the health care system to be able to address the negative behaviours and implications of negative or maladaptive expressions of masculinity (Englar-Carlson & Kiselica, 2013). Whereas if masculinity is viewed as inherently

negative, as seen in the literature, then men cannot be helped. They will continue to face the significant negative effects associated with inherently negative masculinity, such as earlier mortality rates, higher rates of disease and higher rates of death via suicide (Robertson et al., 2018).

The results instead suggest that rather than focusing on the maladaptive practices, it is more beneficial to men and their health to focus on the strengths of masculinity. This provides a way forward for men towards better health outcomes (Seidler et al., 2018). For masculinity to be leveraged, the notion of hegemonic masculinity needs to be discarded, reflecting the more recent research on the plurality of masculinities (Englar-Carlson, 2006). The results suggest a more diverse, rich, and complex way of being masculine needs to be embraced, one in which the individual is responsible for and in control of their own masculine ways of being. Leveraging masculinity was seen in the results to focus on embracing this complex and multi-faceted view of masculinities. To leverage masculinity, men need to explore their masculinity to understand themselves, and to choose to utilise positive masculine traits.

This concept was reflected in the quote ‘So that’s kind of where I’m working towards; is getting clinicians to see that men have so many shades and when we do that we have gender competence; gender competence is the idea that we see men for their complexity and their depth and their strengths. (sp2, 228-231)’

The analysis of the theme adapting the system identified four themes related to the importance of explaining the therapeutic process, changing the language used within the health care system, tailoring it to individuals and asking the appropriate questions. Speakers addressed

the issue of understanding the impact an individual's gender has on their identity and building rapport by working with men and using their strengths to create an egalitarian relationship. The results showed gender competent practitioner were vital to this process. Gender competent practitioners work to teach men how to understand themselves, their masculinity and how to control its use. The existing literature on gender competent practitioners reflects the importance found in the results of practitioners understanding the flexibility and depth of masculinity to work effectively with men (McGregor et al., 2013).

Instead of the current discourse that is presented within the more recent literature on masculinity which is a health care system that pathologizes men, and pushes them out of the system, leveraging masculinity aims to draw men in (McDermott et al., 2019). The results suggest the discourse of seeking help should be one of strength, rather than weakness. This change in discourse would address the stigma found within the research of help seeking being feminine and weak. This change in discourse and attitude would not only benefit men, with a broader, more diverse way of being, but would also benefit women and other individuals. It allows for men to function in a productive, pro-social manner, that does not rely on the subordination of women, such as the ideal of hegemonic masculinity as presented in the introduction (Seidler et al., 2019). Men's masculine identities would need to shift from the masculine being defined as that which is not feminine, to the masculine being defined as adaptive, productive, pro-social ways of being male. The analysis suggests that the health care system needs adapting to meet men's needs; this was suggested to be achieved through leveraging masculinity. One aspect of leveraging masculinity identified in the results was providing a framework to work within. This sentiment was seen in the statement "Really to

provide a pretty strong framework for what masculinity can and should look like in a prosocial and healthy manner, rather than working on what it doesn't do you know, what it can't do, what you shouldn't be as a man. (sp2, lines 140-143)". To effectively leverage masculinity, the definition of masculinity needs to change, it needs to be seen as a complex and changing part of individuals identities. A clear framework and gender competent practitioners were seen as a vital part of adapting the system along with discussing the therapeutic process and working with men to achieve better health outcomes for men (Rice et al., 2017; Seidler et al, 2018a).

4.2 Strengths

Research on the detrimental health effects of masculinity for men is vast and currently dominates men's health care policy and practice. In comparison the research exploring more positive or productive views of masculinity is just starting to emerge (Seidler et al, 2019). This new line of research is presenting an interesting challenge to the dominant discourse of negative masculinity. As the field is just emerging, the research papers exploring the strengths and protective factors of masculinity are currently dominated by a few notable researchers. The conference recording used in this study offered a unique data set that allowed for the analysis and comparison of three different researchers/practitioners who are prominent within their own respective areas of the men's health field. The speakers provided a broad interdisciplinary set of data, each representing different fields of health care. The first presenter is a physician/researcher, the second a researcher/psychology practitioner and the third presenter being a professor working within a science and health department. Being able to analyse and compare three different perspective from three different branches of men's health provided a richer and more complex picture of masculinity and how it is addressed within the field of health

care. It also allowed for a broader analysis on how masculinity should be viewed moving forward, and what factors were relevant to achieving better health outcomes for men.

4.3 Implications

This study puts forward a discourse of purpose and provides a productive way forward. If masculinity is not inherently negative but rather a choice, and something that can be learnt and improved on, then men can take control of their health and achieve better health outcomes. The results also support the importance of practitioners having an understanding of the role sex and gender have in an individual's life. Gender competent practitioners are suggested to embody the changes needed to move the health care system forward in a way that leverages masculinity.

The area of strengths-based masculinity is evolving and developing, this study uses thematic analysis to provide a rich, in-depth analysis of an interdisciplinary conference addressing masculinity and men's health. The study provides a unique comparative analysis of different fields views of masculinity within men's health. The findings in this study suggest that the health care system needs adapting and the discourse around masculinity needs to shift to a more productive view…

4.4 Limitations and future research

Qualitative research offers a unique and in-depth analysis of data but is limited in the way it can be generalised across population and situations (Braun and Clarke, 2013). Due to the interdisciplinary nature of the data, this study aimed to provide data that are potentially more

generalisable, but the results would best be interpreted as a representation of the Australian health care system, and the way to leverage masculinity within this context. Future research could expand on the interdisciplinary nature of this research and compare different cultures or countries ideas of the way to progress men's health.

Another limitation noted in this study was that the data was transcribed from a recording of the Australian Men's Health Forum workshop held in November 2018. The conference itself could have created a biased data set as its primary focus was on examining the relationship between masculinity and health. The workshop was hosted by the Freemasons Foundation Centre for Men's Health (FFCMH); this may have biased the individuals who chose to participate and present. It should be noted though that all participants have published research in the area of men's health and their presentations were based off their own empirical, scientific findings. One further limitation was that the researcher was unable to ask the presenters direct questions to explore or clarify any concepts presented within the data. Although the inability to ask questions did present a more natural data set, without the researcher having influenced the topics discussed. Participants who attended the workshop could ask questions though, and were able to explore and clarify any concepts relevant from their experience, to the men's health field. This provided a more enriched and applicable data set, relevant to the Australian men's health field.. Due to the depth and complexity of the workshop's data set and to time constraints, the researchers chose to focus on analysing the existing data set. This avenue of interviewing individuals about the themes found in this study could be persued in future research to provide a richer account.

Future research could explore the concept of 'the missing middle' that was discussed in the results and is seen within one media article identified by the researcher(McGorry, 2019). This could potentially lead to a more practical understanding of what resources men need. Men's sheds as discussed in the introduction could be one way of potentially meeting this concept of the missing middle. Community based initiatives could be further researched and incorporated into a more holistic plan of leveraging masculinity, providing men a potentially more approachable, or available access point (Robertson et al, 2018). This would incorporate a more holistic care approach, as community initiatives such as men's sheds have been shown to alleviate isolation and promote better health and mental health (Nurmi et al, 2018).

Another avenue to pursue would be gender competency training. Evidence informed guidelines on how to train and upskill practitioners and health care providers have been developed by Seidler and published in 2019. These guidelines are intended to address the issue of gender blind practitioners and the gender-blind health care system (Seidler, 2019b). Effective training guidelines would begin to address the issues within the health care system addressed in this study, and research more broadly. Future research could explore practitioners' willingness to engage in gender competency training and could also explore the effectiveness of this training. The effectiveness could be researched from both the practitioner's perspective and the client's perspective.

4.5 Conclusion

This study used qualitative methods to analyse a unique data set and worked towards extending the research on how masculinity can be leveraged to achieve better health outcomes

for men. One of the key findings was that the health care systems view that masculinity is inherently harmful and is the cause for men's poorer health outcomes was considered to be more harmful to men's health than masculinity. The current health care system was discussed as not meeting men's needs. This was attributed to its inherently negative view of masculinity; men internalising the health care's negative views; the health care system not being gender competent and knowing how to engage men; and 'the missing middle' which was described as difficulty in accessing relevant and timely health care. Exploring these themes was not the study's initial aims, but through thematic analysis they were found to be significant, and important factors in understanding how masculinity could be leveraged to facilitate better health outcomes for men. In relation to the study's original aims, the key theme was the health care systems need to adapt, which was argued to be achieved by leveraging masculinity. It was discussed that changing the discourse began by changing the view of masculinity as rigid to a flexible and plural perspective of masculinities. Furthermore, it was found the vital factor to being able to leverage masculinity was providing a gender competent health care system. This study expands on and extends support for a gender competent, strengths-based view of masculinity within the health care system. As this is still a new and developing area of research, further study is required to explore the benefits and practicalities of leveraging masculinity.

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Appendix

Feature	Notation
The identity of the speark; turn-taking in talk	The speaker's name, followed by a colon. Start a new line every time a new speaker enters the conversation
Laughing, Coughing	((laughs)) and ((coughs)) for the speaker ((general laughter)) for multiple speakers
Pausing	((pause)) for significant pauses (.) for short pauses
Spoken abbreviations	Abbreviate when the speaker does
Overlapping speech/ inaudible speech	Type ((in overlap)) before the start of overlapping speech. ((inaudible)) for completely inaudible speech sounds
Uncertainty about who is speaking	Use ? when unsure of who is speaking
Non-verbal utterances	Render phonetically and consistently common non-verbal sounds uttered by your participants
Spoken numbers	Spell out all the numbers
Use of punctuation	It is common to use punctuation to signal some features of spoken language. However, adding punctuation to a transcript is not straight forward. Equally, punctuation enhances the readability of spoken data.
Accents and abbreviations	Signaling the very obvious and common abbreviations