

THE UNIVERSITY OF HULL

Constructions of Masculinity and Men's Experiences of Barriers to Help-Seeking from
Mental Health Services

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I would like to dedicate this to Jill, I hope this would have made you proud.

OVERVIEW

This portfolio thesis is divided into three parts: a systematic literature review, an empirical study and a set of appendices.

Part one is a systematic literature review, exploring the existing literature relating to the barriers men report when accessing mental health services. A total of 8 studies were critically reviewed, evaluated and assessed for quality. The results from these were then explored to consider the themes that men described in the barriers they experienced. The findings from this review are discussed regarding the clinical implications of barriers to care.

Part two is an empirical paper exploring the constructions of masculinity in the language Army veterans use around accessing mental health services. The study utilised a combination of grounded theory and Foucauldian discourse analysis to explore the discourses used by the five veterans. Results looked at the different positions the men took in their discourse and the different actions this allowed them, as well as how they negotiated their masculinity when accessing support. The findings are considered and discussed in relation to their clinical implications.

Part three contains a comprehensive set of appendices from parts one and two; this also contains epistemological and reflective statements to add context to the research that was undertaken.

CONTENTS

	<i>Page number</i>
Acknowledgements	1
Overview	2
Contents	3
List of tables and figures	4
Part One: Systematic Literature Review	5
Abstract	7
Introduction	9
Methods	11
Results	15
Discussion	41
References	46
Part Two: Empirical Study	51
Abstract	53
Introduction	55
Research design and methods	58
Results	62
Discussion	82
References	86
Part Three: Appendices	92
Appendix A: Guidelines for Submission to Psychology of Men and Masculinity	93
Appendix B: Data Extraction Form	101
Appendix C: Quality Assessment Checklist	102
Appendix D: Scores Articles Achieved on the Quality Checklist	105
Appendix E: Participant Information Form	106
Appendix F: Participant Consent Form	111
Appendix G: Interview Schedule	112
Appendix H: Documentation of Ethical Approval	113
Appendix I: Example of Analysis	114
Appendix J: Epistemological Statement	116

List of Tables and Figures

	<i>Page number</i>
Part One: Systematic Literature Review	
Figure 1. Summary of the article selection process	13
Table 1. Summary of the main characteristics of the included studies	17
Table 2. Themes and subthemes identified through the synthesis of the data	25
Part Two: Empirical Paper	
Table 3. Participants' demographic details.	60

Part One: Systematic Literature Review

This Paper is written in the format ready for submission to the journal

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See Appendix A for submission guidelines.

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MEN'S EXPERIENCES OF BARRIERS TO MENTAL HEALTH SERVICES: A
SYSTEMATIC LITERATURE REVIEW

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ABSTRACT

Background

This review explores the themes that emerged from the extant qualitative literature, regarding barriers that men reported when accessing mental health services (MHS). It considers how these themes may affect male service use and help-seeking behaviour (HSB), as studies investigating this using qualitative methodology, often focus on a specific mental health difficulty (MHD) and the barriers concerning this. Therefore, this review aimed to explore themes across studies, to consider what barriers are potentially universal across different difficulties.

Method

A systematic review was performed using five electronic databases: Web of Science, PsycINFO, PsycARTICLES, CINAHL Complete and MEDLINE. The results of the included studies were synthesised using a thematic synthesis approach.

Results

The results of 8 papers included within this review explored the barriers that men may face when accessing MHS. The findings were expressed by three themes: “Society and Social Identity”; “Perceived Gendered Rules” and “Responsibility”. These findings imply that there are several different factors influencing men’s experiences of barriers to MHS: stigma; gender roles and practical barriers (such as cost).

Conclusion

This review shows the different experiences men describe as barriers to seeking support from MHS. It has implications for clinical practice, as by recognising difficulties men may face when trying to seek support from services, services can better try to alleviate

these problems, helping men engage better within services or when trying to access services.

Keywords: Men, barriers, mental health, help-seeking, thematic synthesis.

INTRODUCTION

In recent years, men's MHD have come into the public psyche. YouGov's recent figures reveal an increasing public awareness regarding the problem of male suicide, with 33% of those questioned in November 2016 recognising the problem, compared to 29% in December 2015 (Campaign Against Living Miserably [CALM]., 2016). Additionally, campaigns such as The Sides of March (CALM., 2017a) and Movember (Movember Foundation., n.d.) have been designed to increase awareness of men's MHD. Charities such as Andy's Man Club (Andy's Man Club., 2017) and CALM (CALM., 2017b), have recently been created to help men discuss the difficulties they face. The establishment of the above organisations demonstrates this growing realisation that there are difficulties that men experience and that need acknowledging. Within political and medical spheres there is growing recognition that a greater understanding of men's MHD is needed and how these difficulties can present (Men's Health Forum (commissioned by the Department of Health [DoH])., 2008). For example, the World Health Organisation ([WHO]., n.d.) is advocating for a reduction in gender disparities in service access and greater recognition of the need for gender sensitive services.

Statistics regarding male suicide have become increasingly discussed, with reports showing that whilst men and women show similar rates of suicidal ideation, men have much higher rates of suicide (CALM., 2014). Suicide is the highest cause of death in men under forty-five (UK), with figures recently reaching a fifteen-year high (CALM), and men accounting for most suicides worldwide (WHO., 2000). This suggest whilst distress is suffered similarly by both genders, men and women may experience and seek help for this differently. Logan et al (2008) found that men were more likely to externalise emotional distress and would become violent towards themselves or others.

This increased violence towards others may account for the differences seen within forensic services, with men accounting for 95% of the prison population in the UK (Wilkins., 2010).

Concerning Primary Care Services, IAPT (Increasing Access to Psychological Therapies) was created in 2007 in the UK, to help increase access to talking therapies. IAPT's quarterly reports from 2015/2016 indicate that men accounted for on average 35.85% of all referrals made (Health and Social Care Information Centre [HSCIC]., 2016). Of those referred, only an average of 34.73% completed treatment, compared to 64.85% of women, and of those that did complete therapy, only an average of 46.25% recovered (HSCIC., 2016). These rates have since declined further over the first two quarters of 2016/2017, with a reported 34.2% of men completing treatment compared to 65.4% of females (Community and Mental Health Team, NHS Digital., 2017).

There appears to be little qualitative research that explores the barriers to accessing services, from the perspective of men that have accessed them. Studies that have investigated this often focus on a specific MHD and the barriers concerning, for example, depression (Cramer et al, 2014; Rochlen et al, 200) or eating disorders ([ED] Dearden & Mulgrew, 2013; Räisänen & Hunt, 2014; Robinson, Mountford & Sperlinger, 2012). Currently, barriers across different difficulties have not been reviewed, to investigate the degree of overlap and consider what barriers are potentially universal.

Therefore, the rationale for this review was to explore the themes that emerged from qualitative literature surrounding HSB men report when accessing MHS, given that currently research has investigated this primarily for specific MHD and not across the spectrum of difficulties.

The research question for this review was:

What barriers do men describe when accessing MHS for support with MHD?

METHODS

Search Protocol

A systematic search was completed with predetermined search terms, using synonymous suggestions from the EBSCOhost thesaurus. The Web of Science database was used, along with the following databases, accessed via the EBSCOhost service: PsycINFO; PsycARTICLES; CINAHL Complete; MEDLINE. Databases were searched up to and including February 2017. The “All Text” field was selected, to ensure all relevant papers were included. The following search was used:

(masculine* OR gender* OR m?n OR “gender dif*” OR “sex dif*” OR “human male*” OR “human sex dif*”) N3 (“help seekin*” OR “help-seekin*” OR support* OR “help-seekin* behav*”)

AND

(“mental health service*” OR “psych* service*” OR “community mental health service*” OR “health service*” OR psych* OR therap* OR “psych* therap*” OR treatment*)

AND

(barrier* OR obstacle* OR difficult* OR challenge*)

The limiters: English Language and Peer-Reviewed Journal were then applied.

Inclusion and Exclusion Criteria

Inclusion:

- Explores men's HSB and barriers they face in MHS.
- Participants are currently/have previously accessed a MHS.
- Peer-reviewed.
- Uses qualitative or mixed methodology.

Exclusion:

- Not in English.
- Participants are not accessing MHS/ are giving hypothetical accounts of accessing services.
- Review or discussion articles.
- Participants give only a third person perspective on those that access MHS, for example, professionals.
- Only quantitative methodology used.
- Intervention studies.
- Solely discusses enablers to help-seeking.
- Discusses HSB around health problems in health/medical settings.

All identified articles were screened by title and abstract, those not meeting all inclusion criteria or met one (or more) of the exclusion criteria were discarded. In instances where an article's suitability was unclear full versions were retrieved. Retrieved articles were reviewed in full and inclusion and exclusion criteria were applied. A final sample of 8 studies remained (see Figure 1).

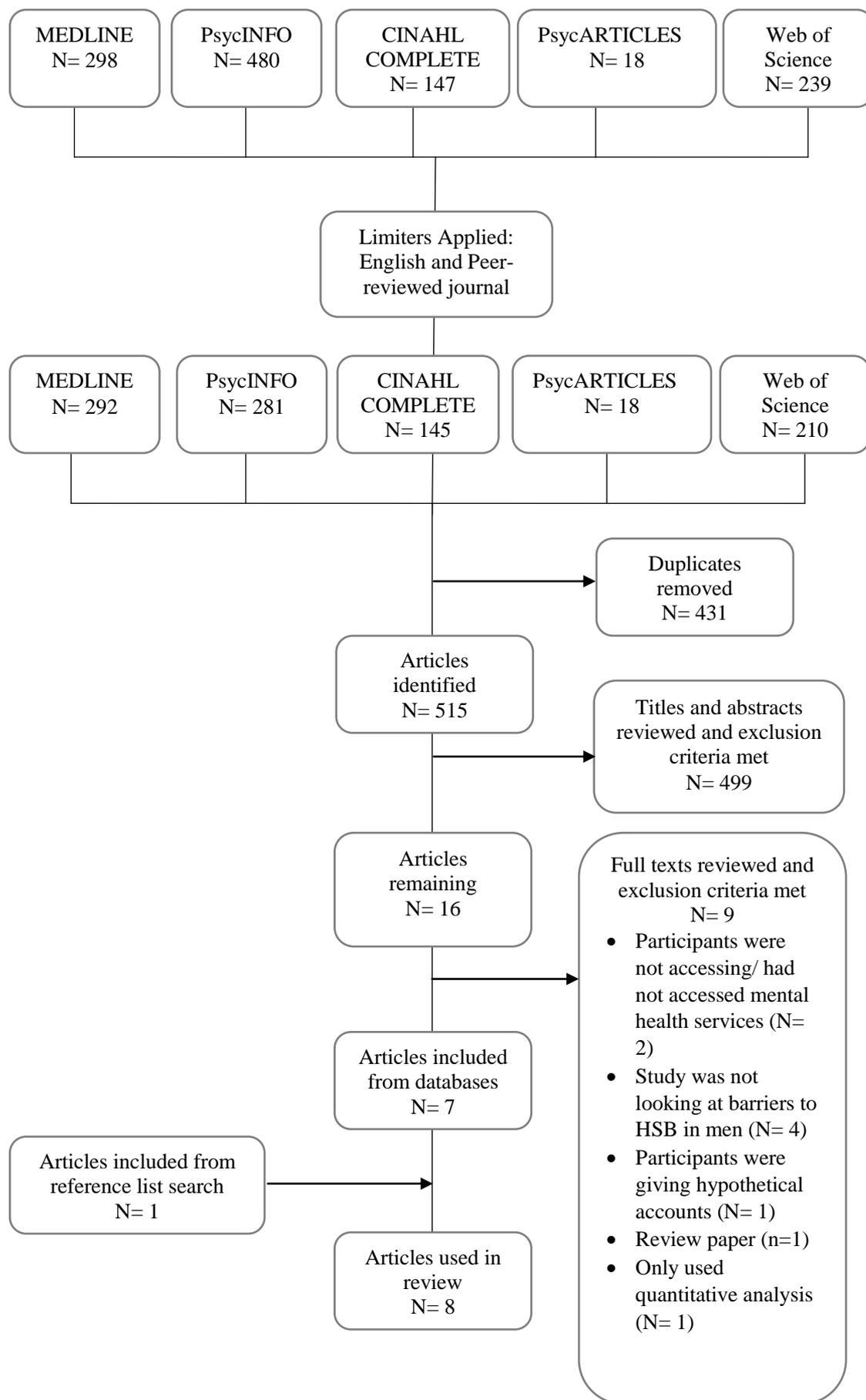


Figure 1. Summary of the selection process.

Data Extraction

Data were extracted from the articles utilising a data extraction form designed for the current review (Appendix B). Data extraction included the following topics:

Research aims

Methodology and theoretical approach for analysis

Participants used and their recruitment

Findings/themes discovered

Quality Assessment

A checklist was created to calculate the quality of studies to be reviewed, this was created using parts of the National Institute for Health and Clinical Excellence ([NICE]., 2012); Critical Appraisal Skills Programme ([CASP]., 2013) and Mixed Methods Appraisal Tool ([MMAT] Pluye et al., 2011) qualitative checklists (Appendix C), to ensure that a range of quality aspects were included. As all studies were qualitative, scores on bias were included in the quality checklist, to consider the degree to which researchers recognised and discussed the relationship between the researcher, the research and the participants. Articles were reviewed using the quality checklist, scores were then calculated to give an overall percentage of the article's quality (Appendix D).

To ensure that this process was reliable the highest, median and lowest ranking papers were sent to a clinician to ascertain an inter-rater check. They used the checklist to score papers independently, any discrepancies that were found between the researcher and the inter-rater were then discussed, until a decision for the score could be agreed upon.

Data Synthesis

Data were analysed following thematic synthesis to allow identification of themes within the literature. Themes were synthesised to go beyond the content of the original studies and create analytical themes to help further develop concepts, understandings and hypotheses from the original study's reports (Thomas & Harden., 2008). Thematic synthesis permits the primary themes to be translated, as well as explore similarities and differences that exist within the original studies (Noblit & Hare., 1988).

Thematic synthesis follows three stages, as recommended by Thomas and Harden (2008):

1. Coding text from the studies, including quotes, themes discovered and the study's results section.
2. Developing descriptive themes by grouping codes into a hierarchy, with new codes being developed to capture the meaning of the code's groups.
3. Generating analytical themes by using the descriptive themes to answer the review questions and consider how these relate to one another in terms of barriers to help-seeking.

RESULTS

Characteristics of Included Studies

The included studies explored the experiences of men's access to MHS, the provision of care for men with MHD or men's recognition of MHD. Studies were conducted across four countries: England, Australia, Canada and the USA. Most studies utilised semi-structured interviews (N=5), some combined this with group observations and questionnaires; the remaining studies used focus groups (N=2) and open-ended surveys (N=1). Some of these studies were mixed gender, with only the

data from male participants included within this review. Two studies employed mixed methodology (Dearden & Mulgrew., 2013; Thom., 1986), with the qualitative data only being included in this review, the remaining studies used only qualitative methodology. Thematic analysis was the predominant analytic approach used (N=7), with the remaining paper using an Interpretative Phenomenological Analysis approach. The MHD that studies were exploring included psychosis (N=2), depression (N=1), ED (N=3), depression and anxiety (N=1) and alcohol dependence (N=1; see Table 1 for a detailed summary of studies' characteristics and findings).

Table 1. *Main characteristics of the included studies.*

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
Cramer, Horwood, Payne, Araya, Lester & Salisbury (2014) England	Investigate the availability of groups for depression and anxiety. Explore men's experiences and perceptions of support.	Group observations and semi-structured interviews.	Group observations- men attending groups for depression, anxiety or anger management. Interviews- men who accessed a group for depression or anxiety (n=17), and group facilitators (n=12, 6 of whom suffered from MHD).	Thematic analysis.	Difficulty accessing support due to pride and embarrassment, having to help themselves, the influence of masculine ideals on being able to talk openly. "Isolation and the social benefit of groups". "The value of groups and strategies for attracting men", "Accessing support and the role of health professionals"	36 (69%)
Dearden & Mulgrew (2013) Australia	Investigate service provision for men with ED, development of difficulties,	Mixed, surveys and open ended survey questionnaires.	Organisations providing treatment to at least one male with an ED (n=15), practitioners providing treatment	Thematic analysis.	Awareness of eating issues in men, the stigma of men with EDs, problems with availability of care, recognition of men with EDs, motivation, perceived	39 (75%)

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
	inhibitors and facilitators to recovery.		to at least one male with an ED (n=10), men with ED within these services (n=5).		usefulness of treatment, and cost and travel implications of care all as barriers.	
Ferrari et al (2015) Canada	Explore gender and its role in pathways to care in individuals with psychosis.	Focus groups.	Recruited from a larger study into ethnicity and care. Focus groups were based on gender and ethnic origin; with one male group for each ethnic origin: African (n=3), Caribbean (n=3) and European (n=7) and a female European group (n=8).	Thematic analysis.	Gender stereotypes influencing disclosure of difficulties and help-seeking, using other coping strategies such as illicit substances, viewed as “more dangerous” when experiencing psychotic symptoms. “The need to be strong and in control” “Physicality and differences in responses between gender”	35 (67%)

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
Räisänen & Hunt (2014) England	Explore how young men recognise ED symptoms, seek help and their experience of initial contact with services.	Semi-structured interviews.	Participants were recruited from a larger study on experiences of living with an ED. Participants were 10 men taken from the larger study's sample.	Thematic analysis.	Help-seeking was a last resort and when problems could not be hidden, fear of not being taken seriously, fear of being a burden, uncertainty as to where or how to seek help. "Accounting for early signs and symptoms", "Recognising the problem", "Routes to help-seeking".	39 (75%)
Robinson, Mountford & Sperlinger (2012) England	Develop an understanding of how men experience living with an ED and their experience of seeking help and receiving	Semi-structured interviews.	Participants were men recruited from an ED service in London (n=8).	Interpretative Phenomenological Analysis.	" <i>Difficulty seeing self as having an ED</i> " with sub-themes "Difficulty admitting ED", "Men with EDs are invisible", "Fear of negative reaction from others if disclose ED", "Difficulty seeing ED as a problem when also a solution", "Links	46 (88%)

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
	treatment.				between ED and discomfort with identity”. “ <i>Experiences of treatment: how important is gender?</i> ” with sub-themes “Importance of feeling understood and cared for by professionals” and “Issue of gender in treatment”	
Rochlen, Paterniti, Epstein, Duberstein, Willeford & Kravitz (2010) USA	Understand the influence of masculine role expectations on recognition of depressive symptoms, reactions to male-type depression and	Focus groups.	Focus groups were based on gender, neighbourhood and income group. This article reported the results from 6 focus groups compromising of men only (n=45). Participants either had a personal and/or	Thematic analysis.	“ <i>Incongruence between male role, depression and treatment</i> ” with sub-themes “Happiness not linked to masculinity” and “Depression dialogue atypical for men”. “ <i>Male-type or masked depression</i> ” with sub-themes “Looking good and remaining in control”, “Covering up depression with	41 (79%)

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
	treatment.		a family history of depression.		substances...”, “Self-mask/refusal to recognise”. “ <i>Reactions to treatment and treatment providers</i> ” with sub-themes “Barriers”, “Preference to solve problems on own”	
Thom (1986) England	Investigate barriers to treatment entry for alcohol dependency.	Interviews-structured questions, questionnaires, checklists and open-ended questions.	Men and women referred to an alcohol clinic (men n=25, women n=25).	Thematic analysis.	Difficulty identifying as an alcoholic, feeling they should control drinking themselves, the impact and embarrassment of going to services and fear of what was to come.	32 (62%)
Wilson, Cruickshank & Lea (2012) Australia	Explore how young rural men, and their families, manage	Semi-structured interviews.	Participants were recruited from a media release and further snowballing. Participants were	Thematic analysis.	“Reluctance to identify as having a mental health problem”, “The barrier of limited vocabulary”, “Unpredictability and social	42 (81%)

Authors (Year) and Country	Aims of the study	Methodology	Participants	Analysis	Key topics and themes	Quality assessment score (maximum= 52)
	emergent MHD and barriers to services		either young rural men or a parent of a young rural man who had experienced emergent psychosis (young men n=3, mothers of young men n= 8, fathers of young men n=2).		discomfort” and “How long is a piece of string?” (describing the loss of hope and profound uncertainty about the future, and how long they could cope)	

Methodological Quality

Of all the included studies only one discussed and recognised the relationship between the researcher, the research and the participants (Robinson et al., 2012), with this criterion receiving the lowest overall score on the quality checklist. Therefore, it must be acknowledged that results from most of the studies, may potentially demonstrate bias regarding their subjectivity, by not considering the role of the researcher in the research process (Cramer et al., 2014; Dearden & Mulgrew., 2013; Ferrari et al., 2016; Räisänen & Hunt., 2014; Rochlen et al., 2010; Thom., 1986; Wilson et al., 2012). Two-thirds of articles included considered bias, by demonstrating to some degree explicit consideration, as to how findings relate to the context participants are in (Dearden & Mulgrew., 2013; Räisänen & Hunt., 2014; Robinson et al., 2012; Rochlen et al., 2010; Wilson et al., 2012).

Whilst most of the studies discussed the study's approval by an ethics committee, there were two that made no reference to this (Dearden & Mulgrew., 2013; Thom., 1986). Although most commented on the study's approval by an ethics board, only two considered the ethical issues surrounding the study and its implications (Dearden & Mulgrew; Ferrari et al., 2016). This is important to ensure results are of a sufficient quality and that research is undertaken in an ethical manner.

Only half of the studies provided a theoretical justification as to why participants were sampled and selected in the method they were (Cramer et al., 2014; Dearden & Mulgrew., 2013; Räisänen & Hunt., 2014; Robinson et al., 2012), making it unclear as to the potential suitability of some participants. Similarly, three

studies failed to explain why participants that were selected for the study were the most appropriate choices (Ferrari et al., 2016; Robinson et al; Rochlen et al., 2010).

These must be considered when interpreting the results of the studies, due to the potential implications they have on the results obtained. No articles were excluded from this systematic review based upon the methodological quality, as none of the studies rated lower than 62%. Given the quality scores achieved, it was judged that the results from the selected papers, when considered together, would be significant in developing a further understanding of the barriers men can face when accessing MHS.

Synthesis of Findings

A synthesis of the data identified three themes and seven subthemes (see Table 2 for the papers relating to each theme).

Table 2. *Themes and subthemes identified through the data synthesis.*

Super-ordinate themes	Subthemes	Papers
1. Society and social identity	What men do/who men are	Cramer et al, 2014; Dearden and Mulgrew, 2013; Ferrari et al, 2016; Räisänen and Hunt, 2014; Robinson et al, 2012; Rochlen et al, 2010; Thom, 1986
	Rejection	Cramer et al, 2014; Dearden and Mulgrew, 2013; Ferrari et al, 2016; Räisänen and Hunt, 2014; Robinson et al, 2012; Rochlen et al, 2010; Thom, 1986; Wilson et al, 2012
	I don't fit, I'm different	Dearden and Mulgrew, 2013; Ferrari et al, 2016; Räisänen and Hunt, 2014; Robinson et al, 2012
2. Perceived gendered rules	Hard to explain	Cramer et al, 2014; Räisänen and Hunt, 2014; Robinson et al, 2012; Rochlen et al, 2010; Thom, 1986; Wilson et al, 2012
	It's not the same for women, they're different	Cramer et al, 2014; Dearden & Mulgrew, 2013; Ferrari et al, 2016; Robinson et al, 2012
3. Responsibility	Burden	Cramer et al, 2014; Räisänen and Hunt, 2014;
	Trying to get by	Cramer et al, 2014; Dearden and Mulgrew, 2013; Ferrari et al, 2016; Räisänen and Hunt, 2014; Robinson et al, 2012; Rochlen et al, 2010; Thom, 1986

The emergent themes reflect the difficulties and barriers men described experiencing, regarding accessing MHS and the factors that contributed to this.

1. Super-ordinate Theme: Society and Social Identity

All the articles recognised how fear of social rejection, the taboo and shame associated with MHD made it difficult for men to access support. Fear of social rejection appeared to be caused by a recognition of the taboo nature of men having difficulties, feeling as though they were different and would be rejected if they asked for support.

Subtheme: What Men Do/Who Men Are

Most studies found that men discussed the role of what it means to be a man, regarding their access to MHS and the difficulties this created. This included an acknowledgement of masculine ideals and what is expected of men and trying to fit these standards and roles.

...he tried to bring me up with his standards and I always tried to live by those standards [] He used to say things like 'anyone can be born male but if you wish to be a man in the true sense of the word you have to be two things: You have to be invincible and indestructible.' (Cramer et al., 2014, p.296)

Masculine role ideals were discussed by the men as something that they had to do, suggesting that these traits are not inherent and must be proven. This need to prove oneself as a male was linked to anxiety in some men, fearing that they may not fit this ideal.

The idea of being a “man” frightens me. “Boy” or “guy” are both fine, but “man” has connotations of big, strong, muscly- things I don’t want to be...

(Dearden & Mulgrew., 2013, p.597)

The degree to which men feel they conform to typical masculine stereotypes, may have an influence on service use and how available support feels. Masculine ideals also appeared to incorporate the idea that weakness was contrary to being a man, that being depressed was part of being weak:

My role (as a man) is to be strong. It’s weak to be depressed and sad and cry. (Rochlen et al., 2010, p.4)

However, interestingly this was not consistent amongst participants:

The definition of what it means to be male doesn’t include necessarily happy. It’s productive, self-reliant, tough, strong, stoic. Happy is not really part of it... (Rochlen et al., 2010, p.5)

This conflict in ideas between participants suggests that whilst there can be stereotypical ideals about masculinity, there may still be subtle differences in how men perceive masculinity. This perception will then affect how these men identify with difficulties, as considering happiness to not be an aspect of what it means to be a man, may result in some men not feeling that a lack of happiness is a problem for them, consequently not wishing to access support services for this.

These concepts of masculinity and what it means to be male are also shared by health care professionals and society, with some describing how men were invisible within MHS, as it was not something that they were considered to struggle with. This invisibility applied to some presenting difficulties more than others, which

meant that health professionals did not recognise their difficulties and would either misdiagnose or not know how to provide support for the men accessing their service.

... 'You haven't got bulimia, you're just depressed' ...I'm probably quite confident in saying that that was probably because you know I was male, you know I didn't live up to the stereotype of being young and female ...

(Räisänen & Hunt., 2014, p.5)

Moreover, men described a lack of literature around men's MHD, as well as a lack of discourse around this in the media, resulting in men feeling as though it was not a difficulty they should be experiencing, which for some led to a feeling of being different.

All the books are directed at women which is even more 'this shouldn't be affecting me. This is not something I should have a problem with.' (Robinson et al., 2012, p.180)

What they see in the papers is young girls trying to get themselves down to size zero. Do you ever read about men trying to do that? I don't...

(Robinson et al., 2012, p.180)

Therefore, it appears that this works in a cyclical process whereby men's difficulties are not accounted for in the literature. This, in turn, informs clinicians' perceptions of difficulties and leads to an invisibility of men within services and society.

This theme also incorporated a sense of accountability men appeared to feel for others, how this could influence their ability to seek help from MHS and what they could discuss around this. For example, Cramer et al (2014) reported one participant

feeling he could not discuss his MHD with his GP, as his life insurance would be invalid if he subsequently committed suicide. This feeling of responsibility in relation to what it meant to be a man, therefore influenced barriers to MHS. This was also affected by cultural constraints as well for certain participants. The example below demonstrates this, discussing the difficulties experienced around the burden of expectations in arranged marriage

My mum and dad are old and the other problem, if anything happened to them my brothers blame me for it. [] If I was to divorce my wife at the beginning it could be a big impact for the rest of my brothers for getting married... [] somebody had to be the oldest son and unfortunately it was me.
(Cramer et al., 2014, p.298)

Subtheme: Rejection

All the studies found that men discussed fears or experiences of rejection as affecting their ability to access MHS. This theme of rejection had multiple facets to it, the first being a fear that services would think they were not ill enough to require help and not be accepted for treatment, for some this was an anticipated fear, whereas for others this stemmed from previous experience.

I had not sought treatment because there is not enough awareness about eating disorders and the different categories, so I never thought I was sick enough to be considered needing treatment... (Dearden & Mulgrew., 2013, p.599)

The GP I went to, back when it was first starting and I was a somewhat healthy weight still dismissed my concerns as 'just stress'. It would seem that if you are willing enough to receive help for you eating issues, then you

mustn't have any. However, a diagnosis would have been useful to accept and come to terms with my eating issues sooner... (Dearden & Mulgrew., 2013, p.598)

Fear of being rejected from services for not being ill enough appeared to link to rejecting and denying their own pain and difficulties to themselves.

It's easier to stay in a state of denial than to have to admit something, because when I admit if I'm depressed I have to take action. (Rochlen et al., 2010, p.6)

I knew at the time that I probably did have some kind of disorder with my eating, because being sick isn't normal. But I'd always discount those kind of things. (Robinson et al., 2012, p.180)

Rejection was also feared from health professionals, friends and family regarding whether their difficulties would be taken seriously. Similarly, the fear of rejection about not being ill enough, relating to this anxiety, was due to both anticipated responses, as well as previous experiences of some men.

I think it's about fifteen years ago since I first went to the doctor. And I had trouble sleeping, I couldn't stop thinking about things...[I] was pretty much fobbed off...[] I had considered chucking myself under a train at one point. (Cramer et al., 2014, p.299)

I didn't say anything. I was dumbfounded, like I couldn't believe a physician would say something like that, because I just thought, you know, if there's nothing physically wrong but something's happening surely that means there's something psychological. And if it's to the extent that I've lost three

stone at this point, you know, shouldn't I be getting referred... basically I walked outside and punched a wall and broke my knuckle because I was so angry... (Räisänen & Hunt., 2014, p.5)

However, some men undertook research around their difficulties and utilised this when seeking support from services, as a way of providing information to health professionals, as with this information they perceived that they would know what to do and not be unsure as to how to proceed.

[I] did a little bit of research, at least if you go in to see him [GP] with a suggestion, he'll push it through. It's very difficult for him at times to come up with an initiative himself because he doesn't... he may not understand the problem then doesn't know where to look. (Robinson et al., 2012, p.180)

Subtheme: I Don't Fit

Half of the studies found that men had a feeling of being different and not fitting into services, with some describing how services were for women and gay men and not for “them” (Dearden & Mulgrew., 2013). This theme also included the feelings of isolation that many men appeared to describe in terms of being the only one struggling with difficulties:

I felt 'I'm the only guy in the world this has happened to' So it can be quite an isolating thought as well and no other guy have had this problem. What's wrong with me? (Robinson et al., 2012, p.180)

I thought I made it up myself...you know, something that only I did...
(Räisänen & Hunt., 2014, p.3)

However, this feeling of being different sometimes also resulted in isolation and they would remove themselves from situations due to feeling different to how they perceived they should:

I took some drastic actions and sailed away... (Cramer et al., 2014, p.296)

Interestingly, whilst this feeling different and isolated appeared to cause some men to remove themselves from their environment, for some this isolation actually enabled help-seeking. However, this may vary depending on whether the men were attending group support services or individual services.

I was struggling at University so I didn't know too many people, so I suppose it was a sort of social aspect...[And] of the [therapeutic] group works well then it adds a social dimension. (Cramer et al., 2014, p.294)

This feeling of being different was also experienced by some men, regarding the need to be diagnosed in order to access support. There was a reluctance to be diagnosed by some of them, which therefore created barriers to care. Although, others found that they did not meet service criteria, despite having difficulties, or services giving more attention to physical problems than psychological; further reinforcing a perception of being different and not fitting the norm, and perhaps exacerbating the narratives of what men do and must be and the difficulties they must face, as discussed earlier in regard to male invisibility within services.

Needing a low BMI to be diagnosed anorexic is like needing to be terminally ill to be diagnosed with cancer. There needs to be an understanding that psychological issues can not be classified with a physical attribute like weight... (Dearden & Mulgrew., 2013, p.598).

2. Super-ordinate Theme: Perceived Gendered Rules

Seven of the articles reviewed commented on themes that fell into this category and alluded to how seeking support from services would be different if they were not a man. This described how men found that talking about difficulties was problematic for them, due to a lack of vocabulary around emotions and it being something that they had never done. Also, reference was made to how this was different for women, and that help seeking dialogue was available to women. This suggests that if these men were not considered male, they would be able to seek support. Moreover, women were described as different in terms of men's ability to speak with them.

Subtheme: Hard to Explain

Most of the articles described how the men found it hard to explain how they were feeling and the difficulties they were experiencing to others. For some, this difficulty in expressing how they felt was due to uncertainty as to what was wrong and not knowing how to describe what they were experiencing to themselves, which therefore made it more difficult to do so with others.

It was pretty tough admitting it to myself, and then admitting it to my parents, I think the rest of it was quite easy after that. (Robinson et al., 2012, p.179)

I don't even know whether I'm depressed or whether I'm just a lazy twat who's feeling sorry for himself [] I can't really explain it to me-self how I feel. [] I don't think it's in our nature to open up. [] ... I don't, you know, wanna tell anybody that I'm having a bit of a concern about anything.

(Cramer et al., 2014, p.298)

Some men described how they found the concept of talking about their difficulties with others confusing, as even talking about themselves or their lives generally is not something that they felt men do naturally, therefore they felt that talking about more personal matters felt even more inappropriate.

Well, it's an unfortunate thing that we as men don't talk about our lives with people. You know, you- you said you work with a guy for 20 years- do you have kids? You know, you don't talk about your life. And so why would you ever talk about depression if you can't talk about your own kids?... (Rochlen et al., 2010, p.4)

This concept was expanded on by others, who described that conversations were to have a purpose and a result of this talking about their feelings would be an unusual experience for them.

We tend to talk about things when there is a clear purpose, not just share experiences. I think that we tend to have a more limited vocabulary when it comes to emotion and so on. (Rochlen et al., 2010, p.4)

Furthermore, this reluctance to talk appeared to be linked to a limited vocabulary that they had developed regarding emotions, adding to the difficulty they experienced when trying to articulate facing difficulties. However, as noted in the above quote, some men could recognise the benefit of talking to others, even if it felt like something that would not come naturally to them.

I definitely think it helps you manage your own mental health, whether it would stop you getting down into a huge depression I don't know but in terms of like just sharing with people on a weekly basis who say aren't

members of your family and aren't close friends and cos it's entirely in confidence I just think that can be you know sort of quite healthy. (Cramer et al., 2014, p.295)

Although, talking was often discussed in terms of talking to others and not family and sometimes not even friends either, but instead in support groups or within a therapy context. Therefore, it appears that whilst talking is something that some men feel is hard to do, there are contexts where they feel they can do this, although it may feel unnatural and hard to articulate, due to a limited vocabulary around emotions and a limited understanding of their difficulties themselves.

Subtheme: It's Not the Same for Women, They're Different

In a few articles, men described feeling that women were different and that things they struggled to talk about may be different if they were female. This theme appeared to include the idea that it is easier for women to cry, feel pain and that they feel more able to do this; as well as acknowledging that this is not how it feels for men.

...sometimes you look at a woman and you think oh I wish I could have a good old ball like they, like women do... (Cramer et al., 2014, p.298)

Oh her and mum talk about it [depression] all the time. [] my sister was actually receiving medication for I think it was a good year before I was [] she spoke to my mother about it, she spoke to her GP, her friends [] I'm completely the polar opposite of my sister [] I didn't want to burden them [friends or family]... (Cramer et al., 2014, p.295)

For the first quote, it appears that this participant envied women, feeling they were allowed to cry and he expressed the wish to be able to do this himself. Moreover, some described how it was also easier to talk to women, as opposed to other men, whilst this was not a view that was shared amongst all participants, there appeared to be a feeling that women were intrinsically different from men and were experienced differently by the men themselves.

...You know, it's easier to talk to a woman. Or I find it easier to talk to a woman and anyway...I wouldn't even go anywhere near it [if it was a male GP] no. (Cramer et al., 2014, p.298)

I would feel most comfortable being treated by a woman, as I feel a lot safer with women emotionally and physically. (Dearden & Mulgrew., 2013, p.602)

Another way in which men described their difference to women was in how others perceived their difficulties and responded. In some accounts from men accessing support for difficulties with psychosis, there was a recognition that women were offered support more readily than men were, as men could be perceived as dangerous as opposed to in need of support

...it's a double standard, but I feel like when guy is flipping out, it's most likely 'Okay, let's do something with him. Let's, you know, let's lock him up' as opposed to, you know. Where with a woman they might be empathetic more to the situation and be like, 'Okay, this sounds like a mental health issue, maybe we'll, maybe we'll do something about it.' ... (Ferrari et al., 2016, p.5)

However, for others, this difference seemed less prominent, with a man with an ED describing how he perceived his difficulties as gender-excluding and in this way, feeling as though the difficulties that he shared with others reduced the differences between the genders.

I think it's pretty much gender-excluding as a disorder. The reasons why you get there are probably slightly different but in the end all roads lead to Rome.

(Robinson et al., 2012, p.182)

3. Super-ordinate Theme: Responsibility

Seven of the articles reviewed contained themes that described a reluctance to seek help or ask for help, which was a barrier to care. This related to the feeling of responsibility that the men had towards regarding their need to be responsible for themselves, and self-sufficiency, as well as perception that they were also responsible for others in their lives. There was a theme of feeling like a burden and therefore not wishing to seek help, as they did not want to be a nuisance to others. Moreover, there was a reluctance to seek help, as men felt there were other ways they could manage their feelings instead. However, for some, the strategies they used to manage their emotions or difficulties were the reason behind their referral into services, so whilst there was a reluctance to lose these behaviours, they also enabled men to receive the support they needed.

Subtheme: Burden

In a few articles, men described feeling as though they were a burden; this included a feeling of wasting others' time and therefore not wanting to seek support. This feeling of being a burden did not appear to be towards a specific group and

seemed to apply to both friends, family and health professionals alike. For some, this was an anticipation of feeling like a burden, whereas for others there were encounters that they referred to, in which they had been made to feel as though they should not have accessed support, this was in turn interpreted as them wasting the time of others.

I didn't want to burden them [friends or family] I didn't want cos you know I don't wanna drag everyone down with my problems so, I don't wanna sit there and be the miserable one. (Cramer et al., 2014, p.295)

I think I've got a bit of a drinking problem...[] all the old crew split up. Mrs, kids, with her. Lost me job. But that was years ago...[The GP] Just told me to pull me socks up basically...So basically yeah, here's the number, if you wanna help yourself, go and help yourself... (Cramer et al., 2014, p.297)

There were also some who felt that when support was provided by others that it was done so out of obligation and not from a place of genuine care and compassion.

Absolute zero, absolute zero [to friends and family around] ...I got family [] I was brought up in a children's home...[family members] certainly wouldn't listen. [] I see a mate now and again [] I even said to my, well kind of an ex-girlfriend, I phone her and that's all I do, I don't see her, 'I can't support you, I can't support myself [] there's nothing there for us to be together' (Cramer et al., 2014, p.295)

These ideas caused some men to feel as though support was available but not necessarily that others wanted to provide this for genuine reasons, with care feeling dehumanising for the men accessing it. Furthermore, there was a fear born out of both anticipation and prior experience that they would be perceived as a burden and that they had wasted others' time. This led to some men describing how they did not need help and that it was unacceptable to ask.

Subtheme: Trying to Get By

Most of the articles reviewed described how men tried to get by on their own, without the support of others, leading them to feel they did not need the help of others. Men described how they attempted to cope on their own, through trying to distract themselves from the difficulties they were experiencing. For some, this was with the use of illicit substances, which whilst masking the problem, did not help overcome the difficulties they were struggling with:

The alcoholism probably kicked in around 18/19 and carried on till...yes about 30/31... []...and realise the, over the years...I hadn't actually combat or even beaten, I haven't beaten depression, I just masked it with alcohol...
(Cramer et al., 2014, p.297)

Whereas, whilst others also used illicit substances, there was a recognition that this avoidance could be achieved in ways that would be deemed more socially appropriate, and therefore perhaps may not be noticed as a way of avoiding difficulty:

I work 60 hours a week. You drink, smoke pot, and get into reading, you know, novel after novel. And all kinds of behaviours to keep the mind away

from it, you know, and I see people, men, do that all the time, especially workaholics... (Rochlen et al., 2010, p.5)

This theme of trying to manage on their own appeared to be linked to keeping up appearances for some, which could be done simply through looking the part physically, so as to not allow others to see that they were struggling.

I'll feel really bad sometimes, and I don't want to shave. And I don't want to do, and it's like, but I do it anyway, 'cause I don't want anybody to know. So I clean up and I shave and I get tight and I go out in the world, and no one knows. (Rochlen et al., 2010, p.5)

However, trying to manage could lead some men to develop problems that then led to them accessing services, causing a conflict of interest with the men wanting to get better. This conflict lay in not wanting to lose the strategies that had helped them for so long as it helped some men avoid stigma they felt they would experience in other parts of their life. Therefore, these were perceived as both damaging and part of their identity, which they did not wish to sacrifice.

It [ED] a significant barrier for everything that I wanted to do or wanted to achieve. Absolutely I knew that it was creating problems at the time. It was just very difficult because you know at the same time you know I can't live without it.... (Räisänen & Hunt., 2014, p.4)

Part of the thing that I really value about being underweight is that it suppresses my sexuality. (Robinson et al., 2012, p.181)

DISCUSSION

Overview of Findings

This review aimed to synthesise the different experiences of barriers to MHS that men described. Studies demonstrated that men experience barriers in a multitude of different forms. The main barriers revealed were “Society and Social Identity”, “Perceived Gendered Rules” and “Responsibility”, with these themes appearing to be interconnected by the concept of identity, which included self-identity, social and gender identity, and therefore arguably masculinity and the men’s perception of this. Further, barriers that were recognised were practical aspects of accessing care, such as price, knowing where to access support and the relationship they had with their GP.

Barriers were also experienced around men’s shame associated with accessing MHS and the influence their perception of male gender has on this process. As the masculinity literature indicates, a fear of perceived vulnerability and a need to be self-reliant (Brooks., 1998; Connell., 1987; Levant, Hirsch, Celetano & Cozza., 1992; Doyle., 1995) appears to impact on men’s ability to seek help from MHS (accounting for the reduced rates of men seen within services and the increased risk-taking behaviour), with the results of this review showing similar experiences for the men who took part. Whilst barriers exist within the services themselves, barriers are also perceived depending upon men’s perception of masculinity, what it means to be male and their gender identity. These societal influences need to be considered in the services offered to men, who are seeking support for MHD. It is important that awareness campaigns reflect on these perceptions, to help men feel more able to access support, without feeling as though their gender identity is

questioned. This review identified commonalities amongst research into barriers to care, suggesting that whilst there are specific barriers that may be faced within specific MHD, that there are common barriers that are perhaps faced by men generally irrespective of the difficulties that they are facing or seeking support for.

Despite the Department of Health (Men's Health Forum., 2008) recommendation that there needs to be a greater understanding of men's MHD and how these may present differently to women's, there still appears to be a lack of this understanding, both within society and health services themselves, from the experiences of the men in these studies. Furthermore, whilst the WHO (n.d.) are advocating for more gender sensitive services, there still appears to be a lack of sensitivity to gender differences regarding MHD, within Primary Care services and those that may refer service users on to specialist services. This suggests that whilst these recommendations are on the agenda for the future of services and their development that perhaps there is still work that needs to be done to help this transition take place.

Limitations

Due to the qualitative approach taken in this review and the synthesis of previous findings, it is imperative to recognise the influence of the author during the analysis of these results (Willig., 2001). Hoffman (1990) recognised the degree to which research findings can be a result of bias due to the author's lens, which therefore needs to be considered, given the subjective nature of qualitative analysis. However, this was alleviated as much as possible through ongoing discussion between the research team, to ensure that a consensus was reached regarding the findings.

Due to few papers reaching the inclusion and exclusion criteria of exploring men's personal accounts of accessing MHS, using a qualitative approach, the review could only synthesise a limited number of papers. Despite this, due to the depth and richness of the data that was collected within qualitative studies, it was not felt that this would affect the depth of the synthesis (NHS Centre for Reviews and Dissemination., 2001).

As discussed earlier the methodological quality of some papers must be considered in the interpretation of the findings from the preliminary studies, given that only one did consider the role of the researcher on the interpretations and findings of the research. Thus, whilst this was considered in the current review, this reflexivity was not present in the original studies themselves, therefore possibly influencing the reliability of the findings of the initial studies and consequently, in turn, this current review.

Regarding the transferability of this synthesis, it is necessary to recognise that all the studies that were reviewed were undertaken in Western countries; hence this synthesis may not be relevant to all cultures. However, similarly these countries will have idiosyncrasies in their cultures as well as the provision of MHS, therefore variation may still be seen within these papers. Similarly, the studies that were included only covered a few different MHD, with three of the eight papers relating to services for ED, thus the results from this synthesis may only be representative of a limited number of difficulties, and may potentially be skewed towards experiences that are related specifically with certain MHD.

Consequently, it may be beneficial for future research to explore the different experiences of men with different MHD, in order to consider whether different

barriers are associated with different difficulties. Furthermore, future studies may consider experiences of barriers to care within different cultures.

Implications for Research and Practice

Whilst there is a growing recognition and awareness around men's MHD within society, there appears to be a lack of literature around men's experiences of accessing MHS, especially regarding barriers that they face. Given that Primary Care services like IAPT have been shown to have lower attendance and completion rates of therapy for men, services need to further explore potential difficulties in the process of help-seeking, to ensure that the best clinical results are seen.

A theme that was uncovered within most studies was that barriers that men may face are part of the system that they are trying to access. Although, there is an increasing recognition that services that use diagnostic criteria and psychiatric labels can be damaging for service users (Hummelvoll, Karlsson & Borg., 2015; Timimi., 2014) these men's experiences illustrate that these diagnostic criteria are still used, and result in men feeling as though they cannot access services as they do not want a diagnosis, but similarly do not fit the full criteria for referral whilst still experiencing distress. Whilst, not fitting full criteria is not gender specific, it is important to consider given the men's describing the perception that MHD were something they should not struggle with, and the difficulty in accessing support from MHS; as not fitting service criteria may be experienced as invalidation of their difficulties and reduce the likelihood of future access to services for those that do seek support.

Therefore, this review highlights the importance of person-centred care within MHS, to ensure that service users feel services are accessible to them and reduce the perception that they cannot refer themselves or be referred to them.

However, the men also described invisibility of men's difficulties as a barrier, quoting the gendered perceptions some health professionals have in regard to certain MHD; consequently, there also needs to be a greater awareness within referral services themselves, to ensure that men's difficulties are recognised, validated and referred on correctly, instead of being misdiagnosed or missed altogether.

Findings also suggest that as many men try to cope through utilising other strategies, such as illicit substance use, there needs to be a greater awareness within services and demonstrated to men that MHD do not fit a specific pattern for everyone. Furthermore, given that some of these men described using substances to help manage their difficulties, this could help inform assessment of service users of drug and alcohol services, as men presenting within these services may have difficulties in other areas as well. Through this increased awareness men may be more able to recognise strategies they use to cope that have become a problem themselves, and therefore feel more able to access services and support for this.

Conclusion

This review amalgamates the experiences reported by men accessing MHS and the barriers that they can face when doing so. Men face barriers both in terms of fears of rejection and social stigma, their perceptions of gender, as well as practical barriers to accessing support. This review has implications for clinical practice, as by recognising difficulties men face when trying to seek support from services, services can better try to alleviate these, therefore, helping men engage better.

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Part Two: Empirical Paper

This Paper is written in the format ready for submission to the journal

Psychology of Men and Masculinity.

See Appendix A for submission guidelines.

Total word count: 8534 (excluding tables, references and appendices)

“MAN DOWN”: A DISCOURSE ANALYSIS OF YOUNG MALE VETERANS’
ACCOUNTS OF ACCESSING MENTAL HEALTH SERVICES.

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ABSTRACT

Background

This study explored the masculine relevant discourses male Army veterans drew on when talking about seeking help from mental health services (MHS) and considered the potential barriers this could create in accessing care. Through developing this understanding, clinical practice can be better informed for working with this population.

Method

Semi-structured interviews were held with five participants, who accessed MHS when they were under 25. Interviews were audio-recorded and transcribed. Data analysis employed a social constructionist approach, using a combination of grounded theory (Charmaz, 1990) and Foucauldian discourse analysis ([FDA] Willig, 2001), as seen within the masculinities literature (Willot and Griffin, 1997).

Results

The men used differing and, at times, conflicting discourses within three themes derived from the data: “Legitimising Actions”; “Cracking On” and “Managing Identities”. They took different positions within each of these, and despite the difficulty that accessing MHS posed, their discourses allowed them to preserve positions within hegemonic discourses of masculinity.

Conclusion

This study found that despite the threat accessing MHS posed to their masculinity, the men recreated hegemonic masculinity discourses (HMD) in their accounts of

accessing services. Results have implications for clinical practice; by recognising the threat that accessing MHS can cause to men's views of their masculinity, services can acknowledge the difficulties these men may have when trying to access and navigate such a system. In understanding their perspective regarding the appropriateness of talking about their difficulties, services can better understand how else these men may communicate their distress and how to respond accordingly.

Keywords: Men, veterans, mental health services, discourse analysis, masculinity.

INTRODUCTION

Gourash (1978) defines help-seeking as communicating information about a problem, with the aim of obtaining support or assistance. However, many do not seek help from MHS due to perceived stigma (Vogel & Wade., 2009). Lorber (1997) suggests that this reluctance towards accessing support is due to the social construction of illness, as it can be considered a weakness, which impacts on people's willingness to access services.

Connell (1995) described different forms of masculinity; hegemonic masculinity (HM) has been associated with risk-taking (Lloyd, Forrest & Davidson., 2001), autonomy, self-reliance and lack of concern for health (de Visser., 2009; Kimmel., 1997); with O'Brien and White (2003) suggesting needing to reinforce masculinity causes increased risk-taking. Statistics from UK health organisations support this: in 2006/2007 13.2% of illicit drug use was seen in men against 6.9% women, with men accounting for 79% of drug misuse deaths (NHS Information Centre for Health and Social Care., 2008); men accounted for 65% of alcohol-related hospital admissions (Health and Social Care Information Centre, Lifestyle Statistics., 2014); 31% of men compared with 24% of women drank more than twice the recommended daily limit (Lifestyle Statistics., 2014). Whilst both sexes have nearly equivalent rates of suicidal ideation, in 2010 men accounted for 75.5% of all suicides (Campaign Against Living Miserably [CALM]., 2012). Considering Lorber's (1997) suggestion that help-seeking behaviour (HSB) is socially constructed, it appears that gender influences HSB constructions, which is supported by research exploring the social constructions of masculinity (Addis & Mahalik., 2003; Courtenay., 2009; Wilkins., 2010).

Connell (1987) describes HM (the dominant discourse of masculinity) as stoicism, being emotionless and invulnerable. Levant, Hirsch, Celetano and Cozza (1992) described male role norms, including: avoidance of femininity; restricted emotionality; pursuit of achievement and status; self-reliance and strength. Doyle (1995) identified; self-reliance; success; anti-femininity and aggression. Brooks (1998) comments that as society teaches men to deny their vulnerability, they become less likely to partake in preventative health behaviours or seek help. Therefore, HM can be a potential help-seeking barrier.

Connell and Messerschmidt (2005) explain the different manifestations of HM can change through time and culture. For instance, the changes in societal perceptions of reactions to war; “shell shock” and “war neuroses” were perceived as ways of escaping the frontline and associated with weakness (Crocq & Crocq., 2000). Recently there has been increased awareness of post-traumatic stress disorder (PTSD), with increased media exposure, and research after the Iraq and Afghanistan wars (Samele., 2013). PTSD is considered a more acceptable diagnosis than “war neuroses”; support services are available specifically for veterans with mental health difficulties (MHD), for example, Combat Stress (Combat Stress., 2015).

Within the military, bravery is central to service; during the First World War, those viewed as cowards, fleeing the battlefield, were later tried and killed by firing squad (Taylor-Whiffen., 2011). However, Madigan (2013) argues bravery and weakness are key to understanding military culture and war. This theme of strength is reiterated in the British Army’s motto “Be the Best” (The British Army., 2015), suggesting soldiers must be successful, with no option of weakness. Research suggests masculine socialisation is more intense within the military (Lorber &

Garcia., 2010), therefore it is important to consider how those from the military access support.

Kapur, While, Blatchlet, Bray and Harrison (2009) found suicide rates in UK Armed Forces veterans were highest for male Army veterans aged under 24. Results showed whilst some accessed MHS, contact was lowest for those at greatest risk, with only 14% of those aged under 24, who later committed suicide, accessing services beforehand. Green, Emslie, O'Neill, Hunt and Walker (2010) aimed to explore the experiences of younger veterans to gain an understanding of emotional distress and constructions of masculinity, though limited participant numbers did not allow this, and inclusion criteria were extended from under 25 to include veterans up to 44. Although statistics exist around access, currently research has not examined discourse, its link to masculinity and the distress experienced by young male veterans.

Woodhead et al (2011) found those leaving the military with shorter service history were more likely to be heavy drinkers, have suicidal thoughts or self-harm. Green et al (2010) suggest for those who enrol as teenagers the transition from civilian to soldier mirrors the transition from boy to man; therefore, being a soldier is central to being a man and may result in difficulty when discharged, as one participant commented: *"training breaks you down and then rebuilds you... that's the way they make soldiers"*. This may influence perceptions of accessing care and whether this is something they feel their role permits, as it may not be in how they are built. Levant and Richmond (2008) found endorsement of traditional male gender role norms, were stronger in younger populations. Therefore, younger veterans may be more at risk, yet also less likely to access support.

Research exploring barriers to HSB for men, within the general population using qualitative methodology, has uncovered themes around stigma and lack of awareness of men's MHD (Dearden & Mulgrew, 2013), perceived gender norms (Rochlen et al, 2010; Ferrari et al, 2016) and using substances to help them cope (Ferrari et al). Therefore, research should explore the perspectives of veterans, to gain an understanding of barriers they may specifically face.

The rationale for this study was to explore the constructions of masculinity young veterans' draw on when accessing MHS, given that young veterans are an at-risk group that do not engage well with MHS. Through using FDA this study would consider the veterans' discourse in relation to institutions of power and the positions that are available to the veterans and thus the actions they feel they can make, to help services better understand this process. It is hoped that in understanding this, MHS can become more accessible to veterans. The research question was:

How do male veterans draw on masculine discourses when accessing or talking about help-seeking?

METHOD

Design

A qualitative study was employed using semi-structured interviews to explore how veterans constructed masculinity regarding accessing MHS.

Sample

A purposive sampling method was employed to create an appropriately homogenous sample. Individuals had to meet inclusion criteria; this was also based

on their clinician's judgement of their suitability, if they were still within services. Seven participants were recruited from NHS veterans' services in the North of England (North East: two; North West: five). Of the participants that agreed to be approached, two did not continue communication with the researcher and were assumed to disengage, so the final sample was five. Inclusion criteria were:

- Male.
- Accessing/have accessed an NHS veterans' service.
- Aged 24 or under when accessing care.
- Army Regular veterans.
- Native English speakers.

Exclusion criteria were:

- Female.
- Army Reserve veterans.

Participants' ages ranged from 22-27 (mean= 24.2) and all identified as White British. Number of service years ranged from 3-5 years (mean= 3.9), all held the rank of Private when leaving (see Table 3, pseudonyms are used for anonymity).

Table 3. *Participants' demographic details.*

Name	Age	Rank	Years of service
Greg	27	Private	5
Jack	25	Private	4
Rhys	24	Private	3
Sam	22	Private	4.5
Thomas	23	Private	3

Ethics

During the study's development interview schedules, consent forms and participant information sheets were reviewed by a group of serving Army personnel (Appendix E: participant information form, Appendix F: consent form, Appendix G: interview schedule). This ensured interview questions and forms were considered appropriate; suggested amendments were made.

This study was reviewed and granted approval by the NHS Research Ethics Committee and NHS Health Research Authority (Appendix H). All data were anonymised, to ensure confidentiality and audio-recordings were deleted once transcriptions were completed. Written consent was gained prior to interviews commencing, and after participants were informed of the study's aim and their right to withdraw.

Data Collection

Data were collected from semi-structured interviews, with an interview schedule guiding the process; however, this was guided by the direction of

participants' speech. Participants were informed that the researcher was interested in hearing their experiences of accessing MHS, how this was managed and things influencing this.

Interviews were audio-recorded and transcribed verbatim and ranged from 27-67 minutes.

Data Analysis

Data analysis used a social constructionist approach, with a combination of grounded theory (Charmaz., 1990) and FDA (Willig., 2001), previously adopted in the masculinities literature (Sloan, Gough & Connor., 2010; Willot & Griffin., 1997; see Appendix I for an example analysis). Grounded theory type thematic analysis, based on the social constructionist version described by Charmaz (1990), derived themes from the data, which were subjected to FDA to consider the discourses used. The “bottom-up” approach of grounded theory allowed the creation of themes from data, to ensure that themes were based within this, before exploring how these were constructed within the discourse using FDA, a “top-down” approach (Willot & Griffin., 1997). This explored the subject positions participants placed themselves in and the practices used, given these subject positions (Willig., 2001). Through combining these analytic methods, the authors hoped to ensure that the discourses that were uncovered within the data were based within the data, and reduce bias. Analysis aimed to understand the process of accessing care, through reflecting upon the institutional and social discourses available for male veterans, regarding accessing MHS, and the subject positions available (Frost et al., 2010).

Given the interpretive nature of qualitative analysis, the primary author reflected on the lens through which data were collected and analysed (Hoffman.,

1990), and the author's epistemology to reduce bias (Willig., 2001; Appendix J: epistemological statement). The primary author utilised a reflective group with colleagues, whilst keeping a reflective journal to help awareness of reactions to the research process, interviews and analysis (Appendix K: reflective statement).

RESULTS

Data analysis revealed three themes, constructed in differing, and at times, contradictory ways; "Legitimising Actions"; "Cracking On" and "Managing Identities". These were explored to uncover the ways they were constructed within the discourse; with emphasis on how masculinity was constructed and negotiated.

"Legitimising Actions"

Within this theme, the men described MHS, within the NHS and Army, as a "system", which was constructed as "prescriptive", stigmatising, unable to recognise distress and therefore not to be trusted. Positioning MHS as a "system" seemed to serve the function of showing its power, positioning the men as powerless. Through describing the "system" in this way, the men legitimised the actions they took and within their discourses they justified their actions and reactions to this "system" based upon how it was perceived to be. In responding to this powerful "system", the men spoke about taking control, despite being "ill" and "weak", to regain autonomy and counter their powerlessness.

The "system[']s" power is demonstrated when some men negotiate their powerlessness by naturalising the situation's inevitability ("*the end of the day you know that's happening*"). Here Jack discusses the "finances" around veterans' support:

“Yeah, well, it’s finances at the end of the day innit, that’s what it’s about...would you be paying £1600 a month for someone who’s ill or would you rather pay £600 a month to... a new soldier what’s been in training... yeah well, obvious- you know... the end of the day you know that’s happening, no one, no matter what er, it’s all about money at the end of the day, but to the people lower it’s about the people, so, yeah... it’s always like that, there’s always cutbacks, and when there’s cuts, you know, people are worse off than us, so yeah” (Jack)

This shared understanding (“*you know that’s happening*”) that “*higher ups*” were “*all about money*” led to veterans distancing themselves, demonstrating their lack of willingness to engage with the “*system*” and therefore taking control. Jack describes how veterans are figures to the “*higher ups*”, their worth having monetary value. Jack explains how it makes financial sense that veteran’s support is limited (“*would you be paying £1600 a month for someone who’s ill or would you rather pay £600 a month to... a new soldier*”); he justifies the lack of resources for veterans, describing how this is rational, following HMD around men’s rationality. The rationality of “*finances*” legitimises Jack’s passivity in not challenging the “*system*”, whilst maintaining his masculinity. This also demonstrates the position of “*just becoming a number*” that other veterans described. Jack presents a naturalised view (“*yeah well, obvious-*”) demonstrating how this is understandable as this belief would be shared by others, and “*ill*” veterans are not financially worthy. Other veterans shared the “*just becoming a number*” discourse, leading to them distancing themselves from the “*system*”, as they perceived it as unable to accommodate them.

In “*just becoming a number*”, they described the “*system*” as untrustworthy and something that can harm you (“*mess me up*”); this mistrust exacerbated reluctance to seek help. Here Thomas discusses his reluctance to seek support after his admission:

...well definitely from the first little stint in the hospital, yeah, I had nothing but negative outlooks on the entire thing, erm didn't really wanna get involved in it because I was afraid it'd mess me up... (Thomas)

Thomas' mistrust and avoidance are legitimised, as he takes control of his health, making the rational decision to avoid making things worse. Within this discourse of mistrust, Thomas describes how the “*system*[‘s]” support is from a position of power and service users are acted upon, and he is passive (“*it'd mess me up*”). Through expressing his desire to avoid services he exercises autonomy, within an all-powerful “*system*”, allowing him to maintain HMD (Sloan, Gough & Conner, 2010).

For those that disengaged, this was due to their mistrust of the “*system*” and belief that others could not understand their difficulties.

I should put the caveat that talking is a very good thing, it's what helped me ultimately I just talked it out and just normalised it in my head, you know 'It did happen, it weren't my fault' ...but...it's hard...overcoming that initial barrier to talk to someone, especially when in your head they don't know what you're actually talking about, you know it's hard to translate that across to someone who doesn't understand cos you know you've seen some nasty stuff or whatever it may be, you've lost mates or blah blah blah and in

*your head these people have never had **that** and 'Fuck 'em they don't know'*

(Greg)

Greg's disclaimer ("*I should put the caveat*") indicates whilst he is aware of "*what [ultimately helps]*" he did not do this within services, as he helped himself, demonstrating his ability to take control. In describing how to talk to someone else, he would need to "*translate*" his experiences, Greg illustrates the barriers he faced when talking to "*someone who doesn't understand*". Soldiers and veterans have a different language, perhaps not one that is shared with civilians. This perceived language barrier legitimises his disengagement, allowing Greg to take a position of control, compared to quitting and being unable to continue with therapy, which could be emasculating.

This mistrust and perception of the "*system*" as unwelcoming, was also because veterans felt that if they sought support, they would be viewed as a "*biff*" (someone who spends lots of time on sick leave) or as "*blagging it*". To legitimise their need for help, some described how they showed their distress physically, enabling them to access support and avoid rejection.

Sam: *'Cos they think you're blagging it that's the problem with 'em... or they'll say "Man up" and that I'm like "What you saying that for?" ...*

Interviewer: *Yeah, so almost like there's nothing to be-*

Sam: *Yeah, yeah-*

Interviewer: *Kind of struggling with?*

Sam: *Yeah, aye. At the first stages yeah.*

Interviewer: *And how long did it take for them to stop saying that maybe, and seeing things that way?*

Sam: (pauses)...er....probably...probably when I was getting in trouble off the police, stuff like that...cos I got arrested on the [month], I drank a full bottle of vodka like before 12 o'clock in the morning and I got arrested at like 1, you know, and that's not a normal time to be drunk you know, that was the first time then, and then 2 weeks later I tried to take an overdose, I took an overdose, an' it didn't have that much of an effect on me, but I tried to, and I was sick and stuff, but that was the time when they actually knew it was bad.

Sam illustrates that along with being accused of “*blagging it*”, his difficulty managing his feelings is seen as feminine (“*Man up*”). Sam continues to describe how only when he was “*getting in trouble off the police*” that others started to recognise his difficulties, questioning whether he was “*blagging it*”. This may be since drinking and involvement with the police aligns better with HMD (Courtenay, 2000); despite Sam’s comment “*that’s not a normal time to be drunk*”. Sam takes control by proving his difficulties are severe enough to receive support from a “*system*” that questions the reality of his difficulties. Sam’s description of his suicide attempt, further demonstrates this perception that suffering must be shown to be acknowledged, proving he is not “*blagging it*” to receive support. Interestingly, Sam comments on how his overdose “*didn’t have that much of an effect on me*”. Stating this, he positions himself as impervious to the consequences of what for many is a final act, thusly perhaps demonstrating his strength and maintaining his masculinity. Sam’s description: “*I was sick and stuff*”, could be interpreted as his reluctance to discuss the experience, providing only functional information and avoiding the emotional aspects around a suicide attempt.

Thomas reflected a similar point, of others thinking he was “*blagging it*”, when discussing his parents’ responses to his difficulties:

...my parents don't really understand, I've, well when I got attacked and er like the 2 weeks after I just got attacked my parents thought I was like putting it on a little bit you know, but they didn't really understand sort of like in denial and then when I went to the hospital with it, it was like, pretty serious after that so they started to support me after they knew this was actually helping me, this is actually real, there was no, no hiding from it anymore from anybody... (Thomas)

Here it is not only the “*system*” questioning if Thomas is “*blagging it*”, this is something his parents also felt. Thomas’ use of minimisers such as “*a little bit*”, perhaps serve to reduce the severity of what he describes, with his parents not believing him, with “*sort of in denial*” attempting to explain why they may think he is “*blagging it*”. Thomas’ use of “*pretty serious*”, after his inpatient admission, appears to reduce the severity of his difficulties, potentially showing how Thomas could have continued to manage. One could argue that, through minimisation Thomas maintains a degree of emotional detachment to what he describes and therefore maintains a greater sense of masculinity, than he would in acknowledging his emotions.

For some, accessing the “*system*” appeared such a difficult concept to consider, due to its stigma, that helpful support could not be viewed as part of the “*system*”. For example, in the discussion below, Greg discusses his attendance at a breakfast club where he meets other veterans:

Interviewer: ... you're not part of [service] anymore but what's it kind of like now, or now that you're accessing support from other services, like the breakfast club that you mentioned-

Greg: That's not really a service it's just a social ent- that's just a thing that I go to, cos like I said for me, sorting myself out was, I had to sort it out myself because I have to do things, it's just the way I work, I have to do it myself and I found people I can talk to, I've got control of my life, I'm now in charge of my own fate sort of thing...

Greg describes the breakfast club as “just a social ent- that's just a thing that I go to”, and in accessing this “thing” he could “sort it out [himself]”. Greg minimises the significance of him accessing this “thing”, in using the word “just” (“it's just a social ent- that's just a thing”). Greg's reluctance to acknowledge this could be a form of support service, is perhaps due to the stigma surrounding MHS and support services, and men that access them. Therefore, by denying this Greg ensures he is not positioned as “ill”, as it's “just a thing”, thus normalising his access. Greg's description of how he was able to “sort it out [himself]” as he “[has] to do things” as “it's just the way I work”, suggests his difficulties are something to be “sorted” and by choosing to access support, from a service of his choosing, he takes an active position and control. In describing “the way I work”, Greg demonstrates an uncritical position, that it is the way things are, downplaying his taking control, and normalising this. Greg's description: “I'm now in charge of my own fate” illustrates he is his own man and demonstrates his autonomy (Sloan et al, 2010), recreating HMD.

Accessing or seeking support could also lead the men to take the position of stigmatised individuals, who were different and misunderstood by the society and their troop. This came from society's perception, that they were responsible for their difficulties, as by joining the Army they had "*put [their] name down for it*" and were expected to struggle with MHD. This stigma resulted in some not wanting to talk about their difficulties or not accessing supports; though not talking resulted in them feeling lost and the situation feeling hopeless:

It's a military thing [stigma] but it's hard to implement [cultural change] because at the same time every squaddie and his dog will fight it tooth and nail cos they don't want to be seen to be making the Army soft as there's a lot of, if you read all the blogs and Facebook groups and everyone is just saying "What the hell?" it's Army 2020, it's not a man's Army anymore, but at the same time that...well some parts I agree with, other parts there are guys killing themselves left, right and centre and there's gotta be a reason why, and I do think there's an attitude within the Army to mental health, it's just stigmatised you can't speak about it, you don't speak about it because "That guy's bloody suicidal so we can't give him a gun then" so they take his gun off him and you know you've just emasculated him in front of all his mates.

(Greg)

Greg describes cultural change within the Army around the stigma of MHD would be "*hard to implement*", as soldiers do not want to "*be seen to making the Army soft*". Greg demonstrates the ideology that soldiers, and the Army by association, must be hard and strong, and by implication suggesting that MHD are neither of these and thus can tarnish the reputation of the Army. Greg demonstrates

the HMD of men having to be strong and invulnerable. In describing how they “*will fight it tooth and nail*” to prove that the Army is not “*soft*”, he illustrates this masculine ideal is not inherent and must be proved through the soldier’s actions. However, Greg goes on to show his acknowledgement of the difficulties others may have, positioning himself as different from these men (“*there are guys killing themselves left, right and centre*”). Greg describes how these difficulties are something that “*you can’t speak about it*” and even if you wanted to “*you don’t speak about it*”, for fear of emasculation, as speaking has consequences (“*“That guy’s bloody suicidal so we can’t give him a gun then” so they take his gun off him and you know you’ve just emasculated him in front of all his mates*”). Interestingly, this contrasts Sam’s description of “*actions speak louder than words*”, where he described how he needed to show his distress to others (“*‘cos I acted on them and they has to do summat*”), suggesting that speaking about distress is unacceptable, yet showing it is not. Greg draws upon masculine discourses of men being combat, masculine-warriors (Dunivin., 1994); as soldiering is viewed as masculine, the removal of one’s weapon emasculates the men and causes them to experience shame.

For others, this perceived stigma from civilians was based on feeling responsible for having difficulties, leading them to find it difficult to access support and becoming aggressive. Rhys describes how he has “*ended up in fights so many times*” defending himself for struggling, further creating a sense of being different from civilians:

“I mean there’s this stigma where it’s more the case of, erm ‘Well you put your name down for it, to do it’, but I mean I’ve ended up in fights so many times because of it, and erm, people say ‘Well you put your name down for it,

you knew what was happening' and I said 'Yeah I did put my name down for it, and yeah I did know what I was going into' but...when you're there and you see some of your best mates get blown up, shot, killed, obviously it does take a toll on you, you know what I mean so, it does, it does effect what's, what's going on..." (Rhys)

“Legitimising Actions” involved the men resisting the “*system*”, due to its perceived power and their lack of choice, resulting in them taking control of their journey. This was done by positioning the “*system*” as untrustworthy and “*prescriptive*”, thus legitimising their reluctance and difficulty to engage with it, due to it rationally being an unwise idea. To resist the “*system*[’s]” power the men took control, either choosing to access services, avoid them or disengage. This was enacted due to feeling powerless and wanting to fight this. This discursive positioning functioned to recreate HM, which positions men as in control, enabling them to maintain their masculinity when this was questioned due to their difficulties, within a context that associates difficulties with “*biff*[s]” and weakness, and therefore could lead to emasculation.

“Cracking On”

Within this theme, men described trying to manage and “*cracking on*”, when accessing services or managing alone, as their difficulties caused them to feel “*ill*” and “*weak*”. This “*cracking on*” and persevering, despite their difficulties, was something that soldiers and veterans did, with the men alternating between positioning themselves as each of these; whilst they described struggling, the pain they felt was generally denied.

This position of illness and weakness was associated with increased risk or suicide attempts, by “*cracking on*” they counter this. Here Thomas describes the difficulty in “*cracking on*”:

Yeah, it's just cracking on [with therapy], it's difficult (laughs) it's the hardest thing I think I've done, but you know it's possible, it's either that or die, and I didn't want to, you know, after 2 failed suicide attempts I didn't want to you know, go back to that. (Thomas)

Thomas describes how “*cracking on*” was a difficult thing for him to do, acknowledging it is the “*hardest thing*”, however he managed to do this (“*it's possible*”). This allows Thomas to demonstrate his strength and ability to persevere, therefore following HMD. Interestingly, Thomas does not deny his vulnerability, acknowledging this is “*difficult*”, contrary to the HM concept of being invulnerable (Connell, 1987). However, Thomas’ laugh after admitting this was “*difficult*”, could demonstrate his uncomfortableness at acknowledging this and appearing vulnerable; therefore, in stating “*it's possible*” Thomas reaffirms his masculinity by demonstrating his strength in doing this. In describing “*it's either that or die*”, Thomas illustrates that whilst accessing support is difficult he has to “*crack on*” as he has limited options, as he “*didn't want to...go back to that*”. By referencing “*that*” Thomas avoids discussing his suicide attempts and the pain that he experienced, following HMD of being emotionless (Connell, 1987; Levant et al, 1992).

Greg also described an increase in risk when he was “ill”:

Interviewer: Ok, so what kind of helped, I suppose what kind of triggered you to go [access support] was it the kind of the situation or what kind of clicked in your mind?

Greg: ...my mood changes had gone from just low mood to quite aggressive behaviour and I was getting more and more aggressive, you know, I'd started hitting things I shouldn't have, you know, just being quite anti-social with people, so at that point it was 'something's changing here' and like I said, I was starting to feel a lot lower in that sense.” (Greg)

Greg describes how his difficulties progressed from “*just low mood to quite aggressive behaviour*”, by using the minimiser “*just*” Greg reduces the impact of his “*low mood*” and denies the emotion he was experiencing, therefore showing restricted emotionality and following masculine discourses (Connell, 1987). As Greg became “*more and more aggressive*”, his difficulties are here positioned as actions that are associated with HM (Doyle, 1995; Levant et al, 1992), thus are easier to communicate, as there is a reduction in his emotions (“*just low mood*”) and increased physicality (“*more and more aggressive*”). Greg acknowledges it was when his aggression increased that “*something's changing here*” and he could seek support, suggesting this is as a legitimate difficulty, compared to “*low mood*”. Furthermore, Greg's willingness to seek support when he has become a potential risk to others, fits with HMD of being responsible for others (Emslie, Ridge, Ziebland & Hunt, 2006).

Sometimes the men could “*crack on*” when positioned as “*weak*” and “*ill*”, whereas for others it led to feelings of incapability and stigmatising themselves, as they could not get better:

Yeah [being a man makes it harder], ‘cos I thought ‘This is me being weak’ you know, ‘I’m better than this, I should try and rise from this’ and erm, every time I tried to rise fr- rise to it, you know, the mental health shit just kicked in and I was like ‘I can’t do this’ (Thomas)

Thomas describes how accessing services causes him to feel “*weak*”, leading him to self-stigmatise “[*he’s*] *better than this*” and should be able to “*crack on*”, as is indicated when describing how his difficulties are something that should be “*rise[n] to*”. His perceptions of weakness created barriers to him accessing services, as this would mean being weak and unable to “*crack on*”; thus, creating a dilemma, similar to the limited options he described earlier.

Thomas also reflects on the position of a soldier, and how this had shaped his actions:

...as I started clearing out the unit it was “here, here’s someone who can help ya with your problems when you do leave” so erm, sort of touched into-tapped into that erm and then, well it was embarrassing (laughs), I didn’t want to do it cos erm, like back then, when, like, I think when you’re a young lad, you’re in the Army you know, you’re full of it basically (laughs) you know you’re invincible, the whole world’s your oyster pretty much and you know, you don’t want anything that’s going to make you feel weak and that’s, something like that potentially does make you feel weak, so that’s why I didn’t really wanna go there in the first place but, the condition I was, I

couldn't even see myself, you know what I was doing to people around me so I just carried on going to these sessions and eventually it got a little bit better. (Thomas)

Thomas describes his “*sort of*” access of services, using this minimiser to reduce its significance, and the shame experienced due to its stigma; this is reiterated when he states “*it was embarrassing (laughs)*”. Thomas describes his reluctance to access support (“*I didn't want to do it*”), as he was a soldier and “*full of it*” and “*invincible*”, drawing on masculine discourses around strength and invulnerability (Connell, 1987). In explaining the “*world's your oyster*” and accessing support can “*potentially...make you feel weak*”, it appears that to admit weakness is associated with reduced opportunity, therefore legitimising his reluctance to access support. Despite this, Thomas “*just carried on*” and persevered even though in doing so he could be emasculated; however, as he “*cracks on*” and perseveres in this difficult situation, he maintains his masculinity by showing his strength.

The men described how “*cracking on*” involved the practice of drinking alcohol; this was associated with positions of being ill or a veteran. This was considered how veterans cope and therefore a legitimate way of coping (“*I did this, and a lot of other veterans have done this*”), and is common within military culture (Fear et al, 2007; Iverson et al, 2009), whilst simultaneously conforming to constructions of HM (Lemle & Mishkind, 1989).

..., I didn't manage it (others not understanding), 'cos I was drinking... I didn't manage it right...It's the only way that I thought, 'cos I weren't getting no support off 'em really... (Sam)

Drinking was sometimes described as how they managed due to it being who they were, and that is how they do things (“*it’s the only way that I thought*”), with this being an inevitable response to their difficulties.

In “Cracking On”, men described how they attempted to persevere despite their difficulties. “*Cracking on*” was a result of the men feeling “*ill*” and “*weak*”, and was associated with positions of being a soldier or a veteran. This discursive positioning functioned to recreate HMD, by allowing participants to deny their pain and speak about how they had persevered, demonstrating their strength and invulnerability.

“*Managing Identities*”

The veterans described the different identities they try to manage and how these were constructed whilst accessing support and experiencing MHD. These different identities seemed to relate to “*who I was*” and who they had become (“*if I was better*”), with seeming to relate to a sense of loss of a previous identity. They were described as separate from “*civvies*”, and “*ill*” people. They described themselves as soldiers, but also someone who was not a soldier, yet had a “*strong squaddie mindset*”, in this identity confusion the men struggled to acclimatise back into civilian life, but also found it difficult to relate to and trust civilians, as they were perceived to be unable to understand them due to their differing backgrounds. Therefore, this theme describes the confusion they had regarding their different identities and managing these in this new context on “*civvy street*”.

Whilst all the men had accessed MHS, interestingly they described themselves as different from “*ill*” people who accessed services. Here Thomas

describes his inpatient admission and the response from “*the lads*” on his return to base:

*...there were some pretty ill people in there and like, civvies... they were really ill, like **really, really** sort of thing and then it's like I thought even I wasn't that bad and then yeah (laughs) but when I got back to my unit like my mates just were like pfft there was a bit of sympathy but that was it, they didn't want to talk to me after that, cos they thought you know I've been to a mental health hospital that's it, I'm mental now basically (laughs)... but the majority of the lads that er were in my troop basically saw me as in like “Man down” that's it, that's me gone now. (Thomas)*

Thomas describes his encounter with “*pretty ill people*”, whilst an inpatient before clarifying that these are “*civvies*”, seeming to serve the function of distancing himself from them on two levels, as they are “*ill*” and “*civvies*” and he is neither from his discursive positioning. This position of not being “*ill*” alters when Thomas returns to his troop and he witnesses “*the lads[']*” response, which contradicts his position of not being “*ill*” (“*I thought even I wasn't that bad*”). Thomas describes recognising he was “*bad*” but not realising it was “*that bad*”, suggesting there are degrees of illness and he did not consider himself as “*bad*” as the “*ill people*”. In using “*just*” when describing “*the lads[']*” response (“*just were like pfft*”) Thomas minimises its significance and importance, thereby denying his emotional response to this rejection. In describing “*that's it, I'm mental now basically*” Thomas implies finality in this position of being “*mental*”, as this position will remain with him, there is no going back. Thomas' finishing words of “*Man down*” draws on military terminology used when a soldier is injured, therefore positioning himself as a soldier

still, despite this rejection from “*the lads*”. In describing his troop’s rejection of him, Thomas demonstrates his transition from one of “*the lads*” to being rejected. Whilst “man down” within the military can describe any form of injury, and the troop can save their comrades or protect them, his closing of the sentence with “*that’s it, that’s me gone now*” suggests that he feels as though he is now lost, that he is “*mental now*” and cannot get back to his troop or return to how things previously were.

Continuing with discourses around “*the lads*”, the men took a position as both one of “*the lads*”, whilst also not being one, and therefore able to reflect on the response “*the lads*” gave:

I think an attitude change from the lads themselves, being able to talk about things cos, as far as I’m aware, you know, young soldiers are one of the highest suicide groups, as far as I’m aware, and I think that’s largely because we’ve been brought up from day one going “Don’t be a fucking fanny about things, man up and get on with it” so that means in your head you go “Well I can’t talk to anyone cos they’ll just call me an absolute fanny, there’s no point and I know what the answer is”... (Greg)

Greg positions himself as separate from “*the lads*”, as he talks about how “*an attitude change*” may be needed, regarding talking about difficulties. Greg positions himself as a knowledgeable outsider (“*as far as I’m aware...young soldiers are one of the highest suicide groups*”), allowing Greg to reflect on “*the lads*” and their difficulties whilst remaining objective. Greg describes how his thoughts around an attitude change are due to the suicide rate, allowing Greg to be concerned and recognise that talking may be beneficial, without being emasculated, as his

reasoning is based on rational thought and statistics. Greg suggests *“the lads”* were not always this way (*“that’s largely because we’ve been brought up”*) and their reluctance to talk is something they have been taught. Interestingly, Greg uses the phrase *“we’ve been brought up”* describing their development in the Army, suggesting they have grown up there. When Greg explains they are *“brought up”* being told *“Don’t be a fucking fanny about things, man up and get on with it”*, he refers to HMD around persevering and self-reliance (*“get on with it”*), as this is something men do, and they are not yet men (*“man up”*); suggesting if they do not *“get on with it”* they will be emasculated. This is reiterated with *“Don’t be a fucking fanny”*, this reference to female genitalia furthers the message they will become feminised if they do not *“get on with it”*. Greg explains, it is therefore rational that they learn not talk about their difficulties, as *“there’s no point and [they] know what the answer is”*.

Rhys gives a similar account:

...because the Army is all well and good in breaking you and making you into a soldier, but they’re not, they’re not willing to help you get back into civilian life... (Rhys)

Like Greg’s description of *“be[ing] brought up”* within the Army, Rhys describes how *“the Army...break[s] you and mak[es] you into a soldier”*. Compared to Greg’s description, which appears more nurturing in its relation to child-rearing terminology, Rhys describes more aggressively (*“break[s] you and mak[es] you”*), where the men are passive, as they are taken apart and rebuilt. Rhys describes how they are taken from being *“civvies”*, broken down and remade into soldiers. Rhys believes *“[the Army are] not willing to help you get back into*

civilian life”, suggesting they are left as soldiers within the wrong context, that when they return to civilian life they are still soldiers. This is reflected in Thomas’ description:

I mean my best mate said something to me, erm, when I was still trying to figure out er how civvy street really worked sort of thing, interaction wise, and erm he said “You know you were a civvy before, you can do it again” and I, I turned around and I said “It’s a little bit different now, because I’ve seen that sort of, side of life and it’s sort of drilled into me, you know, it isn’t really easy to try and adopt a civvy mindset” (Thomas)

In explaining his attempt to “*figure out...civvy street...interaction wise*” Thomas comments on how now he is back on “*civvy street*”, he does not know how to communicate with others, like Greg’s comment on having to “*translate*” to civilians; indicating that Thomas feels he no longer knows the language of “*civvy street*”. Thomas reiterates Greg’s and Rhys’ earlier point on how “*it’s a little bit different now*” as “*it’s sort of drilled into me*”. Thomas illustrates he is no longer a “*civvy*” as being a soldier has been “*drilled into [him]*”; this idea of having it “*drilled into [him]*” is like the aggressive metaphor Rhys used, whereby the men are manipulated and made into soldiers.

Greg reflects that whilst there are different identities taken on within the Army, there can be confusion around these when struggling:

...we’re conflicted people, to say the least, cos we want to be seen as a soldier, but at the same time we struggle as well, cos we’ve got no one to turn to and you know, it’s a pain in the neck, just the way the Army is set up,

because we need to be these steely eyed dealers of death type things, in our heads we're all fat lazy fuckers really, but you know... (Greg)

Greg describes how it can feel conflicting as they “*want to be seen as a soldier*”, suggesting there is a role to play, and ways that soldiers act; however, despite this they “*struggle*”. In describing “*we struggle as well*” Greg suggests soldiers are not thought to struggle and this is contrary to how soldiers are viewed by others. This positioning of being a soldier and not being expected to struggle leads them to feel like “[*they've*] got no one to turn to”. Greg explains it is “*just the way the Army is set up*” inferring this cannot change, and it is inevitable. Greg describes how soldiers “*need to be these steely eyed dealers of death type things*” and how this is contrary to how they would position themselves (“*we're all fat lazy fuckers really*”).

“Managing Identities” describes the men’s attempt to negotiate their different identities and manage these in the context of “*civvy street*”. This was due to feeling they had been built into soldiers and not rebuilt into “*civvies*” before leaving the Army. These different identities meant the men responded in a variety of ways to the situation, as they did not consistently position themselves in one way. These different identities meant the men could still engage in a soldier’s behaviour and maintain their strength, whilst avoiding positioning themselves as “*ill*” and thereby recreating HMD. Interestingly, the men infrequently spoke from the position of a veteran, positioning themselves more as a soldier, possibly demonstrating how ingrained this identity is. This is important to consider if services are offering support to veterans and they do not identify as this population group, as this may make it difficult for veterans to then access these services themselves.

DISCUSSION

Overview of Findings

This study found the main themes in young male veterans' discourse around MHS were "Legitimising Actions"; "Cracking On" and "Managing Identities". The men felt as though they had to legitimise their actions, appearing to do this in response to viewing MHS as an overpowering "*system*", and considered a powerful institute from a FDA perspective. Due to this, the men appeared to not want to, or were reluctant to, be associated with it due to mistrust and feeling they would not be heard. In accessing the "*system*" the men were positioned as "*weak*" or "*ill*", associated with relinquished control and emasculation, given HMD suggesting a need for control and autonomy. From these positions, they responded by taking control and describing how their journey was their decision, to regain autonomy due to feeling powerless. This power struggle appears to stem from the veterans' views around the power held by the "*system*" given the size and prevalence of the institution, this in turn shapes the options available to them regarding their positioning against this "*system*" and therefore the behaviours and actions that were available to them.

"Cracking On" described taking control and persevering, either in services or managing alone. However, the men often felt limited in their options, as they described acknowledging things could get worse and alluded to this potentially becoming more serious and life-threatening. Those that took control by accessing services maintained their masculinity, whilst engaging in something that is contrary to HMD. For instance, describing how they chose to access support and had taken control in doing so, as opposed to talking about their difficulties; they compensate

for a potentially feminine action by demonstrating masculinity in other ways, as previously seen in the literature on masculine capital (de Visser & Smith, 2007; de Visser, Smith & McDonnell, 2009).

“Managing Identities” appeared to influence both above themes, and the men described confusion around their identity, apparently relating to transitions when leaving the Army and accessing MHS. The men took different positions and identities in their discourses and this seemed to create difficulty in understanding how to navigate the “*system*” and “*crack on*”, as they were unsure how to do this depending on their position, as this seemed to alternate.

The men within this study drew on masculine discourses throughout their speech, which was evident in each of the three themes that were uncovered. Although this appeared to be to a greater degree within the “Managing Identities” theme, whereby the men described their different identities and within these recreated masculine discourses in differing ways. This theme seemed to mirror the findings of Green et al (2010) who suggested that for those enrolling in their teenage years that soldier becomes synonymous with man, therefore making it difficult to understand their identity when leaving the Army. The men interviewed drew on masculine discourses in describing both their actions and their identities in the process of accessing MHS, therefore maintaining their masculinity throughout the process of accessing something that is socially constructed as weak and therefore potentially feminine (Lorber, 1997).

Limitations

Due to the small sample size, the results may not be representative of all male veterans accessing MHS; furthermore, these accounts are only from those who

accessed MHS, therefore does not reflect those of veterans who never engaged with services. Moreover, all participants were White British, so results cannot be generalised to other ethnicities. It is also important to consider that information was not collected on why the veterans left the Army; whilst three participants disclosed this was due to medical discharge, this was not necessarily shared amongst the veterans. This is significant as their reason for leaving the Army may influence their readiness for entering civilian life and their experiences of discharge, and therefore potentially their access and journey through MHS. Furthermore, some participants had accessed MHS whilst still within the Army, whereas others accessed services for the first time once they were veterans, which may also have influenced their access of services or the ways in which they perceived MHS.

Implications

Given the mistrust of services veterans may have, services may need to better demonstrate that they are able to understand the language the veterans have for their difficulties. Similar to Walton and Seager's (2015) services need to learn to listen differently to what they are trying to communicate, for example not expecting men to communicate distress and emotional difficulty in a way that is similar to women, when they may not have the same language for this. Furthermore, due to the difficulties the men describe with managing their different identities, it may be beneficial for services to provide greater support during the transition to civilian life.

Given the veterans' descriptions of the community and comradery that they felt they lost when they were no longer in the Army, and finding it difficult to connect with others who have not served it is suggested that community psychology projects may be beneficial for this population; especially during transition when

isolation can be high, combined with the mistrust of MHS and reluctance to engage in talk around difficulties.

Future research into areas such as community psychology and work with veterans may be a helpful avenue to explore, given the results from this study. Furthermore, as this study did not consider the different forms of discharge from the Army it may be helpful to investigate potential differences that may be seen in veterans who leave the Army through different means. Finally, as these results demonstrate how veterans construct their masculinity when accessing MHS, future research exploring this within the general population may be beneficial to consider different ways that this process may be experienced and the different ways men may construct their gender identity around this.

Conclusions

This study found that despite the threat that accessing MHS posed to their masculinity, the men recreated HMD in their accounts of accessing services by drawing on HMD in describing both their actions and identities within MHS. Results have implications for clinical practice, as in recognising the threat accessing MHS can cause men's masculinity, services can accommodate for difficulties they may have when accessing support. In understanding their thoughts regarding the appropriateness of talking about their difficulties, services can better understand how these men may communicate their distress and respond to this accordingly.

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Part Three: Appendices

APPENDIX A: GUIDELINES FOR SUBMISSION TO PSYCHOLOGY OF MEN AND MASCULINITY

Prior to submission, please carefully read and follow the submission guidelines detailed below. Manuscripts that do not conform to the submission guidelines may be returned without review.

Submission

Submit manuscripts electronically (.rtf or .doc file) through the [Manuscript Submission Portal](#).



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If Microsoft Word Track Changes was used in preparing the manuscript, please execute the "accept all changes" procedure, and remove all comments prior to submission.

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Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. The first page of the manuscript should include only the title of the manuscript and the date it is submitted. Footnotes containing information pertaining to the authors' identity or affiliations should be removed.

Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Please ensure that the final version for production includes a byline and full author note for typesetting.

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Review APA's [Checklist for Manuscript Submission](#) before submitting your article.

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We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

- Go to the Text section of the Insert tab and select Object.
- Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

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Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

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We request that runnable source code be included as supplemental material to the article. For more information, visit [Supplementing Your Article With Online Material](#).

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If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

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All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

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- **Authored Book:**

Kiselica, M.S., Englar-Carlson, M., & Horne, A.M. (Eds.) (2008). *Counseling troubled boys: A guidebook for professionals*. New York: Routledge

- **Chapter in an Edited Book:**

Wong, Y. J. & Horn, A. J. (2016). Enhancing and diversifying research methods in the psychology of men and masculinities. Y. J. Wong & S. R. Wester (Eds.). *APA Handbook of Men and Masculinities* (pp. 231–256). Washington DC: APA.

Figures

Graphics files are welcome if supplied as Tiff or EPS files. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file.

The minimum line weight for line art is 0.5 point for optimal printing.

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Ethical Principles

It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

APA expects authors to adhere to these standards. Specifically, APA expects authors to have their data available throughout the editorial review process and for at least 5 years after the date of publication.

Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

- [Download Certification of Compliance With APA Ethical Principles Form \(PDF, 26KB\)](#)

The APA Ethics Office provides the full [Ethical Principles of Psychologists and Code of Conduct](#) electronically on its website in HTML, PDF, and Word format.

You may also request a copy by [emailing](#) or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

- [Appeals Process for Manuscript Submissions](#)
- [Preparing Auxiliary Files for Production](#)
- [Document Deposit Procedures for APA Journals](#)

APPENDIX B- DATA EXTRACTION FORM

Study Title:

General

Author(s)

Year of publication

Research aims

Participants

Sample size

Demographics of sample

Country

Methodology

Method of data collection

Theoretical approach

Methodological quality
checklist score

**Findings and
Conclusions**

Main findings

Limitations

Generalisability

Conclusions

APPENDIX C- QUALITY ASSESSMENT CHECKLIST DEVISED FROM NICE (2012), CASP (2013) AND MMAT (2011)

Author, Title and Date:		Overall Score			
Theoretical Approach:		Yes/Appropriate	Partly/Partially appropriate	No/Inappropriate	N/A or Irrelevant
Item	Scoring Criteria	2	1	0	
Introduction					
Background	Is there an adequate review of the literature and reference to this?				
Objectives	Is there a clear statement of the aims of the research?				
Method					
Participants	Is there an explanation as to why selected participants were the most appropriate for the study?				
Recruitment	Is the recruitment strategy appropriate to the aims of the research?				
Sampling	Is the sampling and selection of participants for the study theoretically justified?				
Study design	Are the research design and methodology appropriate for the study's rationale?				
	Are the sources of qualitative data relevant to address the research question?				
Data collection	Are data collection methods clearly described?				
	Were the appropriate data collected to address the research question?				
	Was the data collection systematic and rigorous?				
Analysis	Is the process for analysing the data relevant to the research question?				

	Is data analysis sufficiently rigorous?				
	Is the analysis reliable?				
Bias	Has the relationship between researcher and participants been adequately considered?				
	Has appropriate consideration been given to how the findings relate to the context?				
Results					
Findings	Are the results clearly described?				
	Are extracts from the original data included?				
	Are the findings relevant to the aims of the study?				
Discussion					
Key findings	Are findings discussed in relation to the original research question?				
	Is the value of the research to the field of existing knowledge discussed?				
Interpretation	Are there clear links between data, interpretation and conclusions?				
Limitations	Is there adequate discussion of any limitations encountered?				
Ethics	Have ethical issues been taken into consideration?				
	Was the study approved by an ethics committee?				
	Have the consequences of the research been considered?				
Generalisability	Is there consideration of how or whether findings can be generalised to other populations?				

APPENDIX D- SCORES ARTICLES ACHIEVED ON THE QUALITY CHECKLIST

Study	Checklist Item Number																										Total & Percent	
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26		
Cramer et al (2014)	1	2	2	2	2	1	1	2	1	1	2	1	2	0	0	2	2	1	1	2	2	1	0	2	1	2	36 (69%)	
Dearden & Mulgrew (2013)	2	2	2	2	1	2	2	1	2	1	2	2	2	0	1	2	2	2	2	2	2	0	1	0	1	1	39 (75%)	
Ferrari et al (2016)	1	1	0	1	0	2	2	1	2	2	2	2	2	0	0	1	2	2	2	2	2	1	1	1	2	1	2	35 (67%)
Räisänen & Hunt (2014)	2	2	1	2	1	2	2	1	2	2	2	2	2	0	1	2	2	2	1	2	1	1	0	2	1	1	39 (75%)	
Robinson et al (2012)	2	2	0	2	1	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	0	2	1	2	46 (88%)	
Rochlen et al (2010)	2	2	0	1	0	2	2	1	2	2	2	2	2	0	1	2	2	2	2	2	2	2	0	2	2	2	41 (79%)	
Thom (1986)	2	1	1	2	0	2	2	1	2	2	1	1	1	0	1	2	2	2	2	1	2	0	0	0	1	1	32 (62%)	
Wilson et al (2012)	2	2	1	1	0	2	2	2	2	2	2	2	2	0	1	2	2	2	2	2	2	1	0	2	2	2	42 (81%)	
	14	14	7	13	5	15	15	11	15	14	15	14	15	2	7	15	16	15	14	15	14	8	2	12	10	13		

APPENDIX E- PARTICIPANT INFORMATION FORM

Participant Information Sheet

Title of the study: Discourses of Help-Seeking in Army Veterans Accessing Mental Health Services

We would like to invite you to take part in our research study looking into the way army veterans speak about accessing mental health services. Before you decide if you would like to participate in this study, we would like to you to understand what it will involve for you if you decide to participate. The researcher will answer any questions you may have.

Introducing the Researcher:

This study is primarily being done by Dannielle Claridge, a Trainee Clinical Psychologist, under the supervision of Dr Jennie Ormerod, Dr Tim Alexander and Dr Claire Sloan.

I am a Trainee Clinical Psychologist, currently in my 6th year of training, with and an interest in male psychology and the ways in which men seek help from services. I am doing this research into veterans' access of mental health services as part of a doctoral thesis which is needed for my training to qualify as a Clinical Psychologist. I developed an interest in the way veterans access mental health services through researching the area and finding there was not a large amount of research that existed already in this field, which sparked my interest further as it seems to be an area that needs further exploration. I hope that through doing this research I can add to the research pool in this area, and better understand the process of accessing help for veterans. Through this further understanding, it is hoped that services can be better informed on how this process is experienced by veterans to help consider ways this can potentially be improved.



What is the purpose of the study?

This study is looking to understand how army veterans discuss the use of mental health services and how they experience the process of seeking help from these services. We hope that this study will aid our understanding of this process, and help services to consider how to be more accessible to those who are not currently seeking their help and support.

Why have I been invited?

You have been invited to take part in this study as we are hoping to collect information on your thoughts on accessing services and your experiences of this as a young male, who has served as a Regular in the Army

Do I have to take part?

Participation in this study is voluntary, and if you decide to take part you will be asked to sign a consent form to indicate that you agree to do so. You are free to withdraw from this study up to the point where the study results are analysed and written up, and you do not need to provide a reason for this. Your decision to take part in this study or not will not affect your medical care or your legal rights.

What will happen if I decide to take part?

If you agree to take part in this study please leave your contact details with a member of staff, who will then give this information to the main researcher. The main researcher will then contact you after at least 48 hours to arrange a meeting at a convenient place and time, if you have any questions about participating in the study you will be able to ask these over the phone as well.

On the day of your appointment, you will answer some short questions about yourself, for example, your age, your rank on leaving the army, your role within the army and the number of years you served. Then you will have a conversation with the researcher which will last between 60 and 90 minutes. The researcher will be asking you some more questions about your experience of using the outreach service and will audiotape the discussion. There are no right or wrong answers and we are only interested in your opinions, your thoughts and your experiences of using this service.

What are the possible benefits of taking part?

Currently, there is evidence that shows that out of the number of army veterans that may need to seek help from mental health services to help with difficulties they are experiencing, there is a large population that do not do so. Therefore, being able to review these services to consider things to help with their improvement and development if they are to continue into the future is vitally important. It is hoped that taking part in this study will give you the opportunity to think about your experiences of accessing mental health services. Therefore, you may be able to potentially influence how services are structured for other veterans, which could be of benefit to others accessing services in the future.

What are the possible disadvantages and risks of taking part?

Taking part in this study will require between 60 and 90 minutes of your time. Whilst you will not explicitly be asked to recount the circumstances that have led you to access services, or of the experiences you have had whilst serving in the army, some of the topics may cause you experience some distress. If this happens during the conversation the interviewer will offer support and encourage you to speak with your keyworker within the outreach team, or other support services after the interview has finished if you feel this is necessary.

What will happen if I decide I no longer wish to take part?

You are free to withdraw from the study before the results are analysed and the study is written-up without giving a reason. This will not affect your legal rights or the medical care that you receive.

What if there is a problem?

If you have a concern about the study you can contact the researcher (Dannielle Claridge) or their supervisor (Dr Jennie Ormerod) who will do their best to answer your questions. Otherwise, if you have a complaint or query at any point during the study please contact Patient Advice & Liaison Service (PALS) on **01482 303966**.

Will my taking part in this study be kept confidential?

Yes, all the personal information that you provide will be kept strictly confidential. Any information that could be used to identify you will not be used in the research. If you decide to participate you will be given a code to protect your anonymity. During the study, all data will be stored within a locked cabinet in the researcher's office at the University of Hull and will be kept within a locked bag at all times of transportation. After the research is completed all the audio recordings will be destroyed. All personal data will also be destroyed after the completion of the study and will always be held separately to research data to protect data security and confidentiality. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is at risk of serious harm. If this happens during the interview the researcher will need to contact appropriate authorities to ensure that you and other people are safe; however, it is unlikely that this will happen and the researcher will try to discuss this with you. Your keyworker within the Veterans' Service will be informed of your participation in the study, in case you wish to discuss your participation with them at a later date; although they will not be given any further information in regards to what is discussed in the interview, only that you have agreed to participate in the study and the study's aims.

What will happen to the results of the study?

Once the results have been analysed they will then be written-up and submitted for publication in an academic journal. Some direct quotes from your interview may be used in the write-up, however, your personal details and any identifiable data **will not** be included in the write-up.

Who is organising and funding the research?

The research is funded and regulated through the University of Hull as part of a doctoral research project in Clinical Psychology. Some relevant sections of data collected during the study which are relevant to taking part in this research may be looked at by responsible individuals from the University of Hull or from regulatory authorities to ensure that appropriate guidance was followed by the researcher.

Who has reviewed the study?

The study is reviewed by an independent organisation which is called a Research Ethics Committee. The Research Ethics Committee protects the interest of people who participate in research. This study has been reviewed by the Research Ethics Proportionate Review Sub-Committee and has received a favourable opinion.

Further information and contact details

If you have any further questions, comments or queries, please don't hesitate to contact Dannielle Claridge. Thank you for taking the time to read this information.

Yours Sincerely,

Dannielle Claridge
Trainee Clinical Psychologist

Supervised by,

Dr Jennie Ormerod
Consultant Clinical Psychologist

If you are interested to take part in the study please leave your contact details in the space provided below. You will be contacted by the researcher to arrange a meeting at a convenient place and time.

Name:

.....

Address:

.....

.....

.....

Telephone Number:

.....

Mobile Phone Number:

.....

Are there any times of the day that you prefer to be contacted?

.....

Do you have any further comments?

.....

.....

Signature:.....

Date:.....

Thank you very much for your interest!

APPENDIX F- PARTICIPANT CONSENT FORM

CONSENT FORM

Title of Project: Discourses of Help Seeking in Army Veterans Accessing Mental Health Services

Name of Researcher: Dannielle Claridge

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated **19/12/2016 (Version 1.2)** for the above study. I have had the opportunity to consider the information. If I had any questions, they have been answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason up to the point of data analysis and transcription, without my medical care or legal rights being affected.

3. I confirm that direct quotes from the interview may be used in future publications and understand that they will be anonymised. I understand that although names will not be used in the final report, people may be able to identify me by what I have said if I give descriptions of unique situations or events.

4. I agree to my keyworker within the Veterans' Outreach Service being informed of my participation in this study.

5. I agree to take part in this interview study and understand that my interview will be audio taped.

Name of participant

Date

Signature

Name of person taking consent

Date

Signature

When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.

APPENDIX G- INTERVIEW SCHEDULE

Interview Schedule

- What led to your decision to come and seek help?
 - What is it like asking for support?
 - Were there any positive aspects?
 - Were there any negative aspects?
 - How did you work around these?
 - What did you do?
 - If those things weren't in the way, do you think accessing support would be different?
 - What do you think would have to change for that to happen?
 - Either to support services or in the wider community?
 - Were there things that made it easier to seek help?
 - Before you accessed this support service were there other forms of support you sought out?
 - From whom?

- What is it currently like, now that you are accessing this support service?
 - How do you think your experiences may have influenced this?
 - As a veteran, as a man...

- Would this conversation be different if we were having it with other veterans present now?
 - How would it change?

- What does the word masculinity mean to you?
 - Where do you think your ideas about this come from?
 - Have any of your ideas about this influenced your decisions when choosing to access support?

APPENDIX H: DOCUMENTATION OF ETHICAL APPROVAL

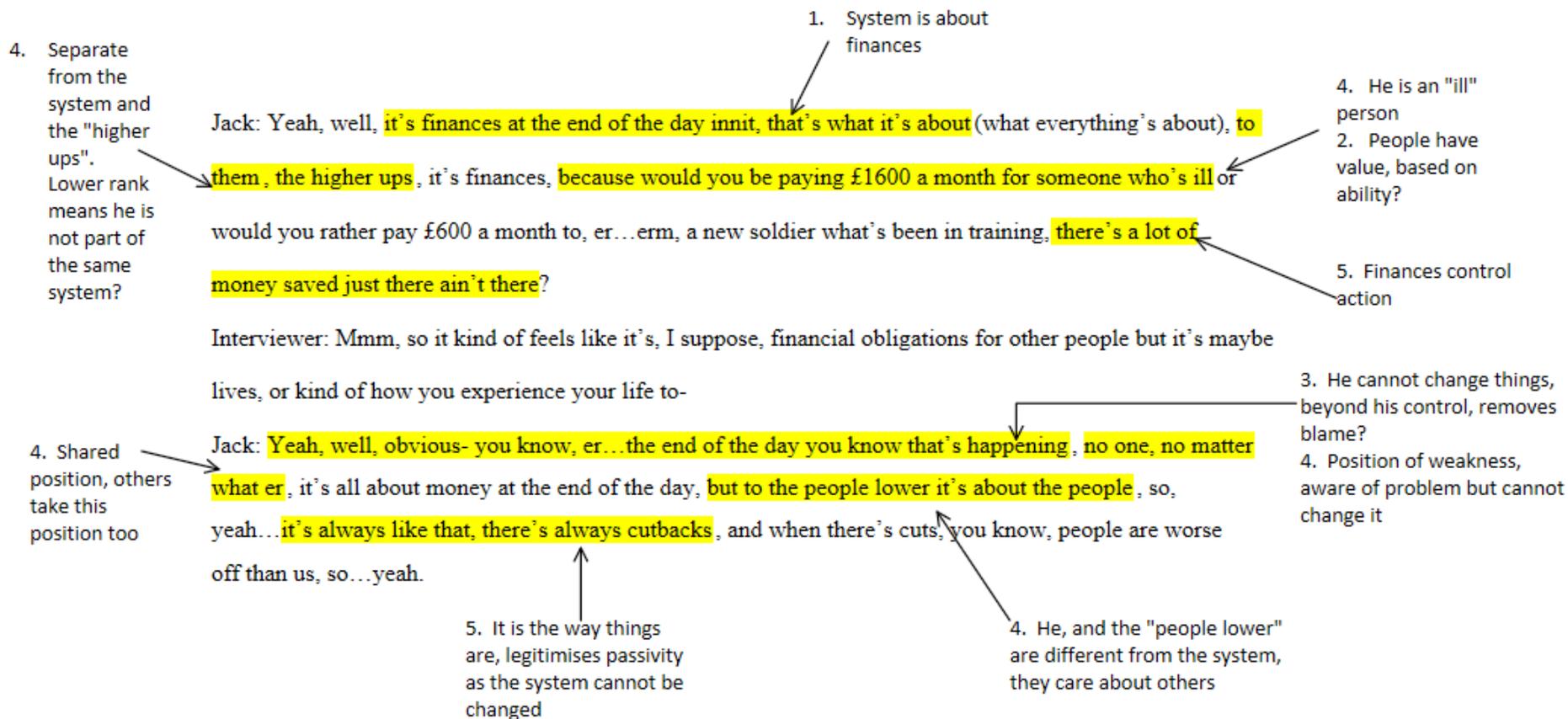
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APPENDIX I- EXAMPLE OF ANALYSIS

The FDA part of the data analysis followed the six stages set out by Willig (2001), these six stages are as follows:

1. Discursive constructions of the object- this involves the identification of how objects are constructed in the text, both implicitly and explicitly
2. Discourses surrounding the object- once various discursive constructions of the object have been identified these are then considered in relation to the wider discourses surrounding the object
3. Action orientation- considers what the subject gains from constructing the object in this way, and what this achieves
4. Subject positioning- considers the subjective position constructing the object in this way provides the subject
5. Practice- considers the relationship between discourse and practice, what does constructing the object in this way permit the subject to do and ways of acting
6. Subjectivity- considers the result of constructing the object in this way, what can be felt, thought and experienced because of this construction

The example provided uses these numbers to indicate the stage that is being considered as well as the information that was interpreted from this.



APPENDIX J- EPISTEMOLOGICAL STATEMENT

Due to the nature of analysis it is important to reflect on the lens through which research is undertaken; Hoffman (1990) describes how it is through our own personal lens that the world is seen and experienced, and that to truly interpret what we see and perceive that one must reflect on one's own lens. This reflection on one's own personal lens and the basis of knowledge are the underpinnings of epistemology and the study of knowledge (Snape & Spencer., 2003). Epistemology is an important concept to consider when undertaking research of any form, especially qualitative, given its interpretative nature (Willig., 2001).

Epistemological perspectives are generally separated into those that are more positivist in nature and those that are interpretivist. Given that this research aimed to consider the experiences of barriers to help-seeking within the review and constructions of masculinity within the empirical paper, this research better aligns itself with that of an interpretivist perspective. In further considering methodology to use for the empirical paper, and perspectives from which to approach this, due to it aiming to explore constructions within language, it was considered to lend itself well to social constructionist perspectives and viewpoints. I feel my research topics themselves were in part influenced and chosen due to my views around social constructionist perspectives, as well as my personal values and perceptions of the world, truth, reality and knowledge.

Social constructionism is based upon the following assumptions: taking a critical stance toward taken-for-granted knowledge; historical and cultural specificity; knowledge is sustained by social processes and knowledge and social action go together (Gergen., 1985). However, this research aimed to also consider

the power dynamics involved in the constructions of masculinity within language. Therefore, as previously utilised within the masculinities literature (Willott & Griffin., 1997), a feminist social constructionist perspective was the basis of the interpretation of this study, as it allowed the researcher to consider the veterans' experiences of their gender constructions, whilst considering the influence of power dynamics on this.

It is important to consider, as previously commented, that my personal lens will have influenced the content of the interviews, the questions I asked within these interviews and the way these were done; reflecting greatly the concepts I had learnt and practiced throughout my training, that conversations are co-created by all those involved. Therefore, I had to remain aware of what I would potentially bring to the encounter, as well as the men that I was interviewing; this formed the basis of my reflections throughout the interviews and the process in full (see reflective statement for a more detailed account on reflexivity). Within the interviews I held I attempted to address the potential for bias by allowing participants to speak and describe things to me, without leading them with questions or avenues of enquiry; similar to how I would when working therapeutically with clients. Thus, I tried to ensure that I was as self-reflective as possible throughout the interviews and the process as a whole, to ensure that my results were as close to the veterans' subjective reality as possible.

References

Gergen, K. J. (1985) The social constructionist movement in modern psychology.

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- Willig, C. (2001). *Introducing qualitative research in psychology: Adventures in theory and method*. Philadelphia, PA: Open University Press.
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APPENDIX K- REFLECTIVE STATEMENT

The Research Topic & Methodology

As a self-proclaimed feminist with a keen interest in gender and how it's enacted in everyday life, when I was initially confronted with the decision of choosing a research topic for my thesis, there was never a question in my mind that it would relate, in some way, to gender. I feel this interest in gender is due to my personal experiences growing up in a single-parent family, with a mother who did not necessarily fit typical gender roles in her occupations, and I feel growing up with a Mum who had a "man's job" was possibly the beginning of my understanding that gender was more complex and less rigid than some perceived it to be. Therefore, exploring this within research and the prospect of a research topic in such an area excited me, as it would provide me with the opportunity to further my interest and understanding in this field.

It was whilst exploring the wonders of TED talks online one day that I came across a fantastic video by Dr Jackson Katz, discussing violence against women. A comment he made in that video resonated with me from that day and led me to query and consider the point that he had made. Katz's comment was that when people speak of gender, this is often perceived as synonymous with women, for example, gender issues are typically women's issues and men are ignored in this situation. There appears to be a degree of blindness within society, where whilst those within the dominant group in any sphere of life have privilege over those that are not, to what degree does this privilege also create a blindness to their existence and become their own curse? Through Katz's discussion, I began to contemplate whether men were perhaps given the short straw in the movement of feminism? For those that

recognise the difference between feminism and misandry this answer is clear- that men and women should be treated equally- but in reality, to what extent are men perhaps suffering too but remain unheard and unseen?

It was from these musings that I began to consider exploring men's mental health and their experiences of this. Through brief ventures into the research and articles that were already in existence, I began to realise the merit of the notion that Katz had suggested; whilst there was an apparent wealth of knowledge and research into women's experiences and mental health, men's experiences seemed almost non-existent. Article upon article commented on the lack of understanding and research into this area and this furthered my interest even more. Whilst there is continually growing support for the feminist movement, gender equality and their increased recognition, there appears to be a bias in the literature; one that is recognised by those in this specific field, yet seemingly appears to still only be beginning to reach the consciousness of the rest of society; with Seidler (2006, p.51) accurately commenting:

“We too easily assume that if men are powerful then they cannot suffer...”

Whilst it was apparent from the initial phases of this project that this study lends itself well to qualitative research, given its social constructionist stance, I recall feeling uncomfortable and resistant to this during the beginning of the process. My recollections of undergraduate psychology and research methods brought with them the concept that qualitative research was in a way sub-standard and inferior to quantitative methodology; as though it held more “truth”. This feeling of being torn between the two methods remained, and in the initial stages of development, I contemplated doing mixed methods in an attempt to find comfort and familiarity in

quantitative work, which had prevailed in my studies at undergraduate level, as well as the research I had previously assisted in. It was through mindful consideration of what this research meant to me, to others, and the participants themselves that I realised my reluctance to immerse myself in something so different to what I had previously known, would be a disservice to us all and with that I cast aside all thoughts about mixed methodology. Enough statistics already existed on men and their difficulties, the number that did or did not attend services, and the number that unfortunately struggled so much that they committed suicide, yet very little existed about their experience of accessing services and experiences within services. Their story and views around this did not exist to the same extent, they had little to no voice. Much of the literature that I had read over spoke about how masculinity needed to be “rediscovered”, as though it was toxic and had resulted in the difficulties that some men were facing in their lives; yet there was very little on how these men enacted the role of “being a man” in the face of a society that typically expects them to be stoic and unmoved by their environment, in a service that expects them to share their feelings and emotions. It was during this process that I recalled another point that had been made by Katz in his presentation, a point that has been repeated by others such as Dr Vikki Reynolds, the importance of being an ally. Although there are separate and vastly different issues that face women in society, as a woman I have an outsider perspective of masculinity and the construction of maleness. I have the privilege of a different perspective. This enthused me further, I felt I had a duty to recognise this difference whilst helping others’ voices to be found and heard, as well as creating a discussion around things that some men may struggle with; to utilise the different perspective that I am privileged to have.

Recruitment

In the whole research process, I feel recruitment was the hardest for me to persevere with and my enthusiasm towards the project did drop at times, which was a difficult process to manage given how important it had felt to me in the earlier stages and again towards the end of the project. I feel it was around this time that I started to lose sight of what it was that I was trying to do and the difference I hoped to make, which I feel was potentially exacerbated by personal circumstances that were happening in my life at the time as well.

After potential participants had been looked up by clinicians in the Veterans' service and the numbers were modest at best, I started to worry this was not going to progress as I had hoped and that my fear that this hard to reach group would be inaccessible to me was going to become a reality. Potential participants were contacted and it was around this time that the process of gaining approval to recruit from another service began, in hopes that it would have a larger participant pool available.

As this progressed and approval was received and participants from the second service began to come forward, the anxiety started to reduce and with it, my interest and passion for this field re-ignited at the anticipation of finally beginning interviews. It is only through reflection with my supervisor about our reactions to this, that I realised how true to the previous literature this experience was. The participant pools were much smaller than the organisations had imagined they would have been for the inclusion criteria that I had set, illustrating very clearly that this was a population that did not seek support, or very few of them did.

The Interview Process

In the interviews, I recall feeling very aware of the fact that I felt so much younger than all the men that I was interviewing, even though I was not younger than some of them; feeling naïve compared to them. As well as this, there was nervousness as to how they would perceive me and whether they would be able to speak with me, given that most of them had disengaged from services and I myself worked for such services. I also felt rather confused as to my role within the research during these interviews at times, given that I felt I was a Trainee Clinical Psychologist, yet I was not here in that capacity and confusion around “who I was” when I was interviewing these men as “researcher” was not an identity I was as familiar with. Interestingly, it seems this is a parallel to what the veterans described in their interviews.

However, amongst all this I feel this is the time I felt most inspired by the whole process, as I was seeing and speaking with the people it was all about, hearing their stories and getting to know their views; proving to me that this is why I had indeed chosen qualitative approaches for my work, as I was able to perceive something that numbers do not give you, the participants’ personalities and a glimpse of their lives. It was through these interviews that I could not help but recognise the difficulties these men had faced and some were still facing, and feel moved by these, hoping that perhaps my research could be the start of something that maybe things could change. I recall after my first interview I spoke with an elderly veteran that worked at the centre that I met my participant at, and we were discussing my research and the importance of support for all veterans when he said: “*Yeah, because they don’t look like they’re broken*”. It was at that moment I started to

wonder to what degree was this something that the veterans felt themselves, and whether this was a shared secret amongst them, that people could not see that they were broken, and how this concept of being broken affected this whole process for them, which I feel interestingly is reflected within the discourses I discovered around proving their difficulties.

I was also extremely aware during the interviews that I was a female speaking with men about their masculinity and how they accessed support. I wondered if at times this was a strength and enabled the conversation, as I could be perceived as less of a threat to their masculinity, given my position as feminine and therefore being unable to compete with them in terms of masculinity, despite how anti-masculine they felt they appeared to be; which could result in them being more open and honest with me. However, at other times I wondered whether perhaps this was a barrier to both the conversations, and perhaps also my interpretation and questioning; as I could only analyse and query from a female's perspective, with no lived experience of the gender difficulties that men experience, as those that I experience as a female are different to these.

Data Analysis

Data analysis was a tentative process for me at first, and I recall worry around "doing it", feeling very out of place with qualitative research given my lack of previous experience with it and doubt was a common friend throughout the process. However, this said re-reading the transcripts over and over again, it brought back the men in my mind, their voices, intonation and character in their words, they had believed in this project and I was doing this for them, as well as all the other men this may affect. It was this that helped in the moments of fear and dread around

getting back to the data, where I feared that I was not “getting it right”. Whilst, cognitively I knew there was not so much a right or wrong way of analysing the data, due to my influence over the data because of my personal lens, I wanted to ensure that I was true to the men, and find the right words to explain the journeys; I wanted to do them justice.

Once I started finding themes in the transcripts and in the process of working the themes, I felt like the study was coming together, and more importantly, I could be creative in this process and reflect on what they were describing and talking about. As the discourse analysis aspect began at times I felt it harder to grasp and thoughts of “getting it right” started to resurface again at times, but I had moved with this process and through a lot of reassurance from supervisors, I managed to persevere and keep these thoughts at bay as best as possible. As I moved into the write-up phase of the study it felt as though the discourses began to make even more sense and I could see how things were woven together and related to one another.

Systematic Literature Review

Whilst within the final stages of my systematic literature review I felt very connected to the research and enjoyed the process of writing it up and exploring the themes from the previous literature, this was not the experience of the entire project. Unfortunately, I found that I developed much of an opposite relationship to my review, compared to my empirical study at the beginning; not due to perceptions around this form of research but more a feeling that I was unable to be as creative as I would like to with research. This was something I struggled with throughout, trying not to distract myself with my empirical to the detriment of my review paper.

Whilst I enjoyed the some of the more procedural parts of doing the review such as search terms and running the searches themselves, finding motivation for this was much harder than for my empirical. I feel on reflection it was due to a sense of feeling as though I was being limited, and unable to create something of my own, as this was investigating others' work. It was through time and reading through and cutting down the papers to make the final selection that I started to develop a deeper interest in this, like that of the empirical paper; as there was so little out there that fit with what I was looking to review. I had found the male blindness again and the fire inside me started to ignite again, this needed to be done; it might not be creative in the sense that I could create and make something of my own, but I could still tell the story of what had been found and I still had information to share and a duty to this. I grew to become passionate for this too, and learnt to let it share centre-stage with my empirical paper research.

Final Thoughts and Reflections

Setting out on this research journey I knew what I wanted to explore was never going to be any easy task, and would be difficult to execute and it has been with many hurdles and road blocks along the way. However, I knew from the beginning that my research had to be something that fuelled the fire inside me to make a difference and explore an area that meant something to be on a deeper level and I was passionate about; I am proud to say that in writing this, I realise that this project has kept that fire alive, and I am thankful that my supervisors have supported me throughout this in making it a reality.

Looking back, it feels a lot longer than three years ago that I started this process and thinking back to all the changes and alterations, things learnt and

explored, as well as the stress and late nights endured, I feel I have developed as a person because of this. I feel I have discovered so much in this process, about undertaking research, veterans, gender, myself and my values and beliefs. I know that I have much more left to learn throughout my life and career as a Clinical Psychologist, and I am happy to know that I can do this through research further in the future; hearing the stories that others are willing to share with me, so that I can uncover narratives and help develop understanding of these within society and academia alike.

References

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