THE UNIVERSITY OF HULL

Understanding young men's experiences of seeking help for a mental health difficulty.

Being a thesis submitted in partial fulfilment of the requirements for the degree

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Overview

This portfolio thesis includes three parts; a systematic literature review, an empirical study and supporting appendices.

Part one, the systematic literature review, looked at the effectiveness of mental health campaigns at engaging men and analysed the factors that produce effective campaigns. A systematic search of databases resulted in nine studies being identified. A narrative synthesis was then completed along with a methodological assessment of the quality of the articles. The implications for mental health campaigns targeted at men are then explored.

Part two is an empirical piece of research that used a qualitative methodology to explore the experiences of young men that had sought help for a mental health difficulty from primary care services. The theoretical and clinical implications are then discussed with considerations for future research.

Part three is the appendices that support both the systematic literature review and the empirical paper. Included in the appendices is a reflective statement drawing upon experiences from the research process.

Total word count: 29,218 (Including tables, appendices and references)

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Part One: Systematic Literature Review

This paper is written in the format ready for submission to

The Journal of Men's Studies

See Appendix A for submission guidelines.

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A systematic review of the factors that influence the effectiveness of mental health awareness campaigns for men.

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Abstract

This review investigated the factors that influence the effectiveness of mental health campaigns at engaging men in help-seeking. PsycInfo, Cinahl, Medline and Academic Search Premier were used to search for academic articles that reviewed mental health awareness and promotion campaigns, and their impact upon men. The quality of the papers was then assessed using the Mixed Method Appraisal Tool (2011) and a narrative synthesis was completed to summarise the findings. The review aimed to investigate how effective mental health campaigns are at engaging men in seeking help and the factors associated with effective programmes. The four databases were searched between October 2018 and January 2019. In total, nine studies are included in the review.

The findings of the studies were synthesised into themes. The three major themes that impacted on campaign efficacy were; the campaign aims, the campaign approach and identifying a demographic.

There was no conclusive evidence to suggest mental health campaigns significantly change men's beliefs about mental health. Rather, effecting a brief change in awareness may be more achievable.

The research reviewed here indicates that mental health awareness campaigns may not be an effective means of mental health promotion with regards to changing men's beliefs about mental health.

Key Words:

Mental health, awareness, promotion, campaign, men, review

Introduction

Gender disparities in help-seeking for health related difficulties have long been recognised (Addis & Mahalik, 2003). High rates of premature deaths and physical health related issues amongst males in the United Kingdom remains a public health concern (Marmot, 2010). The discrepancy is even greater in mental health, with men being consistently less likely than women to seek help from family, friends and professionals for a mental health related difficulty (Andrews, Issakidis, & Carter, 2001; Smith, Braunack-Mayer & Wittert 2006; Mental Health Foundation, 2016). Understanding the challenges men face in recognising and seeking help for mental health difficulties has been the focus of many research projects. Theorists highlight the idea that engaging in psychological therapy is in direct conflict with traditional masculine characteristics (Rochlen & Hoyer, 2005).

The scope of this difficulty is widely recognised with reports highlighting that men commit suicide at over three times the rate of women in the United Kingdom (Office for National Statistics, 2017). Highly disproportionate rates of substance misuse, violence and under-reporting of depression are also evident amongst men (Curtin, Warner & Hedegaard, 2016). One assumption underpinning this review is that increasing engagement of men with mental health services would be beneficial.

Conversely, from a community psychology perspective it could be that men's increased utilisation of mental health services reinforces the view that they are a necessity for helping to solve individuals' personal difficulties (Smail, 2001). Moreover, from a social constructionist perspective, the view that seeking help is not a male characteristic is one prevalent discourse, but not the only way to understand men's health behaviour (Durrheim, 1997).

Mental Health Promotion Campaigns

As a result of the previous inequalities, the role of health promotion campaigns has become increasingly prominent (Rochlen & Hoyer, 2005). The World Health Organization describes health promotion as a process where individuals are empowered to improve their health by taking control over its determinants (Haddad, 2013). The subsequent rise in mental health awareness campaigns has focused on specific populations or psychological difficulties. Questions have arisen about the effectiveness of these different approaches (Rochlen & Hoyer, 2005).

Initially, some research indicated that campaigns promoting help-seeking in a way congruent with traditionally masculine characteristics may encourage men to overcome their potentially negative perceptions of psychological therapies (Robertson & Fitzgerald, 1992). Other campaigns have attempted to reduce the stigma around mental health, by taking a normalising approach (Seidler et al., 2018).

Numerous large scale public health initiatives have targeted men. Campaigns such as the Real Men Real Depression, (National Institute of Mental Health) (NIMH, 2003) Man Therapy (Beyond Blue, 2013) and In Your Corner, (Time to Change, 2017) have attempted to adjust attitudes towards mental health and promote help-seeking behaviour. These campaigns have focused on engaging men in services in a way that promotes a hegemonic view of masculinity that is consistent with help-seeking (Good et al., 1995). This approach attempts to overcome the gender role conflict (GRC) associated with seeking help. In this context GRC can be defined as a negative psychological state where gender roles have an adverse impact on a person's well-being (O'Neil, Helms, Gable, David, & Wrightsman, 1986).

Some mental health campaigns have focused on a different theoretical approach using non-gendered campaigns to engage men in help-seeking for a mental health difficulty

(Rochlen, Blazina, & Raghunathan, 2002). Furthermore, the effects of such campaigns have compared somewhat favourably to traditional approaches that have solely focused on masculine traits and help-seeking. Yet, despite theoretical advancements in approaches to marketing mental health services, stark gender differences remain (Patrick & Robertson, 2016). Some have questioned the effectiveness of implementing programmes and policies; (Baker, 2015) and whether mental health awareness campaigns are an effective way of engaging men in mental health services.

There are diverse approaches to improving men's attitudes to help-seeking for a mental health difficulty. A host of factors impact men's engagement in health services following a campaign. It is also important to recognise that not all men adhere to traditional masculine discourses regarding help-seeking for a mental health difficulty. Furthermore, assuming that help-seeking is equally difficult for all young men ignores the critical roles that race, social class and culture play in accessing healthcare. The Mental Health Foundation (Lubian et al., 2014) identified that people who are White British are more likely to seek mental health treatment (13.3%) compared to BAME (7%) and black ethnic minority groups (6.2%).

Moreover, mental health campaigns have been criticised for perpetuating a diagnostic view of mental health difficulties, where the problem is situated in the individual, rather than in social injustices, inequalities or relational traumas (Johnstone et al., 2018). Longden and Read (2017) stated that mental health campaigns have often been used to promote mental health literacy, educating the public with the implication being that mental health difficulties are primarily founded in a biogenetic basis.

Yet the facts remains that four in five suicides are carried out by men. Under the age of 35 the most common cause of death is suicide, and 16-24 year olds are less likely than any other age demographic to receive mental health support (Counselling Directory,

2016). Furthermore, in 2018 the House of Commons Library reported that in England around 1 million people entered treatment for a mental health difficulty, with just 35% of those being men. Successfully promoting psychological interventions to men continues to prove a significant challenge of great importance. The purpose of this review is to appraise research that has attempted to engage men in help-seeking for a mental health difficulty and to consider how effective such campaigns have been.

Research Questions:

- How effective are mental health campaigns at engaging men in help-seeking?
- What factors are associated with effective programmes?

Method

Search Strategy

Between October 2018 and January 2019, electronic databases were searched for relevant literature using the EBSCO host service (www.ebscohost.com). Databases included MEDLINE, PsycINFO, Cumulative Index to Nursing and Allied Health Literature (CINAHL) and Academic Search Premier. These databases were utilised to ensure relevant literature published over the last 15 years in applied healthcare was identified. Patterns of suicides have become more prevalent amongst males under the age of 35, which have subsequently been recognised as part of influential policies (Conrad & White, 2010). In response, the World Health Organisation (WHO) (2004) and the Sainsbury Centre for Mental Health (2006) identified mental health and well-being promotion as a key component of public service delivery (2006). Resultantly, mental health promotion campaigns have increased since this time. It was decided that campaigns over the last 15 years would be included in the present review.

Search terms were developed in collaboration with a data search specialist. Initial searches were adapted in order to identify a series of words that would capture the largest amount of relevant literature. Key words from pertinent papers were also scanned. The final search terms were ("public health" or "mental health") N3 (campaign* or market* or promot* or advert*) AND male* man or boy* AND effective* or efficacy or success* or access* or engag* or impact*. Articles that met the inclusion criteria and featured these key terms in the title or abstract were retained. Search limits were applied; papers were only considered if they were published in English and after the year 2004. Reference lists of included articles were reviewed to identify appropriate papers. Grey literature was also reviewed but these papers were excluded on the basis that there was often no analysis of results or consideration of implications.

Selection Criteria

The Assessing the Methodological Quality of Systematic Reviews (AMSTAR) (Shea et al., 2009) tool was used to address potential areas of bias in the development of the review. The AMSTAR tool aims to reduce bias and predicts the likelihood that a systematic literature review will produce impartial results. The 37 item assessment tool provides a structure by which reviews can maintain a level of internal consistency. The implications for this review were that it encouraged a consistent selection criterion, a reflection on the potential effects of biases including publication and researcher bias.

Preliminary searches were broad in order to collate as much relevant literature as possible. It was clear that many papers had focused on physical health campaigns or looked at the effectiveness of mental health interventions. However, fewer focused on the factors that produce effective awareness or promotion campaigns for men's mental health.

Therefore, mental health awareness campaigns that targeted men and women, but were deemed as having sufficient depth of analysis of the effects on males were also included. Sufficient depth was defined as specifically addressing issues with the campaign in relation to males. If a paper reported factors that impacted male engagement within the campaign and addressed this quantitatively or qualitatively then they were considered. Papers that reported results of men's engagement, but did not consider the factors influencing the results were excluded.

The inclusion and exclusion criteria are listed below with their associated rationale:

Table 1. Inclusion Criteria with associated rationale:

Inclusion Criteria	Rationale
Studies with targeted mental health promotion/advertisement/awareness campaigns.	Studies reviewing a mental health campaign may have implications for effectiveness.
Campaigns with male participants across the age range (Adolescence to late adulthood, 14-65).	Campaigns that targeted men of any age - Due to the limited number of studies reviewing a mental health campaign, wide age parameters had to be used.
Studies with a measure or description of effectiveness of a campaign.	Studies considering factors that impacted campaign efficacy to allow for a synthesis of results.
Studies that considered the impact of the campaign specifically upon men.	Studies that reviewed campaigns conducted upon men and women were included when there was a significant enough proportion of the analysis dedicated to how the campaign impacted

	men. This meant that men had to be considered throughout the study and with explicit focus in the analysis and the results.
Studies with Quantitative, Qualitative or Mixed Methods Designs.	Narrative synthesis allows for a range of methodologies to be included and analysed. Qualitative themes are included in the synthesis as well as statistical analysis.
Studies written in the English language.	To allow for analysis given that the researcher only speaks English.

Exclusion Criteria:

Table 2. Exclusion criteria with associated rationale.

Exclusion Criteria	Rationale
Published prior to 2006	Since 2005 there have been a series of notable mental health campaigns (Time to Change, Man's Therapy) and an increase in different approaches.
Intervention studies	The present review focus was on the factors that produce effective campaigns. The goal was not to review mental health interventions (e.g. Psychological Therapies).

|	
Non-mental health related awareness campaigns	The focus of the present review specifically was on mental health help-seeking.
Studies with an insufficient measure of the impact or effectiveness of men from the mental health campaign.	Studies that statistically analysed the impact of their programme upon males but did not have significant consideration of the factors that influenced those results were excluded. Many campaigns included statistics about the impact of the programme upon males, but did not address these findings at length. Many campaigns did not focus on the factors impacting males to males and were therefore excluded e.g. Sampogna, Bakolis, Evans-Lacko, Robinson, Thornicroft & Henderson (2017).

Search Outcome

From the four databases 2,259 papers were identified. Papers not written in English and duplicates were removed leaving 1,576. The titles of these papers were reviewed leaving 54 articles for further analysis. Thirty of these articles were removed on the basis of the exclusion criteria following an abstract analysis. Sixteen articles were removed following a full text analysis. There were 11 articles, three of which were removed due to there not being sufficient information about the effectiveness of the campaign in relation to men (see Appendix B for examples of papers that were excluded following a full text analysis). Another article was found by reviewing the reference lists of the remaining papers (Erentzen, Quinlan & Mar, 2018). Many studies initially included were intervention studies and did not analyse the effectiveness of a mental health promotion campaign (e.g. Kivari, Oliffe, Borgen, & Westwood, 2018; Lee, Roche, Duraisingam, Fischer & Cameron, 2012).

Identified articles were screened by abstract, those that did not meet all of the inclusion criteria, or met one or more of the exclusion criteria were removed. When an abstract analysis was insufficient, the full versions were retrieved and reviewed. Following the abstract analysis the inclusion and exclusion criteria were applied to the remaining journals. There were nine papers in the final sample. See Figure 1 for a diagrammatic representation of the article selection process.

Figure 1: Article selection process.
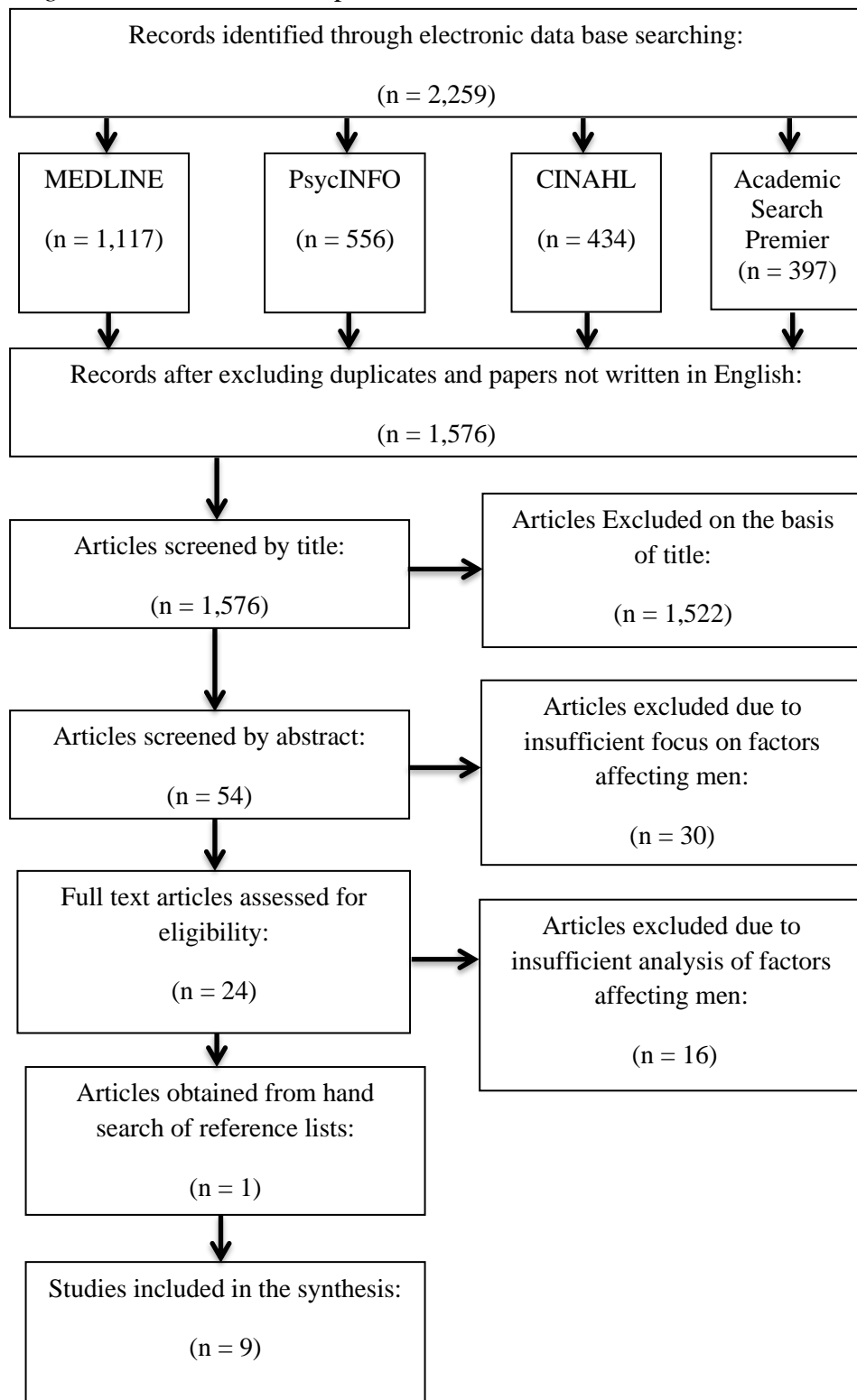
Data Extraction

Data related to factors impacting the effectiveness of campaigns was extracted. Bias was considered here, efforts were made to impartially review the effectiveness of campaigns by using a pre-made data extraction from. Factors resulting in ineffective campaigns were considered and included as part of the data extraction.

The relevant information including the research aims, study design, campaign method, campaign outcome and preliminary conclusions were extracted using a bespoke form (see Appendix C for an example of the form).

Quality Assessment

A quality assessment was completed on the nine articles. Poor or low quality ratings did not result in exclusion from the review; nonetheless, it does provide a measure of the credibility of their findings. Given that the present review includes quantitative, qualitative and mixed method research, the Mixed Methods Appraisal Tool (MMAT) (Pluye et al., 2011) was used to analyse the quality of the nine studies. Questions were added to the MMAT in order to improve the relevance of the quality assessment (Appendix D). The assessment section of quantitative descriptive studies (section 4.4) of the MMAT (2011) includes the question: Is there an acceptable response rate (60% or above)? This question was replaced with: 'is there a statistically significant difference between experimental and control conditions?' Campaigns tended to assess a dependent variable on an experimental condition such as self-referrals into a mental health service pre and post campaign. As a result, this question was deemed more relevant for assessing campaign efficacy as opposed to response rates.

The MMAT (2011) provides a statistical measure of quality for a range of methodological approaches and produces a percentage score that allows for comparison

between studies. Pace, Pluye, Bartlett and Macauley et al. (2011) tested the reliability and efficiency of the MMAT (2011) and found it to be an effective, easy tool to use. Furthermore, Pace et al. (2011) review identified a moderately high inter-rater reliability (76%). When reviewers used the MMAT (2011) the global quality score between reviewers was 0.72 pre discussion and 0.94 post discussion. Due to the MMAT's (2011) utility and reliability, it was considered an appropriate tool to review the four quantitative, four mixed method and one qualitative paper as part of the present review.

To ensure and maintain a high level of reliability for this process, papers were sent to a fellow researcher for an inter-rater check. The MMAT (2011) guidelines recommend that scores are reviewed by another assessor. The researcher identified as an inter-rater and used the MMAT (2011) checklist to independently score three of the eight papers included in this review. The lowest (25%) (Rochlen, McKelley & Pituch, 2006) and highest (100%) (Till, Sonneck, Baldauf, Steiner & Niederkrotenthaler, 2013) rated papers along with one paper of a medium rating (50%) (Livingston, Tugwell, Korf-Uzan & Clanfrone, 2013) were reviewed by the inter-rating researcher. When reviewing both researchers' scores, one discrepancy resulted from the Livingston et al. (2013) paper. The inconsistency was discussed between the researcher and the inter-rater until an agreement was reached. An example of the researcher's ratings and comments are included in the appendices (Appendix E).

The MMAT (2011) provides a score of 0, 25%, 50%, 75% or 100% for each study. All nine studies were adjudged to meet a quality score of at least 25% on the MMAT (2011), meaning that there were elements of the research methodology that would produce some generalizable findings. Methodological quality ranged from 25% to 100%. Rochlen et al. (2006) study was the one study that received a rating of 25%. Two studies had a methodological quality score of 50%, four of the studies were rated as

75% and one received a rating of 100%. A breakdown of the studies scores and a brief summary of their methodological strengths and weaknesses are provided in the appendices (Appendix F).

Data Synthesis

As qualitative, quantitative and mixed methods studies were included in this review, a narrative synthesis was completed to summarise the research findings and report key similarities and differences (Popay et al., 2006). A mixed method approach was selected due to the limited number of studies published in this area. This enables limited research with differing methodologies to be included in one review.

Conclusions can be drawn from a heterogeneous pool of studies that generate implications for future research, in this case mental health campaigns and the factors predicting their effectiveness at engaging men. The main stages of a narrative synthesis include developing an initial theory, then an initial synthesis, exploring the relationships in the data and finally assessing the robustness of the synthesis (Popay et al., 2006). The proposed theory for the present review was that men's increased engagement in mental health services is a pressing health concern, and that awareness campaigns could be an effective means of achieving this.

As part of the synthesis for the present review, key findings were extracted from each study and the factors that impacted on the campaign outcomes were listed. A methodological critique was also conducted in order to analyse the effect this had on campaign results. Themes were extracted from each study and listed. These themes were compared across studies in order to identify the most prevalent determinants impacting campaigns. The groupings were explored during research supervision with the research team in order to minimise bias. A clear methodology to narrative synthesis (Popay et al., 2006) was selected prior to data synthesis, which meant the process was

controlled and reproducible. An example of a completed synthesis form for one of the research papers is presented in (Appendix G).

Results

Campaign approach

Eight of the nine studies reviewed a multimedia or social marketing approach to advertising a campaign (Booth, Britney Jenkyn, Li & Shariff, 2018, Hammer & Vogel, 2010, Erentzen, et al., 2018, Demyan & Anderson, 2012, Robinson, Braybrook & Robertson, 2014, Rochlen et al., 2006, Till et al., 2013, Livingston et al., 2013). Three studies reviewed the effectiveness of social media campaigns, two of which included a famous sports figure in an attempt to reduce mental health stigma. One campaign used billboard advertisements; one used a mass media public announcement video on Television. One used a social marketing strategy, by means of a multimedia and community approach to advertising mental health. Two used brochures or posters amongst a university student population.

Studies also varied in how they measured campaign effectiveness. Studies included four quantitative (Livingston et al., 2013, Hammer & Vogel, 2010, Booth, et al., 2018, and Erentzen et al., 2018, Demyan & Anderson, 2012), four mixed methods (Robinson et al., 2014, Rochlen et al., 2006, Till et al., 2013) and one qualitative (Robertson et al., 2014). Of the eight studies that used a quantitative measure of effectiveness, five used a measure of attitudinal or belief change to analyse campaign efficacy. Some of the commonly used measures included the Intentions to Seek Counselling Inventory (ISCI) (Cash, Begley, McCown & Weise, 1975) and the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) (Surgenor, 1985). Two studies measured the impact of a campaign by analysing surveys of public awareness before and after the release of a campaign (Livingston et al., 2013, Robinson et al., 2014).

Other quantitative approaches used comparative methods to measure the impact of a campaign on help-seeking. Interrupted time series analysis was used to measure the number of outpatient mental health visits, or mental health related calls within a region preceding and following a campaign (Booth, Britney Jenkyn, Li & Shariff, 2018; Till et al., 2013).

Considering the measures used in the various campaigns provides an insight into how campaign effectiveness can be viewed. Four studies made use of twelve different measures. See Appendix H for an overview of the measures used in the included studies (Demyan & Anderson, 2012, Hamer & Vogel, 2010, Rochlen et al., 2006 and Erentzen et al, 2018). Demyan and Anderson (2012) used eight measures as part of their study.

The one qualitative paper looked at the experiences and perspectives of mental health professionals on promoting mental health, making reference to numerous campaigns (Robertson, Gough, Hanna & Raine, et al., 2016). Qualitative data was gathered through interviews that were then transcribed and thematically analysed. In summary, the range of studies included in the present review employed divergent methods to analyse the efficacy of mental health campaigns. This makes for a direct comparison somewhat challenging. Furthermore, measures such as the ISCI (Cash, Begley, McCown & Weise, 1975), the ATSPPH (Surgenor, 1985) and the BSRI (Bem, 1974) used to measure key constructs such as attitudes towards mental health and gender, must be questioned in terms of their present day ecological validity as it is reasonable to assume that attitudes, beliefs and norms have changed significantly since these measures were published.

Research Context

Three of the studies were based in the United States of America, two in Canada, three in the United Kingdom and one in Austria. Given the differing cultures in which these campaigns took place it is important to note how this may impact their analysis and

findings. Help-seeking beliefs and attitudes will invariably differ between these countries, making the direct comparison of results more complex. The number of participants that completed a questionnaire or survey following a campaign varied from 228 (Demyan & Anderson, 2012) to 4,649 (Till et al., 2013). Four studies reviewed campaigns that did not specifically target gender. All nine studies included a review of a campaign to promote mental health. With regards to the included campaigns, two focused on depression (Hammer & Vogel, 2010; Rochlen et al., 2006), three attempted to change attitudes by reducing stigma (Demyan & Anderson, 2012, Livingston et al., 2013; Booth et al., 2018), two were suicide prevention campaigns (Till et al., 2013; Robinson et al., 2014;), and one campaign promoted help-seeking more generally, without focusing on a specific mental health issue (Erentzen et al., 2018).

Table 3. An overview of included studies.

Author(s), Year & Country	Title	Research Aim/Question	Target Population of the campaign	Method	Campaign	Campaign Outcome & Key Factors	Standardised Measures
Booth, Britney, Jenkyn, Li & Sharriff (2018). Canada	Youth Mental Health Services Utilization Rates After a Large-Scale Social Media Campaign; population-Based Interrupted Time Series Analysis		Youth aged 10-24 years of age.	Quantitative: Interrupted time series analysis. Monthly outpatient mental health visits to secondary and primary care services were obtained.	2012 'Bell Let's Talk' campaign – Prominent female athlete that opens up and talks about mental health – promotes social media usage to break down stigma.	Interrupted time series, autoregressive integrated moving average modelling was implemented to evaluate the impact of the campaign on rates of monthly outpatient mental health visits. Males of the same age cohort experienced a monthly increase from 9.7/1000 to 9.8/1000 (slope change of 0.052 following campaign, $P<.001$).	

Demyan & Anderson (2012). United States of America	Effects of a Brief Media Intervention on Expectations, Attitudes, and Intentions of Mental Health Help Seeking	What are the effects of a mass media video intervention on the expectations, attitudes and intentions to seek help from professional mental health care services?	270 participants from undergraduate psychology. 228 Returned to complete the questionnaire. (131 women & 97 men)	Quantitative: 2 x 2 x 2 x 2 between-subjects multivariate analyses of variance (MANOVA) Intentions to seek counselling (ISCI) Attitudes towards seeking professional psychological help scale. Stigma scale for receiving psychological help Thoughts about psychotherapy survey Distress disclosure index	Mass media video intervention. Focus groups were held in order to identify how to best develop a help-seeking message. The video was a 2 minute announcement that went on TV after a health-related public service announcement.	No significant impact of the media campaign intervention upon the belief-based barriers to services. $F(8, 175)$ 0.90, $p = .53$, $n^2 = .04$. The MANOVA, however, yielded a significant main effect for gender, $F(8, 175) = 3.00$, $p = .001$, $n^2 = .14$, and clinically significant distress, $F(8, 175) = 7.18$, $p = .000$, $n^2 = .24$. There was no significant main effect for previous treatment. No significant interaction between the media campaign and attitudes towards help-seeking. Those that were in the	Intentions to Seek Counselling Inventory (ISCI) (Cash, Begley, McCown & Weise, 1975). Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPH) (Fischer & Farina, 1995) Stigma Scale for Receiving Psychological Help (SSRPH) (Komiya et al., 2000) Distress Disclosure Index (DDI) (Kahn & Hessling, 2001) Self-Concealment Scale (SCS)

				Outcome Questionnaire.		media intervention group had significantly greater intentions to seek help for a psychological difficulty compared to the control group.	(Larson & Chastain, 1990) Disclosure Expectations Scale (DES) (Vogel & Wester, 2003) Outcome Questionnaire (OQ-45) (Lambert et al., 2004)
Erentzen, Quinlan & Mar (2018). United Kingdom	Sometimes you need more than a wingman: masculinity, femininity, and the role of humour in men's mental health help-seeking campaigns.	Can humour be used in a mental health campaigns to destigmatise masculinity and promote help-seeking?	Study 1: 222 psychology undergraduates from a Canadian University were recruited (in exchange	Quantitative: Advertisement funniness rating, Message Receipt, Defensive reactance, mental illness stigma, Sex Role Inventory were all measures used following the viewing of the ads.	Public health campaign posters comprising of four advertisements created by the researchers. Funny and Non-Funny conditions.	The level of funniness in the ad was positively correlated with persuasiveness to seek help, without stigmatising mental health issues. Men's femininity was the strongest predictor of positive reactions to help-seeking. The hypothesis that	Day Mental Illness Stigma Scale (Day, Edgren & Eshlemen, 2007) Bem Sex Role Inventory (BSRI) (Bem, 1974)

			for course credit)	Study 2 replication of study 1 with 2 revisions: Study completed in a lab rather than online, Full 28 item Mental Illness Stigma Scale was used rather than a shortened version.		humour would reduce defensive thoughts for those high in masculinity was supported. The overall model was statistically significant, $R^2 = .08$, $F(5,175) = 3.21$, $p = .009$, and a significant condition $\times$ masculinity interaction was observed.	
			Study 2: 234 male undergraduate students				
Hammer & Vogel (2010). United States of America	Men's Help Seeking for Depression: The efficacy of a Male-Sensitive Brochure About Counselling.	How effective is a male sensitive brochure at improving attitudes about seeking counselling and reducing the self-stigma of help-seeking?	Men with depression who had not previously sought help (1,397 – 18 to 69 years).	Quantitative analysis of attitudinal change. Repeated Measures ANOVA of male-sensitive brochure vs RMRD vs. gender neutral campaign. 4,967 men were recruited via Internet and completed a 10 item questionnaire to	Male sensitive brochure with male testimonies and male specific MH stats.	Male sensitive brochure produced significantly more attitudinal improvements than the RMRD brochure $F(1, 871) = 6.7$, $p = .01$, partial $h2 = .008$, but not the GN brochure ($p = .086$) Self-stigma; male sensitive brochure produced significantly	Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Farina, 1995) Self-Stigma of Seeking Help (SSOH) (Vogel et al., 2006) Center of Epidemiological

						greater improvements than the RMRD and GN brochures.	Studies Depression Scale (CES-D) (Radloff, 1977)
Livingston, Tugwell, Korf-Uzan & Clanfrone (2013). Canada	Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues.	Market Penetration and attitudinal changes as a result of the 'In One Voice Campaign'	Young adults (13 to 25 years) Immediately post = 180 2 months Post = 195	Independent Successive Samples Design Quantitative (Cohort Study)	Social Media – 'In One Voice' Using a prominent male sports star. Questionnaire – immediately before and 2 months after the campaign launch. Governmental campaign.	30.2% males remembered the campaign compared to 19.2% of females. Change in awareness of the mindcheck.ca site increased from 7.3% pre to 16.6% post campaign.	Depression Stigma Scale (DSS) Griffiths et al. (2004) adapted for younger people by Calear et al. (2011).
Robertson, Gough, Hanna, Raine, Robinson, Seims & White (2016).	Successful mental health promotion with men: evidence from 'tacit knowledge'	What works in promoting mental health for men – an analysis of the knowledge of mental health professionals?	Mental health professionals working with men (13 professionals)	Qualitative Research Thirteen mental health professionals took part in interviews. Thematic analysis	No reflections on different campaigns and interventions in different cultural settings.	Difficulties men have navigating the healthcare system. Language used needs to identify with men in a way that empowers men	

United Kingdom				was conducted on these interviews.		without reinforcing negative masculine traits. Shoulder to shoulder approach, informal chats as opposed to talking therapies.
Robinson, Braybrook & Robertson (2014). United Kingdom	Influencing public awareness to prevent male suicide.	To evaluate a suicide prevention public awareness campaign – Choose Life, North Lanarkshire.	Homeless, unemployed, isolated, recently bereaved males. Phase 2: 500 participants	Qualitative & Quantitative Methods. Qualitative Interviews with stakeholders alongside a survey. Quantitative Review: Phase 1 = of databases (Samaritans, Breathing Space & A&E admissions). Phase 2 = Survey of	'Choose Life' Reduce suicide by 20% between 2007 and 2013. Increase awareness and encouraging people to seek help early. Social Marketing strategy – Motherwell Football Club, public transport, pubs, pharmacies, libraries etc. Governmental campaign.	40% of male respondents said that the campaign made them more aware of the services they could seek help from. Positive correlation between campaign awareness and level of altered attitude toward help-seeking. 50% recorded no change in attitudes due to campaign.

				public awareness of the campaign 3.5 years post campaign starting.		19% of men said they would now talk to someone thinking about suicide.	
Rochlen, McKelley & Pituch (2006). United States of America	A preliminary examination of the "Real Men. Real Depression" Campaign.	How effective was the National Institutes – Men's Mental Health campaign? What were the most and least helpful elements of the content used in the brochure?	209 male college students from undergraduate educational psychology classes.	Mixed Methods: Demographic Questionnaire GRCS: Gender Role Conflict Scale. ATSPPHS: Attitudes toward Seeking Professional Psychological Help.	Real Mean Real Depression (RMRD) campaign (National Institute for Mental Health, 2003)	Quantitative: Men with low levels of gender conflict and low negative help-seeking attitudes found the campaign more appealing and effective. Qualitative: Helpful – Symptom list, testimonials and quotes, prevalence and contact info, treatment options and contact info. Unhelpful – Vague treatment options,	Gender Role Conflict Scale (GRCS) (O'Neil et al. 1986). Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS) (Fischer & Farina, 1995) Mental Health Ad Effectiveness Scale (MHAES) (Rochlen et al., 2002)

						unconvincing and lacking credibility.
Till, Sonneck, Baldauf, Steiner & Niederkrotenthaler (2013). Austria	Reasons to Love Life – Effects of a Suicide-Awareness Campaign on the Utilization of a Telephone Emergency Line in Austria.	Does the use of a billboard advertisement effect the utilization of an Emergency Telephone Crisis Service Hotline?	Total Men: 20 Control Region: 17 Intervention Region: 3	Mixed Methods: Quantitative: 3 month period of calls measured post introduction of the campaign. Qualitative analysis was not gender specific.	Billboard campaign depicting everyday family scenarios with a focus on promoting family ties and well-being and then promoting the use of the services hotline.	Quantitative: The number of suicide related phone calls to the campaigns phone line increased from 4,439 in the control period to 4,649 (+4.7%) in the intervention period. There was no significant gender-specific change regarding the number of suicide-related phone calls from men between the control and experimental period (p = 1.00)

Methodological quality

Quantitative approaches

Generally, samples were sizeable with seven of the nine studies reviewing large scale campaigns engaging hundreds and in some cases thousands of individuals. However, Demyan and Anderson (2012), Erentzen et al. (2018) and Rochlen et al. (2006) recruited undergraduate and postgraduate psychology students. The attitudes and responses from this demographic to mental health content therefore may not be representative of the general population.

Five of the nine studies solely focused on male samples (Robinson et al., 2014; Hammer & Vogel 2010, Robertson et al., 2016; Rochlen et al., 2006 & Erentzen et al., 2018). Four considered gender in their analysis, but their campaigns were not gender specific. Although there was a stringent inclusion criteria, the extent to which the studies focused on gender does somewhat vary. Inevitably, this variation means that some studies include a more considered and thorough analysis of campaign factors that affected males, compared to those studies where this was considered secondary. Furthermore, Robertson et al. (2016) paper relied on staff perspectives to understand men's preferences, the extent to which these views accurately represents the views of men may be limited.

The included quantitative studies varied in the amount of information disclosed regarding recruitment methods. For most studies, participants were recruited through targeted media campaigns aimed at specific sub-sections of the population. Some researchers recruited from university courses, often psychology students (Demyan & Anderson, 2012; Erentzen et al., 2018; Rochlen et al.,2006).

Four studies measured the effectiveness of campaigns based on the number of visits or calls to mental health services pre and post campaign. Population-Based Interrupted Time Series Analyses were appropriately used in these studies to measure the impact of a campaign on a dependent variable, such as the number of visits to a health service over time. This method allows for a direct comparison of the impact of a dependent variable, in this case, a mental health campaign. However, one factor that significantly influences this methodological approach is the seasonal variations in health service utilisation, which needs to be accounted for. Of the four studies that used a time series analysis, two studies compared variations in the experimental region to a control region in order to account for seasonal changes in health service utilisation. The changes measured in those studies that did not account for seasonal variation is somewhat limited given that this significant methodological limitation was not sufficiently considered (Till et al., 2013; Robinson, et al., 2014).

Qualitative Approaches

Robertson et al. (2016) completed a thematic analysis to identify effective approaches at engaging men in health services following interviews with a series of healthcare professionals. The conclusions that can be drawn from this paper are somewhat limited given that it did not directly seek the perspectives of men engaged in a single campaign; instead anecdotal accounts from mental health staff working on promotion campaigns worldwide were included. Their interviews focused on what they found effective in engaging men in mental health initiatives. This paper added depth to the analysis by including real life accounts of factors that impacted campaigns. Although the contrasting methodological approach used makes it harder for comparisons to be made with other quantitative or mixed methods research, it did allow for triangulation of research findings and a more thorough narrative.

Synthesis of Findings

The aim of this review was to investigate how effective mental health campaigns are at engaging men in help-seeking. The secondary aim of the review was to identify factors that influence the effectiveness of mental health campaigns at engaging men.

In terms of campaign effectiveness eight of the nine studies in the review included a measure of effectiveness. All eight studies included a measure of effectiveness related to awareness and six of these studies were effective in fulfilling their goal of increasing awareness (Booth et al., 2018, Till et al., 2013, Hammer & Vogel, 2010, Erentzen et al., 2018, Robinson et al., 2014 and Livingston et al., 2013). However, of the eight studies that included a measure of effectiveness, four included a measure of effectiveness related to beliefs or attitudes. I.e. the goal of the campaign was to significantly change attitudes regarding mental health. None of these four studies significantly changed attitudes or beliefs regarding mental health (Booth et al., 2018, Erentzen et al., 2018, Till et al., 2013 and Robinson et al., 2014). This importantly highlights that increased awareness of service provision was achievable, but not significant in changing attitudes or beliefs regarding mental health.

With regards to factors that produced effective campaigns the key findings from this review were categorised into three main themes; Campaign aims, Identifying a demographic, and Campaign Approach. Six subthemes were also identified.

Table 4. Major themes and subthemes.

1.Campaign Aims	2.Identifying a Demographic	3.Campaign Approach
a. Increased awareness or Enduring Belief Change	a. Prior Help-Seeking Experience	a. Gender Roles and Masculinity
	b. Target Population	
	c. Campaign Medium and Reach	
	d. Campaign Setting	

Campaign aims

Increased Awareness or Enduring Belief Change

One recurring theme that appeared throughout the studies was that a campaign alone was not sufficient in significantly altering attitudes or beliefs regarding mental health. Temporary changes, for example, in awareness of service provision were observed (Livingston et al., 2013; Demyan & Anderson, 2012; Booth et al., 2012). These findings were confirmed by a range of measures. For example, Livingston et al. (2013) reported that an education and awareness campaign alone was not sufficient in creating substantial, enduring change in attitudes. In the target population campaign awareness significantly increased. As many as 15.6% of respondents were aware of the educational website post campaign compared to 6% prior, but there was no significant change in attitudes or beliefs regarding help-seeking.

An increase in respondents' awareness of a mental health campaign did not significantly impact willingness to seek help or meaningfully influence behavioural change (Livingston et al., 2012). Booth and colleagues' (2012) focus on social media campaigns also found that rates of men's mental health service utilisation were not significantly different after their large-scale social media campaign. Although respondents reported that they might be more likely to seek help, the effect on attitudes and beliefs regarding stigma were limited. These findings suggest that mental health awareness and willingness to seek help may be related but not causal.

Robinson et al., (2014) multimodal awareness campaign reaffirmed the distinction between increased awareness and enduring attitude change. Their research showed that 39% of males within the experimental region were aware of the 'choose life campaign' following its launch. The campaign aimed to actively engage those men identified at the highest risk of committing suicide (homeless, unemployed, isolated and recently bereaved males). Yet, over half of respondents did not feel as if their attitudes towards help-seeking had changed as a result of the campaign. Therefore, clearly defining the aims of a campaign is integral to measuring outcome. Significant changes to attitudes and beliefs may be less likely than raised awareness of local service provision.

Identifying a demographic

Prior Help-Seeking Experience

Identifying a target population that could engage with campaign content was also an important element. Eight of the campaigns under review were designed to be focused on a particular population e.g. youth and adolescents. Researchers also found that individuals who had previously sought help for a mental health difficulty reported being more likely to seek help when compared to individuals that had never sought help before (Livingston et al., 2013, Demyan & Anderson, 2012, Robertson et al., 2016).

Target Population

Hammer and Vogel's (2010) analysis found that a male-sensitive brochure produced significant attitude change toward help-seeking for professional counselling. In this study, males who personally identified and were clinically assessed as being depressed experienced significant attitude change and reduced stigma after reading the male-sensitive brochure. This suggests that targeting a specific message of a campaign to a particular demographic can result in attitudinal change. Robinson et al., (2014) supported this conclusion when they reported that targeting specific sub-sections of the male population may be more effective than a campaign that tries to raise awareness for all adults. Specific approaches and campaign settings may be more helpful for engaging different demographics that have differing needs. For example, three of the eight studies used student populations to evaluate the success of a campaign. However, none of the campaigns were explicitly designed to be used solely amongst student populations (Rochlen et al., 2006; Erentzen et al., 2018 and Demyan & Anderson, 2012), which means the ecological validity of these findings are limited.

Campaign Medium and Reach

The medium of the campaign also transpired to be a significant factor. With regards to awareness campaigns, Robinson et al. (2014) found it easier to increase consciousness of an initiative amongst younger men and early middle age men. Engaging middle age to older men was more challenging (Robinson et al., 2014). However, engaging this demographic was still an important area to focus on with three of the eight campaigns including older adults as part of the campaign (Robinson et al., 2014; Hammer & Vogel; 2010; Till et al., 2013). Factors that may increase campaign reach and effectiveness were also considered by Hammer and Vogel, (2010) whose demographic analysis found that their male sensitive brochure was significantly more effective for

men over the age of 23. Demyan and Anderson (2012) reaffirmed these findings. Their targeted media intervention failed to significantly alter young males' expectations and beliefs regarding help-seeking. They concluded that a deeper understanding of the different predictors and mediators of help-seeking amongst different subpopulations are required. It may be that identifying an appropriate medium for a particular demographic is important in order to maximise campaign reach and impact.

Although Till et al. (2013) conducted a large scale suicide awareness campaign, they struggled to reach and significantly motivate people in crisis. Their analysis observed a slight decrease in suicide related calls post-campaign. Positive images of families designed to help potentially suicidal men reconsider were presented on billboards in public spaces. The potential reach of this campaign medium is questionable given that adverts in the public domain were used to target potentially socially isolated suicidal men. Till et al. (2013) concluded that greater success would be possible if there was greater campaign duration and diversity in the use of media.

Campaign Setting

The settings in which men interact with a campaign may also be a significant factor that impacts effectiveness. Erentzen et al. (2018) conducted three variations of their mental health help-seeking campaign in different settings. They deduced that campaigns observed in the public domain with other people present may produce a more socially desirable response as opposed to a genuine interest in seeking help. In other words, men may act according to the intended outcome of the campaign as they believe it will increase social desirability. It is clear that numerous social factors could be impacting men's decisions in different social settings. Recognising these factors also has implications on where campaigns are publicised. In a laboratory setting, the researcher's presence may have influenced participants who produced more sensitive responses

when dealing with masculinity and stigmatisation towards mental health (Erentzen et al., 2018)**.**

Furthermore, studies found that campaigns promoting the use of service utilisation may not have considered the importance of male friendly environments for the proposed intervention (Robinson et al., 2014). Safe settings in which men feel comfortable to engage in help-seeking are often not statutory or mainstream healthcare services according to Robertson et al. (2018). As such, formal environments may engender a sense of stigma within the individual. Informal, social settings where men are already engaging may prove more appealing when promoting an intervention as part of a campaign.

Campaign Approach

Gender roles and masculinity

The studies under review utilised different theoretical approaches to promote key messages. One approach used to engage men in help-seeking was to reaffirm that pursuing support for a mental health issue is consistent with masculinity, thus maintaining a sense of self congruent with the individuals' gender (Rochlen et al., 2006). For example, using language that is akin to how men might describe help-seeking was identified as important by Robertson et al. (2016). It is possible that using direct, solution-focused approaches to advertising therapy allows men to maintain a sense of masculinity whilst admitting the need for help.

The primary aim of this approach is to overcome gender role conflict (GRC) and enable men to engage in help-seeking. Gender role conflict refers to the negative consequences that can occur as a result of one's adherence to gender roles (O'Neil, Helms, Gable, David & Wrightsman, 1986). For example, some men may find help-seeking

behaviours difficult if they perceive them to be in conflict with their masculine identity. Therefore, by promoting help-seeking in a manner consistent with the dominant cultural discourse of masculinity it is hypothesised that men may be more comfortable to overcome expected behavioural norms (Addis & Mahalik, 2003). However, in reality the efficacy of this campaign approach seems to vary significantly. Rochlen et al. (2016) analysis of the Real Men Real Depression (RMRD) campaign concluded that males with high levels of GRC were not effectively engaged using this approach. The study also found that men identified campaigns as most helpful when there were testimonials from individuals with lived experience. Furthermore, men felt better informed about mental health when there were lists of identifiable, relatable symptoms that helped to reduce stigma (Rochlen et al., 2016). One element seemingly present throughout the studies was that men with lower gender role conflict often had better attitudes towards help-seeking and engaged better with campaigns (Rochlen et al., 2016; Demyan & Anderson, 2012; Hammer & Vogel, 2010).

Erentzen et al. (2018) also considered the role of masculinity and femininity when assessing participant's responses to mental health adverts. They used the Bem Sex Role Inventory (BRSI: Bem, 1974), which is designed to assess the degree to which individuals believe they can be described by traditionally masculine or feminine traits. The inventory was used to examine the effects of adhering to masculine and feminine traits and the impact this has on mental health attitudes. Their conclusions regarding gender were that increased affiliation to traditionally feminine or masculine characteristics as measured by the BSRI were positively correlated with an increased awareness of mental health issues. However, only increased association with traditionally feminine characteristics correlated with interest in seeking help from counselling services (Erentzen et al., 2018). The conclusions that can be drawn from their research into the role of femininity in advertising mental health to males are

limited given the lack of research in this area. Nonetheless, traditionally feminine characteristics e.g. affection, gentleness and compassion, were the strongest predictor for all the help-seeking advertisements. The gender characteristics that are presented in mental health advertisements are seen to be important when considering how this impacts behaviour.

Discussion

Primarily, this review aimed to identify whether mental health campaigns were effective at engaging men in areas such as attitudinal change, increased awareness and engagement in services. Although campaigns produced significant increases in awareness of mental health provision, such changes in beliefs regarding mental health were not achieved. This finding may have important implications for the use of mental health campaigns in the future and their role in promoting healthcare.

Furthermore, this paper also reviewed the factors that produce effective mental health campaigns for men. A number of key determinants were identified. These included the predefined aims set to measure campaign success, the targeted demographic, and the theoretical approach underpinning campaigns. The review supports the conception that men seek help at comparably lower rates than women (Booth et al., 2018; Galdas, Cheater & Marshall, 2005; Addis & Mahalik, 2003). Upon review, five of the eight campaigns did not meet their primary objective (Livingston et al., 2013; Booth et al., 2018; Rochlen et al., 2006; Till et al., 2013; Erentzen et al., 2018).

This review highlighted the importance of clearly defined campaign aims. Mental health campaigns can often be brief focused initiatives designed to increase willingness to seek help for a particular difficulty (Wakefield, Loken & Hornik, 2010). Campaigns to raise awareness may create a short time period where certain individuals, such as those who have previous experiences of help-seeking, feel an increased willingness to seek help.

However, evidence suggests that belief changes may not occur as a result of brief media interventions alone (Demyan & Anderson, 2012; Erentzen et al., 2018). Rather, a brief attitude change may be more likely. Furthermore, campaigns often had multiple aims and attempted to increase awareness, promote visits to services as well as altering mental health beliefs. For example, Robinson et al. (2014) attempted to change attitudes and increase awareness. The goal of increasing awareness was achieved and attitudes were altered, but not significantly. Therefore, the campaign could be deemed as ineffective. Having clearly defined, manageable campaign aims may help to measure campaign effectiveness and help to decipher which campaign approaches are best at engaging men in help-seeking behaviour.

Wakefield and colleagues (2010) review found that careful planning and testing of campaign content with target audiences resulted in more successful outcomes. Factors including the nature of the campaign and the environment in which individuals interacted with the campaign also had an impact on campaign efficacy. Therefore, further developing an appreciation of how men experience these calls to help-seeking is required. Moreover, understanding what proves effective when promoting help-seeking for different difficulties may help with tailoring campaigns to help-seeking for specific difficulties.

Limitations and implications for future research

Due to the nature of qualitative research, the investigator becomes an instrument through which data is collated and analysed (Chenail, 2011). The researcher's perspectives and biases inevitably impact on their work. It is important to recognise that the researcher is part of the social world they are investigating. Without acknowledging this it is not possible to actively reflect on the values and preconceptions that inescapably shape the work (Jootun, McGhee & Marland 2009).

The impact of researcher bias was addressed through ongoing research supervision and discussions with the research team who helped to critique the method and results of the review. Furthermore, papers were shared with the research team and colleagues to corroborate findings at key stages of the research.

Nine papers met the inclusion criteria for the present review resulting in a narrative synthesis being conducted. Due to the depth and quality of the data extracted from the studies, it was considered sufficient to conduct a narrative synthesis. Moreover, as a result of the paucity of research evaluating the efficacy of campaigns, studies that included men across the age range were included. Campaigns also targeted different issues ranging from suicidality to attitudes towards help-seeking. A wide array of participants and campaign aims were included in the review. This variance in participant population and campaign makes it more challenging to extrapolate and compare the findings of each study.

All nine of the studies were conducted in predominantly western cultures (Canada, United States, United Kingdom and Austria) which somewhat impacts the transferability of the research findings. The conclusions drawn from this study may not be applicable to other cultures. Furthermore, there will be further sub-cultural nuances that impacted the respondents in these different countries, resulting in a degree of variation between the included studies.

Although the present review identified important factors that may seemingly improve the scope of mental health campaigns aimed at men, future research may consider men's experiences during their help-seeking process. Examining men's experiences of help-seeking may identify whether the role of media and campaigns are significant in their decision making process or whether other methods may be more effective.

The campaigns under review here also paid little attention to factors of race, diversity, social class and sexuality. Constructs were used to measure masculine and feminine gender roles such as the BSRI (Bem, 1974). Social constructs of masculinity will have assuredly evolved over the past 35 years (Burr, 2018). Forthcoming campaigns may consider using more appropriate measures, focusing on tailoring the initiative to the needs of a specific sub-section of the population that have unique mental health care needs. Reviewing campaigns targeting men between the ages of 18 and 65 may well miss the variations in help-seeking barriers that prevent sub-populations of this large group of people from accessing services.

Furthermore, the use of mental health promotion and anti-stigma campaigns could arguably continue to reify prevalent paradigms regarding mental health. Namely, that mental health difficulties are situated in the individual rather than systemic, societal issues that perpetuate injustices resulting in distress (Johnstone, Boyle, Cromby, Dillon, Harper & Kinderman et al., 2018).

As long as gender disparities in help-seeking persist, men's mental health will remain in focus. It is conceivable that targeted campaigns will continue to be a method of attempting to engage men in help-seeking behaviour. Yet, in order to inform and improve the use of these campaigns crucial factors should be considered.

The themes synthesised as part of this review found that initially, a thorough analysis of the campaigns target population must identify an achievable campaign goal and report how a successful campaign would be measured. Furthermore, engaging typically difficult to engage populations remains a challenge (Robinson et al., 2014). Therefore, if mental health campaigns are to be more effective, matching the setting and medium of the campaign to the targeted demographic may well be very important.

Conclusions

Six of the eight studies reached their primary goal and were able to significantly impact awareness of mental health provision as a result of a campaign. However, the review found limited evidence to suggest that campaigns are effective at changing attitudes or belief based barriers towards mental health. Changes in attitudes regarding help-seeking were seldom observed. Thus, given that campaigns can be effective in increasing awareness of mental health service provision, it is important to examine whether increased awareness directly results in service utilisation.

Many factors impact the eventual outcome of a mental health campaign. Each campaign's eventual success depends on a host of factors. Maintaining a clear focused and coherent campaign, including aim, measures and delivery may help in identifying whether or not campaigns can be an effective tool in bridging part of the gap between men and mental health services.

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Part Two: Empirical Paper

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UNDERSTANDING YOUNG MEN'S EXPERIENCES OF SEEKING HELP FOR A MENTAL HEALTH DIFFICULTY.

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Abstract

Young men's reticence to seek help for a mental health difficulty is well documented. Research has attempted to define the barriers and facilitators young men face when attempting to utilise mental health services. Seldom explored are the experiences of young men in their help-seeking journeys. The present study explored young men's experiences of seeking help for a mental health difficulty, offering insights into the accounts of men who sought support from a service offering psychological therapies. The results indicate men had to overcome an initial sense of scepticism and uncertainty before they felt able to ask for support. Men also felt a sense of duty to seek help in order to be able to protect and maintain relationships. Connecting to others and overcoming a sense of isolation also prompted the desire to get help. This study provides valuable information about six young men's journeys to mental health services.

Key Words

Young men, mental health, help-seeking, experiences, primary care

Introduction

In the United Kingdom, suicide is the leading cause of death among young people (age 20-34), with men taking their lives at a considerably higher rate than women (Mental Health Foundation, 2018). Research has also highlighted that as many as three in four people who commit suicide seek support for mental health difficulties from primary care providers within one month of taking their lives (Luoma, Martin & Pearson, 2002). Therefore, being a young male with a mental health difficulty is a significant risk factor in terms of suicidality.

Considerable research has reinforced the view that men are more resistant to seeking help than women (Addahis & Mahalik, 2003). Studies have suggested that this is particularly the case when it comes to seeking professional support for a mental health issue. It has been found that young men are more likely to hold negative attitudes about help-seeking for a mental health issue and are less likely than their female peers to access psychological therapies (Chandra & Minkovitz, 2006).

Researchers in western contexts have attributed such differences to masculine characteristics, which result in a gender role conflict (GRC), i.e. that traditional male values are in direct contrast to help-seeking (Good, Dell & Mintz, 1989). However, more recently theorists have considered how psychological services may not take into account males' therapy preferences (Liddon, Kingerlee & Barry, 2018). For example, research conducted in Improving Access to Psychological Therapies (IAPT) services indicated that men preferred solution focused and occupational support, whereas, women preferred counselling (Health and Social Care Information Centre, Community and Mental Health Team, 2014). Therefore, it is important to reflect on how mental health services are structured, the assumptions which they are based on and how this impacts routes to help-seeking.

Research has attempted to identify the barriers men must overcome on their journey to accessing support (Gulliver, Griffiths & Christensen, 2010). Savage et al., (2016) identified barriers including fears of being stigmatized for seeking support and negative expectations of mental health services. Researchers have also examined barriers from the perspective of health services. For example, Morison, Trigeorgis and John (2014) have questioned whether mental health services are inherently feminised. Men engaging in help seeking within NHS mental health services will correctly perceive that it is an environment predominantly occupied by women. With as much as 80% of those who provide mental health services within the NHS being women, the lack of male provision within mental health services may dissuade men who are already less likely to seek help (Morison et al., 2014).

The four most commonly delivered psychological therapies within the NHS are: cognitive behavioural, psychodynamic, systemic and humanistic therapy. These interventions require emotional disclosure in an environment of empathy. The importance of emotional dependence and disclosure in psychological therapy may be considered as contrary to traditional masculine norms of emotional independence and stoicism (Morison, et al., 2014).

This theory is supported by the referral information collected as part of IAPT's statistical report from 2018/19 which found that 34.1% of males completed a course of treatment compared to 65.7% of females (Health and Social Care Information Centre, 2019). Furthermore, IAPT's 2018/19 annual report stated that between the ages of 18 and 35 as many as 523,763 women were referred for therapy, compared to 263,422 men. Highlighting that more women are being referred for talking therapies and a higher percentage of these referrals are completing a course of treatment when compared to men. The extent to which traditional therapeutic approaches dissuade men from seeking

help for a mental health difficulty should be considered. Does this impact how men perceive the appropriateness of psychological interventions offered by services, resulting in an apparent unwillingness to access them?

As well as identifying barriers, researchers have also investigated the facilitators to engaging young men in mental health services. Rice, Telford, Rickwood and Parker (2018) conducted a qualitative analysis of the facilitators and barriers young men encounter when accessing community based mental health care. Their study aimed to highlight barriers and facilitators to services as opposed to a phenomenological exploration of men's experiences. Rice at al., (2018) identified the importance of positive initial contact with care providers. They also highlighted targeted mental health messages and respecting preferences regarding clinician gender as key factors that aided men when seeking help. Furthermore, Gulliver, Griffiths and Christensen's (2010) systematic literature review identified positive past experiences as the primary significant facilitator for young men engaging in mental health services. Although comparatively under researched when compared to barriers, facilitators of young men accessing mental health services represent an important factor to be considered.

Identifying facilitators and barriers to seeking help from psychological services constitutes just one part of men's help-seeking experience. The complexity of the help-seeking process is not limited to a set of universal barriers and facilitators. For a young man navigating his way to and then through mental health services, his journey is a personal and unique experience. An important and often neglected element in this process is men's personal accounts of overcoming prevalent social challenges to seek help.

The rationale for the present study was to explore young men's experiences of seeking help for a mental health difficulty from primary care services. The study focused on

individual's experiences of identifying the need for support from mental health professionals. It is hoped that by exploring experiences of young men, more information will be gathered regarding what it takes to seek help for a mental health difficulty. An advanced understanding of how the journey to mental health services is experienced by young men that felt able to take the initiative to engage in psychological therapy is presented here.

When considering the impact of gender on help-seeking, it is important to critique traditional conceptions of gender in order to go beyond a superficial analysis of masculinity. This study takes the position along with other researchers in recognising that gender, at least in part, is a socially constructed phenomena and that like other social constructs it is continually evolving (Street & Dardis, 2018). Gender roles are likely to be more nuanced than discrete categories. When describing the experiences of young men, this is by no means an attempt to subsume all young men's experiences.

Research Questions:

The study aimed to address the following research questions:

- How do young men experience seeking help for a mental health difficulty from primary care services?
- How do young men themselves perceive barriers and facilitators to seeking help?
- What is their experience in overcoming these difficulties?
- How do young men experience disclosing the need to receive professional support?

Method

Design

A qualitative design was used, and semi-structured interviews were conducted to explore young men's experiences of seeking help from mental health services.

Sample

A purposive sampling method was used to appropriately identify participants and maintain homogeneity within the sample. Participants met referral criteria based on a literature review and Increasing Access to Psychological Therapy mental health services (National Health Service). Inclusion criteria were:

- Male.

- Age 18-30.

- Sought help for a mental health difficulty (accessing or previously accessed support) from primary care services including Improving Access to Psychological Therapies (IAPT). The IAPT programme is a large scale initiative introduced in 2008. Its aim is to significantly increase the availability of NICE (National Institute for Clinical and Health Excellence) recommended treatments for common mental health issues such as depression and anxiety provided by the NHS in England (Clark, 2011).

- Identify as having or having had a mental health difficulty.

- Fluent English speaker.

Exclusion criteria were:

- Involved with secondary care services. It was recognised that individuals in secondary healthcare services may not have been as actively help-seeking as

individuals being referred or self-referring into IAPT. The focus of this study was to understand experiences of help-seeking, hence primary care services was identified as appropriate for recruitment.

Participants' age ranged from 20 to 27 (mean= 22.83). Five participants identified as White British, one participant identified as British from an Indigenous American background. Three were accessing support whilst three had completed a course of therapy within the last 12 months.

Table 1. Participant's demographic and other relevant information.

Name (Pseudonym)	Age	Stage of Therapy	Ethnicity	Presenting Problem
1. Ryan	22	Completed within the last 12 months	White British	Depression
2. Simon	27	During	White British	Anxiety
3. Adam	21	Completed within the last 12 months	White British	Anxiety
4. David	27	Completed within the last 12 months	White British	Depression
5. Callum	20	During	White British	PTSD
6. Gerri	20	During	Indigenous American British	Anxiety

Ethics

This study was reviewed and granted approval by the Leeds Bradford Research Ethics Committee and the National Health Service Health Research Authority (Appendix I). The study's consent form (Appendix J), interview schedule (Appendix K), information sheet (Appendix L) and poster (Appendix M) were all reviewed as part of this process. All data was anonymised to maintain confidentiality and audio recordings were deleted as soon as the interview was transcribed. Written informed consent was obtained from participants prior to the interviews. Participants were also informed of their right to withdraw. There were no incentives offered to participants.

Data Collection

Qualitative data was collected from semi-structured interviews. Flowers and Larkin's (2008) Interpretative Phenomenological Analysis (IPA) guidance was used to inform the interview schedule. The discussion was directed by the participants and the interview schedule served as an aide. Before the interview participants were told that the researcher was focusing on their experiences of accessing support for a mental health difficulty. Interviews were audio recorded and ranged from 48 to 72 minutes in duration.

Method of analysis

IPA was chosen due to it primarily being used in the field of psychology and health; it uses a qualitative methodology to provide an in-depth, experiential perspective (VanScoy & Evenstad, 2015). Given that the focus of this project was young men's help-seeking experiences for a mental health difficulty, it was considered an appropriate methodology.

Data was analysed in keeping with the principles of IPA (Smith, 1996). IPA is used to explore in detail individual participants' views of the subject in focus, which in this case was their own help-seeking experience. IPA involves a dual process, firstly, participant's description of their understanding of the subject, and then the researcher's attempts to interpret this.

The analysis that ensued followed the steps highlighted by Smith, Flowers and Larkin (2008). The first stage of analysis included a thorough examination of each transcript, annotating and making initial comments. Initial comments were conducted at three different levels, a descriptive level which addressed the content of each interview, a linguistic level, considering the language ascribed to each person's responses, and a conceptual level, looking at the deeper implications of each interview. Emergent themes were then identified and collated together through a process known as abstraction to produce super-ordinate themes. These super-ordinate themes were then re-grouped in order to form new sub-groups.

The next step of the analysis involved identifying shared themes across the young men's accounts. Groupings of super-ordinate themes were formed. Extracts from transcripts relating to the super-ordinate themes were collected. These groups and supporting extracts were then reviewed by the research team in order to assess the validity and transparency of the developing themes. See Appendix N for an example of an annotated transcript.

A central purpose of IPA is to be grounded in the experience of the participant. Yet, it is important to recognise the impact of the researcher's characteristics and assumptions which are present throughout the research process. IPA recognises that as the participant is attempting to understand their personal experience of the social the world, the researcher accesses the participant's accounts through their own pre-conceptions

(Shinebourne, 2011). The participant's and researcher's experiences are inextricably linked in a dual process known as the 'double hermeneutic'. It is the role of the researcher to be engaged in a state of constant reflection (Alase, 2017). This state of self-reflection involved; the collecting of a journal to inform research supervision, a reflexive interview with research supervisors in order to be aware of the researcher's lens (Hoffman, 1990) and how this might affect data analysis and discussions in supervision to shape questions that would provide the depth required for IPA research. The research supervisors were also involved in assessing the validity of the process of data analysis e.g. looking at excerpts from transcripts and comparing them. A detailed table of themes, subthemes and supporting quotes has been included in the appendices (Appendix 7).

Researcher's position

Another purpose of the reflexive interview was to reflect on how the project assumed an interpretative approach to the method and analysis, recognising that the researcher's own experiences, beliefs and attitudes invariably influenced the research. As per the nature of semi-structured interviews in interpretative research, the researcher's own interests and biases may probe areas of discovery and questioning. The lead researcher is a White British Male, a trainee clinical psychologist and has long held an interest in men's mental health. Given the researcher's interest in studying men's utilization of healthcare services, consideration was taken to understand how this could affect the research project. The potential impact of this was intentionally minimised through the use of the research journal, the reflexive interview and in supervision with the research team.

Results

As a prelude to the results it is important to note that help-seeking was explored as a
process across a period of time rather than a distinct moment. Understandably, it could
be perceived that help-seeking for a mental health difficulty refers to a moment in which
an individual decides that they require help and refers themselves to services or speaks
to a healthcare professional. Each participant understood this process differently and
mentioned an ongoing journey of help-seeking that went beyond the initial referral.
Therefore, the themes presented here relate to individual's idiosyncratic experience of
help-seeking, and do not represent a series of ubiquitous or chronological stages.

Three super-ordinate and eight sub-ordinate themes emerged from the data which have
been outlined in Table 2. Each theme has been substantiated with verbatim quotations
from an interview transcript. Pseudonyms have been used to maintain participant's
anonymity. Identifiable information has also been anonymised to protect participants.

Table 2. Super-ordinate and sub-ordinate themes.

Internal decision-making process	Duty, taking responsibility to seek help	Connecting and relating to others
Overcoming a barrier before seeking help	**Blaming self, shameful to have to get help**	**Loss and Isolation**
"The hardest thing to overcome is the initial barrier. The rollercoaster ride afterwards is sort of you're sat there and you let it happen to you but getting through the barrier is all you" (Ryan)	*"I felt numb just completely numb and guilty at the time and I was at the beginning when I first saw (therapist) I was quite self-deprecating I was beating myself up"(David)*	*"saying it was my fault that he died but I had my biggest feelings of numbness and not feeling like I connected not being able to show my emotions" (David)*
	"erm its annoying, the reason I can't do it is my fault, I have no motivation, no work ethic…" (Gerri)	

Scepticism, unwillingness to seek help	Duty to seek help to protect others	Easier to relate to people with shared experience.
"I went into it sceptical and thinking it wouldn't work but I got used to it. It was hard for me to answer honestly at first, I wouldn't lie but I wouldn't say the whole truth" (Adam)	*"I've got a son and everything and if I lost my life and losing it to this stuff (mental health) and being how I am my son would have grown up with no Dad…"(Callum)*	*"…he's helped me through everything but he understands himself because he's been there himself and like stuff like that it helps"(Callum)*
Difficulties have to be severe before getting help		
"It actually came to me trying to … took an overdose of painkillers and then I was in hospital and I was actually referred to the (service) by the team in the hospital. So it was not so much that I sought the help until I had already done something" (Ryan)		

The impact of the perceptions of others

"I still don't really like to talk about it as I

feel I've got this difficulty of there's nothing

really to see, I still feel like I've got this

barrier… what would their reaction to it be?

And there's till the can I be taken seriously

issue"(Simon)

Internal decision-making process

The purpose of this study was to understand the experiences of young men seeking help for a mental health difficulty. An important area that emerged was an internal feeling of needing to overcome a barrier first. Men's accounts reflected an obstacle to verbalising a need for help. Overcoming this blockade was perceived as being one of the most difficult challenges in men's help-seeking journeys. Men were presented with the challenge of confronting their own scepticism and unwillingness to get support, as well as the tangible impact of the perceptions of others. Fearing others would judge them, or see them as seeking attention, was inhibiting; leading to prolonged periods of deliberation, eventually stalling efforts to seek help.

Overcoming a barrier before seeking help

In attempting to articulate this 'barrier' Simon drew parallels to physical challenges. In doing so it highlighted the sense of struggle and a potential lack of inner belief that he was even capable of asking for support. Furthermore, Simon's reference to second-guessing his thoughts indicates the lack of trust he had in himself and his own experiences. Whilst he was aware of his sense of struggle and difficulty he was unsure if he wanted to receive help. This feeling was common in the men's accounts.

It was like trying to run through a brick wall, you can't manage it. It made me feel like I was second-guessing my thoughts and what I wanted to do. (Simon)

This view was shared by Ryan who said:

…it was difficult at first when you push yourself to talk about it, eventually it becomes easier and when someone reacts positively to it you can trust them. (Ryan)

Ryan implies that his initial resistance was due to questions of whether he could trust others. Fear of opening up was a consistent theme; followed by a sense of achievement or reassurance that things would then get better:

…it's new to you so you're going to be scared talking about, it actually helps a lot more (Callum).

Scepticism, unwillingness to seek help

Reports of a barrier to seeking help could be linked to experiencing an uncertainty and a doubt about the effectiveness or appropriateness of therapy. Along with others Adam reported this scepticism:

I went into it sceptical and thinking it wouldn't work but I got used to it. It was hard for me to answer honestly at first, I wouldn't lie but I wouldn't say the whole truth. (Adam)

Adam's initial reticence had implications for his approach to therapy and potentially the therapeutic relationship. His guardedness meant that he withheld information during his early therapeutic dialogue.

Scepticism may come from individuals not seeing how therapy can help to overcome what may seem unsolvable. Not being able to see how therapy can alleviate the psychological difficulties experienced may well engender a sense of hopelessness. For example, David stated that:

…there aren't words that can fix someone … you understand the reality of situations or gravity of things that happened, nothing can ever fix it. (David)

Avoiding therapy guards against the possibility that things may not be 'fixable' and this could be one reason that prevented these young men from engaging in services sooner. It may also be that this sceptical outlook towards therapy provides these men with a

credible reason to not have to seek discomfort and overcome a difficult barrier in help-seeking.

Difficulties have to be severe before getting help

Men expressed that before accessing services they vacillated before making the decision to seek support. Additionally, men described a high threshold of what they deemed as a significant enough difficulty to get professional help. Accounts suggested that men felt their difficulties had to be severe and at times critical before formal help-seeking was seen as a viable option. Callum stated:

I came to the end of my rope there was two options, there was death and help and I chose help and that's why I'm sat in front of you right now. (Callum)

This account of coming to the end of a rope demonstrates how Callum felt that all other alternatives had been explored. It also indicates how difficult it was to ask for professional help, given that it was mentioned in the same vein as the end of his life. A strong desire to be able to find one's own solution without having to rely on interventions from others was clear.

It actually came to me trying to … took an overdose of painkillers and then I was in hospital and I was actually referred to the (service) by the team in the hospital. So it was not so much that I sought the help until I had already done something. (Ryan)

Ryan's difficulty in describing his experience parallels the challenge he had asking for help, he clearly experienced significant distress and felt as if making an attempt on his own life would be less sufferable than getting therapeutic support. Ryan indicated that the beliefs he was raised with encouraged him to be able to deal with his difficulties alone. The experience of having to accept one's own failure to cope autonomously

meant prolonged periods without support and help eventually coming in a crisis situation:

I don't want to waste their time and my time I've got on with it for 20 odd years I'll get on with it for however long more.(David)

The impact of the perceptions of others

Within the men's accounts a central issue was that of the perceptions of others and how this then impacted their own decision making. Before making a decisive choice about their own health care needs men undertook an analysis of the potential impact of help-seeking. Worries arose about how they might be viewed, and that others might see them as unable to cope. Earlier, a barrier to telling other people was referred to. Linked to that barrier were the perceptions of others:

I haven't told that many people ... I still don't really like to talk about it as I feel I've got this difficulty and there's nothing really to see, I still feel like I've got this barrier… what would their reaction to it be? And there's still the can I be taken seriously issue. (Simon)

There's very few people that you can kind of trust and won't judge you for it, I feel like that's a big issue as well, worrying about people judging you for struggling, still there's a few people that I know that don't believe that mental health is such a thing they think that things like depression and anxiety are ... what's a good word for it ... attention seeking. (Ryan)

Here Simon refers to the barrier. There is an element of unknown that comes from opening up and talking to other people, and a worry of then having to justify his difficulty. With mental health difficulties being something that are not always easily discernible, the issue then of not being taken seriously becomes a concern. Another

noticeable worry was that of being seen as someone seeking attention for disclosing mental health difficulties.

It may be that there is two interacting cultural dynamics resulting in trepidation. Firstly, that keeping one's difficulties to oneself and being able to cope with them is desirable:

Not to say that I didn't manage, I kept under the radar. (Gerri).

By protecting their difficulties from others they are managing and in control. The other is that men need to open up and talk in order to receive the required support.

I've always tried to talk as much as possible but erm there's a limit to how much you can open up to people you don't want people to worry about you. (Ryan)

However, it is important to note that there were also contrasting views presented by Gerri. He stated that the reason he sought help was for himself and that the opinions of other people were not significant.

No I couldn't care less what other people think … probably an issue in and of itself but no I did it for me not for anyone else as far as anyone else is concerned… I'm not too bothered about other people think … (Gerri)

Duty, taking responsibility to seek help.

The second major theme relates to the men's conviction that it was their duty and responsibility to seek help. Seeking help for a mental health difficulty from primary care services and engagement in psychological therapy generally requires an element of volition and choice. However, in their accounts young men referred to help-seeking as if it was something they had to do. An initial feeling of shame and guilt appeared for having to seek support before being able to take ownership of the help-seeking process.

Blaming self, shameful to have to get help

Confronting the shame of having to get help resulted in blame being directed inwardly. Gerri's account reflects a frustration and self-blame for not being able to do his job due to his anxiety:

…it's annoying, the reason I can't do it is my fault, I have no motivation, no work ethic. (Gerri)

Compounding the difficult step of having to get help is the added psychological strain that he believed it was his own doing. Here and elsewhere in the accounts it was clear that there was not just the self-blame of having a mental health difficulty but also for the impact it has on and others.

I felt numb just completely numb and guilty at the time and I was at the beginning when I first saw (therapist) I was quite self-deprecating I was beating myself up. (David)

I drove a wedge between me and her because of my mental illness I made us two split up because I didn't acknowledge it was the fact I was getting angry. It was me. (Callum)

Here Callum describes his role in the breakdown of the relationship with his partner. In his account it is clear to see the internalised sense of blame, as if to disregard the other determinants involved in the development of a mental health difficulty and the end of a relationship. Throughout the accounts, feelings of shame and guilt were associated with the development of mental health difficulties and the impact it had on those around.

Duty to seek help to protect others

The sense of a duty to seek help in order to protect others provides an important insight into the motivators that might have driven these young men to seek help. Men who

seem to have taken responsibility for the welfare of family and friends took the onus to get support when they felt as if they were negatively impacting the well-being of others. Significant transitions in family life cycles also increased individuals' desire to fulfil their roles and responsibilities to a higher standard.

...the only thing that kind of stopped that restrain from getting the help was that I didn't want to be a bad dad because I was depressed ... I didn't want my son to grow up and think why is dad always sad? (David)

I love my girlfriend to bits, when she said I can't be with someone who is like this that instantly tore my heart out ... that was a big motivator and there was my mum and my little brother and sister, I love them too... (Adam)

David's role as a father was crucial in his desire to overcome his depression. His appraisal that he may not be able to provide as a father was what ultimately made the difference. Whether providing as a father or as a partner, the desire to support and protect others was undoubtedly a salient motivator that led to seeking help. An internal assessment of one's own role as a family member seemingly engendered a desire to improve and become healthier. Intrinsically linked to these men's own mental health was the welfare of those in close proximity.

Connecting and relating to others

The importance of interpersonal connection, feeling understood and the loneliness and isolation that can be felt when these things are lost was another theme that emerged. As aforementioned, men's accounts of their help-seeking experiences were deeply embroiled in the social relationships surrounding them. At a time when men felt ostracised and socially excluded, those relationships with individuals who shared similar experiences were most valued.

Loss and isolation

An example of the sense of isolation comes through in Ryan's account. The feeling of having to take on his difficulties alone due to not knowing who could lend support is clear. Ryan's perceived distance between him and his relative's results in him feeling lonely, even though he recognises that he was not completely alone.

It was incredibly isolating … in a sense you feel like you're on your own but not necessarily because you are, you can't see who is there to help you, it can feel a little bit lonely I suppose as well, I felt lonely. (Ryan)

Knowing what my life is about, not even knowing where I come from, that's why I thought let's get some help with it (suicidal thoughts) then looking at myself having no father figure, no dad and not knowing what my life is about, not even knowing where I come from, that's why I thought let's get some help. (Callum)

This perceived isolation was preceded by a feeling of loss. Callum lost his father and the opportunity to have a relationship with him. This was crucial for Callum in seeking help for his own suicidal thoughts. Reflecting on the loss of his father and the resulting confusion that ensued, Callum became open to the possibility of getting help. Callum's experience resulted in him feeling as if he lost a sense of himself. He implies that this loss may be the reason for his difficulties and that by seeking help it could help to lift the uncertainty around his sense of identity.

Easier to relate to people with shared experience

The final subtheme referred to here is that of relating to others. The non-linear and novel experience of developing a mental health difficulty for the first time was difficult to describe:

I said I feel quite ill, I feel like there's someone gripping some part of me inside like there's a hand gripping me ... Anxiety? I've never felt anxiety ... so I didn't even know what anxiety felt like until I was 20 years old. (Adam)

Finding commonalities with others made it easier to feel connected due to the challenge of articulating experiences that were profoundly difficult to describe. Having a sense of being part of a group contributed to feelings of belonging. Talking to people who had not experienced mental health difficulties was seen as more challenging.

They (parents) did encourage me to seek support and they tried to help where they could but with them not experiencing it themselves it was difficult. (Simon)

Callum described his relationship with a close friend that also had similar challenges with mental health.

He's helped me through everything but he understands himself because he's been there himself and like stuff like that it helps. (Callum)

These young men's challenge in describing their difficulties to other people implies a lack of trust in those individuals that might not fully grasp the nature of their struggle. This is something that is re-experienced when accessing health services and disclosing difficulties to new people. David also found that this experience was difficult and resulted in him feeling low afterwards:

I remember feeling a bit further down almost afterwards just because of that being on the phone again and talking about what happened. (David)

These accounts shed light on the internal world of individuals seeking help, of the efforts to feel a connection, to maintain and protect relationships and the challenge of articulating their difficulties. In summary, the internal decisions that had to be made, the

experiences and the desire to relate all had a significant impact on men's help-seeking journeys.

Discussion

The aim of this research was to understand the experiences of young men seeking help for a mental health difficulty. This study provides an understanding of the complexity of the social and relational determinants impacting young men's help-seeking journeys. An in-depth exploration of the accounts of young men that did make the decision to seek help from primary care services has been explored.

The key focus of this study was to highlight what men experienced in seeking help for a mental health difficulty. In analysing their accounts, what could have been perceived at a surface level as an unwillingness to seek help, was the outcome of an internal conflict between competing factors. These factors included the desire to help others, whilst also wanting to be able to cope autonomously. The consequence of this dilemma was a prolonged deliberation and an uncertainty about the appropriateness of help-seeking. Men concealed their difficulties in order to protect an image of autonomy, which led to feeling isolated, out of control and eventually crisis. There is evidently some desire to maintain a high level of internal locus of control (Rotter, 1990).

Evidence suggests that help-seeking may come harder to men, with young males one of the least likely sub-sections of the population to seek help for a mental health difficulty (Oliver, Pearson, Coe & Gunnell, 2005). One view being that this stage of life is synonymous with a desire for autonomy (Erikson, 1994). The present analysis indicates that these men were at times sceptical of professional support. Decisions were influenced by an array of factors, and efforts to engage in help-seeking were catalysed by a desire to feel connected and close to others. Help-seeking offered these men a refuge from isolation and a hope of restoring strained relationships. This links to

attachment theory, which describes an innate desire to relate, and the deprivation associated with the loss of connection (Bowlby, Ainsworth, Boston & Rosenbluth, 1956).

Efforts to engage young men in mental health services may consider the extent to which therapy can be described as a means of helping men to feel supported and how this may enhance the likelihood of help-seeking. The participants desire to connect to their own emotions and to those important relationships was a consistent driver. In this context, rather than seeing unwillingness as something that is inherently difficult for men (Morison, Trigeorgis, & John, 2014), aiding men to perceive that seeking help for a mental health difficulty can by synonymous with providing for and helpings one's family could help to promote therapy as a more viable option.

However, further consideration must also be given to the origins of men's shame at having to seek help. In particular, the potential role of mental health services in maintaining the individuated view of mental health difficulties. Discourses about distress being individualised reinforce introspective blame. It was unmistakeably connections and relationships that made these young men seek help. As long as society holds the belief that mental health difficulties originate and reside in the individual, men may feel that they are to blame and persist in coping alone. Moreover, it is clear that treating individuals as symptomatic and then returning them to the same structures that created their problems fails to recognise the importance of broader social and structural change (Denborough, 2001).

Clinical implications and limitations

This research has a number of implications of relevance for those engaged in offering support to young men with mental health difficulties. Firstly, the importance of exploring implicit motivators to engagement; rather than being a distinct moment in

time, help-seeking was experienced as a process and individual's motivation fluctuated. Canalising motivators such as the desire to be a better father, brother and or partner may aid in supporting men to pursue help and continue to engage in help-seeking behaviours.

It is also important to recognise the active process young men go through in making efforts to initiate help-seeking and then continuing to do so. Part of this process may involve an analysis of reasons to disengage with therapy. Appreciating individuals' desire to cope autonomously and the perceived social and cultural implications of seeking help, may support and give context to a perceived unwillingness to pursue mental health support. Furthermore, due to the process of potentially having deliberated and put off support, young men may find themselves asking for help in a crisis situation. Although men may be seeking help in primary care settings such as IAPT, their difficulties may well be associated with more complex and enduring care needs, putting them into a situation where they may be referred to secondary care services, further complicating the systems perception of their initial presentation. This could also suggest that some young men may be unaware as to what constitutes an appropriate level of difficulty in order to get professional help.

The importance of relatable experiences was also emphasised in this research. The significance of being able to connect to the experiences of others that are often difficult to understand or verbalise was clear. This study suggests the heightened importance of shared experience and how it can engender a sense of hope. It may have implications for how people engaging with young men draw on their own experiences. Self-disclosure can be beneficial and lead to a sense of trust and shared identity, whilst reducing uncertainty (McKenna, Joinson, Reips & Postems, 2007). Being exposed to discourses on mental health difficulties could be a validating experience.

However, some discourses regarding mental health and help-seeking can understandably reinforce experiences of isolation and culpability. Mental health campaigns often place the onus on the individual to shed stigma and be strong enough to seek help (Real Men Real Depression Campaign, National Institute of Mental Health, 2003).

These messages may result in men engaging in a self-evaluation in which they compare themselves to an ideal, stronger self or other that is capable of seeking help. It has long been recognised that a dissonance between a sense of current self and an ideal self, results in an increased likelihood of experiencing mental health difficulties (McDanial & Grice, 2008, Kelly 1995). With men consistently reporting a high level of internal locus of control, it could be that some mental health dialogues promote an individualistic view that perpetuates self-blame.

Whilst this study has made important contributions to this field of research there are limitations regarding some of the findings. The homogeneity of the sample that is required for IPA research meant that young men were recruited from one healthcare provider. Furthermore, the study was based on the accounts of a small group of men and it is important for men from other settings be able to explore their experiences of seeking help.

The present study focused on the experiences of men seeking help for a mental health difficulty from a trans-diagnostic perspective, choosing to focus on the experience of seeking help, rather than the presenting mental health difficulty. However, it is conceivable that different factors may have impacted men's experiences based on their mental health issue. Furthermore, men participating in this study were at different stages of their journey through mental health services. Some were at the very start of therapy.

Others had completed therapy within the last 12 months. Men could have been reporting on factors characteristic of different stages of help-seeking.

Given that this study examined the experiences of young men that did seek help for a mental health difficulty, the accounts of individuals who did not seek help have not been explored. There were also individuals who chose not to engage in the research. Due to the anonymity of the recruitment process the reasons as to why are unknown. It could be that their accounts would have presented a different perspective. However, given that the participants in the present research came from a homogenous sample, and presented with a range of different mental health difficulties, it could indicate that the findings of the present research have meaning for a wider group of young men's experiences.

Some forthcoming researchers may consider the effect that help-seeking in a crisis has on individuals, communities and health services. If help-seeking was deliberated upon by men but postponed, what are young men's perceptions of when a difficulty is severe enough to seek support? Further research into early intervention and prevention may help in promoting individuals understanding of adverse mental health experiences, thus reducing the time of potentially untreated distress. Further research is also required to understand the full implications of the findings presented here.

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Part 3: Appendices and Reflective Statement

Appendix A: Relevant sections the Journal of Men's Studies 'Submission Guidelines'

Manuscript preparation.

The Journal of Men's Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (6th ed., 2009). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References. Basic formats are as follows:

Journal article:

Chua, P., & Fujino, D. C. (1999). Negotiating new Asian-American masculinities: Attitudes and gender expectations. The Journal of Men's Studies, 7, 391-413.

Article in an Internet-only journal:

Gordon, R. (2004, June 15). The men among us. Library Journal.com. Retrieved October 15, 2006, from http://www.libraryjournal.com/article/CA423789.html

Figures.

Graphic files are accepted if supplied as Tiff files (.tiff). High-quality printouts are needed for all figures. The minimum line weight for line art is 0.5 point for optimal printing.

Review Procedure.

The Journal of Men's Studies uses a masked review process. Authors are asked to include all identifying information in the cover letter, including the manuscript title, the authors' names, institutional affiliations, and e-mail addresses. The first page of the manuscript should include only the article's title, abstract, and keywords. Footnotes containing information that would reveal the authors' identity and/or affiliation should be removed. Every effort should be made to see that the manuscript itself contains no clues to the author's identity.

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Publication Policy.

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Appendix B: Examples of excluded papers

Authors (Year)	Title	Reason for exclusion
Sampogna, Bakolis, Evans-Lacko, Robinson, Thornicroft & Henderson (2017)	The impact of social marketing campaigns on reducing mental health stigma: Results from the 2009–2014 Time to Change programme	Reported statistics of male and female engagement with the study but did not specifically consider gender. No comment on how males and females may have interpreted campaigns differently.
Kivari, Oliffe, Borgen, & Westwood (2018)	No Man Left Behind: Effectively Engaging Male Military Veterans in Counseling	The study's aim was to measure the effectiveness of a counselling intervention for men military veterans, rather than the efficacy of a campaign.
Cheng, Benassi, Oliviera, Zaheer, Collins & Kurdyak (2016)	Impact of a mass media mental health campaign on psychiatric emergency department visits	The study reported male and female numbers of health visits but did not consider the implications of gender upon the results. No specific reference was made to the trends observed between genders

		and the factors that may have impacted males engaging with the social media campaign.

Appendix C: Data extraction form

Authors (Year)	
Title	
Research Aims/Questions	
Target Population of the Campaign	
Method	
Campaign	
Outcome/Parameters	
Standardised Measures	

Appendix D: MMAT form (quality assessment checklist)

Types of mixed methods study components or primary studies	Methodological quality criteria	Responses			
		Yes	No	Can't tell	Comments
Screening questions (for all study types)	Are there clear quantitative research questions (or objectives*), or a clear mixed methods question (or objective*)?				
	Do the collected date allow address the research question (objective)? E.g., Consider whether the follow up period is long enough for the outcome to occur (for longitudinal studies or study components).				
1.Qualitative	1.1. Are the sources of qualitative data (archives, documents, informants, observations) relevant to address the research question (objective)?				
	1.2. Is the process for analysing the qualitative data relevant to address the research question (objective)?				
	1.3. Is appropriate consideration given to how findings relate to the context, e.g., the setting, in which the data were collected?				
	1.4. Is appropriate consideration given to how findings relate to researchers' influence, e.g., through their interactions with participants?				
2. Quantitative randomised controlled trails	2.1. Is there a clear description of the randomisation (or an appropriate sequence generation)?				
	2.2. Is there a clear description of the allocation concealment (or blinding when applicable)?				
	2.3. Are there complete outcome date (80% or above)?				
	2.4. Is there low withdrawal/drop-out (below 20%)?				
3. Quantitative non-randomised	3.1. Are participants (organisations) recruited in a way that minimises bias?				
	3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?				
	3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups?				

	3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)?				
4. Quantitative Descriptive	4.1. Is the sampling strategy relevant to address the quantitative research question (quantitative aspect of the mixed methods question)?				
	4.2. Is the sample representative of the population understudy?				
	4.3. Are measurements appropriate (clear origin, or validity known, or standard instrument)?				
	4.4. Is there an acceptable response rate (60% or above)?				
5. Mixed Methods	5.1. Is the mixed methods research design relevant to address the qualitative and quantitative research questions (or objectives), or the qualitative and quantitative aspects of the mixed methods question (or objective)?				
	5.2. Is the integration of qualitative and quantitative data (or results*) relevant to address the research question (objective)?				
	5.3. Is appropriate consideration given to the limitations associated with this integration, e.g., the divergence of qualitative and quantitative data (or results*) in a triangulation design?				

Appendix E: Inter-rater reliability table

1. **Livingston, Tugwell, Korf-Uzan & Clanfrone (2013) - Evaluation of a campaign to improve awareness and attitudes of young people towards mental health issues**

Quantitative – Successive independent samples Design. **Quality Score = 50% (MMAT, 2011) ****

3.1. Are participants (organisations) recruited in a way that minimises bias?		**No**		A market research company were identified to survey respondents and administered the online questionnaire. No explanation of how the company identified individuals. *Inter-rater comment:* **Agreed with this score – plausible study but needs to acknowledge some of the limitations like you mentioned around bias.** *Inter-rater comment:* **Agreed – they need to acknowledge the bias that this creates.**
3.2. Are measurements appropriate (clear origin, or validity known, or standard instrument; and absence of contamination between groups when appropriate) regarding the exposure/intervention and outcomes?	**Yes**			Referenced the use of a standardised measure of stigma that has been appropriately adapted for use with young people. *Inter-rater comment:* **I'm left wondering about the rationale for some of the questions in their survey. They mentioned that they defined helping someone as knowing how to give advice etc but what steps did they take to define that? It would have been helpful to include how they arrived at that definition.** **Good that they included already standard measures (E.g. personal stigma)**

3.3. In the groups being compared (exposed vs. non-exposed; with intervention vs. without; cases vs. controls), are the participants comparable, or do researchers take into account (control for) the difference between these groups? **Is the measured group representative and allows for comparison to other members of that same population?**	**Yes**			Analysis of Variance conducted to control for ethnicity. Participants were appropriately randomised.
3.4. Are there complete outcome data (80% or above), and, when applicable, an acceptable response rate (60% or above), or an acceptable follow-up rate for cohort studies (depending on the duration of follow-up)? **Is there a significant difference between pre and post campaign comparison Groups?**		**No**		One quarter of the T2 survey respondents remembered hearing/seeing the campaign. 30% males. 19% females. Response Rates: T1 males: 44.7% T2 Males: 48.4% T1 Females: 55.3% T2 Females: 51.6%

Further Qualitative Comments:

Market Research Company were hired in order to conduct the recruitment for the study which does not indicate how this was completed. 806 13-25 year olds participated in the study. Penetration of the study at 2 months follow up was low. Males had lower response rates but remembered the campaign more – likely due to the male sports star in the campaign.

Appendix F: Summary of the methodological quality of each paper as rated on the MMAT.

Author & Year of Publication	MMAT (2018) Quality Rating	Summary of the methodological strengths and limitations of the study
Livingston, Tugwell, Korf-Uzan & Clanfrone (2013)	50%	Clearly referenced lists of appropriate measures that were identified to track changes in awareness and attitudes. Participants were appropriately randomised to conditions and ethnicity was controlled for. However, an external agent was responsible for recruitment and there was no mention of how this took place.
Robinson, Braybrook & Robertson (2014).	75%	Clear description of method used to measure qualitative data. Clear efforts to use qualitative and quantitative data, but no explicit mention of triangulation design.
Hammer & Vogel (2010)	75%	Large sample of male participants across the age range. Sample only comprised of depressed males, no information about men with other mental health issues.
Robertson, Gough, Hanna, Raine, Robinson, Seims & White (2016)	75%	In depth interviews took place across a broad range of professionals in different settings, over 100 interviews in total. However, the impact of interviewer-interviewee relationship, aspects of power and the context in which those interviews took place is not given due thought in the paper.
Booth, Britney, Jenkyn, Li & Sharriff (2018)	75%	Longitudinal study, 10 years of mental health service visits were recorded, 5.66 million in total. However, visits were based on diagnosis codes and may not capture other, non-diagnosed mental health issues. Increases in mental health service utilisation as a result of the social media campaign were statistically

		insignificant.
Rochlen, McKelley & Pituch (2006)	25%	Participants were recruited from educational psychology courses but the Real Men Real Depression campaign that was under analysis was aimed more broadly at men with depression.
Till, Sonneck, baldauf, Steiner & Niederkrotenthaler (2013)	100%	A control region was used to compare the effects of the awareness campaign to the experimental region.
Erentzen, Quinlan & Mar (2018)	50%	Mental health stigma was measured using referenced scales e.g. Day mental illness stigma scale and the Bem Sex Role Inventory. Only undergraduate psychology students were recruited which may impact how representative this data is.
Demyan & Anderson (2012)	75%	A selection of measures were used to collate data regarding the impact of the media intervention on expectations, attitudes and intentions to help seeking. The participants were 270 undergraduate psychology students who may have differing views regarding help-seeking.

Appendix G: Synthesis form

| 5.Robinson, Braybrook & Robertson (2014). Influencing public awareness to prevent make suicide. | Effectiveness of the 'choose life campaign'

39% of males with some awareness of the campaign said it increased their awareness of available services.
Positive correlation between levels of campaign awareness and altered attitudes in the post campaign survey results, however, only a high awareness level was strongly correlated with altered attitudes.

Almost 50% of respondents did not feel as if their attitude changed as a result of the campaign.

Less than a third of adults within the campaign area were aware of the campaign. | **Environment/settings in which men engage with the campaign**

Providing the campaign in a meaningful environment that is often accessible in collaboration with local institutes may help to build campaign reach and interaction. Younger people preferred lifestyle settings e.g. fashion/food industry settings, whereas older adults recognised television adverts.

Campaign approach
a) Those using language with a focus on mental health (awareness)
b) Those using language with a sense of urgency and clear focus on intense distress and immediate action (urgency). Public engagement requires the campaign to go beyond raising awareness. A multimodal approach may be required including normalising messages from peer influencers and relatable experiences that normalise suicidal ideation. Campaign showed some evidence of increased capacity and confidence in seeking help, however, attitude change was limited.
Social marketing approach – training indigenous resources outside statutory healthcare providers (barbers, taxi drivers, postal workers, volunteers, sports coaches) to be able to discuss help-seeking and normalise mental health issues. Asset based approach – recognising the local differences and strengths in each community and drawing upon these rather than blanket approaches that try to address the needs of all in one campaign.
Demographic
Easier to raise awareness of a campaign among young men | Social marketing approach – harder to reach and engage rural populations and middle aged, unemployed older adult men.

Longitudinal outcomes only measured using qualitative methods. Campaign goals were to measure the impact longitudinally and there is no longitudinal measure of suicidality.

No explicit aim of the study or | Targeting specific sub-sections of the male population may be more effective than a campaign that tries to raise awareness of all adults. Specific approaches and campaign settings may be more helpful for engaging different age demographics.

Campaign approach

Community approach including the engagement of wider organisations and community likely to have greater impact on long lasting attitudinal change regarding suicide and mental health issues.

Campaign Reach |

		and early middle aged men. Whereas engaging middle aged and older men is often more difficult but can also be more important. Difficult to engage 'hard to reach' populations in social marketing approach (e.g. unemployed, older adult and older middle aged men).	target/focus on a particular demographic. Lack of consideration for different ethnicities.	

Appendix H: Full table of scales used in the studies review

Scale	Developed by	Studies using this scale
1.Attitudes Toward Seeking Professional Psychological Help Scale	Surgenor, 1985 Fischer & Farina, 1995	Demyan & Anderson, 2012 and Hamer & Vogel, 2010
2.Intentions to Seek Counselling Inventory	Cash, Begley, McCown & Weise, 1975	Demyan & Anderson, 2012
3.Mental Health Ad Effectiveness Scale	Rochlen, Blazina & Raghunathan, 2002	Rochlen et al. 2006
4.Gender Role Conflict Scale	O'Neil, Helms, Gable, Laurence, & Wrightsman, 1986	Rochlen et al. 2006
5.Bem Sex Role Inventory	(Bem, 1974)	Erentzen, 2018
6.Stigma Scale for Receiving Psychological Help	Komiya, Good & Sherrod 2000	Demyan & Anderson, 2012
7.Thoughts About Psychotherapy Survey	Kushner & Sher, 1989	Demyan & Anderson, 2012
8.Distress Disclosure Index	Kahn & Hessling, 2001	Demyan & Anderson, 2012
9.Self-Concealment Scale	Larson & Chastain, 1990	Demyan & Anderson, 2012
10.Disclosure Expectations Scale	Vogel & Wester, 2003	Demyan & Anderson, 2012
11.Outcome Questionnaire	Lambert, Gregersen & Burlingame, 2004	Demyan & Anderson, 2012
12.Day Mental Illness Stigma Scale	Day, Edgren, & Eshlemen, 2007	Erentzen, 2018

Appendix I: HRA approval letter

Removed for Digital Archiving

Appendix J: Consent form

CONSENT FORM V1.2

Title of Project Understanding young men's experiences of seeking help for mental health difficulties.

Name of Researcher: Joseph Cleasby

Please initial boxes

1. I confirm that I have read and understand the information sheet (Version 1.1) 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 audio-recording of my interview may be used in future publications and I understand that they will be anonymised.

☐

4. I understand that data collected during the study may be looked at by individuals from regulatory authorities or from the NHS Trust, where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

5. I agree to take part in the interview stage of this study and I understand that my interview will be audio recorded and transcribed.

☐

Name of participant   Date   Signature

_____   _____   _____
___   ___   ___

Name of person taking   Date   Signature
consent

_____   _____   _____
___   ___   ___

When completed: 1 for participant; 1 for researcher site file.

6. I would like to receive a copy of the study results when they are completed

Email Address:

_____

Appendix K: Interview schedule

Interview Schedule V 1.1

The interview schedule will not be strictly followed but rather used to guide questions and general direction of the discussion.

Research Question:

What are the experiences of young men who have sought help for a mental health difficulty from Improving Access to Psychological Therapy (IAPT)?

Interview aim:

1. To investigate the experiences of young men seeking help for a mental health difficulty and discuss the barriers and facilitators to seeking support.

Questions:

Introduction & demographics: How long have you been with this service?

1. **Can you talk about what brought you to this service?**

Prompts:

What did you notice?

How did it feel?

What did it mean to you?

What influenced you?

Who else knew? What was it like telling people?

2. **What was it about the experiences that made you think you needed help?**

Prompts:

How did you feel about this? What did it mean to you? How did it influence the way you thought about yourself?

3. **What helped you to access support from services?**

Prompts:

What was this like for you? What changed for you? How did it affect your life?

What did you do to find help who did you talk to?

What was it like telling them? What happened what was that like for you?

Appendix L: Information sheet

Research Study – Information Sheet V1.2

Title: Understanding young Men's (18-30) experiences of seeking help for mental health difficulties.

We would like to invite you to take part in our research. This sheet explains the purpose of the research and what could happen if you do decide to take part. You can talk to someone if you want to have a chat before you make a decision. You also have 48 hours to make a decision after the initial phone call describing the study.

What is the study about?

The aim of this study is to explore the experience of men who sought help for a mental health difficulty. This study hopes to look at the experience of the process of seeking help e.g. why you decided to seek help and what this was like. We are aware that seeking help for a mental health difficulty is experienced differently by everyone, for some it may be an uplifting experience, for others it might be a time of uncertainty. We are interested in finding out what this experience was like for men between the ages of 18 and 30.

Why are we inviting you to take part?

We are asking men between the ages of 18 and 30 who have engaged in therapeutic work to take part in informal discussions with myself (the Chief Investigator – Joseph Cleasby) to and talk about their experiences of seeking help.

What will I have to do?

If you would like to take part, you will have a conversation with me about your experience of seeking help from IAPT. The discussions will have a flexible structure with the focus being on how you experienced your route to seeking support for a mental health difficulty. You can choose which areas of this process are of most importance to you. The discussion could take up to an hour. The discussion will take place at the service where you are seeking/have sought support (IAPT Service).

The discussion will be recorded so that it can be listened to and typed up later. All of the recordings will be stored securely and locked away, they will not be identifiable as they will have no personal information attached to them. Recordings will be deleted within twelve months of the interview.

What are the potential disadvantages of taking part?

The study may require up to an hour of your time. You will not receive payment for your participation in the study. Talking about the experience of seeking help and talking about mental health difficulties can be a sensitive topic, it could bring up some difficult feelings. However, if this happens, the researcher will offer support and help to gain access to help from your GP, or other local services, if this is necessary.

What are the possible benefits of taking part?

Although there will be no payment, some people find it useful to talk about their experiences. It is hoped that the information you share with us will contribute to a better understanding of how young men may experience seeking help for a mental health difficulty. It may help us to understand; what are some of the things that affect this process? What is unhelpful and what can be unhelpful? This may help to improve support and awareness for healthcare staff and how services function.

Do I have to take part and what if I change my mind?

You are under no obligation to participate in this study. Participation is completely voluntary. If you decide to take part you will be asked to sign a consent form to indicate that you agree to take part. Even after you have given consent to take part you can still ask to withdraw at any time by informing myself (Joseph Cleasby – Chief Investigator), however, the information you share during the discussion will not be deleted until the end of the study due to the analysis that may well have already taken place.

Will my details be kept confidential?

All the typed up discussions and information about you will be stored securely in a locked cabinet, in keeping with the University of Hull's guidelines, for up to ten years, after which it will be destroyed.

As this research is being used for a university course, it will be sent for assessment to the University of Hull. The research may also be sent to an academic journal, which means that others that may be interested in this research will be able to read it. It will not be possible for anyone to know who you are from the research as all material will be anonymised and different names will be used.

The only time we may breach confidentiality is if we become concerned about the safety of you or the safety of someone else we would discuss this consider together what is best to do next.

Who is organising and funding this study?

The researcher (Joseph Cleasby) is a doctoral student in Clinical Psychology at the University of Hull and also an employee of Humber NHS Foundation Teaching Trust. This study is part of his doctoral research project. Research expenses are being provided by the University of Hull.

Who has reviewed the study?

Independent Research Ethics Committees protect the interests of people who participate in research. This study has been reviewed by the Faculty of Health and Social Care Research Ethics Committee at the University of Hull and the Bradford Leeds Ethics Research Committee. This study has received a favourable opinion from both committees.

What if there is a problem?

If you have any concerns about the study, please discuss these with the researcher. You may also contact the researcher's supervisors at the University of Hull.

I am interested in participating and would like further information

If you are interested in participating you can contact the researcher via the details provided as part of this information pack.

Contact Details

Researcher: Joseph Cleasby

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Thank you for taking the time to read this leaflet.

If you are interested in taking part in this 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 time and place. This consent form will be stored in a secure location at the University of Hull and will then be destroyed at the end of the study.

Name:

_____

Telephone Number:

_____

Mobile Phone Number:

_____

What time of the day do you prefer to be contacted?

_____

When did you seek support from IAPT?

Currently receiving Support ☐   Within the last 6 months ☐

Within the last 12 months ☐   More than 12 months ago ☐

Do you have any further comments?

_____

_____

Signature:

_____

Date:

_____

Thank you for your interest!

Appendix M: Research Poster

Emergent Themes

-Waste of time, wasting others time.

-I'll get on with it myself for however long it takes.

-No longer ashamed.

-Easier to share when there's less shame.

-It was my story and my

Appendix N: Examples of annotated Transcripts

J: Who else knew you were seeking help?

A: Erm, initially I told, my wife she tried to convince me before I asked for help to get some but I didn't for a long time (laughs at this).

J: Why was that?

A: **Just not seeing how it could help and that**. I guess **not wanting to waste other people's time as part of that**, like what's the point it's not going to help **I don't want to waste their time and my time I've got on with it for 20 odd years I'll get on with it for however long more**. I think she was the only one that knew first before I actually asked, since might have been anyone that's cared or who I've had a conversation with **I don't hide it at all since the last time I've been writing a blog talking about my experiences of therapy** and just mentioned about coming. So ye a lot is out there I guess it's not something I feel ashamed of that it's just something that I do on my evenings almost ye it's I mention it as much as I mention going swimming.

J: Why is that?

A: Erm I don't feel ashamed by it or the reason that I guess it's different for me than it is for other people is in the sense that **nothing happened directly to me** in either of the cases so I don't have the issue of fighting with myself in the sense of misplaced shame or anything whereas someone who has been through something awful that has happened to them might blame themselves or might not want to share that **experience I've not really told anyone about what happened in my childhood because that was not my thing to tell and it's just not something I want to share with people but with losing my son I share that with everyone and I feel that I wouldn't be how I am today if I hadn't had asked for help and its juts part of my process for hopefully feeling better and if I can tell other people about it hopefully that will change their perception of it that its alright to do it and if they need it then if it's not a big thing for one person two people ten people then it's not a big thing for you so ye its if maybe if people around had have been like that before I initially asked for help maybe it wouldn't have seemed as pointless if there was that perception that other people were benefitting from it so if I can help someone else to have a bit of a clearer mind towards it the that's only a good thing for them hopefully.**

J: You might have touched on it but what was it about the experiences you had that made you think I need help? A: So the really dark feelings were after I asked for help so that wasn't what necessarily the reason why I initially asked for it the initial reasons were I Just felt so nothing I guess.

Appendix O: Extended list of themes, subthemes, quotations and images of theme development.

Master table of themes

1. **Internal-Decision Making Process**
- *Overcoming a barrier before seeking help*

RYAN: difficult at first but when you push yourself to talk about it, eventually it becomes easier ye and when someone reacts positively to it you can trust them and talk to them more about it.

(Lines 179-181)

RYAN: **The hardest thing to overcome is the initial barrier.** The rollercoaster ride afterwards is sort of your sat there and you let it happen to you but getting through the barrier is all you. I don't know how to word it.

(Lines 186-188)

SIMON: It was like trying to run through a brick wall, you can't manage it. It made me feel like I was second-guessing my thoughts and what I wanted to do.

(Lines 247-252)

CALLUM: but its new to you so you're going to be scared talking about it actually helps a lot more I never spoke to nobody in my entire life about any of this stuff and in these last couple of months I have spoken to people and now I just can't shut up.

GERRI: it was good at helping me help myself in some ways push myself to do better things so ye.

- *Scepticism, unwillingness to seek help*

RYAN: Ye, that definitely changed it was far more effective than I thought it was going to be for me…

(Lines 272-273)

ADAM: I went into it sceptical and thinking it wouldn't work but I got used to it. It was hard for me to answer honestly at first, I wouldn't lie but I wouldn't say the whole truth.

(Lines 148-15)

ADAM: for the most part I wouldn't get in to my genuine mental health too much that wasn't the focus perhaps it should have been a bit more I don't know.

(Lines 175-177)

ADAM: Which didn't bother me because I was sceptical in the first place I wasn't looking forward to it I wasn't dreading it.

(Lines 272-274)

DAVID: especially the first time I went as a space for me I know that no one can, there aren't words that can fix someone

(Lines 87-88)

- *Difficulties have to be severe before getting help*

RYAN: It actually came to me trying to … took an overdose of painkillers and then I was in hospital and I was actually referred to the (service) by the team in the hospital. So it was not so much that I sought the help until I had already done something.

(Lines 4-7)

DAVID: I mean there's that thought of when I decided to ask for help it can't be worse than what it is and that was part of that wanting to do it for someone else it's not going to make me worse than what I am so it was worth a try in that sense but ye I don't think there's anything else.

(Lines 267-270)

CALLUM: I came to the end of my rope there was two options there was death and help and I chose help and that's why I'm sat in front of you right now

GERRI: well because I was not in a good place so I didn't think about it as I was in college, then I was unemployed but I was getting by I wasn't dead so there was that

DAVID: I don't want to waste their time and my time I've got on with it for 20 odd years I'll get on with it for however long more.

- *The Impact of the perceptions of others*

RYAN: I suppose you kind of feel trapped because you know the option is there but also it could potentially have a negative impact on you it makes it a very difficult option to go for.

(Lines 20-22)

RYAN: Erm very few people that you can kind of trust and wont judge you for it I feel like that's a big issue as well worrying about people judging you for struggling, still there a few people that I know that don't believe that mental health is such a thing they think that things like depression and anxiety are … what's a good word for it … attention seeking.

(Lines 44-47)

RYAN: two worries that I had was, one I was that I was either going to be seen as someone who was seeking attention

(Lines 52-53)

SIMON: It was worrying that I wouldn't be believed really. That and trying to accept it myself.

(Lines 216-218)

SIMON: I haven't told that many people I've told, still don't really like to talk about it as I feel I've got this difficulty of there's nothing really to see, I still feel like I've got this barrier… what would their reaction to it be? And there's till the can I be taken seriously issue.

(lines 341-353)

SIMON (Lines 499-505)

ADAM: It was embarrassing at first I still don't tell people about it but I know it had to happen because if I had told my past self that in a years' time I'll be going to therapy I would have laughed.

(Lines 49-51)

DAVID: I didn't feel that I don't see how it could help I was a bit blind to it I guess and because I think maybe part if it was that my mums been in therapy for most of her whole life and she's not any better I guess so I guess subconsciously that kind of played on my mind as well…

(Lines 112-115)

GERRI: Not to say that I didn't manage I kept under the radar, people didn't care but it's just stressful all the time people shouting

GERRI: I went to therapy it's not something I'm going to label and plaster everywhere 'look at me I am broken' there's no point in doing that that's a cry for attention when there doesn't need to be one,

RYAN: I've always tried to talk as much as possible but erm there's a limit to how much you can open up to people you don't want people to worry about you

2. **Duty/Taking Responsibility**
- *Blaming, shameful to have to get help*

RYAN: …I was supposed to be strong, mentally and physically. Should be able to shrug off whatever life throws at you. I thought because it was something he could do that it was something that I could do (seek help).

(Lines 216-219)

ADAM: : Ye I said embarrassed, I can't remember, I don't know I just felt ashamed

(Line 56)

DAVID: I felt numb just completely numb and guilty at the time and I was at the beginning when I first saw (therapist) I was quite self-deprecating I was beating myself up.

(Lines 13-14)

CALLUM: And I drove a wedge between me and her because of my mental illness I made us two split up because I didn't acknowledge it was the fact I was getting angry it was me.

GERRI: erm its annoying, the reason I can't do it is my fault, I have no motivation, no work ethic…

- *Duty to seek help to protect others*

RYAN: I've always tried to talk as much as possible but erm there's a limit to how much you can open up to people you don't want people to worry about you, you don't want the added stress of them checking up on you erm you just want to pretend that everything's fine, it doesn't work out that way it just increases the stress of it all.

(Lines 32-35)

ADAM: I made them feel like I was and when they said that and when they said they were genuinely scared of me that kind of broke my heart in a way because I know I'd never hurt my mum I'd never hurt my sister or my girlfriend.

(Lines 39-41)

ADAM: Not really, it was if it was up to me and I didn't have friends, family and my girlfriend I wouldn't have joined, I would have just stayed being myself if no one would have told me to pack it in

(lines 78-80)

ADAM: I love my girlfriend to bits, when she said I can't be with someone who is like this that instantly tore my heart out because you know I love her and I know she loves me and I'll do anything to make sure you know she stays in love with me and I don't put her off or scare her or make her feel threatened and I was doing all that so that was a big motivator and there was my mum and my little brother and sister I love them two…

(Lines 87-90)

ADAM: Well like I said I felt bad for (therapist) I felt like it was a bit of a middle finger to her oh ye thanks for spending 8 weeks with me but its I can't be arsed no more I don't know so I like I say I almost came in for her more than I did for me just to not make her feel like she's failed or something you know but.

(Lines 354-357)

DAVID: So it was as I said the main one was becoming a father and with that not only being a father being a husband and because I felt difficult to it felt difficult to connect with my son.

(Lines 127-129)

DAVID: the only thing that kind of stopped that restrain form getting the help was that I didn't want to be a bad dad because I was depressed I was like just really low all the time and not fun to be around or anything and I didn't want my son to grow up and think why is dad always sad

(Lines 41-44)

DAVID: the only thing that pushed me to do it is that it wasn't for me in the end. But when I came for help here and since it's been more for me…

(Lines 54-55)

CALLUM: I've got a son and everything and if I lost my life and losing it to this stuff (mental health) and being how I am my son would have grown up with no Dad…

3. Connecting - Relating
- *Loss and isolation*

RYAN: It was incredibly isolating, it's not that, in a sense you feel like you're on your own but not necessarily because you are you can't see who is there to help you, it can feel a little bit lonely I suppose as well I felt lonely.

(Lines 291-293)

RYAN: Its hardest thing to face on your own I think.

(Line 296)

RYAN: people that do take it seriously but don't know how to act around you. It's like they're walking on egg shells I don't want that either. It's sort of isolating.

(Lines 54-56)

ADAM: I had a stage of feeling no one really gives that much of a shit about me.

(Line 111)

ADAM: Lines 116-115

DAVID: saying it was my fault that he died but I had my biggest feelings of numbness and not feeling like I connected not being able to show my emotions

(lines 15-16)

CALLUM: knowing what my life is about, not even knowing where I come from, that's why I thought let's get some help through with it (feeling suicidal) then looking at myself having no father figure, no dad and not knowing what my life is about, not even knowing where I come from, that's why I thought let's get some help.

- *Easier to relate to people with shared experience*

RYAN: I felt like if he hadn't sought help maybe I wouldn't have sought it myself.

(Lines 214-215)

SIMON: Ye, it was difficult because I knew that I had the issues it was just about whether I could explain it or not in a way that could lead to something being done about it, rather than people just thinking it's you when it's not.

(Lines 256-262)

SIMON: they did encourage to seek support and they tried to help where they could but with them not experiencing it themselves it was difficult for them as well.

(lines 172-177)

SIMON: Well I had to try and explain it to them in a way that could be understood, in a way that wasn't what you would read in a book about psychology, in a way that could be understood, that was quite difficult.
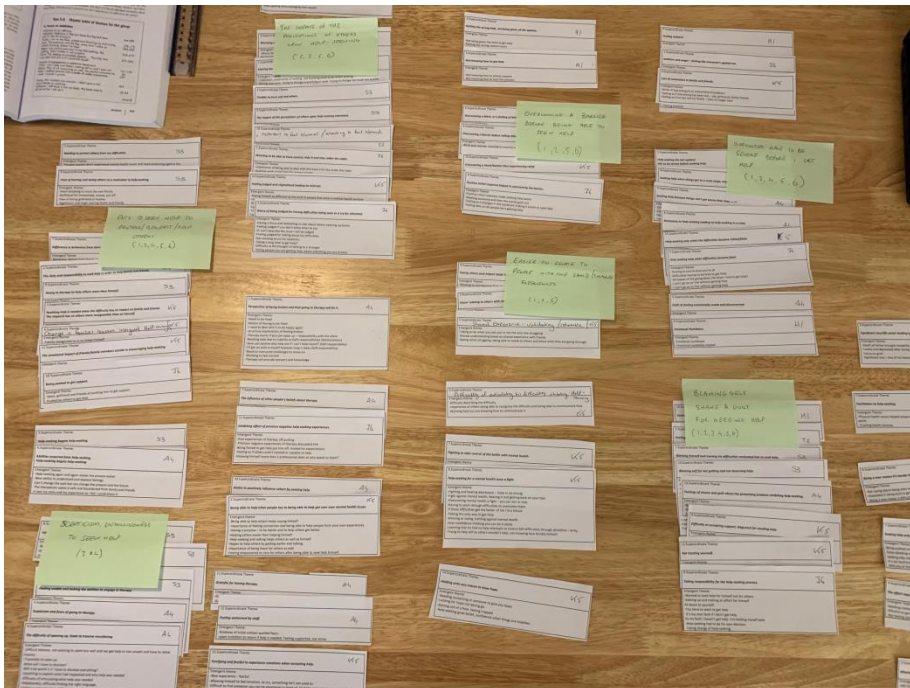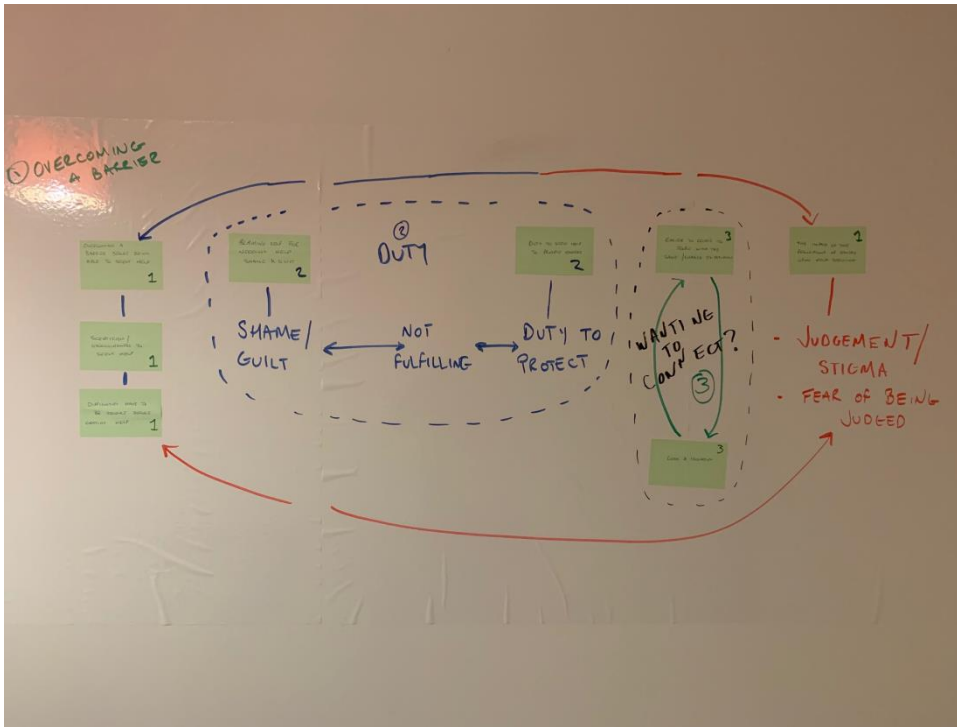
(lines 181-187)

SIMON: Ye it was not easy to explain, even now it's not easy to explain

(Lines 190-191)

SIMON: Lines 197-193

CALLUM: he's helped me through everything but he understands himself because he's been there himself and like stuff like that it helps.

RYAN: I thought because it was something he could do that it was something that I could do (seek help).

Appendix P: Epistemological statement

This statement is intended to clarify the epistemological and ontological position of the researcher in approaching the research, thus highlighting the assumptions underpinning the project.

Ontology is the study of being; ontological assumptions are concerned with the nature of reality, of what things are and how they work. Epistemology is concerned with forms of knowledge, how knowledge is created and the relationship between the researcher and the subject of study (Scotland, 2012).

The ontological stance of the present project was a social constructionist position, i.e. that meaning is not discovered; rather meaning exists as a result of the world we experience and is therefore created through our interaction with it. Furthermore, it is principally concerned with integral aspects of culture such as class, gender, language and discourses that contribute to systems of knowledge (Siegel, 2006). As opposed to assuming that there is a definite observable truth that a positivist might adopt (Denyer & Tranfield, 2006).

In the present project, the researcher principally perceived himself as concerned with the subjective meaning of the young men's accounts and their interpretation of their own experiences (Holstein, 2007). The empirical project was an attempt to understand men's experiences and was concerned with individual's subjective perspectives. Therefore, in terms of epistemology, an interpretative approach was taken to the research, trying to understand the behaviour and experiences of the participants, rather than trying to measure or explain them (Green & Thorogood, 2014). Reflecting upon the interpretative approach to research confirmed that Interpretative Phenomenological Analysis was in fact an appropriate methodology that could be used to explore young men's help-seeking experiences.

The interpretative researcher is not concerned with generalising findings, whereas with a positivist researcher this may rank as a primary aim. Instead interpretative approaches recognise that the social researcher cannot segregate their thoughts, actions and belief systems from the world. The interpretative researcher recognises the methodological implications this invariably has upon the research findings and accepts their subjectivity (Larkin, Watts & Clifton et al., 2006). In this context, the interpretative researcher's impact upon the social world is seen as a strength. It allows for them to embrace a flexible approach and to fully explore the participant's intended meanings.

Whereas the systematic literature review was a narrative synthesis, drawing upon qualitative and quantitative data to produce a story (Popay et al., 2006), a story of why certain factors may be significant in producing effective mental health campaigns. A narrative synthesis was selected as it is designed to provide information in order to advance theoretical models in a given a field, as was the goal of this review.

It should be noted that the papers obtained as part of the systematic literature review often contained a quantitative element. Here the research is more positivist as studies attempted to measure the impact of predefined constructs upon help-seeking tendencies. Thus, there are assumptions, that an increased level of men's help-seeking is desirable. Nonetheless, variant research approaches can be incorporated in a narrative synthesis, through an exploration of the methodologies in the narrative.

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Appendix Q: Reflective statement

Research Topic

My interest in men's mental health is on some level rooted in my own experiences in life as a young man. In my own friendships I often wondered as to why being open and honest with emotions seemed largely absent. It concerned me that so many people were experiencing mental health difficulties and felt as if they could not speak to people about them.

During my undergraduate studies I volunteered with the mental health charity MIND and supported young men in offending institutions thinking about how they might reintegrate back into the community. It astounded me seeing how difficult life had been for some people and yet how resilient and hopeful they continued to be.

Starting the Clinical Doctoral Training there was an emphasis on how psychological skills could be used at the level of public health to promote mental well-being. I started to think about gender disparities in reported mental health rates and how a deeper psychological understanding could be achieved to explain these differences. Conversations with Dr Chris Sanderson and Dr Anjula Gupta helped me to see how this aspiration could be conceptualised and pursued in a research project. I was interested in men's experiences of seeking help and of their journeys to mental health services. We began to discuss the possibility of exploring young men's experiences of seeking help for a mental health difficulty.

Method and approach

Whilst reviewing the literature regarding men's mental health service utilisation, many of the academic papers focused on the facilitators and barriers facing men before being able to seek help. There was also a host of research proposing that certain therapeutic

interventions might or might not be effective. However, there was a marked absence of qualitative, exploratory research looking into young men's experiences of seeking help. I made the assumption that young men who had actively sought help for a mental health difficulty would most likely be in primary care services given the stage at which these services provide support within the tiered healthcare structure. I thought that interviewing young men from primary care services would provide a good opportunity to explore experiences of seeking help for a mental health difficulty.

Recruitment

Initially I hoped to recruit any individual who had sought help for a mental health difficulty. However, in order to understand the nature of people's experiences it was necessary to recruit a homogenous sample. I decided to recruit from IAPT services due to the remit of their clinical focus. I also thought about using a trans-diagnostic approach, not focusing specifically on one mental health issue, but instead exploring the help-seeking process.

Recruiting from mental health services I found challenging. The time it took to get NHS ethics, the struggle of carving out time from a busy academic and clinical workload to build relationships with willing services, and the preoccupations and time-stressors facing services and their staff ensured that my research project was at the bottom of people's to do list. I found myself contacting more services and changing my research procedure to open recruitment up to as many potential participants as possible. I unsuccessfully attempted to recruit from universities and charities offering mental health support. I started to worry. I also began to wonder if staff were able to recruit, or whether they felt a sense of inevitability about men not wanting to give up their time to talk about their mental health. At times I felt my research project was a heavy burden. What was reassuring was hearing that trying to recruit from a typically difficult to

engage population was always going to be a challenge. Many conversations in research supervision were dedicated to the process of recruitment, until one practitioner gave my project the time and effort to get the participants required. Worry gave way to excitement and the long awaited first interview arrived.

Interviews

I remember being very nervous for the first interview and thinking, if this is how I feel, "what must the participant be feeling?" The first interview was such a raw and emotional experience. There were long pauses at times as the participants struggled to articulate their emotional experiences. I also battled between validating participant's experiences and maintaining the focus and the researcher-participant relationship. I had to constantly think about the position of this research; there are no right or wrong answers. I was shocked by how much participants were willing to be open and how much they had to say. For me, the interviews were the most enjoyable experience of the research process. I felt the space created by the project meant participants could explore their experiences whilst contributing to the research in this field.

Throughout the interviews I was mindful of being a young man, close in age to the participants and how this might have impacted the discussions. I was aware that for some participants it might be easier to speak to another young man. I was also wary that it may have the opposite effect for others.

Analysis & Write-Up

By the time the process of transcription arrived I was highly motivated and ready to take on the cumbersome task of transcribing. It was useful to become acquainted with the data and the accounts of the participants. The initial transcribing and development of emergent themes was exciting, it was a new experience for me. Through the process of

abstraction groups of themes were developed. Identifying super-ordinate themes was a creative process and it was rewarding to see the fruits of the project.

Staying grounded in the experience of the participants, looking back to the context of the quotes, and conversations with research supervisors helped to stay as true as possible to the experience of the participant's. I took time to reflect and recognised the role of the researcher, the interpreter in interpretative phenomenological analysis.

Systematic Literature Review

One method of engaging men in discussing mental health help-seeking that has gained traction is mental health campaigns. Seeing these attempts to tackle the difficulties around men's mental health interested me and I wondered to what degree is this approach effective? I found that there were many campaigns, but few academic papers that had examined at a deeper level their implications. The rigid procedure by which a Systematic Literature Review is completed was at times frustrating. However, the certainty of having the literature in hand, with no other unpredictable factors helped me to feel a sense of certainty. This was a project that felt under control, contrasting my empirical research.

Journal Choice

The Journal of Men's Studies was chosen for both the systematic literature review and the empirical project. The journal is internationally known and has a keen focus on health related issues that men face. I hope that the empirical paper is received well by those interested in men's experiences of disclosing mental health difficulties.

Summary

This research project has been one of the most challenging tasks I have undertaken and it proved a true test of resolve. I am glad that I chose a topic that is engaging and I am

passionate about, otherwise it is difficult to see how this could project could have come to fruition. Although it was a new way of working and was theoretically and practically very difficult at times, I am glad that I chose to use a qualitative methodology which allowed the depth and time to explore these men's accounts. I have no doubt that the personal attributes and research skills I have gained throughout this project will serve me well in my future career as a clinical psychologist.