THE UNIVERSITY OF HULL

Learning from teenage boys from low-income families: attitudes towards expressing emotions and seeking support in times of distress

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OVERVIEW

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

Part One: A systematic literature review featuring the available research regarding barriers to help-seeking for mental health difficulties in low-income populations.

Part Two: A qualitative empirical paper exploring the attitudes of boys from low-income families around emotional expression and help-seeking in times of distress. Inductive Thematic Analysis is used to analyse the results.

Part Three: Appendices including all relevant documents for the systematic literature and the empirical paper. Epistemological and reflective statements can be found here.

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CONTENTS

Page Number

Page number

List of Tables and Figures

Part One: Systematic Literature Review

Part Two: Empirical Paper

Part One: Systematic Literature Review

A systematic review exploring the barriers that people from low-income populations experience when help-seeking for mental health difficulties

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A systematic review exploring the barriers that people from low-income populations experience when help-seeking for mental health difficulties

ABSTRACT

Objectives: Worldwide, health outcomes for people experiencing economic disadvantage are consistently poorer. In particular, increased rates of mental health difficulties (MHD) in low-income populations have been associated with higher levels of stress and experiences of adversity. Inequalities in the access to health care have also been highlighted. This review aims to reveal more insight into the experiences of barriers to help-seeking for MHD for people from lower socio-economic status.

Methods: A systematic literature review was conducted, synthesising the findings from a total of eleven studies. A narrative synthesis was used to present the results of the available literature in this area.

Results: The findings of included papers were summarised through three themes: ‘Stigma’, ‘Relationship with Services’ and ‘Logistical Issues’. Within each theme, the impact of economic disadvantage was highlighted.

Conclusions: The review provides an overview of the barriers that people from low-income backgrounds experience when accessing support for mental health difficulties. Suggestions for clinical practice have been considered in an attempt to reduce the impact of such barriers.

Key words: *low-income, economic disadvantage, help-seeing, access to support, mental health.*

Introduction

The impact that living in poverty has on mental health has been well documented (Murali & Oyebode, 2004). Consistently, studies have found that rates of mental health difficulties (MHD) are higher in low-income populations, with children from low-income families being 2-3 times more likely to develop difficulties later in life (Reiss, 2013). A growing body of evidence has shown that there is a socioeconomic gradient in mental health; people of lower socioeconomic status (SES) have a higher likelihood of experiencing MHD (Allen, Balfour, Bell & Marmot, 2014).

There is discussion around the direction of the correlation between SES and MHD: poverty-related stress can result in psychological distress (Lipman & Boyle, 2008) and severe MHD can increase the likelihood of poverty (Breslau, Lane, Sampson & Kessler, 2008). Generally social causation theory has the most support. This theory describes how the stress associated with economic adversity results in an increased likelihood that someone will develop MHD (Mossakowski, 2014). There are several hypotheses of why low SES is associated with MHD. The systemic impact of living in poverty can result in stress at many levels; social, educational, occupational and cultural (Bronfenbrenner, 1992). Furthermore, people living in poverty are more likely to experience uncontrollable life events which may result in reduced power and autonomy (Ennis, Hobfoll & Schroder, 2000). An implication of this is that there may be a higher need for mental health care in low-income populations.

Populations with the highest rates of deprivation have the lowest availability of support services; with the poorest countries spending the lowest percentages on mental health (Saxena, Thornicroft, Knapp & Whiteford, 2007; World Health Organisation, 2015). This highlights the disparity in the availability of resources. Income and wealth are a major cause of health inequality; having sufficient finances allows people to pay for the services and goods they need to maintain health, both physical and mental (Morris, 2010; Vasiliadis, Lesage, Adair, Wang & Kessler, 2007).

People from low-income backgrounds have been found to have higher rates of psychotropic medication use. This is often attributed towards negative perceptions of more psychological interventions (Anderson, Brownlie & Given, 2009). People experiencing poverty in early life are more likely to use psychotropic drugs in adulthood (Morton & Ferraro, 2018) as well as inappropriate medication (Lesén, Andersson, Petzold & Carlsten, 2010). Generally, it has been concluded that this is due to a preference for medical intervention. Alternatively, it may be that people from low-income backgrounds are over-prescribed and incorrectly prescribed medication for emotional distress.

Recent reviews have focused on barriers to help-seeking for MHD in working age adults, without specifying SES. Schnyder, Panczak, Groth and Schultze-Lutter (2017) found that personal negative attitudes about people with MHD were associated with a decreased likelihood of help-seeking for psychological difficulties. Interestingly, perceived public stigma was not found to be a significant predictor help-seeking. However, a review focusing on help-seeking for suicidality revealed that stigmatising public attitudes was a key barrier (Han, Batterham, Calear & Randall, 2018). Further barriers were revealed including self-reliance and perceived lack of need. In reviews focusing on barriers to help-seeking in general adult populations, factors at the individual level, rather than systemic, appear to dominate the literature.

Socio-economic inequalities have been found to negatively impact the use of mental health services (Amaddeo & Jones, 2007). Many people in low-income populations rely on the self-management of MHD including health compromising behaviours such as illicit drug use, binge drinking and fast food consumption (Walsh, Senn & Carey, 2013). This highlights the need to explore the reasons why low-income populations do not access mental health care in order to provide information for service development. However, this conclusion may be criticised as it places the responsibility of access and engagement on the individual rather than the service. For example, outreach working and community based centres can be an effective way of improving access and engaging people with MHD (Wennerstrom et al., 2011).

Barriers to help-seeking for MHD in low-income populations have not been systematically reviewed. The focus of this review included barriers, rather than facilitators, in order to offer insight into potential ways of reducing such challenges. It is hoped that this will gain more depth and understanding into people's experiences in order to inform clinical applications.

The research question for this review was:

> *What barriers do people from low-income populations experience when seeking help for MHD?*

Methodology

Identification of Studies

This review aimed to evaluate the literature on barriers to help-seeking for MHD in low-income populations. The review covered all age ranges and dates of studies.

The following databases were accessed via the ESBCOhost service: Academic search premier, CINAHL Complete, MEDLINE, PsycARTICLES, PsycINFO. Databases were searched up and including up to February 2020. The 'All Text' option was selected in order to ensure that all relevant papers were included in the search. Limiters included papers written in the English language and articles which had been peer-reviewed.

Inclusion and Exclusion Criteria

Criteria to ensure the inclusion of relevant and high quality papers are presented in Table 1.

Table 1. *Summary of the exclusion and inclusion criteria applied to the search, with rationale.*

Criterion	**Rationale**
Excluded if help-seeking for anything other than mental health	Review and research study aim to look at mental health specific difficulties (rather than physical health or other areas).
Excluded if not looking at barriers	Review aimed to look at the factors which may prevent someone from accessing support, rather than facilitate. This is to give consideration to the problems and challenges which may affect low-income population.
Participants not identified as low-income	People from a low socio-economic status were the population under consideration.
Help-seeking for others, not self (e.g. children)	The current research study is looking at personal experiences of help-seeking therefore studies investigating the experience of help-seeking for another person would highlight different factors.

Qualitative design only	Focus was on individual's experiences of help-seeking therefore rich, descriptive data was selected. Qualitative analytical methods required.
Not a literature review	The present review aimed to review original studies and findings.
Peer-reviewed only	To increase quality of included papers

Search Strategy and Study Selection

The search terms were identified by examining papers in the field and replicating the key terms used within their titles and identifiers. The following search terms were used:

- (barrier* OR obstacle* OR difficult* or challenge* or issue* or problem*)
- AND (seek* OR request*) N3 (help* OR support*)
- AND (“mental health” OR “mental disorder” OR “mental illness*” OR distress*)
- AND (“low-income” OR poverty OR “low socioeconomic status” OR “low SES” OR poor OR disadvantage* OR “working class”)

The above terms were applied to title only in order to reduce the number of irrelevant papers revealed through the search. Following this, 1164 records were identified with 644 remaining after duplicates were removed. Figure 1 summarises the selection of studies, using the PRISMA flow diagram (Moher, Liberati, Tetzlaff & Altman, 2009).

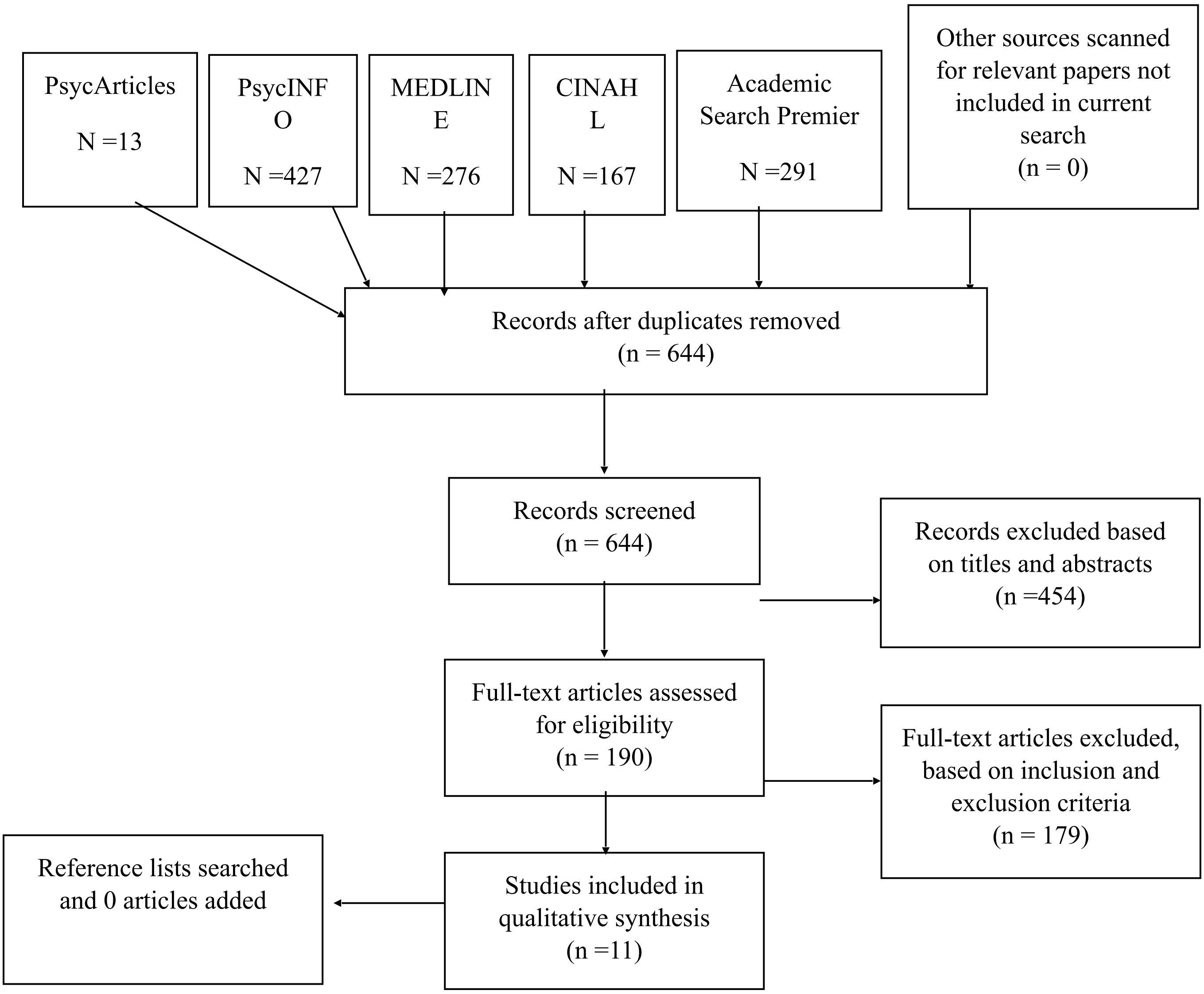

Figure 1. *PRISMA diagram to illustrate the selection process.*

Common reasons for the exclusion of papers included no indication of low-income population; experiences of help-seeking for others (e.g. children) and barriers identified for physical health related issues. See Appendix B for examples of excluded papers.

Data Extraction

Information was extracted from the articles using a data extraction form designed for the purpose of the current review (see Appendix C). The following topics were used to identify key information: country, sample characteristics, low-income criteria, methodology, data analysis and main themes (barriers). A summary of the data is included in Table 2. The data extraction process was conducted alongside the quality assessment.

Table 2. *Data extraction form with included studies following the database search.*

Author (s)	**Country**	**Sample**	**Low-income criteria**	**Methodology**	**Data Analysis**	**Main themes (barriers identified)**	**Quality Score (% to nearest whole number)**
Berry et al., (2020)	Malaysia	9 young people (5 male, 4 female) ages 16-23. 2 of Malaysian, 2 of Chinese, 3 of Indian and 2 of Indigenous Orang Asli ethnic groups.	Access to social enterprise working with young people from low-income areas.	Questionnaires (assessing psychological wellbeing) + Individual semi-structured interviews.	Thematic Analysis.	Limited knowledge and awareness of MHrD; cultural discourses of shame and weakness associated with MHrD; cultural stigma of asking for help; treatment perceived as challenging and lacking efficacy; individual compassion and desire to help others.	100

Doornbos, Zandee, Doornbos & Maagd-Rodriguez (2013)	USA	61 females. 22 of Black, 19 of Hispanic and 20 of White ethnic groups.	Residents of ‘impoverished’ neighbourhoods (self-identified as having insufficient finances to meet personal and family need).	Three focus groups stratified by ethnicity. Semi-structured interview guide.	Template analysis.	Practical (long waiting times, lack of transportation, lack of awareness, lack of financial resources/ insurance); psychosocial (stigma, lack of trust, lack of confidence in professionals); cultural (perceived discrimination by health care workers regarding ethnicity and SES).	82

Snell-Rood et al., (2017)	USA	28 women age 20-66. 27 of White and 1 of Black ethnic groups. Depression score of over 15 on CES-D.	Income 200% of poverty line.	Individual, semi-structured interviews.	Content Analysis.	Doubts about treatment (efficacy of counsellors, worries about addiction to pharmaceuticals; trust and confidentiality); self and external stigma; self-sufficiency.	91
Jesse, Dolbier & Blanchard, 2008.	USA	21 (16 of Black and 5 of White ethnic groups) pregnant or recently pregnant women.	Clinic eligibility criteria.	Focus groups, semi-structured interviews.	Content analysis.	Lack of trust; judgement/ stigma; dissatisfaction with health care; not wanting help.	82

Dupere, O'Neill & De Koninck (2012)	Canada	22 men, median age 47. Ethnicity not specified.	Self-identified as experiencing poverty.	Individual, semi-structured interviews	Grounded Theory.	Nature of the problem (recognising problem, debilitating symptoms); narratives around help-seeking (feeling powerless and incapable of asking, pride and masculine steretypes); service factors (lack of knowledge, practical barriers, negative past experiences).	73

Cruz, Pincus, Harman, Reynolds & Post (2008)	USA	43 (38 female, 5 male) people of Black ethnic groups with a diagnosis of depression (and engaging with psychotherapy in low-income neighbourhood).	Insurance through public health or public assistance programs for low-income recipients	Individual, semi-structured interviews.	Standard qualitative analytic methods	Internal factors: dysfunctional coping behaviours (e.g. ‘dealing with it’); shame; denial; perception of care as negative; lack of trust; hopelessness and religious beliefs. External factors: stigma; lack of finances; lack of resource knowledge; discrimination.	64

Wells, Lagomasino, Palinkas, Green & Gonzalez, (2013)	USA	24 Emergency Department patients. 19 female, 5 male, 23 of Latino ethnicity.	Education level, access to insurance and employment status.	Telephone interviews.	Grounded Theory	Negative perceptions of medication; embarrassment; transportation problems; cost concerns; employment/ unemployment concerns; provider dissatisfaction; immigrant documentation worries.	82
Abrams, Dornig & Curran, (2009)	USA	14 mothers. 8 of Latino and 6 of Black ethnic groups. Post-partum depression symptoms present.	Low household income (equal or below 185% of poverty line).	Focus groups and individual interviews (semi-structured). .	Grounded Theory.	Stigma; negative past experiences; cultural barriers; practical barriers (e.g. financial); lack of knowledge.	91

Ijadi-Maghsoodi et al., (2018)	USA	76 (26 male, 50 female) Black, Asian, Latino and multi-ethnic groups.	Living in ‘under-resourced’ area.	Focus groups (semi-structured)	Content analysis.	Embarrassment; fear of judgment; confidentiality; keeping things inside and lack of awareness.	91
Anderson et al., (2006)	USA	127 mothers with mental health difficulties (‘mood and anxiety disorder). 50 of Black and 77 of White ethnic groups.	‘Disadvantaged’ communities – high rates of unemployment and poverty. Over 50% household income under $15000.	Semi-structured individual interviews.	Ethnographic analysis.	‘Getting on with it’; not needing help; fear of being judged as an inadequate mother; therapists judged as inadequate and negative past experiences.	91

Copeland & Snyder (2011)	USA	64 mothers of Black ethnic groups.	Information regarding income collected but unclear what constituted 'low-income'.	Quantitative measures and semi-structured individual interviews.	Content analysis.	Fear of losing children; economic stressors; role strain (negative perceptions of the system and violence and survivorship.	82

Notes: Ethnic terms throughout are written in accordance with the guidelines by the American Psychological Association (2001). This may vary from the actual terms used in text of the above papers.

Characteristics of Included Studies

A brief overview of geographical location and participant characteristics is provided in Table 2. The majority of the studies were conducted in the USA (9/11). The remaining 2 studies were conducted in Canada and Malaysia. Eight of the studies focused on the experiences of underrepresented ethnic groups. All identified participants as being from low-income backgrounds. Some of the studies focused on additional participant demographics including gender and motherhood.

Quality Assessment

The Critical Appraisal Skills Programme (CASP; 2013) checklist was used to assess the quality of the studies included. This checklist is well recognised as an appropriate method for assessing the quality of qualitative studies (Claydon, 2015). For the purpose of this review, a question was added regarding the inclusion criteria for participants as 'low-income'.

The checklist was adapted in order to generate a numerical score (out of 11) for each study. For each of the 11 questions, a score of 1 was given for studies that satisfied the criteria, and a score of 0 was given for those that did not, or if the answer was unclear. A summary of the quality assessment checklist is given in Appendix D.

The lead author completed the quality assessment. An independent rater was asked to score four of the studies in order to assess inter-rater reliability. Quality scores were generally similar, with the independent rater scoring three studies 1-2 points higher. These areas of disagreement were discussed and scores adjusted accordingly.

Methodological Quality

Generally, included studies received high ratings using this scale (range 64-100%, mean = 84.5%, SD = 9.47). Conclusions made from studies rated as having lower quality did not differ significantly from those at the top end of the scale. A criterion that was frequently scored as 0 was regarding a consideration of the relationship between the researcher and participants. Only one paper briefly discussed the role of the researcher in the research process. An implication of this is that the analysis and interpretation of results may have been influence by bias; for example, researchers from a particular background may have attended more to information that matched their experiences. See Appendix E for a table of scoring.

There was variability in how low-income was defined. Many studies did not adequately explain how this was operationalised or how participants were sampled. Although there was some description of this in all eleven papers, the inclusion criteria for this characteristic was not always clear. It may be that this was not included in the reporting due to word count limitations.

All of the included studies utilised qualitative methodology, however data analysis procedures varied. This may have impacted the reporting of results, with one study not featuring extracts from interviews in the results. An implication of this is that the author's interpretation of data is the only information available. This could have led to further bias in the review as the themes reported may not accurately capture the voices of participants.

It is important to consider how quality may have influenced the results and conclusions of the studies. In particular, the interpretation of results may be skewed due to potential bias as described previously. However, no studies were excluded from this systematic review based upon methodological quality as generally, scores were sufficiently high. When considered together, the results from the selected papers are deemed to be significant in developing understanding of the barriers that people from low-income populations experience when help-seeking for MHD.

Data Synthesis

Due to the qualitative methodology of all included studies, a narrative synthesis was used to produce a summary of knowledge in relation to the review question. Although there was a certain degree of heterogeneity with regards to ethnicity, culture and geographical location, the vast majority of the studies shared similar characteristics. The narrative synthesis focuses on the barriers explicitly reported in studies but also reports themes and patterns within and across data that may constitute barriers but were not necessarily described this way in the original research. Narrative synthesis followed recommendations made by Popay et al., (2006).

Synthesis of findings:

The barriers described in each paper were summarised and patterns across studies were identified and compared. A synthesis of the data produced three superordinate themes and seven subthemes as outlined in Table 3.

Table 3. *Themes and subthemes identified through the data synthesis.*

Superordinate themes	Subthemes	Papers
Stigma	Internal	Abrams et al., (2009); Anderson et al., (2006); Berry et al., (2020); Copeland & Snyder (2011), Dupere et al., (2012); Ijadi-Maghsoodi et al., (2018); Snell-Rood et al., (2017); Wells et al., (2012); Cruz et al., (2008); Jesse et al., (2008)
	External	Abrams et al., (2009); Anderson et al., (2006); Ijadi-Maghsoodi et al., (2018); Copeland & Snyder (2011); Cruz et al., (2008); Doornbos et al., (2013); Snell-Rood et al., (2017); Jesse et al., (2008)
Relationship with services	Lack of awareness	Abrams et al., (2009); Ijadi-Maghsoodi et al., (2018); Dupere et al., (2012); Cruz et al., (2008); Doornbos et al., (2013); Berry et al., (2020)
	Lack of trust	Doornbos et al., (2013); Snell-Rood et al., (2017); Ijadi-Maghsoodi et al., (2018); Jesse et al., (2008); Dupere et al., (2012); Cruz et al., (2008); Anderson et al., (2006); Copeland & Snyder (2011); Berry et al., (2020)

	Negative perceptions / experiences	Snell-Rood et al., (2017); Berry et al., (2020); Abrams et al., (2009); Anderson et al., (2006); Wells et al., (2011); Dupere et al., (2012); Cruz et al., (2008); Doornbos et al., (2013); Copeland & Snyder (2011)
Practical issues	Economic issues	Doornbos et al., (2013); Abrams et al., (2009); Anderson et al., (2006); Wells et al., (2013); Copeland & Snyder (2011); Dupere et al., (2012); Cruz et al., (2008)
	Competing responsibilities	Wells et al., (2013); Copeland & Snyder (2011); Dupere et al., (2012); Cruz et al., (2008); Anderson et al., (2006)

Results

The themes identified by the researcher reflect barriers to help-seeking for MHD in low-income populations. Each superordinate theme describes a factor that the literature found to be an obstacle to accessing support.

1) Super-ordinate Theme: Stigma

All but one of the articles discussed the role of stigma as a factor contributing towards difficulty seeking support. Stigma was divided into two subthemes: internal and external. Internal stigma refers to an individual's own sense of devaluation in relation to a characteristic that is perceived as negative or undesirable (Scambler, 1998). In contrast, external stigma is used to describe actual experiences of discriminatory views (Brown et al., 2003). Whether this stigma was described as external or internal, pejorative attitudes towards those who identified with MHD seemed to result in people not sharing difficulties with others through fear of judgment or ostracism.

Subtheme: Internal Stigma

The literature discusses how many participants held derogatory beliefs about the meaning of experiencing MHD. Many participants in the articles referred to an association between MHD and being 'crazy'.

> *'You don't want people knowing your business…I don't know, I think it's just, I think I'm probably just plumb crazy.'* (Snell-Rood et al., 2017)
>
> *'I don't want anyone to think that I'm crazy.'* (Abrams, Dornig & Curran, 2009)
>
> *'I thought I didn't want to go in therapy because I'm scared, that they are going to say that I'm really, really crazy!'* (Copeland & Snyder, 2011)

Studies included in this subtheme indicated that people felt abnormal and different from their peers. Three papers discussed beliefs that people with MHD were in some way more dangerous.

> *'When he and his friends went out to town and everything…when he saw [a] guy like…yeah crazy people…he say…like even though they with many friends they feel scared because…that person can harm him…since they are not sane…the police can't*

> *do…cannot charge him obviously…so yeah that person can do anything to the.' (Berry et al., 2020).*

This stigma appeared to be internalised by some people, leading to them experiencing shame and embarrassment.

> *'A person wouldn't be embarrassed for…a physical, but they would be embarrassed to come talk about their depression.'* (Ijadi-Maghsoodi et al., 2018)

This comparison with physical health difficulties indicates the differentiation between the mind and body and the taboo that is associated with less tangible illness. This may be a reflection of the 'invisibility' of MHD; in comparison with physical conditions, people may feel like their difficulties are not legitimate.

> *'It's not the same as if you hurt yourself working at the plant.'* (Dupéré, O'Neill & De Koninck, 2012)

The experience of shame or embarrassment when experiencing MHD appeared to be fuelled by the idea that physical suffering is in some way more valid. Therefore by seeking support, the individual was in some way 'wasting' resources or 'abusing the system'. Feelings of embarrassment often resulted in people keeping their problems to themselves.

> *'I guess I was just embarrassed. Sometimes the embarrassment is too much that it prevents you from letting people know how you feel.'* (Wells, Lagomasino, Palinkas, Green & Gonzalez, 2013)

Other studies also discussed how internal stigmas lead to people feeling unable to share with others how they were feeling. Some participants described how they masked emotion with a more socially acceptable facial expression, in order to distract others from their emotional distress.

> *'I always have a smile on my face…I come into work like everything's just wonderful and…I mask it'* (Snell-Rood et al., 2017)

The internal stigma around MHD was frequently related to a perception that such experiences are in some way a reflection of deficit. This appeared to be related to a narrative that by experiencing distress, an individual could not control their emotions and was therefore 'weak'.

> *'In Malaysia…it's quite uncommon… [people] don't really want to let other people know they have mental health problems, they are scared to be viewed [by] their weakness…'* (Berry et al., 2020)

> *'Because it would mean showing my weak side, it would make it easier to take advantage of me later. It's happened to me before, you know'.*(Dupéré, O'Neill & De Koninck, 2012)

The stigma around 'weakness' was not just in relation to the experience of MHD, it was also described with reference to the idea of seeking support. Six studies outlined how asking others for help was in some way admitting defeat; thereby resulting in a lack of pride. It was also implied that those who seek support are viewed as lacking internal resources to manage the problem effectively.

> '*I am too proud to go looking for help. It's hard for me to 'swallow my pride' enough to get the help I need.*' (Dupéré, O'Neill & De Koninck, 2012)

> *‘People think you’re a wimp that you need someone to help you like you can’t handle your own problems’ (Ijadi-Maghsoodi et al., 2018)*

> *‘You know, I get through life managing…I’m depressed but I manage, I’m not one of those women who falls apart’* (Anderson et al., 2006)

A consequence of these attitudes around help-seeking was that people often tried to manage difficulties on their own. Some people described how they struggled to even acknowledge personal difficulties due to internalised stigma.

People described a sense of being ‘different’ from other people, which seemed to contribute towards discourses around abnormality. However, over-normalisation of problems also acted as a barrier to help-seeking. Some studies discussed how people felt invalidated by others when told their experiences were common and ‘normal’. Some people also talked about how they self-minimised problems.

> *‘I don’t need a therapist. I don’t think so because I function fine. I go to work; I do what I have to do, so it’s fine. I take care of the kids, its fine’* (Anderson et al., 2006)

> *‘…You know, compared to other people, I still function…I get up in the morning’* (Dupéré, O’Neill & De Koninck, 2012)

The distinction made between functional and dysfunctional MHD appears to reinforce the idea that wellbeing is synonymous with productivity. The studies that described this idea were based in western, capitalist societies (USA and Canada); these narratives may reflect conceptualisations of success and the emphasis on individualism. Therefore, although participants were experiencing distress, the ability to be functional appeared to result in the assumption that they did not need support.

Subtheme: External Stigma

As well as internalised beliefs and attitudes, eight of the studies found that experiences of discrimination by others resulted in a reluctance to seek help. Many studies outlined how people had experienced negative reactions after talking about their MHD, or had witnessed other people receive discriminatory treatment. This resulted in a barrier to accessing support as people feared adverse consequences by people in the community.

> *'They'd probably be embarrassed if someone saw them go to that office…people see and they just talk.'* (Ijadi-Maghsoodi et al., 2018)
>
> *'If you tell someone you are going to [name] Mental Health, the first thing they say is, 'you crazy, something's wrong with you.'* (Jesse, Dolbier & Blanchard, 2008).

This theme reflects the impact on social relationships and social status in the community. Some studies reported how people had felt ostracised from their community. This theme was more prevalent in studies exploring the experiences of non-White ethnic groups, perhaps indicating an interaction with xenophobia and racism.

It appears that both anticipated and actual loss of social status resulted in people keeping problems to themselves in order to protect their social-image and self-esteem. People also worried that being associated with existing stigma could have detrimental effects on employment.

> *'It's hard to get a job when you're in therapy. Employers may believe you're crazy'.* (Cruz, Harman, Reynolds & Post, 2008)

When focusing on experiences of people from low-income backgrounds, fears around unemployment may be more prevalent due to the significant consequences of income loss. This may be exacerbated for single parents or in households where one parent provides the income.

Studies that focused on low-income mothers highlighted experiences where children had been removed from families with care-givers diagnosed with MHD. This often led to fear of help-seeking from services. Mothers explained how they felt powerless and perceived health care professionals to be capable of judging them to be 'unfit' to raise their child. Low-income status seemed to intensify this belief; in addition to MHD, mothers believed that because they had limited finances, this would contribute towards people in authority deeming them to be 'bad' parents.

> '*And the male therapist made a diagnosis that she wasn't capable of taking care of her kids. And then what happened to her? The children were removed…And going in with that knowledge in some ways make you think twice about whether you want to admit that some of the things that you're dealing with are like what someone else has dealt with and then lost their kids.'* (Copeland & Snyder, 2011)

People described fear of being judged as an inadequate mother by both services and the community. In the studies focusing on mothers, many explained how those who experienced MHD following the birth of their child were viewed in a derogatory way by others in the community. Some also explained how they were previously the ones who instigated such criticism.

> *'Well I would listen to others say that when they had a baby they would get depressed…I would think they were immature…that's what I thought'* (Abrams, Dornig & Curran, 2009)

> *'Somebody who is depressed is' constantly sad, is tuned out of the world and wants to kill themselves. They want to hurt their children…when parents hurt their children, it's because they had depression, right?'* (Anderson et al., 2006)

These experiences of stigma (whether experienced by others or being the agent themselves) seemed to contribute towards people deciding against seeking support for MHD; instead people expressed a preference for managing difficulties themselves or 'getting on with it'.

> *'I don't know I've always been one to deal with it and move on…at times I be down but never letting anyone know that I broke down, you know.'* (Anderson et al., 2006)

> *'Grandma used to tell me, pull your big girl pants up and let's go.'* (Snell-Rood et al., 2017)

Many people acknowledged the negative consequences of the belief that they must be self-reliant; for example feeling overwhelmed, symptoms increasing in severity or reliance on drugs and alcohol. In many studies, it was discussed how campaigns to increase awareness of MHD and challenge prejudice and stigma could be beneficial in removing this barrier to help-seeking. Some papers outlined how attitudes were changing and the positive influence of this.

> *' If we talk about it in front of the whole class…they might like laugh…but like 3 or 4 students inside that class might think in their head…I might really need this…'. (Ijadi-Maghsoodi et al., 2018)*

This illustrates the potential for attitudes and stigma to change. Education, compassion and positive experiences seemed to facilitate this process.

Although many people said they would not seek support for themselves, they expressed willingness to be there for other people in times of distress. Despite holding negative views around mental health support, some papers outlined how the same individuals would endorse help-seeking for other people in their community.

2) Superordinate theme: Relationship with services

All of the articles discussed how factors associated with service delivery or perceptions of services resulted in a reduced likelihood of them accessing support for MHD. The knowledge, or lack of knowledge, that people had of mental health services seemed to contribute towards concern around the quality of care being offered. Therefore, the relationship between participants and services often acted as a barrier to help-seeing as people held negative beliefs about the outcome of attending such places.

Subtheme: Lack of awareness

Six studies found that limited knowledge of resources affected people's ability to seek support. As people did not know where or how to access services, this meant that they did not pursue help-seeking further.

> *'A lot of people don't know how to go about getting treatment.'* (Cruz, Pincus, Harman, Reynolds & Post, 2008)

> *'People don't know where they can go…yeah lack of awareness of different resources'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

Some participants described expectations that health care providers should take responsibility for this lack of awareness. Ideas were suggested to raise awareness of provision by increasing advertising in local communities. Comparisons were made with physical health services in that participants were better able to recall existing provision and avenues of help-seeking for physical health difficulties.

> *'I never really personally met the [school mental health provider] so I think she should…hold an assembly…because a lot of people didn't know'* (Ijadi-Maghsoodi et al., 2018)

> *'It's true there are resources, but you know it's easier to use resources when you know about them, they gotta tell you about them!'* (Dupéré, O'Neill & De Koninck, 2012)

This theme suggests that people may want to access support, but due to a lack of knowledge they are unable to act upon this. By increasing awareness, this may have an impact on the number of people who receive mental health input. Some papers highlighted how financial strain may result in people being unable to find such information themselves.

> *'When you're living in poverty, you don't have time to find out about programs, about resources. You have to figure out how to get money…surviving's like a full time job'* (Dupéré, O'Neill & De Koninck, 2012)

This indicates that due to economic pressures, people may not prioritise seeking support for MHD. The above quote emphasises how other, more fundamental needs, may take precedent over seeking psychological support.

As well as resource knowledge, five papers discussed the impact of limited awareness regarding the symptomology of MHD. Participants explained how they may not seek support from services due to a lack of recognition that their distress could be conceptualised in this way. Many participants explained how they assumed that everyone had similar difficulties and they had to simply 'get on with it'.

> *'Say someone has anxiety issues, but they had it their whole life…they wouldn't know they had mental problems.'* (Ijadi-Maghsoodi et al., 2018)

> *'…Never encounter this kind of thing…I have no idea.'* Berry et al., (2020)

Therefore, in some cases, it may be that people have resource knowledge, but do not categorise their distress in a way which means that they would consider accessing these resources. Some papers outlined how the way that individuals and communities conceptualise MHD may differ from the models used in services. Cultural differences also affected the way people understood distress, as outlined in papers exploring the experiences of people from underrepresented ethnic backgrounds. This raises questions around whether existing resources are universally accessible.

Subtheme theme: lack of trust

Nine of the papers discussed a barrier around a lack of trust in services. In particular, this theme highlighted concerns regarding confidentiality as well as a lack of faith that services can or will help with a problem. Concerns about confidentiality may relate to the previous theme around stigma; people describe being concerned that others will be told sensitive information which could lead to stories being shared across communities.

> *'Doctors always say it is going to be kept confidential. Then they compare to other doctors and stuff like that. It gets on my nerves sometimes when another doctor comes and asks something that he shouldn't even know about. I guess you can trust them one time, but then when they do you wrong you never trust again. I mean you gonna have to take chances.'* (Jesse, Dolbier & Blanchard, 2008).
>
> ' *...It's the lies…the girl tell her story but the guy go tell all round tell all the story… tell all the stories about her…and so she, she felt sad…now I know this, I don't like psychology.*' (Berry et al., 2020)

The fear that others will be told personal information acted as a major barrier for many people. Participants also expressed a worry that other health care professionals will be told about their MHD; people wanted to talk about their difficulties with one trusted person. When they became aware information had been shared with other professionals, this resulted in a feeling of betrayal. Consequently, people avoided returning to services. Confidentiality also appeared to interact with factors relating to socioeconomic status (SES).

> *'They have programs out here for women – depression programs and whatever. I would not suggest them only because once you get into these programs, you are in the system and everybody is in your business. They say it is confidential but it's not confidential to the housing department! It's not confidential to the case worker! It's not confidential to CPS (crown prosecution service).'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

In many papers, the feared consequence of a break in confidentiality was that their living situation could be affected, for example being evicted from their home. Many people from low-income populations may not have the security of owning their own property; therefore this concern may be more prevalent. In order to reduce the risk of information being shared with local authorities, people tried to manage their MHD independently, or with friends and family.

The literature also highlighted how people had a lack of trust that their problems would be taken seriously by professionals.

> *'You'd have to be pissing blood to get any attention nowadays…They'll tell you that it's not an emergency and they'll send you home after you've waited for eight hours… Nobody has the time to listen to you or give you advice anymore.'* (Dupéré, O'Neill & De Koninck, 2012)

People felt that services were primarily designed for medical emergencies and that MHD were regarded as less urgent. For some, this appeared to reinforce personal experiences of invalidation and ineffective caregiving.

> *'Ive been abandoned all my goddamn life. You know, never once in my life has someone listened to me. I don't trust people.'* (Dupéré, O'Neill & De Koninck, 2012)

A commonly reported theme was that people also did not have trust in the intentions of professionals working in services.

> *'People come into this community all the time, but when the money runs out so do they. This happens over and over.'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

People were therefore less likely to seek help from services due to concerns around trustworthiness and reliability of the health-care professionals.

Subtheme: Negative past experiences

Across the literature, people described how they had previously sought help for their MHD, but due to negative experiences, they were now sceptical about the care they would receive. People identified various aspects of their help-seeking experience that led them to disengage with care, including practitioner qualities and treatment factors.

> *'The therapist just sat there and she wrote for a bit at her desk. And I'm sitting there. And she said 'why are you here?' I said, 'I was referred here'. 'Yes, but why are you here?' I said, 'I'm not sure. I don't know.' And she would say, 'Okay. When you're ready to talk, talk.' And I was like oh my God, what's that mean? What do I say? And I sat there uncomfortably for the next 50 minutes and did not say one word. I kept saying, 'I'm sorry. I don't know what to say. I don't know what to say.' And she was determined to force me to say something. And I just – I didn't like that approach, I didn't like that feeling at all. That was the end of my therapy'.* (Anderson et al., 2006)

This illustrates how the way in which practitioners relate to those seeking help can result in disengagement from services. This theme also highlights how health care professionals can be perceived as being in positions of power, which may be reinforced through negative experiences.

> *'As a psychologist for her, she feels is that it is a person who goes in the brain and they, they kind of take informations.'* (Berry et al., 2020)

> *'I wouldn't like somebody all dressed up and looking like, you know what I'm saying? Just looking like they're doing an experiment.'* (Abrams, Dornig & Curran, 2009*)*

Several papers made references to medical imagery such as 'lab coats' and 'testing'. A consequence of this was that people felt inferior, leading to the belief that professionals would not or could not understand their problems.

> *'And I figured [therapy] is not going to work because all she is going to do is read from a textbook. You know, she's not going to really know my experiences or nothing else.'*(Anderson et al., 2006)

> *'I'd rather talk to somebody…that's not using the big medical terms, that's talking to me down to earth. They throw out the medical terms and 'oh we'll start you on this medication'. I don't want medication; I just wanted someone to talk to'.* (Snell-Rood et al., 2017)

This suggests that people wanted to speak with people who had some understanding of the context that they lived in, rather than someone who had academic proficiency. People indicated that they desired a 'regular person' (Abrams, Dornig & Curran, 2009) and someone who would take the time to make sense of their experiences in a non-judgemental way. In contrast, some papers outlined opposing ideas; they believed that health care professionals were inadequate or underqualified and wanted them to display more ‘expert’ qualities.

> *‘Just real low grade counsellors; they’re just not even qualified actually to be doing counselling; they just use whatever they’ve got to put in the slot.’* (Snell-Rood et al., 2017)

Seven papers discussed participant’s previous experiences of not been listened to. It was frequently described how people valued talking as an effective way of reducing psychological distress. In contrast with this, an overarching theme was that people had previously been given medication as a ‘quick fix’ for their problems.

> *‘You want pills, here you are, we’ll give you pills! Have some smarties!’* (Dupéré, O’Neill & De Koninck, 2012)
>
> *‘I went to the doctors and they gave me Xanax and I said ‘I’m not gonna take it’ and they say ‘just take when you feel like you can help things and just to relax but don’t drink it all the time’ and I got it but I threw them away in the toilet.’* (Abrams, Dornig & Curran, 2009)

People described how they had experienced medication being prescribed without thorough explanation of risks and side effects. Participants experienced their Doctor to be more willing to prescribe psychotropic medication as this was considered to be ‘easier’ than exploring other avenues. In this sense, did not feel partners in treatment choices. This perceived over-prescription of medication led to people avoiding help-seeking as they worried that attempts to receive more psychological intervention would be ignored. Of the papers that discussed medication, all participants reported adverse reactions.

> *'I don't even like to take pills. I don't like medication. I always feel that I need to be able to function well, like do my work, read, knit, well you know stuff that I like to do. So I feel like that distract me. "I don't like taking medication for depression because it makes you addicted. That is what I have heard and I know by experience.'* (Wells, Lagomasino, Palinkas, Green & Gonzalez, 2013)

> *'They wanted to kill my craziness, I wanted to understand it.'* (Dupéré, O'Neill & De Koninck, 2012)

Many people discussed actual experiences or fears about addiction to psychotropic medication. Despite previously described scepticism, many people expressed a preference for psychological approaches to distress and were willing to engage with longer-term approaches. It seemed that medication was seen as a way of 'masking' underlying issues rather than trying to make sense of them.

3) Superordinate theme: Logistical Issues

Nine of the studies talked about practical factors that compromised the ability to seek help for MHD. It was discussed how social care, government policy, government funding and community resources may be helpful in addressing some of these logistical barriers. Although some papers addressed potential solutions to these issues, it was acknowledged how systemic and societal change was necessary.

Subtheme: Finances /economic

Seven papers discussed the impact of financial deprivation. This topic was raised multiple times with reference to barriers to help-seeking, but also in terms of people's understanding of the cause of their MHD: 'You'd be depressed too, if you lived my life.' (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013). People explained the stress associated with economic disadvantage and how this limited their ability to seek support.

> *'I live off my credit cards; I was grocery shopping on them. And it's like the snowball's rolling down the hill now, you know? I miss a day of work, I have no sick days. And my last pay wasn't quite $100.00. You know, it's like that – nothing can go wrong. It's the pressure that nothing can go wrong, but everything seems to.'* (Anderson et al., 2006)

The stress involved with debt and financial insecurity meant that people were restricted in their ability to research the pathways to access mental health resources. The pressure of economic hardship resulted in worry that acknowledging emotional distress would disrupt their ability to function in other domains in life. People acknowledged that support could be useful; however they were unable to put this need above others which were perceived as more urgent.

> *'My finances are awful right now. I'm trying to work out getting out of debt…' 'I need the insurance first…but the counselling, I see people benefiting from the counselling and the medicine.'* (Copeland & Snyder, 2011)

> *'You know, if it's between do you get your kid a winter coat or do you pay for the counselling appointment – you know what you need to go do.'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

This highlights global differences in the cost of healthcare. In countries where access to services involves significant cost, the economic barrier may be more pronounced.

> *'Talking to someone else and you're having to pay for it, is not seen as a smart purchase in our community'* (Abrams, Dornig & Curran, 2009)
>
> *'You know the kids if they don't have insurance they have Medicaid, but it is harder for an adult to get Medicaid. There has to be an alternative to that!'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

It seemed that mental health support was viewed as a luxury and those who could access support were perceived as privileged; highlighting health care inequalities. Even if people were able to get insurance or fund treatment, an economic barrier existed in that people were still required to travel to services.

> *'I could not go because of transportation – the bus. Tokens were not provided. I think even though I was feeling really bad, I would have shown up if someone would have gone to pick me up at my house'.* (Wells, Lagomasino, Palinkas, Green & Gonzalez, 2013)
>
> *'What barriers might exist? Transportation!'* (Doornbos, Zandee, DeGroot & De Maagd-Rodriguez, 2013)

Many participants in the studies could not afford to have their own vehicle. This meant that they relied on public transport to attend appointments. The cost and inconvenience associated with this meant that many people did not engage with health care services. This theme was expressed more frequently in studies focusing on the experiences of underrepresented ethnic groups highlighting the intersectionality of 'low-income' (Carbado, Crenshaw, Mays & Tomlinson, 2013).

The studies reviewed also highlighted how access to a phone or having a permanent address were significant barriers to people being able to benefit from health care. Health care services often rely on telephone or postal contact with service user, which means that people in these circumstances often miss out on vital information. Participants often felt ashamed and embarrassed when they discussed their limited finances.

Subtheme 2: Competing responsibilities

A final logistical barrier identified was that people often did not have the time to seek-support due to roles and responsibilities. Commitments associated with these roles meant that people were unable to prioritise their own mental health needs and seek out necessary forms of support. One of these roles included being an employee.

> *'Yeah, because I was at home, and where I lived in XXX, I work all the time. I did like three of four double shifts just so I could take care of all three of them because I'm the only breadwinner…I never could even have time to worry about the problem before because I was always working.'* (Cruz, Pincus, Harman, Reynolds & Post, 2008)

> *'…Because of my job, I was working a lot during that time so I could not go see her. I work really long hours and really later, or else I would have gone.'* (Wells, Lagomasino, Palinkas, Green & Gonzalez, 2013)

In some studies, participants described how they could not take time off work in order to attend to health care needs. Consequences of having time off work included reduced income and threat of unemployment.

> *'I have a job where I don't get sick days. I don't get personal days.'* (Anderson et al., 2006)

This subtheme interacts with the previous in that those with low-income, the risk of losing employment may have more significant consequences for the individual and family. People described significant pressure to maintain stable employment. Several papers described how services had limited opening times which added to the practical issue of having limited time to access professional support.

Further responsibility included the role of being a parent; in particular, it was mothers who described the difficulties associated with this. Three of the studies included featured accounts from mothers specifically. People discussed how their responsibilities as a mother impacted their ability to find time to seek-help for MHD. Furthermore, women described how they placed their child's needs before their own; often resulting in them paying less attention to their own wellbeing.

> *'It's just awful. Not knowing what was going to come next. I couldn't leave the room unless my husband was in there. I couldn't go do laundry. I couldn't do anything. I had to be in the room watching [my daughter] 24/7.'* (Anderson et al., 2006)

This emphasises the struggles associated with being a parent of a child with additional needs; in this case a child with emotional and behavioural difficulties. This may add a further level of complexity to the role strain of being a parent whilst attempting to seek-help for MHD. The cost associated with childcare may also result in parents being unable to take time to visit health care centres for mental health appointments.

The studies identified also reported accounts of domestic violence and adverse living conditions. This relates to competing responsibilities in terms of the needs to prioritise safety before addressing MHD through more formal support. This interacts with the subtheme of 'lack of trust' as people described worry that their abusive partner would learn about them seeking help; potentially leading to further danger.

> '*Three months ago, I and my three children were coming out of an abusive situation. We were also making a state-to-state transitional move. So that was like two crisis things, not only for myself as a mother, but also for my children*.' (Copeland & Snyder, 2011)

> *'And I know its not me. I know its [abusive husband]. And I know its never going to change unless I get away. To go in front of somebody and say 'okay, well, I think you're depressed'...It's the way he's doing things to me is making me like that*.' (Anderson et al., 2006)

Discussion

Overview of findings:

The aim of this review was to synthesise the barriers to help-seeking for MHD that people from low-income populations experienced. The majority of papers explored barriers in the context of a person who is not currently receiving any mental health input, although some featured accounts from people with previous experience of help-seeking. The main barriers were found to be ‘Stigma’, ‘Relationship with services’ and ‘Logistical issues’. The impact of economic disadvantage, health inequalities and discrimination was referenced throughout these themes, often exacerbating existing barriers.

In line previous reviews exploring barriers to help-seeking in general adult populations (Schnyder, Panczak, Groth & Schultze-Lutter, 2017), stigma was a major theme described which acted as a deterrent for seeking support. Stigma appeared to be internalised resulting in shame and embarrassment which in turn contributed towards people feeling unable to share their difficulties with others. Although awareness and acceptance of MHD has increased in recent years (Breslin, Shannon, Haughley, Donnelly & Leavey, 2017), the historical influence of negative discourse may have had long lasting effects on the opinions that people hold around distress and mental health. The papers identified in this subtheme span from 1974 to 2020; the more recent papers still identified negative attitudes around mental health, suggesting this is a prevalent issue.

In contrast with previous research, this review found that public attitudes and external stigma were significant factors which acted as a barrier to help-seeking. Systemic level barriers were discussed often in relation to peers, family, services and employment. The stress and pressure associated with low SES featured across superordinate themes. It was feared that disclosing MHD or taking time off to seek support could risk unemployment. In relation to income, many studies outlined how other needs were often prioritised over seeking support for MHD. This idea is supported by Maslow (1954) hierarchy of needs, in that in order to engage with higher-level processes, people must have their basic human needs met. In order for mental health interventions to be effective, it is important that people are supported with access to food, housing and safety (Kreuter, McQueen, Boyum & Fu, 2016).

In the USA, non-dominant ethnic groups are more likely to have lower SES (Williams, 1996). This is reflected in the number of participants with non-White ethnicity included in this review. Institutional racism is associated with limited socioeconomic mobility for non-dominant ethnic groups due to reduced opportunities (Miller & Garran, 2007). The interaction between low SES and ethnic minority status has also been related to poor mental health outcomes (Briones et al., 1990; Mossakowski, 2008). This review highlights barriers which were more prevalent in underrepresented ethnic populations, including access to transportation. Papers featuring experiences from non-dominant ethnic groups also discussed the role of community more frequently. In the US, non-White ethnic groups score higher in collectivism despite the US being an individualistic, capitalist society (Coon & Kemmelmeier, 2001). This may contribute towards the emphasis of systemic and family factors reported as barriers in this review.

A further example of discrimination was the fear that children would be removed from families where the caregiver experienced MHD. This was mentioned by predominantly women from non-dominant ethnic groups. In the US, Black children are more likely to be removed from families in comparison to White children (U.S, Department of Health and Human Sciences, 2004).This has partly been attributed towards discrimination by society and the practices of welfare workers (Needell et al., 2003). This relationship is exacerbated by low-income, with non-dominant ethnic groups with low SES being overrepresented in the child welfare system (HHS, 2004). The interaction between economic disadvantage and xenophobia is emphasised through these findings; highlighting the intersectionality of low-income status and the complexity of the barriers to help-seeking.

Experiences of racism are consistently linked with adverse psychological and physiological outcomes (Pieterse, Todd, Neville & Carter, 2012). In societies where negative cultural stereotypes are accepted, this can lead to unfavourable self-evaluations and internalised stigma (Williams & Williams-Morris, 2000). In mental health care, people from Black ethnic groups are disproportionately admitted into inpatient settings (Care Quality Commission, 2010) whilst being underrepresented in community and early intervention settings (McManus, Bebbington, Jenkins & Brugha, 2016). This demonstrates the impact of racism and oppression on mental health, but also raises further questions about barriers to health care prior to the point of acute care. Based on the findings from this review, the relationship between SES, race and mental health is systematic in nature relating to fears around perceived authoritarian organisations and acts of discrimination relating to housing, child welfare and employment.

The relationship that people described with services accounted for much of the scepticism and distrust around help-seeking. In communities where mental health care may be disproportionately underfunded (World Health Organisation, 2015), it may be that a lack of resource and adequate provision has contributed towards negative past experiences. In this review, the subtheme ‘negative past experiences’ highlighted how unsatisfactory healthcare may result in tarnished reputations throughout communities. Many people described wanting to engage with psychological treatment, however felt unable to do so due to worries about confidentiality and the outcome of seeking support. It also seemed that psychological therapy was delivered without collaboration or consideration of personal circumstances. For those who did not engage with therapy, mediation appeared to be the only other option offered. In many cases, medication was the only option offered when people accessed services.

The logistical barriers identified, including competing responsibilities and economic factors, suggest that people with low SES may face additional challenges in regards to accessing formal services. The disparity in being able to afford transportation or childcare may contribute towards health care inequalities across SES (Marmot & Allen, 2014). In particular, with psychological interventions which require frequent and regular travel to services, this barrier may have more acute impact. In relation to this, the review captured other inequalities in the pattern of prescription of psychotropic medication rather than non-medical treatment. This is consistent with Anderson, Brownlie & Given (2009) who found that people from lower income backgrounds were more likely to be prescribed psychotropic medication. From this review, many people reported negative effects of medication including addiction and apathy.

Limitations and Strengths

The lack of reflexivity in selected studies may have resulted in bias. Due to the qualitative approach taken in this review, the influence of the author's lens during the analysis may have led to further bias (Hoffman, 1990). In order to reduce the impact of this, ongoing discussion with the research team was used to establish a consensus with regards to the meaning of results.

Although inclusion criteria involved the specification of low-income populations, the way in which papers identified this varied. Some papers relied on self-report methods whereas others used individual or community measures of deprivation. The inconsistency in the definition of low-income could impact the homogeneity of studies.

Furthermore, the majority of the studies were conducted in Western countries, which may result in a different conceptualisation of economic disadvantage. It is likely that the challenges and living circumstances for participants in studies conducted in the USA differed from those in Malaysia. The limited geographical mix of papers may have further reduced generalisability.

The cost of health care varied throughout papers, depending on where the study was conducted. Due to the interaction with SES, it is likely that reported barriers varied depending on whether health care was free at the point of access. As the current review was conducted in the UK, where the National Health Service (NHS) provides health and social care, it was important that the author was aware of different contexts and processes of receiving health care, in order to limit the effect of this lens. Interestingly, none of the included studies were conducted in the UK, despite economic disparities and significant levels of poverty (Wells, 2016). Despite this, findings from the current review may be considered in order to improve health inequalities relating to poverty in the UK. For example, although healthcare is free at the point of access in the UK, there are still likely to be additional barriers associated with the cost of travel to appointments. Furthermore, Salaheddin and Mason (2016) found that stigma was a significant barrier for young adults accessing mental health services in the UK; based on the current review, it is possible that discrimination relating to SES may interact with this existing perceived stigma in the local context.

The review presents an up-to-date, comprehensive synthesis of the barriers to help-seeking for MHD for low-income populations; it is the first review to do so. The included studies were of reasonable quality, identified through the use of well-recognised quality checklists, conducted by both the author and a peer reviewer. Despite the described limitations, this review offers valuable insight into the challenges that may impede help-seeking for those with low SES.

Implications for Practice and Future Research

Many mental health services utilise policies which mean that people are discharged after repeated missed appointments (Mitchell & Selmes, 2007). The findings from this review highlight the importance of exploring reasons for not attending, as factors such as shame, external stigma and scepticism about service provision may result in difficulties attending. In particular with low-income populations, arranging childcare, time off work and transportation to services may pose significant challenges.

Campaigns to raise awareness of available support and to challenge stigma may also be helpful in removing some of the barriers to care for people from low-income populations. Some of the studies identified already reported the benefits of education in challenging stigma and normalising distress (Ijadi-Maghsoodi et al., 2018). Jorm (2012) proposed a whole community approach to mental health literacy, including interventions in education settings, mental health first aid training and information websites. As well as education, contact with people with MHD has been found to reduce stigma for both adults and adolescents (Corrigan, Morris, Michaels, Rafacz & Rüsch, 2012). Many services have employed ‘experts by experience’ whereby people with current or past MHD are involved with service delivery (Horgan et al., 2018). This may be an effective way of challenging the internal stigma and shame as well as external stigma in the community.

Experiences of discrimination were discussed with reference to low-income and ethnicity. Some of the barriers highlighted in this review seemed to be exacerbated by ethnicity, for example the fear that children would be removed from families. When working in disadvantaged communities, this emphasises the importance of cultural competence (Sue, 2001). Recruitment and retention of staff who reflect the cultural diversity of the community as well as developing culturally competent healthcare settings are key ways of addressing some of these healthcare inequalities (Anderson et al., 2003).

This review also raises questions about the delivery of services. People often found it difficult to engage with services, whether due to negative past experiences, competing needs or practical limitations. Assertive Outreach (AO) services have been developed in response to this issue for people with serious mental health problems (Wright et al., 2003). This approach emphasises the role of the team assertively engaging with service users, using creative methods to meet people in their home or preferred locations. Robinson and Bawden (2007) found that service users of outreach services felt well informed, more confident, better supported and experienced improved care and outcomes. Integrated approaches to mental health can also help address a range of social and health needs through a single point of access (Krupisnki, 1995); thereby allowing basic needs to be attended to prior to psychological input. This approach may be an effective way of engaging people who do not traditionally utilise mental health support by providing an alternative resource. In economically disadvantaged communities, AO models may be effective ways of delivering holistic approaches for multi-layered care needs. .

Future research may explore the intersectionality of social GRACES (Burnham, 2018) in low-income populations. For example, the current review did not identify any studies which focused on the experiences of people with disability, people from the LGBT+ community or older adults. The multi-layered issues which interact with low-income may reveal important considerations for professionals working in specialist services.

Conclusions

This review has synthesised the available literature exploring barriers to help-seeking for MHD in low-income populations. People described how stigma, relationship with services and logistical issues all impeded their ability to access support. Despite limitations in quality, depth and generalisability, there are a number of useful recommendations that have come from this review that may be considered when engaging with people from low-income populations.

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Part Two: Empirical Paper

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

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See Appendix A for submission guidelines.

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Learning from teenage boys from low-income families: attitudes towards expressing emotions and seeking support in times of distress

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ABSTRACT

Background: Traditional constructions of masculinity have been found to influence attitudes around emotional expression and help-seeking from a young age. Socio-economic status (SES) has consistently been linked to poor health outcomes. A gap in the literature is how boys from low-income families understand rules of masculinity and how this may impact their ability to share with others how they feeling. It is also not understood how these factors relate to the help-seeking process.

Method: Semi-structured interview were held with five participants who were eligible for free school meals (marker of low family income). Data was analysed using an inductive Thematic Analysis approach.

Results: Three themes were generated across and within data sets: 'Man up', 'I don't think it would go very well, me telling them' and 'Why shouldn't I cry?'. Ideas around the role of masculinity featured across these themes, with participants internalising different aspects of such discourses. The systemic influences contributing towards the perspectives of the boys are discussed throughout.

Conclusions: This study outlines how dominant masculine ideals influenced the boys' need to remain emotionally unaffected and stoic. The function behind conforming to such norms included self-preservation and protecting others. Some participants were critical of these stereotypes and described experiences of acting against the norm. Individual and systemic factors appeared to enable some of the participants to act with agency despite the threat of ostracism and bullying.

Key words: *Boys, masculinity, low-income, working class, help-seeking, emotional expression.*

Introduction

The complex relationship between gender and health-related behaviour continues to be a major focus of research (Evans et al., 2011). Gender is increasingly understood as a social construction, (Risman, 2004) varying across history and culture (Czarniawska, 2008). Although gender is defined across a spectrum, binary definitions still dominate in many societies (Knights & Kerfoot, 2004). Dominant western masculine norms include the importance of emotional control; dominance; pursuit of status; self-sufficiency and winning (O'Neil, 2008; Hammer & Good, 2010). Previous literature has revealed that increased adherence to these norms correlates with negative attitudes towards help-seeking for mental health difficulties (MHD; Hammer & Vogel, 2013; Piña , 2012); hypothesised to result in a decreased likelihood of seeking support (Yousaf, Popat & Hunter, 2015). This association may, in part, help explain why completed suicide continues to be overwhelmingly by males in the UK (Office for National Statistics, 2018).

Rules for emotional expression may vary between males and females from childhood; it is less socially acceptable for boys to be emotionally expressive in some cultures (Brody, 2009; Brody & Hall, 2008; Pollack, 2000). By conforming to dominant masculine norms 'too much', boys risk detrimental effects to their wellbeing and mental health (Lomas, 2014). However by not conforming, there is a risk of social rejection and ostracism (Mac an Ghaill & Haywood, 2012; Oranksy and Marecek, 2009). Fifty percent of MHD are established by age 14 (Kessler et al., 2005) and health outcomes among boys continue to be substantially worse than girls (Baker et al., 2014). There is a gap in the literature regarding whether gendered expectations are understood by people from more marginalised social groups in similar or different ways.

Socio-economic status (SES) has also been explored in relation to mental health and help-seeking. In the UK, economically disadvantaged individuals are disproportionately affected by MHD; the lower the income, the greater the risk of developing symptoms of depression and anxiety (Lund et al., 2010). A global review found that the socioeconomically disadvantaged children and adolescents were 2-3 times more likely to develop MHD than those with higher family income (Reiss, 2013). Although wealth is not a guarantee of mental wellbeing, it has been generally established that economic hardship may contribute towards MHD due to associated stress, limited resources and unemployment (Conger et al., 2002). Based on these statistics it may be assumed that the majority of people seeking-help for MHD are from low-income backgrounds. Although research is limited, statistics suggest this is not the case (Bromley, 1983; Crouan, 1994).

Furthermore, the majority of professionals working in counselling and psychological fields are from middle-class backgrounds (Ballinger & Wright, 2007) resulting in a lack of representation and potential social power differentials in the therapeutic relationship (Balmforth, 2006). Often, evidence-based treatments for MHD are researched in university settings with participants from predominantly White, middle to high-income individuals (US Department of Health and Human Services, 2001; Miranda et al., 2003). Although many therapies have been shown to be effective across SES (Santiago, Kaltman & Miranda, 2013), there may still be societal ideas that therapy is designed for and therefore used by White, wealthy individuals. There is still relatively little understanding of how people from low-income populations conceptualise help-seeking for MHD and what attitudes around this exist.

Images of traditional masculinity may be more prevalent in lower social classes (Möller-Leimkühler, 2002), hypothesised to contribute towards a tendency to minimise or ignore psychological symptoms. It is unclear whether attitudes around help-seeking for MHD in men are passed down through generations or whether young people have constructed new meaning. In the current study, attitudes will be explored in order to encompass the systemic influences which shape the beliefs, opinions and perceptions of a particular cohort. In line with a social constructionist stance, these attitudes are shaped by societal norms and cultural expectations (Burr, 2015). Psychological research has traditionally neglected to consider class differences in the experiences of distress or the access to resources (Lott, 2002); this may result in cognitive distancing from issues of social justice. It is hoped this research will provide a voice for a historically underrepresented group of people, gaining further insight into disparities in the UK.

What attitudes do young men from low-income families hold around emotional expression and seeking support in times of distress?

Methodology

Design

A qualitative study was conducted using semi-structured interviews to explore attitudes around emotional expression and help-seeking in boys from low-income families. Inductive Thematic Analysis (TA; Braun & Clarke, 2006) was chosen as it can be used to address questions about people's experiences and perspectives. Furthermore, it can be used to look at patterns and contradictions across data sets.

Semi-structured Interview Schedule

Smith's (1995) recommendations were used to develop the semi-structured interview schedule meaning that questions were open-ended and aimed to encourage participants to reflect on experiences and perspectives. The content of questions was informed by literature regarding masculinity, help-seeking and emotional expression. Questions were adapted in order to be accessible for the target age group. The schedule was followed loosely, allowing flexibility.

The schedule was piloted with a pastoral support lead and a group of adolescents who met inclusion criteria. The interview was considered appropriate however recommendations were made regarding language and phrasing. The adolescent group suggested having more informal questions at the start of the interview to help participants feel more comfortable. Ethical approval was granted by the University Ethics Committee (see Appendix F).

Procedure

Participants

This study operationalised 'low-income' through eligibility for free school meals (FSM). FSM are available to students whose parents are in receipt of one or more benefit payment or net income is lower than £616.67 per month; indicating low family income ("Free school meals: guidance for schools and local authorities", 2019).This has been used by a number of studies, including the House of Commons Education Committee (2014).

A purposive sampling method was used in order to ensure individuals met inclusion criteria. Individuals, rather than families, were recruited following discussion at the pilot group where the consensus was that adolescents were more likely to be open and authentic without guardians present. It was deemed important to speak with individuals in order to represent their voices and learn about the experiences of young people without this being filtered in the presence of family.

All participants were currently eligible for FSM; aged 11-16; and identified as male. Participants were excluded if they had current involvement from mental health services or had access to FSM due to Service Student Premium. In smaller studies, a higher degree of homogeneity is helpful (Braun & Clarke, 2006) and therefore a demographic questionnaire was also given to potential participants to complete (See Appendix G).

Although there are no specific requirements for sampling in TA, Braun and Clarke (2006) recommend 10-20 participants for a UK Professional Doctorate. This number was aimed for however the COVID-19 pandemic resulted in prospective interviews being cancelled.

In total, five participants took part in interviews. Ages ranged from 13-15. All identified as being of White ethnicity, British heritage and Male gender.

Procedure

Recruitment took place at a local secondary school where 30.7% of students receive FSM. The local authority where the school is based was ranked as the 4th most deprived in England through the Index of Multiple Deprivation (IMD = 70.634) (McLennan et al., 2019).

Individuals who met the various criteria were identified by the Assistant Headteacher. Letters were sent to home addresses including an information sheet (student and guardian, see Appendices H and I respectively), demographic questionnaire and guardian consent form (see Appendix J). Students returned completed demographic questionnaires and guardian consent forms to their head of year teacher. Parental consent was required in order for pupils to continue with the study.

The researcher met with students during school hours in a private room. Each meeting lasted approximately 1 hour. Participants completed a consent form (see Appendix K) and were given the opportunity to ask any questions. Interviews were recorded on an encrypted and password protected laptop. Questions were asked in accordance with the semi-structured interview guide (see Appendix L). A debrief sheet was given at the end of each interview (see Appendix M).

Data Analysis Procedures

Data was analysed using inductive Thematic Analysis (TA), in accordance with Braun and Clarke (2006). This approach to coding is active and reflexive; it is important for the researcher to consider the effect of their own assumptions and experiences as this may influence the process of interpretation. As the approach is inductive, the themes generated are strongly linked to the data themselves (Patton, 1990) rather than being shaped by the specific research question or areas of theoretical interest. TA is a flexible method that can be used widely across the epistemological spectrum (Braun & Clarke, 2006).

The methodology proposed by Braun and Clarke is a six stage, bottom-up process. The following stages were followed:

- Reading and re-reading of transcripts
- Development of initial codes (see Appendix N for a worked example)
- Comparison of codes: similarities and contrasts highlighted
- Transcripts read again
- Changes made and process repeated several times

Researcher's Position

The researcher reflected on their lens in order to increase awareness of potential bias (Hoffman, 1990). This was facilitated through a reflexive interview, reflective groups with colleagues and the use of a reflective journal. It is noted that the researcher identifies their gender at the female end of the spectrum and was raised in an area with high rates of deprivation where traditional ideas around masculinity were prevalent. Despite this, the researcher positions themselves as being relatively economically privileged; being in the minority of people at school who were able to pursue higher education. Epistemological and Reflective statements can be found in Appendix O.

Results

Six themes were created following the TA procedure, with three super-ordinate themes (see Table 4 and Table 5 for frequency counts).The first super-ordinate theme outlines the boy's understanding of masculinity and the expectations they placed on themselves and others in accordance with this. The second theme reflects how conforming to such ideals served the function of avoiding harm. The final theme describes experiences of challenging the ideals that had been internalised as male. These themes are interconnected yet separate; the analysis aims to highlight patterns across data whilst capturing the nuances within stories.

The names used in the results section are anonymised through the use of pseudonyms. 'R' is used in extracts to refer to the researcher.

Table 4. *Super-ordinate and Sub-themes*

Super-ordinate Themes	**Sub-themes**

‘Man up’	1. Strength vs weakness 2. Keeping it to myself
‘I don’t think it would go very well, me telling them’	1. Self-preservation 2.Protecting others
‘Why shouldn’t I cry?’	1. Finding my own way 2.Enabling factors

Table 5. *Frequency counts for each superordinate and subtheme.*

	Jayden	Leo	Ryan	Callum	Ashley
1					
Strength vs weakness	x	x	x		x
Keeping it to myself	x	x	x	x	x
2					
Self-preservation	x	x	x	x	x
Protecting others	x	x	x	x	x
3					
Finding my own way	x	x	x	x	
Enabling factors		x	x		x

1) **<u>Superordinate theme: ‘Man up’</u>**

The first super-ordinate theme relates to how the participants constructed the concept of masculinity. This theme captures the prevalent ideas that the boys held around their gender and the expectations associated with this. The first subtheme outlines how the boys understood masculinity for themselves and others. The second subtheme reflects responses to these ideals with reference to emotional expression.

Subtheme 1: Strength vs weakness

All of the participants described masculinity in terms of 'strength'. Interestingly, participants spontaneously related strength to emotional stoicism.

> *"Well I think that comes from, like, you want to be the strongest person around you want to be the guy people come to for safety and comfort, but if you want to be that person people think you can't show emotions, to be confident you have build yourself up without being sad without showing any sign of weakness. Weakness, as people would say, is emotion*." (Leo (15), Lines 303-306)

The equivalence of emotion, in particular sadness, with weakness suggests that Leo devalues emotional expression. He talks about the need to 'build yourself up', implying that weakness is related to vulnerability. In response, a stoic exterior is presented. Many of the boys discussed expectations of what it means to be 'a man' and described internalised norms consistent with those found in dominant Western cultures.

> "*Well when I think of what people say about being like being a man and stuff, it's like 'man up, pull yourself together' got to be like strong and like not let things get to you.*
> *R: That phrase 'man up', can you explain to me in your own words what that actually means?*

> *… Well when you hear that it's usually like, stop feeling sorry for yourself, just get on with it…Can say it to girls too though not just lads….usually with girls though it's like when they're crying over pointless little stuff."* (Ashley (14), Lines 101-111)

Ashley describes how the experience of emotion is regarded as weakness. This demonstrates how he may invalidate his own feelings in order to meet the expectations that are placed on him with regards to his gender. Ashley also distinguishes the role of 'manning up' between genders; he appears to dismiss the emotional expression of girls, perhaps reflecting attitudes or experiences.

Several of the boys discussed their understanding of the synonymous relationship between femininity and weakness.

> *"They'd say oh look he's, err, I don't know like saying oh look he's crying over music oh look at him he's a pussy he's weak like. They wouldn't say weak, but say a pussy or a fanny or summat.*
>
> *R: Are those words, 'pussy' and 'fanny', are they the same as being weak?*
>
> *Essentially yeah they're saying like he's weak, he's scared.' (Ryan (14), Lines 295-298)*

Ryan illustrates how fear is perceived as weakness, perhaps again due to feelings of vulnerability. Masculinity appears to be devalued through the use of language colloquially associated with female genitalia.

This idea was experienced by other participants:

> ‘*When I see people like XXX who have to hide it and that I think he thinks it’s a weakness he thinks that were all gonna interrogate him were going to say what are you doing that’s just girly or something but we wouldn’t’.* (Leo (15), Lines 308-310)

However, in this quote Leo describes how despite his friend’s concern about being labelled as feminine, he does not believe his peer group would respond to distress in this way.

Subtheme 2: Keeping it to myself

In response to the perceived pressure to conform to masculine ideals, all of the participants described how they limited sharing emotional states with others, often through masking or avoidance.

> *“…Like I don’t want to go home or, or just go sleep at my mates, and then just not come back to school, not go back home, cos it annoyed me so much. When I said to my mum ‘you know I’m not good in school’ I got excluded on purpose, cos of everyone who kept on asking me about this problem.”* (Callum (13), Lines 49-52)

Callum refers to an experience where he had been seen by peers and staff at school to be upset, following bullying. He describes intentionally being excluded from school in order to avoid being questioned about such difficulties.

Several of the other participants described the idea that emotional distress should be hidden from others. This rule seemed to be applied to males in particular.

> *“I haven’t seen anyone in this school cry at all as a boy. Like I’ve seen I think I saw one boy cry but that’s because he got I think he got punched by a year 11 real hard so*

> *he had to go to medical obviously… So physical pain and not emotional…Because emotionally its… physical it's something on the outside it will eventually heal but emotional, it sticks with you it doesn't go away."* (Ryan (14), Lines 307-314)

Ryan highlights how school culture can inform what is deemed as acceptable; in this instance, crying as the result of physical pain is not criticised in the same way as being emotionally upset. He describes emotional pain as something that 'doesn't go away', possibly reflecting feelings of helplessness.

Some of the boys talked about times where they had felt able to speak with friends about how they were feeling. Usually, this was after drinking alcohol.

> *'…Well it's more like when you're a bit tipsy it might all come out… It's not like we drink all the time but sometimes you can like say summat to your mates when you're drinking then at least no one will mention it again…but you've had a laugh, been with your mates, so you forget about it for a while don't you.'* (Ashley (14), Lines 145-151)

Emotional expression appeared to be more acceptable in the context of drinking alcohol. It appears that drinking alcohol allows Ashley to reduce any emotional suppression, described as 'it might all come out'. Being drunk may also act as a form of externalisation; emotional vulnerability can be attributed towards the stimulant rather than the self.

Ashley also describes how fun and humour are key components in his friendship group. The role of humour in managing emotions was talked about by three of the participants.

> *'They normally react in person by, they tell me a joke to crack me up a bit make me a bit happier. Or doing summat funny or putting something funny on like a little video. Doing, doing something that like lightens the mood right away… so you walk in with*

> *a negative and just instantly crack it up with a positive like they want to get rid of it as fast as possible.'* (Ryan (14), Lines 431-436)

In this quote, Ryan describes how emotional distress is perceived as detrimental in the friendship group. Friend's attempts at 'getting rid' of distress seem to be valued by Ryan. This may also indicate the use of emotional masking or invalidation; when feeling upset Ryan is encouraged to display a 'positive' exterior.

Participants talked about emotional avoidance with regards to family modelling. Four of the boys discussed how they had witnessed the inhibition of emotional expression by family member, in particular males.

> *'R: Can you have a think about how you'd know they were upset?*
>
> *Erm… I don't think I'd probably know straight away…Erm…I dunno…people and that, males in my family don't really show if they're upset in front of us, in front of me'* (Jayden (14), Lines 116-119)

All of the participants talked about fathers as a reference point for keeping emotional distress private.

2) Superordinate theme: 'I don't think it would go very well, me telling them'

The second superordinate theme features two subthemes which relate to the function of conforming to masculine ideals as described in the previous theme. This superordinate theme explores the perceived threat associated with emotional expression and help-seeking.

Subtheme 1: Self-preservation

All five boys spoke about how masculinity served the function of protection. Many talked about the negative consequences of emotional expression and behaviours which did not typically align with expectations of masculinity.

> *'R: And why wouldn't you want other people to know?*
>
> *It's none of their business really…*
>
> *R: What kind of thing would happen if other people did find out?*
>
> *Erm, I should imagine some would take fun out of ya, take mick out of you. Your mates would probably ask how you were feeling.'* (Jayden (14), Lines 449-454*)*

Jayden describes a belief that people would use his emotional vulnerability as the subject of humour and potential bullying, possibly based on previous experiences. He highlights a contradiction in peer responses as he forecasts that his friends would be supportive when talking about his feelings.

> *'Well yeah because if everyone was miserable all the time just wouldn't work, wouldn't enjoy spending time with each other as much so I don't know if we'd be mates to be honest. I know some people who are bit like…well a bit of a fanny and take offensive to anything, get all upset. And we wouldn't wanna be mates with someone like that…'* (Ashley (14), Lines 157-160)

In contrast, Ashley describes how in his friendship group, those who express how they are feeling are disapproved of and ostracised. Again, colloquial terms for female genitalia are used as a way of devaluing the social status of people considered part of the out-group.

Therefore, the ability to ‘man up’ may serve the purpose of maintaining friendships and avoiding social rejection.

This experience was shared by other participants:

> *‘…and I’ve had fall outs with other people, they’re like oh you’re gay, gay and all like this, saying I’m gonna knock you out because I’ve told someone about it…Cos they’ll just start ask ‘what’s up?’ and they’ll go tell them saying I’ve been slagging them off..’.* (Callum (13), Lines 197-200)

Callum shares his experience of bullying, in particular with regards to sexual orientation. He explains how telling peers about such incidents could lead to further abuse, both verbal and physical. Telling others about the emotional impact of such incidents is interpreted as ‘slagging off’, referring to the act of being insulting or critical. In order to avoid actual or threatened mistreatment from peers, participants described keeping problems hidden from others.

In regards to help-seeking, all of the boys discussed how they may avoid seeking support for emotional difficulties as they worried that this would lead to torment from peers.

> *‘Erm…maybe…well I don’t know I’m not sure I would actually….just because it’s actually in school, like it would be hard to go there and other people not know about it.*
>
> *R: Why wouldn’t you want people to know?*
>
> *Well it’s nothing to do with anyone else… I wouldn’t want people saying s*** about me’.* (Ashley (14), Lines 229-236)

> *'I can only think of one kind of barrier, it's kind of minuscule, but like the fear of being bullied for asking for help…The fear of people saying you're weak, you're inpartial, you don't matter in the world because you need help. But to me, that wouldn't matter because if they think that then they can think that but what you think is the truth'.* (Leo (15), Lines 383-388)

Both Ashley and Leo describe barriers to help-seeking from existing resources in the school setting. Ashley talks about a belief that others may make derogatory remarks, thereby protecting himself from becoming the subject of ridicule but denying himself support.

In contrast, Leo acknowledges the fear of potential bullying, but this is not sufficient in preventing him from accessing help. These two accounts highlight the perceived risk associated with help-seeking and the different ways that people may respond to such threat.

Subtheme 2: Protecting others

When considering why people may avoid emotional expression, participants also described a belief that this would protect others.

> *'They just have that look on their face; you know it's kind of droopy…Just shows they're upset. But sometimes they do try and hide it, but you always find out there's something, a little twitch in what they're saying or something…They always say 'nothing, nothing, nothing is wrong', trying to hide it'*
>
> *R: Why do you think they try so hard to hide that?*

> *Well, I think they're trying to like show kind of a strong exterior so if say a bully, we don't get bullied, but say a bully came into our group, they could like defend everyone.'* (Leo (15), Lines 157-169)

Leo refers to the previous theme of 'man up'; in particular the equivalence of strength with emotional stoicism. He relates this to a need to defend others in the friendship group. Interestingly, Leo uses the pronoun 'they' in this passage, which suggests that he does not embody this role in the friendship group. There may be designated friends who mask internal feeling states with external displays of confidence and 'strength' in order to protect others in the group.

> *'You can only see it with one of em…Cos the rest of them it's like they put on a mask like a feigned emotion and you can, you can tell if one of them's depressed… but some of them hide it well. But then at one point they crack and you can see it…But then, they might hide it as well just so they don't worry their friends as well. Because some of them like to keep others happy.*' (Ryan (14), Lines 259-265)

Ryan discusses how hiding distress serves the function of reducing worry in the friendship group. This is understood by Ryan as a way of keeping the social circle 'happy'. Diagnostic mental health labels were commonly used to describe emotion that could not be hidden.

Other participants talked about this idea in relation to family members.

> *'Err, maybe not to like put it onto somebody else, like how they're feeling*
>
> *R: How would that be putting it onto other people do you think?*

> *Erm 'cos like if you were to see someone upset you're going to ask them questions aren't you and like try to help them out.'* (Jayden (14), Lines 149-152)

Jayden refers to the belief that talking about distress may burden others. Displays of sadness seem to be interpreted as placing unnecessary stress on the people he cares about. Instead, Jayden talked about how he would usually 'watch and wait' to see if emotional distress reduced. If this was unsuccessful, he described talking to friends through online gaming consoles; something which two other participants also described.

For some of the boys, modelling of other males in the family may have contributed towards the idea of protecting others.

> *'He is grumpy, but then sometimes I'd say he gets real angry because maybe somethings happened that he doesn't want us to know about…well the thing I was thinking about was one time my Dad was real cross, like kinda ranting with us all, but then we found out from my Mum that it was because he'd lost his job…well I'd say he probably wasn't even angry but didn't want to get upset or like cry or owt in front of us…because I know he was upset but I've never seen my Dad cry so I don't think he would have wanted to cry.'* (Ashley (14), Lines 198-208).

Ashley describes how his Dad masked sadness with anger following losing his job. When talking about this, it seemed that Ashley may have admired his Dad for doing this, as he believed that he was acting in the best interests of the family. For Ashley, seeing his Dad angry or 'grumpy' may be preferable to thinking about the possibility of him being upset or frightened about the prospect of unemployment.

When referring to help-seeking, three of the participants spoke about how they may avoid utilising resources at school due to feared consequences that family members will be told.

> '*But then, I wouldn't want to say owt to school in case they told me Mam. Because… well I reckon they'd then start asking her loads of questions and I've heard about times when…well that's where they start saying 'oh because you're not alright it must because of stuff at home'. And then…I don't know what might happen, but you do hear about all this stuff with people going in to your house and talking to your parents about the way they treat you.'* (Callum (13), Lines 124-128)

From the boys who talked about this concern, part of their worry seemed to be regarding 'self-preservation'; if parents were told about emotional difficulties, this may lead to embarrassment of discomfort. However, they also spoke about their concern that their parents may be viewed negatively by the school or other perceived authoritarian organisations. Therefore, the intention behind avoiding talking with staff seemed to be to protect the reputation of the family.

3) Superordinate Theme: 'Why shouldn't I cry?'

The final superordinate theme outlines exceptions to the previous themes and provides examples of changing internalised beliefs and behaviours. The influences of individual and systemic factors are described as key components which may enable this process.

Subtheme 1: Finding my own way

Despite acknowledging the pressures associated with masculinity, four of the boys, when prompted, were able to recall experiences where they had acted against the stereotype they had previously described. Participants shared stories of agency and acting in accordance with personal values, even though this was often met with adverse consequences.

> *'I was listening to music and I started tearing up, because I loved it… I think it got to me because they said he's weak, he's crying over music but it's not really weak it's something that I enjoy, why shouldn't I cry over it?*
>
> *R: Has that affected you, that experience?*
>
> *Not really. It doesn't, to be honest, I still cry over music, I still love it, but if they say 'well you're crying over music', say, start ragging me over that, I just say I'm enjoying it, why shouldn't I cry?'* (Ryan (14), Lines, 288-293)

Ryan articulates how his love of music helped him resist the pull of self-preservation and express his emotions openly. Although peers still taunted him over this, he is able to defend himself. Music may act as a vehicle for self-expression; Ryan described feeling unable to share how he was feeling in relation to personal circumstances, however in this context he allows himself to cry.

> '*Well, I think that you can show emotion and still be strong cos I do…I show emotion all the time *laughs* and I still think I can protect my friends if needs be, but some like my friend XXX is quite a, he's quite in himself….But he also really, really cares for us all, so he wouldn't want to show his emotions so much and make him feel, make himself feel less confident if a problem arises.'* (Leo (15), Lines 175-181)

With reference to the theme ‘protecting others’, Leo talks about how his friend tries to portray a ‘confident’, emotionally unaffected exterior to manage threat. However, Leo acknowledges that for him, protecting others can be achieved without the need for emotional masking. Although having previously described similar ideas, here he provides a counterexample where he is able to create his own definition of strength.

Participants also talked about examples where they had asked for support.

> *‘I asked to go there because I knew it would help me, but at first they said no, then they said like you can go in there for one lesson then they said you can go in there an hour a day…*
>
> *R: Was it hard to do that at first or was it quite easy to go and talk to someone there? It was quite easy because I knew it wouldn’t get passed on to anyone cos like at the XXX there’s one teacher there that helps me with my anger so I don’t get real annoyed.’* (Callum (13), Lines 358-366)

Callum refers to a support group affiliated with the school which is offered to students who exhibit behaviours that challenge. He talks about his agency in asking for this. Help-seeking for anger appeared to be less controversial than other emotions. It seems that confidentiality and trust facilitated help-seeking for Callum, perhaps as this limits the threat of consequences for the family as previously described.

> *‘Listening, listening to me and knowing that they were just there if I needed them, just talking to them…Family, friends.*
>
> *R: Would you ever turn to someone at school and tell them if you weren’t feeling alright?*

> *Erm…yeah, but it would only be like a few like close mates.'* (Jayden (14), Lines 392-399)

Many boys described a preference for emotional support from friends or family, rather than school. This highlights how help-seeking does not just involve professional services or institutions. None of the participants were aware of any external mental health or wellbeing services they could access. When asked to describe preconceptions of services, words and imagery associated with a medical model was used including 'lab coat', 'professional', 'formal' and 'clipboard'.

Subtheme 2: Enabling factors

Family systems, cultural shifts and personal experiences all had important roles in allowing the boys to create new ideas around emotional expression and masculinity.

> *'Quite different now with me I think, because me mam has influenced my dad as well because my dad like never used to, his mam and dad never used to say I love you to him apparently very often. And they never used to get like a kiss goodbye, but me mam's influenced that with my dad because me nanna used to do that to me mum, and she's influenced him and that's made him more positive.'* (Ryan (14), Lines 377-381)

This demonstrates generational change in families. In particular, Ryan highlights the role of females in challenging dominant masculine stereotypes. He describes this change in his father as making him 'more positive' suggesting that this is something he has valued. Further examples were described regarding the role of family.

> *'It was just…well the funeral itself, the funeral…it was the first time I'd been to anything like that. I even saw my Dad cry that day…and my Dad was even more upset because he'd already lost his Mum and now his Dad too.*
>
> *R: Was this something you talked about with your Dad?*
>
> *Oh yeah. Was a bit weird…well not weird but just like strange seeing him upset. But I do talk to my Dad now about that.*
>
> *R: What does Dad say when you talk about stuff like that?*
>
> *Well he'll just like remind me of the good times because we all went rugby together… if I do cry its normally because me and Dad are talking about a good time and that makes me feel a bit, a bit like missing him.'* (Ashley (14), Lines 362-372)

Ashley describes the novelty in seeing his Dad cry; this was experienced as unusual however seems to have promoted emotional connection between father and son. This exemplifies how supportive family relationships can be an invaluable form of support throughout adolescence and periods of grief or adversity.

In addition to learning from older generations, three of the participants talked about their role in challenging masculine norms around emotional expression within the family.

> *'Because my dad, he doesn't really cry, like even when like my sister died when she was young. Like we were twins and she died…Me eh, my dad though apparently he didn't cry over it. He was really close to though. He was talking to me about it though and he was saying how he gets really close to crying every time and I said to him,*

> *'one day you're gonna crack and you're gonna cry and you're gonna feel so much better for it.' And he said 'I hope that day comes'.* (Ryan (14), Lines 346-349)

Both Ryan and his father seem to recognise the potentially damaging effects of emotional stoicism. Ryan seems to offer advice to his Dad with the intention of helping him through the grieving process. This contradicts the previous theme of 'protecting others' suggesting that contextual factors are important in determining behaviours.

In contrast, some boys described how family members played a role in reinforcing masculine stereotypes.

> *'…But like when this happens my mum keeps me in during the day so I don't get real thingyed (upset) but then like my dad comes up and says why didn't you just hit him back, stop being a wimp. I'm like, I'm not a fighter…. it's my mum and dad saying I had to go through it at school, you'll get it all your life unless you stand up for yourself now.'* (Callum (13), Lines 134-140)

Both Callum's parents appear to be drawing from their own experiences and use this to offer advice around 'self-preservation'. Callum receives messages from his father that physical aggression is the most effective way of managing conflict. However, Callum demonstrates how his values and sense of identity allow him to resist retaliation: 'I'm like, I'm not a fighter'. Despite family scripts around physical violence and protection, Callum articulates how he wishes to act differently.

Two of the boys talked about awareness of wider cultural and historical attitudes around gender and how they perceived this to have changed in their lifetime.

> *'…like over time women are seen as like growing the ladder I guess you could say, or climbing the ladder… But like over time they've just blown that out the water and shown that no guy can control them *laughs*.*
>
> *R: How about in terms of masculinity? How would you define that now for your age group?*
>
> *…Err to me mascul- to be masculine is to be the strongest person in the room to be the one who can outsmart everyone, who can like climb the wall and no one can….But as a person because anyone can be masculine, a girl or a guy like there's no specific gender that can be classed as masculine in my eyes.'* (Leo (15), Lines 326-338)

Leo references feminist ideas and historical developments in gender disparities. When discussing modern ideas around masculinity, it seems that awareness of such cultural shifts may have influenced Leo's perception of gender as a less binary construct. Although he talks about traditional masculine ideals such as power, strength and hierarchy, he applies this to all genders.

When previously asked, all of the boys described concern around seeking help for themselves. However, when asked about what they would advise for a friend, four of the boys advocating talking to others.

> '*Yeah, probably tell them it's not much of a big thing to go ask for help, it's just, if you need help you've got to ask rather than try bottle it up… cos otherwise if nobody says it people are likely to just bottle it up and can get really depressed and stuff like that.'* (Jayden (14), Lines 547-555)

Jayden gave this advice in the context of speaking about personal experiences of grief following death by suicide. He said how he ‘didn’t need’ support himself, however recommended help-seeking for others. It seems that this personal experience enabled Jayden to appreciate the benefits of help-seeking. However, potentially due to reasons outlined in this study, he still seemed to find it difficult to apply this advice to his own experience of emotional distress.

Discussion

Overview of findings

This study aimed to learn more about the attitudes around emotional expression and help-seeking in the context of masculinity and low SES. The main themes identified were: ‘Man up’, ‘I don’t think it would go very well, me telling them’ and ‘Why shouldn’t I cry?’. Expectations around masculine norms connected each theme. Conforming to such stereotypes seemed to act as a form of self-preservation, allowing the boys to maintain social status and minimise the risk of being bullied. In addition, an altruistic function was described; stoicism was viewed as a way of protecting others from worry or harm. In contrast, some participants reflected on times where they had acted against such ideals. The role of family, culture/ society and personal experience were all important factors which enabled the boys to ‘break the mould’, despite the threat of social rejection and ostracism.

In this study, masculinity was understood in terms of strength; both physical and mental. Being emotionally affected was often perceived as weakness. Those who presented an emotionally stoic exterior were considered ‘confident’ and often bolstered in terms of social ranking. Those who did not conform to such ideals were devalued in masculinity; often through the use of terminology such as 'fanny' or 'pussy'. The use of such terms has been found to reflect the socialisation of boys in patriarchal societies (Marrone, Seethaler & Terranova, 2019; Fair, 2011).

These findings mirror those by both Mac an Ghaill and Haywood (2012) and Oransky and Maracek (2009) who found that boys who did not conform to masculine ideals faced rejection from the peer group and bullying. However, the current study reveals novel findings by identifying experiences where the boys were able to challenge such stereotypes. This may reflect changing attitudes in the wider culture as well as the family unit. For those that described feeling unable to challenge such norms, it seemed that messages of traditional masculinity were reinforced through family scripts. Participants in this study were in the developmental stage of adolescence, where Erikson (1963) describes the psychosocial stage of 'identity vs role confusion'. During this stage, adolescents search for a sense of personal identity, whilst desiring to belong and fit in with society. In this study, participants described being sensitive to the expectations of the collective, but were also discovering independent values. In the theme 'Finding my own way', participants explained how they were redefining masculinity for themselves and exploring their role and sense of identity within society.

In this population of teenagers, ideas of strength and protection dominated the data, offering a different perspective from previous research. This is perhaps reflected in the communities where the boys live with many referencing ideas of gang culture, crime and violence. Some boys discussed feeling unsafe at times in their community and how fighting and violence were common ways of securing status. Therefore, it may be inferred that socioeconomic background and community factors have contributed towards the conceptualisation of the theme 'Man Up'.

In line with social learning theory (Bandura, 1977) many participants described modelling their behaviour from the observation of others. Learning from father figures and male friends was a key process in the development of values, attitudes and expectations. Often, this modelling contributed towards a belief that men should not display emotion. This is supported by findings by Halberstadt et al., (1999) who describes a positive correlation between family level of emotional expression and that of the child.

Often, emotional stoicism was valued as a way of protecting family members. However, as the boys' transition through a key stage of adolescent development (Petersen, 1988), a possible implication of this learnt stoicism could be difficulties in emotional regulation. For example, if a child has limited opportunity to observe the management of emotion in others, they may be less likely to recognise and manage this emotion for themselves (Morris, Silk, Steinberg, Myers and Robinson, 2007).

Strengths and limitations

This study is the first to ask boys from low-income families how they understand emotional expression and help-seeking in the context of gender and low-income. The culture within the school and wider environment provided important considerations which differed from those highlighted in research with other populations. The staff at the target school played a fundamental role in providing a secure and private room for interviews. They ensured that participation remained anonymous and the recruitment process was discrete.

These factors may have facilitated relaxed, open and comfortable conversation throughout the interview process which is reflected in the dialect, language and expression used in the extracts.

A challenge in the research was deciding how to operationalise low-income. Initially, the intention was to look at class as a social construct rather than simply family income. Common measurements of class include income, occupation and education level (Diemer, Mistry, Wadsworth, López & Reimers, 2013) as well as subjective self-definitions (Rubin et al., 2014). Although the school's locality may be described as 'working class', it was deemed unethical to use this as the boys may not have associated the term with the same pride that many working age adults do (Jones, 2012). The author recognises that by restricting eligibility to family income alone, some of the complexity, intersectionality and identity associated with social class is potentially diluted.

Although deemed necessary to maintain confidentiality, the sampling technique had limitations. As the information sheet described the purpose and process of the study, this meant that those who volunteered were likely to be more comfortable talking about the subject matter. This could lead to a skew in the findings. Furthermore, those who took part were likely to have parents/guardians who were supportive of them taking part in extra-curricular activities, as adult consent was required. Complex family factors may have unfairly disadvantaged some students in taking part in the study.

Furthermore, the study was conducted around the time of the COVID-19 pandemic. This meant that five interviews had to be cancelled due to ethical issues contacting participants outside of the school premises. As a result, the final sample size was limited.

Although exclusion criteria were applied in order to maintain a level of homogeneity, this restricted sample size may have impacted the reliability of themes generated across data.

Clinical Implications and Future Research

None of the boys talked about formal or professional services that they would utilise in times of significant distress. An overarching theme discussed by all participants was the association with services and the medical model, with imagery such as ‘clipboard’ and ‘lab coat’ used to describe ideas of what speaking to a mental health worker may involve. This is consistent with findings by Bostock and Freeman (2003) where young people emphasised a preference for informal, community based health and wellbeing services. More accessible, third sector resources may help bridge the gap between the community and mental health services. In the UK, policy proposals have led to an increased role of schools in the provision of wellbeing support for young people (Department of Health & Social Care, 2019) in order to improve accessibility. By implementing support within a school setting, this removes barriers associated with researching services and travelling to appointments. In this study, none of the pupils were aware of external services, although many described available support provided by the school. Many studies have found school-based interventions to have positive effects on mental health outcomes (Fazel et al., 2014; Werner−Seidler, Perry, Calear, Newby, & Christensen, 2017). However, a common criticism of this approach is that this places additional demand on teachers and is not adequately established with regards to training and staffing (Perfect & Morris, 2011). Increased budgeting for the implementation of school-based support may help establish this as a viable route of help-seeking. In line with the findings from this research, issues around confidentiality and anonymity may also need to be considered when utilising school-based approaches due to concerns relating to stigma.

Following a systemic approach to wellbeing, throughout themes participants emphasised the importance of relationships. Friends and family often provided valuable outlets for emotional expression, whether this was in person or through online gaming. This demonstrates the importance of relational and systemic support, strengthening existing networks. However, for those who do not have this network, services may offer a vital opportunity for self-expression and emotional support. The theme 'keeping it to myself' highlighted how many individuals considered emotional expression to be a private experience; often only sharing this with others when drunk. The use of technology, allowing the virtual delivery of services, may reduce this barrier to help-seeking by increasing anonymity. For low-income populations, this may also improve accessibility to services by reducing the cost and time associated with travelling to appointments.

The critical psychology literature challenges the idea of increasing access to psychological services which may perpetuate the idea that 'problems' exist within individuals (Parker, 2015). The current study brings attention to the systemic and socioeconomic factors which may influence attitudes around mental health. In line with this, addressing social inequalities may be a necessary part of improving health and wellbeing in a UK context. Social determinants of health (SDH) are the conditions that people are born and age in (Marmot & Wilkinson, 2005). Systemic factors such as SES, education, environment and access to care are all related to health outcomes including reduced mortality for those in lower-income populations, with area code being a stronger predictor of health than genetics (Graham, Ostrowski & Sabina, 2015). Health in All Policies is an approach which aims to reduce health inequalities through collaborative decision-making across sectors and policy areas, focusing on reducing the SDH (Rudolph et al., 2013). By addressing critical determinants of health including education, structural racism, wealth inequality and neighbourhood characteristics, the aim is that overall population health will be improved (Rigby, 2011).

In this study, many of the boys were able to reflect on the pressures associated with masculinity but also identify times where they had been able to challenge such norms. Further research may explore whether people living in communities with high levels of violence are able to challenge such stereotypes in the same way, or whether the need for self-preservation takes precedent over emotional needs. This may offer considerations for forensic psychology and youth offending.

This study focused on the experiences of a small, relatively homogenous group. All participants in this study were of White British heritage. Research has found that emotional expression and concepts of mental health differ across cultures (Bhui & Bhugra, 2002). Ethnocultural differences are expected to impact the understanding of gender and emotional expression, with endorsement of masculine norms being linked with marginalisation (Cassidey & Stevenson, 2005; Majors & Billson, 1992). Gendered expectations may interact with cultural ideas around the meaning of distress, providing nuanced barriers to help-seeking. Further research may explore such interactions in order to inform how mental health and wellbeing resources can be more culturally sensitive and appropriate.

Conclusions

This is the first study to provide insight into the attitudes that boys from low-income backgrounds hold around emotional expression and help-seeking. Young people highlighted the function of masculinity and identified examples where they were able to challenge perceived stereotypes. Systemic influences were discussed throughout the results, emphasising the importance of relationships and community. It is hoped that this research accurately captures the voices of young people from disadvantaged communities, adding important considerations to a currently limited body of research.

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Appendices

APPENDIX A – INSTRUCTIONS TO AUTHORS

SYSTEMATIC LITERATURE REVIEW:

Cultural Diversity & Ethnic Minority Psychology® seeks to advance the psychological science of culture, ethnicity, and race through the publication of empirical research, as well as theoretical, conceptual, and integrative review articles that will stimulate further empirical research, on basic and applied psychological issues relevant to racial and ethnic groups that have been historically subordinated, underrepresented, or underserved.

Especially welcome are articles that

- Contribute to the psychological understanding of issues related to culture, race, and ethnicity through theory-driven or community-driven research. These issues may include (but are not limited to) developmental processes, family relationships, intergroup relations, mental health and well-being, disparities in mental health, health, and education/employment, and treatment and intervention;

- Involve new, innovative or underutilized research and statistical methods and paradigms. These approaches may include development or cultural adaptation of psychological measures, laboratory experiments, community-based participatory research, meta-analyses, mixed-methods and qualitative, longitudinal, cross-national, and biological and genetic approaches.
- Apply psychological science to the education and training of psychologists in matters regarding persons from diverse cultural, racial, and ethnic backgrounds, including delivery of evidence-based interventions to racial and ethnic groups that have been underrepresented and underserved; and
- Critique and promote better science, public policy and service delivery through appropriate application of psychological theory and research on culture, ethnicity, and race. These articles may involve new theory or conceptualization and integrative reviews.

Cultural Diversity & Ethnic Minority Psychology is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 50+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

Types of Articles

Multi-study papers

Multi-study reports involve quantitative and qualitative research with 2 or more studies using different samples. Multi-study papers are more integrative in nature and provide a strong theoretical and empirical contribution to the literature. Manuscripts are limited to 10,000 words of text, including abstract, though shorter manuscripts are strongly encouraged. The word limit does not include reference pages, tables, and figures. Manuscript longer than 10,000 words need to be approved by the editor prior to submission and must make a truly outstanding contribution.

Single study reports

Single study reports of quantitative and qualitative research are between 4,000 and 6,000 words of text (including abstract). The word limit does not include reference pages, tables, and figures. Theoretical, conceptual, and integrative review manuscripts also must adhere to this word limit.

Brief reports

Brief reports are between 2,000 and 3,000 words of text (including abstract). The word limit does not include reference pages, tables, and figures.

Submissions involving pilot data findings, replication of published study findings, psychometric investigations of culture-specific measures, or substantial cultural adaptation of existing measures are most suitable for brief reports. Mere translation and validation of existing psychological measures that are not culture-specific are not appropriate for the journal.

Registered Reports

In addition to full-length research papers reporting novel findings, the journal publishes registered reports, negative findings, replications, commentaries and reviews. Preregistration of replication studies is strongly recommended, but not required.

Registered reports require a two-step review process. The first step is the submission of the registration manuscript. This is a partial manuscript that includes hypotheses, rationale for the study, experimental design, and methods. The partial manuscript will be reviewed for significance and methodological approach.

If the partial manuscript is accepted, this amounts to provisional acceptance of the full report regardless of the outcome of the study. The full manuscript will receive rapid editorial review, for adherence to the preregistered design, and expedited production for publication in the journal.

Special Issue and Section Protocol

Cultural Diversity & Ethnic Minority Psychology welcomes proposals for special issues or sections that address a substantive area in the psychological study of culture, ethnicity, and race.

The editorial team will collectively review and approve all proposals. An Associate Editor will serve as the action editor for all special issues/sections and work closely with the guest editor(s) of the special issue/section.

In addition, the journal editorial team (composed of the Editor and Associate Editors) will initiate special issues and sections to address gaps in the literature. In these instances, a call for papers will be announced and widely distributed to solicit manuscripts.

Authors wishing to submit a proposal for a special issue or section should submit the following to the editor.

Proposals must include the following information in this order.

- Clearly describe the topic or theme for the special issue/section and a rationale for why the special issue/section is needed right now. Be sure to articulate how it is directly related to the advancement of the psychological study of culture, ethnicity, and race. This description should be no longer than 2 paragraphs or 1 page.
- Briefly explain whether the solicited or accepted papers will be empirical or integrative reviews. A collection of position papers is strongly discouraged unless they include empirical data or integrative reviews. Empirical papers will be given a

higher priority as well. Only one commentary by a distinguished expert in the field is allowed for a special issue/section.

- Denote whether it will be a special issue or special section. Special sections (approximately 6–7 papers) are preferred, especially if contributing authors and papers are already identified.
- Specify whether the papers are still to be invited through an open call or whether it is a set of proposed papers that have already been identified. Provide a rationale for either approach.
    - If a call for papers, provide the actual call for papers announcement that will be distributed. Provide examples of how proposals will be solicited, reviewed, and selected.
    - If a set of proposed papers, provide the titles, authors, and abstracts.
    - If a commentary is part of the special issue/section, provide the name and affiliation of the commentator, including areas of expertise.
- Provide the name and contact of the proposed guest editor, as well as a brief description of the person's qualifications to serve in this capacity. All guest editors will work with the assigned Associate Editor, who will make the final editorial decisions.
- Provide a timeline for the special issue/section, including solicitation dates, submission due dates, review and revision completion deadlines, and publication target date.
- A list of potential reviewers and some information on their areas of expertise.

Peer Review

Because *Cultural Diversity & Ethnic Minority Psychology* uses an anonymous peer-review process, authors' names and affiliations should appear only on the title page of the manuscript.

Style of Manuscripts

When providing racial or ethnic designations, please use initial capital letters. *Webster's New World Dictionary of American English, 3rd College Edition*, is the accepted source for spelling. Define unusual abbreviations at the first mention in the text.

The text should be written in a uniform style, and its contents as submitted for consideration should be deemed by the author to be final and suitable for publication.

Please highlight all changes made in revised manuscripts in yellow.

Author Contributions Statements using CRediT

The APA *Publication Manual* (7th ed.)

stipulates that "authorship encompasses…not only persons who do the writing but also those who have made substantial scientific contributions to a study." In the spirit of transparency and openness, *Law and Human Behavior* has adopted the Contributor Roles Taxonomy (CRediT) to describe each author's individual contributions to the work. CRediT offers authors the opportunity to share an accurate and detailed description of their diverse contributions to a manuscript.

Submitting authors will be asked to identify the contributions of all authors at initial submission according to this taxonomy. If the manuscript is accepted for publication, the CRediT designations will be published as an Author Contributions Statement in the author note of the final article. All authors should have reviewed and agreed to their individual contribution(s) before submission.

CRediT includes 14 contributor roles, as described below:

- **Conceptualization**: Ideas; formulation or evolution of overarching research goals and aims.
- **Data curation**: Management activities to annotate (produce metadata), scrub data and maintain research data (including software code, where it is necessary for interpreting the data itself) for initial use and later re-use.
- **Formal analysis**: Application of statistical, mathematical, computational, or other formal techniques to analyze or synthesize study data.
- **Funding acquisition**: Acquisition of the financial support for the project leading to this publication.
- **Investigation**: Conducting a research and investigation process, specifically performing the experiments, or data/evidence collection.
- **Methodology**: Development or design of methodology; creation of models.
- **Project administration**: Management and coordination responsibility for the research activity planning and execution.
- **Resources**: Provision of study materials, reagents, materials, patients, laboratory samples, animals, instrumentation, computing resources, or other analysis tools.
- **Software**: Programming, software development; designing computer programs; implementation of the computer code and supporting algorithms; testing of existing code components.
- **Supervision**: Oversight and leadership responsibility for the research activity planning and execution, including mentorship external to the core team.
- **Validation**: Verification, whether as a part of the activity or separate, of the overall replication/reproducibility of results/experiments and other research outputs.
- **Visualization**: Preparation, creation and/or presentation of the published work, specifically visualization/data presentation.

- **Writing — original draft**: Preparation, creation and/or presentation of the published work, specifically writing the initial draft (including substantive translation).
- **Writing — review & editing**: Preparation, creation and/or presentation of the published work by those from the original research group, specifically critical review, commentary or revision — including pre- or post-publication stages.

Authors can claim credit for more than one contributor role, and the same role can be attributed to more than one author.

Title Page

The title page should contain the complete title of the manuscript, names and affiliations of all authors, institution(s) at which the work was performed, and name, address, telephone and fax numbers of the author responsible for correspondence.

Please include the word count of the text and abstract.

Authors should also provide a short title of not more than 45 characters (including spaces), and up to 5 key words, that will highlight the subject matter of the article.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. For commentaries and special section/issue introductions, the abstract is limited to 150 words. For research and review articles, the abstract is limited to 250 words and the following headings are required:

- **Objectives:** Study aims or hypotheses. The abstract must begin with this heading (i.e., no sentences should precede the Objectives heading)
- **Methods**: Sample description (including size, race or ethnicity, gender, average age) and research design
- **Results:** Results that pertain to study aims or hypotheses
- **Conclusions:** Implication of findings
- After the abstract, please supply up to five keywords or brief phrases. Phrases are limited to three words maximum.

Public Significance Statements

Authors submitting manuscripts to *Cultural Diversity & Ethnic Minority Psychology* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper.

This description should be included within the manuscript on the abstract/keywords page. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility.

All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "It has been suggested that when people read words, they think of the images and sensations that are linked to that word. That idea was supported by the results of this study, which showed that people seemed to think of words' visual and sensory characteristics, even though they were not required to do so."
- "Different countries have different systems of math education. The basic arithmetic concepts of adults educated in China and Canada were compared. The adults educated in China had stronger knowledge of arithmetic than did the adults educated in Canada, likely due to differences in the way math concepts are taught."
- "People tend to remember words better after reading them aloud than after reading them silently. The reasons for this production effect were examined, and results suggested that there are multiple explanations: saying words aloud seems to make them more distinctive and also seems to store them more effectively in memory."

To be maximally useful, these statements of public significance should not simply be sentences lifted directly from the manuscript. They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

Journal Article Reporting Standards (JARS)

Authors are to adhere to the APA Style Journal Article Reporting Standards (JARS) for quantitative, qualitative, and mixed methods research. Updated in 2018, the standards offer ways to improve transparency in reporting to ensure that readers have the information necessary to evaluate the quality of the research and to facilitate collaboration and replication. The new JARS

- Recommend the division of hypotheses, analyses and conclusions into primary, secondary and exploratory groupings to allow for a full understanding of quantitative analyses presented in a manuscript and to enhance reproducibility;
- Offer modules for authors reporting on N-of-1 designs, replications, clinical trials, longitudinal studies and observational studies, as well as the analytic methods of structural equation modeling and Bayesian analysis;
- Include guidelines on reporting on registration (including making protocols public); participant characteristics, including demographic characteristics; inclusion and

exclusion criteria; psychometric characteristics of outcome measures and other variables; and planned data diagnostics and analytic strategy.

JARS-Qual are of use to researchers using qualitative methods like narrative, grounded theory, phenomenological, critical, discursive, performative, ethnographic, consensual qualitative, case study, psychobiography, and thematic analysis approaches. The guidelines focus on transparency in quantitative and mixed methods reporting, recommending descriptions of how the researcher's own perspective affected the study as well as the contexts in which the research and analysis took place.

Participants: Description and Informed Consent

The Method section of each empirical report must contain a detailed description of the study participants, including (but not limited to) the following:

- age
- gender
- ethnicity
- nativity or immigration history
- SES
- clinical diagnoses and comorbidities (as appropriate)
- any other relevant demographics (e.g., sexual orientation)

In the Discussion section of the manuscript, authors should discuss the diversity of their study samples and the generalizability of their findings.

The Method section also must include a statement describing how informed consent was obtained from the participants (or their parents/guardians) and indicate that the study was conducted in compliance with an appropriate Internal Review Board.

Manuscripts that report on clinical trials using randomized controlled trial designs must include as a figure the CONSORT flow diagram which displays the progress of all participants through the trial. Additionally, authors should follow the 25-item CONSORT checklist when writing the study methods and results. The CONSORT flow diagram and checklist are located on the CONSORT website.

Update: Authors must be sure to report study participant characteristics related to socioeconomic status (SES). SES demographic characteristics allow researchers and journal readers to properly contextualize and interpret research findings. We recognize that there is no standard definition or measurement criteria for SES and related indicators (e.g., social class, income, education, occupation), but authors must document SES demographic characteristics to the best extent possible in their manuscript submission. Additionally, authors are strongly encouraged to incorporate such demographics in future research studies and to take these factors into consideration when developing research questions, conducting analyses, and interpreting results.

For reference, authors are encouraged to read the following article on SES conceptualization and measurement: Diemer, M., Mistry, R., Wadsworth, M., Lopez, I., & Reimers, F. (2013). Best practices in conceptualizing and measuring social class in psychological research.Analyses of Social Issues and Public Policy, 13, 77-113. doi:10.1111/asap.12001.

When providing racial or ethnic designations, please follow APA's language guidelines. See the Publication Manual of the American Psychological Association (APA, 2001, pp. 75–76). Use initial capital letters (i.e., Black and White instead of black and white). Do not use the term Caucasian when describing Whites or people of European descent. Manuscripts using the term Caucasian will be returned without review until the correction is made. Authors are encouraged to review Thomas Teo's article, "Psychology Without Caucasians" (2009, Canadian Psychology, Vol. 50, pp. 91–97) for more information on the use of racial descriptors.

Measures, Study Design, and Data Analysis

The Method section of empirical reports must contain a sufficiently detailed description of the measures used so that the reader understands the item content, scoring procedures, and total scores or subscales. Evidence of reliability and validity with similar populations should be provided.

The policy of *Cultural Diversity & Ethnic Minority Psychology* is to publish papers where authors follow standards for disclosing key aspects of the research design and data analysis. Authors are encouraged to review the standards available for many research applications from http://www.equator-network.org/ and use those that are relevant for the reported research applications.

Statistical Reporting of Effect Size and Confidence Intervals

We now require that authors report means and standard deviations for all continuous study variables and the effect sizes for the primary study findings. Note that the *Publication Manual of the American Psychological Association* (APA, 2001, pp. 25–26) emphasizes the importance of reporting effect sizes in addition to the usual tests of statistical significance.

Effect sizes, or similar statistics such as "goodness-of-fit" indicators for structural equation modeling, can be generated by most statistical packages that are used in the behavioral sciences. If effect sizes are not available for a particular test, then authors should convey this in their cover letter at the time of submission.

Citations in the Text

In the text, references should be cited by the name and date system. Both names are cited for a work with two authors. When a work has fewer than six authors, cite all names the first time the reference in the text appears; subsequent citations should only cite the first author's name, followed by "et al." When a work has six or more authors, cite only the first author's surname, followed by "et al." Refer to the following citation examples.

- In a similar case study, Haley (1973) utilized…

- One authority (Green, 1991) suggested…

Data Citation

All data, program code and other methods must should be appropriately cited. Such materials should be recognized as original intellectual contributions and afforded recognition through citation.

- All data sets and program code used in a publication should be cited in the text and listed in the reference section.
- References for data sets and program code should include a persistent identifier, such as a Digital Object Identifier (DOI). Persistent identifiers ensure future access to unique published digital objects, such as a text or data set. Persistent identifiers are assigned to data sets by digital archives, such as institutional repositories and partners in the Data Preservation Alliance for the Social Sciences (Data-PASS).
- Data set citation example:

Alegria, M., Jackson, J. S., Kessler, R. C., & Takeuchi, D. (2016). Collaborative Psychiatric Epidemiology Surveys (CPES), 2001–2003 [Data set]. Inter-university Consortium for Political and Social Research. http://doi.org/10.3886/ICPSR20240.v8

Reference List

References should be arranged in alphabetical order of the author's names. Multiple entries by one author are arranged chronologically, with the earliest publication appearing first. When more than one publication by the same author is cited for a year, arrange the citations alphabetically by title and distinguish the citation by lowercase letter: 1991a, 1991b, etc.

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The first line of the reference should be indented; subsequent lines should be flush left. Please adhere to stylistic guidelines set forth in the *Publication Manual* when preparing your reference list. Please note that the page numbers should be inclusive and journal or monograph series titles should not be abbreviated.

Note the punctuation in the following examples:

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- **Authored Book:**
  Rogers, T. T., & McClelland, J. L. (2004). *Semantic cognition: A parallel distributed processing approach.* Cambridge, MA: MIT Press.
- **Chapter in an Edited Book:**
  Gill, M. J., & Sypher, B. D. (2009). Workplace incivility and organizational trust. In P. Lutgen-Sandvik & B. D. Sypher (Eds.), *Destructive organizational communication: Processes, consequences, and constructive ways of organizing* (pp. 53–73). New York, NY: Taylor & Francis.

Tables

Each table must have a title and should be self-explanatory. Avoid duplicating information in the text. Number tables with Arabic numerals in order of appearance in the text. Indicate in the text where tables should be inserted.

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If a manuscript includes excerpts from transcripts of therapy sessions, you must obtain a signed release authorizing publication of the transcript from the client. Because the identity of patients may be confidential, we ask that you do not submit the signed release forms with the manuscript; you must, however, retain the signed release forms for your files.

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Data, Analytic Methods (Code), and Research Materials Transparency

The policy of *Cultural Diversity & Ethnic Minority Psychology* is to publish papers where authors indicate whether the data, methods used in the analysis, and materials used to conduct the research will be made available to any researcher for purposes of reproducing the results or replicating the procedure.

Authors must, in the author note and at the end of the method section, indicate whether they will or will not make their data, analytic methods, and study materials available to other researchers. If an author agrees to make materials available, the author must specify where that material will be available. If an author does not make data, methods, and materials publicly available, the authors should note their ethical or legal reasons for not doing so and are expected to abide by APA's data preservation policies, specified below under "Ethical Principles."

Authors must disclose any prior uses of data reported in the manuscript in the author note and in the cover letter, which should include a complete reference list of these articles as well as a description of the extent and nature of any overlap between the present submission and the previous work.

Authors must disclose all sources of financial support for the conduct of the research (e.g., "This research was supported by NIDA grant X"). If the funding source was involved in any other aspects of the research (e.g., study design, analysis, interpretation, writing), then clearly state the role. If the funding source had no other involvement other than financial support, then simply state that the funding source had no other role other than financial support. Also provide a conflict-of-interest statement disclosing any real or potential conflict(s) of interest, including financial, personal, or other relationships with other organizations or companies that may inappropriately impact or influence the research and interpretation of the findings. If there are no conflicts of interest, this should be clearly stated.

If the manuscript has been posted to a preprint archive, include a link to the preprint.

Open Science Badges

All authors publishing in *Cultural Diversity & Ethnic Minority Psychology* may apply for Open Science Badges. Introduced in 2013 by the Center for Open Science's Open Science Framework, these badges may be awarded to authors for making data or materials public or for preregistering their studies. Meant to encourage the sharing of data and materials, as well as pre-registration of studies and analysis plans, these badges are digital objects associated with journal articles and are available in four types:

Open Data:
All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.

Open Data: Protected Access:
A "PA" (Protected Access) notation may be added to open data badges if sensitive, personal data are available only from an approved third-party repository that manages access to data to qualified researchers through a documented process. To be eligible for an open data badge with such a notation, the repository must publicly describe the steps necessary to obtain the data and detailed data documentation (e.g. variable names and allowed values) must be made available publicly. View a list of approved repositories.

Open Materials:
All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.

Preregistered:
At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.

Preregistered+Analysis Plan:
At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

In addition, notations may be added to badges or open practices notes to indicate, for example, that an analysis plan was registered before the observation of outcomes (DE, Data Exist) or that there were strongly justified changes to an analysis plan (TC, Transparent Changes).

For all badges, items must be made available on an open-access repository with a persistent identifier — and in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system (e.g., ClinicalTrials.gov, Open Science Framework, and so on).

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If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.

Authors should also note their eligibility for the badge(s) in the cover letter.

Authors must, in acknowledgments or the first footnote, indicate if they did or did not preregister the research with or without an analysis plan in an independent, institutional registry.

If an author did preregister the research with an analysis plan, the author must:

- Confirm in the text that the study was registered prior to conducting the research with links to the time-stamped preregistrations at the institutional registry, and that the preregistration adheres to the disclosure requirements of the institutional registry or those required for the preregistered badge with analysis plans maintained by the Center for Open Science.
- Report all preregistered analyses in the text, or, if there were changes in the analysis plan following preregistration, those changes must be disclosed with explanation for the changes.
- Clearly distinguish in text analyses that were preregistered from those that were not, such as having separate sections in the results for confirmatory and exploratory analyses.

Replication Studies

The policy of *Cultural Diversity & Ethnic Minority Psychology* is to encourage submission of replication studies, particularly of research published in this journal.

Manuscript Preparation

Until May 31, 2020, prepare manuscripts according to the *Publication Manual of the American Psychological Association* using the 6th or 7th edition. Starting June 1, 2020, all manuscripts should be submitted in the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 3 of the 6th edition or Chapter 5 of the 7th edition).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

If your manuscript was mask reviewed, please ensure that the final version for production includes a byline and full author note for typesetting.

APA Ethical Principles state that authors should "take responsibility and credit, including authorship credit, only for work they have actually performed or to which they have substantially contributed" and that authorship should "accurately reflect the relative scientific or professional contributions of the individuals involved" (Standard 8.12). Each submitted manuscript must include a paragraph (not included in the word count), after the body of the main text and before any acknowledgments, that states each author's contribution.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*. Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

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

To construct your equations with MathType or Equation Editor 3.0:

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

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

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

Computer Code

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

In Online Supplemental Material

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

In the Text of the Article

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

Tables

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

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

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- $900 for one figure
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- An additional $450 for each subsequent figure

Ethical Principles

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

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

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

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

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

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

EMPIRICAL PAPER – Instructions to authors

Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). Please include your submission's word count on the title page.

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

Psychology of Men & Masculinities is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

If you are submitting a literature review, please read the Literature Review Guidelines.

Masked Review Policy

Psychology of Men & Masculinities uses a masked review process.

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

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

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

Manuscript Preparation

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Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the PsycARTICLES® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

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

Public Significance Statements

Authors submitting manuscripts to *Psychology of Men & Masculinities* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the abstract/keywords page. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

- "A brief cognitive–behavioral intervention for caregivers of children undergoing hematopoietic stem cell transplant reduced caregiver distress during the transplant hospitalization. Long-term effects on caregiver distress were found for more anxious caregivers as well as caregivers of children who developed graft-versus-host disease after the transplant."

- "Inhibitory processes, particularly related to temporal attention, may play a critical role in response to exposure therapy for posttraumatic stress disorder (PTSD). The main finding that individuals with PTSD who made more clinical improvement showed faster improvement in inhibition over the course of exposure therapy supports the utility of novel therapeutic interventions that specifically target attentional inhibition and better patient-treatment matching."
- "When children participated in the enriched preschool program Head Start REDI, they were more likely to follow optimal developmental trajectories of social–emotional functioning through third grade. Ensuring that all children living in poverty have access to high-quality preschool may be one of the more effective means of reducing disparities in school readiness and increasing the likelihood of lifelong success."

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript.

They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public health significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

References

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

Examples of basic reference formats:

- **Journal Article:**
  Rochlen, A. B., McKelley, R. A., & Whittaker, T. W. (2010). Stay-at-home fathers' reasons for entering the role and stigma experiences: A preliminary report. *Psychology of Men & Masculinities*, 11(4), 7–14. doi.org/10.1037/a0017774
- **Authored Book:**
  Kiselica, M.S., Englar-Carlson, M., & Horne, A.M. (Eds.) (2008). *Counseling troubled boys: A guidebook for professionals*. New York: Routledge
- **Chapter in an Edited Book:**
  Wong, Y. J. & Horn, A. J. (2016). Enhancing and diversifying research methods in the psychology of men and masculinities. Y. J. Wong & S. R. Wester (Eds.). *APA Handbook of Men and Masculinities* (pp. 231–256). Washington DC: APA.

Figures

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

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Authors of accepted papers must obtain and provide to the editor on final acceptance all necessary permissions to reproduce in print and electronic form any copyrighted work, including test materials (or portions thereof), photographs, and other graphic images (including those used as stimuli in experiments).

On advice of counsel, APA may decline to publish any image whose copyright status is unknown.

- Download Permissions Alert Form (PDF, 13KB)

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Starting in August 2017, articles are eligible for open science badges recognizing publicly available data, materials, and/or preregistration plans and analyses. These badges are awarded on a self-disclosure basis.

At submission, authors must confirm that criteria have been fulfilled in a signed badge disclosure form (PDF, 33KB) that must be submitted as supplemental material. If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.

Authors should also note their eligibility for the badge(s) in the cover letter.

For all badges, items must be made available on an open-access repository with a persistent identifier in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system.

Data and materials must be made available under an open license allowing others to copy, share, and use the data, with attribution and copyright as applicable.

Available badges are:

Open Data:
All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.

Open Materials:
All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.

Preregistered:
At least one study's design has been preregistered with descriptions of (a) the research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.

Preregistered+Analysis Plan:
At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

Note that it may not be possible to preregister a study or to share data and materials. Applying for open science badges is optional.

Publication Policies

APA policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications.

See also APA Journals® Internet Posting Guidelines.

APA requires authors to reveal any possible conflict of interest in the conduct and reporting of research (e.g., financial interests in a test or procedure, funding by pharmaceutical companies for drug research).

- Download Disclosure of Interests Form (PDF, 38KB)

Authors of accepted manuscripts are required to transfer the copyright to APA.

- For manuscripts **not** funded by the Wellcome Trust or the Research Councils UK Publication Rights (Copyright Transfer) Form (PDF, 83KB)

- For manuscripts funded by the Wellcome Trust or the Research Councils UK Wellcome Trust or Research Councils UK Publication Rights Form (PDF, 34KB)

Ethical Principles

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

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

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

The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

Other Information

Visit the Journals Publishing Resource Center for more resources for writing, reviewing, and editing articles for publishing in APA journals.

APPENDIX B– EXAMPLE OF EXCLUDED PAPER

Excluded due to quantitative methodology as outlined in Table 1.

Fox, Blank, Fox & Rovnyak (2001)	646 people living in a rural, low-income neighbourhood.	Quantitative measures (with follow up qualitative interviews)	Quantitative reporting of results (no reporting of interviews)

Lee, Gianturco & Eisdorfer, (1974)	223 (80 male, 143 female). 111 of White and 109 of Black ethnic groups	Qualitative postal survey.	Data analysis Unclear – reporting of statistics		In comparison to ‘higher social classes’, barriers reported by those in the ‘lower social classes’ reported: lack of knowledge about the purpose; mental health problems viewed as physical problems; association with ‘mental’ and ‘crazy’; lack of information

APPENDIX C – DATA EXTRACTION FORM

Author (s) and Country where study conducted	
Sample - Sample size - Demographics including age, ethnicity, gender and other descriptions stated.	
Methodology - Method of data collection - Individual vs group setting - Materials used	
Data Analysis - Procedures and theoretical approach	
Main themes - Barriers to help-seeking - Contradictions / exceptions - Conclusions	

APPENDIX D – QUALITY CHECKLIST

Question	Yes = 1	No = 0	Unclear (N/A)
1) Was there a clear statement of the aims of the research? Consider: • what was the goal of the research • why it was thought important •its relevance			
2) Is a qualitative methodology appropriate? Consider • If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants • Is qualitative research the right methodology for addressing the research goal			
3) Was the research design appropriate to address the aims of the research? Consider • if the researcher has justified the research design (e.g. have they discussed how they decided which method to use)			
4) Was the recruitment strategy appropriate to the aims of the research? Consider • If the researcher has explained how the participants were selected • If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study • If there are any discussions around recruitment (e.g. why some people chose not to take part			
5) Was the data collected in a way that addressed the research issue? Consider • If the setting for the data collection was justified • If it is clear how data were collected (e.g. focus group, semi-structured interview etc.) • If the researcher has justified the methods chosen • If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide) • If methods were modified during the study. If so, has the researcher explained how and why • If the form of data is clear (e.g. tape recordings, video material, notes etc.) • If the researcher has discussed saturation of data			
6) Has the relationship between researcher and participants been adequately considered? Consider • If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location • How the researcher responded to events during the study and whether they considered the implications of any changes in the research design			

7) Have ethical issues been taken into consideration?
Consider
• If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained • If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study) • If approval has been sought from the ethics committee

8) Was the data analysis sufficiently rigorous?
Consider
• If there is an in-depth description of the analysis process • If thematic analysis is used. If so, is it clear how the categories/ themes were derived from the data • Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process • If sufficient data are presented to support the findings • To what extent contradictory data are taken into account • Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation

9) Is there a clear statement of findings?
Consider whether
• If the findings are explicit • If there is adequate discussion of the evidence both for and against the researcher's arguments • If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst) • If the findings are discussed in relation to the original research question

10) How valuable is the research?
Consider
• If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g. do they consider the findings in relation to current practice or policy, or relevant research based literature • If they identify new areas where research is necessary • If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used

11) Is it explained how 'low-income' was operationalised or determined through the recruitment process?

Adapted from:
Critical Appraisal Skills Programme (2018). CASP Qualitative Checklist. [online] Available at: www.casp-uk.net. Accessed: 09.11.19

APPENDIX E – QUALITY ASSESSMENT SCORING

	1	2	3	4	5	6	7	8	9	10	11	TOTAL (/11)
Cruz et al., (2008)	0	1	CT	0	1	0	1	1	1	1	1	7
Wells et al., (2013)	1	1	CT	1	1	0	1	1	1	1	1	9
Copeland & Snyder, (2011)	1	1	1	1	1	0	0	1	1	1	1	9
Jesse, Dolbier & Blanchard, (2008)	1	1	1	1	1	0	0	1	1	1	1	9
Abrams et al., (2009)	1	1	1	1	1	0	1	1	1	1	1	10
Snell-Rood et al., (2017)	1	1	1	1	1	0	1	1	1	1	1	10
Doornbos et al., (2013)	1	1	1	0	1	0	1	1	1	1	1	9
Berry et al., (2020)	1	1	1	1	1	1	1	1	1	1	1	11
Ijadi-Maghsoodi et al., (2018)	1	1	1	1	1	0	1	1	1	1	1	10
Anderson et al., (2006)	1	1	1	1	1	0	1	1	1	1	1	10
Dupere, O'Neil & De Koninck, (2012)	1	1	1	1	0	0	0	1	1	1	1	8

APPENDIX F: LETTER OF ETHICAL APPROVAL

UNIVERSITY
OF HULL

University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 464030 | E:T.Alexander@hull.ac.uk
W: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Martha Harrison
Faculty of Health Sciences
University of Hull
Via email

1st July 2019

Dear Martha

REF FHS143 - An exploration of the attitudes that young men from working class backgrounds hold around expressing emotional distress and seeking support.

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

I wish you every success with your study.

Yours sincerely

Dr Tim Alexander
Deputy Chair, FHS Research Ethics Committee

UNIVERSITY
OF HULL

Tim Alexander | Research co-ordinator | Doctorate Course in Clinical Psychology
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
t.alexander@hull.ac.uk | 01482 464030
@UniOfHull /UniversityOfHull universityofhull

APPENDIX X – DEMOGRAPHIC INFORMATION SHEET

If you are interested in taking part in the study, please fill out the following form. Put the form inside the envelope provided and hand it into your **head of year** at school.

They have been told to hand the completed forms directly to me. **Please try and hand this in within 2 weeks of receiving this letter.**

Full name:

Year group:

Date of birth:

Gender:

Religion:

Ethnicity:

Country of birth:

Thank you for showing your interest in the research. If your name is chosen, a time will be arranged for us to meet at the school.

APPENDIX H – PARENT/GUARDIAN INFORMATION SHEET

UNIVERSITY
OF HULL

Hull and East Yorkshire Hospitals NHS
NHS Trust

NHS
Humber Teaching
NHS Foundation Trust

Parent / Guardian information sheet

An exploration of the attitudes that young men on free school meals hold around expressing emotions and seeking support

Hello, my name is Martha Harrison. I'm studying for my doctorate in Clinical Psychology at the University of Hull. As part of this course, I am carrying out some research that will become my thesis project. I have chosen to explore the thoughts and opinions that young men have around expressing their emotions and whether there is anything that makes this easier or harder to do. I am also interested in the ways that this group of people manage these feelings and what they find helpful/ unhelpful.

Your son has been invited to take part in this research. This information sheet is to explain what the research is and to ask whether you are happy with your son taking part (if they decide that they want to). If there is anything that isn't clear, or if you have any questions, please feel free to contact me. My contact details are at the bottom of the sheet. Your son might want to talk with you about the study or see if you have any thoughts about what it involves.

What is the point of the research?

The study aims to understand what attitudes young men on free school meals hold around expressing emotion. It also aims to find out more about the opinions this group of people hold around what is helpful / unhelpful in times where they may feel emotional distress.

It is important to know that your child has not been selected because they have been upset or have mental health difficulties. The research is aimed at understanding emotional wellbeing in general; as something that everyone has.

What do I have to do?

You have been contacted as you are a parent or guardian of a young man aged 11-16 years who is eligible for free school meals. As your son is under the age of 18, your consent is needed before they can participate in the study. There is no cost involved in taking part in this study. If your son wishes to be involved and you give your consent (after reading this sheet) you will need to sign the consent form attached. Your son will need to put this completed consent form in the envelope along with their completed form. They will hand this into their **head of year** at school.

Does my son have to take part?

Absolutely not. I want this research to be a joint project. It is key that the young people take part because they are interested, not because they feel like they have to. If your son does wish to be a part of the research, they can still change their mind up until the point where I have written out the information from the interviews (around 3 weeks after the day of the interview). They don’t have to give a reason why and they will not be in trouble because of this.

What happens if my son wants to take part?

Your son will have a copy of their own information sheet. When they have had a read through this, they can decide whether they want to be a part of the research. If they do, they will need to fill out the form so that I know their name, year group and date of birth. This is so I can contact them and arrange a meeting. No other children will know that your child is taking part in the study. The meeting will take place at the school in a private room. **Your son’s completed form as well as your completed consent form need to be placed inside the envelope addressed to myself and given to their head of year at the school.**

Before the meeting starts, your son will be asked to sign a consent form, similar to the one that you have a copy of. I will meet with your son during school time so other members of staff will be around if needed. After they have signed the form and asked any questions, I will ask them some questions and we will have a conversation around wellbeing and seeking support. This is expected to last around 1 hour but can be shorter if needed. I will be asking questions in order to gain understanding about the opinions that they hold around these topics. After the interview, I will type up what your son said. It is after this point that they will not be able to withdraw their data.

Will people know my son is taking part?

Your son’s name will not be included in the research and all identifiable information will be removed (e.g. names of other people, addresses and locations). Therefore, other people will not be able to identify the information as coming from your son. Staff at the school will be aware that your son is taking part in the study so that they can help facilitate arranging meetings. However, they will not know about what was spoken about in the interview.

Your child's information will be stored confidentially in a locked cabinet at the University of Hull. All recordings are kept on a password protected laptop and destroyed after they have been typed up.

Only the researcher and authorised persons (e.g. supervisor) will have access to the information. Once the study is completed, the information will be kept for ten years in a locked cabinet before being destroyed.

If information is shared during the interview that raises concern for the safety of your child or anyone else, confidentiality may be breached in line with current legislation. If this happens, your child will be informed first. Following this, appropriate people will be notified in order to ensure that your child is safe. This will be done in line with the school's safeguarding policy and pastoral support pathway.

What will happen with the results of the study?

The results will be collected and analysed by me. I will then write up the results which will be used as my thesis project. The study may be submitted for publication in a professional journal. If you would like to find out the results of the study please contact me on the details provided below and I can provide you with a copy or summary of the finished research. Your son will be provided with a summary of the research so they can have a copy of how their words have been used to shape the study.

What if there is a problem?

You, or your son, can always contact me using the details below if you have any questions or concerns. If your son becomes upset during the interview, it can be finished early or he can chose to complete it at a later date. They will be given appropriate support through the school and contact numbers following this.

Has anyone reviewed the study?

The study has been reviewed and approved by the Health and Social care Faculty at the University of Hull.

Thank you for taking the time to read this information sheet. If you have any further questions please contact me using the details below:

Martha Harrison
Trainee Clinical Psychologist
Clinical Psychology
Aire Building
The University of Hull
Hull
HU6 7RX

Telephone: [redacted]

Email: [redacted]

APPENDIX X – PARTICIPANT INFORMATION SHEET

UNIVERSITY
OF HULL

Hull and East Yorkshire Hospitals NHS
NHS Trust

NHS
Humber Teaching
NHS Foundation Trust

‘Summatup mate?’

An exploration of the attitudes that young men on free school meals hold around expressing emotions and seeking support

Participant information sheet

Hi, I'm Martha. I'm a Trainee Clinical Psychologist at the University of Hull. I am doing a piece of research as part of my qualification. I am really interested in representing the views of young people. The purpose of this project is to give you a voice and allow your opinions to be heard.

This sheet will tell you about what the research is about. You can have a think after reading this about whether you would like to take part or not. If you want to be a part of the project, there is information on this sheet about what the next steps are.

If there anything that isn't clear or if you have any questions, you can get in touch with me to have a chat. Feel free to talk with your family, teachers or anyone else you feel comfortable with. My email address and phone number are at the bottom of the last page in this letter. You can contact me on either of these. If you prefer, you can ask someone else to contact me instead.

What is the point of the study?

This study is trying to find out about what young men on free school meals think about talking to other people about how they are feeling. The aim is also to understand whether there are any things that make this easier or harder to do. Questions will be asked with the aim of gaining a better understanding of how you and other males in your life show their emotions and what kind of things they do to manage this.

It is hoped that this is a chance for you to express yourself and get your view point heard. This study has never been done before.

Why have I been contacted?

You have been contacted because: you attend the [redacted]; you identify as male; you are aged 11-16; you are from a British background and you are eligible for free school meals.

Research often focuses on different groups of people. For the sake of this research, these are the criteria that I am interested in in order to find out what opinions exist for this group of people.

Do I have to take part?

No; this is your decision. It is important that you take part in the study because you want to, not because you feel like you have to.

You can take some time to have a think about whether you want to join in with the research. If you decide that this is something that you are interested in, you will need to sign a form when we first meet. As you are under the age of 18, your parents will also be given a form to sign which says that they are happy for you to take part (form included in this letter). The research cannot go forward unless your parents sign this form.

Even if you sign this form, you do not have to commit to being part of the research. You can change your mind up until the point where I have written up the interview (approximately 3 weeks after the day of the interview). No one will mind if you do change your mind.

What will happen if I want to take part?

If this is something that you are interested in, you can fill in the bottom part of this sheet. Your parents also need to fill in their consent form to say that they are happy with you taking part. If they do not sign this, unfortunately you will not be able to take part.

You will need to put both completed forms back in the envelope and give to your **head of year** at school. Please try and do this **within 2 weeks** of receiving the letter. From the names that are received, people will be selected at random to take part in the study. If this is you, you will be asked to meet with me during school time to talk some more about the study and complete some forms. I will then ask you some questions and we will have a conversation about some of the topics that are raised. I would like to talk to you during this meeting about your experience of emotions and how you express these to other people. What we say will be recorded on a password protected laptop (which means that no-one else will have access to it). In total, this meeting will last around 1 hour. **You do not have to talk about anything that you do not want to.**

Will what I say be kept private?

I will use a number rather than your name as soon as I begin typing out what we talked about. I will get rid of any information that could be used to trace what you said back to you (e.g. friend’s names). This means that no-one else will know that these are your words. Some members of staff at your school will know that you are taking part just so they can help arrange the meeting. They will not talk about this with anyone other than me and they will **not** have access to the recording or typed version of what was said. The typed version of the meeting will be kept in a locked cabinet for ten years. After this time it will be destroyed. The recording will be deleted after it has been used.

The only time that I would have to tell someone about what we talked about is if I am concerned that you / someone else is at risk of harm. Also, if you become upset during the meeting, I may need to contact the pastoral support team at school so that

they can support you afterwards. In this case, I will also inform your parents so they are aware of what has happened. If you do become upset, we can stop the conversation and you can choose whether or when you want to continue with it.
I will also give you information about sources of support and we can talk about what options are available if this is something that you want. **I will always try and speak with you first if I am going to talk to someone else about what was said in the interview.**

Will other people know that I've taken part?

It is **your choice** whether you want to tell anyone about the study. Meetings will take place during the school day in a private room. I will ask you to meet me in this room so that you are not being collected. If you forget to meet at this time, I may ask someone from reception to come and get you (but they will not be told why).

What happens to the information that I give?

I am going to write about what I find out for my Doctorate qualification. I might also talk to people who work with young people about what was revealed through speaking with you and others involved. This could help them gain a better understanding for their work. I will give you a written summary of the finished project so that you can see how your words have helped shape the study.

Thank you for taking the time to read this information sheet.

Martha Harrison

Contact details
Mobile: [redacted]
Email [redacted]

APPENDIX J – PARENT / GUARDIAN CONSENT FORM

Parent / Guardian Consent Form

Title of study: An exploration of the attitudes that young men on free school meals hold around expressing emotions and seeking support

Researcher Name: Martha Harrison

Please read the statements below carefully and complete your details if you are happy for your son to take part in the study outlined in the information sheet.

Please write your initials in the boxes if you agree with the statement:

1. I confirm I have read the information sheet about the above research project. ☐
2. I understand what the project is for and what it involves. ☐
3. I understand that participation in the project is voluntary and that my son can withdraw up until the point where I have typed up the data. ☐
4. I understand that any information about my son will be kept confidential ☐
5. I have had the opportunity to ask any questions and if so have received satisfactory responses to these. ☐
6. I have considered all of the information provided and **I am happy for my son to take part in the study.** ☐

Name of parent/guardian: ____

Signature of parent/guardian: ______________________________

APPENDIX X – PARTICIPANT CONSENT FORM

Consent Form

An exploration of the attitudes that young men on free school meals hold around expressing emotions and seeking support

Please circle your answer to each question:

Have you read about / has somebody explained this project to you? Yes / No

Do you understand what this project is about? Yes / No

Have you asked all the questions you want to? Yes / No

Do you understand that it's ok to stop taking part up until the point that I type up your interview? Yes / No

Do you understand that the research interview will be recorded and that anonymised quotes may be used in research reports? Yes / No

Are you ok with information being shared with parents / teachers if concerns are raised? (outlined in information sheet) Yes / No

Are you happy to take part? Yes / No

If any answers are 'no' or if you have decided you **do not** want to take part, please **do not** sign your name.

If you **do** want to take part, please write your name on the line below.

Your Name: ____

Date: ________________________

Thank you for your help.

APPENDIX L – SEMI-STRUCTURED INTERVIEW GUIDE

Interview Schedule

These questions will be asked alongside general prompts such as ‘can you tell me a bit more about that’, to get a more detailed answer or to elaborate on a subject they seem particularly interested in. As the design is a semi-structured interview, this allows for new ideas and questions to be generated in response of what the interviewee says. The questions below provide a framework of general themes to be explored

1. Can you tell me a bit about yourself:
    a. What do you enjoy doing in your spare time?
    b. What hobbies/interests do you have?
2. What's it like growing up in Hull?
    a. What kind of things are there to do where you live?
3. Can you describe the area where you live? Do you like it? What are your neighbours etc. like?
4. How are things going at school? What parts of school do you like / dislike?
5. As you have read, the aim of the study is to find out more about how boys express their emotions and whether there is anything that makes it easier or harder to ask for support. To start, can you help me understand what it's like to be a male growing up in this day and age
    a. What does masculinity mean to you? What ideas about masculinity have you heard about?
    b. What pressures are there? Are these similar or different to females?
6. What ideas about masculinity have you seen in other people?
    a. Is this different to what messages females get? Examples.
7. For yourself, how would people know if you weren't feeling ok, emotionally?
    a. What would they see? How would you feel?
    b. Can you give me an example of a time where you may have shown this (or not)?
8. Do you ever see this in friends or family members?
    a. Examples where may have hidden this.
    b. Do you think men in your life ever hide this?
    c. What about females?
    d. Can you think of any reasons why people may hide how they feel?

9. What do you think other people would think if you were to show distress (upset, angry, scared)?
    a. What would they do?
10. What would you do if you weren't feeling good emotionally?
    a. Would you tell anyone?
        i. And what would this be like?
    b. Do you know of any places you can go inside or outside of school to get emotional support?

APPENDIX M – DEBRIEF SHEET

Thank you!

I want to say a huge thank you for taking part in my study. I hope that you have enjoyed being a part of this project. I really appreciate you taking the time to share your experiences.

If you have any questions for me after the interview you can contact me on:

Mobile: [redacted]

Email: [redacted]

If you are upset or worried about anything following the study, you can talk to:

- Family or friends
- Someone at school
- Pastoral support
- Your GP

I have also included some numbers of places that you can ring up for free. They can offer support or guidance for any difficulties that you may be experiencing.

Childline - 0800 1111 / www.childline.org.uk

This is a free and confidential service (which means that no-one else will know that you have phoned them). You can talk to a counsellor about things that may be bothering you. You can also use their online chat service which means that you can have a 1 to 1 chat with a counsellor through text.

YoungMinds - www.youngminds.org.uk

This is a great website where you can find all sorts of information about emotional distress and mental health difficulties. There is advice and guidance on what to do if you are experiencing difficulties. If you need urgent help, you can also text **YM to 85258** for free.

Mind - 01482 240 200 / info@heymind.org.uk

Hull and East Yorkshire Mind provide one to one support for young people experiencing a range of difficulties. They also have groups for people aged 11-17 which offer the opportunity to meet other young people going through similar experiences in a fun and relaxed way. The groups involve learning skills to manage things such as stress, anxiety and low mood in a supportive environment.

ReFresh - 01482 331 059

This service offers information and support about drugs, solvents and alcohol. If you ring the number, ask for ReFresh. They can offer advice over the phone and make a referral for group work if this is something that you would like.

Samaritans - 116 123

This is a free service available 24 hours a day. They provide confidential emotional support for people who may be feeling distressed, upset or suicidal. A volunteer will listen to you and talk to you about any concerns or troubles.

Child and Adolescent Mental Health Services (CAMHS) crisis response team – 01482 335 600

This service is for young people who are experiencing a mental health crisis. This may include self-harm, emotional distress which is causing you significant difficulties, or risk of harming others.

If your physical or mental health needs urgent attention (e.g. if you are harmed or there is a threat to life) you must phone 999 so that appropriate care can be given. You can also phone 111 if you have a health need that is not urgent. 111 can provide free and confidential health assessments and refer you to appropriate services.

APPENDIX N – CODING EXAMPLE

Code:
Yellow – Descriptive

Purple – Linguistic
Green – Interpretative

Pt: Cos the rest of them it’s like they put on a mask like a feigned emotion and you can, you can tell if one of them’s depressed, like you tell if they’re depressed but some of them hide it well. But then at one point they crack and you can see it	Masking of emotion – hiding distress Diagnostic labels Masking ineffective – distress remains
R: What do you think makes them hide it?	
Pt: Id mainly say the male stereotype, just showing emotion, showing some kind of emotion can lead to weakness which people think, which it can’t like if you spread your emotions you’ll think you know you’re stronger because you’re spreading emotions to people you wouldn’t usually do it to. But then, they might hide it as well just so they don’t worry their friends as well. Because some of them like to keep others happy.	Showing emotion = weakness – men should be strong Contraction – acting in accordance with stereotype but believing that strength is gained in other ways Masking functions as way of protecting others Talking about others – deflecting from talking about self ?

APPENDIX O: EPISTEMOLOGICAL AND REFLECTIVE STATEMENTS

<u>Epistemological Statement</u>

When analysing data and constructing themes, it is inescapable that the researcher's lens will impact the information that is payed attention to and the sense that is made from this (Hoffman, 1990). My lived experiences, access to discourses and cultural ideas, beliefs and thoughts may be reflected in the questions I asked during interview and the way this has been written up. Although I tried to remain neutral and aware of any potential biases, the results are inevitably a co-construction.

Epistemology is an important concept to consider in the research process, in particular when using qualitative methods such as the current study. Epistemology is the theory of knowledge (Cater & Little, 2007); how we make sense of information and the meaning we take from this. Given that this research aimed to consider experiences (of barriers in the review and of emotional expression and help-seeking in the empirical) it follows that it is written in line with an interpretivist perspective. When conducting interviews, it was important for me to explore the way that each participant understood concepts of masculinity, ideas around emotionality and seeking support. I did not want to make assumptions about their experiences, instead letting them teach me about their world and the way that they have come to develop attitudes and ideas. I also wanted to capture the nuances in people's experiences, reporting examples of the changing social context and contradictions in behaviour and thoughts.

I would therefore describe myself as aligned with a social constructivist stance; I believe that the relationship between the researcher and participant is crucial in capturing the essence of what is being said and how this relates to an individual's experience of reality (Ponterotto, 2005). Social constructivism emphasises the importance of culture and context in shaping how someone makes sense of the world. A principle of this perspective is that knowledge is sustained by social processes (Gergen, 1985). Throughout the research, I have tried to examine the societal and systemic influences that may have contributed towards the opinions and perspectives of individuals.

The use of a reflective journal and engaging with my own reflexive interview has been helpful in allowing me to unpick my lens and the biases that this may bring. I was aware that my upbringing and experience of gender and social class (see reflective statement) could pull the interview in a direction imposed by myself, rather than the boys'. Similarly to therapeutic work, I tried to reflect in the moment and paused to consider why I was asking a question before saying it out loud. This resulted in a balancing act between stepping back enough to view my lens whilst staying connected and in tune with the process of the interviews.

Reflective Statement

Literature Review:

In comparison to my empirical project, I found the process of writing the review to be challenging. At times this felt procedural and somewhat monotonous. I think this was in part due to the review becoming overshadowed by my enthusiasm for the empirical research; synthesising the work of other people did not bring me the same satisfaction as finding my own project. However, as I began to sift through the papers and find meaning in the words written on the pages, I found that I gained momentum. The review allowed me to read about experiences from people from a range of different backgrounds. Reading the words of underrepresented ethnic groups, mothers and people with adverse life experiences taught me a lot about the layers of deprivation and the multifaceted nature of the term 'low-income'.

Research Topic:

When first considering the topic for my empirical research, I found myself becoming somewhat contrived by the process of writing for ‘clinical psychology’. I think this may be a reflection of my feelings of inadequacy sometimes in the profession; sometimes trying to become what I think I ‘ought’ to be rather than find confidence in my authenticity. I was encouraged to draw on my interests and find enthusiasm for the project I was about to dedicate 3 years of life to. Naturally, this led me to think about social class.

I have grown up in a town with mining heritage. My Grandad was a miner and this has always been a source of great pride in the family. ‘Working class’ culture is celebrated at home and is welded into the identity of many communities, families and individuals. Although difficult to define exactly what this is, I became acutely aware of these roots when embarking in University education. Interestingly, in the context of my home town, I come from a family which would often be considered ‘posh’. I have the privilege of being able to pursue higher education and have financially always been somewhat ‘stable’. Soon after settling into University life, I found that I was now referred to as having a ‘broad accent’ and my nickname was affectionately known as the location of my home town. After years of working on my accent to get rid of it’s ‘poshness’ I now found myself emulating the more ‘middle-class’ accent of my mother in an attempt to fit in.

This straddling of the class brackets has developed in me an almost Chamaeleon ability to adapt to social settings. It has been woven into my identity; reflected in my taste, interests and merging accent. When choosing my research project, I feel like I predominantly drew on my experiences of the need to belong and ‘fit in’. However, as I identify as female, this study is not related to my experience of fitting in, but that of the many boys I witnessed at school as they tried desperately to bury any trace of vulnerability under the mask of being ‘hard’. My brother fit very well into this world, being one of the boys who could ‘stand up for himself’ in the school playground, well known for his football and rugby prowess. He was also a brilliant dancer; my sister and I sworn to keep photographs of him in blue sequins hidden away. This offered me insight into the multi-layered nature of masculinity and the notion of public persona and private self (Schlenker, 1986).

It was important for me to consider, based on my epistemological position, that this experience of comprehensive school was unique and would not be understood in the same way for other people. However, after working in a CAMHS with boys who often shared that speaking about how they were feeling was an alien experience, it was a subject that I was passionate to pursue.

Throughout the refinement process of this research, I was acutely aware of the possibility that I was feeding into the dominant, binary understanding of gender that restrains so many people. I completed a 6-month placement in a Gender Identity Service where people across the gender spectrum spoke of the challenges associated with the dichotomy of gender labelling. Again, I drew on the social constructivist position which enabled me to consider that I was simply exploring one version of truth and reality.

Recruitment and Interviews:

As class is inherently a social construction, I struggled to think of a way of operationalising class without removing the complexity and intersectionality. During recruitment, students who met the inclusion/exclusion criteria were sent letters in order to gauge interest. Throughout the recruitment process, I was aware that I was inviting boys to participate in something which may be a novel and intimidating concept to them. Furthermore, conversations with staff at the school revealed that gaining parental/guardian consent was problematic due to a host of reasons. Building a relationship with the school was a crucial part of the recruitment process. Despite the extensive pressures and demands of working in the school, the staff that supported this project were enthusiastic, motivated and immensely helpful.

Unfortunately, due to the COVID-19 pandemic, recruitment was cut short. However, from the boys that I was able to speak with, I gained valuable insight into their world and the way in which they navigated this. I came out of each interview with different perspectives, questions and ideas. Despite the differences and nuances in experience, the boys shared common ideas which have been reported in this research. Due to the reasons outlined above, I was conscious of taking a step back during interviews and tried to let the narrative develop naturally; limiting the amount of questioning and prompting that I added in an attempt to reduce steering the topic of conversation. In particular, I remained vigilant that I held beliefs that boys may find it more difficult to speak about emotional expression, based on my lens as well as reading through previous literature. I wanted to emphasise the changing attitudes and contradictions highlighted from the interviews, which offered a new perspective to the literature (in particular in superordinate theme three).

Throughout the interview process, I was aware that my gender may influence the relationship during interviews. I wondered how the boys would respond to me during conversations around gender, emotionality and help-seeking. I am also from an older age bracket to the boys in the study, which perhaps contributed towards a feeling of dissonance. I was aware that the same barriers that may prevent young men accessing services may be present during interviews; potentially resulting in the young people feeling uncomfortable and unable to speak openly. However, after conducting the interviews, I considered that the difference in age and gender had a positive influence on the interview process. Being so unlike the peer group of the boys, this may have allowed them to feel that they could show a different side to themselves, enabling open and honest conversation. I also made it clear in the interviews that I was not affiliated to the school; I tried to illustrate this through my choice of clothing and offering of fizzy pop and biscuits. This may have signalled to the boys that the conversations would be kept separate from their school life, adding to the security and freedom that comes with anonymity. However, at times I also wondered whether the boys may feel a need to 'protect' me from some of the more harsh and frank details of their experiences, particularly around 'lad culture' (Phypps & Young, 2015). Although the use of language developed throughout the interviews, the societal association with femininity and fragility (Skrla, 2003) may have led to the perception that I was part of the 'out group' and therefore would not understand or be able to handle information told in more depth.

Data Analysis and write-up

For me, the data analysis procedure was a long and tentative process. My inexperience at using qualitative methodology and worry about getting 'it right' led to several iterations of refinement and re-reading in order to check that I had accurately captured what the boys were saying. I think my anxiety around 'getting it right' also contributed towards me, at times, trying to find meaning in the data that answered my research question, rather than letting the data guide me. My supervisors were key in helping me stick with the methodology, allowing the boys' voices to shape the results in line with the bottom-up process.

As the themes started to take shape, I grew confident that I was offering a credible representation of the data. Reading and re-reading the boys' words offered me motivation and renewed enthusiasm at times where I was feeling fatigued with the process of writing. The dialect and use of language lit up the data for me. I enjoyed reporting something that may be considered unconventional in academic literature; albeit at times censoring some of the expletives. I hope the reader feels the same life and vibrancy as I do when reading through some of the quotes.

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