Men's relationship with psychological therapy: Exploring how gender-roles may restrict men's engagement in psychological treatment.

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Preface

As an undergraduate, I remember reading an account about George Kelly visiting Freud. Upon meeting the great man, Kelly apparently recounted an observation of a boy he saw on his way to the meeting. Freud, without hesitation, reflected that the boy represented Kelly himself, something that Kelly denied and refuted. In this instance however, unlike Kelly, this portfolio is undoubtedly a conscious and unconscious reflection of my own wrangling with the traditional masculine gender-role.

I have come to realize that this research has been somewhat influenced by the defences I have deployed against the shame of not living up to the man, according to formative social scripts, I was supposed to be. The story starts with my father, a powerful and strong man who was unable to share his fears or process difficult emotions. He coped by avoiding issues and reflecting anger, which aligns with the traditional male gender role. A smoker, he contracted lung cancer at 55 and died 9 months later, angry and scared, unable to seek psychological support. At 19, I was helpless to support him, even if he had been able to voice his fears. At his death, it was expected that I would step into his shoes, adopting a strong, sure and strident masculine façade. To some extent, that is exactly what I did, sending me head-first, into my own debacles with life.

Having witnessed my father's inability to cope and then struggling myself, at 33, I found myself sitting in front of a male psychologist, an imperfect man with his own blind-spots, but someone who was able to talk about all the difficult issues that were taboo in my own family. Upon reflection, it appears that my generation found a greater permissiveness in being able to be emotionally open, than the more restrictive times of my forefathers.

Indeed, there has been a surge in interest in men's mental health over the last decade. Society, it seems, has started to accept that men are just as likely as women to be susceptible to psychological distress. More and more frequently, mental health charities appear to be encouraging both sexes to take care of their psychological health and to seek help when necessary, advice that is echoed by service-users, professionals and princes.

Such positive and affirming rhetoric is welcome and necessary. However, beyond the rhetoric, more searching questions need to be raised. Why have men been so reluctant to seek psychological support? Why has it taken so long for society to recognise these issues? Socializing factors, particularly gender roles, appear to provide some potential answers to such questions; the expectation on men to be strong, stoical and resourceful, potentially confounding their ability to ask for help.

Rather than starting from the top-down i.e. defining the tenets of the masculine gender role and then making suppositions about the likely behaviour of men, this portfolio is grounded in the experiences of actual men who have sought and engaged with psychological therapy. Here, a research project is undertaken to understand, from the ground up, how actual men try to cope, what causes them distress, how they recognise distress, seek help, experience the current psychological provision and how they are affected by their experience.

In order to form a coherent narrative, the aim of the research proposition was to conceptualize the entire client-journey within a single, holistic model, from which recommendations could be derived to inform policy makers and service-providers towards an equal service uptake between men and women. The research project includes a review of the relevant literature, an exposition of the philosophical approach adopted, and the methodology employed. To make the outcome of the research as relevant as possible, the results section aims to keep the reader in close contact with the participants whilst respecting the social structures that exist within the contemporary health-care environment.

In order for the recommendations of the research to have any impact, the details of the study have to be disseminated. The second part of the portfolio presents an article for publication, a condensed form of the main research project which may act to facilitate a wider audience.

One of the outcomes of the research was the trepidation some men continue to experience in disclosing about their therapeutic experience, even having become relatively enlightened about the need to care for their own psychological health. Indeed, many participants were mindful of the prevailing stigma attached to mental health issues, particularly in work environments and so were very selective about who they disclosed to. Such reticence, to speak openly about their psychological wellbeing, showed a degree of subversion as, even though privately there was a dilution of the traditional male gender-performance, publicly, many participants continued to feign a far stricter adherence.

With the appreciation that men may have varying levels of conformity to the traditional male gender-role, and that gender performance may be regulated, the final part of the portfolio represents a reflective account of my practice with a variety of men exhibiting a range of levels of gender-conformity. Attention was given to the male-gender role, both as it related to the problems the men presented with, and in how gender-roles may interfere with the therapeutic relationship.

The men in this reflective review range from those who barely conform to traditional male gender-roles, to those who struggle as their capacity to adhere to traditional masculine norms becomes

diminished. One of these men dealt with his distress passively, another with aggression. Others despaired as, despite their best efforts to conform to all the strictures of what they thought masculinity should be, their efforts appeared to go unrewarded and unappreciated. Finally, a man losing some of his masculine prowess due to age learns to release the more extreme hypermasculine characteristics that had, hitherto, formed the basis of his identity.

In my therapeutic practice, I often find myself providing men with permission to be human rather than part-human, to be able to admit and accept frailty, vulnerability, sadness or fear. In considering this portfolio as a whole, the common message is one of permissiveness, to avow each individual man to seek help whenever it is required, regardless of the presence of gender-practices.

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Part 1. The research thesis.

Mapping men's journey through psychological crisis and treatment.

Abstract

Men tend to be significantly under-represented in primary care psychological services despite a range of social indicators which suggest that men may experience psychological distress at equivalent rates as women. This study aims to explicate the therapeutic journey undertaken by men to inform service providers how a greater proportion of men may be engaged with primary care psychological services. Adopting a subtle realist ontology, a grounded theory analysis was applied to semi-structured interviews with 30 male participants who had completed a psychological intervention within five years. Participants were recruited via advertisements displayed in a range of waiting rooms and on social media. Analysis of the emergent data allowed for the development of the 'Humpty Dumpty' model conceptualizing the entire therapeutic journey men undertake. Formative experiences, including family role-models, traditional gender-roles and a lack of awareness of psychological matters, resulted in the pre-therapy coping strategy, 'just keep going.' When crises occurred, typically relating to work and relationships, then generic, individual, psychological support was valued, suggesting that existing services are both appropriate and fit for purpose. Although participants reported their experiences to be transformational, they tended not to disclose their experiences, potentially contributing to a pervasive unawareness of psychological issues amongst men. A range of recommendations are extruded from the model, aimed at increasing men's engagement in primary care psychological services.

1. Introduction

An apparent incongruence exists between the range and severity of men's psychological distress, as demonstrated in a range of behavioural indicators (Box 1), and men's unequal representation in primary care psychological services (ONS 2002, 2016). Differential utilization levels of psychological services between men and women suggests the presence of inhibitory forces, prohibiting equal access to treatment, potentially rendering men as a relatively disenfranchised therapeutic group (NHS, 2016).

Data provided by the Office for National Statistics, utilizing The Adult Psychiatric Morbidity Survey (APMS), are used by Government and statutory health-providers to plan and organize primary care services. Highly influential, the APMS consistently demonstrates a higher proportion of women reporting common mental health disorders (CMD) (0NS, 2002, 2014). Indeed, the 2014 APMS (revised in 2018) reports 19% of women (19.4% in 2002), compared to 12% of men (13.5% in 2002) reporting CMD symptoms with 10% of women and 6% of men reporting severe CMD symptoms. However, like all surveys, data-gathering methods remain inherently flawed.

The AMPS conducted in 2000 and published in 2002, was particularly significant as the data formed the basis for the advent of the IAPT initiative (Improving Access to Psychological Therapies), the current framework for primary care psychological services within the NHS. Conducted throughout England, Scotland and Wales, the survey collected data from 8,800 interviews (representing 69% of those approached). The interviews were conducted by non-clinical researchers conducting interviews that involved a battery of self-reports. Neurotic disorders were assessed by the presence of various symptoms occurring within the week of the interview.

Respondents indicating more aberrant symptoms (pertaining to personality disorders) were subsequently interviewed by clinical staff. These more rigorous clinical interviews revealed a bias of personality disorder towards men; 54/1000 men and 34/1000 women being assigned a personality disorder. The distribution of those disclosing psychotic symptoms were approximately equal, 5/1000 women and 6/1000 men.

The sample itself, however, may not be representative of the general population. Of the respondents invited to participate (which excludes all those in the penal system), 31% (3,009) declined to participate. The following reasons were provided for non-participation; 25% could not be bothered, 23% genuinely too busy, 20% do not like surveys, 15% invasion of privacy. The gender of those declining was not reported, although the survey authors report that weightings were applied to account for discrepancies in age, sex, region and size of household.

Table 1. Percentage of incidents of various psychiatric conditions: Adult Psychiatric Morbidity Survey (ONS, 2002).

	All	Women	Men
Psychosis (mainly schizophrenia)	0.5	0.6	0.5
Depressive episode	2.6	2.8	2.3
Generalized anxiety	4.4	4.6	4.3
Phobias	1.8	2.2	1,3
Obsessive compulsive disorder	1.1	1.3	0.9
Panic attacks	0.7	0.7	0.7
Other (mixed depression and anxiety)	8.8	10.8	6.8
Any of the above	16.4	19.4	13.5

The validity of the data remains entirely dependent upon the respondent's willingness to disclose and ability of the interviews and self-report forms to capture relevant, accurate information. The authors recognised the Clinical Interview Schedule employed in the interviews to be a relatively blunt instrument, not designed to detect many specific neurotic disorders, like somatoform disorder for example (Lewis & Pelosi, 1990; Lewis et al., 1992). Consequentially, respondents whose scores reached the threshold for 'case recognition', but were not allocated to a specific category, were referred to the 'mixed anxiety and depression' category. Information about conditions including dementia, eating and sexual disorders were not sought or collected.

In 2009, the government published the results of the 2007 APMS which, for the first time, included data about the over 75 age group. It was reported that, within this older-adult population, 12.3% of women and 6.3 % of men reported a CMD, demonstrating wider gender-disparity of reported symptoms within this age group (ONS, 2009). Thus, across many surveys and over decades, APMS data consistently shows women to report greater psychological distress than men.

Following the publication of the 2002 APMS, the Department of Health (UK) reacted by publishing guidance for mental health practitioners in support of women's greater mental health needs; 'Into the Mainstream' (DoH, 2003). This publication recognised gender as an important and relevant factor, highlighting the need for gender-specific services and emphasising the specific needs of women. Indeed, the authors formally ratified the persistent social rhetoric that:

> 'Despite the fact that more men commit suicide than women, men's mental health in general is much better.'
>
> (Department of Health, 2003)

Referral and service-utilization rates reflect patterns identified in survey-data, with only 36% of NHS primary care psychological service-users (IAPT) being male (NHS, 2016). However, upon closer inspection, taking a broader range of behavioural indicators of men's psychological and emotional well-being into consideration, consistently high levels of behavioural dysfunction appear to be evident among men (Box 1).

Box 1: Behavioural indicators of men's psychological and emotional well-being.

- Death from intentional self-harm is over three times more likely for males (ONS, 2017).
  - Male 15.7 /100,000
  - Female 4.8 /100,000
- Alcohol-related deaths in the UK: (ONS, 2017)
  - Male 16.2 /100,000
  - Female 6.5 /100,000
- In 2018/2019, 84% of people reported to be homeless in London were male (Clark, 2019).
- Class A drugs are used by males twice as frequently as women; 70% of drug-related deaths are males (ONS, 2015).

In recognition of the need to adopt a broader approach to the assessment of men's psychological distress, almost two decades ago, the World Health Organization (2001) provided data relating both affective and behavioural ill health (Table 2.). When such an inclusive range of indicators are considered, men and women are seen to experience approximately equivalent levels of distress.

Table 2. Distress experienced by men and women due to affective and behavioural ill-health. Units shown are Disability Adjusted Life Years (World Health Organization, 2001).

	Female	Male
Affective ill-health conditions (e.g. depression and anxiety)	15.9	11.6
Behavioural ill-health conditions (e.g. alcohol use and suicide)	2.4	8.1
Total distress	18.3	19.7

In Britain, legislation (The Equality Act, 2010) imposes a 'gender duty' on all public bodies to take gender into account when planning and delivering local and national services, to provide equal access to services and to strive for equal health-outcomes between men and women. However, with respect to mental health, such political rhetoric does not necessarily reflect clinical practice, as indicated by NHS service utilization rates (NHS, 2016).

Thus, considering the data, gender-moderated differences appear to be apparent, in the way that men and women experience psychological distress and in the coping mechanisms they adopt, women being more likely than men to report psychological distress and to engage in psychological treatment.

Such differential behaviour may be due to essential differences and/or differential socialization or performative forces and/or due to biases applied by the psychological and medical establishment. Essential differences between men and women (Geary, 2010), especially with respect to emotional disclosure (Levant, 1998), have been disputed by feminists and by an emerging generation of post-modern men (Okun, 2014).

> ‘Many people are fed a steady diet of how different men and women are, and confirmation bias easily occurs as people selectively highlight experiences that there are deep-seated and enduring differences between men and women….The empirical data suggest that men and women are more similar than different, and that when differences occur they are small, inconsistent, and limited to the influence of contextual and situational demands.’
>
> (Englar-Carlson, 2014, p. 349)

Social definitions and stereotypes, responsible for defining ‘male’ and ‘female’, may have directed gender-related behaviour to ‘contain, constrain or set free’ individuals to perform their ‘gendered practises’ leading to a differential in the way psychological distress both manifests between the sexes, and how society manages such distress (Branney & White, 2010, p. 14). With respect to the way distress is experienced by each individual, many factors are likely to impact upon each man and woman, including, ‘early life, the unconscious, biographies, relationships, discourses, performativity, affect, gender relations, material bodies, social contexts and constructions of wellbeing’ (Ridge, Emslie & White, 2011, p. 157).

Studies, investigating the preferences and experiences of actual men in distress, and who seek support, have demonstrated an incongruence between the reported attitudes of participants and pervasive assumptions regarding men’s reluctance to engage in psychological therapy (Berger, et al., 2013; Sierra Hermandez et al., 2014). Such studies have utilized quantitative data, albeit bespoke surveys, to extrude conclusions regarding men’s preferences for psychological therapy, leaving many questions about the nature of men’s subjective and individual experience of psychological distress and help-seeking.

Adopting a qualitative approach to establish an ‘empirical basis to situate the nature of the male experience’ (Addis & Cohane, 2005, p. 644), this study aims to uncover a more coherent understanding of the lived experience of a sample of men as they encountered psychological problems, then sought and experienced psychological support.

In order to contextualize this study, a review of the literature relating to men’s help-seeking behaviour, the potential reasons for their under-representation in psychological services, men’s treatment-preferences and therapeutic experiences is explored below.

2. Men's help-seeking behaviour.

Survey data suggests that women generally consult a medical professional more frequently than men, primary care consultation rates for males reported to be 32% lower than that for women, even when corrections are made for reproductive issues (Wang et al., 2013). Wang et al., reported the greatest difference in consultation rates within the 16-60 age range, consultation rates being less pronounced between the sexes once specific morbidities are diagnosed.

Qualitative differences may also be evident during consultations, female patients enjoying longer consultations and asking more questions than their male counterparts (Waitzkin, 1984, 1985), with men receiving less advice (Courtenay, 2000). Female doctors have also been reported to spend over 2 minutes longer per consultation than their male counterparts, talking with and looking at patients more, factors that may indicate a potential gender-mediated qualitative differential in medical consultations (Brink-Muinen et al., 1998; Jefferson et al. 2013).

When consulting with medical professionals, men reportedly emphasize physical symptoms (Schofield et al., 2000; Kapur et al., 2005). Men may also avoid some topics, including male sexuality, personal relationships and depression (Banks, 2001), topics which may be obscured by masculine bravado and sex-role performance (Obrien et al., 2005).

With respect to mental health problems, survey data indicates that the majority of people do not seek professional support (Bebbington, 2000; ESEMed/MHEDEA 2000 Investigators, 2004), with males and younger people representing those least likely to seek help (Oliver et al, 2005). When help is sought, informal sources may be preferred; friends, then parents, partners, psychologists and finally psychiatrists (D'Avanzo et al., 2012).

Gender differences may pervade informal help-seeking behaviour with up to 30% of young men reporting that they would never seek help from anyone for emotional problems, compared to 6% of young women (Rickwood et al., 2007). However, the charity MIND report that 52% of males may disclose low mood to partners, 31% may share their feelings with family and 29% talk to friends (MIND, 2009).

With respect to psychological issues, many studies over a number of decades, have suggested an apparent gender-mediated disparity relating to formal help-seeking behaviour, even when levels of distress are comparable (D'Arcy et al., 1979; Kessler, Brown & Bowman, 1981: Robertson, 1988; Stead et al., 2010; Cox, 2014).

If such studies capture an existent differential between men's and women's willingness or ability to recognise and/or disclose problems and/or seek help, then what factors influence the disparity; nurture or nature?

2.1 Essential differences.

In spite of the fact that male and female chromosomes differ, the concept of essential difference between men and women appears to be an increasingly controversial topic, even within academia, as society moves towards a more egalitarian meritocracy. However, an omission of the topic could disavow the rigour required by any academic appraisal that purports to examine differential behaviour between the sexes.

Genetic material is stored in chromosomes, with Homo sapiens usually inheriting 46 chromosomes (23 pairs); 22 pairs are somatic chromosomes which are identical between the sexes and encode common structural features. However, one pair of chromosomes, the sex chromosomes, differ; females carrying two X chromosomes (XX) and males carrying one X chromosome and a smaller Y chromosome (XY). However, reporting a clear dichotomy, even at the genetic level is an over-simplification.

Sometimes, individuals are born with different combinations of sex-chromosomes; an additional X chromosome (Klinefelter's syndrome; XXY, XXXY or XY/XXY mosaic), for example, produce a phenotype that is often regarded as being male due to the presence of testis and may account for up to 1 in 500 men (Geschwind & Dykens, 2004). Another genetic variant that produces a male phenotype is the addition of a Y chromosome, sometimes called Jacob's Syndrome (XYY). Individuals are usually tall and produce higher levels of testosterone; many men remain unaware of the condition. One study indicated that XYY men had fewer partnerships, lower incomes and educational levels, were less likely to become fathers, and experienced higher mortality rates than either controls or those with Klinefelter's syndrome (Stochholm, Juul & Gravholt, 2012).

Sex-related chromosomal syndromes are worthy of respectful consideration whenever gender, gender-roles, or masculinities are discussed, as they are a common phenomenon which demonstrate the blurring of the generally accepted dichotomous delineation of sex.

Differing genotypes, between the sexes, translate into the development of differential structures (including gonads), a differential mix of biochemicals factors (particularly hormones), and of complementary reproductive processes that some commentators have cited as being highly influential in the development of sex-roles (Geary, 2010). Other workers have published studies that appear to corroborate the presence of essential sex-roles. Alexander and Hines (2002), for example, reported how the biological sex of Vervet monkeys apparently influenced preferences for gender-related toys; male juvenile monkeys preferring toys typically preferred by boys and female juvenile monkeys preferring toys typically preferred by girls.

Experimental psychology continues to elucidate biologically-mediated differences between males and females and, with the advent of neuropsychology, a burgeoning body of literature exemplifies the potential potency of biological or essential factors in every-day human behaviour, including social interaction (Box 2).

Box 2: Hormonal effects on male behaviour.

- Oxytocin has been shown to modulate the distance that men in monogamous relationships keep between themselves and an attractive woman during a first encounter (Scheele et al., 2012).
- Administering testosterone has been demonstrated to reduce lying and increasing honesty in men (Wibral et al., 2012).

Indeed, biological sex has been demonstrated to relate to a range of social phenomena. Rotter and Rotter (1988) found women to be significantly better at discerning emotional expressions on the faces of both women and men, including the expression of anger on the faces of women. Men, however, were found to be better at discerning the expression of anger on the faces of other men. Such studies provide compelling evidence towards an essentialist perspective. However, although intriguing, the output of this type of experimental psychology has failed to provide clear or coherent explanations and has tended to raise many more questions than answers.

With respect to the response to distress and help-seeking, the hormone oxytocin has been cited as being potentially responsible for differential sex-related responses to distress; the masculine response being described as 'fight or flight' and the feminine equivalent described as 'tend and befriend' (Taylor, 2000, 2006). Taylor cites compelling evidence to support her conclusion, suggesting a hormonally mediated explanation for women's apparent greater proclivity towards greater social capital and to pay more attention to the health of themselves and others.

Some social factors have been reported as attenuating help-seeking behaviour, potentially adding levels of complexity which confound essentialist explanations; for example, the presence of intimate partners has been reported to be a positive influence in men's help-seeking behaviour by a number of commentators (Tudiver & Talbot, 1999; Wilkins & Kemple, 2010). Indeed, marital status was reported to be a statistically significant moderating factor in men's GP consultations in the two weeks preceding an AMPS survey with 118/100,000 single men and 128/1000 married and cohabiting men seeking GP consultations (ONS, 2001).

In addition to the availability of social contacts to actively prompt, encourage and communicate the need for help-seeking behaviour, primary romantic relationships may have also been linked to essential, biologically-moderated, factors. Oxytocin, the hormone associated with social affiliation in both sexes, has been reported to alter in response to the presence or absence of a primary romantic relationship (Turner et al., 1999). Oxytocin is thought to have a moderating effect on the stress response; 'the evidence that high levels of exogenously administrated oxytocin attenuate stress responses is strong in animals and suggestive in human studies… the quality of social contacts during stressful times may be a pivotal variable' (Taylor, 2006, p. 275). Thus, the presence of an intimate partner may create a biologically-moderated influence on men's help-seeking behaviour.

In addition to the presence of a primary relationship, survey data also indicates that other social and cultural factors may moderate help-seeking behaviour; GP consultation-rates having been reported for the following groups - Bangladeshi men 17%, Indian men 17% and Black Caribbean men 16%, compared to 12% for all men (ONS, 2001).

Other social factors have been reported as correlating with help-seeking behaviour including educational status (Doherty & Kartalova-O'Doherty, 2010), which further confounds an essentialist position. Indeed, Addis and Cohane (2005) warn that a focus on biological difference alone; 'as an organising framework is severely limiting when it comes to understanding men's (or women's)

experiences', which should consider 'the interwoven social formulations involving historic, economic, political, linguistic, interpersonal, and psychological threads' (p.635). In the absence of a coherent biological theory to explain differential help-seeking behaviour between the sexes, social factors become more compelling avenues to explore.

2.2 Social factors

The socialization of males and females, towards established definitions of manhood and womanhood, potentially starts before birth as, for the majority, gendered names are allocated. The process of gender-socialization is then reinforced by the provision of sex-typed toys, codes of play, colours and differential dress (Karniol, 2011). Thus, the formation of a construed gender is perpetuated and ensconced into developing cognitive structures; gendered-schemata (Bem, 1981; Pleck, 1981; O'Neil, 1982). Indeed, infants with a rudimentary working language (two-year-olds) have been found to talk about sex-categorized activities (Gelman, Taylor & Nguyen, 2004).

'Males and females learn masculine and feminine shoulds and musts' (Mahalik, 2005, p.218) creating a gendered self-schema (Ruble & Martin, 1998; Meth, 1990; Pleck 1995). As an idiosyncratic, self-identifying schema becomes increasingly well-defined, items from the prevailing societal archetypes and/or stereotypes are added or deleted, leading to degrees of conformity or non-conformity. Individuals may then evaluate others with reference to their own 'self-schemata' (Miller, 1984).

Bem (1974, 1981, 1984) introduced the notion of androgyny as an alternative to the traditional male-female dichotomy, suggesting that qualities from each traditional role may be incorporated into the other, or that a gender-neutral identity may be an aspirational ideal. Bem's Sex Role inventory (BSRI) has been extensively used to measure gender-identity, providing scores to calibrate the degree of masculinity, femininity and/or gender-neutral traits.

Gender-scales, reflecting established masculine norms, have been widely utilized to identify and predict various behaviours, including men's help-seeking behaviour. Indeed, a high degree of conformity to masculinity norms has been correlated with higher levels of stigma towards help-seeking behaviour and towards traditional therapy (McKelley & Rochlen, 2010).

A wide range of social and demographic factors have been linked to male help-seeking activity (Box 3) (Angst & Dobler-Mikola, 1984; Tudiver & Talbot, 1999; Addis & Mahalia, 2003; Oliver et al., 2005; Vaswani, 2011).

Box 3: Factors previously linked to male help-seeking activity.

Facilitating factors:

- Access to familiar or trustworthy services.
- Triggers and prompts from partners, friends or peers.
- Previous positive experiences of help-seeking.
- Having a degree of control in the intervention or regaining a sense of control.

Inhibiting factors:

- Embarrassment.
- Stigma.
- Sense of invincibility (young men).
- A concern about doctor's training.
- Concerns about medication.
- Fears that issues recorded in medical histories could compromise future job prospects.
- Reluctance to appear weak, foolish or hypochondriacal.
- The tendency of men to forget symptoms over time.
- A lack of male care-providers.
- Distrust of the establishment.
- Previous negative experiences.
- Lack of knowledge of help available.
- Inaccessibility of services – times and locations.
- Quality of relationships with gatekeepers, or first point of contacts, particularly GPs.
- Need to cope for the sake of maintaining role as provider.
- Procrastination.
- Substance-dependency.

Men reporting high levels of embarrassment may be up to seven times less likely to consult their GP, rendering this as a potentially highly significant moderating factor (Doherty & Kartalova-O'Doherty, 2010). Stigma, or fear of stigma, has also been described as being a highly influential consideration in men's help-seeing behaviour; public stigma, the potential for, or actual negative judgement or disapproval of others (Jorm & Wright, 2008; Vogel & Wade, 2009) and self-stigma, i.e. the threat to self-identity and self-worth (Krugman, 1998; Vogel et al., 2007). Indeed, 'hegemonic models of gender position a concern for one's health as a feminine characteristic: men are positioned as 'naturally' strong, resistant to disease, unresponsive to pain and physical distress and unconcerned with minor symptoms' (Lee & Owens, 2002, p. 211).

Zoske (in Okun, 2014, p. 271) explains how men tend to perceive their health in two ways; initially, 'from the outside-in', taking the perspective of the other (the strong) and observing the needy or ill man as being weakened, and secondly, 'from a performance point of view', monitoring his own relative productive worth in comparison with that of others. Zoske concludes that problems are compounded when the form of ill-health is generally perceived as a 'woman's disease' which may cause a sense of emasculation, embarrassment, social isolation, and fear of being perceived as unmanly and suggests disorders perceived as being feminine, and therefore more difficult to report, may include anorexia, bulimia, and distorted body image.

Attempting to attribute help-seeking behaviour to any single factor is clearly a naïve project. Addis & Mahalik (2003) rather, propose a model that cites five main influences on men's help-seeking behaviour; men's perception of normativeness, the perceived ego-centrality of problems, the characteristics of the potential helper-givers, characteristics of the social groups to which individual men belong and perceived loss of control. Their model highlights the importance of the ego-centrality of the prevailing problem in influencing the likelihood of seeking-help. For example, if work is affected, then a key source of worth, identity, and status may be challenged, and so action may be taken. The transactional nature of help-seeking is also given consideration, men being potentially more likely to seek support when there is an opportunity to offer reciprocal help 'by avoiding indebtedness and by marking oneself as a strong and competent man' (Addis & Mahalik, 2003, p. 11).

The model suggests that perceptions of non-conformity pose great threats to self-esteem, prevailing norms acting as powerful moderating factors, making role-models and reference-groups of particular significance. Group-therapy is cited as a potential extrapolation of both transactional and normative moderating factors, a group dynamic providing men with a permissive environment and one that allows for reciprocity (Andronico, 1996).

With 74% of clinical psychologists and 76% of counselling psychologists being female (British Psychological Society, 2016) and with counselling organizations reporting even greater gender disparity (British Association for Counselling and Psychotherapy, BACP, reporting 84% female membership and the UK Council for Psychotherapy, UKCP, reporting 74% female membership), then psychology and psychotherapy may be generally perceived as being a feminine activity, subsumed into feminine-gendered schemata.

Indeed, systemic gender-disparity appears to be reflected by major pillars of the psychological establishment; The British Psychological Society created a division for women in 1988 but the equivalent division for men did not materialize for more than two decades; The American Psychological Association formed fifty divisions before creating a division for men, Division 51. The result of such institutional inertia, to acknowledge men's psychological needs, may potentially contribute to the perception of 'psychological need' as being a predominantly feminine predilection.

Early notions of masculinity, within the academic literature, tended to be defined as 'young, married, white, urban, northern (American) heterosexual, Protestant father, of college education, fully employed, of good complexion, weight and height, and a decent record in sport' (Goffman, 1963, p. 236). Indeed, almost six decades ago, Goffman recognised the potential influence of masculine scripts; 'any male who fails to qualify in any one of these ways is likely to view himself… as unworthy, incomplete, and inferior' (p. 128). The tenets of such 'traditional masculinity' (Pleck, 1995) or 'hegemonic masculinity' (Connell, 1995) have been repeatedly reported to compromise men's ability to seek psychological support (Robertson & Fitzgerald, 1992; Goode et al., 1995), potentially resulting from pressures to adhere to expected masculine norms.

If masculine ideologies have had a malign influence on men's ability to express distress or to seek help, then what factors define and confine men? A frequently cited and highly influential early conceptualization of normative masculinity was provided by David and Brannon (1976), who reduced masculine qualities into four themes that largely disavow any form of weakness or vulnerability (Box 4).

Box 4: Early definitions of masculinity.

- **No sissy stuff** – avoiding feminine activities including dependency, warm feelings or urges; avoiding feminine possessions and feelings for other men.
- **The big wheel** – attaining power, status and dominance at any cost; especially in work, sports or in heterosexual 'conquests'.
- **The Sturdy Oak** – independence, self-reliance, stoicism and with control over ones' emotions; hiding pain and grief and weakness.
- **Giv'em Hell** – Courageous, risk-taking, bravado and being prepared to use violence.

(David and Brannon, 1976, with elaborated descriptions by Pollack, 1998 and Kilmartin, 2010)

Following on from David and Brannon's definition, many commentators contrived their own definitions, elaborating and refining characteristics which apparently characterized late twentieth Century, largely North American notions of masculinity. Levant (1992), for example, described seven traditional masculine norms which appear to somewhat dehumanize men (Box 5).

Box 5: Levant's definition of masculinity

- Avoiding all things feminine
- Restricted emotionality
- Toughness and aggression
- Self-reliance
- Achievement and status
- Non-relational attitudes towards sexuality
- Fear and hatred of homosexuals

(Levant, 1992)

Rather than being descriptive norms, such masculine characteristics potentially represent idealized prescriptive norms to which contemporaneous men may have felt compelled to adhere; impossible mandates of masculine performance that restricted both emotions and behaviour (Pasick, 1992) (Box 6).

Box 6: Mandatory masculine imperatives.

- We must be self-reliant.
- We should be competitive in all endeavours.
- We should not reveal our fears.
- We should be in control of ourselves at all times.
- We need to be cautious about getting too close to anyone because intimacy weakens self-reliance and control.
- We should focus on achieving power and success.
- When we encounter a problem, we should be able to fix it through action.
- We should keep score and always know where we stand relative to others.
- We should remember that we are superior to females and not have to depend on them.
- We should never allow ourselves to be weak or to act like a girl.

(Pasick, 1992)

During the latter stages of the twentieth century, masculinity as a social construct, appears to have become defined and refined as a set of qualities, traits and characteristics or 'sex-roles,' which academics then set about measuring and delineating, producing a veritable cornucopia of masculinity scales (O'Neil, 2010). The Male Sex Role Identity Paradigm (Pleck, 1995), for example, deployed a male sex-role scale which could act as a nomothetical measure to assess the degree to which an individual's masculinity compared to statistical norms. However, Kahn (2009) points out that 'the problem with identity models, based on self-report scales, is that many reflect the ways in which experts believe that people *should* be, rather than truly tapping into the way they (men) are' (Kahn, 2009, p. 80).

If ‘masculinity’ is a socially constructed phenomenon, then it remains mutable and dynamic (Kimmel 2000). So, moving towards a more dynamic, less prescribed model of masculinity, Mahalik et al. (2003) devised a model to explore the degree of conformity to contemporary gender-role norms and considered sociocultural influences, norm communication, group and individual factors, the extent of conformity, and the effects of conformity (Mahalik et al., 2003, 2005; Mahalik & Rochlen, 2006). Masculinity, as defined by their model, is conceived as being an iterative process between men and the culture in which they live, rather than any fixed identity or collection of behaviours located within an individual. According to Mahalik, sociocultural masculine norms included the themes highlighted in Box 7 (within the period and culture he published).

Box 7: Mahalik’s socio-cultural masculine norms.

- Winning
- Emotional Control
- Risk-taking
- Violence
- Dominance
- Playboy
- Self-reliance
- Primacy of work
- Power over women
- Distain of homosexuals
- Pursuit of status

(Mahalik et al., 2003)

Between 1976, when David and Brannon’s definition emerged, to 2003, little change appeared to have occurred regarding the norms of ‘traditional’ masculinity. Mahalik et al. hypothesized that contemporary norms are formed through various socializing mechanisms, including observation (imitating in-group and rejecting out-group behaviour), societal expectations of being (how to think, feel, behave) and role-models, establishing descriptive, injunctive and cohesive norms. Conformity or deviancy was described as being dependent upon the degree of adherence to, or violation of, each type of norm, a mechanism that exerts social pressure upon the individual. The model assumes that the pervading definition of masculinity is a reflection of society at any point which therefore assumes masculinity to be a fluid and malleable property rather than a fixed state.

Indeed, 'The assumption that a single masculinity exists (i.e. white, middle-class, heterosexual, American) is erroneous, short-sighted, and biased' (O'Neil, 2010, p. 381-384). Indeed, as gender-fluidity becomes an increasingly appreciated concept, and multi-cultural commentators contribute to the debate, a broader range of potential gendered social constructs or 'masculinities' are made available which may reduce the restricted practices 'traditional' masculinity prescribes.

Some commentators have described how pressure to adequately perform the traditional masculine role can cause strain on the individual; 'it's hard to be a man….Men who don't measure up are wimps, sissies, fags, girls' (Jensen in Okun, 2014, p. 80/81). Such pressure may originate from the individual men themselves; 'men continually struggle to satisfy their fantasized male judges and harshest internalized male critics' (Good & Brooks, 2005, p. 3), their inner and often persecutory, 'male chorus' (Pittman, 1990).

In adhering to prescribed, socially mediated masculine norms and expectations, a maladaptive or 'toxic masculinity' may therefore be contrived that 'deforms men, narrowing emotional range and depth' (Jensen in Okun, 2014, p. 81/83) and which may affect men's willingness and/or ability to seek help (Mansfield et al., 2005; O'Brien et al., 2005).

A number of researchers have described parallel theories of how adherence to traditional masculine roles may cause inherent distress; gender-role strain (Pleck, 1995), gender-role conflict (O'Neil et al, 1986), and gender-role stress (Eisler, 1995). Eisler evokes schema theory, describing how, through reward and punishment, rigid masculine and feminine gender role schemata are maintained which direct future behaviour and which act as a template to which a man should adhere. Masculine gender-role stress occurs when a man believes he is not living up to the expected gender role behaviour. Thus, pressure to adhere to a masculine ideology may precipitate distress which cannot be addressed because the internal ideology forbids seeking help, a double jeopardy (Good & Wood, 1995). In reviewing the various models proposed, O'Neil (2010) concedes that nobody has explained how the various strain, conflict and stress paradigms overlap or deviate from one another and so contemporary commentators have tended to assimilate such theories into a generic strain paradigm (Kilmartin, 2010).

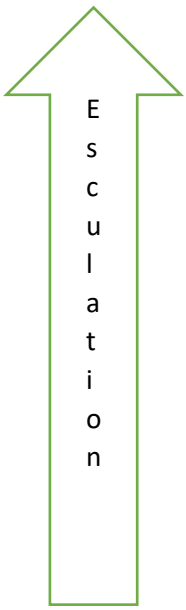
2.3 Men in Distress

Kilmartin (2010), describes how pervasive gender-role norms may act as a lens through which psychological distress may be differentially channelled; gender-typed women typically 'acting in' or internalizing psychological distress, leading to depression, while gender-typed men may 'act out', externalizing problems which manifest as substance abuse and/or violence. If men's responses to psychological distress are predominantly behavioural, then more men than women may be captured by the criminal justice system, a hypothesis that incarceration data appears to reflect; the male to female prisoner ratio in the UK being 20:1.

Studies examining religious communities, where alcohol is not used and violence is abhorred, have reported depression rates to be approximately equal between males and females (Egeland & Hostetter, 1983). The implication of such studies is that when maladaptive behavioural coping-strategies are restricted or absent, then psychopathology is not masked and may be free to manifests at more equivalent rates.

If men do tend to 'act out' their distress as they adhere to traditional masculine-roles, then how might such maladaptive behaviour manifest? One model of masculine coping strategies described a hierarchy of tactics that men may typically employ as their level of distress increases (Brownhill, et al., 2005)(Figure 1). The model describes how initial mechanisms involve denial and distraction, avoiding problems in the hope that they will go away, followed by an attempt to numb problems through the use of substances, including alcohol and drugs. Next, escapism may be deployed, with escalating problems eventually being projected onto others, resulting in potential acts of outward-violence and finally, deliberate self-harm. Seeking professional psychological support is absent from the model with all tactics employed, potentially contributing to, rather than resolving, underlying psychological distress.

Figure 1. A model of masculine coping strategies (Brownhill et al., 2005).



Pervading gender-roles may not only affect men as they experience and react to distress; the same forces may act on the system created to address their distress. Studies have indicated bias within the medical and psychological professions, psychiatrists and therapists being shown to attribute and interpret symptoms in terms of traditional sex-role stereotypes (Loring & Powell, 1988; Worrell, 1992). Anti-social personality disorder, for example, has been shown to be diagnosed twice as frequently when a generic case study was presented as a male (Ford & Widiger, 1989).

The World Health Organisation (2017) is unambiguous in accepting the existence of systemic gender-bias within psychological medicine, specifically referencing the diagnosis and treatment of depression.

> 'Gender bias occurs in the treatment of psychological disorders. Doctors are more likely to diagnose depression in women compared to men, even when they have similar scores on standardized measures of depression or present with identical symptoms. Female gender is a significant predictor of being prescribed mood-altering psycho-trophic drugs'
>
> (WHO, 2017)

Culturally-mediated gender-bias may be deeply embedded within psychiatry and the psychological establishment (Busfield, 1995; Branney & White, 2010). Indeed, studies which have applied 'gender-fair' criteria or weightings to survey data, have demonstrated equivalent proportions of men and women with depression (Murphy et al., 1988; Wilhelm & Parker, 1994, Martin et al. 2013).

A secondary analysis of a national morbidity survey (US), suggested how the application of traditional definitions of depression resulted in more women than men being diagnosed with depression (Martin et al. 2013). However, when other, potentially masculine manifestations of depression were included in the analysis, then frequency rates of depression in men and women were found to be equivalent. Relevant conclusions of the study are highlighted in Box 8.

Box 8: Conclusions of a study considering a wider range of diagnostic criteria for depression.

- A wider range of symptoms may need to be considered to define depression in both males and females.
- Reliance on men's disclosure of traditional depressive symptoms could lead to an under-diagnosis of depression in men.
- Masculine symptoms of depression may include anger attacks/aggression, substance abuse and risk-taking behaviour.
- When inclusive measures were applied to the data-set, incorporating masculine symptoms, the rates of depression in men and women was equal.

(Martin et al., 2013)

Many commentators, therefore, cite classification manuals (American Psychological Association: Diagnostic Statistical Manuals and World Health Organization: International Classification of Disease) as being instruments of institutionalized systemic bias (Cosgrove & Riddle, 2004; Branney & White, 2008; Kilmartin, 2010). In addition to the symptoms included in the diagnostic manuals, non-diagnostic symptoms have also been reported to occur in depressed men and depressed women, the inclusion of such indicators of distress (Box 9), potentially capturing a more complete conceptualization of distress (Pollack, 1998; Branney & White, 2008, 2010).

Box 9: Non-diagnostic symptoms of depression.

Non-diagnostic symptoms relating to men include:

- Increased social withdrawal
- Over involvement with work
- Denial of pain
- Rigid demands for autonomy
- Change in sexual interests
- Increase in angry outbursts and hostility
- Reliance on substances that are numbing
- Denial of sadness
- Inability to cry
- Harsh self-criticism
- Scarcity of gestures
- Slow movements
- Slow speech

Non-diagnostic symptoms relating to women include:

- Bodily Pains
- Stooping posture

In summary, men and women may manifest differential responses to distress. The performance of traditional masculine scripts may contribute to reducing men's proclivity to seek support, may pervade the medical and psychological establishment, including diagnostic criteria that omit masculine symptoms, and may create biases within healthcare professionals.

3. Men and mental health services.

It appears that gender is a determinant factor regarding an individual's likelihood to access a psychological service. Men's under-representation in psychological services may have many antecedent determinants but few studies empirically explore how actual men prefer to be emotionally and psychologically engaged and supported (Feo & LeCouteur, 2013). However, speculation regarding how men may wish to be treated is relatively commonplace within the literature.

With regard to the gender of the therapist, for example, male therapists have been proposed as being more efficacious for men as they may act as role-models and moderators of the dominant masculine code (Myers, 1996; Robertson, 2005); one telephone service for men reporting that 'comforting, accepting, empathic men's voices (are) encouraging men to engage with their problems' (Anderson, 2010, p. 243). However, other commentators reflect that male-male therapeutic dyads tend to 'create hierarchies and rankings among themselves according to criteria of 'masculinity'' (Pleck, 1980, p. 34). Male therapists may, therefore, be perceived as being potentially competitive and judgemental (Rabinowitz, 2014).

> 'Two men in a room is a scary and unusual phenomenon. Just what are they doing there? Being intimate? Unlikely. Trusting each other? Less likely. Being competitive? Very likely.'
>
> (Scher, 2005, p. 308)

Commentators continue to debate the potential advantages and disadvantages of the male-client, female-therapist dyad; reported benefits include an avoidance of the analytic model's punishing and potentially castrating father, a space where vulnerability can be shown in the absence of competition (Johnson, 2005), and where maternal issues may be addressed. However, female therapists are warned about the potential for generic transferences, an 'expectation of the archetypal woman who soothes and protects him' (Welxer, 2009, p. 91), while he will 'retain the authority and power' (Johnson, 2005, p. 296) and set the agenda (Pleck, 1980).

Box 10: Factors that male therapists may consider when treating men.

- The initial contact should be honest and considerate but with restrained affection.
- Non-stereotypical male behaviour can be modelled and permission to be different can be offered.
- A willingness to use whatever modality that will help the client can be demonstrated.
- Be challenging and direct.
- Be aware of how gender-socialization experiences affect the therapist, to prevent regression towards being controlling, directive and judgmental.
- Demonstrate and appreciate a sense of humour.
- Have a sense of the absurd.
- Be a loving and supportive person.

(Scher, 1979, 1990; Robertson, 2005).

Sexuality is frequently noted as being another area where men may attempt to influence the power-dynamic over women (Scher, 2005), the potential for the sexualisation of the female therapist requiring firm conceptual boundaries in order to provide a secure and safe environment for both parties (Potash, 1998). Indeed, 'If women are afraid of angry men, their offices are not safe places for angry men' (Sweet, 2006, p. 83). Sweet (2006) suggests that female therapists may consider the following factors when working with male clients (Box 11).

Box 11: Factors that female therapists may consider when treating men.

- How they, as a woman, perceive masculinity.
- The extent to which sexual feelings are a natural part of male-female interaction.
- If they are afraid of men's anger.
- How previous experiences with men shape expectations of male clients.
- Whether being devalued by a male client would be tolerable.
- If they genuinely like men.

(Sweet, 2006)

Despite the theoretical rhetoric regarding the potential benefits and pitfalls of either male or female therapists, clients of both sexes are reported to prefer certain generic human qualities in a psychotherapist, including; being healthy and well-adjusted, personable, persistent, self and other aware, and emotionally available without being emotionally needy (DeGeorge et al., 2013). It would appear that neither sex holds either the moral authority or innate abilities to offer a superior treatment-experience for men. Indeed, therapists of both sexes may be likely to share similar responses to male anger, male emotional inexpressiveness and displays of vulnerability (Kilmartin, 2010).

> 'Issues of gender (like race or sexual orientation) tend to fade into the background in the therapeutic relationship. A good therapist is a good therapist, and a good therapeutic relationship is a good therapeutic relationship. Men in treatment, ultimately, care more about the quality and accuracy of the input from the therapist than the shape of the body or the chromosome structure of the person offering the help. Relationship and rapport trump gender differences.'
>
> (Wexler, 2009, p. 82)

It would appear that in the absence of robust empirical data, theoretically based commentary about men's preferences for treatment may provide more questions than answers. The review below focuses on the few studies that have been conducted with male service-users that seek to elucidate men's actual preferences for psychological treatment.

Impetus for new, empirical studies is, in part, fuelled by a move towards evidence-based practice (Swift et al., 2011) and the realization that the success of treatment is contingent upon meeting client-preferences (DeGeorge et al., 2013).

A project in Canada, involving three separate studies, aimed to ascertain the differential preferences of men and women (Sierra Hermandez et al., 2014). The first study sought the preferences of men and women making their first visit to a psychiatric outpatient clinic. Participants (n 140) completed three questionnaires; a demographic questionnaire, a symptom inventory and a treatment-preference questionnaire which proposed three treatment-options; 'medication', 'talk-therapy' or 'wait and see'.

The sample included 43% males, with 52% of the total sample being single, 44% being unemployed, and 65% having received previous psychiatric treatment. Surprisingly, experience of psychiatric treatment was not found to be significantly associated with treatment preference. The results indicated that 70% of the men demonstrated a preference for talking therapy, with 27% preferring medication and 3% preferring a wait and see approach. As a comparison, 75% of women indicated a preference for a talking therapy, with 21% preferring medication and 4% opting for a wait and see approach. There was no statistical difference between the reported preferences of men and women.

The second study also sought the preferences of patients making their first visit to a psychiatric clinic (n 193); treatment preferences (individual or group) and readiness for psychotherapeutic interventions were investigated in greater detail. Participants completed 5 forms; a demographic questionnaire, a symptoms inventory, a self-esteem measure, a readiness for psychotherapy index, and a treatment preference questionnaire. The sample comprised, 47% male; 54% were unemployed and 55% had received previous psychiatric treatment.

Results were similar to the first study with 61% of men preferring psychotherapy, 33%, favouring medication and 6% opting for no treatment. In comparison, 64% of women indicated a preference for psychotherapy, 29% of women preferred medication and 7% favoured no treatment. Again, no statistical differences were evident between the treatment preferences of men and women. Of those men indicating a preference for psychotherapy, 91% indicated a preference for individual therapy with 77% of their female counterparts also preferring individual therapy. This difference was found to be statistically significant, although no significant difference was found between men and women with respect to preparedness to engage and participate in therapy.

The final study was conducted with a further 74 participants, who completed a battery of measures to solicit the individual's view of the causes of their problems and their preferred treatment styles. Seven psychological orientations were considered; psychodynamic, humanistic, behavioural, cognitive, organic, social and naïve. Participants comprised 27% male, 60% unemployed and 68% with a psychiatric history.

The results indicated that the men in the study attributed most of their problems to cognitive factors, with behavioural and interpersonal factors being seen as other causes of their distress. Male participants (n 20), endorsed cognitive, humanistic & interpersonal and behavioural treatment

modalities. However, no significant differences were found between men and women with regard to either problem attribution or treatment preferences.

In their discussion, the authors reason that their results show that, like women, men may prefer psychotherapy as a psychiatric intervention of choice. Men, however, appear to prefer individual rather than group therapy, a choice that may enable them to 'preserve practices of masculinity such as independence and autonomy, and minimize exposing vulnerability' (p. 86).

The authors of the study acknowledge a number of limitations. Firstly, participants were categorized by biological sex rather than by gender, factors which may not map uniformly. Further, across all three studies, the majority of men were classified as being of Caucasian ethnicity (84% in study 1 and 70% in study 3), an ethnic bias that may not allow generalizability to other ethnic groups. In addition, the questionnaires were forced-choice, which may have restricted the participant's ability to express actual, individual preferences. Finally, the test-sites involved major hospital locations in Canadian cities, limiting the generalizability of the findings to that country and to predominantly urban populations.

Other recent studies also appear to confound the persistent theoretical narrative about the incompatibility of men and psychological therapy. A community sample of men were asked about various aspects of mental health, including different forms of help-seeking; 'medication', 'psychotherapy', 'friends and family', 'romantic partner', 'doctor' and 'psychotherapist' (Berger, et al., 2013). The study reported that, overall, men indicated a preference for talking therapy with a psychotherapist rather than medication or other forms of help-seeking.

An online survey, exploring treatment-preferences and coping strategies of men and women, recruited 115 men and 232 women via websites and social media and found that men preferred support groups more than women and used sex and pornography to cope with stress more than women (Liddon, Kingerlee & Barry, 2017). However, although differences in preferences of men and women for treatment-modalities were reported at the statistical level, the differences were small and the authors concede in their conclusion that 'there are many similarities in the preferences of men and women regarding therapy'.

In another study, Conversational Analysis was applied to calls made to a male-counselling helpline and found a degree of asymmetry between the orientation of callers and counsellors, callers wanting

to report troubles and to 'just talk', whilst counsellors tried to provide an action-based response, further challenging the, now established assumption, that men prefer remote action-orientated psychotherapeutic provisions (Feo & LeCouteur, 2013).

To investigate how men consider counselling, Millar (2003), employed a grounded theory approach to interviews with ten male clients, all Caucasian and aged between 27 and 61 years of age, one of whom was in a same sex relationship. Two participants had undertaken one counselling intervention with the remainder having more experience of counselling (up to 5 episodes).

Emergent themes included societal perceptions of counselling and gender roles, change of experience over time and knowledge - knowing and not knowing the protocols of counselling. Millar reports that before embarking on their own counselling journey, participants had harboured negative impressions towards counselling, as it was associated with psychiatric disorders, and that counsellors were seen as being 'nutters'. Her participants reported that, with an increase in publicity about counselling, a more acceptable image of counselling was emerging.

Those participants with a greater experience of counselling tended to participate in more sessions during subsequent interventions, leading to the paradox that those men most in need, were most unsure of what was happening to them and least likely to know how to go about resolving their issues. A major barrier to counselling was described as being a lack of knowledge about the protocols and differing types of counselling which potentially engendered a sense of incompetence at a time when the men felt most out of control.

Participants reported being particularly dependent upon their GPs to facilitate a counselling treatment-pathway, a journey that was more easily facilitated with accrued experience. Hearing about other peoples' counselling experiences was reported as being a useful intervention towards help-seeking. However, the men in the study were concerned about the idea of expressing emotions, which generated fear and apprehension. Millar's recommendations for engaging men in counselling are described in Box 12.

Box 12: Recommendation for engaging men in counselling.

- Increase publicity about counselling; with an emphasis on confidentiality, the process of counselling and the normality of counselling for men.
- Improved liaison between the counselling profession and GPs; ensuring that GPs are well-informed about counselling, that referral pathways are clear and that information about counselling is available at the point of referral.
- Clarity regarding the exposition of the process; how arrangements are made, who the therapist is, ethical parameters, fees, timing, the methods employed and the structure of the sessions.
- An increased awareness of male gender-role constructs within the mental health profession.

(Millar, 2003)

Large scale governmental and health-service-led projects to investigate men's apparent apathy for traditional psychological services continue to be absent from the field of men's psychological health, leaving individuals, pressure groups, charities and advisory bodies to pursue the disparity in men's access to psychological treatment. In 2010, for example, the now defunct National Mental Health Development Unit (NMHDU), commissioned a report from MIND and the Men's Health Forum to look at how men's psychological wellbeing may be more robustly addressed. The issues were discussed with a panel of interested professionals and a series of group-interviews were undertaken with service-users. The resultant report, 'Delivering Male' made the following recommendations (Box 13).

Box 13: How men's psychological wellbeing may be more robustly addressed.

- Treat men as individuals.
- Address stigma.
- Promote services to men.
- Understand the role of third parties (friends, relatives, co-workers) in helping men to access treatment
- Facilitate a more joined up approach to the treatment of men.
- Improve professional training.

(Wilkins & Kemple, 2010)

A more recent pamphlet, 'Promoting mental health and wellbeing with men and boys: What works?' (Robertson et al., 2015), reported a review of 15 discrete projects and consulted with senior figures, suggesting generic characteristics that may be considered if men and boys are to be more effectively engaged in psychological treatment. The recommendations of this review are highlighted in Box 14.

Box 14: How boys and men may be effectively engaged in psychological treatment.

- Provide male-friendly and culturally sensitive settings to accommodate the specific requirements of different groups of men and boys.
- Interventions should take a male-positive approach.
- Style and language should align with male socializations; 'activity' and 'control' rather than 'health' or 'help-seeking'.
- A non-judgemental and empathic approach.
- Male-familiar activities offer a 'hook' to encourage engagement and to promote group contexts that promote social inclusion.
- Community-based projects should remain grounded and close to the community they serve.
- Interventions that avow diversity, particularly ethnicity and sexual orientation.
- Partnerships are crucial across all phases of intervention development and implementation.
- Virtual platforms, online and telephonic services may be useful.
- An integration of the elements above is required to provide a cohesive process.
- Wider policy and economic contexts bear upon the ability for such services to exist.

(Robertson et al., 2015)

In summary, recent empirical studies appear to confound the pervasive academic narrative of men as being uncomfortable with interpersonal therapeutic relationships. Speculative recommendations have been proposed to help men to engage in psychological treatment to address the gender-disparity in uptake rates but such advice remains largely rhetorical.

4. Conclusion

Survey, audit and service-usage data repeatedly confirms a gender disparity in the uptake of psychological services. Theorists have largely focused their attention on social rather than essential factors to explain the disparity, essential factors largely remaining confused and contemporaneously, more controversial.

Ideological masculine archetypes have been perceived to be influential, the development of gendered sex-roles determining how masculinity is performed. However, the majority of the literature on these topics has described a narrow version of masculinity; white, western and sporty.

Gendered expectations may not only affect prospective male clients, but also the system that is designed to address men's needs, diagnostic manuals and the medical and psychological professions all subject to the same bias.

In dealing with distress, men appear to 'act out' more than women, their distress manifesting as behavioural changes – withdrawing, using substances, violence, which may direct some men towards other services or into the criminal justice system.

Much of the literature describing how men may wish to be treated appears to be based on supposition and conjecture rather than on empirical studies. The limited research that has explored men's actual preferences has tended to confound the pervasive narrative that men prefer remote and action-orientated interventions. Indeed, when asked, men seem to report desiring individual therapy where they can talk and disclose.

Most of the studies seeking men's actual preferences remain quantitative, deploying surveys and questionnaires. In addition, no research appears to have been conducted that takes a more holistic approach to the journey men traverse, from recognising they have a problem, how they subsequently seek help, what their experiences of therapy are like, what they prefer, and how their perceptions may change as a result of their experience.

This study aims to contribute to the understanding of men's under-representation in psychological services by listening to a range of individual experiences and then to generate a model that may provide professionals and service-providers with a 'ground-up' perspective of men's actual, lived experiences throughout the whole process.

5. The development of the research paradigm.

5.1 Philosophical approaches

The philosophy of science has been divided into three historical periods, pre-modern, modern and post-modern (Raskin & Bridges, 2002). Pre-modern science emphasizes rationalism, employing the power of logic and reason; modern science striving to disprove through empirical research; post-modern approaches accepting that all we can know is inevitably constructed, information being processed by our senses and given meaning by the limitations of the human condition.

Traditional physical science, embedded in pre-modern and modern paradigms, accepts 'there is a reality of some sort' (Lombardo, 1987, p.159) which 'exists independently of being perceived' (Phillips, 1987, p. 205).

Epistemologically, the objectivist stance is explored via positivism (after Auguste Comte, 1794-1859); 'the only way to obtain knowledge of the world is by means of……the methods of the empirical sciences; observation and experiment' (Acton, 1951, p.291); experimentation that samples the apparently real world. Within this real and consistent external world, the 'scientific method' is applied; hypotheses, being derived through deduction, are tested and potentially falsified through empirical testing (Popper 1902-1994).

However, following the social trauma of the 1914-18 War, a bourgeoning critique of traditional social structures coalesced to form the critical theory movement. Power, manifesting through the processes of alienation (involving the division of labour) and reification (involving the objectification of individuals) were perceived to produce a herd mentality with independent thought and radicalism being effectively neutered.

The intransigent nature of the establishment became the focus of sceptical devices and rhetoric, heralding a more questioning environment which challenged the pervasive nature of dominant power relations and structures (Foucault, 1981, 1982). As marginalized groups became aware of their relative subjugation and sought intellectual and moral rationales to challenge unfairness and inequality, feminism emerged as a potent influence:

> ‘In the 1970s, several feminist thinkers independently began reflecting on how the Marxist analysis could be transformed to explain how the structural relationship between women and men had consequences for the production of knowledge.’
>
> (Harding, 1993, p. 54)

Harding suggests ‘how bourgeois assumptions have shaped Western sciences’ pointing out ‘the inadequacies of neutral objectivism to identify the androcentric, Eurocentric, and racist assumptions in many of the most widely accepted scientific claims’ (1992, p. 569). Therefore, in questioning the mechanisms that perpetuate gender and social power-relations, more fundamental questions about the feasibility of gathering empirical data to describe human experience, are brought to bear.

In challenging the power-relations within the establishment, post structural/modern and feminist critics have embraced inductive paradigms to social research which inevitably rely upon interpretative processes: ‘Even if one is a realist at the ontological level, one could be an epistemological interpretivist ……our knowledge of the real world is inevitably interpretive and provisional rather than straightforwardly representational’ (Frazer & Lacey, 1993, p. 182).

To accommodate ‘the possibility of alternative valid accounts of any phenomena’ (Maxwell, 2012, p.5), modified forms of realism have been proposed which acknowledge the interpretive lens through which an existent reality may be perceived; ‘critical realism’ (Cook, Campbell & Day 1979), and ‘subtle realism’ (Hammersley, 1992).

Critical realist approaches strive ‘to gain a better understanding of what is ‘really’ going on in the world with the acknowledgement that the data the researcher gathers may not provide direct access to this reality’ (Willig, 2013, p.11-12). Mental phenomena are treated as being part of reality, not as a separate realm, and causality is perceived as being contextual and local rather than being general or regulatory (Maxwell & Mittapalli, 2007). Philosophically, critical realist approaches accept ontological realism and seek to integrate epistemological interpretivism with the aim of establishing a more accurate understanding of the world.

In contrast to the realist stance (naïve or critical), a relativistic philosophical perspective suggests an absence of intrinsic essences or meanings outside of any context, an absence of absolute truths (Guba & Lincoln, 1981; Reber, 1995). Such a relativistic perspective suggests that everything influences everything else, that multiple social realities are constructed. Indeed, in a post-modern academic era, where there may be ‘no claim for the truth, objectivity, universality or moral superiority’ and where ‘arguments about what is really real are futile’, realist approaches may have a significantly reduced influence (Gergen, 2001, p 806- 808).

Social constructivism, for example, has been described as being anti-realist (Hammersley, 1992) and anti-essentialist (Burr, 1995), reality being constructed rather than existing in the abstract (Berger & Luckman, 1991). Burr (1995) describes social constructivism in this rather apt manner:

> 'Our observations of the world suggest to us that there are two categories of human being – men and women…..Social constructionism would suggest that we might equally well (and just as absurdly) have divided people up into tall and short, or those with ear lodes and those without.'
>
> (Burr, 1995, p.3)

Socially constructed rules, frames, repertoires and etiquettes, which allow for the development of shared meaning (Goffman, 1949, 1955, 1956) may become routine and institutionalized, providing an illusionary notion of objectively existent factors, one such societal institution being gender (Berger & Luckmann, 1991). The idea that differential behaviour, between sexes, is culturally defined and arbitrary was established by Mead (2003), an idea that has been extended by many commentators.

> 'Gender is constructed within cultures in response to the particulars of the local situations and histories', it is a constructed and relative phenomenon.'
>
> (Eagly & Wood, 2002 p. 700).

West and Zimmerman's seminal text, 'Doing Gender' (1987), brought insight to the understanding of sex and gender, positing gender as an emergent feature of social situations;

> 'Doing gender involves a complex of socially guided perceptual, interactional and micro-political activities that cast particular pursuits as expressions of masculine and feminine 'natures.''
>
> (West & Zimmerman, 1987, p.125)

The categorization of individuals into discrete gender-identities is seen as a culturally malleable phenomenon, 'the media exemplifying contemporary etiquettes of femininity (lady-like)' and 'bundles of behaviour that produce recognizable enactments of masculinity that have to be delicately honed to subtly accommodate context' (West & Zimmerman, 1987, p. 135).
Judith Butler (1988), however, goes further:

> ‘As opposed to a view such as Erving Goffman’s which posits a self which assumes and exchanges various ‘roles’ within the complex social expectations of the ‘game’ of modern life, I am suggesting that this self is not only irretrievably ‘outside’, constituted in social discourse, but that the ascription of interiority is itself a publicly regulated, a sanctioned form of essence fabrication.’
>
> (Butler, 1988 p. 530)

Butler eruditely cites ‘performativity’ as the process responsible for the impression of gender, a social fiction, which is policed through punishment when it appears deviant and validation when performed well. Butler argues that the fact that gender performance is so rigidly and harshly policed is a sign that ‘on some level there is social knowledge that the truth or falsity of gender is only social and in no sense ontologically necessitated’ (Butler, 1988, p.530).

In discussing Butler’s and Goffman’s versions of constructionism, Brickell (2005) comments that, ‘if gender is best understood as a schedule for gendered enactments or performances, then subversive attempts to add or subtract from the schedule may be possible’ (p.37-38). Dominant constructs, which define and govern performances and understandings of gender, including masculinity, are therefore, potentially subject to modification via the re-construction of frames.

The issues of sex and gender are complex and can be perceived equally validly from a plethora of philosophical and theoretical positions ranging from naïve objectivity to purely relativist. Indeed, ‘no one discipline has a monopoly over the truth’ (Toates, 1996, pp. 45). In an attempt to gain a more complete conceptualization of the forces and factors influencing human behaviour, some theorists have sought to combine paradigms and philosophies in an attempt to create more functional models.

Evidence for interaction between biology and the environment, both physical and social, is substantial e.g. the phenomenon of increasing levels of testosterone through exercise (Galbo et al., 1977) or the process of sexual arousal (Arnow et al., 2002). Changes in behaviour may also directly alter neurological structure, as illustrated by the apparent increase in volume of the posterior hippocampus when navigational skills are acquired by taxi-drivers (Maguire et al., 2006). Further, the emerging science of epigenetics hails the potential dynamic between lived experience and genetics, the former potentially changing the heritable genome.

Morgan and Bale (2011), discuss how disorders like autism and schizophrenia appear to have genetic and environmental antecedents and extend this concept in demonstrating that the process of dysmasculinization may be caused by prenatal stress i.e. heritable phenotypical change being directly created through environmental (including social) factors. The implication of epigenetics posits the influence of social events upon the heritable genetic code which may influence further social change, a dynamic that may confound purely reductionist approaches, including essentialism.

Attempting to gain more encompassing explanations of the perceived reality before them, some researchers have striven to create hybrid models e.g. bio-social or bio-psycho-social models. Eagly and Wood (2002), for example, propose a 'bio-social' approach to the study of differential sexes-roles by considering 'proximal factors', including gender-roles and socialization experiences (based in social constructionism ideology) as well as 'distal factors', including biological processes, genetic factors and sociobiology.

If a systemic approach is accepted as providing a more complete model, then an ontological perspective is required which accounts for the potential reciprocity and dynamic interactions that occur within and throughout the system (Lombardo, 1987, 1996; Barab & Roth, 2006). Lombardo describes such an ecological ontology, 'direct realism,' where knowing, identity and context are in dialectic relationships i.e. an organism-ecosystem interaction. However, the complexity of inclusive ecological systemic models makes their investigation problematic.

5.2 Developing an ontological basis

Medical studies have been historically embedded in positivism; realist ontologies, objectivism, the scientific method and quantitative paradigms, providing statistical relationships between variables. The British Medical Journal continues to take a forthright position; 'we do not prioritise qualitative research because…..qualitative studies are usually exploratory by their very nature and do not provide generalisable answers…some would say that if we were truly interested in the patient's perspective, we would publish more qualitative papers that include the patient's voice…..we have chosen to focus our efforts on quantitative research that reports the outcomes that are important to patients, doctors and policy makers' (BMJ, 2016).

Much of guidance that directs national initiatives and interventions relies on evidence-based research, placing 'systematic reviews and randomised controlled trials at the top and qualitative studies at the bottom' of the hierarchy of research methods that have influence (Aveyard & Sharp,

2009 p.73). Although positivist approaches are excellent at generating descriptive data, they may provide little understanding beyond statistical correlations between variables. The counselling psychology project has embraced a wider range of research paradigms, seeking to gain a greater understanding of social phenomena. However, although potentially providing deeper meaning, understanding and useful insights into the constructed self, inductive, qualitative approaches have been criticised for not regarding pervading social structures or wider historical contexts (Vincent & O'Mahoney, 2017).

Phenomenology, based on idealist ontology, ascribing meaning to the world as it is experienced, the 'lifeworld' (Husserl, 1936), aligns with existential concepts of personal constructs, meanings and personal agency (Smith, Flowers & Larkin, 2009) and affords credulity to the participants' subjective experiences and is often explored via Interpretative Phenomenological Analysis (IPA). However, research based on subjective experiences remain philosophically distant from the evidence-based practice underpinning the majority of medical research, rendering interpretative phenomenological analysis as a less obvious approach towards the generation of theories and models that can be adopted by policy makers.

Social constructionism, widely regarded as holding relativist perspectives, particularly focusing on social symbols and language (discourse analysis, narrative analysis), has been successfully adopted by some researchers exploring men's issues (Seymour-Smith et al., 2002; McKay, 2007). Social constructionist approached certainly pay attention to issues of social injustice and malevolent power-structures. However, again, the usefulness of studies that follow relativistic positions, producing and validating a multiplicity of accounts, has been questioned (Hammersley, 1992), especially with respect to the potential generalizability of their outputs (Murphy et al., 1998).

The forced delineation of research into being either positivist or relativist, each leading to particular epistemologies and research methodologies potentially creates a schism, a forced choice which may render the output of research acceptable or unacceptable to certain medical journals or to policy-makers. Willig (2016) argues that, rather than neatly falling into one philosophical category, ontology (what exists) and epistemology (how we come to know about it) are separate and distinct issues, suggesting that qualitative investigation may be able to provide meaning to existent social structures.

Willig (2016) argues that qualitative research, including constructivist and phenomenological approaches, inevitably, and albeit indirectly, sample an existent world that can be approximated through qualitative investigation. Indeed, philosophical debate continues, however, Bager-Charleson contends that 'rather than arguing about right or wrong, it is probably more constructive to emphasise the importance of being as clear as possible about one's point of departure and framing of the problem' (2014 p.109). In this study, the researcher accepts the existence of the material world and of social structures and processes that are amenable to investigation through inductive means, leading to the conclusion that a form of ontological realism may be married with qualitative approach to the research.

With respect to post structural inductive paradigms, interpretative processes are widely perceived to be unavoidable and inevitable, as covert and unconscious human processes introduce bias to the selection and editing of data (Fine, 2002). Therefore, with respect to qualitative research, to try to enact a naïve realist stance, as positivism would enshrine, the researcher is tasked with remaining neutral and impartial so that 'the investigation can be viewed as value-free' (Ritchie, 2003, p.13), an ideal that, indeed, may be naive.

There-in lies a dilemma; to position this research project to allow for a degree of credulity with respect to the existent social structures, the National Institute for Clinical Excellence, for example, and yet to embrace an ontology that informs beyond the descriptive and which acknowledges inevitable interpretative processes which can then be accepted, addressed and mitigated. Critical realist approaches may provide the resolution as they accept existent structures and embrace non observable factors to consider hidden meaning, allowing generalizations to be extruded from the empirical to the theoretical, generalizations that may extend through space and time (compared to a positivist stance where generalizations can only reside within the empirical) (Danermark, 2002).

Critical realism can be useful to abstract meaning to uncover the 'sequence of causation, or the relations between things that gives rise to the observed regularities….to produce the most plausible explanation of the mechanism that caused the event' (Vincent & O'Mahoney, 2017 p.12). Through this process of abstraction, theory and *a priori* knowledge can therefore help to frame emergent data to provide coherent narratives and causal links. Therefore, a critical realist approach appears to be an excellent fit for the purposes of this research project as data can be viewed through the lens of knowledge of existent social structures and ideas, including non-observable factors, to develop a relevant model that relates to the existent social world.

However, this researcher accepts that, even located within an existent world, it is only possible to know reality from a subjective perspective, even if that subjective world is largely shared with others through the mechanism of symbolic interactionism. In honing the ontological stance further, to theoretically accommodate human factors in qualitative research, subtle realism (Hammersley, 1992; Blaikie, 2007), a form of critical realism, is adopted here. Subtle realism accepts reality as something that exists independently of those who observe it but is only accessible through the perceptions and interpretations of individuals and is thus, reflexive (Hammersley, 1992). Hammersley (1995) redefines validity as confidence, emphasising the need of research to be plausible and relevant which resonates with this researcher's aim to maintain credibility within the social context of the practical delivery of psychological services.

5.3 Honing a methodology

Being epistemologically flexible, critical realist ontology has been described as being methodologically ecumenical, able to embrace a range of qualitative approaches (O'Mahoney & Vincent 2014) and has also been adopted by the discipline of counselling psychology (Ponterotto, 2005).

Aiming to produce a generalizable, credible model to inform primary care psychological service policy makers, both 'thematic analysis' and 'grounded theory' became potential approaches for this project. Thematic analysis (Braun & Clarke, 2006) often being employed by social research programs, commissioned by policy makers, due to its flexibility and pragmatism. Although congruent with the aims of this project towards the development of a generalizable model, the lack of an ontological and epistemological clarity to the approach makes thematic analysis a less desirable proposition within an academic context, this researcher preferring a clear philosophical basis.

Grounded theory, as a mechanism to generate new theory and models from the grassroots (Mruck & Mey, 2007), including specific implications for particular domains of action (Walsham, 1995) became the most plausible candidate for the execution of this research project with respect to the goal; to garner understanding from actual male service-users to inform policy towards the equal use of primary care psychological services.

Charmaz (2003) reinforces the authority of grounded theory as a robust inductive methodological framework, concluding that grounded theory research projects can 'stand on their own because they: (1) explicate basic processes in the data; (2) analyse a substantive field or problem; (3) make sense of human behaviour; (4) provide flexible, yet durable, analysis that other researchers can refine or update; and (5) have potential for greater generalizability than other qualitative works' (p. 109); research objectives that concur with the aims of this study.

Grounded theory has previously been employed to investigate various sub-groups of men, as the following exemplars demonstrate (Box 16).

Box 15: Studies using Grounded Theory that relate to men.

- Tilley and Brackley (2005) developed a 'violent couples' model to understand the development of domestic violence by using grounded theory to analyse the data from sixteen interviews with men participating in a batterers' intervention scheme.
- LaRocco (2007) used a grounded theory approach to explore the process that led to mens' decisions to become and remain nurses. Twenty male nurses were interviewed, and a four-stage linear decision process was described, giving recruiters and employers greater insight into the recruitment and retention of male nurses.
- De Santis and Barroso (2011) used grounded theory to sample and analyse interviews with fifteen men living with HIV infection to develop a theory describing the process by which they become vulnerable. The 'Living in Silence' model included four categories; confronting mortality and illness, struggling with change, encountering a lack of psychosocial support, experiencing vulnerability.

The original approach to grounded theory, now identified as 'classical' grounded theory (Glaser & Strauss, 1967), was an empirical, inductive approach, that took an objectivistic approach within a realist ontology. However, many approaches have since been proposed including constructivist and interpretivist forms, in addition to mixed ontological and epistemological hybrids (Levers, 2013). Such a range of available approaches to grounded theory potentially contributes to a 'methodological fog' that can make the process and application of grounded theory both 'opaque and confusing' (LaRossa, 2005, p. 838), blurred by the abundance of 'various guidelines and

interpretations' (Dey, 2007, p. 172-173). Clarity, from the philosophical approach, to tactical methodology, is therefore required if transparency is to be maintained and replication made possible.

In adhering to a realist ontology and an objectivist approach to data collection, all interpretive issues are negated, rendering mechanisms like reflexivity, totally redundant. In its original form (Glaser & Strauss, 1967), grounded theory followed such a positivist/realist approach (Annells, 1997), reflecting the zeitgeist. Glaser (1978, 2002), subsequently maintained the importance of remaining objective, the researcher being vigilant to be 'open to what is actually happening', allowing for theory to organically emerge in the absence of any 'forcing' of data to fit theory (Glaser, 1978); the researcher effectively removing their influence from the data. Many commentators remain sceptical that true objectivity can ever be practically operationalized (Charmaz, 2000, 2006).

Critical/subtle realism accepts there is an existent reality, which is inevitability sampled through subjective lenses, theoretically enabling the adoption of mitigating processes like reflexivity, to elucidate how the researcher has assimilated data into meaningful theory or models. Indeed, the adoption of a critical realist approach to grounded theory potentially allows for a focus on 'abduction and commitment to fallibilism and the interconnectedness of practice and theory' with particular attention to evidence and meaning (Oliver, 2012, pp.371), providing for a richer outcome as emergent data is conceptualized in respect of prior understanding and social context.

In accepting the inevitability of interpretative processes, the researcher can act to mitigate researcher-bias through reflexive research practice or to adopt a constructionist approach, embracing the 'mutual creation of knowledge by the viewer and the viewed', leading to the creation of multiple social realities (Charmaz, 2000, p. 510) and resulting in an 'interpretive portrayal of the studied world, not an exact picture of it' (p. 10).

Steadfastly, Glaser (2002) suggested that a constructionist approach to grounded theory, as described by Charmaz (2000), represents a qualitative data analytic methodology, rather than a form of grounded theory. However, going further towards an interpretative approach, Corbin and Strauss (2008) sanctioned a relativistic ontology and subjective epistemology to locate their version of grounded theory, perceiving no reality to exist outside of the researcher and accepting that any theory created does not attempt to represent a true reality (Levers, 2013).

As Urquhart (2013) points out, the more positivistic the approach to grounded theory, the greater the potential for the generation of hypotheses that may be tested in the future. Therefore, as this study is socially contextualised within the clinical frameworks abroad in the UK primary care sector and aims to contribute to the existent social processes already appreciated within the healthcare environment, the aim here is to position this research closer to the positivist end of the positivist-interpretivist dimension as is practicable, whilst acknowledging the presence of human factors, *a priori* knowledge and hidden agendas.

Gibson (2007), observes that the more positivistic the stance to grounded theory, the greater the potential to re-state existent power-structures, potentially reifying participants and their data to objects or units of information. Gibson suggests that considerable reflexivity may be required to 'remain ever vigilant, supporting an attitude of radical doubt that the theory could always look different', a position of 'theoretical sensitivity' that questions rather than accepts emergent analysis and theory (Gibson, 2007, p. 451)

Thus, with a subtle realist ontology and with a reflexive approach towards a traditional grounded theory methodology, here, I seek to produce a model or theory that approximates reality whilst remaining free to consider hidden and subtle causal agents and to appreciate *a priori* knowledge.

5.4 Grounded Theory

Antithetically to their earlier 'guideline approach' (Glaser & Strauss, 1967), Strauss later offered more prescriptive versions of grounded theory; Strauss and Corbin (2008) moving towards interpretivism and contriving a more rigid 'conditional matrix'. Other researchers have further expanded on the premise of grounded theory, which has become somewhat of a generic term, requiring researchers to elucidate the approach adopted in each instance. However, there are a number of common features that define grounded theory; coding items of data, constantly comparing items to delineate categories, an iterative process of concurrent analysis and data-collection (theoretical sampling), memo writing and theoretical sensitivity (Glaser & Strauss, 1967: Charmaz, 2000, 2006).

Coding involves the identification of units of data or items, a process that has been perceived as being largely unaffected by epistemological considerations (Madrill, 2000). Glaser (1978) describes

the initial coding phase as ‘open coding’, involving the delineation of items of data, followed by a process of ‘selective coding’, involving the grouping of ‘open codes’ towards the formation of concepts and descriptive categories via the analytical method, constant comparison (Glaser and Strauss, 1967).

Constant comparison involves comparing each unit of data with all other items as they emerge to form groups of similar items to form categories, a practical process that seeks ‘commonalities and differences between incidents’ to ‘reveal two different kinds of theoretical properties’ (Kelle, 2007, p. 196), allowing for boundaries and linkages between categories to be highlighted. The researcher, being intimately familiar with the data, acts to move towards the development of theory by constantly referring to and comparing data, conceptualized as ‘theoretical sensitivity’ (Glaser & Strauss, 1967).

Concurrent analysis and data collection allows for emergent material to guide data collection, driving ‘theoretical sampling’ which means that ‘the analyst can continually adjust their control of data collection to ensure the data’s relevance’ (Glaser & Strauss, 1967, p. 48). Data collection, as directed by emergent themes, may change the nature of the participant sample or the questions included in a discussion guide (Charmaz, 2006) (The researcher has confirmed this point directly in a personal communication with Professor Charmaz, 2018).

Strauss (1987) proposed a form of focused coding termed ‘axial coding’, a process employed to organise a large amount of related data around axes or themes (p.32). Once a central category is established, an ‘axis’, further categories may be added to develop a relational structure to the emergent material. Strauss later re-conceptualized axial coding as general principles rather than a fixed method and recommended the development of diagrams to chart the relationships between categories. The relative positioning of descriptive categories to form more meaningful processes, linkages and hierarchies of interest, may be facilitated through the organising and structuring management process of memo writing (Strauss & Corbin, 1990: Charmaz 2006). Memo writing is a reflexive process that enables the researcher to process and record the large number of observations, assumptions, ideas and hypothesis that are generated during the constant comparison analytic process to derive an analytic narrative (Charmaz,2006).

Core categories are linked, potentially with respect to an axis/axes, to derive an explanatory framework, grounded in the emergent data (Willig, 2013). Glaser and Strauss describe how, during

the course of the analytic process, 'the theory solidifies, in the sense that the major modifications become fewer and fewer' (1967, p. 110). The iterative nature of the process of data analysis and consequential data collection, allows for models and theories to be tested and extruded to a point where additional data does not develop theory any further, a point of 'theoretical saturation'; a substantive theory can then be assumed (Charmaz, 2006).

Glaser and Strauss (1967) recommend the researcher go out of their way 'to look for groups that stretch diversity of data as far as possible' before declaring saturation-point (Glaser & Strauss, 1967, p. 61). However, Dey (1999) recommends a more circumspect termination of the data-gathering process, with the aim of reaching a point of 'theoretical sufficiency'; curtailing the process once categories become robustly defined (p. 257). The reason for the more considered terminology resides in the inherently incomplete nature of any grounded theory analysis.

In conducting interviews, Glaser (1998) warns against using guidelines and scripts (which potentially suggest the existence of *a priori* hypotheses) an approach that remains faithful to a naïve realist ontology and objectivist approach to data collection. A critical/subtle realist approach, however, philosophically permits the use of a scripted interview as context is recognised and accepted as being both existent and necessary to provide meaning.

In adopting a subtle-realist ontology and a reflexive data collection process, the application of grounded theory here aims to follow a reflexive approach. Open coding will initially itemize the data into discrete units which, through the application of constant comparison analysis, will lead to the delineation of descriptive categories. Remaining theoretically sensitive, with respect to both the emergent data and the context which the emergent data relates to, the production of linked categories and an explanatory framework will be facilitated. Memo-writing will, therefore, pertain to the data and how it relates to existent processes and knowledge. Annotated diagrams will be used to represent the positioning of categories with respect to one-another and data collection and constant comparison analysis will continue until a coherent and meaningful theory or model is developed. A discussion guide will be employed and modified, directed by the emergent data, to ensure that theoretical sampling is a core feature. The data-gathering process will continue to a point of sufficiency where the theory or model produced is no longer adjusted by the addition of further data.

6 The research study

6.1 Background

The researcher has been interested in men's mental health issues throughout his training and practice as a counselling psychologist; a previous dissertation 'Big boys really don't cry,' being published as a research article (White, 2009). In addition, the researcher has participated in men's mental health conferences, meetings for professionals and politicians and has participated as a panel-member in projects conducted by the National Mental Health Development Unit (NMHDU) and the charities MIND and the Men's Health Forum.

Previous research undertaken by the researcher (White, 2009), sought to discover the attitudes of young men who had never considered counselling. The results indicated that such young men tend to disavow any need for professional psychological support. However, all 10 participants involved in the study disclosed how they shared their problems with family and friends, a mechanism that potentially negated the need for external support. Many displacement activities were also reported, frustration frequently being released as violence towards inanimate objects. However, a group of participants with no experience of psychological treatment had little to add to the understanding of the male client-journey through psychological distress and intervention.

Millar (2003), investigating men's consideration of counselling, her study being entitled 'Entering the Unknown,' found that men tended to go into therapy with very little knowledge or understanding of what to expect. Indeed, Millar found that a lack of understanding of counselling was inferred in many quarters, including referring general practitioners; a potential insight into one aspect of the relative gender-imbalance reported in the psychotherapeutic treatment of men. Questions remain regarding the nature of men's therapeutic journey: How is psychological distress recognised? How do men access psychological treatment? What influence do gender-effects have on men's experience? A complete exposition of men's therapeutic journey, from experiencing psychological distress, through treatment, and on towards relative health, remains absent from the literature.

6.2 Aim

For a generation, traditional masculine characteristics of stoicism and autonomy appear to have been perceived to be incongruent with the psychological project, received wisdom that may have been accepted and reiterated by the psychological establishment and by society at large. However, recent studies have confounded such longstanding beliefs, raising questions about the preferences and proclivities of actual men.

The aim of this research is to elicit the testimony of men to advance the understanding of the masculine journey through psychological treatment; men's initial attitudes towards mental health, existing coping strategies, men's experiences of psychological distress, the factors that affect help-seeking behaviour, experiences of psychological therapy and attitudes and behaviour following the completion of treatment, in order to ascertain how men may be more equally engaged in primary care psychological services.

6.3 Method

6.3.1 Design

To facilitate the aims of the study, a grounded theory analysis was adopted to address the aims of the research, data being collected from a series of individual interviews towards to development of a model expediting men's psychotherapeutic journey.

6.3.2 Recruitment

In respect of the theoretical sampling approach to grounded theory, the participant group was identified as comprising of adult men who had recently concluded a primary-care level of psychological intervention, primary care psychological services being the tier of psychological intervention with the largest gender-disparity with respect to service-usage. To qualify, the following inclusion criteria were applied (Box 16).

Box 16: Inclusion criteria.

- Identify as being male.
- Be aged 18-80.
- Have completed a course of talking therapy in the last five years.
- Not have experienced an intervention of more than 20 sessions.
- Not be currently in receipt of any psychological intervention.
- Not reporting any current risk.

In order to negate the disparity between biological sex (which may remain ambiguous due to genotypes other than the XX, XY majority) and gender as performed, the inclusion criteria defined being male as anyone choosing being male as their dominant identity. The age restriction, 18-80, was applied for reasons of parsimony, practicality and confidentiality, males below the age of 18 potentially requiring permission from others to participate. In setting an upper age limit of 80, it was hoped that the scope of the research would reach beyond the limits of working age-adults, to explore the potential effects of life-stage and life-cycle on the research proposition. After 80, the potential for issues of physical health and old-age to significantly influence psychological wellbeing of participants was a concern that could potentially distract from the focus of the study.

In stipulating the limitation, 'a maximum intervention of 20 sessions of therapy', the aim was to passively deselect potential participants who may experience severe and enduring mental health issues as evidence suggests that for those groups, the gender disparity in service-engagement disappears. In setting a limit of 5 years, within which time-frame any treatment was to have been experienced, the aim was to capture a sample of relatively contemporary experiences, allowing conclusions drawn or recommendations made, to remain relevant.

To enact a duty of care, only men who were no longer in receipt of psychological support, including talking therapy or medication, were included in the sample. The researcher remained aware of the potential of the research interview to evoke distressing memories and so, in order to mitigate potential risk, prospective participants were asked to report any issues regarding continuing risk, including substance-addition, self-harm, suicidal ideation or forensic risks.

In order to maintain ethical propriety, participants were sourced via a passive advertisement (appendix i). In recruiting a voluntary sample, third-party involvement was negated, maintaining control over issues relating to privacy and confidentiality.

The recruitment advertisement was displayed across a range of public spaces including libraries, community centres, waiting rooms, and notice boards, as well as on social media. The advertisement included details of the researcher's email address and telephone number. When potential participants expressed an interest to participate, an 'Information for Participants' form (appendix ii) was forwarded to them and arrangements were made for a short screening telephone call between the researcher and the participant to confirm the selection criteria were met and to offer an opportunity to address any questions the participant had. If both conditions were satisfied, then an appointment was made for the interview to take place.

6.3.3 Ethical permission

Ethical approval to undertake the main research project was obtained from the Psychology Ethics Committee at City University, London (appendix iii). Particular attention was given to the wellbeing of participants and to the security and confidentiality of the data collected, with safe-guards introduced to maintain standards set by the committee. Permission was granted to display the advertisement in public places and forums but not on NHS premises.

To ensure the safety of researcher and participants, a risk-assessment was conducted (appendix iv) and the date and time of each interview was relayed to the academic supervisor who was then apprised by text, once each interview had been safely completed. Fire safety arrangements were discussed with the participants at the start of each interview.

6.3.4 Data collection

A total of 30 face to face individual interviews, were undertaken throughout England and were audio-recorded using a mobile phone application. The audio-files were transcribed by hand and converted into computerized written documents (Microsoft WORD). Each transcript was imported into Nvivo 10, an analytical computer software program.

Interviews commenced with a review of the 'Information for Participants' form and any queries were addressed. Participants were invited to read and sign the 'Informed Consent' Form (appendix v) upon which participants could leave contact details if they wished to receive a summary of the research outcomes. House-keeping issues were then addressed; fire safety procedures and reasonable travel expenses.

Interviews were conducted with vigilance for the welfare of the participant. The researcher, an experienced, registered, and practicing counselling psychologist, remained aware of the potential for distress caused by the participant's recapitulation of the circumstances that precipitated their need to engage with psychological services.

At the conclusion of the interview, participants were asked about their wellbeing and a 'Debrief Information Sheet' (appendix vi) was presented which detailed potential sources of onward support if assistance were to be needed at a later date. In addition, participants were asked to anonymously complete a 'Biographical Data Form' (appendix vii), identified by a number known only to the researcher. Participants were invited to reflect on their experience and to ask any further questions relating to their participation in the study.

Semi-structured interviews followed the topics outlined by an initial discussion guide, after which, an iterative process was adopted reflecting a theoretical sampling philosophy, emergent material requiring the production of two subsequent, modified discussion guides (Glaser & Strauss, 1967; Charmaz, 2006) (appendix viii).

6.3.5 Confidentiality

All screening telephone conversations and interviews were conducted by the researcher, a registered data processor with the Information Commissioners Office. Consent forms were collected and stored in a locked filing cabinet, these documents representing the only identifiable written documents to confirm participation.

All audio data was transcribed, and the audio files were deleted. The transcribed documents were labelled using numbers, pseudonyms being allocated when the transcripts were uploaded to the Nvivo 10 computer program. All documents were stored on a password protected personal computer. No paper copies of any written transcript were produced.

Biographical Data Sheets remained anonymous and identified only by a number. Relevant anonymous data was transferred to a word document, stored on a password protected personal computer and then paper Biographical Data Sheets were mechanically destroyed in a cross-shredding machine.

6.3.6 Data analysis

Following each interview, transcripts (WORD documents) were imported into the Nvivo 10 computer program, each transcript being analysed before the next interview was undertaken. Preliminary coding was undertaken and, following the process of constant comparison (Glaser & Strauss, 1967), emergent items were scrutinized with respect to other emergent items and grouped into draft concepts and descriptive categories which were refined through a process of deconstruction and reconstruction as new data emerged.

Throughout the analysis of the first six interviews, emergent concepts were identified and a plethora of equivalently important categories, set out as Nodes in the Nvivo 10 program, were identified. As more data were analysed, hierarchies, based on semantic links between categories, were developed. After the analysis of six transcripts, remaining congruent with the iterative analytical paradigm, a re-organisation of all data collected was undertaken. This process involved the creation of a second analytical document in Nvivo where a new hierarchy of nodes was created, each item being re-

appraised and compared with all others to inform the construction of a more representative model of emergent themes.

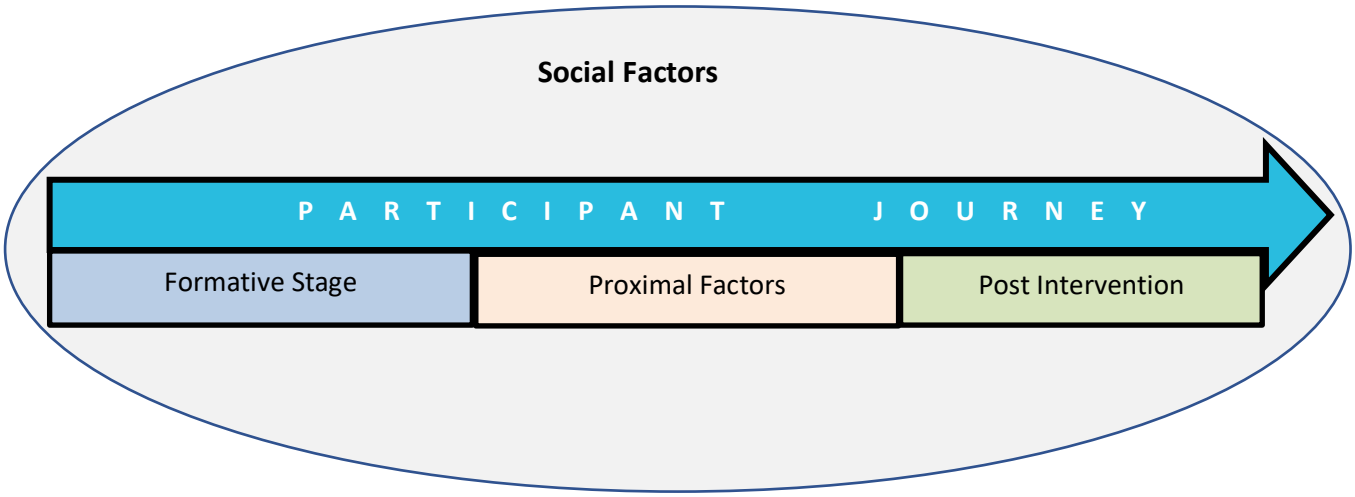
Despite male-gender roles featuring in the literature review, the topic of gender and masculinity was not introduced into the initial interview schedule to allow any gender-effects to emerge without being prompted in order to negate any recapitulation of dominant narratives. However, at the completion of the re-organization at the six interview stage, emergent data included many references to being male, including masculine socialization processes and coping mechanisms employed during the formative phase of the participant-journey. With masculinity emerging as a relevant topic, the discussion guide was modified to accommodate this emergent theme with the addition of questions investigating masculine coping and the effects of the process upon masculine identity (B) (appendix viii).

As further analysis continued, items were both allocated to the reorganized categories and to additional, emergent categories. Each category was constantly re-evaluated with items either being re-allocated to existent categories or into new, more representative categories. After the tenth interview, semantic links started to become apparent and a further re-organization of categories afforded more meaningful links between categories.

After 15 interviews, sufficient material had emerged, regarding changes in the behaviour and attitudes of participants following their intervention experiences, to require further amendment to the discussion guide (C) (appendix viii). A question seeking to establish attitudinal change, particularly with respect to new coping strategies, was included.

All emergent categories appeared to be best related to one of four stages in the participant journey; the participants' early experiences with psychological matters and health, designated the 'Formative Stage'; issues relating to help-seeking and the participant's journey into therapy, labelled 'Proximal Factors'; changes occurring after the conclusion of the therapeutic intervention, labelled 'Post Intervention' and; perceptual changes regarding the wider social environment, labelled 'Social Factors'. Each of the stages of the participant journey therefore provided a theme or axis around which the related categories could be meaningfully positioned (Strauss & Corbin, 1987). The data at this stage represented a descriptive exploratory framework of discrete components that all contributed to the whole participant journey.

Figure 2: The four stages of the participant journey.



Grouping semantically similar categories, provided for a greater capacity to compare and contrast items within thematically-related silos, allowing for more precise delineation of concepts and categories. As analysis proceeded, further refinement and delineation continued until the analysis of additional interviews yielded no new concepts or categories (after the 25th interview). The dataset was then mapped diagrammatically (Strauss & Corbin 1990) which allowed for relationships between categories but within each stage, to become apparent (appendix ix).

In addition to the theoretical need to relate all emerging concepts in and to the data, Charmaz (2006) recognizes the need to 'keep the human story in the forefront of the reader's mind and to make the conceptual analysis more accessible to a wider audience' (p. 108). Having gained a thorough understanding of the emergent data, a generic pattern of the participant-journey emerged. The men in the sample initially reported a lack of awareness and interest towards their psychological wellbeing until their own psychological crises occurred, typically triggered when functionality was challenged. Crisis then led to the need to engage with external support which provided an apparently transformational process, affecting attitudes and behaviour.

The client-journey that emerged appeared to be analogous to the experiences of the protagonist of the children's nursery-rhyme, Humpty-Dumpty. Humpty-Dumpty was initially sitting on a wall when he endured a great fall which attracted the attention of others, 'the king's horses and king's men', who tried to offer help but who could not return him to his former state. Humpty Dumpty's tough shell was apparently forever broken, transformed; presumably allowing the softer inside to leak out.

Using the concept of the Humpty-Dumpty story as an organising structure to relate all four stages of the men's therapeutic journey, a more holistic model allowed for a greater understanding of the links and interactions across and between categories that had previously appeared to be unrelated, allowing for a more cohesive model that highlighted the following stages; The formative stage; Encountering a Problem; Facilitating Factors and Access; Treatment; Post Intervention; Obstacles and Advancements to Social Change. Armed with the more integrated conceptualization of the data, further interviews were conducted to test the model. At 30 interviews, no new themes or interactions emerged and a point of 'theoretical sufficiency' was assumed.

7. Reflective account

7.1 Reflexivity

In adopting a qualitative research paradigm, the researcher becomes encumbered with the responsibility for all aspects of the study, the research question, the methodology employed and the subsequent gathering, analysis and presentation of data. Therefore, whatever the approach adopted, the qualitative study will be highly influenced by the researcher and the filters and lenses through which the researcher perceives the world (Creswell, 2007; Bager-Charlseson, 2014; Gentles et al., 2014). In adopting a subtle realist ontology, reflexivity, becomes an imperative tool to address potential researcher-bias.

Reflexivity may be divided into personal and epistemological reflexivity (Willig, 2013); epistemological reflexivity involves reflection about the theoretical assumptions made and the limiting effects of the research paradigm chosen (explored earlier); personal reflexivity allows for 'reflection upon ways in which our own values, experiences, interests, beliefs, political commitments, wider aims in life and social identities have shaped the research' in conjunction with 'thinking about how the research may have affected and personally changed us' (Willig, 2013, p. 10).

Mruck and Mey (2007) remind researchers how their 'stock of accessible knowledge' has a tendency to direct proceeding; 'researchers tend to prefer topics which refer to their own biographical challenges' (p. 519). Thus, there is an implicit requirement for 'the grounded theory researcher to acknowledge his/her prior knowledge and to bring such knowledge into the open' (Cutcliffe, 2000, p. 1479).

Although 'being reflexive is often claimed as a methodological virtue and source of superior insight, perspicacity or awareness' (Mruck & Mey, 2007, p. 517), if allowed to dominate, the process of reflexivity could contrive to place the researcher, rather than the research, at the centre of a project. Indeed, the benefits of reflexivity have been questioned and a degree of uncertainty and scepticism, relating to the actual improvements made to research projects, remain (Kemmis, 1995; Pillow, 2003). Inevitably, the reflexive process will be partial, limited and flawed (Finlay, 2002). A pragmatic approach is adopted here, allowing 'a balance to be reached in which reflexivity is employed conservatively and only as far as it serves the purpose that the researcher sets for it' (Gentles et al., 2014, p. 4). The amount and focus of reflexivity undertaken therefore needs to be robust enough to provide sufficient transparency, whilst being purposeful, disciplined and relevant.

7.2 Personal history

A Caucasian, middle-aged man, I was raised in a parochial, working class environment, my father holding views of masculinity that significantly overlapped with hegemonic masculine archetypes of the era (twentieth century). However, the cosmopolitan, urban environment of an industrial city engendered a very eclectic and egalitarian approach to community. Indeed, close family friends included same-sex couples and members of a wide range of ethnic groups.

Existential issues, particularly topics relating to death, tended to be disavowed within the family, with practicality taking precedent over discussion and emotional processing. My father was diagnosed with a terminal carcinoma at 55 and perished at 56 (I was 20), his traditional stoic masculinity dissolving into fear and panic, leaving me feeling helpless to support him.

After taking a degree in Biological Science, I became a Biology teacher and was initially granted a positivistic view of the world, especially with respect to scientific enquiry. However, ten years as a pastoral manager in secondary schools, offered the opportunity to develop an interest in the social development of adolescents and the human psyche.

A confluence of personal life-events, including fatherhood and divorce, precipitated a change of career-direction, part-time study culminating in qualification as a Counselling Psychologist in 2007. During the undergraduate and post graduate degrees in psychology, inductive research methods were introduced, and I employed an interpretative phenomenological analysis to my Master degree

dissertation. This earlier research (White, 2009) also afforded me the opportunity to review some of the literature pertaining to masculinity and later, a supervisor suggested I learn more about Critical Theory as a background to the emergence of post-structural ideas and Feminism.

Through the feminist lens, patriarchy could be laid bare, its affective and behavioural consequences upon both women and men becoming increasingly evident. Indeed, my involvement with the Men's Health Forum, attending seminars and conferences, allowed insight into some of the issues faced by men who require psychological support and of the system that appeared to overlook their health needs, patriarchy perhaps acting to undermine their needs.

Later, teaching psychology helped me to frame the physical sciences within a wider range of human explorations of the world, the need to accept a multi-faceted or postmodern set of potential realities or, more accurately, subjectivities, estranging me from any single 'grand narrative'. However, after qualifying as a psychologist and working in the National Health Service, evidence-based research became paramount, with a predominance of quantitative data-driven studies directing the treatments offered (as recommended by the National Institute for Clinical Excellence).

As a practicing psychologist for over 13 years, in both the public and private sectors, I have encountered about fifty percent of clients identifying as male, including transgender clients and clients with sex chromosome variations. In that time, I have also undertaken my own counselling with a male and then a female therapist and have enjoyed the benefits of five clinical supervisors, three women and two men. All of these experiences have enriched my understanding of my own gendered being and, through empathizing with a wide range of clients, I have learned to appreciate the varying influence of gender.

However, upon reflection, my father's struggle with imminent mortality, the anger and despair I witnessed and my inability to save him, probably underpins my desire to save men from the prospect of emotional isolation and psychological despair, leading to the research proposition explored here.

7.3 Values and beliefs

During the initial training to become a psychologist (2002-2007), I developed a stance towards masculinity that broadly mirrored the radical feminism movement of the late twentieth century, perceiving men and women to be unjustly and differentially restricted by traditional gender-roles and by the strictures of patriarchy. Restrictions placed on men to remain independent and strong and to hide their fear and distress was perceived as being inhumane. In response, the Master degree dissertation, 'Big Boys Really Don't Cry', later published as a journal article in 2009, explored young mens' views of psychological therapy.

In practicing counselling psychology a more reflective perspective to gender-related issues has developed, a practical and philosophical approach to living supplanting radicalism. During previous research activity, the self-righteous, human-rights crusader was seeking to justify the 'cause' through garnering the testimony of aggrieved men. However, with maturity, a more objective standpoint has allowed for a calm appreciation of the emergent data in this research project, a humbling and enlightening experience.

I hold a post-modern, post-feminist, existentialist perspective that embraces the atomization of gender, towards individuation and the evolution of true autonomy. Personally, a pluralistic world-view is held that allows for the co-existence of a plethora of ontologies and which tolerates ambiguity.

7.4 Data-collection

As grounded theory is rooted in the symbolic interactionist paradigm, the focus of reflexivity may be most beneficial when directed towards the researcher-participant interaction (Mallory, 2001). Indeed, remaining aware that my actual being may cause demand characteristics in others, my very personhood potentially becomes the confounding factor in my attempt to meet the aims of this research project.

With regard to power-relations within interviews, Charmaz (2006) notes that the 'dynamics of power and professional status, gender and race and age' (p.27), can affect the direction and content of interviews. The potential for implicit power-relations to be generated was, indeed, a concern.

For example, the professional label 'psychologist' and/or 'doctoral student,' potentially creates an unhelpfully oppressive frame. Initial contact with participants was inherently formal; the recruitment advertisement, the 'information for participants' document, screening telephone call and consent form, setting an officious tone that felt antithetical to the emergence of free and unbiased testimony. However, accepting the need for ethical considerations, a degree of formality and officiousness leading up to the interview was inherent.

The difference in age was experienced as an impediment in conducting interviews with some of the younger participants, the dyad potentially representing a father/son model. This most obvious power-dynamic was the most difficult to assuage and one where formality acted as an advantage in maintaining boundaries.

If adopting a classical approach to grounded theory, as espoused by Glaser and Strauss (1967), then epistemologically, there is no requirement for the development of rapport, no need to inhabit the experiential worlds of the participants (as in phenomenology). However, Charmaz (2006) contests this position, believing that building rapport with participants is fundamental in acquiring their authentic perspectives rather than unwittingly recapitulating the researchers' assumptions; 'as we try to look at their world through their eyes, we offer our participants respect and, to our best ability, understanding, although we may not agree with them' (p. 19).

Initial concerns about the relevancy and usefulness of the data being elicited, and with my own performance, I soon realized that too much sycophancy, in combination with a business-like rush towards the formal interview process, may have caused initial interviews to be somewhat awkward and stilted; a potential reflection of my own anxiety. In discussion with my supervisor, more consideration was given to the interview process.

With respect to interviewing male participants, Charmaz (2006) warns of potential difficulties as the artificial situation of the interview challenges hegemonic masculine imperatives. She cites Schwalbe and Wolkomir (2002); 'men may view intensive interviews as threatening because they occur within a one-to-one relationship, render control of interaction ambiguous, foster self-disclosure and, therefore, risk loss of public persona' (in Charmaz, 2006, p. 27). Charmaz adds that 'men who hide their emotions behind a thick wall of impression management may not agree to be interviewed; others may weave around questions rather than address them directly', adding that men's discomfort is likely to increase if topics 'challenge their masculine claims' (p.28).

In order to ameliorate anxiety and to facilitate a more naturalistic and open, non-judgemental masculine forum, a period of rapport-building was introduced before the formal data-collection process started, time to allow for the development of an understanding that the researcher was not going to be judgemental and to allow both parties to relax a little. 'Critical language awareness' (Fairclough, 1995) was adopted throughout the following interviews, being cognisant of, adopting and using *'in vivo'* labels to keep the emergent theory as grounded as possible (Glaser & Strauss, 1967).

Remaining aware that the male-researcher/male-participant research scenario, being a same-sex dyad, has the potential to strengthen stereotypical expectations (Faldt & Kullberg, 2012), masculine narratives were initially omitted from the interview guide, allowing masculine themes to emerge. Such trepidation, however, was not allowed to restrict the potential development of a tangible collegiate atmosphere.

7.5 Analysis and presentation

The personal aims of the researcher and the prospective audience are likely to influence the way the research is presented (Mruck & Mey, 2007), a contextualization that grounds research in human terms rather than being a purely esoteric phenomenon. In paying attention to the emergent material as being inherently valid, a conscious effort to adopt a reflexive stance to all analytic processes was adopted, questioning the meaning of each item from the stance of the participant. After six interviews, a pause was introduced whereby the emergent material was re-assessed in terms of the emergent narratives rather than as a set of pure abstractions, the data being subsequently organized around the four emergent stages of participant's therapeutic journey; Formative years; Proximal factors; Post-intervention; Social factors.

Moving a list of abstracted ideas into a meaningful and interconnected model, was initially facilitated by staying close to the data and positioning categories within a series of linear flow-diagrams for each of the four stages that emerged. Although being a descriptive representation of the four discrete areas of the participant journey, little relationship was apparent between each axis, the usefulness of the constructs being limited by their apparent isolation from one-another.

Linking the axes within a meta-framework introduced meaning, a cogent model, the Humpty-Dumpty model. The entire dataset was revisited and reconceptualised as part of the entire participant-journey; each concept re-evaluated as part of the whole.

7.6 Final reflections

Existentialism appears to be a fundamental process that underpins all aspects of my personal experience. My father's untimely death and my own psychological crises have brought existential isolation into sharp focus, an apparently normative experience for many people. The personal freedom gained from allowing my own human frailty to be recognized and assimilated has been re-capitulated by the outcome of this research, a process that remained unconscious to me until the conceptualization of the emergent model. Being human, rather than being male, may be the fundamental outcome of this research and for my own onward journey.

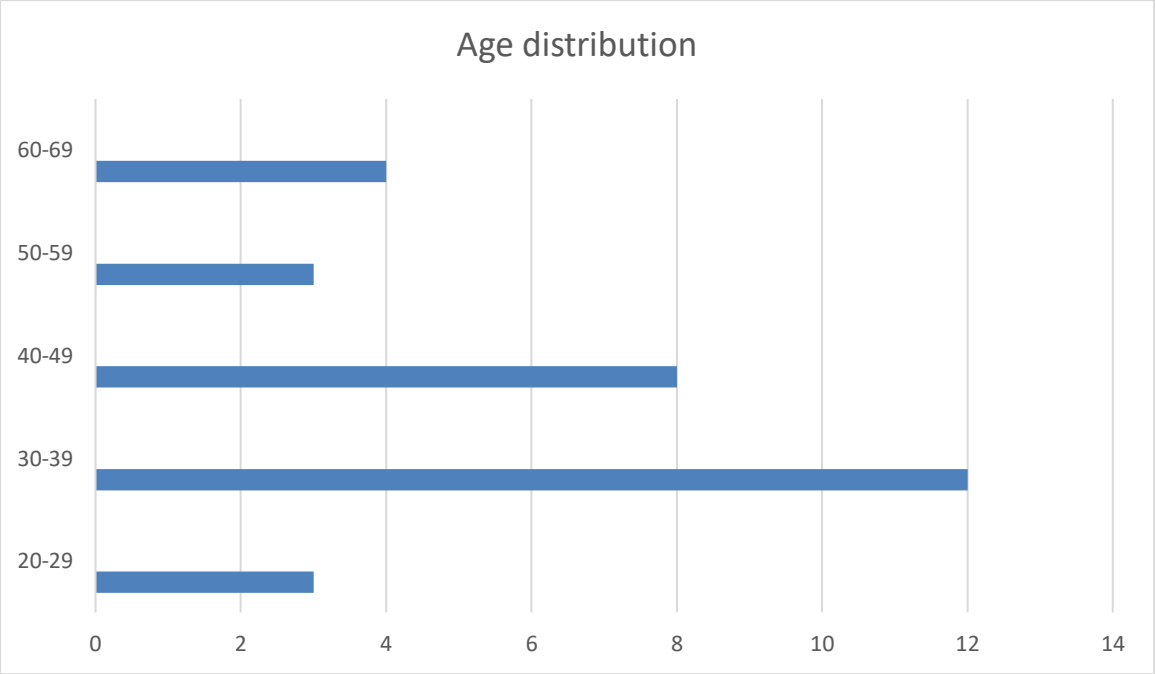
8 Results

Table 3: The demographic profile of participants.

Participant number	Age	Employment status E = Employed SE = Self Employed U = Unemployed R = Retired	Relationship status S = Single P = With partner M = Married D = Divorced	Children Y/N	Type of Intervention
1	45	E	M	N	CBT
2	24	U	S	N	Counselling
3	67	R	P	Y	Counselling
4	44	E	D	N	Counselling
5	41	E	M	Y	Counselling
6	26	U	P	N	CBT
7	24	E	S	N	CBT
8	38	E	M	N	CBT
9	37	E	M	Y	Counselling
10	60	E	M	Y	Counselling
11	40	U	S	N	Counselling
12	47	E	M	Y	Counselling
13	36	E	M	Y	CBT
14	31	E	S	N	Counselling
15	37	E	M	N	CBT
16	62	R	M	Y	CBT
17	43	E	M	Y	CBT
18	36	E	D	Y	CBT
19	41	U	M	Y	CBT
20	64	SE	M	Y	CBT
21	37	E	M	Y	CBT
22	34	E	M	Y	Counselling + CBT
23	35	E	M	Y	CBT
24	36	E	M	Y	CBT
25	35	E	M	Y	Counselling + CBT
26	58	E	M	Y	CBT
27	59	R	M	N	Counselling
28	41	SE	M	Y	Group + CBT
29	55	U	M	Y	CBT
30	39	E	P	N	Counselling + CBT

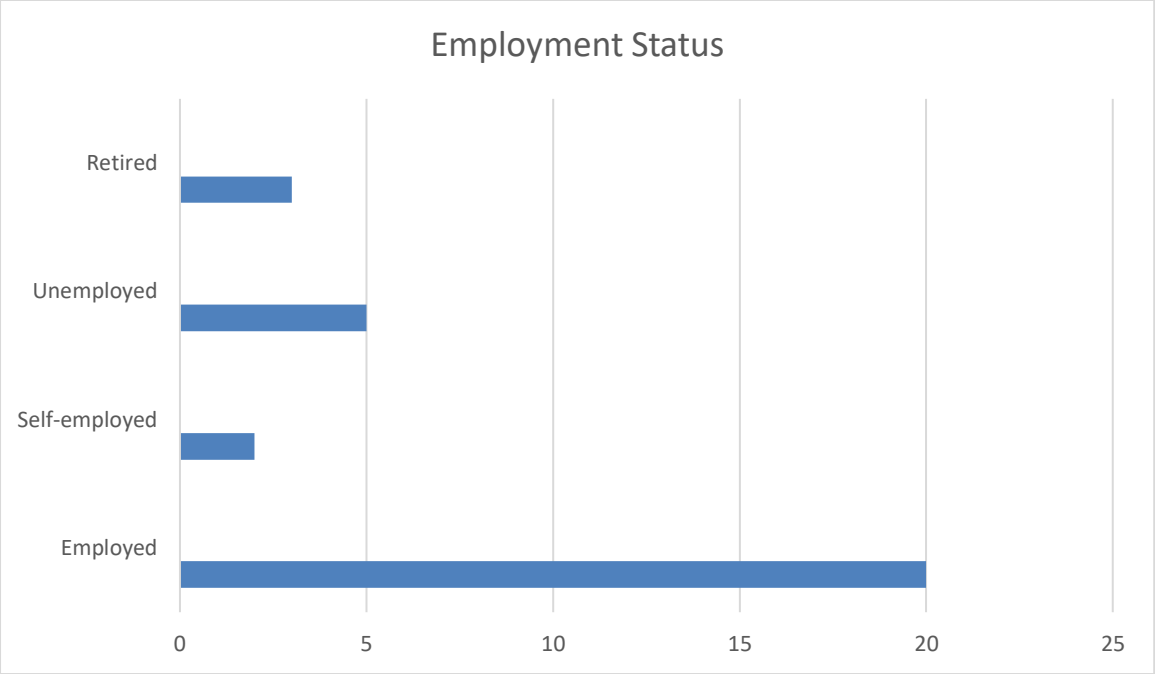
The participants were asked to complete a biographical data sheet at the time of their participation, the data from these questionnaires is summarized below. All participants identified as being heterosexual. In addition, 29/30 participants identified as being of Caucasian ethnicity, with one participant identifying as Indian. One participant voluntarily disclosed a sex-chromosomal genetic issue but he identified as being male.

Figure 3: Age distribution of participants



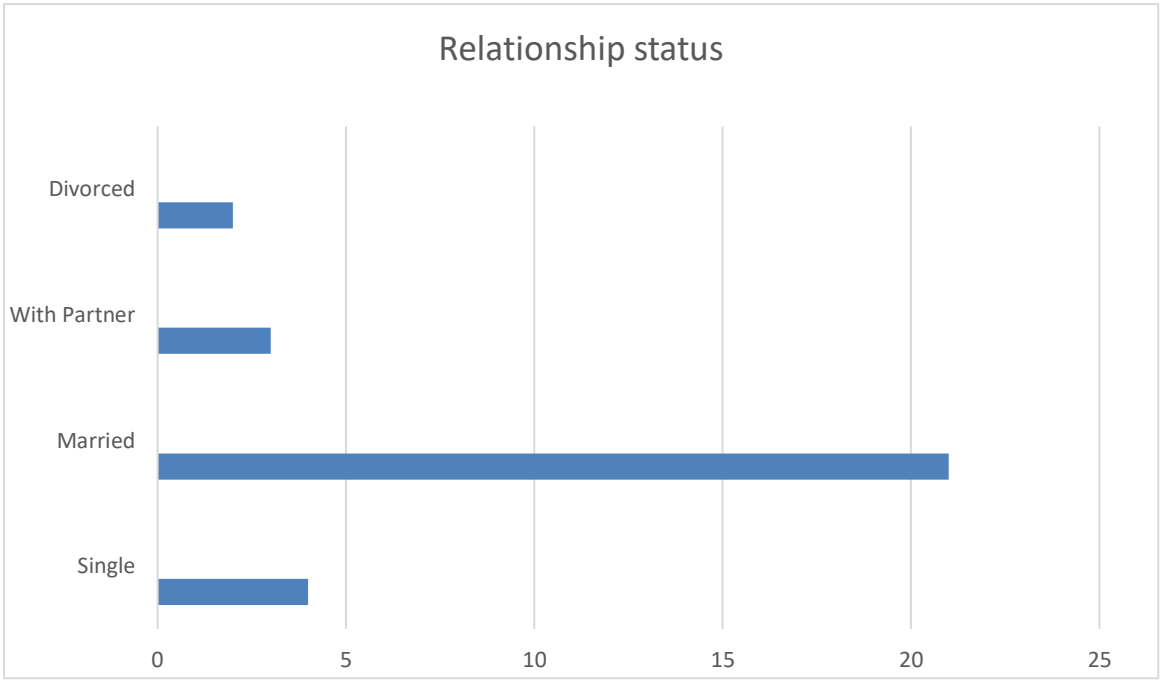
The age of participants ranged from 24 to 67, with a mean average age of 42.2 years.

Figure 4: Employment status of participants



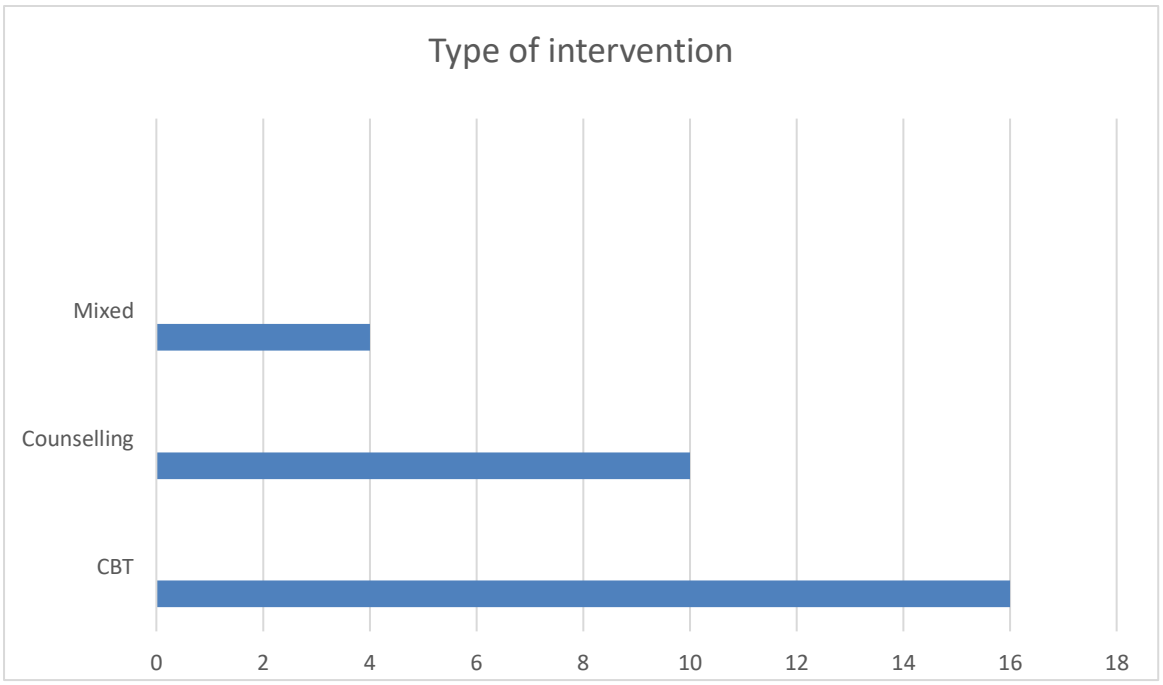
Most of the participants were employed or self-employed in full-time work (77%) with five reporting being currently unemployed and a further three describing themselves as being retired.

Figure 5: Relationship status of participants



Most of the participants were in a marriage or long-term relationship (80%) with four reporting being single (13.3%) and two being divorced (6.7%). As the parameter for inclusion into the study was set at 5 years since being in receipt of psychological treatment, some participants reported finding a partner or marrying since the event that had precipitated the initial psychological distress. Nineteen of the participants had children (63%) and eleven were childless (37%).

Figure 6: Type of intervention



Unsurprisingly, given the recent popularity of Cognitive Behaviour Therapy (CBT) in the NHS, promoted by the National Institute for Clinical Excellence and the adoption of this evidence-based intervention by private medical organisations, the most common form of psychological intervention reported was CBT (53%). Participants reporting counselling were largely unable to specify the type or style of counselling further. Four participants reported experiencing a mixture of interventions, some pre-dating the five-year parameter but all having experienced some intervention with that time-frame.

8.1 Overview

This research project sought to elucidate men's journey through psychological distress and subsequent treatment. After analysis, the emergent data was somewhat reminiscent of the fate of 'Humpty-Dumpty,' made famous in the children's nursery rhyme, and was therefore conceptualized as the Humpty-Dumpty model (Figure 10).

'Humpty-Dumpty sat on a wall,'
Regarding psychological matters, men tend to 'sit on the fence'.

'Humpty-Dumpty had a great fall,'
Psychological dysfunction often experienced as a crisis.

'All the Kings' horses and all the king's men,
Referrers and therapists offer support.

'Couldn't put Humpty together again'
The existential crisis experienced is transformational.

The data suggests that men in the formative period of their journey, the period before they experienced personal psychological difficulties, are somewhat unaware of psychological and mental health issues which remains as a non-descript 'fuzzy concept'. Shrouded and cocooned by social processes that act to maintain an apparent disconnection with the psychological world, participants reported a lack of appreciation of their own psychological vulnerability.

This apparent bubble of unawareness appears to be maintained by local socialization experiences, including family rules and exposure to unrepresentative mental health cases, exacerbated by the performance of masculine gender-roles. The resultant internal narrative omits themes relating to psychological matters, leading to coping strategies following the axiom 'just keep going'. Beyond local masculine factors, a wider social environment exists, strewn with negative and pejorative rhetoric regarding mental health which appears to restrict a psychological narrative for men.

With respect to psychological matters, unaware and uninformed men tend to 'sit on the fence', demonstrating little interested in learning about, or forming opinions, on the topic; an analogous situation to Humpty-Dumpty sitting 'on the wall'.

From this relatively unaware and disempowered position, the men in this sample reported how a variety of triggering events precipitated great emotional and psychological distress, crises which sufficiently interfered with their functionality as to generate a realization that they could no longer cope on their own. Participants described reaching a zenith, 'a great fall', whereby the consequences of escalating dysfunction outweighed the potential loss of independence or the fear of social disapproval.

Participants described a range of facilitating factors that aided in the recognition of their emotional or psychological impairment, effectively supporting them towards seeking support. Facilitating factors included, the feedback of close family and friends and the modelling of help-seeking behaviour by others. However, uncertain and confused pathways, the proclivity of doctors to offer medication and poor service-provision, led many participants to seek support via work-related routes or by utilizing private medical insurance.

The treatment preferred was generally described as individual, face to face therapy with someone who could demonstrate a real and tangible interest in the participant. However, participants demonstrated little interest in the type of therapeutic approaches employed with rapport and trust in the therapeutic alliance remaining of paramount importance.

Referrers and therapists, acting as 'All the King's Horses and all the King's men', could be expected to try to put the clients' lives 'back together again'. However, rather than returning to a former, potentially vulnerable and unaware state, participants reported a developmental process whereby, in private at least, the hard exterior of independence and autonomy previously lived and exhibited, was not re-established. Participants generally reported gaining awareness of their personhood, of their fragility, a humanizing and transformational experience. The existential crisis experienced appeared to herald the end of the era of unawareness and disconnection.

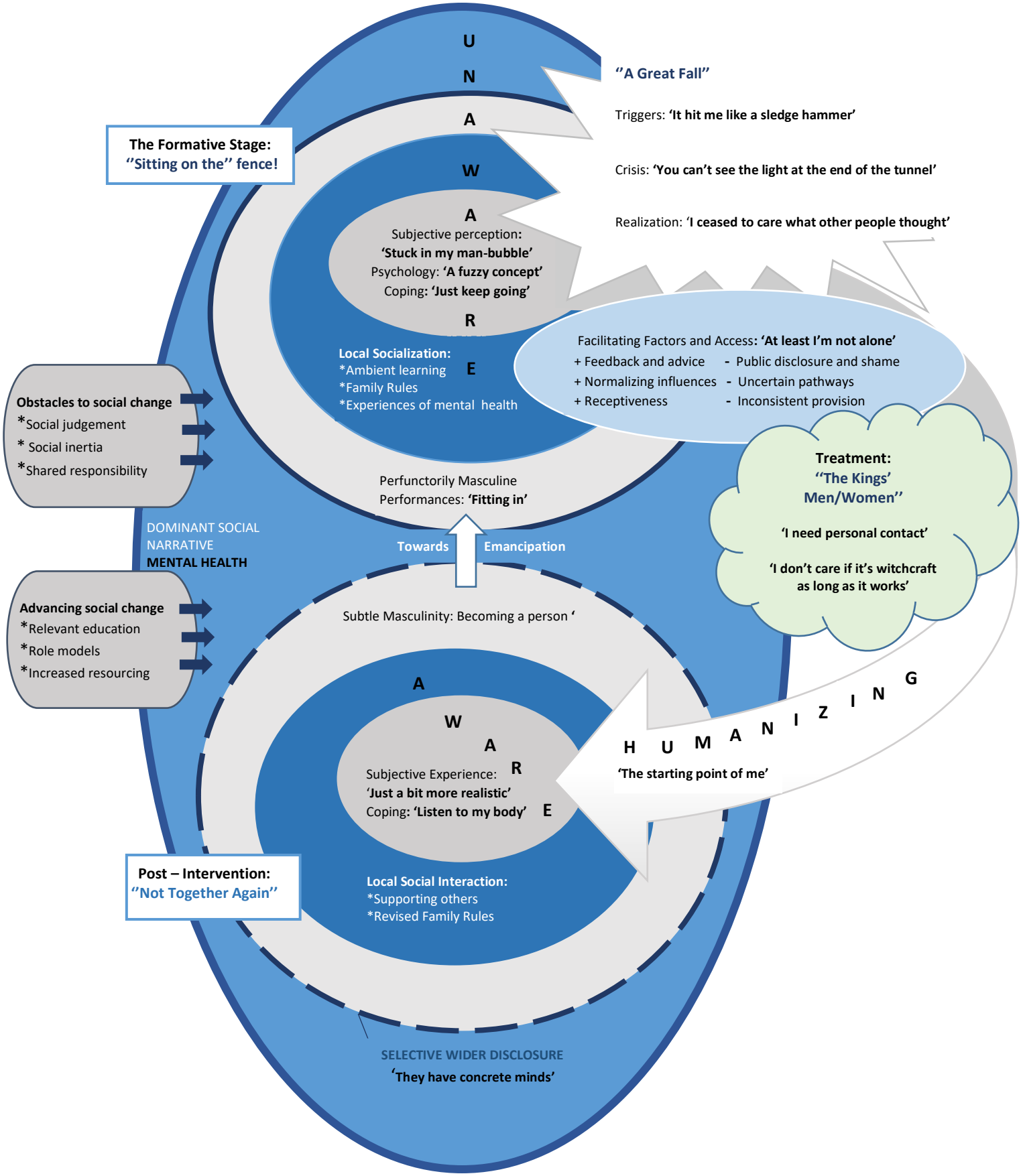
With the advent of greater general awareness of psychological and mental health issues, a degree of emancipation from the dominant social narrative and traditional restrictive masculine gender-practices was evidenced within the private and subjective world of participants. Local factors became modified with differential family practices, more adaptive coping strategies, greater empathy and compassion and increased interconnectedness with others. After treatment and a return to health, participants reported being more realistic about their own human limitations and the need to monitor their emotional and psychological wellbeing; they 'listened to their bodies.'

However, behavioural change was found to be restricted and local with wider public disclosure being carefully manipulated. Overt perfunctory gendered-performance continued to be maintained in situations that could attract negative judgements, like the pub or the workplace. Such selective disclosure was perceived to be necessary as, although now relatively enlightened, participants used knowledge of their own previous attitudes to inform them about the continuing beliefs of the uninformed majority; those with 'concrete minds'.

Although holding modified private perspectives, tacit collusion with prevailing attitudes in public arenas was commonplace, a phenomenon that potentially contributes towards inertia for social change. Indeed, social opinion was perceived as being relatively fixed among older and traditional groups, change being dependent on generational attrition, the young perceived as being the arbitrators of change. In addition, even within this group, who had been through the therapeutic process, responsibility for change was generally perceived to reside with the establishment rather than within the individual. For social change to occur, modifications were perceived to be necessary in a number of areas, including education that improves the relevancy of psychological health to unaware men, clearer referral pathways, less reliance on medication and improved service-provision.

The Humpty-Dumpty model (Figure 9), represents a holistic overview of the emergent data. Each area of the model is then explored in greater detail, supported by quotes that exemplify the tone and attitudes of the participants. Discrete stages include; The formative stage; Encountering a Problem; Facilitating Factors and Access; Treatment; Post Intervention; Obstacles and Advancements to Social Change.

Figure 7: The 'Humpty Dumpty' Model; illustrating men's journey through the experience of psychological distress and subsequent treatment.

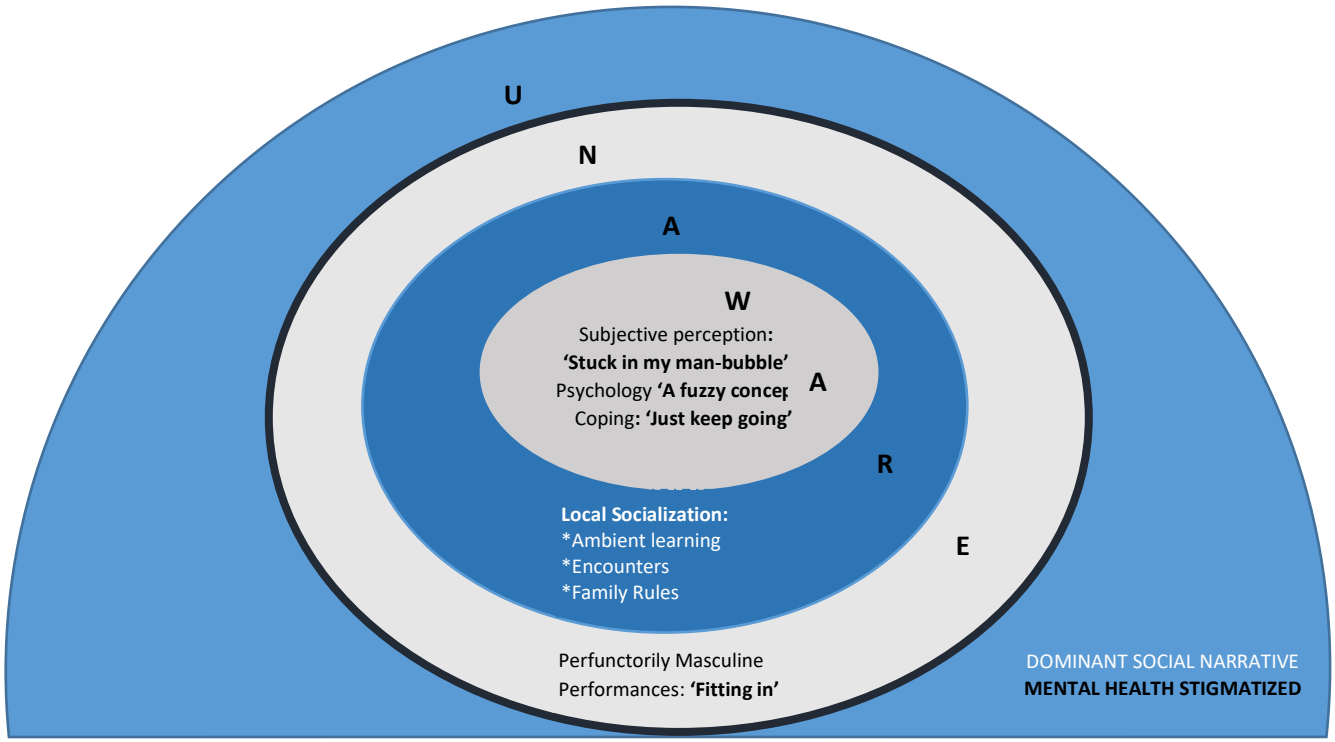


8.2 The formative stage: ''Sitting on the fence''

Participants described a confluence of factors facilitating a subjective reality defined by a general unawareness of all psychological matters, which remained a 'fuzzy concept', the resultant knowledge-vacuum producing a default coping strategy; 'just keep going.' With respect to psychological health, the recapitulation of a perfunctorily masculine performance maintained an independent and autonomous lifestyle.

The development of such a subjective outlook was determined by local socialization factors including ambient learning, direct experiences of mental health and family rules. Such local socialization experiences were embedded within a 'Dominant Social Narrative', representing the wider societal discourse relating to mental health.

Figure 8: The Formative Stage



This formative stage of the male journey is represented diagrammatically in figure 10, the subjective experience of men i.e. remaining unaware and adopting a 'just keep going' coping-strategy, being influenced by local social factors and masculine performance. Unawareness and stigma pervade all social environments, including the family and the wider social narrative.

8.2.1 The dominant social narrative: 'Some things that are not to be owned up to'.

The participant-journey mapped by this study is contextualized within an existent social environment, fixed in time and space, by geography and economics. With respect to psychological and mental health, discourse relating to this wider social context was reported as being almost exclusively negative, the topic being associated with considerable stigma and 'a general sense of disapproval' (Peter):

> 'I mean there are some things that are not to be owned up to, but to be ashamed of.'
>
> James

Psychological problems were typically perceived as 'problems of the weak' (Francis), with psychological matters in general being perceived, by some, as liberal and socialist in nature and, therefore, to be disavowed, avoided or hidden. The therapeutic project was also generally perceived as being a spurious activity with questionable legitimacy:

> 'Hampstead / Camden, left wing image of Freud and couches….a consultant who borrows your watch, and charges you to tell you the time.'
>
> Callum

With respect to the perception of mental health, some societal change was acknowledged but mental health as an issue was perceived to have started from such a low base that it was perceived to remain highly stigmatized. A cultural element was suggested by a number of clients who contrasted the traditional British attitude with the perceived ease with which citizens of the United States of America, for example, appear to engage in psychological services.

> 'The Brits are very much, you know it's a cliché, but a stiff upper-lip thing….chin up!'
>
> Graeme

Such social change was perceived to be a twenty-first century phenomenon, all reports of the twentieth century attitudes being compressed into a universal disapproval of the topic. The young were perceived to be 'far more open about it' not appearing to attribute 'shame to it' (Victor), potentially reflecting formal change, including legislation, which has gone some way to establish anti-discriminatory attitudes (Equality Act 2010).

During the formative stage of the participant-journey, negative appraisals of mental health were found to be influenced by a number of local factors including, ambient learning, encounters or reports of individuals with mental health problems, and family rules.

8.2.2 Local socialization: Ambient learning

Very limited opportunities to learn about psychological matters were reported, messages about mental health being gleaned through passive means; via the media, TV adverts, charitable organizations, historical accounts of shell shock, films and documentaries, fictional characters, stories, rumour, local institutions and hear-say. Any standardized provision in educational settings apparently went relatively unnoticed and unappreciated with only a few participants describing learning opportunities through formal academic or workplace channels. Only one participant had direct experience of the therapeutic paradigm, having volunteered to participate in a university help-line program whilst a student.

With respect to psychological issues, participants described how a generally negative rhetoric was promulgated in the media, a narrative that included political debate about the crises within psychological service-provision within the NHS and of various historic national initiatives like 'Care in the Community'.

8.2.3 Local socialization: Encounters with mental health- 'Your mum's potty'

Many participants reported direct contact with people experiencing psychological-ill health during the formative stages of their life, principally involving close and extended family members and friends. The term 'nervous breakdown' was commonly used to describe such occurrences;

> '….my mum….would collapse on the floor and pass out … had a nervous breakdown. She ended up in what can only be said as a mental hospital. It was quite traumatic to deal with, that your mum's potty.'
>
> Victor

Experiences relating to more distant family and friends tended to be exceptional and extreme examples of mental illness; secure 'mental hospitals', suicides or combat-induced PTSD.

> 'I had an aunt in the mental hospital……I remember pictures of her tied up in a cot… 1930's, 1940's with cotton gloves on because of the scratching and she was quite restrained……Before I was ill I had two friends who committed suicide. One who committed suicide on my 21st birthday.'
>
> Trevor

'Breakdowns', hospitalizations and suicides, being extreme and distressing manifestations of mental health issues are difficult to avoid or to ignore and therefore, potentially contribute to the formation of unrepresentative perceptions mental ill-health i.e. archetypical exemplars all being at the severe end of the mental health spectrum. Less severe conditions and mild and moderate dysfunction were not reported, presumably as less obvious presentations are more amenable to concealment, being absorbed into narratives that effectively disavow their presence.

8.2.4 Local socialization: Family rule- 'Shall we go for a walk?'

The family is probably the social entity that most people would consider to be the focus of early nurture and support. However, familial influence, with respect to emotional and psychological well-being, was reportedly comprised of secrets, denial and received wisdom that generally denigrated and disavowed psychological issues. However, a few exceptional expressions of permissiveness were also reported as being influential and significant.

Participants reported an array of family secrets where psychological ill-health had been hidden by family members. For example, sons were frequently unaware of parental suffering, only discovering the reality after their own psychological problems emerged or, in some cases, after parents had died;

> 'we knew dad wasn't necessarily well and was depressed, we never really talked about it…… I now know that most of my family have been on anti-depressants.'
>
> Peter

Some evidence of gendered rules also appeared to encroach on family dynamics, characterized by many examples of stoic masculinity that were apparently impervious to liberalization;

> ‘the only people that would actually talk openly to me about it were the female members of my family…I then discovered that both my mother and sister are manic depressives, but I was completely oblivious to this, being stuck in my man-bubble.’
>
> Francis

With differential disclosure between the sexes existing within families, both men and women colluding to stifle the disclosure of men’s psychological ill-health, a gendered narrative was reportedly constructed, making the feminine-role more compatible with psychological vulnerability and distress. More generally, family interaction was reported to be replete with placating comments and distracting activities; formal, emotionally restricted family environments effectively neutralizing conversations relating to emotional and psychological matters:

> ‘I have pretty middle-class Guardian-reading parents…who never talk about feelings though. So, yeah, it’s always, you know: ‘Shall we go for a walk?’
>
> Liam

Such avoidant activities potentially represent the synthesis of developing coping strategies for men, strategies which appeared to be largely promulgated by mothers (presumably having more influence over the day to day lives of the participants during their childhood) who preached a ‘get on with stuff, keep yourself busy, and get through it’ (Daniel) approach to life from school days onwards:

> ‘My mother is like you will go to school even if you’re on your deathbed…… You end up hiding it from your family.’
>
> Trevor

Beyond indifference, denial and distraction, some participants reported a family ethos that actively promulgated negative attitudes towards psychological health matters, making fun of the idea of psychological treatment and condemning those requiring such support;

> ‘my dad would often make fun of it….other members of the family would say ‘oh dear your mum’s gone a little doolally’.
>
> Ashley

In contrast to such avoidant or critical family environments, one participant, Guy, reported a family where, rather that stifling emotions, male family members released their emotions as anger; his euphemism ‘spillage’ being a very potent and ominous description of violent undertones.

> ‘I never used to see any men crying. I never used to see any men being upset or over-happy. I used to just see men either shut down or angry. Calm, shut down, contained, or spillage.’
>
> Guy

With such ambivalent, critical or even dangerous family environments, some participants reported that their family would be the last place they would seek advice, frequently perceiving the older generation as being more likely to deliver a lecture or a sermon rather than a listening ear;

> ‘my mum is probably one of the people who understands it the least.’
>
> Graeme

A small minority of participants reported more permissive familial environments, usually created by circumstances that required exceptional and adaptive attitudes. Mike’s father, for example, lived with Parkinson’s disease and Daniel’s father suffered a chronic mental health disorder requiring the respective families to embrace emotional and psychological issues.

Only one participant, Nigel, reported an emotionally permissive environment, his mother, actively encouraging him to share his emotional world, to discuss issues and to seek counselling.

Finally, Finley described a very happy experience at a private boarding school, where pupils were actively encouraged to discuss and share their problems with prefects, house-masters and with ‘matron’, a formative experience that apparently facilitated a life-long open discourse about his psychological world.

8.2.5 Masculine socialization: 'there's always a bit of fitting in to do.'

In order to reduce the potential for the recapitulation of gendered narratives, gender issues, including masculine factors, were deliberately omitted from the initial discussion guide. However, as unsolicited themes relating to masculinity emerged, the topic was adopted and developed in respect of the iterative process described by grounded theory (Strauss & Glazer, 1967).

The received traditional masculine code, so frequently presented in the literature, was reiterated by many of the participants in this sample, often being narrated as though read from a text book;

> 'You're supposed to be strong as a man. You're supposed to be able to cope, you're supposed to be able to get on with it.'
>
> Guy

Outside the family, learning how to recapitulate an acceptable masculine performance, was reportedly gleaned from two main sources, via direct instruction and through vicarious learning. Owen, described the influence of normative reference groups, suggesting that he conformed to the expected stereotype of masculinity in the 1980's, 'in the same way as in the 1950's, the woman would stay at home and do the housework and the man would go out to work. They were the stereo types.'

Modelling appeared to be the most potent factor in the development of masculine gender-performance with fathers being predominant in this role, independence and stoicism being almost universally exhibited in public domains and frequently maintained in private spaces. Such performances included a firm restriction over the divulgence or sharing of emotions;

> 'he (father) wouldn't want to be talking about feelings or anything like that. He was manly.'
>
> James

In addition to modelling traditional versions of masculinity, feminine performance-characteristics, including emotional nurturing, providing succour and the exposition of emotional discourse, as required in counselling, was portrayed as being inappropriate for men;

> ‘I was very much led to believe that it (counselling) was kind of girly things.’
>
> Ashley

Building on parental influences, some participants described additional social environments that applied further rules and restrictions to masculine gender-performance. Such environments included schools, sports, the military, work and peer-groups; situations that involve a degree of competitiveness:

> ‘You don’t show anyone you’re struggling. It was more to do with the sport actually, like a poker face you don’t want to give away how you’re feeling because you’ll lose.’
>
> Trevor

Male-dominated work-place environments, like engineering and banking, were particularly singled out as ‘very sort of alpha-male’ (James), environments where mental health ‘just wasn’t on the table’ (Christopher). Indeed, non-masculine behaviour was perceived as potentially garnering negative appraisal in some settings, which was defended by the adoption of conformist, restricted behaviour patterns;

> ‘I think there’s always a bit of fitting in to do.’
>
> Liam

Such rhetoric suggests the presence of a private-self, exhibiting a situational performance to navigate through the masculinized social world as encountered. Maintaining such a restrictive gendered-performance was for some, an arduous and inauthentic way to live. James described how he spent much of his life pretending; ‘I’m not a alpha-male, aggressive competitive, I’m not that person’. Indeed, he believed that he would have progressed further in his career if he had manifested characteristics more aligned with traditional masculine expectations;

> ‘I probably could have got further had I been able to pretend better.’
>
> James

Thus, the need to progress careers appears to provide a powerful motivation for men to adhere to some uncomfortable behavioural repertoires that could limit social contact and emotional disclosure, factors that could ameliorate emotional distress. However, not all environments were

experienced as being as restrictive, more permissive environments, facilitating deviation from traditional prescriptive norms and allowing a more holistic version of the self to manifest, were also reported. Peter, described adapting his emotional discourse to his audience, happily disclosing emotions to his gay friends but not with 'a man with your football team.'

Attempting to break free from normative masculine expectations, particularly within less permissive environments, was perceived as being a socially risky business. Keith reported how an invitation for a traditional man-to-man conversation may be facilitated by 'going out for a pint', an action that he perceived as remaining faithful to dominant masculine script, particularly the use of alcohol. However, he sometimes wanted to broach emotional issues with other men, perhaps to offer support, but was aware that in suggesting unconventionally masculine liaisons, he may be viewed as being an 'odd person'. Thus, his authentic nature was kept in check by his fears of public opinion.

A few men in the sample, however, described being party to a movement of social change; Owen being confident that 'things have probably changed a fair bit now', was more comfortable to experiment with more varied versions of masculinity and saw himself as a modern man, a position adopted by other younger participants:

> 'I have relationships with male friends where it's not football and the fight as my only subjects.
>
> Liam

In presenting a performance that deviates from traditional masculine norms, however, participants were aware that they attracted public debate relating to their sexuality, commentary that at least two participants had encountered, assimilated, accepted and moved beyond:

> 'My version of masculinity is terribly metrosexual and most people who don't know me think I'm gay because the show I put on is terribly camp.'
>
> Ashley

> 'I got on better with girls, everyone thought I was gay and I was like no, I feel comfortable here.'
>
> Will

As the social world becomes more liberal, some heterosexual men have apparently been able to shed some of the traditional masculine performances, to engage with more authentic behaviour which includes being emotionally open with other men:

> 'My two best friends, probably not a lot I wouldn't tell them…we don't fall into that alpha male trap…..we're quite open with one another. That's a real value.' Harry

In summary, traditional masculine narratives were widely reported to have been modelled by parents, particularly fathers, with masculinized social environments honing the display of male-gender-roles in certain public arenas, particularly work and sports.

Although the majority of participants reported acting-out restricted Perfunctory Masculine Performances in public, such gendered performances were not necessarily congruent with privately held subjective sensibilities. Further, some participants described rejecting traditional masculine narratives, perhaps reflecting a liberalization of society. Such 'early adopters', however, encountered questions relating to their sexuality which, for some men identifying as being heterosexual, did not provide sufficient cause to adopt disingenuous gender-practices.

8.2.6 Subjective experience: 'a fuzzy concept'

The social factors described above; a dominant narrative critical of mental health; of families that collude to hide or disavow psychological distress or foster the idea that women are more susceptible; exemplars of mental health comprising of severe cases; a dearth of learning opportunities; masculine strictures that generally maintain independence and stoicism, all act to create a subjective experience which is expedited below.

Unsurprisingly, participants almost always reported psychological and mental health issues in vague terms, crystalized by Keith's description of 'just a fuzzy concept'. Participants reported a formative era, particularly their youth, as being a period when they were relatively detached from psychological issues, their focus being on the day to day machinations of life. Some participants assumed that their own experience was mirrored by others;

> ‘for me, I was so sort of immune to it at this point…..I woke up and did this and did this, all the drives and all of the feelings that I had, I thought were universal.’
>
> Graeme

Being relatively uninformed about psychological issues, they were typically reduced to a dichotomous view; us and them, ‘sane or mad’ (Harry). An apparent lack of appreciation for the potential diversity and range of psychological disturbance may be engendered by exposure to more severe cases (above), exacerbated by imagery in horror films (‘Psycho’) and of historical accounts of Victorian asylums.

With only a ‘fuzzy concept’ of psychological health and wellbeing, pet theories tended to fill the information-vacuum, providing sufficient rationale to account for people with such difficulties. Common explanations included genetics, being ‘too clever’ or causation due to ‘female issues’ (menstruation, childbirth, menopause). Reflecting dominant masculine societal codes, men were only permitted to be affected by psychological problems while in pursuit of prescribed masculine activities, i.e. combat, speed, risky ventures.

> ‘a massive trauma, you know whether it be Post Traumatic Stress Disorder, or an accident or something like that.’
>
> Francis

However, psychological problems, resulting from anything less significant than a major road traffic accident, for example, was perceived by some as being potentially ‘wimpy’, associated with malingering. Mens’ difficulties were somewhat trivialized, reduced to a pastiche;

> ‘a guy running off with a young girl, driving sports cars and spending lots of money.’
>
> Will

The few stereotypical conceptualizations of psychological treatments reported, being prostrate ‘on the couch’ (Keith), helped to explain the conceptual distance between many participants and psychological matters. Therapy was sometimes seen as a potentially unnecessary indulgence for people with not enough to do;

'lots of ladies who lunch, who go to therapy….it's part of having your hair done, you know it makes them…look more interesting.'

Callum

In summary, participants reported a nebulous 'fuzzy concept' of how psychological ill-health may affect some notional, potentially mad, other type of person; it was, therefore, perceived as being largely irrelevant to the participants.

8.2.7 Previous coping strategies: 'Just keep going'

Holding a vague concept of psychological health matters and concentrating on day to day living within a predominantly restrictive contemporaneous social environment of dominant masculine norms, little thought or effort was apparently devoted to the development of coping strategies. Indeed, some participants reported a total absence of coping mechanisms, an absolute unawareness of the need to consider their emotional or psychological health;

'you don't even think about things like that.'

Mike

Other participants, who had become aware of some emotional and psychological difficulties, reported avoiding, hiding, numbing or disavowing problems, sometimes privately as well as publicly, reflecting some of the coping modalities described in Brownhill's 'Big Build' (Brownhill et al., 2005). The predominant themes reported included the need to maintain independence and to be perceived to cope, a stance that resonates with a notional mytho-poetic, folklore version of masculinity.

'…probably some idealized version of being a warrior poet type thing.'

Harry

'…you wouldn't want to be seen as needing someone to prop you.'

Ian

Resonating with the scolding mother's insistence that the boy must go to school and of stoic, non-disclosing fathers, many men described preserving autonomy despite increasing dysfunction. The mantra consistently reported was 'carry on as usual' and 'just keeping-going':

> ‘Problems were manifesting themselves rather badly…. I kind of just kept on going, kept on going, kept on going.’
>
> Keith

> ‘My own value system was, no matter how tough it gets, you just keep going.’
>
> Harry

The exception to the maintenance of stoic masculinity was the masculinized group, where mutually affirming ‘man-talk’ allowed for the discussion of acceptable topics which conform to traditional masculine norms – i.e. women and business:

> ‘It was a ‘chaps’ thing so you could have a moan like “the woman I’m seeing is driving me crazy” or “business is shit”, you sort of get it off your chest and forget about it.’
>
> Callum

Two participants reported using alcohol to ameliorate stress, a coping strategy that may remain congruent with the masculine code. Exercise was also employed as a coping strategy for a minority of men, exercise being ‘a let out for mental well-being’ (Christopher), an opportunity to ‘run around and let off some steam, and the endorphins play a good role’ (Callum).

Only a small minority of men described a coping style involving an expression of emotion; Nigel and Sabhajit describing how they disclosed and shared problems through discussion with family and friends. Nigel reported how his mother had actively encouraged him to be emotionally open throughout childhood and Sabhajit described how a more collectivist cultural tradition, involving extended family members holding counsel, provided a forum to air and process difficult circumstances and their psychological effects.

In summary, despite the apparent liberalization of masculine norms described by a minority of participants (above), the majority of men in this sample reported clinging to autonomy by denying problems and attempting to struggle on alone. Exercise and permissible ‘man-talk’ potentially afforded some marginal succour but only two participants enjoyed the freedom to share wider issues and emotions, having been granted permission to do so in childhood.

8.3 Encountering a psychological problem: ''The Great Fall''

This section focuses upon the way that psychological problems ensued and describes the process of realization which resulted in external help being sought; three main areas emerging being conceptualized as 'Triggers', 'Crisis' and 'Realization' (Figure 11).

Figure 9: Encountering a Psychological Problem

Triggers: **'It hit me like a sledgehammer'**

Crisis: **'You can't see the light at the end of the tunnel'**

Realization: '**I ceased to care what other people thought'**

8.3.1 Triggers: 'It hit me like a sledgehammer'

Living in a state of relative unawareness, regarding the potency and indiscriminate nature of psychological ill-health, participants reported being in a vulnerable state where 'it never occurred to me that if your brain isn't well you can't trust it' (Harry). A state of unpreparedness prevailed;

> 'being completely unaware of it…with some degree of naivety…. it hit me like a sledge hammer when it happened to me.'
>
> Christopher

Participants reported a plethora of precipitating factors to which they attributed the development of their psychological problems including, existential events, work-related issues, relationship issues, an increase in the severity of existing psychological problems and, sometimes, a combination of such factors.

Existential events were reported to be potent causes of distress and included neurological and cardiac issues, fatal accidents and accidents involving children, reaching a significant age (40), reports of the death of contemporaries and films with themes about death;

> 'turning 40, that did start me off with my panicking issues.'
>
> Sabhajit

Existential reality apparently cannot be continually and universally defended through masculine bravado, distraction or denial, with participants reporting how their predominant defensive strategy, 'just keep going', was insufficient.

Unsurprisingly, factors that interfered with participant's ability to work and to progress in a career were also reported to be significant sources of psychological ill-health, a source of masculine distress that remains entirely congruent with the tenets of traditional masculinity widely reported in the literature (David & Brannon, 1976; Mahalik et al., 2003).

Work-related problems included over-commitment to work, work-related stress, pressures of deadlines, the threat of redundancy, perceived financial ruin and the vacuum created by unemployment. Christopher reported how he irrationally worked himself towards ill-health;

> 'my work ethic of 'get the job done', through an impossible task, meant I was working tirelessly and hadn't had a break mentally…..I was trying to get the job done.'
>
> Christopher

In striving towards the acquisition of resource, participants reported absorbing great stress and hardship, potentially echoing evolutionary or socio-biological imperatives to compete and to attract and keep a mate. Indeed, the rupture of spousal or analogous relationships featured as a source of psychological distress with break-ups, separations, divorce and problematic relationships, all reported as being potent triggers.

Clinging to the 'Just keep going' coping modality, participants reported tolerating difficult relational circumstances for extended periods that inevitably eroded psychological well-being;

> ‘when I found out that she’d been cheating on me, I was pretty depressed for a good three years.’
>
> Hugh

Many participants reported an accumulation of factors, all contributing to an overall load that, having adopted a ‘carry on regardless’ coping strategy, eventually became overwhelming; Callum’s testimony was typical;

> ‘I was under pressure…business was being horrible and I was feeling fairly alone, I was having a topsy-turvy relationship with my partner…..my mother had died a few years before …pressure from the bank, you know.’
>
> Callum

In addition to the effects of external factors, some participants reported experiencing a range of milder psychological problems that had previously been present at a tolerable level, but which had increased in severity so as to create sufficient dysfunction to warrant seeking external support. Milder symptoms of OCD, generalized anxiety disorder, social anxiety, panic and depression were typically reported during the formative period.

8.3.2 Crises and realizations: ‘I ceased to care what other people thought’

As triggering events intensified and/or resilience weakened, participants reported that their subjective experience of life became ever-more difficult, leading to a point of crisis which precipitated the realization that help may be needed. Participants reported a range of indicating factors including aberrant behaviour, loathsome emotional states, unfamiliar physical symptoms and suicidal thoughts. Examples of unusual behaviour that raised awareness included; ‘not answering the phone’ (Victor), ‘becoming almost irrationally angry’ (Liam) and ‘smashing chairs’ (Owen). Typical precipitating physical symptoms including exhaustion (Alan), shaking (Brent), tingling (Eammon), palpitations and sweating (Francis), ‘massive anxiety attacks’ (Ian) and panic (James and Mike);

> ‘I went blue, hyperventilated, my hands all clamped up, got taken to hospital…I realized that wasn’t normal, that wasn’t right.’
>
> Mike

The physical manifestations of psychological disturbances were frequently miss-interpreted as participants remained unaware of the potential for underlying psychological antecedents;

> 'just thinking well something's not right, but I'm not sure what's not right.'
>
> Alan

In the absence of a narrative describing good psychological wellbeing, participants appear to have defaulted to a focus on their physical symptoms, an approach that may defend against potentially shame-inducing psychological problems:

> 'I had a panic attack…I thought I was having a heart attack…went for a battery of tests just in case there was anything physically wrong, there wasn't. I was pretending there was something physically wrong.'
>
> James

In addition to physical symptoms, a minority of participants reported experiencing unfamiliar and worrying suicidal thoughts, potentially considering existential escapes from unbearable situations that appeared to have no other resolution:

> 'I thought to myself 'this is going to make everything go away. This is going to resolve all my problems – I don't have to worry about it anymore.''
>
> Hugh

Perceiving psychological health in dichotomous terms i.e. stable/unstable, sane/mad, moderate responses to potentially assailable problems were not reportedly considered. Rather, extreme options to apparently unassailable and intractable problems appeared to be the only resolution possible. For both Alan and Eric, such extreme thoughts were necessary before sufficient fear and awareness were engendered as to precipitate affirmative action:

> 'You just want to end it here because you can't see the light at the end of the tunnel…it was just the realization that I had to break the cycle.'
>
> Alan

> 'I felt like if I didn't do something about it, I was going to end up killing myself and I knew that I didn't want to do that. I think it was that toss-up.'
>
> Eric

Many participants reported experiencing seminal moments of clarity when, because of the degree of dysfunction or crisis, they were forced to the conclusion that change was necessary, regardless of the potential consequences of breaking the autonomous masculine pact to which they had faithfully adhered. Reaching the point of crisis, the decision to seek help was largely taken out the participant's control as their symptoms simply spilled over; 'I don't think I had much choice…the state I was in' (Ian). Indeed, many participants reported that they experienced such loathsome states that they ceased to care what other people would think about them, all fears of social judgement suddenly becoming nugatory;

> 'bollocks to the world, I clearly need help…..I felt so backed into a corner that I ceased to care what other people thought.'
>
> Peter

> 'I was strong…I could come back from all my disasters…but this time the wheels fell off and I needed help.'
>
> Trevor

> 'You grab onto to something….and you have no shame as you know you can't handle it.'
>
> Mike

However, the acceptance of a need for support was frequently perceived as a form of capitulation, as a perceived defeat, shame being accepted as the fight to maintain the autonomous masculine-self was lost:

> 'I just held my hands up and gone into survival mode, I just threw in the towel.'
>
> Christopher

Giving up the illusion of the heroic, autonomous, strong man was apparently difficult, engendering a variety of emotions; 'I felt like I was broken' (Harry); 'Oh blimey, maybe this does apply to me' not just to 'celebrities and junkies' (Brent); 'realizing it is ok to ask for help' (Will).

Other participants, however, did not have a subjective realization and had to rely on the direct intervention of others, usually close social contacts like friends, family and managers to provide direct feedback or advice. Even in times of crisis, some participants reported how other people had explicitly illuminated their own troubled state; 'he (manager) said 'you need to take some time out, we'll get you some help….and you need to see your doctor" (Francis). For Harry, even suicidal thoughts were not enough to provoke his own epiphany. However, when he told his friend that he was contemplating throwing himself from a car park, his friend replied, 'that's not normal…no you need help' and only then, did Harry consult his GP where he experienced a mixture of both 'relief' and 'shame'.

In summary, participants described, how a naïve perspective of relative invincibility and need for autonomy, had created vulnerability when psychological problems encroached upon their lives. Adopting a 'just keep going' coping strategy resulted in months, and sometimes years, of distress as existential, work-related and relationship difficulties were absorbed. However, resilience was eventually eroded with the manifestation of aberrant and unusual physical, emotional and cognitive symptoms that pushed participants into crisis, to a state where the illusion of the resolute, independent coping man dissolved, and considerations of public judgment evaporated. Significantly, a small number of these participants reported considering suicide as a first, only and last option, to address their distress, their lack of awareness of the range and normality of psychological problems, potentially contributing to a lethal outcome.

8.4 Facilitating factors and access: 'At least I'm not alone'

In addition to the proximity of close friends and family, who sometimes offered direct feedback and advice, participants described other factors that influenced them in seeking support for the psychological issues manifesting in their lives; positive and inhibitory factors are expedited below and summarized in figure 12.

Figure 10: Facilitating factors and access

Hearing about or witnessing other people seeking psychological support reportedly acted as a prompt for participants to seek help, creating localized permissive environments:

> 'A couple of my friends have had psychological problems and they've discussed it with me. I guess you start to rationalize it and say, well, you know: 'They're normal people.'
>
> Brent

Although on-line sources were mentioned, relatively few participants cited the internet as being pertinent to their journey; 'hitting the forums', however, did allow Peter a degree of comfort as he contemplated the suffering of others: 'I feel shit about myself but at least I'm not alone.'

Moving towards a more receptive frame, work-orientated initiatives and editorial commentary in the media also contributed to the promotion of help-seeking behaviour, timely communications suddenly gaining relevancy;

> 'I started paying attention to the posters and articles in the newspapers and being able to recognise I've got to address things slightly differently.'
>
> Will

Having overcome private barriers in conceding a need for external support, for some, a public declaration of help brought shameful feelings as coping was devolved from the self, towards the wider community:

> ‘I’m a professional I’m earning good money….I don’t want to rely on the state, I don’t want to burden the NHS unless I really needed to.’
>
> Keith

Tentative steps were often initially taken, by calling a workplace Employee Assistance Program helpline (Mike), for example, in the hope of gaining ‘advice and hints without opening-up’ (Will). However, in the absence of any understanding of the potential referral pathways and interventions available to support psychological distress, access to treatment was inherently an *ad hoc,* inconsistent and mysterious process.

When help was eventually sought, General Practitioners (GPs) were frequently reported as being the first point of contact. However, older participants, like Victor and Callum (both in their sixties), reported how they had never considered their GP as a potential source of support for mental health issues.

Participants reported a mixed response from their GPs from systemic inertia, the proclivity for doctors to offer medication or a lack of relevant service-provision, through to excellent service that engendered confidence. However, a degree of assertiveness, perseverance and ‘many, many appointments’ (Mike) were frequently required to access the type of treatment preferred:

> ‘I eventually plucked up the courage to go into my local doctors and say: ‘I’m not suicidal, I don’t think I want any drugs, but maybe there’s someone here who could, wouldn’t mind talking to me about how I’m behaving’.
>
> Liam

Indeed, once a diagnosis was forthcoming, further determination was often needed to breach the doctor’s apparent first line of defence, medication:

> ‘He (the GP) went “alright mate, here’s some Prozac” and he went “trust me, it’ll make you feel better” and I was like, alright cool, it’s a doctor you’ve got to trust your doctor.’
>
> Graeme

Some participants were very sceptical of psycho-trophic medication, as it carried a ‘stigma in my head…the US view of mental health that everyone gets hooked on tranquillizers and ends up being a

junkie' (Brent). However, medication was sometimes the only treatment offered by doctors who explained how NHS psychological services were 'not an option' (Keith), with long waiting lists.

Some of the NHS services that were offered sometimes 'seemed trivial….to meet other people with similar symptoms more like a community group' (Christopher). Other participants reported how their doctors appeared to be as uninformed as they were, resorting to simple diagnoses and remedies;

> 'he (GP) was trying to shepherd me into believing it wasn't something mental and maybe if I took the placebo …. I went to another GP and he said 'you're going to have to trust me, a rep came in today, there's this new drug out for just what you're saying'. It drove me mad.'
>
> Ashley

Yet other participants were appreciative of their GP's time, patience and understanding with confident GPs winning trust and providing inspiration. Doctors in the private sector were more roundly lauded for their professionalism, Harry reporting a 'factual and procedural' approach which engendered confidence in their ability to 'fix my problem.'

Having had experiences in both the private and public health sectors, Ian was left with a clearly defined view of the deficiencies within the NHS. His experience in the private sector was 'very good, excellent treatment with loads of courses, mindfulness classes, group therapy…. you can do it as you want, and lots and lots of attention'; then, his NHS experience, which 'was shit, absolutely nothing, you couldn't get anywhere on it….I ended up going round and round in circles, and thought 'sod it' and spent my own money.'

A number of participants reported how their doctors advised them to fund their own private therapy which, some participants were able to achieve by utilizing private medical insurance schemes and Employee Assistance Programs. Work-related support, however, particularly Occupational Health services, were not universally applauded, with poor administration and unreliability being cited as continuing frustrations.

8.5 Treatment: ''The King's Men/Women''

This section reviews participants' views and experiences of the treatments undertaken, what was important and what remained largely irrelevant to them; their opinion frequently being antithetical to the expectations of many commentators regarding the masculine psychotherapeutic paradigm.

Figure 11: Experiences of Treatment

Prior knowledge of psychological treatment was almost non-existent with participants reportedly entering into therapy with 'no idea what it was going to be like' (Ashley).

> 'Yeah, just no idea. I thought you just talk about childhood and then, you know, all of a sudden, everything becomes better.'
>
> Brent

The knowledge-vacuum was particularly evident when participants spoke about process issues in therapy. Default imagery, potentially evoked by Hollywood's version of Freudian therapy or of hippy 'alternative therapies', tended to fill the void; 'sitting on the couch and there's things going click-click-click' (Owen) with 'incense and hugs, which I didn't want' (Liam).

A few participants described how their therapists had explained the therapeutic journey being undertaken, providing a structure that was apparently appreciated. Some, who had undertaken cognitive behaviour therapy (CBT), demonstrated a degree of residual understanding of the process.

Brent, was the exception to the rule, the only participant to have taken the initiative to learn about the treatment he was undertaking;

> 'I did go and have a look at it, about CBT. I was a bit cynical to start off with but…cause and effect and it does make sense when you start to get into it….'
>
> Brent

Most participants, however, reported a lack of any exposition of the therapeutic process by their respective therapists, rendering them passive recipients of therapy as it occurred, session by session. Even after two separate interventions, Nigel was not cognisant of the modality of therapies he had undertaken, rather, it was the relational style employed that had impacted upon him, the interactive process perceived as being most constructive.

Unexpectedly and in denial of the belief that men need to maintain control, there was little desire on behalf of participants to understand how the various therapeutic processes employed were supposed to help, process-issues left squarely in the hands of the therapist;

> 'And my joke to my therapist is that I don't care if it's witchcraft as long as it works. I don't need to know how it works as long as the witchcraft works.
>
> Liam

In the absence of informed participation in psychological treatment, there was an inherent assumption that the therapist 'knew what they were doing' (Eric), a naïve assumption that underscores the importance of regulation in the psychotherapeutic environment. However, although being relatively uninformed about psychological treatment protocols, participants were able to convey various preferences regarding treatment formats and therapist characteristics. Participants reported a strong preference for inter-personal, face to face contact with therapists, even when alternatives were made clear;

> 'my sister found that mums-net is very useful for online support groups. I can't imagine myself doing it, maybe because I feel like I need like a personal contact.'
>
> Eric

The idea of telephonic counselling was considered to be 'just pointless' (Owen), due to the absence of non-verbal communication, face-to-face contact perceived as being be crucial to 'get to know each other' (Keith) and to 'build a rapport' to facilitate the development of 'a pretty high level of trust' (Liam).

At the point of first contact with psychological services, group therapy was also perceived as an anathema, psychological disclosure being perceived as 'a private thing' (Mike). Ian attempted to engage in group therapy but found it a struggle as he 'didn't like listening to and hearing what other people have to say', finding himself to be judgemental, either reacting with contrition; 'oh my god, my issue is so insignificant' or with intolerance; 'will you just shut up, what are you going on about?'

Time and again, personal contact was consistently seen by participants as being fundamental to an effective therapeutic encounter;

> 'I can't even comprehend any other thing than just wanting a person to talk to you.'
>
> Mike

The characteristics deemed to be important for successful engagement included 'somebody completely independent to sit and listen' (Hugh), engendering a 'personal connection….like we were working on this together' (Eric), a therapist who is trusting, empathic, positive, open, welcoming and non-judgemental (Trevor, Blake, Eric, Finley, Francis). Liam was effusive about his therapist;

> 'she was spot on…perfectly charming, a chirpy person who had…brilliant listening skills…a decent sense of humour….someone who is interested in me as a person.'
>
> Liam

Peter echoed the importance of genuineness and positive regard in his gritty but succinct proclamation;

> 'a problem shared is a problem halved, but only if the other person gives a shit.'
>
> Peter

Indeed, if therapists had not been listening or were inattentive or had forgotten, it was noticed; 'sometimes she wouldn't remember….that wasn't very good' (Blake). Eric was not impressed with one therapist he encountered who was 'sitting lower in her chair, and slumping back….apathetic, but at the same time judgemental.'

Participants confirmed how the fundamental precepts of counselling, espoused at the inception of the counselling movement, appear to hold true for contemporary men, who appreciate attentive, genuine, caring therapists who become engaged in their client's subjective world.

A range of unsuccessful experiences were also reported with biblio-therapy, CBT and psycho-dynamic interventions all being subject to criticism. Some more bizarre events were also reported, including strikingly poor terminations and unhelpful comments:

> 'Your mind is a blank rulebook. It makes it up as it goes along and I can't help you anymore.'
>
> John

Relatively little data emerged with respect to the physical contexts within which psychological treatments occurred, commentary being inconsistent and contradictory across accounts and reflecting individual differences. Alan preferred the informal setting of his therapist's home which provided for a 'relaxed' and 'comfortable' environment where 'chat' could occur, whereas Trevor, was looking for a more formal, clinical setting, the therapist's home feeling amateurish and therefore, potentially less efficacious.

Commentary, relating to the gender of therapists, once again reflected individual differences and needs rather than contributing to any generalized preferences. Keith, a dominant and imposing man, reported how two female therapists had been 'very much softer and more kindly' but he was 'not necessarily looking for the nurture,' rather, he believed he needed 'a certain stick element' to help him to 'keep one foot in the real world.' Daniel, however, reported how he found female therapists easier to talk to. Eric summed up the issue of therapist's gender rather eloquently and philosophically, rendering the topic somewhat of a non-issue;

> **'**there seemed like there was more sort of issues with my mother….but then maybe if I worked with a male therapist, I would've found more issues with my father!'
>
> Eric

Finally, the issue of the timing of therapy appeared in the dataset as little more than a footnote, Keith being a lone voice, commenting how interruptions to the working week, caused by attending therapy, had exacerbated his stress levels.

In summary, participants tended to look upon therapists as experts, demonstrating little interest in the techniques used or in the therapeutic paradigms with which they were engaging. Personal contact with genuine and interested therapists was of far greater importance as it facilitated the development of trust. Remote forms of therapy were therefore seen as being undesirable. Group therapy was not seen as being appropriate as an initial therapeutic intervention but rather as a potentially useful secondary intervention. Ancillary factors, like therapeutic setting, therapist gender and timings appeared to be dependent upon individual preferences.

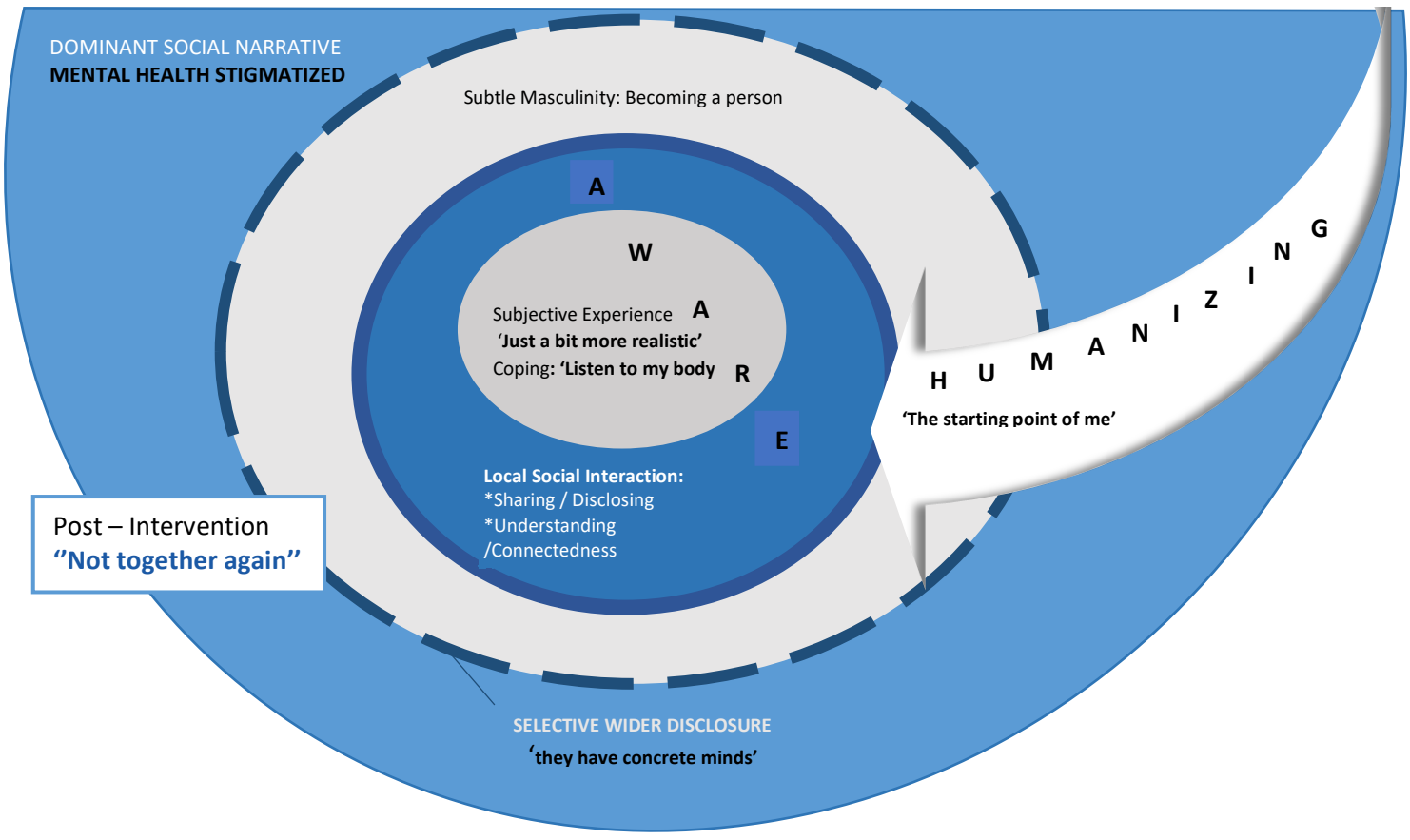
8.6 Post intervention: ''Not together again''

The experience of encountering a psychological problem and engaging in subsequent treatment had many transformational effects upon participants who reported permanent change defined by the development of a more holistic sense of self, an increased understanding and connection with others, more adaptive coping strategies and revised family rules. In addition, emancipation within the private sphere at least, allowed for some relaxation of selective gender-practices.

Thus, in terms of the model, the tough exterior, façade or shell, having been permanently split open, allowed the softer, more vulnerable interior to be acknowledged. The transformative experience was universally perceived to be a positive, enriching, developmental process. The re-constitution of the former, defended and unenlightened self was neither craved nor sought, never to be put together again in the same way.

Figure 14 represents how, having been humanized, the relatively enlightened man, being more realistic and listening to his body, is privately more empathic, understanding of others and relatively emancipated, yet, still holds a protective limit to disclosure, remaining aware of persisting social judgement.

Figure 12: Post-Intervention



8.6.1 Humanized

In becoming aware of their psychological health and wellbeing, participants reported modified attitudes towards their own human limits and frailties as well as those of others, a realization that engendered a sense of personal growth:

> 'It has been the starting point of me realizing who I am.'
>
> Christopher

Having been directly affected by psychological ill-health and accepting that 'it can happen at any point' (Will), many participants reported that they no longer perceived the capitulation of autonomy as being shameful. Indeed, having transcended the confines of 'independent man', Harry remains aware that 'it lurks there' and that 'it can take over' which requires 'being more aware of yourself' (Robert). The experiences these participants encountered appeared to reduce the focus on instrumentality, i.e. actions in the external environment, towards reflexivity, raising questions about prescriptive narratives; restrictive cognitive, emotional and behavioural repertoires that had previously been rehearsed and repeated:

> 'I was 34 when this happened. I was chasing, was moving up the corporate ladder, I'm not bothered about that now, I earn enough money.'
>
> Christopher

Many participants described feeling more complete as an individual, feeling 'like a much better person' (Trevor), gaining an 'absolutely fantastic benefit' (Liam) from their experience. Participants reported learning about facets of themselves that were previously out of reach or disavowed, engendering a more holistic sense of self:

> 'I'm probably a more rounded person than I was before.'
>
> Owen

With hindsight, many participants reported their experiences of psychological crisis and treatment as being transformative, even transcendental:

> 'From the person I was, to the person I am now, you know, we're on two completely different planes.'
>
> Hugh

What was initially experienced as an unexpected and unwelcome crisis, was later perceived to be inevitable, given the restricted life being led, with maladaptive expectations and non-existent coping strategies:

> 'I can divide my life into two halves. I didn't really understand…didn't have the maturity, perspective, tools, skill, awareness or experience to deal with it, just a little lost boy in an adult's body.
>
> Peter

Post-treatment, a more liberated human being appeared to emerge who was allowed to be 'just a bit more realistic' (Nigel). With a sense of enlightenment, participants reported an increased degree of control, reduced feelings of fear, greater confidence and higher levels of empowerment. Indeed, many participants reported a relative increase in personal agency, a more positive outlook and a sense of future opportunity that had created a more enjoyable life:

> 'When I look back at what happened to me……I wouldn't actually change anything that's happened.'
>
> Christopher

8.6.2 New coping strategies

Shakespeare's Shylock exults the universal vulnerability of all humans in the statement, 'If you prick us, do we not bleed?' A reference that applies equally to men and women regarding their respective tolerance and management of psychological distress. The transition from independent and restricted masculinized beings to human being, with all the requisite vulnerabilities and flaws, created a new subjective awareness within participants who became aware and respectful of personal limitations. Armed with insight, greater confidence, improved control and less regard for the judgement of others, participants reported a range of new coping strategies.

Participants reported taking more care of themselves; more inclined to 'listen a lot more to my body' (Ian), better able to 'recognise the warning signs' (Owen) and to ensure the maintenance of a more diverse and balanced life-style. A 'measured approach' (Owen) to life with 'downtime' and 'time for recovery' (Christopher) was supported by increased communication;

'speaking to somebody, a friend….just to air it…to take it off your chest'

Christopher

Alan, reflecting Sabhajit's supportive extended family forums, suggested that a close male network could be beneficial in helping men to process their difficulties and reflected how such networks are frequently missing from contemporary men's lives:

'It's probably the biggest issue, if you don't have a friendship group of males you trust.'

Alan

In summary, participants reported increased monitoring of their psychological health, recognizing and challenging unhelpful thoughts, emotions and behaviours, setting boundaries, relinquishing independence and regaining control.

8.6.3 Improved connection

Having experienced their own difficulties, participants described becoming far more cognisant of the well-being of others, particularly those who were experiencing analogous life-events:

'I'm a lot more aware of what people can go through, it's definitely made me more considerate.'

Owen

Participants reported how their experiences had increased the degree of empathy they now felt and, with 'experience to draw on' (Will), there was an improved subjective quality in inter-personal connections:

'One of my friends was in the military and I explained to him: 'I totally get it.'

Brent

With more insight into mutually experienced emotions, a 'tool of how to connect' (Guy), some participants, like Christopher, described how they now 'savour talking to people' and even offer help and support. Having gained greater insight, some participants spoke in evangelical terms about their new-found proclivity to engage with others, to share the journey and to convey a new hope;

'they can speak to somebody who's actually done it…and then come out the other side.'

Owen

Having modified their sense of self through adjustments in their private, subjective worlds, many participants reported forthright and open disclosure across a range of settings, a potentially potent agent of social change. Open disclosure was most commonplace amongst family and close friends, with one or two participants being fully disclosing to a wider audience:

'I have no problems telling anyone that I've had counselling, even potential new relationship partners, maybe obviously not the first date!'

Keith

A minority of participants even reported disclosing confidently in the, hitherto, hallowed environment of the workplace. These crusading advocates of psychological treatment faced a range of reactions however, ranging from public acceptance and surprise, to an offer to collude to conceal their apparent 'problem', the latter reaction reflecting the continuing widely held negative view of psychological and mental health problems.

'I don't really care if anyone calls me a lunatic, that's their ignorance….But, I do know people will have the attitude that I use to have, absolutely.'

Francis

8.6.4 Selective disclosure: 'They have concrete minds'

Despite the general sense of liberation engendered by the whole process, with some participants feeling able to share their psychological journey with a wider group, the great majority of participants reported restricting the disclosure of either their psychological distress and/or treatment. Participants recognized that their lack of understanding and consequential attitudes, held in the formative stage of their journey, are probably echoed by others who remain in such an unaware state.

'I wouldn't want to tell them because they have concrete minds.'

Mike

The potential for negative social judgement by the uninformed majority created trepidation when

contemplating unfettered disclosure, participant's actual disclosure being consequently rather circumspect:

> 'I don't trust people not to judge….it's almost like military classified data…I think it's a point of gossip...and I know a lot of people think like I did before I had my episode.'
>
> Harry

With insight into how other people may interpret and judge, participants identified places and situations where disclosure would be particularly avoided; 'down the pub' (Alan and Callum) and the workplace. Even those who feel liberated and evangelize the benefits of psychological therapy in a range of settings, sometimes reported feeling restricted in the workplace. Ashley described;

> 'massive fear that I won't get that promotion….because he (boss) might think of me as the weak link in his team and that fascinates me because it undermines nearly everything I say.'
>
> Ashley

Ashley underscores the point that, despite his own enlightenment, he believes that he should consider and adapt his behaviour towards those still holding pejorative attitudes, his collusion potentially retarding the dissemination of positive messages regarding men's relationship with psychological health and treatment. On balance, Liam was unable to perceive any personal benefit to open disclosure, exclaiming that 'there is no point, there's no benefit to me, and there's potential risks. So, I won't and haven't.' Personal risk, perhaps understandably, takes priority over improved social awareness and understanding.

In order to protect themselves from systemic discrimination, some participants reported being very cautious when making more formal declarations of psychological ill-health; Blake describing how he would not acknowledge mental health issues on a job application and Harry, circumventing the system by seeking private treatment; 'so it's not on my records.'

In addition to the workplace, single men were also keen not to prematurely disclose mental health issues to prospective girlfriends when dating, but not necessarily for fear of being judged; Nigel was more concerned that having a therapist may demonstrate a lack of confidentiality or trust in the prospective relationship;

> 'the way women take it is, you have to talk about our relationship to someone else.'
>
> Nigel

If this insight were generalized, then women's negative reaction to their partners seeking counselling would provide a powerful contributory factor towards the inequity in service usage. Women of partners who seek counsel from a therapist, who remain predominantly female, may feel under-mined as another woman provides their partner with support, denigrating stereotypical feminine codes of nurture and succour.

On balance, this sample of apparently enlightened men who had chosen to undertake psychological treatment, remained reluctant to openly disclose, maintaining a degree of vigilance relating to potentially negative outcomes with respect to work and career progression; the ability to earn a living and to attract women.

8.6.5 Subtle masculinity

The social context, through which the participants have journeyed, has not remained constant, an overall social liberalization of masculinity, away from hegemonic stereotypes, being reported by a handful of participants:

> 'I massively believe there is less of an expectation of being manly in a traditional way than there used to be.'
>
> Ashley

Indeed, a few participants were vocal, perceiving men to be far more likely to be comfortable with seeking support when vulnerable than in the 1990's; 'the Neanderthal going around fighting each other and drinking beer' being described as 'old school' (Christopher).

Having sought support, the hegemonic version of the independent and autonomous man had been confronted by all participants, none reporting any threat to their masculinity. Rather, changes in coping behaviour i.e. 'the opportunity to be able to get help in favour of bottling it up' (Hugh), was seen as a practical solution that added to the capacity to cope and thus, strengthening their masculine role;

> 'by asking for help you find yourself more capable of coping...you are more of a man.'
>
> (Peter)

De-bunking the stoic, mytho-poetic warrior-type version of masculinity, precipitated by psychological crisis, allowed for the development of a wider-definition of masculinity, allowing progress towards becoming 'persons'.

In summary, rather than attempting to correct or re-assert previously held concepts of masculinity by re-building the traditional masculine façade of independence (putting the tough exterior back together again), a new, subtler version of masculinity apparently developed, allowing progress towards a more enlightened plane of existence, embracing human frailty and the need for more meaningful emotional connections.

8.6.6 New family rules

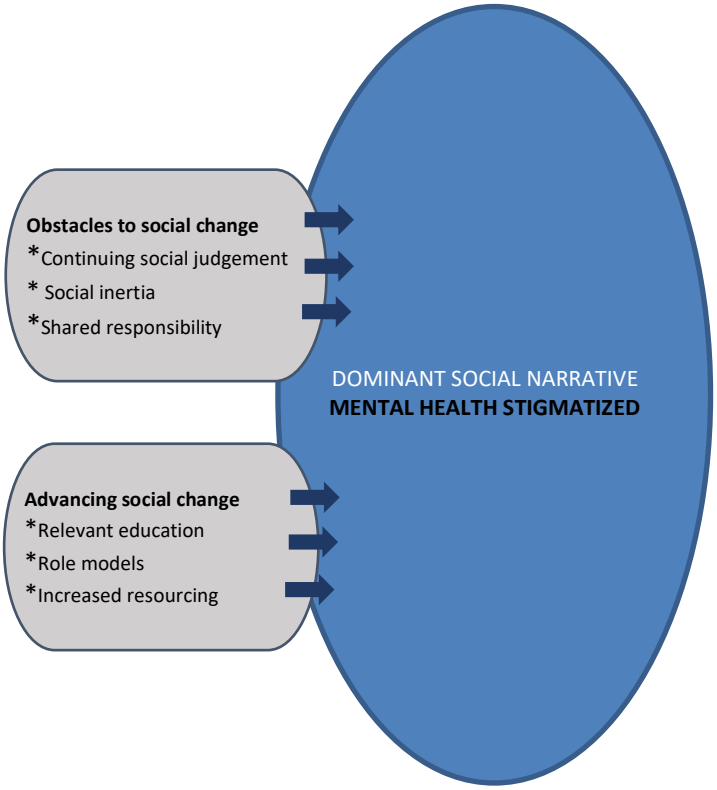
Having experienced the unhelpful nature of restrictive family rules that promulgated secrets, avoidance and distraction during their formative years, those participants with younger children reported how they had changed the emotional environment within their own families to allow for greater disclosure and emotional permissiveness. Indeed, James, Brent, Christopher and Guy, pledged to provide a nurturing and emotionally open environment for their own children:

> 'When my son starts to get upset, I let him go through that, and when he wants to talk about why he felt upset, I let him go through that as well. And I hold him and I comfort him.'
>
> Guy

8.7 Social change: 'If no-one talks about it then no one talks about it'

In addition to the restricted disclosure described above, three further areas emerged as continuing impediments towards a more permissive and tolerant society with respect to men and mental health, continuing social judgement, social inertia and the allocation of responsibility. However, other factors were viewed as being supportive of social change, including relevant education, influential role-models and the potential for increased resourcing for psychological services (Figure 15).

Figure 13: Obstacles and advancements to social change



Interestingly, having been through their own therapeutic journeys, some participants who effused with enthusiasm for the whole psychological project and the transformational journey experienced, remained sensitive to the dominant narrative and contingent social judgement, generally avoiding certain terms deemed to carry negative connotations:

> ‘I still think there is some form of weakness associated with it, which is why I don’t use the term anxiety.’
>
> Christopher

Negative commentary across settings acted to curtail and restrict dialogue on the topic of mental health, quips in the workplace for example, being typical of perceived on-going public critique;

> ‘someone made a joke comment about taking four months off (work) ‘tending to his garden’.’
>
> Francis

If those men with insight fail to broach the topic in public, to raise conscious awareness of mental health, then social change remains relatively stymied as the status quo continues unchallenged:

> ‘And it’s self-fulfilling. If no-one talks about it then no one talks about it.’
>
> Brent

Victor, one of the older participants, suggested that senior generations may not be able to adjust to more liberal views about mental health. Rather, he perceives younger generations to be far more permissive in their attitudes towards mental health. Indeed, Ashley commented that some younger people appear to wear mental health labels as ‘a badge of honour.’ Social change was, therefore, seen by some, as being dependent upon existential attrition, unenlightened and ill-informed views disappearing with the generations that hold such beliefs, a view that creates both short term pessimism and longer-term optimism.

Responsibility, also emerged as a key factor in contributing to the impediment of men’s help-seeking for psychological problems, with some participants describing how unaware men appear to be reliant upon societal structures and systems to help them to recognize their problems and to gain access to the support they require:

> ‘If you don’t recognise you’ve got a problem then you’re never going to seek any help.’
>
> Owen

Inhibitory processes apparently occurred at the level of the individual and within the system; individuals disavowing problems and experiencing trepidation which only enhanced confusion engendered by unclear referral pathways, causing a synergistic inhibitory mechanism;

> 'without the individual meeting the professionals, the state halfway, how can they do anymore? It's got to be a two-way street.'
>
> Francis

Systemic problems were identified as including, poor education on the topic of mental health, difficulties in gaining access to talking therapies, an over-reliance on pharmacological solutions to psychological disorder and ultimately, the lack of appropriate resource-allocation by Government.

> 'they keep handing out… happy pills…instead of trying to promote it (therapy) at all.'
>
> Douglas

Participants cited role-models, editorial material and documentaries, reports in the news, the internet, the rise of mental health charities, EAP helplines and workplace training courses, as contributing to an increased awareness and consideration of mental health issues. The advent of the internet was cited, by a vocal few, as being a significant factor in the development of acceptance of psychological and mental health issues as, with little effort, access to many testimonies, narratives and potential remedies and treatments are possible which serve to normalize and educate men experiencing such distress;

> 'there are places like YouTube where people are terribly honest about what they are feeling. I think for men, you need to see people you look up to getting support.'
>
> Ashley

Indeed, famous role-models, including sporting heroes, were also seen as being highly influential normalizing influences:

> 'I don't think there is anything as useful as some star who's on TV suddenly going "well I've had these issues", and people go "oh they've had these issues, then, anyone else can".'
>
> Daniel

The use of credible role-models as part of formal educational programs in schools was also proposed as a device to move mental health from an abstracted issue that has little relevance, towards a tangible and relevant topic for young men.

In summary, pervasive negative social narratives serve to curtail openness about mental and psychological health matters, maintaining an unhelpful and uninformed critique of the topic. Generational time-periods may be required to facilitate change with no single solution being able to effect appreciable change. Responsibility for the psychological wellbeing of men may need to be accepted and shared between individuals, communities and national social structures.

9 Discussion and implications

9.1 Introduction

The aim of this inductive study was to gather empirically-derived data regarding the experiences of actual men as they encounter psychological problems, seek help and take a journey through psychological treatment to provide an emergent model which offers a cogent and holistic perspective that can be useful to service-providers.

The emergent model demonstrates congruence with some previously hypothesized theories whilst disputing others. The emergent model:

- Corroborates and augments previous theory describing how, for the majority, the socialization of males to conform to restrictive gender-practices potentially maintains psychological vulnerability, including the propensity for suicide.

- Highlights facilitating factors that may increase help-seeking behaviour in men and describes systemic problems that may hinder men's access to psychological treatment.

- Confounds long-held beliefs about how men may prefer to be treated for psychological problems and suggests preferences that may be readily offered.

- Elucidates men's distinct private and public gendered-selves and suggests why transformation in the private sphere may not translate to public reformation.

- Suggests how and where interventions may be facilitated to encourage social change towards gender-equality with respect to the consideration and treatment of psychological problems.

The discussion below aims to relate the model to previous understanding and theory and suggests how sociological and clinical interventions may be augmented and enhanced to improve men's psychological wellbeing by working towards parity for men with respect to accessing psychological services.

9.2 Stoically vulnerable

Having traversed the therapeutic paradigm, participants in this study reported gaining insight and an improved level of connectedness that had been previously disavowed or hidden, a new world-view that, once revealed, became obvious. Although such a transcendence was frequently restricted to the private worlds of participants, increased self-awareness and commensurate freedom of choice contradicts the notion of essential factors as being complicit in the differential manifestation of psychological distress in men, whether they be genetic (Geary, 2010) or ideological in origin (More & Gillette, 1990).

Rather than the 'self' being implicitly performative, as Butler (1988) suggests, the men here appeared to be aware of a personal 'self' that performs perfunctory gendered behaviour to 'fit in' with local situational factors. Indeed, social factors appeared to be very relevant to the maintenance of identity and the avoidance of social judgement both before and after psychological treatment. However, conscious of social pressures to conform to prescribed gender-roles, participants before treatment reported overt collusion in public and yet, continued to unwittingly adhere to gendered scripts in their private spheres; in the adoption of gender-specific coping strategies, for example.

Alerted to the need to attend to a wider range of gender-influenced scripts, the mediating arena for the reappraisal of needs and relevant decision-making was the conscious mind. Cognitive factors therefore remain pertinent to further discussion.

Two main issues emerged as influencing men's relationship with mental health, the pervasive stigmatization of mental illness in society at large (Wilkins & Kemple, 2010) in combination with socialization factors pertaining to the construction of masculinity (Mahalik et al., 2003). Interaction between these two factors appeared to produce a synergetic effect to further distance men from psychological health matters, exacerbating men's vulnerability.

Negative societal attitudes toward mental health, appeared to be exacerbated by dichotomous thinking and attitudes, creating categories of people as sane or insane or psychological problems being defined as trivial or severe. Adopting a binary, rather than a dimensional perspective, potentially works to exclude the majority from acknowledging psychological distress; smaller issues being dismissed as inconsequential and unworthy of special attention, whilst more severe issues are assumed to be catastrophic i.e. going mad, and to be avoided at all cost.

The absence of a dimensional perception of psychological health, with varying degrees of severity, appears to preclude the possibility of seeking help for mild or moderate impairment, the precipitation of a crisis being required before help-seeking behaviour is actioned.

With little or no formal education about mental or psychological health matters being recounted by participants, a knowledge-vacuum is potentially filled with messages gleaned from the media and by a variety of local sources, the most potent of these being family rules, where emotional and psychological matters were generally avoided and where all but the most severe cases of mental illness were denied. With respect to social learning theory (Bandura, 1977; Bandura & Bussey, 2004), children being raised in such emotionally-restricted and secretive family environments, may develop the perception that such restriction is expected and normative.

In addition to modelling emotionally restricted environments, families were also reported to be the cauldron where profound gendered socialization occurred; both male and female family members apparently colluding in the manufacture of men as stoic, independent beings who cope by 'just getting on with it.' Male family members typically modelled such behaviour (Corbett, 2009), whilst female family members issued instructions and edicts in robust support of such behaviour, processes core to the tenets of social learning theory (Bandura, 1977; Bandura & Bussey, 2004).

The few exceptions, where permission to talk about problems was given at an early stage, apparently led to a life-long freedom to seek emotional support without contingent feelings of guilt or embarrassment. Further, having completed therapy and having gained greater insight into the frailty of all people, participants with children (19/30) frequently reported how they actively fostered a more permissive emotional environment with their own children, adopting a parenting style antithetical to that experienced in their own childhood and one designed to protect their sons and daughters from the vulnerability and isolation that emotional restriction can induce and propagate.

The extent of early socialization experiences has been previously elucidated (West & Zimmerman, 1987; Dunn, Bretherton & Munn, 1987), potentially resulting in the formation of gendered schemata that may be conceptualized by both sexes; how boys should be/what boys should do, how girls should be/what girls do (Bem, 1981, 1984; Martin & Halverson, 1981). A significant opportunity may therefore exist, within the early years of life, to reconceptualise emotional permissiveness, through

the development of more adaptive and inclusive gendered-schemata that assimilate emotional and psychological issues as an undifferentiated phenomenon.

In automatically complying with rigid gendered-schemata, a maladaptive form of autonomy may be perpetuated that serves to disavow problems or which limits the potential to disclose or both. Even within this sample of men, representing a sub-group of men who have sought help, a large majority reported previously following traditional gendered scripts in attempting to cope with emotional and psychological distress alone. It may be surmised, therefore, that men in the general population may be even more restricted by such ubiquitous gender-roles.

For a few participants, their previous potential coping repertoires included escape by suicide, reflecting the model of men's coping described by Brownhill et al. (2005). Indeed, it was not until these participants voiced such concerns that friends and family acted to intervene. In the absence of a nurturing and caring social network or in the absence of honest disclosure, such individuals could continue to be vulnerable and act out such extreme coping methods.

9.3 No Push: No Pull

Whilst maintaining autonomy, men experiencing just-tolerable levels of psychological distress were apparently loath to seek external help and the health system appears to be set up to only deal with acute and severe mental health issues. Indeed, relatively apathetic approaches from both the men and the system/psychological establishment was reported, potentially resulting in a scenario with no push and no pull.

If the tenets of traditional masculinity are accepted - autonomy, independence, strength and stoicism – then admitting to incompetence potentially evokes both internal and public shame (Jorm & Wright, 2008; Vogel et al., 2009). With respect to shame brought about by the judgement of others, participants perceived men to require justifiable reasons to seek psychological support, like post-traumatic stress disorder (PTSD), precipitated by manly exploits in war or in undertaking risky adventures. However, seeking help for relationship-issues, for example, could potentially garner public criticism and condemnation, as injunctive norms, prescribing how men should cope, are challenged and potentially breached (Mahalik et al., 2003).

If a restrictive gendered self-schema is well-established, then such breaches in masculine codes may additionally induce private shame which may be a more potent inhibitor to help-seeking than external pressures (Vogel et al., 2007). Thus, both external and internal pressure to maintain a façade of emotional and psychological strength, potentially retards and inhibits help-seeking behaviour, resulting in the escalation of distress towards as a state of crisis, described here as including, violent outbursts, dysfunction in the family and/or workplace and/or suicidal ideation. Such an explanation is supported by previously reported models of masculine coping strategies (Brownhill et al., 2005) and statistics indicating the greater propensity for men to complete suicide while fewer present with traditional depression (ONS, 2011).

In order to breach the tough shell of masculinized autonomy, high levels of dysfunction had to be reached before the men in this sample gained the realization that help was required, issues including work-place performance or parenting capabilities, being cited as providing sufficient cause to seek help (Addis & Mahalik, 2003). In the absence of clear protocols to facilitate men's access to therapy, *ad hoc* environmental and situational factors appeared to act as default triggers.

Previous commentators report a number of important influencing factors in the promotion of men's help-seeking behaviour, including prompts from partners and friends, access to trustworthy services, previous positive experiences of help-seeking and a degree of control in the intervention (Angst & Dobler-Mikola, 1984; Tudiver & Talbot, 1999; Sixsmith & Boneham, 2002; Oliver et al., 2005; Vaswani, 2011).

Participants here reported a number of factors that potentially promoted help-seeking including; modelling of help-seeking behaviour by contemporaries, a normalizing influence (Addis & Mahalik, 2003); targeted communications presented in the media and in the workplace, an indicator that passive communications may be usefully employed in spaces frequented by men (Hopkins & Voaden 2010; Shankar & Roberts, 2017); direct feedback and suggestions from friends, family and managers.

The participants in this study echoed previously described uses of information technology in providing access to information prior to engagement in help-seeking behaviour (Banks, 2001; 2004). Work-place schemes, anonymous help-lines and the internet, were all reportedly used by a minority of participants as exploratory, information-gathering 'points of interest' during a contemplative phase, rather than a main point of access, which predominantly defaulted to the general practitioner.

With respect to the availability of trustworthy services, elderly participants reported that they did not associate their general practitioner with the capacity to support psychological problems, the medical establishment being perceived as remedy for purely physical maladies.

Participants reported a mixture of responses from their general practitioners, from the very good to the very poor, with many participants reporting how persistence was frequently required to ensure their needs were met. The use of scales, questions about suicide and rhetoric affirming that service-provision is only immediately available for the suicidal, only served to enhance feelings of shame for presenting with less than life-threatening problems, reinforcing the dichotomous perception of mental health reported above.

In promulgating the narrative that NHS psychological services are limited and over-stretched, referrers, albeit inadvertently, potentially dismissed and disrespected the efforts of the men presenting in overcoming internal obstacles, including shame, and external obstacles, including public ridicule (Courtenay, 2000). Rather than applauding the men for taking affirmative action to deal with their problems, the system sometimes denigrated the relative severity of presenting issues or offered relatively cheap pharmacological remedies to both placate patients and encourage continuing self-containment. Of this group of participants, who had all undertaken talking therapy, medication was certainly not favoured as a potential treatment option.

Great favour was, however, given to referrers who dealt with participants and their problems in a confident and caring, professional manner. Those with work-place provision, private-medical insurance or sufficient funds, were often directed by their GP to utilize such services, provision that was generally perceived to be superior to those offered by the NHS. In taking a privately funded route, participants also gained a sense of control over the process and, for a few, the additional level of confidentiality was appreciated.

9.4 On becoming a person

Despite previous research demonstrating how traditional treatments for mental health issues are equally effective for women and for men (Jonghe et al, 2001; Quitkin et al., 2002), the majority of commentators of men in therapy reiterate the need for male-friendly treatment options, citing the lack of men-sensitive therapy as an obstacle (Pollack & Levant, 1998; Kennedy, 2001; Englar-Carlso, 2014 Rochlen, 2014; Liddon et al., 2017).

Indeed, therapists are frequently told how they should adopt male-friendly approaches by sharing small talk, using everyday language, avoiding jargon, avoiding lengthy and intellectual theoretical explanations, being action-orientated, avoiding silences and passivity, using metaphors and stories from masculine domains, using humour, using natural gestures and body language, avoiding dimly lit spaces with perpendicular chair positioning, being conservative in confrontations and to share information based on research or experience without giving direct advice (Robertson & Good, 1992; Potash, 1998; Courtenay, 2005; Good & Mintz, 2005; Johnson, 2005; Kiselica, 2005; Pollack, 2005; Robertson, 2005; Englar-Carlson, 2006; Wexler, 2009; Brooks, 2010; Rabinowitz, 2014; McKelly, 2014).

One participant reported a self-initiated extended trip to a wilderness environment (six weeks) to remove themselves from situational factors causing distress, a form of escape that potentially resembles descriptions of Adventure Therapy. However adaptive this particular response was for the participant concerned, being the sole advocate of such a response results in this coping strategy being explained as an individual difference.

However, the thirty participants here did not raise any substantive commentary regarding the nature of therapeutic paradigms undertaken. Rather, participants were unanimous in their desire for face-to-face individual therapy with an interested, genuine, authentic, non-judgemental, empathic, positive therapist with a decent sense of humour. Such qualities resonate with the basic principles and tenets of fundamental humanistic counselling, exalted by Carl Rogers (1951; 1957) and of Motivational Interviewing that advocates acceptance and compassion (Miller & Rollnick, 2012). Indeed, the results of this research echo a minority of previous commentators who acknowledge the generic need of all clients, male or female, to be heard and nurtured (Wexler, 2009).

Opposing experiences, including apathetic and forgetful therapists or those unable to demonstrate sufficient interest, were not appreciated. Overall, the therapeutic relationship was reaffirmed as the key parameter determining participants' subjective appraisals of successful treatment.

Participants here corroborated more recent studies suggesting that men, like women, want someone real to talk to (Berger, et al., 2013; Feo & LeCouteur, 2013; Sierra Hermandez et al., 2014). Individual, face-to-face therapy was practically unanimously perceived as the most desirable form of intervention, in direct opposition to the school of thought that suggests information technology may match men's apparent desire for a less connected, less intimate approach (Benston, 1988; Banks, 2004; Mallen, Vogel & Rochlen, 2005; Reese, Conoley & Brossart, 2006). Similarly, in opposition to previous commentary (Brooks, 1996; Rabinowitz, 2005), group therapy was not perceived as a desirable modality for the initial therapeutic intervention, but possibly a reasonable secondary form of support.

The lack of information available to prospective clients, in regard of all matters psychological, potentially makes men's expeditions into the world of psychological treatment rather precarious, hap-hazard affairs, with a propensity to, rather naively, trust the therapist absolutely. This makes the need for regulation and the maintenance of high professional standards in counselling and psychological therapy an imperative. Indeed, one participant reported consulting a therapist who worked above a barber-shop, practicing an exotic but unknown mode of treatment, his business cards being placed in the barber-shop counter. The participant in question, had no information regarding the therapist's qualifications or status, the paradigm practiced or how complaints may be made.

Other than a clear preference for individual therapy with an interested therapist, no other generic preferences became apparent from this study. Issues relating to the gender of the therapist, the venue and the timings of therapy were defined by individual differences and preferences rather than representing generic masculine proclivities, making the advent of prescriptive man-friendly protocols unnecessary. Rather, as with therapy for all people, seeking out the individual client's preference and accommodating them, may be a more appropriate approach to treat men (DeGeorge et al., 2013).

9.5 Private emancipation: Public circumspection

Aspects of traditional masculinity, so widely described in the literature (Pasick, 1992; Levant, 1999), were indeed, acknowledged and promulgated by this sample of men, who referenced peer-groups in schools, sports, the military and work, as being highly influential in maintaining traditional masculine rules through the performance of injunctive and cohesive norms (Mahalick et al., 2003). However, rather than being subsumed into a generic masculine culture, men here reported, even during the formative stage of their journey, remaining aware of a process whereby they appraised social environments and then performed a perfunctory repertoire of gendered acts in order to maintain contextual conformity with the dominant situational masculine narrative.

Although cognisant of displaying a masculine performance, the subjective perceptions of individuals, during the formative, pre-crisis, stage appeared to omit some issues, the internal narrative remaining restricted. Omissions included the need to attend to psychological wellbeing of self and others, parenting styles and the possibility of seeking external support for psychological problems. Thus, maladaptive coping strategies (e.g. just keep going or alcohol), emotional and psychological illiteracy and isolationist behaviour was maintained.

The advent of a psychological crisis witnessed a perturbance in the maintenance of the status quo, in respect of a standardized gendered performance, forcing a breach that allowed participants to stand outside their constrained worlds. Participants reported how, during their journey, their internal narratives had become modified to include; improved psychological self-awareness, the need to manage psychological distress, being sensitized to the psychological state of others, being more emotionally available to family and friends and to generate an emotionally permissive environment for their children.

The reconceptualization of the masculine identity, now incorporating broader internal narratives, that respect human frailty, resulted in the performance of a wider set of behaviours within private arenas, with family and close friends. The humanized subjective-self, however, was also newly emboldened to adopt a range of more adaptive coping strategies in defence of future crises, providing a degree of liberation from the gender-role strains associated with restrictive gender-practices (O'Neil et al., 1982; Pleck, 1995; Eisler, 1995).

Within public contexts, however, participants reported a continuance of the perfunctory masculine performance, particularly in environments perceived as being relatively masculine, typically workplaces and with sports teams, where competitiveness was perceived as a superordinate imperative. Thus, a subtler form of masculinity became apparent whereby the humanized man selected behaviours from a wider array of potentialities whilst remaining cognisant of expected levels of conformity.

In continuing to publicly collude with dominant masculine narratives, a pernicious cycle is perpetuated, however, that maintains the taboo associated with psychological disorder, effectively prohibiting social change. A feminist perspective may suggest that such feigned masculine performances of strength and autonomy only serve to reaffirm the relative heroic status of men (Lerner, 1986), maintaining their relatively ennobled status and commensurate privilege (Kahn, 2009), a colluding fraternal elite. Indeed, one participant was confused by the apparent disparity between his consciously liberal, gender-free aspirations and his actual masculinized performance in real situations.

The reasons given by the participants involved in this study for maintaining a relatively consistent public performance, maintaining and conveying an expression of strength and autonomy, were exclusively in respect of external factors rather than internal issues, like shame. Significantly, fear of social judgement was the overriding mechanism in maintaining conformity with the dominant masculine narrative, with particular reference to concerns about undermining competitiveness in the workplace and being successful with women.

Interestingly, an antithetical perspective was also muted as a potential mechanism in influencing men's apparent reluctance to seek external support, the female gender-role expectation being indirectly culpable. Men in long-term heterosexual relationships, who seek counsel from a therapist (predominantly another woman), could inadvertently displace their partners from the role of primary nurturer and care-provider, displacement that could convey notions of inadequacy upon the female partner, a situation that does not occur when females seek external support. Thus, to avoid betraying or undermining their partner's prescriptive gender-role, men may avoid seeking support for emotional or psychological matters outside of the relational dyad.

9.6 Leaving the island

John Donne stated that 'no man is an island', an axiom that is supported by this study and one that became apparent to men as they struggled to cope alone, onward until crisis. Yet, before facing a crisis, participants who had not been given specific permission to share emotions, appeared determined to maintain their autonomy, effectively confining themselves to 'island' status. If men are to be reached before they become embroiled in a crisis, they may need to learn how to become more aware of their potential for psychological vulnerability and to practice connecting with others in respect of emotional and psychological matters i.e. as part of a normal behavioural repertoire.

The data suggests a number of potential intervention-points that may ameliorate men's isolationist coping strategies, particularly as responsibility appears to be frequently abrogated to others and to systems. Such sensitive periods/opportunities include; family influences upon the developing child; formal education in schools and colleges to address the apparent knowledge-vacuum regarding emotional and psychological wellbeing; work-environments where training may be facilitated; and with relevant promotional material in areas frequented by men, particularly those men who may be nearing crisis (GP waiting rooms).

Conversely, general practitioners, the psychological and medical establishment, the NHS and the government also have work to do in providing a receptive, informed and appropriately resourced environment to encourage successful early interventions that would potentially reduce some of the antisocial and destructive coping strategies currently adopted by isolated and unenlightened men (Brownhill et al., 2008; ONS, 2004, 2006, 2013).

Parents of all sexes may benefit from understanding the emotional needs of all human children and how a more permissive and open emotional environment may be facilitated, regardless of the gender of the child. Rather than being a formal part of a taught curriculum, schools may consider providing emotionally nurturing environments, with certain personnel who can model emotionally-connected behaviour and who can provide non-judgemental emotional support; pastoral staff and school counsellors perhaps?

Relevant and credible role-models were seen as being the most powerful influences for change, supporting previous theory relating to cohesive norms (Mahalik et al., 2003). Role models have potential importance in two respects, in establishing more liberal and fluid gender-schemata in the young, which may then persist throughout life and in providing men with a permissive and normalized environment to seek help when facing a crisis. Thus, modelling help-seeking behaviour may be more effective as part of a normalized and continuous process. Indeed, princes William and Harry have recently disclosed how their own psychological needs were met following the death of their mother and they have established a mental health charity 'Heads Together'.

The data also suggests that men's early experience of mental health tends to be punctuated by more extreme examples, those severe enough to breach family secrecy or to justify attention in the media. The wider disclosure of a greater breadth of psychological issues may be more beneficial, perhaps within families, communities, in the media and within service-provider's literature, to erode the dichotomous perceptions held and to create a more inclusive conceptualization of psychological disorder.

Terms like 'mental health' and 'breakdown' and diagnoses like 'anxiety' or depression' suggest categoric constructs that men may perceive as being negative and extreme and therefore not relevant to them. Terms and nomenclature that suggest dimensional rather than categoric concepts may be helpful when male patients interact with the medical establishment and when mental health is promoted or discussed in the media.

If a wider range of potential psychological distress was accepted and discussed, with everyone (at times) placed somewhere on a dimensional scale, a less-judgemental narrative may allow friends and relatives to raise issues and to intervene at an earlier stage without such comments and feedback being perceived as being critical or shame-provoking.

Well-meaning editorial, unfortunately often misses the point in affirming the notion that men should have justifiable reasons to require psychological support; action in war, accidents involving speed and risk or the death of parents. Such exemplars potentially only serve to restrict permission for the majority of men to breach their autonomy and to seek help for more mundane and commonplace causes and events; work-related stress and/or relationship issues, the very reasons why the men in this study sought help.

Older men, with potentially relatively fixed gendered-schemata, may be less able to adapt to new ways of relating and help-seeking, making resource-allocation regarding promotional activity more efficiently targeted towards the young, who may have greater capacity to incorporate emotional permissiveness and help-seeking into their cognitive and behavioural repertoires.

The men here placed an emphasis on work. Such a focus on work can add to gender-role strain but can also offer an excellent environment to gain men's attention regarding the importance of psychological wellbeing. Indeed, some participants expected their employer to offer tuition and support to address stress with some managers being able to meet such expectations by offering weekly catch-up meetings with participants struggling with stress and anxiety. Other participants reported less direct support, such matters being deferred to employee-assistance programs that were promoted via posters placed on notice-boards, services that were noticed and used by some participants.

The public health system is perceived to be largely unresponsive to the psychological needs of men, participants recognizing that limited resource may not stretch to encompass adequate provision for them, potentially reaffirming a belief that they should be able to cope on their own. Therefore, if society is to benefit from a reduction in men's maladaptive coping strategies, including substance-dependency and/or violence, the system will need to improve provision. There is no benefit in changing attitudes if there are no treatment options, other than medication, available.

If suitable service-provision were to be developed, then some of the observations participants made here would encourage a number of modifications. Firstly, clear messages in venues like doctor's waiting rooms and workplaces about how 'normal' men may sometimes have psychological problems that can be supported i.e. an affirming rather than a deficit model of help-seeking (Kilmartin, 2010). General practitioners would be sufficiently trained to demonstrate an understanding that men may be as equally appreciative of psychological therapy and that standardized psychological treatments are just as appropriate for males and females.

Psychological treatments offered, whatever paradigm employed, would place the therapeutic relationship at the heart of the intervention, with therapists providing an overview of the structure of the intervention without necessarily delving into psychological theory. More remote interventions are not indicated.

In summary, whether the levels of psychological distress experienced by men and women are equivalent, remains untested. However, the differential under-utilization of primary-care level psychological services by men does not appear to be accounted for by any essential factors that prevent men from disclosing and communicating emotions. Indeed, men here report a clear preference for relational therapists who demonstrate care, warmth and genuineness.

Rather than lacking the innate skill or capacity to be emotionally connected beings, it would appear that men face socially-constructed barriers that need to be overcome before the flawed and emotionally vulnerable human-self, is allowed to be exposed and made available for support.

Social obstacles that restrict men's disclosure regarding psychological health, appear to be derived from an interplay between the wider social stigma related to mental health and traditional masculine narratives that extol strength, autonomy and stoicism as core masculine virtues. Such narratives appear to be forged in the early years of gender-formation, often within the family, and reiterated in various masculine social environments.

The resultant masculine performance disavows adaptive coping strategies, including discussion, and perpetuates the continuance of isolationism, a mechanism that makes men vulnerable. A crisis is frequently required to breach the pervasive strictures of the masculine code.

Through engagement in psychological therapy, men report gaining a degree of permissiveness, a transformational process that facilitates a more open and rewarding level of interaction and some private emancipation which allows more adaptive coping strategies to be adopted. However, remaining sensitive to wider social perceptions of mental health and continuing masculine norms, men report maintaining a level of collusion with traditional gender-roles to maintain credibility through conformity, particularly in the workplace.

10 Outcomes and recommendations

A set of outcomes and recommendations have been extruded from the Humpty Dumpty model to provide discrete and operational proposals for change.

10.1 Key outcomes

- Psychological ill-health is largely disavowed within many levels of society, including within families, male psychological illness being particularly denied. Men, therefore, may have relatively impoverished knowledge about psychological matters.

- Limited understanding and knowledge tends to result in the dichotomous categorization of mental and psychological health-issues which results in their perceived irrelevancy until a crisis ensues.

- The disproportionate reporting of more extreme psychological cases in the media, and the association of the manifestation of men's psychological vulnerability under extreme circumstances, like war-service, potentially serves to maintain men's reluctance to seek help for more commonplace issues.

- The need to attend to psychological health does not appear in the contemporary masculine gender-role. Therefore, men try to cope autonomously until crisis is reached.

- When permission is given in childhood to embrace support for emotional issues, help-seeking behaviour may persist into adulthood. Men who have experienced emotional emancipation report a desire to raise their children in an emotionally permissive environment.

- Relevant and credible role-models, including parents, managers and the famous, remain powerful influences with respect to the development of formative and continuing masculine gender-roles and narratives.

- Workplace and relationship issues are largely responsible for causing psychological distress in men.

- A degree of receptiveness towards posters and role-modelling, relating to help-seeking behaviour, may become evident as crisis ensues.

- Perceptions that psychological services are under-resourced and over-stretched, and the use of medication as a default treatment option, potentially act as barriers to men's engagement in psychological therapies. Men without access to non-public service-provision may be at considerably greater risk.

- Men may prefer individual, face-to-face, relational therapy modalities; the therapeutic relationship being key to the perceived value and effectiveness of psychological therapy.

- Other than the development of a robust therapeutic alliance, no further generic preferences relating to therapeutic intervention were reported, individual differences accounting for the likes and dislikes of specific interventions.

- Men tend to place trust in the therapist as the expert and have little understanding of, or interest in, the different types of psychotherapeutic practitioner or of the theory underpinning treatment protocols.

- Men tend to maintain a performance of autonomy and stoicism in public, even after experiencing private emancipation regarding emotional connectedness, reducing the transmission of new learning and potentially maintaining gender-strain syndromes.

10.2 Recommendations

In attempting to bring operational relevancy to this research project, the recommendations below are aimed at a wide audience, including those with responsibility for social and healthcare policy and social welfare. Many of the recommendation inevitably remain broad, reflecting the stance taken towards the project i.e. encompassing the entire participant-journey. Further research in specific areas, as discussed below, would be required to generate further resolution to each of the areas highlighted.

- With respect to emotional and psychological matters, the development of more permissive gender-roles would be helpful to facilitate parity in help-seeking behaviour, regardless of sex or gender. Parents, professionals who deal with boys and media that is directed at children and adolescents, may have key roles to play in altering unhelpful conceptualizations of autonomy and independence with relation to the developing masculine behavioural repertoire.

- In order to address the stark absence of knowledge about psychological health and wellbeing reported by men, formal, continual education programs could be introduced for young people and for adults. Such psychoeducational programs could include information regarding the monitoring of psychological health, the range of potentially beneficial coping strategies available, what external support exists and how such help may be accessed. Appropriate education may render ignorance an obsolete factor in the development of a psychologically healthier population.

- Unrepresentative, extreme exemplars of male-psychopathology, like war-related post-traumatic stress disorder, should be positioned as part of a plethora of potential antecedents of psychological distress, rather than being portrayed as a typical masculine problem. Commonplace causes of psychological distress could be promoted more widely, particularly workplace or relationship-related problems. The media, including public health information sites, may be significant in introducing and maintaining a more balanced and realistic view of the psychological health of men.

- Clear and accurate information, regarding the dimensional nature of psychological health and wellbeing, could be promoted as being a main-stream phenomenon; normative issues that affect all, which require attention and, sometimes, support.

- The use of categoric labels and medical nomenclature, relating to abnormality and psychopathology, may be counter-productive in attempting to provide inclusive services to men. Health professionals and services may consider how the imposition of clinical/medical terms may affect the self-worth of potential and actual service-users.

- As messages suggesting and offering psychological support may be more readily accepted when men are approaching a crisis, then help-seeking promotional material may be more effective if targeted at men experiencing significant changes in their work or relationship status. Such messages may be linked to change processes, like organizational restructures and redundancies, in annual appraisals, with divorce-lawyers' literature, in doctors' surgeries and on social media.

- As feedback from friends and family is important in facilitating help-seeking behaviour, then wives, partners, relatives, managers and friends should be advised to remain vigilant of men's psychological health. Promotional material may therefore be directed towards a wider audience as indirect channels may be more productive in reaching vulnerable men.

- A more adaptive narrative towards help-seeking could be developed which ascribes strength and robustness to men who act to overcome problems. Role-models, perceived as being successful with respect to the traditional masculine code (entrepreneurs and sportsmen), may be imbued with the credibility necessary to effect such change.

- Psychological services that only intervene when an extreme crisis is apparent, like imminent suicide, potentially alienates men with lesser problems, reducing their willingness to seek psychological support. Timely public sector psychological support, that validates and treats mild and moderate dysfunction, would potentially reduce the need for expenditure relating to crisis-intervention.

- Referrers, particularly general practitioners, should consider that men may generally avoid presenting until they have reached a critical tipping point and so, should pay respect to men's admission of psychological distress and offer equal access to whatever psychological services are available.

- As men report little knowledge of psychological services and imbue therapists with great trust, improved education, regarding the different types of therapists and therapies should be a priority. Professional bodies and regulatory organizations may have a role to play in communicating the parameters of each type of practitioner (psychiatrist, psychologist, CBT practitioner, counsellor), to the general population, ensuring that men are included in the target audience.

- In parallel with improving men's knowledge, inclusive regulation for all psychotherapeutic and counselling practitioners may provide a safeguard to protect vulnerable men. Systemic protection of the vulnerable may also be increased by ensuring that referrers and gatekeepers receive training about the different types of therapists and psychological treatment available.

- Special, remote-access, action-orientated, male-orientated treatment modalities may not add any additional benefit to men presenting with psychological difficulties. As resources become available, increasing access to good quality, individual, generic psychological treatments and counselling should take priority to best serve the needs of male clients.

11 Limitations

11.1 Introduction

This research project represents a limited and inevitably flawed attempt to understand the experiences and attitudes of actual men who have encountered psychological distress and who have taken action to address their problems by engaging with a psychological treatment. The following areas are recognized as limiting both the validity and generalizability of the research project; scope; recruitment methodology; demographic effects and the unrepresentativeness of the sample; researcher-participant interaction effects and researcher bias.

11.2 Scope

The researcher was responsible for the funding and execution of the project in its entirety, working full-time to provide sufficient resource. However, the project was ambitious in its attempt to map the entire participant-journey; aiming to explore how men perceived psychological issues, experienced crisis, sought help, experienced psychological treatment and how they had been affected by their experiences.

Undertaking a qualitative approach and generating data via individual interviews, a trade-off between breadth and depth of the research topic was inherent. Taking an in-depth approach to any particular area of the participant-journey was not considered to be prudent at the time the research was proposed as, without an over-arching framework to act as a guide, the relative importance of specific areas of the topic could not be fully assessed. The project therefore sought to gain a more holistic appreciation of the male experience of encountering and dealing with psychological problems.

With the framework in place, however, it has become apparent that the scope of the research was possibly too ambitious, and a more targeted aim may have provided for a more useful output; for example, a study to investigate contemporary male coping strategies or how men engage or do not engage in primary care psychological services.

11.3 Recruitment

To maintain ethical propriety, and indeed, to comply with the requirements of the ethical committee responsible for certifying the research, a voluntary sample was sought, participants being invited to respond to advertisements displayed in public spaces. It was anticipated that such a recruitment methodology may produce additional bias as the theoretical sample, the whole range of men who have experienced psychological therapy, is reduced to those willing and prepared to give up their time to share their experiences in a research interview.

It may be surmised that such a sub-group potentially comprises those participants who have an interest in the topic, have had a particularly good or particularly bad experience, or those with time on their hands. The study is therefore potentially distorted by non-participation bias (Haapea et al., 2007). Representing a relatively niche group of ex-clients, the potential for the output to be generalized beyond this participant group is, consequentially, reduced.

11.4 Demographics and representativeness.

As recruitment was conducted on a purely voluntary basis, the widest distribution of the advert was afforded with the use of social media. The demographic of the participants who responded was diverse in some respects whilst being very restricted in others. Disappointingly, the demographic with respect to sexual orientation, gender-identity and ethnicity was almost without variance with all 30 participants identifying as being heterosexual and with only one non-Caucasian participant.

A number of assumptions could be drawn from such a voluntary sample. Participants may simply reflect the researcher and the local professional network and/or the sample could suggest that non-heterosexual and non-Caucasian men may be either less willing to disclose their experiences or may have better coping strategies, making them less likely to require psychological support. People not included in the sample may find emotional and psychological support from partners, families, or religious organizations, for example. Indeed, the one Indian participant explained how he would regularly meet with extended family members, particularly cousins, to talk through practical and emotional difficulties.

11.5 Researcher effects

In acknowledging the only way to sample an existent world is through the subjective human lens, by definition, a researcher becomes an instrument of bias. Areas of particular concern remain the effects of *a priori* knowledge, pervasive social narratives, idiosyncratic interpretations, researcher-participant interaction effects (Salazar, 1990; Davis et al., 2009) and participant bias (Goodwin, 2010).

With the adoption of a critical realist ontology, *a priori* knowledge can help to make sense and give meaning to emergent data. However, the possibility that emergent material will be interpreted through the researcher's personal filter, encompassing formal knowledge and personal experience, means that the output is inevitably one version of a theme. If other workers and inter-raters had been involved in the analysis and development of the model, then a more reliable representation of the data may have been afforded.

The nature of the voluntary sample potentially adds to the potential scale of participant-related bias as, having been informed about the topic and electing to contribute, participants may therefore attempt to be 'good subjects' (Orne, 1962), adhering to the perceived demand-characteristics of the research. Indeed, participants described how, throughout their lives, they had always assessed their social setting and then performed perfunctorily masculine behaviours to conform to normative expectations. Thus, the researcher, performing the role of researcher and the participants faithfully playing the role of participant, potentially creates a space where scripts may be acted out, each colluding with the expected performance. Within this safe dyad, dominant social narratives may have a place to breath. The adoption of a discussion guide may ameliorate the excesses of such a pairing as a standardised format is imposed on each interview.

In summary, the research conducted here may have been improved with the targeting of specific areas of men's difficulties, like men's existing coping strategies, the inclusion of a wider range of participants, particularly with respect to sexual orientation and ethnicity and with the benefit of a team of interviewers and analysts to reduce bias introduced by any one researcher.

12 Further Research

This project could be construed as a starting point for future research rather than an endpoint as it represents an initial overview of the therapeutic journey that some men undertake. However, in order to address one of the considerations raised in the limitations (above), the model produced could be presented to the original participants, or to new participants, for their input and consideration. Such a refined version of the model may be more representative and more generalizable.

In addition, two areas for further research are suggested; analogous studies designed to explore the therapeutic journeys of a greater diversity of men and women and more focused research, examining the nuance of various stages of the therapeutic journey, for example, the current coping strategies of contemporary men, and the mechanisms and processes that lead men into or away from psychological services.

Analogous studies, involving a broader diversity of participants, could explore which generic themes apply to all people and which parts of the journey have specific nuances for particular subgroups. This may allow service-providers to employ more sophisticated and targeted service-provision for each subgroup, to assuage bias in the service-usage currently witnessed. Men and women of differing ethnicities, sexual-orientations, trans-genders, specific age-groups, geographical locations, disabilities and presenting with specific psychological conditions (e.g. depression or OCD), could all be the subject further investigation.

In addition to exploring similar journeys of other groups, specific areas of interest were highlighted by this study. Improving the understanding of how men currently cope and/or how men engage or do not engage with psychological services, for example, could be a more targeted area for further study. More specific studies might include longitudinal studies to determining the effectiveness of educational interventions on men's psychological wellbeing and help-seeking behaviour, or of specific training for GP's in the identification of psychological problems in men. However, the over-riding issue is one of resource. If primary care mental health services are not sufficiently resourced, then the capacity will not be there to treat additional male patients. Fiscal research, to establish the cost implications and potential long-term savings to society of early interventions for men may therefore be required.

13. Achievement of the Aims

The aim of this study was to provide an overview of how actual men experience psychological problems and how they seek and experience professional support. The methodological aim was to generate a model or theory that 'fits or works' with respect to the data collected, 'that accounts for much of the relevant behaviour' (Glaser & Strauss, 1967, p, 30).

The Humpty Dumpty model produced represents an initial rather than a definitive response to the aim, limited by the parameters of the study, particularly the nature of the ethical recruitment process, the range of the sample and the lone-researcher paradigm which engenders bias. The model confirms some previously held assumptions and yet challenges others, demonstrating some value towards contributing to the understanding of the treatment of men's psychological distress.

The gender-inequity in primary care mental health services would appear to be due to a range of factors rather than any one over-riding issue; family rules, early experiences of mental health, male gender-roles, emotionally distant role-models, historic conceptualizations of mental health, a lack of education about psychological health, mental health as a taboo topic, competitiveness, poor coping strategies, a fear of social judgement, the assumption that only severe conditions require treatment and the perceived unavailability of services. The culmination of such influences is that men may be largely unaware that they are experiencing psychological problems, until functionality is affected, and a crisis ensues. Once this occurs and treatment is sought, then the men in this study reported that standard, caring psychological support was valued, making existing services both appropriate and fit for purpose.

In respect of usefulness, it is hoped that the conceptual model, describing men's relationship with psychological treatment, in combination with the outcomes and recommendations derived, may provide policy-makers and healthcare providers with accessible and practical insights to support more informed decision-making regarding the psychological treatment of men.

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Index of Appendices

Appendix i: Recruitment Advertisement

CITY UNIVERSITY LONDON

Department of Psychology
City University London

PARTICIPANTS NEEDED FOR RESEARCH IN COUNSELLING AND PSYCHOTHERAPY

We are looking for volunteers to take part in a study on
***men**'s experience of counselling or psychotherapy.*

You would be asked to participate in an interview with the researcher to explore your experiences.

Participants will be male, aged 18-80, who have completed a counselling or psychotherapeutic treatment of no more than 20 sessions within the last five years.
Your participation would involve one interview which will last for approximately 60 minutes. Minor travel expenses will be available.

For more information about this study, or to take part, please contact;

Andrew White
(Doctoral Research Student at City University London)
[redacted]
or
[redacted]

This study has been reviewed by, and received ethics clearance through the *Psychology* Research Ethics Committee, City University London PSYETH (R/L) 15/16 136

If you would like to complain about any aspect of the study, please contact the Secretary to the University's Senate Research Ethics Committee on [redacted]

Appendix ii: Information for Participants

Men's experiences of psychotherapy and counselling

We would like to invite you to take part in a research study. Before you decide whether you would like to take part it is important that you understand why the research is being done and what it would involve for you. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information.

- **What is the purpose of the study?**

The World Health Organization recognizes that men and women experience equal amounts of psychological and emotional distress. However, men engage with psychological therapies only half as frequently as women.

By asking men about their experiences of counselling and psychotherapy, it is hoped that a better understanding can be gained about the appropriateness of the services provided for men.

This research project is the topic of a PhD. The data collected will be used to develop theory that will be reported in a written thesis and may form the basis of published academic articles.

- **Why have I been invited?**

The research seeks the opinions and experiences of adult men who have completed a contract of counselling or psychotherapy within the last five years.

You can be included in the study if you:

- Identify as being male.
- Are aged between18-80.
- Have completed a course of talking therapy within the last five years.
- Are not currently receiving treatment for a psychological problem.
- Are not at risk – that is, you are not considering harming yourself or others and are not substance-dependent.

- **Do I have to take part?**

Participation in the project is entirely voluntary. You can withdraw your-self or your data from the process until three months after the interview when the data collected may be incorporated into a written thesis. If you choose to withdraw, you will not be penalized or disadvantaged in any way.

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. If you decide to take part you are still free to withdraw your data up to three months after the interview without giving a reason.

- **What will happen if I take part?**

  You will be asked to participate in one semi-structured interview that may last up to an hour. The interview will be audio-taped. In addition, some demographic data will also be requested which will be only identified by a number. Participants will also be asked to provide details of their GP.

  Only the researcher will have access to information that can identify data, including demographic data, with any participant. The interviews will take place in a private meeting room in medical centres or equivalent public facilities.

  A qualitative research design is being used to generate theory about the therapeutic experiences of men. **The study will not involve any discussion about the psychological problems for which you originally sought help and no psychological treatment or advice will be offered.**

  If the researcher is concerned about your health or safety, the researcher will discuss this with you and refer you to your GP or other appropriate services.

  Expenses

  Travel expenses to a maximum of £10 can be claimed to cover the cost of parking, petrol and local public transport etc. Please present any receipts or costs at the beginning of the interview so that all housekeeping matters can be concluded before the data collection process starts.

  What do I have to do?

  You will be asked to describe your journey through the psychological treatment you have experienced. The following topics provide a clearer idea of the areas that will be explored; your impressions and opinions of psychological therapy before your treatment started; how you recognized there was a problem; the referral pathway you experienced; any difficulties, impediments or positive experiences you encountered; who you have disclosed your experience to since the treatment ended; what you would recommend to other men in distress.

  What are the possible disadvantages and risks of taking part?

  It is possible that talking about the time you received psychological treatment may bring up some of the feelings and thoughts you were dealing with at the time. If you think that such feelings and thoughts would be too upsetting, then it is prudent not to participate. If upsetting thoughts or feelings unexpectedly arise during the interview, then you can ask to stop the interview and to leave.

- **What are the possible benefits of taking part?**

- An opportunity to reflect on your therapeutic experience can be of benefit in reminding you to monitor your wellbeing into the future and to apply the techniques learned in therapy. The data you provide will be used to understand how psychotherapy and counselling may be made more relevant to a wider range of men with the aim of improving the lives of individual men, their families and the wider community.

- **What will happen when the research study stops?**

  Information about your identity will be kept separately from the data collected which will be made anonymous with the use of pseudonyms. If the research stops, then all material that can identify a participant will be destroyed along with the original audio files and any verbatim transcripts. If the research is completed but there is no published works, then all data will be destroyed after one year. However, if academic articles are published, the audio files and transcripts will be stored securely for five years before being destroyed (in accordance with the standards set out by the British Psychological Society).

- **Will my taking part in the study be kept confidential?**

  Only the researcher will have access to data collected before it is made anonymous. This data and audio files will be kept in a locked cabinet or password protected independent electronic storage device until they are destroyed by shredding and or other physical means. Personal information and identifying data will be stored separately and will not be shared with any other party.

- **What will happen to the results of the research study?**

  The results of the study will be written into a doctoral thesis that will be examined by academics. The study may also be reported in academic journals. The anonymity of participants and their data will be maintained throughout.

  If participants wish to view any journal articles that arise from the research then they are requested to provide an email or postal address and to tick the box on the consent form.

- **What will happen if I don't want to carry on with the study?**

  Participants are reminded that they are free to withdraw themselves or their data from the study up to three months after the interview without prejudice and without any negative consequences.

- **What if there is a problem?**

  If you have any problems, concerns or questions about this study, you should ask to speak to the researcher. If you remain unhappy and wish to complain formally, you can do this through the University complaints procedure. To complain about the study, you need to phone 020 7040 3040. You can then ask to speak to the Secretary to Senate Research Ethics Committee and inform them that the name of the project is: Men's experiences of psychotherapy and counselling.

  You could also write to the Secretary at:
  [redacted]
  Secretary to Senate Research Ethics Committee
  Research Office, E214
  City University London
  Northampton Square
  London
  EC1V 0HB
  Email: [redacted]

- City University London holds insurance policies which apply to this study. If you feel you have been harmed or injured by taking part in this study you may be eligible to claim compensation. This does not affect your legal rights to seek compensation. If you are harmed due to someone's negligence, then you may have grounds for legal action.

- **Who has reviewed the study?**

  This study has been approved by City University London *Psychology* Research Ethics Committee, PSYETH (R/L) 15/16 136

- **Further information and contact details**

  The researcher is Andrew White, a registered Counselling Psychologist and Doctoral Research Student at City University London: [redacted]

  If you wish to talk to someone other than the researcher about this study then please contact [redacted]

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

Appendix iii: Ethical Approval

Psychology Research Ethics Committee
School of Arts and Social Sciences
City University London
London EC1R 0JD

11th December 2015

Dear Andrew White, Paula Corcoran and [redacted]

Reference: PSYETH (R/L) 15/16 136
Project title: Men's experience of counselling and psychotherapy
:
I am writing to confirm that the research proposal detailed above has been granted approval by the City University London Psychology Department Research Ethics Committee.

Period of approval
Approval is valid for a period of three years from the date of this letter. If data collection runs beyond this period you will need to apply for an extension using the Amendments Form.

Project amendments
You will also need to submit an Amendments Form if you want to make any of the following changes to your research:

(a) Recruit a new category of participants
(b) Change, or add to, the research method employed
(c) Collect additional types of data
(d) Change the researchers involved in the project

Adverse events
You will need to submit an Adverse Events Form, copied to the Secretary of the Senate Research Ethics Committee [redacted], in the event of any of the following:

(a) Adverse events
(b) Breaches of confidentiality
(c) Safeguarding issues relating to children and vulnerable adults

(d) Incidents that affect the personal safety of a participant or researcher

Issues (a) and (b) should be reported as soon as possible and no later than 5 days after the event. Issues (c) and (d) should be reported immediately. Where appropriate the researcher should also report adverse events to other relevant institutions such as the police or social services.

Should you have any further queries then please do not hesitate to get in touch.

Kind regards

[redacted]

Appendix iv: Risk Assessment Form

Psychology Department Risk Assessment Form

Please note that it is the responsibility of the PI or supervisor to ensure that risks have been assessed appropriately.

Date of assessment: 10 December 2015

Assessor(s): [redacted]

Andrew White (Student)

Activity: Meeting participants off-site

The risk assessment will be implemented before each interview.

Hazard	**Type of injury or harm**	**People affected and any specific considerations**	**Current Control Measures already in place**	**Risk level** Med High Low	**Further Control Measures required**	**Implementation date & Person responsible**	**Completed**
General hazards of utilising a public health centre.	No identifiable specific risk.		The researcher is meeting participants in 3 Medical Centres (see below) which all have stringent health and safety policies in place. The researcher will adhere to all Health and Safety measures as advised by each individual Centre. www.dapdune.co.uk/practice-policies.aspx www.greystonesurgery.nhs.uk/info.aspx(QM)p20 www.southwatersurgery.co.uk/legal-issues.php	Low	The researcher and supervisor will liaise before and after interview sessions. The researcher will text the supervisor on the days he is doing interviews, with details of the locations and times. The researcher will text the supervisor when the interviews are complete on each particular date.	The risk assessment will be implemented from the date of the first interview sessions. Supervisor and Researcher have joint responsibility.	

Appendix v: Informed Consent Form

Title of Study: **Men's experience of counselling and psychotherapy**

Ethics approval code: PSYETH (R/L) 15/16 136

Please initial box

1.	I agree to take part in the above City University London research project. I have had the project explained to me, and I have read the participant information sheet, which I may keep for my records. I understand this will involve being interviewed by the researcher and allowing the interview to be audiotaped. Some demographic data will also be collected along with the name of my GP and recorded on a sheet that will be identified by a number.	
2.	This information will be held and processed for the following purpose: in developing theory and understanding about how men experience psychological treatment which will be reported in a written thesis as well as in published articles. I understand that any information I provide is confidential, and that no information that could lead to the identification of any individual will be disclosed in any reports on the project, or to any other party. No identifiable personal data will be published. The identifiable data will not be shared with any other person or organisation.	
3.	I understand that my participation is voluntary, that I can choose not to participate in part or all of the project, and that I can withdraw my data up to three months after the interview without being penalized or disadvantaged in any way.	
4.	I agree to City University London recording and processing this information about me. I understand that this information will be used only for the purpose set out in this statement and my consent is conditional on the University complying with its duties and obligations under the Data Protection Act 1998.	
5.	I agree to take part in the above study.	
6.	I request a summary of the research findings and any published articles resulting from the research. Please provide an email address or postal address below if you wish to receive a copy of the findings or published articles. Research findings or articles may be sent to……	

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of Researcher	Signature	Date

(Andrew White Doctoral Research Student at City University London) When completed, 1 copy for participant; 1 copy for researcher file.

Appendix vi: Debrief Information Form

CITY UNIVERSITY LONDON

Men's experience of counselling and psychotherapy

DEBRIEF INFORMATION

Thank you for taking part in this study. Now that it's finished, we'd like to explain the rationale behind the work.

Although equality legislation aims to encourage similar service usage and treatment outcomes for men and women, primary care psychological services consistently report that twice as many women use their services. Some men still tend to resort to negative coping strategies. Although many theorists have speculated why men may not access supportive psychological treatments as frequently as women, there is very little understanding of how men view and experience psychological services.

By seeking the experiences of men who have used such services, it is hoped that insight can be gained into what may be causing the consistent disparity in service-usage and treatment. If recommendations can be made to allow more men to access psychological treatment, then more socially harmful coping strategies may be avoided.

If participation in the research has evoked problems, then please tell the researcher and seek support from your general practitioner.

We hope you found the study interesting. If you have any other questions, please do not hesitate to contact us at the following:

*Andrew White (*Doctoral Research Student at City University London)
[redacted]

[redacted]

Ethics approval code: PSYETH (R/L) 15/16 136

Thank you for your participation in this study.

Appendix vii: Biographical Data Form

Participant number

Age

Type and duration of treatment

Ethnicity or cultural identification

Employment status

Sexual orientation

Relationship status

Appendix viii: Discussion Guides

Initial discussion guide: A

Prior knowledge and expectations.

- What was your attitude towards mental health and psychological treatments before you experienced any difficulties?
- What influences informed this understanding?
- Have your views changed over time?

The path to psychological treatment

- How did you recognize you were unwell?
- Did you discuss your health with anyone?
- Did anyone encourage you to seek help?
- What did you do to seek help?
- Describe the route you took from feeling unwell to meeting the therapist?

The psychological treatment undertaken

- What was it like going along to therapy?
- Was it what you expected?
- What type of therapy did you undertake?
- What was the therapist like?
- Do you feel that you gained benefit – what helped?

Attitudes to psychological treatment and disclosure

- Have you told anyone about your treatment?
- Are there any reasons why you would or would not share your experiences?
- What advice or recommendations would you give to distressed men and women?

The Future

- What would improve your knowledge or understanding of psychological health and wellbeing?
- Is society changing, if so, how?

Modified discussion guide: B

Prior knowledge and expectations.

- What was your attitude towards mental health and psychological treatments before you experienced any difficulties?
- What influences informed this understanding?
- How did you used to cope?

The path to psychological treatment

- How did you recognize you were unwell?
- Did you discuss your health with anyone?
- Did anyone encourage you to seek help?
- What did you do to seek help?
- Describe the route you took from feeling unwell to meeting the therapist?

The psychological treatment undertaken

- What was it like going along to therapy?
- Was it what you expected?
- What type of therapy did you undertake?
- What was the therapist like?
- Do you feel that you gained benefit – what helped?

Attitudes to psychological treatment and disclosure

- Do you disclose about the treatment and are there any limits?
- Are there any reasons why you would or would not share your experiences?
- What advice or recommendations would you give to distressed men and women?
- Has the experience had any effect on your masculine identity?

The Future

- What would improve your knowledge or understanding of psychological health and wellbeing?
- Is society changing, if so how?

Modified discussion guide: C

Prior knowledge and expectations.

- What was your attitude towards mental health and psychological treatments before you experienced any difficulties?
- What influences informed this understanding?
- How did you used to cope?
- Did being male have any impact on your experiences and attitudes?

The path to psychological treatment

- How did you recognize you were unwell?
- Did you discuss your health with anyone?
- Did anyone encourage you to seek help?
- What did you do to seek help?
- Describe the route you took from feeling unwell to meeting the therapist?

The psychological treatment undertaken

- What was it like going along to therapy?
- Was it what you expected?
- What type of therapy did you undertake?
- What was the therapist like?
- Do you feel that you gained benefit – what helped?

Attitudes to psychological treatment and disclosure

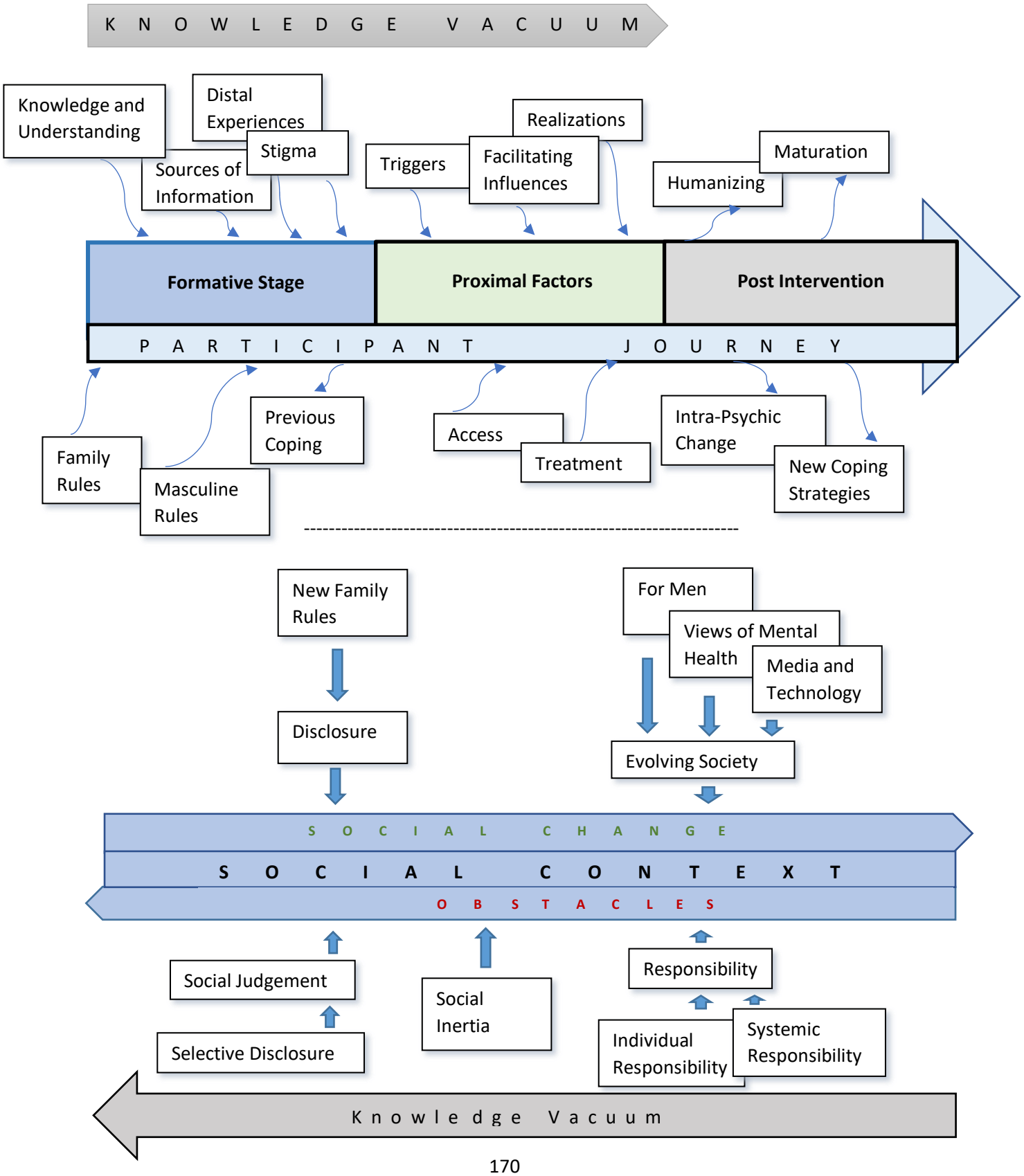
- Do you disclose about the treatment and are there any limits?
- Are there any reasons why you would or would not share your experiences?
- What advice or recommendations would you give to distressed men and women?
- Has the experience had any effect on your masculine identity?

The Future

- What would improve your knowledge or understanding of psychological health and wellbeing?
- What do you do differently since your experience, how do you cope now?
- Is society changing, if so how?

Appendix ix: Preliminary relationship between emergent axes and categories

Overview of the emergent data demonstrating the four emergent axes; The Formative Stage; Proximal Factors; Post Intervention; Social context.



'The Formative stage': A diagram to illustrate the initial organization of emergent categories relating the development of pre-crisis attitudes, concepts and behaviour.

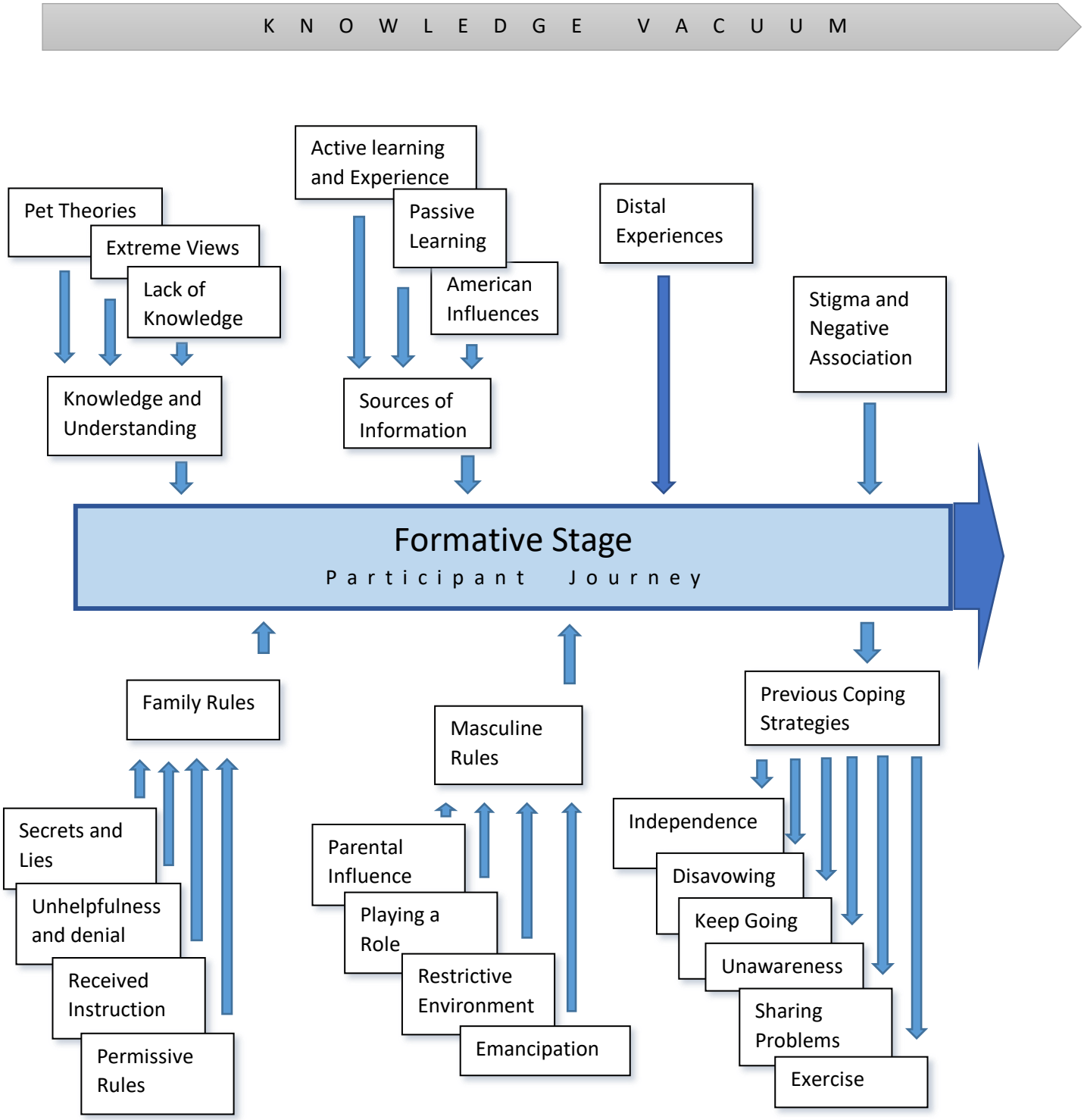


Diagram to represent the initial categories associated with the stage 'Proximal Factors'.

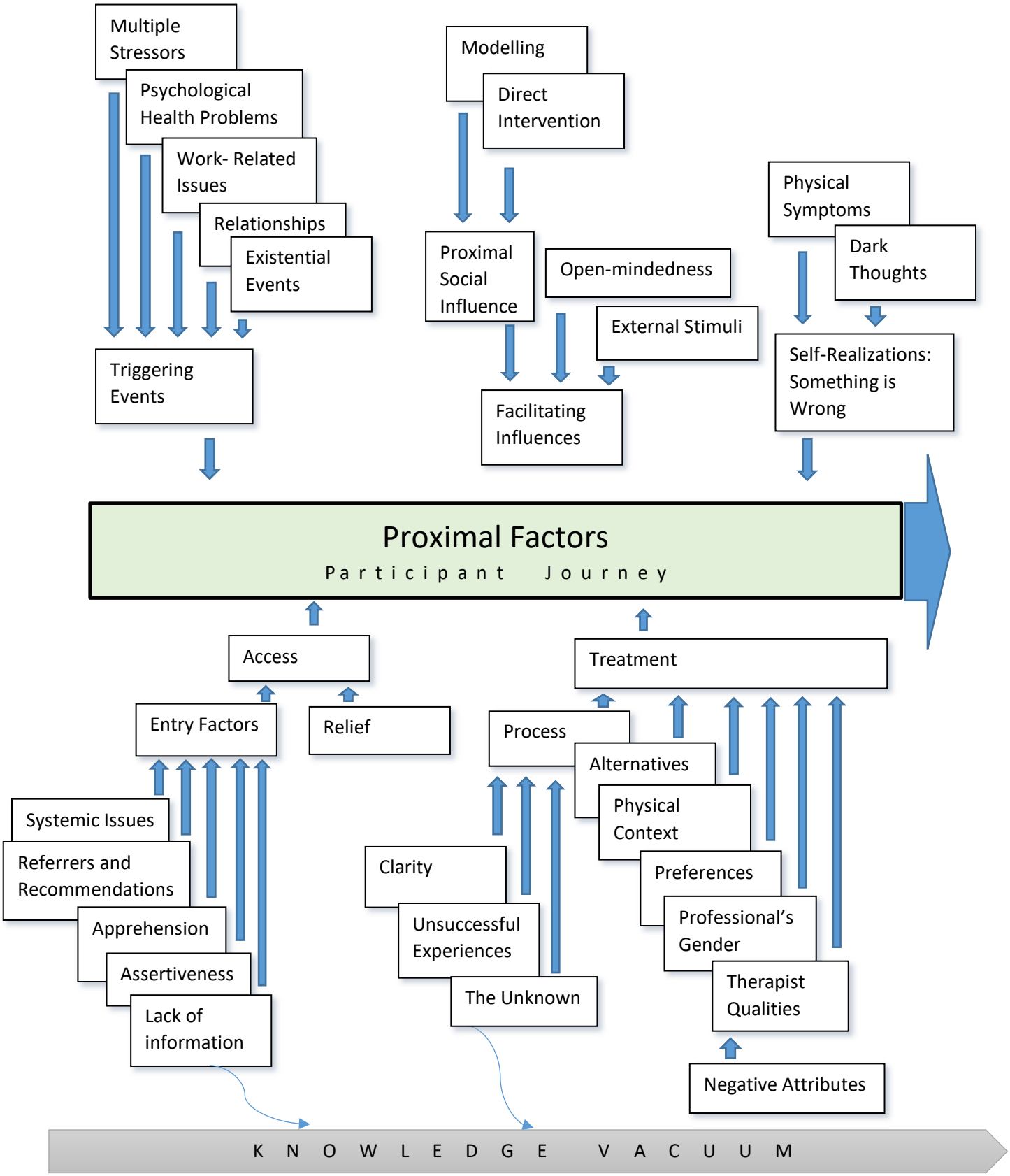


Diagram to represent the initial categories associated with the stage 'Post Intervention'.

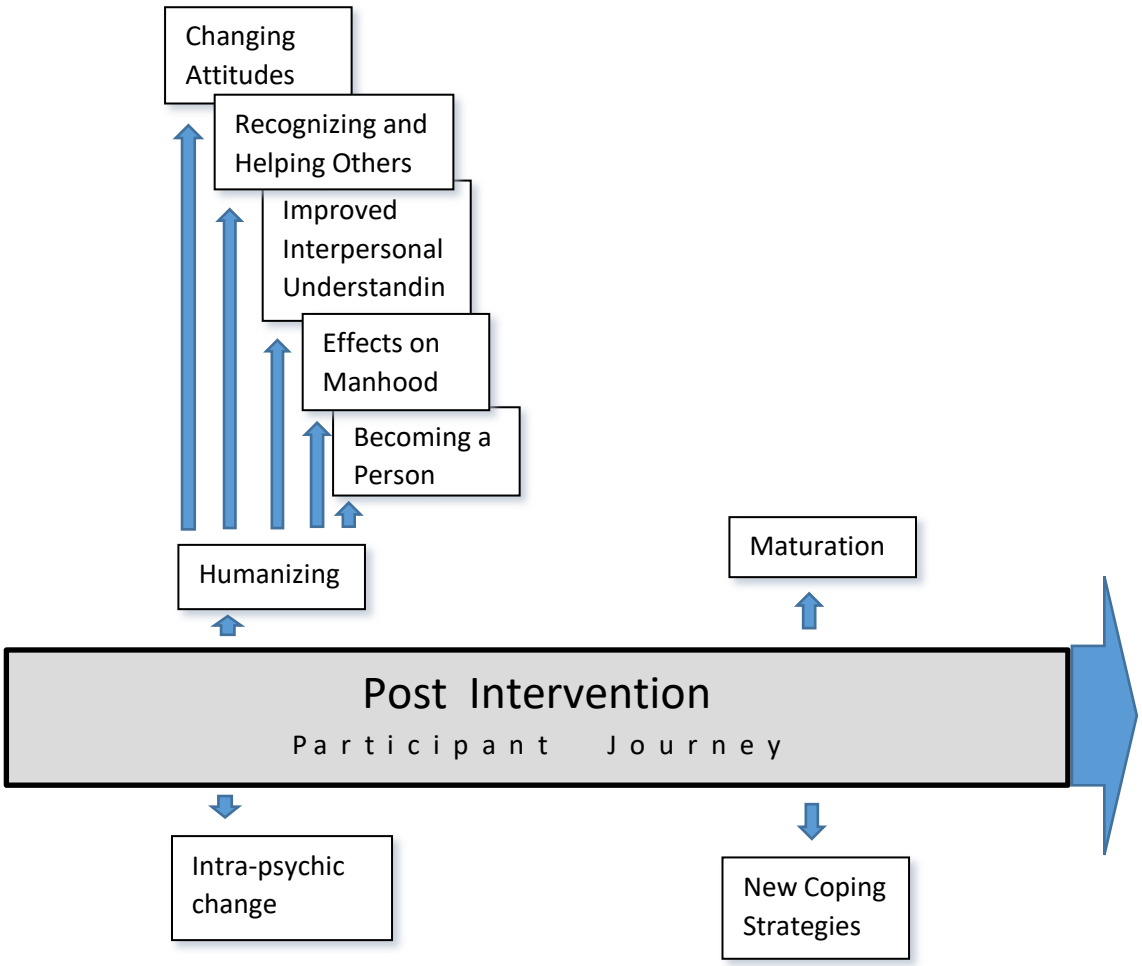
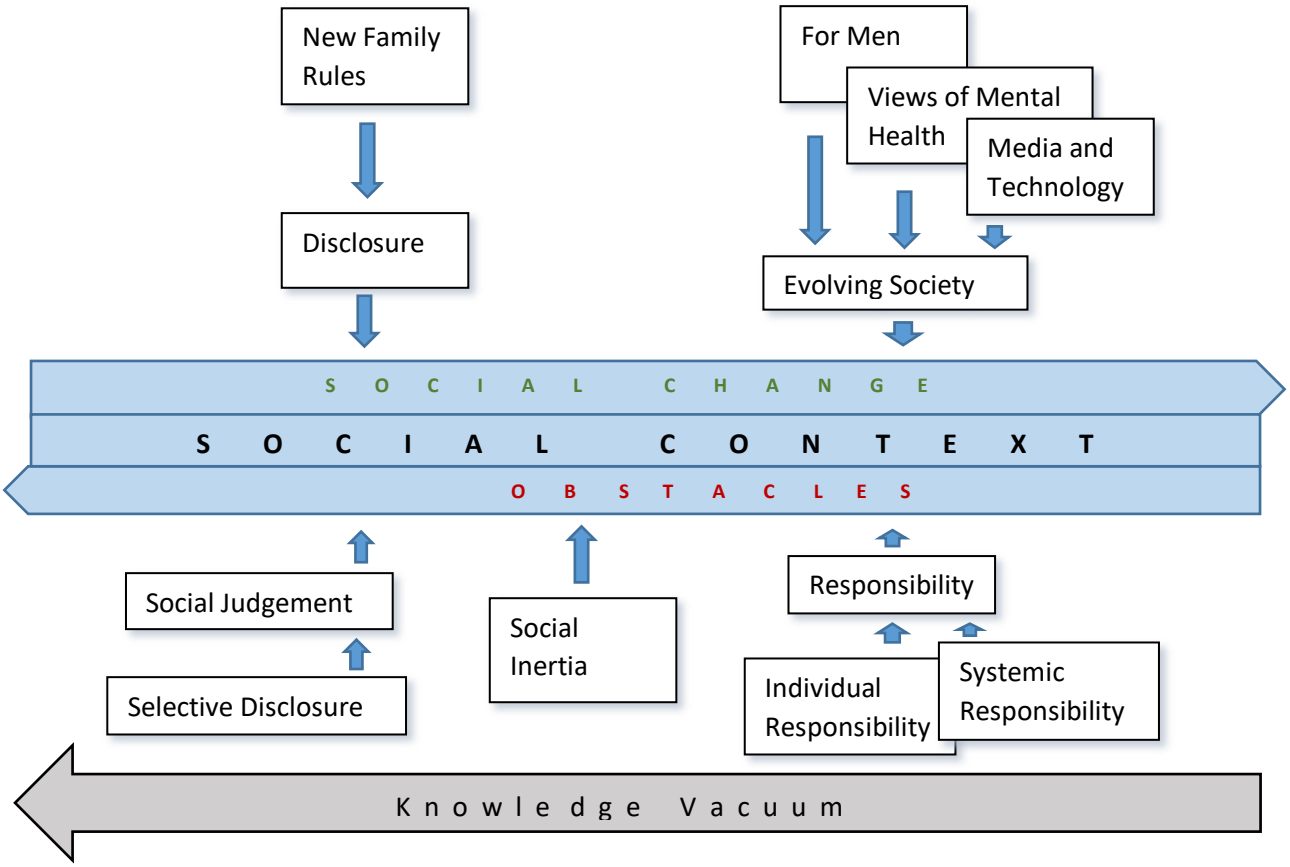


Diagram to represent the initial categories associated with the stage 'Social Change'.



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Part 2: Publishable article.