Exploring older males perceptions of help seeking in relation to mental health and depression.

Emily Moore

Supervised by: Dr. Jo Ashby          April 2017

Exploring older males perceptions of help seeking in relation to mental health and depression.

## ABSTRACT

The research aimed to explore older men's perceptions of mental health, depression and help seeking. A qualitative approach was followed; using semi-structured interviews of six males, aged 45-59 who are members of the Men's Shed association. My research objectives were to understand how these men construct mental health. What their perceptions were about help seeking and what factors might have influenced their help seeking perceptions. A thematic analysis was conducted, and the first theme identified was 'Masculinity as a barrier to help seeking' and was an integrated theme throughout. The second theme 'Self-Reliance as a barrier to help seeking' and the third theme 'Constructing therapeutic talk as women's work: '*Women can cry and have feelings but we can't so'.* The fourth theme was 'Masculinity: Restricting therapeutic talk'. We then explored what would encourage these men to seek help: 'Entering therapeutic talk: Entering the shed' and then finally what we have learnt to 'Bridge the Gap'. The implications of the findings are discussed below, regarding the impact that masculinity has on help seeking perceptions and possible actions considered, in terms of the Men's shed as a community therapeutic project.

| KEY WORDS: | 45-59 YR OLD MALES | PERCEPTIONS OF MENTAL HEALTH | HELP SEEKING | QUALITATIVE | THEMATIC ANALYSIS |
|---|---|---|---|---|---|

## Acknowledgements

**Contents**

## Background

A growing body of research suggests that men, especially those who suffer with psychiatric illnesses, specifically depression, are not seeking help when they need it. Evidence suggests that men are more likely to complete suicide because they are less likely than women to seek help, or to discuss their depressive or suicidal feelings (Brownhill et al, 2005; Courtenay, 2000). Cleary (2012) suggests that a role in this is that men are not looking, or receiving treatment for their depression. In addition, statistics have shown that between 2002 and 2012, 72% of people who commit suicide had not been in contact with any health professional about their feelings in the year before their suicide (Hewlett, 2015).

To my knowledge, there is little research on middle-older aged men. However, the highest UK suicide rate in 2013 by broad age group was among men aged 45 to 59, at 25.1 deaths per 100,000, which is the highest for that age group since 1981 (ONS, 2013). Therefore, my research aimed to fill this gap by interviewing men aged 45-59 about their perceptions of mental health, depression and help seeking.

**Why are mental health issues and depression in men not recognised or diagnosed as frequently as it is in women?**

Ridge (2011) suggests that when men experience mental distress they express their suffering in different ways to women, which could make it hard for medical professionals to diagnose and treat correctly, which consequently, could be putting men under the radar. In addition, Cochran & Rabinowitz (2000) proposes that men's mental health can be 'masked', which implies that even though statistically men are not diagnosed with depression as commonly as women, they may still suffer with it. Further evidence in a Swedish study found that women were able to express feelings and able to speak more openly about their distress, in comparison to men who were less likely to openly express their feelings. Danielsson and Johansson (2005) found this when comparing narratives between men and women with a diagnosis of depression.

An early study by Weissman & Klerman (1977) found that the men in their research unanimously stated that they would be hesitant to ask for help, even from friends informally. Men in this study also reported that they would not seek psychotherapy for depression. More currently, statistics have shown that compared to women, men are still significantly less likely to get psychological help. An example of this is from the Mental Health forum, which found that during 2015; only 36% of people accessing psychological therapies were men (Mental health forum: Reference: IAPT quarterly data file).

Another suggestion of why the rate of depression in men is underestimated is that men have a tendency to express depression in certain ways that do not correlate with the Diagnostic and Statistical Manual of Mental Disorders (DSM; e.g., Cochran & Rabinowitz, 2000). Pollack (1998) found that for some men who suppress their emotions, their symptoms could often be mistaken as normal male behaviours. Thus not being diagnosed for what is depression but expressed in slightly different ways.

**Why do men not ask for help about their mental health?**

Mental health has a lot of stigma surrounding it, which is specifically prevalent in males. This was highlighted in a survey conducted by the Opinion Leader for the Men's Health Forum (2016:online), which found that:

Of 1,112 employed men, 34% of the men would be embarrassed or ashamed to take time off work for a mental health problem. There was also a concern around taking time off for anxiety or depression, in comparison to 13% for a physical injury. 38% of the men reported that they would be worried that their establishment would think poorly of them if they took time off work for a mental health concern – compared to 26% for a physical injury.

There is also evidence that suggests that men have difficulty in personally identifying depressed moods or sadness in themselves, this is because they abide by the norm that men often restrict their emotions and therefore men cannot recognise it in themselves (Fischer & Good, 1997; Kilmartin, 2005). Subsequently men are less aware and so typically less likely than women to seek help from professional mental health facilities (Addis and Mahalik, 2003).

This leads onto the construction of men and masculinity by society, which has found to influence men and help seeking. Research has frequently shown that gender role conflict and abiding to hegemonic masculine norms are related to whether males are willing to seek help (Addis and Mahalik 2003; Courtenay, 2000). Magovcevic and Addis (2005) found that men whose beliefs and principles are associated with masculine norms perceive problems, such as depression as negative. Supporting this is Johnson et al (2012) who found that the constructions of gender by society, influenced men's overall help seeking processes. Courtenay (2000) suggests that having the mind-set that men should act and be a certain way can have a negative impact on men's physical and mental health, particularly the construct that men should be 'tough' and not show their emotions. Similarly, other research indicates that help seeking is controlled, and more importantly constrained by social expectations surrounding masculinity (Ridge, Emslie, & White, 2011). Evidence like this indicates some explanations as to why men are not as willing to seek help (Addis & Mahalik, 2003). Factors like gender role conflict and abiding to hegemonic masculine norms can often lead men to resort to silence rather than getting help about the way they are feeling (Addis, 2011). Hernandez et al (2014) found when interviewing formally diagnosed men with depression, that men often spoke spontaneously about gender socialization and masculinity regarding help seeking. Therefore, Kilmartin (2005) suggests that therapists who treat men should be educated about their views of masculinity as part of the context of the problem.

However, we have to consider that the sample of many of these studies are taken from views of men who did seek help for their depression, and therefore we need to consider the men who do not seek help from services. Addis and Mahalik (2003) claims that:

Not all men are the same, nor does it make much sense to assume that individual men behave similarly in all help-seeking contexts. From a clinical standpoint, it is precisely this sort of inter- and intra-individual variability that needs to be understood.

**Older adults and help seeking**

James and Buttle (2008) found that older adults were higher in help seeking but less psychologically open than the younger participants in a New Zealand study. Murray (2006) interestingly found that professionals felt that older people are more likely to base their symptoms on physical complaints and to use somatic descriptors rather than say about how they are feeling. Murray suggests that this is because older adults may not be familiar with psychological terms and so may not feel comfortable talking about their emotional symptoms to experts. Furthermore Switzer et al (2006) suggests that older adults could see depression as a something that they personally have to deal with and not for a professional.

Past research has shown that the media can be useful in creating an awareness of depression and acceptance of it within society (Hegerl et al, 2003). This is based on social learning theory (Bandura, 1977) to change men's beliefs about depression and mental health in general, to ultimately encourage help seeking. Addis and Mahalik (2003) also suggested that things like public service announcements, magazine advertisements or creating awareness within educational, and religious contexts are appropriate to increase the normalisation of men asking for help.

We have to consider that the majority of the surrounding research on men, mental health, depression and help seeking are based on a younger demographic of males (Klineberg et al, 2011; Tang, 2014; Russel, 2004). There is a lot of criticism surrounding previous evidence because the majority of the research's sample population are undergraduate students. There is also research on specifically 'older' men where the average sample age is above 60 years old (Switzer, 2006; Murray, 2006).

However, between 2012 and 2015 a Governments national well-being survey found that it was those aged 45 to 59, who had the lowest levels of life satisfaction (ONS, 2015). This survey, in conjunction with the statistics demonstrate that there is strong evidence that middle-aged men are being neglected in the literature, and that there is a serious need to explore men in the 45-59 age range and their perceptions of mental health and seeking help.

Therefore, my overarching research aim was to explore the perceptions of help seeking in relation to mental health among males aged 45-59.

More specifically my research objectives were to understand:
• How older men construct mental health
• Older men's perceptions in relation to help seeking about mental health
• What factors might have influenced their help seeking perceptions

**Methodology**

**Philosophical underpinnings of the research**

I had a social constructionist epistemological viewpoint with my research as it is largely based on, how older men construct their views on mental health and depression. It is how society talks about it, which frames men into abiding by these constructions that society has posed. This then influences how men feel about mental health. It is argued from this perspective that men abide by these constructs, which means they have this masculinity stereotype that they have to hold. Burr (2015) suggests that with a social constructionist view we have to question reality, as our understandings of the world are not a direct perception of reality. Rather that our culture or society constructs its own account of reality. Gergen (1985) also suggests that the world we understand is not automatically driven by nature but is the result of an active outcome of relationships. Kessler and McKenna (1978) investigated the social construction of gender and examined the way different cultures and subcultures understand genders differently therefore suggesting that gender is just merely a social construction.

I took a critical realistic ontological approach, as my research was not to measure, or to be able to quantify what all men think about mental health and help seeking. My research was not to generalise my findings to all men but to look into a specific group of men, who are of a specific age in a community group. It was to explore how this group of men construct their world, as it is important to draw on the social structure. However, this was a realist approach because I was aware that every man's experiences are different and unique. I was able to look at this realistically and know that it is within a realistic setting. Willig (1999) proposes that critical realism recognises the way individuals make their own meaning of their experiences, but also how their wider social context influences their meanings, whilst recognising the material and the limits of reality. In addition, I acknowledged that there is a real world that exists independently of their constructions, but also appreciate that their world is unavoidably a construction from their own perspectives. A critical realist approach teaches that theories signify what is known about reality, but also what is not known and has not yet been found (Lakatos, 1970).

**Taking a qualitative approach**

Quantitative approaches are not appropriate for all questions we might ask (Aroboto and Shaw, 2006) and therefore qualitative is more suited to gain an understanding on the experiences and knowledge specifically to each individual. This is because everyone experiences different things in life and therefore we should "...embrace the messiness of human existence" (Araboto and Shaw, 2006, p17) which is appropriate as in the study I did not want to generalise what these men say. Qualitative methodologies contributed to me exploring my aims, an approach that involves men telling their own stories and thoughts on topics, such as how these specific men construct mental health. Qualitative research also allowed me to understand their perceptions around help seeking in relation to mental health. Furthermore, it allowed me to explore what factors might influence help seeking for each individual man. Research on men, mental health and help seeking

informed by an epistemological social constructionist perspective allows a contrast to the dominant quantitative surrounding literature. To allow the research to be grounded by men's accounts (Willig, 2016) rather than filling in questionnaires for example, could create findings that are more accurate for those individuals. I therefore used a qualitative approach as it fits well with being able to find in-depth, enriched data from the actual people who experience being men and how they perceive mental health.

## Using interviews as a method

To carry out this research appropriately I interviewed six participants. Interviews were a valuable way of getting the story behind the participant's thoughts and views, as they were able to communicate in depth and personal opinions. Interviewing allowed me to gather information by face to face questioning, whilst also allowing questions to be clarified and expanded on. One to one interviewing was useful as well because it meant that I was able to reassure/ create a rapport with the participants, which may have improved the access to data (Rubin, 2004). In addition, it allowed me to explore the subjective meanings of the research topic amongst participants. The main benefit of interviewing is that it is the individual's interpretation of events, which is the most important (Rubin, 2004).

To do this fittingly I chose semi structured interviews because it further allowed the men to freely express their viewpoints and how they construct their own thoughts. It enabled rich, unique data as the men's answers were explored in more detail and it allowed me as a researcher to modify the set questions or to ask new ones. I used Oliffe (2005) to influence my interview schedule (appendix 3) as they had given advice on how to interview men. I used factors like letting them know before the interview began that there are no wrong or right answers they can give. My interview schedule began with a general discussion to make the participants feel relaxed with me so that later I was able to move on to more sensitive topics like their perceptions of mental health. I spoke hypothetically and sometimes asked questions about 'other people' like 'what would your friends do?' This was to make the participants feel that they do not have to discuss personal feelings on the sensitive topics and can feel comfortable (Job, 1982).

## Approach to analysis

Qualitative research can be analysed by a range of different methods, such as phenomenological to narrative analysis, which all operate under different theoretical frameworks. However, for my research I identified thematic analysis as the most appropriate for my project because it highlighted the significant concepts that were raised from the interviews whilst allowing me to identify commonalities, differences and recurring themes within the data. It also allowed me to consider how contextual factors may have influenced the differences. By using a social constructionist and a critical realistic approach, thematic analysis was a method that worked both to reflect reality and to consider reality.
I used techniques written by Braun and Clarke (2006) so I:

• Immersed myself in the data by reading and re reading the transcripts.
• The next step during data collection was to code.

•Then from the data, I found the emerging themes and attached codes to the transcripts that represented the themes.
• After data collection, I then displayed the themes, and developed explanations.
• Finally, from the displayed data I identified the central points.

This analysis encompassed the important concepts and processes identified in the study, also the patterns of experience. I used a deductive/ theoretical (e.g. Boyatzis, 1998; Hayes, 1997) approach to thematic analysis (Braun and Clarke, 2006) as a lot of my interview schedule was based upon previous literature and therefore my themes were specific. This is because I am interested in men's perceptions specifically on mental health and getting help. However, when the participants spontaneously spoke about a theme not discussed in previous research then I considered those themes in my discussion, which meant that part is data driven (e.g. Frith and Gleeson, 2004). I also considered my reflexivity and acknowledged that I, as a researcher have influenced the research process and therefore the possible outcomes.

**Recruitment of participants**
I used a sample size of six men because I was not trying to generalise my findings to all men in that age bracket. I used purposeful sampling to look into a specific community based group of particular people. Therefore six men was a sufficient number of men to interview to gain in depth rich data (Willig, 2013). My participants were men who attend the 'Men's Sheds Association' once a week. It is a group where men, mostly of an older age meet and together do woodwork and gardening. It is a chance for the men who attend to socialise and share their knowledge and experiences with each other. I got in contact with the project leader as my gatekeeper. He assisted me in recruiting six men who were willing to participate and are between the ages of 45-59. All of the men I interviewed had previously sought help from professionals due to them being depressed which gave a unique insight to their experiences.

**Ethical considerations**
The information sheet (see appendix 4) informed the participants the topic, what the research aimed to do, why they had been selected to participate and what participation actually involved. Prospective participants were given twenty-four hours to make an informed decision after receiving the information sheet if they would like to participate. I had specified on the information sheet and consent form that the participants must not currently be diagnosed with a mental illness. The participants were then given a consent form (see appendix 5) to sign to show they have agreed to take part and fully understand the process.

Ethical dilemmas I personally had to face and had to consider within my research is the fact that I am a female lone-worker going into a space where I did not personally know the older men that I was interviewing. Consequently, I considered a risk assessment and I contacted my supervisor before and after my interviews. I also visited the space beforehand and became more familiar with the people I was interviewing. In addition, the gatekeeper was present in the building whilst the interviews took place. I also had to consider the way in which I worded my questions

so that I did not offend these men of a different generation to me. Furthermore, the questions were sensitive to the fact that talking about mental health could possibly be difficult for some individuals. I also used Oliffe (2005) to influence my interview schedule to make the men feel more comfortable.

When the interview had taken place, the men were given a pseudonym, which kept them anonymous. All of the participants had the right to withdraw which was stated on the information sheet, consent form and debrief sheet. They had a week after the interview had taken place to get in contact with me via my university email.
I recorded the interview so that I was able to transcribe the interview. The participants were told this on the consent form and again before the interview. Their data was stored securely on a password-protected computer where access was strictly controlled; this is in line with the Manchester Metropolitan University Data Protection Policy. The recording of the interview was permanently deleted after transcription and the transcript will be kept for up to 10 years, which complies with the Data Protection Act (1998).

When the interviews were over they were given a debrief sheet (see appendix 6) which gave them sufficient information and if they felt that they need further help, relevant counselling services information were given.

## Analysis and Discussion

In order to understand these men's experiences my overarching research aim was to explore males aged 45-59, perceptions of help seeking in relation to mental health.

The first theme identified was 'Masculinity as a barrier to help seeking' and through analysis it was clear this was an integrated theme throughout. The second theme was 'Self-Reliance as a barrier to help seeking'. The third theme common to all the accounts from these men was: 'Constructing therapeutic talk as women's work: '*Women can cry and have feelings but we can't so*' and then the fourth theme 'Masculinity: Restricting therapeutic talk'. We then explored what would encourage these men, in their eyes to seek help: 'Entering therapeutic talk: entering the shed' and finally what we have learnt to 'Bridge the Gap' in relation to the Men's Shed as a community therapeutic project.

### Masculinity as a barrier to seeking help
For these men, mental health and depression was felt as something that did not adhere to their masculine identity, particularly to the idea that men have to be 'tough'. When asking why older men don't seek help, many used words like 'weakness' to describe themselves if they were to seek help about mental health. This complies with research, which has frequently shown that gender role conflict and abiding to hegemonic masculine norms are negatively related to whether males are willing to seek help (Addis and Mahalik 2003; Courtenay, 2000). Barry described it as:

> '*We like to be tough don't we, and don't like to be um, we see it as a weakness talking about it, even round here.*'

In addition to this internal belief of asking for help as a 'weakness', these pressures are being intensified by surrounding people, like their family, who use phrases like 'man up'. Carl below expresses:

> 'It's still not that uncommon that people say 'oh man up' 'stop crying about it yeah?'(…) 'Don't talk about issues'.

Courtenay (2000) suggests having the mind-set that men should act and be a certain way can have a negative influence on men's mental and physical health, particularly the construct that men should be 'tough' and to not 'talk about issues'. Previous research has found that traditional masculinity ideology is linked with less positive feelings toward seeking psychological help (Berger et al, 2005) and less willingness to seek help (Robertson and Fitzgerald, 1992). As analysis went on it was clear masculinity as a construct was evident throughout the interviews, and so is being considered as an integrating theme within this discussion (King and Horrocks, 2010).

Overall, the way in which these men are framing their viewpoint is by drawing upon a hegemonic masculine ideal that says that they need to be 'tough' and 'man up'. Therefore what is evident in this theme is that help seeking behaviour is constructed as negative, conflicting with their masculine identity and therefore something that they should not be doing.

**Self-reliance as a barrier to seeking help**

Switzer et al (2006) suggests older adults often see depression as something they personally have to deal with and not for a professional, or possibly anyone else for that matter. When asking David why he thought older men would not seek help, he said:

> 'Yeah well they are trying not to be a nuisance aren't they. Trying to 'it'll go away', 'I don't need to go to the doctors' yeah. Urr that's probably sad, but it's like saving face a little bit you know, 'oh I'm alright' yeah? (…)You tell lies and say 'Yeah I'm alright' you tell white lies a little bit'

David constructed that asking for help around mental health as being a 'nuisance' and that is why 'you shouldn't discuss it'. He even tells 'white lies' to avoid seeking help or alerting anyone of his problems. The men described their experiences and perceptions of mental health in various ways. However, a common theme was of them wanting to sort out their problems themselves. David then went on to say when I asked what he would do if he needed help with his mental health:

> '… I'd have a good job at trying to sort it out myself love I would, (…) If I offload, I'm giving somebody my problems love. (…) You just shouldn't offload really. You shouldn't discuss it.'

Joe also stated that:

> 'Like some people don't want any fuss, some people would rather be on their own, and deal with their own problems with depression.'

David and Joe's accounts resonate with the surrounding literature on men wanting to be self-reliant. Wuthrich (2015) found the greatest barrier for older adults to seek help was their desire to help themselves. Furthermore, Mansfield et al (2003) found that a key masculine ideology that men hold is to be self-reliant which emphasises men's reluctance to seek help (Oliffe and Phillips 2008). Addis and Mahalik (2003) claim that men who do seek help are in conflict with their learnt behaviours of being masculine, like being self-reliant and suppressing their emotions, to then having to rely on others.

> *'I don't know err probably cause they like cope with it on their own, I don't know err, maybe just an age thing.'*

John above constructed that age is a factor as to why they would not ask for help, but to 'cope' with it on their own. Therefore, his older age of now being over 50 is a reason to why he thinks that him and his friends would not be so open and willing to seek help. This resonated with the other men as well. Therefore the above suggests these men are constructing self-reliance as a barrier to seeking help, because as an older male they want to sort out their problems themselves and will even tell 'white lies' to avoid people knowing about their issues.

**Constructing therapeutic talk as women's work: '*Women can cry and have feelings but we can't so*'**

A key theme all of the men mentioned was that women would definitely be more open about their mental health, many reasoned this because women 'look after themselves more', with examples that women wear 'makeup' and have interest in their 'clothing'. All of the men interviewed expressed how different men and women are when it comes to seeking help about mental health. This was summarised by Barry below:

> *'I do find that a lot of ladies I know suffer with mental health don't they? And maybe men do, but you don't see it, or you don't take note of it. Or maybe that the lady would see it?'*

Barry is expressing that women are more knowledgeable or aware of mental health, to be able to 'see it' in comparison to men. Cochran and Rabinowitz (2000) proposes that men's mental health can be 'masked', which implies that even though statistically men are not diagnosed with depression as commonly as women are, they may still suffer with it. Further evidence in a Swedish study found women were able to express feelings and able to speak more openly about their distress, in comparison to men who were less likely to openly express their feelings (Danielsson and Johansson, 2005). This was also found for these men interviewed, with a good anecdote from Carl:

> *'Examples like, a lady who we knew, her husband had died over the weekend and she walked into the café on Monday morning (…) and said 'Eric passed away at the weekend'. And it was just like in the open, and the next minute there is a whole conversation going on (…). Now I can't think of many men*

*who would do that um, not saying that they wouldn't, but it would be done in an entirely different way, and that they would become withdrawn about it.'*

This highlights how aware these men are of the different way men and women deal with certain issues. Another interesting concept is that these men clearly expressed that there are definite constructs of what women can do, and what men cannot do. Leslie below states:

*'It's the way I've grown up… um we're not supposed to show feelings; we're not supposed to be soft are we? Women can cry and have feelings but we can't so.'*

This suggests a barrier to men seeking help is that these men believe they are not allowed to be emotional but that women are. Emslie et al (2005) found the recovery process for men was talked about as successfully renegotiating a masculinity, something we should consider when working out how to encourage men to seek help.

## Masculinity: Restricting therapeutic talk

David in the quote below was clearly ascribing to the hegemonic masculine roles, and taking on the role of a patriarchal family. Abiding to patriarchal masculine traits, like independence and self reliance was found to be a barrier to men utilising psychological help (Courtenay, 2000; Gibbs et al, 2004; Lee and Owens, 2002; Mahalik et al, 2003). When asked why he thinks older men don't seek help as much as younger men David said:

*'Yeah cos you are you're a bit…you're a bread winner, you're a dad, you're a granddad, you want to be a little um independent, I mean you go a bit soft if you get into it… yeah no I'll leave it at that, is that ok?'*

It was evident when talking with David in the interview that when the conversation was an emotive or sensitive topic, David self-consciously avoided those discussions by saying 'I'll leave it at that'. David also frequently stated how he did not want to 'go soft' by talking about emotive topics. Not talking about emotions and feelings can often lead men to resort to silence rather than getting help about the way they are feeling (Addis, 2011) particularly those who adhere to hegemonic masculine norms.

There is also evidence that suggests men have difficulty in personally identifying depressed moods or sadness in themselves, this is because they abide by masculine norms that often restrict their emotions (Fischer and Good, 1997; Kilmartin, 2005). Like David, who stunts any emotive conversation, Carl below expresses his frustration in not being able to verbally communicate to people how he was feeling. Masculinity is a part of this, as abiding to the masculine norm of not expressing emotion has perhaps led to what Levant (1998) called Alexithymia. This is where people struggle to identify and describe emotions in themselves and in

others. Sullivan (2015) found normative male alexithymia to be correlated with British men's negative attitudes towards seeking help.

> *'It's again there's this sort of just lack of understanding, but equally a part on me being the person in the situation not being able to still explain that emotional turmoil that you are going through, you can't put a handle on it, you can't explain why you're feeling that way and you're almost looked at... And it almost reinforces your hesitance or your reluctance to seek help. (…) Back to man up, stop worrying about it and so you get into a bigger, you become more insular and you think, well it must be me.'*

Therefore, we have seen here with David that he does not want to divulge too much into the emotional, sensitive topics. In comparison, Carl expresses his frustration about not having the skills or resources to be able to express his emotions. Consequently we see a problem rising; by abiding to the masculine norm of supressing emotion these men are restricting therapeutic talk, whether that being conscious or not.

**Entering therapeutic talk: Entering the Shed**

Interestingly when reflecting on their GP experiences, all of the men interviewed resonated with negative experiences of being prescribed pills when they had asked for help. This is due to the current medical model, which is seen here to be insufficient. Leslie expressed, when asked what support he believed he had from a GP:

> *'I have no idea, I've got no faith in GP's, they just seem to dole tablets out really easily. I know that's my experience, they give you five minutes and that's it, you're gone. They don't give you time to sit there and tell them everything.'*

Then, when asked what would encourage them to ask for help these men surprisingly expressed a more mutual aid, therapeutic discourse. This is in stark contrast to their previous discourse of abiding to their masculine roles. When asking what would encourage men in their view to seek help, Carl declares:

> *'Um… comfort, more caring, more kind, it's the softer side and that's ironic that isn't it? Because a man, robust, strong, what is actually saying I need comfort, I need support and compassion, I need a bit of love maybe.'*

Which is interesting as Carl is even recognising himself he perhaps needed a more talking and intimate treatment. Therefore, we are beginning to see tensions building for these men between not being able to express, or not wanting to express how they are feeling yet are aware they need help through therapeutic, talking therapies. Joe below, and the other men also communicate the idea of needing human interaction but in a more mutual aid way:

> *'I'd feel comfortable if I was with a group of people sat, and they all had the same symptoms as what I've got, you know what I mean, you could talk sort of that way, feel comfortable.'*

Andronico and Horne (2004) also found group support significantly promoted the psychological well being of their male participants. Overall it was clear from all of the interviews there are internal conflicts, that these men know what they are supposed to do i.e. talk, but because of the masculine norms that they abide by they cannot. Evidently these men are well aware and capable of reflecting and insightfully communicating what they believe they need.

**Bridging the gap: Men's shed**

These men recognised the need for talking therapies as a way to help with their mental health. Although they also acknowledged the need to be able to keep their masculinity intact, whilst seeking help. When I asked what could make help seeking feel more approachable they mentioned mostly being able to relate to someone and being in an appropriate setting. For example being in the Men's Shed. Barry expresses:

> *'Urr this sort of thing helps, groups like this, not directly going and sitting in a circle.'*

The Men's Shed project originated from Australia and has spread to several countries, including the UK (Wilson and Cordier, 2013). In a study conducted in Australia, the Men's Shed was found to decrease self reported symptoms of depression (Culph et al, 2015). A similar study should be conducted in the United Kingdom to test the effectiveness of the Men's shed on mental health and wellbeing.

These men expressed that what they want are community projects like the Men's Shed, where they have all been through tough times and are able to relate to people. Barry suggests that:

> *'Making groups like this more available, not just this. Not a class just specifically for talking face to face but you need to integrate it with something else to make it easier (…) don't make it straight in like 'tell me about yourself', because you're not going to get the whole story that way.'*

**Summary**

Overall, an overarching finding was that ascribing to the hegemonic masculine identity is very important for the men that I interviewed. In addition, they constructed that getting help for mental health issues is seen as going against those masculine roles, which was consistent with Addis and Mahalik (2003). However, interestingly when asked what help they wanted, they mentioned more mutual aid and therapeutic, counselling elements of help. Although perhaps this is too far down the talking therapy route because when asked what they wanted it was things like the Men's Shed, where they do not have to directly address their problems straight away, but are able to integrate it with something that they enjoy and still abides with their masculine identities. Therefore, it is important to consider that for these men, their masculine identity is constructed as very important, so encouragement and help should be utilised within community therapeutic projects. This will enable men to still abide by the hegemonic norms but talk about their feelings in a way that is

comfortable to them, by being with similar people who understand and relate to what they are going through.

Reflecting back on the previous themes after doing the analysis, is it possible that perhaps these specific men I interviewed were so reflective and able to express what they want and need because of them being in the Men's Shed. If they did not have the Men's Shed experience would they have such retrospective, reflective accounts? We should also be mindful that the men's involvement in this study displays their willingness to be reflective about their depression and mental health issues in general. However, we should consider there are men who are not willing to partake in interviews like this, who are still being neglected in the research. Further study should be conducted at the Men's Shed to see the effectiveness on improving these men's mental health and wellbeing, like the study in Australia, so that more projects like this can be implemented.

**Reflexive Analysis**

I had to take into account my role as a young female going into a male dominated area and had to consider that this may affect the interview. The men could have altered what they were saying because of the age gap and the gender difference. For example, many of them felt they should not swear in front of me. However, even though these were factors to consider I thoroughly researched and planned before the interviews and took the time to getting to know the participants. I also had lunch with them to create a rapport and I felt that the men were comfortable enough to openly share their opinions and experiences with me.

**REFERENCES**

Addis, E. and Mahalik, R. (2003) 'Men, Masculinity, and the Contexts of Help Seeking.' *American Psychologist*, 58(1) pp. 5-14.

Addis, E. (2011) *Invisible men: Men's inner lives and the consequences of silence*. New York, NY: Henry Holt and Company.

Andronico, P. and Horne, M. (2004) 'Counseling men in groups: The role of myths, therapeutic factors, leadership, and rituals.' *Handbook of group counseling and psychotherapy*, pp. 456-468.

Aroboto, T. and Shaw, L. (2006) 'Why we use qualitative methods in psychology.' *Qualitative Methods in Psychology Section Newsletter,* 2, pp. 17-18.

Bandura, A. (1977) *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall, Inc.

Berger, J., Levant, R., McMillan, K., Kelleher, W., and Sellers, A. (2005) 'Impact of gender role conflict, traditional masculinity ideology, alexithymia, and age on men's attitudes toward psychological help seeking.' *Psychology of Men & Masculinity*, 6 pp. 73-78.

Boyatzis, E. (1998) *Transforming qualitative information: thematic analysis and code development,* SAGE: London.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative Research in Psychology,* 3(2) pp. 77-101.

Brownhill, K., Wilhelm, L., Barclay, V. and Schmied. (2005) ''Big build': hidden depression in men.' *Australian and New Zealand Journal of Psychiatry*, 39 pp. 921–931.

Burr, V. (2015) *Social constructionism*, 3rd ed, London: Routledge.

Cleary, A. (2012) 'Suicidal action, emotional expression, and the performance of masculinities.' *Social Science & Medicine*, 74 pp. 498–505.

Cochran, V. and Rabinowitz, E. (2000) *Men and depression: Clinical and empirical perspectives*. San Diego, CA: Academic Press.

Courtenay, H. (2000) 'Constructions of masculinity and their influence on men's well-being: A theory of gender and health.' *Social Science and Medicine*, 50 pp. 1385–1401.

Culph, J., Wilson, N., Cordier, R. and Stancliffe, R. (2015) 'Men's Sheds and the experience of depression in older Australian men.' *Australian Occupational Therapy Journal,* 62(5) pp. 306-315.

Danielsson, U. and Johansson, E. (2005) 'Beyond weeping and crying: a gender analysis of expressions of depression' *Medicinska fakulteten, Umeå universitet, Allmänmedicin & Institutionen för folkhälsa och klinisk medicin Scandinavian Journal of Primary Health Care*, 23(3) pp. 171-177.

Data Protection Registrar. (1998) *The Data Protection Act 1998: An Introduction*. Wilmslow: DPR.

Emslie, C., Ridge, D., and Ziebland, S. (2005) 'Men's accounts of depression: reconstructing or resisting hegemonic masculinity?' *Social Science and Medicine*, 62 pp. 2246–2257.

Fischer, A. R. and Good, G. E. (1997) 'Men and psychotherapy: An investigation of alexithymia, intimacy, and masculine gender roles.' *Psychotherapy: Theory, Research, Practice, Training*, 34 pp. 160–170.

Frith, H. and Gleeson, K. (2004) *'*Clothing and embodiment: Men managing body image and appearance*.' Psychology of Men and Masculinity,* 5(1) pp. 40-48.

Gergen, J. and Davis, E. (1985) *The Social construction of the person.* Springer-Verlag: New York.

Gibbs, L., Oliffe, J., Macdonald, J. and Crawford, D. (2004) 'Promoting men's health.' *Hands-on health promotion*, pp. 351-363.

Hayes, N. (1997) *Doing qualitative analysis in psychology,* Psychology, Hove.

Hegerl, U., Althaus, D. and Stefanek. J. (2003) 'Public attitudes towards treatment of depression: effects of an information campaign.' *Pharmacopsychiatry*, 36(6) pp. 288-291.

Hernandez, S., Han C., Oliffe L. and Ogrodniczuk S. (2014) 'Understanding help-seeking among depressed men.' *Psychology of Men & Masculinity*, 15 pp. 346–354.

Hewlett, E. and Horner, K. (2015). Mental Health Analysis Profiles: OECD Working Paper No. 81. Available at: http://www.oecd.org/officialdocuments/publicdisplaydocumentpdf/?cote=DELSA/HEA/WD/HWP(2015)4&docLanguage=En [Accessed on 19/11/16].

James, A. and Buttle, H. (2008) 'Attitudinal differences towards mental health services between younger and older New Zealand Adults' *New Zealand Journal of Psychology*, 37(3) pp. 33-43.

Job, E., Johansen, C., Jones, J. and Spenceley, E. (1982) 'Interviewing very old people.' *Australas. J. Ageing* 1(2) pp. 7–11.

Johnson, L., Oliffe, L., Kelly, T., Galdas, P. and Ogrodniczuk, S. (2012) 'Men's discourses of help-seeking in the context of depression.' *Sociology of Health & Illness*, 34 pp. 345–361.

Kessler, J. and McKenna, W. (1978) *Gender: an ethnomethodological approach,* Wiley, New York: Chichester.

Kilmartin, C. (2005) 'Depression in men: communication, diagnosis and therapy.' *Men's Health Gender*, 2(1) pp. 95-99.

King, N. and Horrocks, C. (2010) *Interviews in qualitative research*. Sage.

Klineberg, E., Biddle, L., Donovan, J. and Gunnell, D. (2011) 'Symptom recognition and help seeking for depression in young adults: a vignette study' *Social Psychiatry and Psychiatric Epidemiology*, 46(6) pp. 495-505.

Lakatos, I. and Musgrave, E. (1970) *Criticism and the Growth of Knowledge.* Cambridge: Cambridge University Press.

Lee, C. and Owens, G. (2002) 'Issues for a psychology of men's health.' *Journal of Health Psychology*, 7(3), pp. 209-217.

Levant, F. (1998) *Desperately seeking language: Understanding, assessing, and treating normative male alexithymia*. John Wiley & Sons Inc.

Magovcevic, M. and Addis, E. (2005) 'Linking Gender-Role Conflict to Nonnormative and Self-Stigmatizing Perceptions of Alcohol Abuse and Depression' *Psychology of Men & Masculinity,* 6(2) pp. 127-136.

Mahalik, R., Good, G. and Englar-Carlson, M. (2003) 'Masculinity scripts, presenting concerns, and help seeking: implications for practice and training.' *Prof Psychol Res Pr* 34 pp. 123-131.

Mansfield, K., Addis, E. and Mahalik, R. (2003) '"Why Won't He Go to the Doctor?": The Psychology of Men's Help Seeking.' *International Journal of Men's Health,* 2(2) pp. 93-109.

Mental Health forum. (2016) [Accessed on 4th November 2016] https://www.menshealthforum.org.uk/news/why-men-dont-talk-about-mental-health

Murray, J., Banerjee, S., Byng, R., Tylee, A., Bhugra, D. and Macdonald, A. (2006) 'Primary care professionals' perceptions of depression in older people: a qualitative study.' *Soc Sci Med*, 63 pp. 1363-1373.

NHS. (2015) [Accessed on 14th November 2016] http://content.digital.nhs.uk/iaptreports

Office for National Statistics (2013). *Suicides in the United Kingdom, 2013 Registrations - ONS.* [Accessed on 10th November 2016]. http://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2015-02-19

Office for National Statistics (2012-2015). *Measuring National Well-being: At what age is Personal Well-being the highest? – ONS.* [Accessed on 10th November 2016]. http://www.ons.gov.uk/peoplepopulationandcommunity/wellbeing/articles/measuringnationalwellbeing/atwhatageispersonalwellbeingthehighest

Oliffe, J. (2005) 'Men interviewing men about health and illness: ten lessons learned' *J Men's Health Gender*, 2(2) pp. 257-260.

Oliffe, L. and Phillips, J. (2008) 'Men, depression and masculinities: A review and recommendations.' *Journal of Men's Health*, 5(3) pp. 194-202.

Pollack, W. (1998) *Real boys: Rescuing our sons from the myths of boyhood*. New York: Random House.

Ridge, D., Emslie, C. and White A. (2011) 'Understanding how men experience, express and cope with mental distress: Where next?' *Sociology of Health & Illness*, 33 pp. 145–159.

Robertson, M. and Fitzgerald, F. (1992). 'Overcoming the masculine mystique: Preferences for alternative forms of assistance among men who avoid counseling.' *Journal of Counseling Psychology*, *39* pp. 240-246.

Rubin, H. and Rubin, I. (2004) *Qualitative interviewing: the art of hearing data*. 2nd ed., SAGE, Los Angeles: London.

Russell V., Gaffney P., Collins K., Bergin A. and Bedford D. (2004) 'Problems experienced by young men and attitudes to help-seeking in a rural Irish community.' *Irish Journal of Psychological Medicine*, 21 pp. 6–10.

Sullivan, L., Camic, M. and Brown, L. (2015) 'Masculinity, alexithymia, and fear of intimacy as predictors of UK men's attitudes towards seeking professional psychological help.' *British Journal of Health Psychology,* 20(1) pp. 194-211.

Switzer, J., Wittink, M., Karsch, B. and Barg, K. (2006) 'Pull yourself up by your bootstraps: A response to depression in older adults.' *Qualitative Health Research*, 16 pp. 1207-1216.

Tang, T., Oliffe, L., Galdas, M., Phinney, A. and Han, S. (2014) 'College men's depression-related help-seeking: a gender analysis' *Journal of Mental Health*, 23(5) pp. 219-224.

Weissman, M, and Klerman, L. (1977) 'Sex differences and the epidemiology of depression.' *Archives of General Psychiatry*, 34 pp. 98–111.

Wilson, J. and Cordier, R. (2013) 'A narrative review of Men's Sheds literature: reducing social isolation and promoting men's health and well- being.' *Health & social care in the community*, 21(5) pp. 451-463.

Willig, C. (1999) *Applied discourse analysis: social and psychological interventions.* Buckingham: Open University Press.

Willig, C. (2013) *Introducing qualitative research in psychology.* 3rd edn, Maidenhead: Open University Press.

Willig, C. (2016) 'Qualitative Research.' In: *The SAGE Encyclopedia of Theory in Psychology* Edited by: Harold L. Miller Jr.

Wuthrich, V. and Frei, J. (2015) 'Barriers to treatment for older adults seeking psychological therapy.' *INTERNATIONAL PSYCHOGERIATRICS,* 27(7) pp. 1227-1236.