



Psychological Help-Seeking: Understanding Men's Behaviour

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Sometimes I know I become
All that's weak in a man, and weak in a boy.
But I keep trying and I won't quit
And that must be worth something more
Than a strong man who believes
That there's nothing left to try for

***Lines On Palms* by Josh Pyke (2007)**

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ABSTRACT

Men have been shown to seek psychological help at lower rates than women (Kessler, Brown, & Broman, 1981). Recent research has demonstrated that much mental illness among men may go unidentified and untreated (particularly depression, Brownhill, 2003). The aim of this research was to identify the barriers that may exist to the identification of mental health concerns among men and to men seeking appropriate professional treatment.

The first study investigated the impact of prior help-seeking, gender-role conflict, mental health locus of origin, personality, and gender on attitudes to psychological help-seeking. Internet based surveys were completed by 635 participants, the majority of whom were university students. Results showed that each of the variables specified above was associated with attitudes to help-seeking.

The second study examined the mental health literacy of university students using vignettes developed by Jorm, Korten, Jacomb and colleagues (1997). Results showed that mental health literacy was lower amongst men than women, and was higher for depression than schizophrenia. Men recommended lay help-seeking for depression whilst women advised seeing a psychologist. Results also indicated that some participants would be unlikely to seek intervention for mental health issues even when they considered this to be the best course of action.

A third study was undertaken to investigate barriers to men and women seeking help for physical and mental concerns. Barriers to help-seeking for physical and mental concerns

were similar. For men barriers included self-reliance, the stigma of being labelled mentally ill, and fear of outcome. The indicators that one was suffering from mental illness and predictions of subsequent action were explored and found to differ between genders. Participants identified education as likely to improve men's help-seeking behaviour.

For the fourth study, 66 general practitioners and mental health professionals from rural and metropolitan locations completed a survey regarding men with mental illness and their psychological help-seeking. Practitioners reported beliefs that men's experience of mental illness differed from that of women. Such differences included that men denied problems, were prompted to seek help, did so as a last resort, and that rural factors impacted negatively on men's help-seeking behaviour.

In order to provide a comprehensive understanding of men's help-seeking behaviour, the fifth study utilised in-depth interviews to investigate the experiences of men from rural and metropolitan locations who had sought professional assistance. Thematic analysis highlighted means of recognition of mental health problems, barriers and facilitators to seeking psychological intervention and associated rationale. Findings suggest that the ability to recognise a psychological problem and beliefs regarding appropriateness of seeking assistance may impede men's help-seeking behaviour.

A number of common themes identified throughout this research were consistent with previous research on men's mental health and help-seeking. These included men's negative attitude towards psychological help-seeking, low mental health literacy, lack of psychological language, stigma, denial of the problem, delay of help-seeking, and the importance of the role of others in men's mental health. Many major themes which emerged throughout this research

can be viewed as aspects of and responses to the pervasive and constrictive nature of 'hegemonic masculinity' (Connell, 2002). Implications for working therapeutically with men are discussed.

CHAPTER ONE

Literature Review

In the past twenty years a large number of research studies have investigated men's help-seeking, illness, and related topics. However, much of this research has focused upon narrowly defined topics such as men's physical health, masculinity, depression, and gender-role conflict. Fewer researchers have examined men's experience of psychological concerns and attitudes to seeking professional help. Research of this kind is needed in order to contribute to our understanding of men's health needs and to facilitate better access to health and mental health care for men. This chapter will consider existing knowledge of men's health, help-seeking behaviour, mental health literacy, stigma, masculinity, and the clinical implications of such knowledge on the psychological treatment of men.

1.1 Men's Health

The majority of research on men's health focuses on physical issues. Men have been shown to have poorer health outcomes in the form of morbidity (Australian Institute of Health and Welfare, 2007), mortality (Australian Bureau of Statistics, 2008) and life expectancy (South Australian Department of Health, 2008) in Australia and throughout Western countries (Garfield, Isacco, & Rogers, 2008; J. Harrison, Chin, & Ficarroto, 1995; McKinlay, 2005; Minister for Health and Children, 2008; Wilkins, 2005). Whilst physical health issues are beyond the focus of this research, similarities exist between men's physical and mental health behaviours. Specifically, low rates of help-seeking are commonly reported for men with both mental and corporal concerns (Gourash, 1978).

Women's health was identified as a significant issue in Australia in the mid 1980's (e.g. New South Wales Health Department, 1999) but men's health has only emerged as an area of separate interest in the past 15 years. Further, few advances in government policy on men's health have been made in this time within Australia or overseas. South Australia has only recently developed a men's health policy (South Australian Department of Health, 2008), and at a national level Australia is still in the process of developing a national men's health policy (Roxon, 2008).

One of the most consistent findings in health research is that men seek support from health services less than women (Gourash, 1978; Jackson et al., 2007; Judd et al., 2006; Leaf & Livingstone Bruce, 1987; Madianos, Madianou, & Stefanis, 1993; Mansfield, Addis, & Mahalik, 2003; Morgan, Ness, & Robinson, 2003; Neighbors & Howard, 1987; Rochlen, 2005; Schober & Annis, 1996), although some authors have reported no gender difference (Adamson, Ben-Shlomo, Chaturvedi, & Donovan, 2003; Albizu-Garcia, Alegria, Freeman, & Vera, 2001; Buller et al., 1992; Goodman, Sewell, & Jampol, 1984).

It is also frequently suggested that men suffer less mental illness than women (Australian Bureau of Statistics, 2006, 2007; Galdas, Cheater, & Marshall, 2005). However, literature on men's mental health argues that this is not the case. Research has shown that in Australia boys have more mental health concerns than girls up to the age of 14 years (New South Wales Health Department, 1999). They also receive more mental health services than girls (National Health & Medical Research Council, 1995). This may be due to boys displaying more externalising behaviours and learning difficulties than girls. For adults, some studies have shown comparable rates of mental illness across genders but with different patterns of distribution (e.g. men may show greater substance use and women greater mood

disorders, see Jorm, 1995 for discussion). Men's greater rates of risk taking and unhealthy behaviours (Addis & Cohane, 2005; Courtenay, McCreary, & Merighi, 2002), along with higher proportions of substance use and abuse (C. M. Harrison & Britt, 2004; New South Wales Health Department, 1999) than women are indications that men are indeed suffering from psychological distress which may remain untreated.

In Australia, men complete suicide at rates three to five times higher than women (Australian Bureau of Statistics, 2008; Goldney, 2006) and yet it has been proposed that men's suicide rates are likely to underestimate actual intentional deaths given the high numbers of men who die in car accidents, from drug use and other risky behaviours (Lee & Owens, 2002; Sugrue, 2004). In terms of frequency, suicide is the third most common cause of premature death in South Australian men, and depression the second most common cause of illness and disability (South Australian Department of Health, 2008).

Differences in symptom expression (Cochran & Rabinowitz, 2003; Kilmartin, 2005) may result in the under-diagnosis of mental illness in men, especially in the case of depression (Hart, 2001). Practitioners have been shown to overlook the signs of depression in men more than women (Brownhill, 2003) even where these meet the criteria for diagnosis (Potts, Burnam, & Wells, 1991). Some researchers argue that lower documented rates of mental health concerns in men are not due to lower prevalence of mental illness (Lee & Owens, 2002; Padesky & Hammen, 1981). Rather, the reported difficulty of many men in communicating psychological distress (Danielsson & Johansson, 2005) and low levels of psychological service utilisation (Morgan et al., 2003) are likely to create under-reported prevalence figures (Horsfall, 2001).

There is widespread acknowledgement both in Australia and worldwide that men's mental health is at risk and that steps should be taken to address this (Banks, 2004; Bonhomme, 2007; Courtenay, 2004; Garfield et al., 2008; Lee & Owens, 2002; Leishman & Dalziel, 2003; Lumb, 2003; McKinlay, 2005; Men's Health Policy Steering Committee, 1996; Miller & Bell, 1996; Minister for Health and Children, 2008; Porche, 2007; Smith & Robertson, 2008; South Australian Department of Health, 2008; White, Fawcner, & Holmes, 2006; Whitley, Jarrett, Young, Adeyemi, & Perez, 2007; Wilkins, 2005).

1.2 Help-Seeking

Research suggests that only a minority of those who suffer from mental illness will seek help (Angermeyer, Matschinger, & Riedel-Heller, 2001; Lauber, Nordt, Falcato, & Rossler, 2003; Lauber, Nordt, & Rossler, 2005; Suhail, 2005). A number of studies have shown that approximately two thirds of sufferers will not seek professional assistance (Andrews, Issakidis, & Carter, 2001; Aoun, Pennebaker, & Wood, 2004; Najman, 1995). Further, men have consistently been shown to seek psychological help at lower rates than women (Anderson, 1995; Jorm, 1995; Madianos et al., 1993; Morgan et al., 2003; Oliver, Pearson, Coe, & Gunnell, 2005; Parslow & Jorm, 2000; Vasiliadis, Lesage, Adair, & Boyer, 2005). Andrews and colleagues (2001) reported that men have only a nine percent probability of consulting someone regarding their mental health issue. Although a literature review conducted by Galdas, Cheater and Marshall (2005) did not fully support the notion that men seek help less than women, these authors did find evidence that men delay help-seeking for longer. Delaying help-seeking for mental illness can result in the worsening of symptoms or a failure to recover for many men (Cusack, Deane, Wilson, & Ciarrochi, 2004).

McKendrick (1995) studied the mental health of Aboriginal Australians and determined that men utilised services less than women, even where services were specifically designed for Aboriginal people. This author concluded that those men who did seek help presented later and at higher levels of chronicity than women. The result of this increased severity was that men's first contact with mental health services was commonly characterised by an involuntary admission to a psychiatric ward. This finding has been shown to reflect behaviour of the wider Australian population by statistics which show that women dominate outpatient mental health care and men inpatient facilities (Issakidis & Andrews, 2006; Parslow & Jorm, 2000). Such findings suggest that men are not receiving appropriate care at early stages of illness.

The self regulation model (Leventhal, Nerenz, & Steele, 1984) suggests that perceptions of cause, curability, consequences and timeline are important in people's understandings of illness. Although this model has historically been employed in studies of physical problems, Lobban et al. (2003) argue it is just as applicable to mental health and illness. These authors claim that this model explains considerable variance in a number of important outcome variables including medication adherence and relapse. Likewise, Fortune et al. (2004) found the self-regulation model to appropriately capture women's experiences of depression. Research on mental health using this model is in its infancy but findings so far suggest that the self-regulation model may be of significance when considering an individual's decision making around mental health issues.

The theory of planned behaviour (TPB, Ajzen, 1980) is also applicable to the experience of seeking help (Shaw, 1999). The TPB suggests that the most important determinant of a person's behaviour is intent. The three major factors within TPB consist of

one's attitude towards performing the behaviour, perceived subjective norm and perceived behavioural control. Therefore, if one perceives that the outcome of seeking help for psychological concerns is positive, the individual will have a positive attitude towards performing that behaviour. If relevant others see seeking help as positive, the individual will be motivated to meet the expectations of others and the subjective norm will be a positive expectation. The product of these contributing factors will determine the individual's behavioural intent.

Most models of help-seeking discuss three basic steps in the help-seeking process. Firstly, one must recognise that a problem exists (Gross & McMullen, 1983; Levant, 1990; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Shapiro, 1983; Shaw, 1999). Confounding recognition may be consideration of identity (Fortune et al., 2004) and ego-centrality (e.g. whether this means there is something wrong with me, Mansfield et al., 2003).

Secondly, one must decide whether the problem is amenable to help (Sheikh & Furnham, 2000) and if one should seek help (Rickwood et al., 2005; Shapiro, 1983; Shaw, 1999). Beliefs about the causes and timeline of illness, along with likelihood of improvement, will shape judgements regarding whether intervention will be useful (Fortune et al., 2004). Self-categorisation theory (Turner, Hogg, Oakes, Reicher, & Wetherell, 1987) is argued to be applicable to such scenarios (Fedaku & Kraft, 2002). This theory posits that individuals consider themselves as members of a group and ascribe to the norms of that particular group. Perceptions of normativeness, or how common the behaviour is amongst others in this reference group, have been argued to be central to help-seeking decisions (Mansfield et al., 2003; Stroebe & Stroebe, 1995). However, normalising illness and the lack of treatment can result in the delay of help-seeking behaviour (Galdas et al., 2005). Conversely, attribution

theory (Weiner, 1985) suggests that when one perceives their own behaviour as non-normative the explanation is located within the individual and therefore leads to feelings of inadequacy and failure (Gross & McMullen, 1983). Normativeness also has implications for how others will respond to particular illnesses or behaviour. Perceptions regarding how other people will respond to behaviour are crucial in decision making (Ajzen, 1991; Conner & Heywood-Everett, 1998). Risks of engaging in behaviour (Addis & Mahalik, 2003; Fortune et al., 2004) such as being embarrassed (Shapiro, 1983; Williams & Williams, 1983) or stigmatised (Ang, Lim, Tan, & Yau, 2004) are contemplated and weighed against possible benefits of engaging in behaviour.

The third basic step in the help-seeking process discussed by most models is that one must decide from where (Gross & McMullen, 1983; Sheikh & Furnham, 2000) and how to seek help (Shapiro, 1983). Many help-seeking models also incorporate perceptions of control over behaviour (Ajzen, 1980, 1991; Fortune et al., 2004; Mansfield et al., 2003; Stroebe & Stroebe, 1995), suggesting that increased feelings of control will result in greater help-seeking behaviour (Courtenay, 1998). This is supported by findings that individuals are more likely to accept help which is offered rather than help which is requested (Shapiro, 1983).

Most models of help-seeking highlight a number of points in the help-seeking process at which barriers can arise. For instance, it has been reported that structural factors such as access and cost can inhibit men from seeking help, especially in the case of rural men (New South Wales Health Department, 1999; Stefl & Prospero, 1985); however, attitudinal factors such as attitude to help-seeking, stigma, mental health literacy, personality and gender issues have also been identified as likely to generate significant impediments to men's psychological help-seeking behaviour (Thompson, Hunt, & Issakidis, 2004).

Attitudes towards seeking professional psychological help have been shown to be more negative among men than women (Ang et al., 2004; Fischer & Turner, 1970; Goh et al., 2007; Gonzalez, Alegria, & Prihoda, 2005; Hao & Liang, 2007; Mackenzie, Gekoski, & Knox, 2006; Sheikh & Furnham, 2000). Perceptions of efficacy (Delaney, Grube, & Ames, 1998) confidence in a psychological service (Milne, Blum, & Roman, 1994) and level of education (Madianos et al., 1993) have also been found to be associated with likelihood of seeking help in a number of non-gendered studies. Predictably, more negative attitudes toward seeking help are associated with lower help-seeking behaviour (Rickwood et al., 2005).

1.3 Mental Health Literacy

The term ‘mental health literacy’ was first coined by Jorm, Korten, Jacomb et al. and encompasses “knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (1997, p. 182). Research by Jorm (1995, 2000) and colleagues (1997) as well as Thompson, Hunt and Issakidis (2004) suggests that lack of mental health literacy may be a major barrier to people seeking help. Men and women have been shown to have difficulty identifying and articulating mental illnesses (Emslie, Ridge, Ziebland, & Hunt, 2007) and mental health literacy has been shown to be low amongst community samples (Jorm et al., 1997; Lauber et al., 2003; Suhail, 2005). In fact, that which people label as ‘stress’ often includes significant mental illness (Arthur, 2002, 2005). Attributing symptoms to erroneous causes has been associated with delays to seeking treatment (Hunter, Grunfield, & Ramirez, 2003). If individuals do not recognise that a problem could be a mental illness they are likely to delay or fail to seek psychological intervention (Jorm, Barney et al., 2006; Wrigley, Jackson, Judd, & Komiti, 2005). Similarly, believing that a particular intervention will not be useful for the problem at hand will prevent help-seeking from that source (Cape & McCulloch, 1999). Women have been shown to be more likely than men to identify

symptoms as possibly psychological in nature and to discuss them in psychiatric language (McMullen & Gross, 1983). Others have noted that women express greater perceived need for help-seeking as opposed to men (Mojtabai, Olfson, & Mechanic, 2002).

One might expect that prior exposure to mental illness would be associated with an understanding of that illness. Research by Lauber and colleagues (2003) found just that, reporting that previous contact with individuals who suffered from a mental illness increased identification rates. However, it has been noted that exposure does not necessarily result in increased knowledge. For example, Goldney, Fisher and Wilson (2001) found that those who suffered from major depression were no more likely than the general population to correctly identify depression in a vignette. Similarly, contact with mental health professionals has been shown to be unrelated to mental health literacy (Goldney, Fisher, Wilson, & Cheek, 2002). These findings suggest that factors other than exposure itself may need to be present in order to modify understanding of mental illness.

Mental health literacy has been shown to increase help-seeking behaviour (Rickwood et al., 2005) and is associated with more positive attitudes towards psychological services (Harlow, 1998). Therefore, authors such as Brownhill (2003) have suggested that men's low mental health literacy may contribute to their commonly delayed help-seeking behaviour. However, mental health literacy is a relatively new field of research (Bourget Consulting, 2004; Jorm, Barney et al., 2006) and some authors have denied that such knowledge affects service use (Green & Pope, 1999). Although findings suggest that gender differences in mental health literacy are significant (Cotton, Wright, Harris, Jorm, & McGorry, 2006) comprehensive investigation is still required.

Perception of mental health locus of origin (i.e. where mental illness comes from) has been shown to impact on a person's acceptance of diagnoses (Fortune et al., 2004; Hill & Bale, 1980). For example, Levi and Haslam (2005) noted that those who believe that mental illness is under an individual's control would feel as though they should have done more to avoid the problem. Studies have shown surprisingly high rates of belief that mental illness is caused by a 'weakness of character' (Suhail, 2005), although these beliefs are noted to be reducing over time (Jorm, Christensen, & Griffiths, 2005b). Other researchers challenge the notion that individuals have fixed beliefs about the causes of mental illness, instead proposing that these are fluid and changeable (Williams & Healy, 2001). However, the research on which this proposition is based investigated the understandings of individuals in the process of receiving a psychiatric diagnosis. It could be argued that at this time any previously held beliefs would be confronted as an individual comes to terms with an undesired label and begins to process the associated ramifications. Thus, whilst beliefs are likely to be modifiable (e.g. through education), it seems unlikely that these would be constantly in flux.

Goldstein and Rosselli (2003) found biological, psychological and environmental explanations of mental illness to be associated with different levels of stigma and beliefs regarding treatment effectiveness. Similarly, research conducted in Taiwan (Han, Chen, Hwang, & Wei, 2006) found that biological psycho-education on mental illness significantly increased help-seeking willingness, while a Hawaiian study (Narikiyo & Kameoka, 1992) also demonstrated attribution of mental illness to social factors to be associated with lower help-seeking from mental health professionals. These studies suggest that beliefs surrounding the origin of mental illness have implications for treatment-seeking, understandings of illness and stigmatising attitudes (Read & Harre, 2001).

1.4 Stigma

Stigma has been described by Goffman (1963) as the definition of an individual by a particular characteristic which is devalued. Goffman conceptualised the stigma of mental illness as ‘discrediting’ in instances where it is visible to others and ‘discreditable’ in instances where it remains (as yet) invisible. Thus, the characteristic by which individuals are stigmatised may be resisted. Individuals may attempt to preserve the invisibility of mental illness in order to delay or avoid being discredited. Seeking psychological help may transform one’s invisible mental health concerns into visible ones. Stigma, or the resistance of such labelling, is a significant barrier to psychological help-seeking (McGorry, 2005; Rickwood et al., 2005). This has been argued to be especially true for men (Rochlen & Hoyer, 2005), particularly for those in rural areas (Gorman et al., 2007; Jackson et al., 2007).

Fear of embarrassment, such as that generated by being stigmatised by others, has been demonstrated to impede help-seeking for psychological concerns (Barney, Griffiths, Jorm, & Christensen, 2006; Vogel, Wester, Heesacker, Boysen, & Seeman, 2006). Stigma may also impact on how a psychiatric diagnosis and treatment are accepted (Dinos, Stevens, Serfaty, Weich, & King, 2004). A worrying finding is that stigma is greatest for those in the service gap; that is, those that need psychological help but do not access it (Stefl & Prosperi, 1985). A common belief portrayed in the media and upheld by Western society is that men do not have mental health problems, and if they do they do not seek help for them (Bengs, Johansson, Danielsson, Lehti, & Hammarstrom, 2008; Johansson, Bengs, Danielsson, Lehti, & Hammarstrom, 2009; Lyons & Willott, 1999).

Self-stigma, defined as “a reduction of self-esteem or self-worth caused by the individual self-labeling...himself as...socially unacceptable” has been shown to be higher for men than women with mental illnesses (Vogel, Wade, & Haake, 2006, 325). It has also been

acknowledged to compound symptomology, such as contributing to the low self-esteem of those suffering from depression (Sims, 1993). Stigma therefore presents an important obstacle to men seeking help.

1.5 Masculinity

Masculinity has been demonstrated to influence attitudes toward mental health and help-seeking (Addis & Cohane, 2005; Addis & Mahalik, 2003; Brownhill, 2003; Courtenay, 2000a; Kraemer, 2000; Kuehn, 2006; Lee & Owens, 2002; Mahalik, Good, & Englar-Carlson, 2003). As such it must be addressed by research on this topic.

Donaldson (1993) explained that: “Hegemony involves persuasion of the greater part of the population, particularly through the media, and the organization of social institutions in ways that appear ‘natural’, ‘ordinary’, ‘normal’” (p. 645). In other words, hegemony is considered to hold up a way of being as ‘standard’. Masculinity is conceptualised as an action performed in social interaction (West & Zimmerman, 1987). Different types of masculinity are hypothesised to be available (Johnston & Morrison, 2007), and individuals enact a particular type through their behaviour. However, Wetherell and Edley (1999) also conceptualise masculinity as fluid and able to be renegotiated. Therefore the same individual may enact different forms of masculinity across situations in which different social expectations exist. According to Connell (2002, 2005), one dominant paradigm of masculinity exists within a culture, that which is termed ‘hegemonic masculinity’. Connell conceptualised hegemonic masculinity as a configuration of practices which are currently valued in a particular society and which are enacted socially. Whilst the traditional hegemonic masculine role is sometimes mocked in the mass media (Addis & Cohane, 2005) or presented as

problematic (New South Wales Health Department, 1999), such references concurrently maintain its dominance.

Hegemonic masculinity in Western society characterises men as powerful, self-reliant, inexpressive, heterosexual, successful and competitive (Levant, 1995; O'Neil, 1981). This conceptualisation influences the socialisation of men in Western culture from childhood (Shepard, 2002) and functions as an archetype of what a man 'is' and 'does' (Kraemer, 2000). From an early age parental responses to children are more accepting of emotion in girls than boys (Pollack, 1995). In their early years boys are taught to 'suck it up' because 'boys don't cry' and that showing emotion or vulnerability will have them labelled 'weak', a 'sissy', or a 'girl' (Bergman, 1995; Hamilton, 2006; Seidler, 1997). Socialisation into what is considered to be masculine ultimately focuses on a separation from what is considered feminine (and in psychodynamic theory, separation from the ultimate model of femininity is a man's mother, see Pollack, 1995).

Traditional masculinity is noted to have evolved from historical expectations of men to hunt, fight and provide food for their families (e.g. Meth, 1990). In such contexts emotion can be seen as a vulnerability which may give a competitor an edge (Niedenthal, Krauth-Gruber, & Ric, 2006). Likewise, such masculinity is valued in professions such as the armed forces, emergency services and the like in which such behaviours continue to be adaptive (Baumeister, 2007). It is therefore noted that in the context of these origins such values are advantageous and effective. However, where these values prevent appropriate help-seeking they can be problematic.

Some authors contend that men's efforts to conform to a hegemonic definition of masculinity are to blame for their reluctance to focus on their health (Ducat, 2004); attention

to health concerns is inconsistent with hegemonic masculinity (Emslie, Ridge, Ziebland, & Hunt, 2006). Kupers (2005) proposes that such masculinity itself is “toxic”, as somehow the very thing that is making men sick, or rather, the very thing keeping them from becoming well. Indeed, traditional masculinity is seemingly incompatible with the role of help-seeker, illness sufferer, or patient (Charmaz, 1995; Rochlen, 2005). These roles require one to relinquish power, to seek help from others, to defer to specialist opinion and to rely on others for recovery (McVittie & Willock, 2006). As such, men may consider health to be a women’s issue (White & Banks, 2004) and seek to resist such positions of disempowerment which are regarded as feminine. Socialisation into notions of traditional masculinity requires that topics of emotion and health are absent from men’s concerns and conversation (Hamilton, 2006; Seidler, 1997). However, because physical prowess, strength and competition are prized characteristics of traditional masculinity, discussions around physical concerns are typically sanctioned within this paradigm (Danielsson & Johansson, 2005; Smith, Braunack-Mayer, Wittert, 2006). In order to cope with psychological distress which may otherwise remain uncommunicated, behaviours which are consistent with hegemonic masculinity, such as alcohol and substance use, risk taking and aggressive behaviours may be undertaken (Shead & Hodgins, 2007).

Hegemonic masculinity does not describe the experiences of many men (Lee & Owens, 2002); however, gender and related expectations are complicit in all social interactions (Connell, 2005). Perceived social norms act to gender health behaviours. Those men who do seek help challenge these social perceptions and therefore their own masculine identity. Understanding the dilemma created by needing to seek help but desiring to uphold one’s masculine identity has been explained using models of gender role stress (Eisler & Skidmore, 1987), gender role strain (Pleck, 1981) and gender-role conflict (O’Neil, 1981).

The notion of 'gender-role conflict' has dominated research into men and help-seeking since (see O'Neil, 2008, for review).

The concept of gender-role conflict was proposed by O'Neil (1981) and later expanded by O'Neil, Helms, David and colleagues (1986). These authors described the gender-role conflict as a psychological state arising from the inherently conflicting and idealistic messages surrounding hegemonic masculinity. The gender-role conflict arises when characteristics of traditional masculinity result in personal restriction and devaluation. As discussed, socialization in the traditional male role is seen as emphasizing physical toughness, emotional stoicism, power and competition, success and achievement, rigid self-reliance and independence, avoidance of the feminine and homophobia (Addis & Cohane, 2005). Thus, O'Neil and colleagues created the *Gender-Role Conflict Scale* to assess restrictive emotionality, success, power and competition, restrictive affectionate behaviour between men and conflict between work and family life.

Research on the gender-role conflict suggests that the extent to which individuals ascribe to a prescribed role of masculinity results in conflicts within the self that create psychological distress (Berger, Levant, McMillan, Kelleher, & Sellers, 2005). Gender-role conflict has been found to be associated with alexithymia (Levant et al., 2003), increased health problems (Courtenay, 1998), increased psychological distress (Good et al., 1995; Hayes & Mahalik, 2000; Simonsen, Blazina, & Watkins, 2000), shame (Thompkins & Rando, 2003), poor attitudes towards psychological help (Good et al., 2006; Wisch, Mahalik, Hayes, & Nutt, 1995) and to be negatively correlated with help-seeking (Addis & Cohane, 2005). Considered through the gender-role paradigm, help-seeking or therapy directly conflict with

traditional masculinity. However, it is also acknowledged that men are not a homogenous group and that gender role issues affect each man differently.

1.6 Clinical Implications

Gender roles have been identified as likely to interfere with men's help-seeking for psychological concerns. The implications of hegemonic masculinity on men in therapy and recommendations for practice have also been addressed by some researchers and will now be discussed.

Research in this field has identified three ways in which therapy with men can be improved (e.g. Good, Gilbert & Scher, 1990; Good, Thomson & Braithwaite, 2005; Mahalik, 1999; Mahalik et al., 2003; Scher & Good, 1990). Firstly, therapists should acknowledge the function of gender roles both in the lives of their clients and the ways in which these may impact on therapy (Chuick et al., 2009; Mahalik et al., 2003; Scher, 1990). Indeed, Komiya, Good and Sherrod (2000) recommended that such considerations be applied to information men receive before attending therapy in order to assure them that they would not be forced to experience emotion where this was undesired.

In practical terms, Mahalik (1999) discussed cognitive distortions which were likely to be consistent with the traditional masculine role. These included: 'I must be successful to be happy' (masculine characteristic of success), 'for things to go right I have to be in charge' (power), 'if I share my feelings with others people will think I'm a sissy' (emotional control), 'a real man isn't afraid of anything' (bold and fearless), 'if I can't do it myself people will think I'm inept' (self-reliance), 'work must take primacy over other commitments or I will

never be successful' (primacy of work), 'without many sexual partners I won't feel fulfilled (playboy), 'I can't be close to other men or people will think I'm a homosexual' (disdain of homosexuals). Practitioner awareness that such internal dialogue may be present could be useful in therapy with men, and in creating homework assignments in the case of cognitive behavioural therapy. Masculinity also has positive aspects which can be highlighted during therapy such as a willingness to sacrifice, willingness to take risks, ability to think logically and loyalty (Cochran & Rabinowitz, 1996). Mahalik suggests that therapists need to acknowledge that some of the beliefs described above may be adaptive in some instances. However, he also recommends that therapists collect evidence to demonstrate that such beliefs can also have a negative influence in men's lives. Tremblay and L'Heureux (2005) argue that mental health workers should be aware of the issues that men have overcome just to get to therapy. These authors note that men are likely to experience discomfort and that the first contact provides a significant opportunity to provide men with a positive experience and thus encourage them to continue to seek help. Considering the feeling of uneasiness that men may experience in this first session of therapy (Wester & Lyubelsky, 2005) if they do not perceive that they will receive the support they desire from the therapeutic relationship they may not return.

The second way in which therapy with men can be improved is for therapists to acknowledge their own gender role beliefs and socialisation so that the effect of this on clients may be addressed and reduced (Robertson & Fitzgerald, 1990; Scher & Good, 1990). Such socialisation may result in assumptions about clients based on gender, such as who may be the aggressor in a relationship or what an individual may value. Challenging such assumptions could allow therapists to establish more open therapeutic relationships where clients are less concerned about being judged negatively. Finally, Good, Gilbert and Scher (1990) argue that gender role socialisation needs to be explicitly addressed in therapy. Utilising understandings

such as those highlighted by Mahalik (1999) may help to achieve this. Male therapists (Fischer & Good, 1997) and group therapy environments also provide good opportunities to model male emotional expression, despite some evidence that suggests men are resistant to group formats (Robertson & Fitzgerald, 1992). Addressing socialised concepts of what a man should 'be' or 'do' may increase an individual's acceptance of being in therapy and reduce the significance of perceived rules of masculinity. As a result it is possible that emotional expression may increase which could have ramifications for a man's social and intimate relationships (Good, Borst, & Wallace, 1994).

1.7 Gaps in Research

It has been established that men suffer significant health concerns yet seek help less than women. A number of factors likely to affect men's psychological help-seeking behaviour have been introduced including health, help-seeking behaviour, mental health literacy, stigma and masculinity. However, the area of men's psychological help-seeking is yet to be fully explored. Whilst restrictive gender-role and associated conflict has been associated with low psychological help-seeking in men, contention exists as to whether this conflict remains a distinctly male phenomenon (e.g. Heppner, 1995). Study one in this thesis will therefore examine gender-role conflict in more detail.

Mental health literacy has been shown to be low amongst community samples. However, little research has specifically investigated the role of gender on knowledge of mental illness and available treatment options (Bourget Consulting, 2004). Study two will therefore investigate mental health literacy in greater depth.

Whilst mental health literacy may have a significant influence on knowledge of available supports and treatments, it is likely that other factors influence the help-seeking of young people. Some research has investigated barriers to psychological help-seeking; however, exploration of how individuals identify problems, seek support and their understandings of men's help-seeking behaviour has been limited (Wisdom, Clarke, & Green, 2006). Study three in this thesis will therefore examine help-seeking behaviour.

Research has examined practitioners' ability to identify psychological concerns in men and their attitudes towards men with mental illnesses. However, little research has explored practitioner knowledge of the lived experiences of men with psychological concerns (Smith, Robertson, & Houghton, 2006). Study four presents the findings of research which captures practitioner experiences of men's psychological help-seeking behaviour (refer chapter five).

It has been identified that lived experiences offer important information for policy makers and researchers. As such, some researchers have examined the experiences of men who have sought psychological help in order to gain better understandings of the help-seeking process. Investigations into men's help-seeking which do not examine accounts from this perspective surely neglect valuable expertise (Tudiver & Talbot, 1999). Whilst some research in the field of men's help-seeking has incorporated the experiences of those men who have undertaken this process, much has not (Townsend & Braithwaite, 2002). Study five in this thesis explores the experiences of male consumers of mental health services.

Finally, although some research studies have investigated one or two factors likely to influence men's help-seeking in isolation, few studies have considered the complex interaction of such factors and thus the 'real world' implications on men's psychological help-

seeking behaviour (see Good et al., 1994, for discussion). This thesis presents research aimed to address a number of factors that may influence men's psychological help-seeking in order to gain a fuller understanding of the environment surrounding men.

CHAPTER TWO

Study One: Gender-Role Conflict and Attitude Toward Help-Seeking

2.1 Introduction

As discussed in chapter one, gender-role conflict has been identified as a likely contributor to failure to seek help. Other correlates may include attitude towards help-seeking, personality, beliefs regarding the origin of mental illness, social support and prior experience of illness. Each of these is discussed in turn.

2.1.1 Gender-Role Conflict

The gender-role conflict model has been extensively applied to research on men and masculinity, beginning with the work of O'Neil (1981) who described the impact of men's socialisation into a narrow and inflexible definition of masculinity. O'Neil proposed that attempts by men to ascribe to a strict repertoire of behaviours and values labelled as masculine produce a psychological dissonance which he termed 'gender-role conflict'.

O'Neil's model of gender-role conflict was developed from Pleck's (1981) 'sex role identity' framework (which the author now terms 'gender-role strain', 1995). Pleck argued that there are three crucial ways in which the societal definition of the masculine gender role produces strain. Firstly, an inability to fulfil male role expectations can lead to negative psychological consequences (due to feelings of failure or 'unmanliness'). Secondly, the process of socialisation into the masculine role involves the punishment of behaviour which does not fit within a restrictive definition of behaviour accepted as masculine. Socialisation

involves demeaning those who express emotion or weakness because this behaviour is associated with femininity. Thus, Pleck argues that even where gender expectations are fulfilled the process of socialisation itself is traumatic. Thirdly, many of the behaviours and interactions which are valued in narrow definitions of masculinity can be seen as “inherently dysfunctional” (Pleck, 1995, p. 17). The gender role strain framework suggests that successful fulfilment of the prescribed masculine role is therefore associated with actions which may be detrimental to the individual or others.

Like Pleck, O’Neil argues that men are socialised in very restrictive and hazardous boundaries regarding what is ‘masculine’. However, the two models differ in their focus. Where Pleck’s gender role strain model discusses the strain narrow gender roles produce in the individual, O’Neil’s gender-role conflict paradigm examines potential outcomes of such stress. O’Neil proposes that these outcomes extend across four domains: the cognitive (how we think about gender roles), affective (how we feel about gender roles), behavioural (how we behave and interact with others according to gender roles) and unconscious (how gender role dynamics affect our behaviour and produce conflicts).

Comparable to the gender strain model, gender-role conflict is said to emerge when restrictive socialised gender roles lead to negative consequences (such as restriction, devaluation or violation) for the individual or others (O’Neil, 2008). Four significant patterns of gender-role conflict emerged from this model: restrictive emotionality, obsession with success, power and competition, restrictive affectionate behaviour between men, and conflict between work and family. These patterns reflect the four factor structure identified by the *Gender-Role Conflict Scale* (GRCS, O’Neil et al., 1986) and validated by a number of studies (Good et al., 1995; Moradi, Tokar, Schaub, Jome, & Serna, 2000; O’Neil, 2008).

Gender-role conflict is said to arise in a number of circumstances, including where men experience gender role transition (such as start of school, puberty, getting married, becoming father, losing father), deviate from or violate the norms of masculinity, try to meet or fail to meet these norms, personally devalue, restrict or violate oneself for failing to meet gender role norms, experience this devaluation from others or commit such devaluation towards others (O'Neil, 2008).

Since its conception in the early 1980s gender-role conflict has become significant in explaining the psychological experience of men. In a recent article O'Neil (2008) reviewed more than 230 studies that utilised this concept. The author noted that 22 separate factor analyses have shown the gender-role conflict scale (GRCS) to have factorial validity, and studies using US college students have shown that it has good construct validity. Inter-correlations between factors have been shown to be moderate (Moradi et al., 2000) indicating that whilst factors (used as subscales) are associated they remain distinct. O'Neil notes that the scale has demonstrated reliable internal consistency across populations, including age groups, ethnicity and sexual orientation, each with comparable outcomes to the author's early studies. Test-retest validity has been shown to be high over a one month period, ranging from .72 to .86 across factors (O'Neil et al., 1986). The convergent validity of the GRCS has also been examined in relation to other masculinity scales. In his review O'Neil confirms that the results have shown an association between scales, but low correlations signify that the GRCS measures something unique. Studies have further shown that the tendency for social desirability to affect responding is "practically insignificant" (O'Neil, 2008, p. 371).

O'Neil's (2008) review reflects how quickly research on this model is expanding. This author notes that the amassing literature posits a number of consistent findings. Firstly, of 27

published studies examining the interaction between gender-role conflict and depression, 24 found there to be a significant relationship (e.g. Good, Robertson, Fitzgerald, Stevens, & Bartels, 1996; Magovcevic & Addis, 2005). Restrictive emotionality, restrictive affectionate behaviour and conflict between work and family were the most predictive of male depression. Similarly, 12 of 15 studies on the GRCS and anxiety found a significant interaction (e.g. Cournoyer & Mahalik, 1995; Sharpe & Heppner, 1991; Theodore & Lloyd, 2000), and all 9 published works on stress and the GRCS found positive correlations (e.g. Good, Heppner, & Fischer, 2004; Hayes & Mahalik, 2000). These results provide evidence of the psychological distress that men's socialisation into gender roles can cause.

Restrictive emotionality (RE) has been found to be a strong predictor of psychological distress for men in clinical and non-clinical samples (Cournoyer & Mahalik, 1995; Good et al., 1995; Sharpe & Heppner, 1991). For example, Shepard (2002) proposes that there may be a connection between RE and a pattern of depressive symptoms characterised by a negative state of mind, and specifically self-dislike, feelings of failure, guilt and pessimism. None of these findings should be unexpected because masculine ideology is inescapably associated with cognitive distress (Mahalik, 1999).

An Australian study investigated the role of age in gender-role conflict (Theodore & Lloyd, 2000). This study found that whilst no difference existed across ages in restrictive emotionality or restrictive affectionate behaviour between men, variance did occur on other factors. The authors reported that young men in their study were focused on success, power and competition, whereas those in middle age were most concerned with conflict between work and family. Heppner (1995) also argues that work/family conflict is now equally

applicable to women and questions whether this scale can still be said to be assessing a conflict which is unique to the male role.

2.1.2 Attitude Toward Seeking Psychological Help

Fischer and Turner (1970) developed a scale for assessing an individual's attitude towards seeking professional psychological help (ATSPPHS) in association with several clinical psychologists. This scale used 29 items and was presented as encompassing four dimensions of attitude. These were recognition of need for psychological help, stigma tolerance, interpersonal openness, and confidence in health professionals. The authors indicated that the scale had an internal consistency of .86, test-retest responses remained reasonably stable over time and no social desirability concerns existed.

More recently Fischer and Farina (1995) asserted that ATSPPHS was in fact a unitary measure and developed a shorter form of the scale which consists of only ten items (ATSPPHS-S). In establishing their case for a unitary measure, these authors observed that each of their ten items was found to produce a loading upon one factor of above .5. The scale was found to have internal consistency (Cronbach's Alpha .84) similar to that of original scale, and the test-retest correlation at a one month interval was .8 (Fischer & Farina, 1995).

The ATSPPHS, in both its original and more recent short form, has been utilised by a number of researchers interested in psychological help-seeking (e.g. Berger et al., 2005; Deane, Skogstad, & Williams, 1999; Fischer & Cohen, 1972; Goh et al., 2007; Good & Wood, 1995; Judd et al., 2006; Komiti, Judd, & Jackson, 2006; Matlock-Hetzel, 2004; Sheikh & Furnham, 2000; Simonsen et al., 2000; Skogstad, Deane, & Spicer, 2006; Wisch et al.,

1995; Yeh, 2002). Findings conducted across cultures consistently indicate that men often have more negative attitudes towards seeking professional psychological help than women (Ang et al., 2004; Berger et al., 2005; Goh et al., 2007; Judd et al., 2006; Komiti et al., 2006; Sheikh & Furnham, 2000; Yeh, 2002).

The interaction between gender-role conflict and attitude toward seeking psychological help has also been investigated, most commonly with college student samples. The consensus of research studying these variables is that characteristics associated with traditional or hegemonic masculinity are negatively related to help-seeking (Addis & Mahalik, 2003; Berger et al., 2005; Good, Dell, & Mintz, 1989; Good & Wood, 1995; Lane & Addis, 2005; Robertson & Fitzgerald, 1992; Wisch et al., 1995).

The pessimistic attitude towards seeking help associated with high levels of gender-role conflict is demonstrated in negative views towards emotion-focused rather than cognitive-focused therapy (Wisch et al., 1995). Similarly, those with high gender-role conflict scores have been found to hold poor attitudes towards individual therapy, psycho-educational workshops, and men's support group brochures (Blazina & Marks, 2001). Other research has shown that this group responds more positively to advertised services which are in line with the masculine socialisation process (self-help materials, classes, workshops) than to those that were not, such as personal counselling (Robertson & Fitzgerald, 1992). These findings suggest that general psychological services which require an expected or actual focus on emotion are likely to be unappealing for men with high gender-role conflict who feel uncomfortable with such approaches.

Higher levels of education (Fischer & Cohen, 1972; Madianos et al., 1993), prior mental health service contact and help-seeking (Goh et al., 2007), experience with the discipline of psychology (Morgan et al., 2003), tendency to self-disclose (Vogel & Wester, 2003), and older age (Berger et al., 2005) have been found to be associated with more positive attitudes towards seeking professional psychological help. Scholastic major (Fischer & Cohen, 1972) and other's opinions about seeking psychological help (i.e. that this is positive or negative, Skogstad et al., 2006) have further been found to predict help-seeking attitudes using the ATSPPHS.

Australian men have been shown to have poorer attitudes toward help-seeking for psychological problems from professional sources than Australian women (Judd et al., 2006) . A recent study by Komiti, Judd, and Jackson (2006) found that 87% of a rural community sample would see seeking help from a professional as a sign of weakness. Likewise, more than 80% of participants in the same study thought they should sort out their own problems and that seeing a mental health professional would be the last resort. Males in particular endorsed a belief that it is admirable to cope without resorting to seeking help from a mental health professional.

2.1.3 Personality & Help-Seeking

Personality has been found to be a significant predictor of help seeking (ten Have, Oldehinkel, Vollebergh, & Ormel, 2005). Shaw (1999) noted that personality style can affect illness representation and coping strategies. That is, personality can affect how one experiences, exhibits and copes with mental illness. Those with different personality styles may have diverse responses to similar symptoms. For example, Shaw asserts that neuroticism is associated with more hostile reactions, escapist fantasy, self-blame, withdrawal, wishful

thinking and indecisiveness. Other authors (ten Have et al., 2005) have reported that neuroticism is a marker for vulnerability to mental disorder, whilst extraversion is associated with rational action, positive thinking, substitution and restraint.

In line with a traditional masculine role which encourages stoicism and lack of emotionality (Connell, 2005), men have been shown to display lower levels of openness to experience than women (Judd, Komiti, & Jackson, 2008). Openness has also been found to be negatively associated with the restricted emotionality subscale of the GRCS (Tokar, Fischer, Schaub, & Moradi, 2000).

The success, power competition subscale of the GRCS has been shown to be related to hostility (Hayes & Mahalik, 2000), and conflict between work and family with a dependent personality style (Schwartz, Buboltz, & Seeman, 2004). An association has also been demonstrated between restricted affectionate behaviour between men and both social discomfort and obsessive-compulsiveness (Hayes & Mahalik, 2000)

Neuroticism and openness to experience have been shown to be predictive of greater help-seeking, and conscientiousness and extraversion associated with lower help-seeking behaviours (Goodwin, Hoven, Lyons, & Stein, 2002). Indeed, Fischer and Turner (1970) noted that the personality components of interpersonal trust and social desirability in men were associated with attitudes towards professional psychological help-seeking. It is therefore useful to include personality correlates in studies of mental health service use (ten Have et al., 2005).

2.1.4 Mental Health Locus of Origin

Mental health locus of origin (MHLOO) refers to beliefs about the cause of mental health and illness. The concept developed from locus of control literature, much of which utilised Rotter's Internal / External Locus of Control Scale (1966). However, Rotter (1966) suggested that locus of control would be useful for practical purposes when utilised in a measure specific to the area being studied rather than as a generalised measure. Hill and Bale (1980) therefore developed the MHLOO scale (in combination with a mental health locus of control measure) in order to study beliefs about the cause of mental illness. The authors define mental health locus of origin as:

...a bipolar construct pertaining to beliefs about the etiology of maladaptive behaviour. At one end of the dimension ("endogenous") lie beliefs emphasizing genetic and physiological factors. The opposite pole ("interactional") consists of beliefs which focus on the interactions between an individual and the social environment. (Hill & Bale, 1980, p. 150)

In the case of mental illness, in order for help-seeking to occur a number of assessments must be undertaken. Firstly, one must see the issue as a problem requiring intervention. Secondly, the problem must be seen as amenable to help (Gross & McMullen, 1983). Therefore mental health locus of origin is important in decisions around help-seeking because etiological beliefs impact on whether an individual sees a problem as amenable to help and on what kind of help may be sought (Williams & Healy, 2001). If one sees a concern as primarily a biological problem they may be unlikely to seek therapy. Conversely, if one

sees a problem as primarily based in the social environment, pharmacological treatment is likely to be seen as unwarranted.

Although etiological beliefs can be seen to impact the management of mental illness, research suggests that such beliefs tend to be inconsistent and changeable. For example, Bhui & Bhurga (2002) found explanatory models of mental illness among first time presenters to mental health services included a variety of explanations that were either held simultaneously or taken up and dismissed rapidly. This challenges models which assume that beliefs are stable over time (Williams & Healy, 2001). However, this does suggest that there is an opportunity to modify beliefs about mental illness through education.

Studies suggest that people typically believe that depression is caused by one's social environment, encompassing factors such as stress, grief, and childhood experiences (e.g. Angermeyer & Matschinger, 2003). However, individuals suffering depression have been shown to identify the disorder as having a biological basis (Williams & Healy, 2001). Thus, such individuals can be seen as externalising the locus of control for this illness. It has also been suggested that beliefs about biological causes of mental illness are associated with negative attitudes towards people suffering from mental illnesses (Read & Harre, 2001). Conversely, other research indicates that emphasis on environmental causation of mental illness rather than biological concepts may result in less rejection of help-seeking (Calhoun, Peirce, Walters, & Dawes, 1974).

2.1.5 Social Support

Social support has been described as the strongest predictor of men's health (Lock, 1989). Insufficient support, or not having someone to cheer you up when you're feeling

down, has been found to be a vulnerability factor for psychological disorder (Miller, Buys, & Roberto, 2006; ten Have et al., 2005), and may increase the negative impact of life events (Goodman et al., 1984). Men have been shown to have smaller social networks than women and fewer sources of support (Antonucci & Akiyama, 1987). The GRCS subscales 'restricted emotionality' and 'restricted affectionate behaviour between men' have also been found to be related to poor social support (Wester, Christianson, Vogel, & Wei, 2007). Despite this, little research has investigated any causal relationship between social support and psychological distress or gender-role conflict.

Rickwood, Deane and colleagues' (2005) study of Australian youth showed that only 6 percent of men who had sought professional psychological help claimed they were not influenced to do so by others. One third claimed they would not have sought help without the influence of others, and almost three quarters reported that they were influenced by more than one source. Similarly, Steel, MacDonald and colleagues (2006) found that social support increased the likelihood of more allied health consultations, suggesting that confidantes encourage sufferers to seek professional psychological support.

Interestingly, research has also shown that low social support increases psychological help-seeking from professionals (Cepeda-Benito & Short, 1998; Goodman et al., 1984). This is likely to be due to individuals lacking non-professional sources of help where they can discuss their problems. Thus social support can be seen as a protective factor against the impact of negative events, a persuasive help-seeking factor and/ or a factor which may delay or deter professional psychological help-seeking.

2.1.6 Prior Experience of Mental Illness

Contact with people with mental illness has been shown to be related to more positive attitudes towards those suffering from mental illness. Further, contact with someone with mental illness has been shown to be related to both more positive attitudes towards psychological help-seeking and increased help-seeking intentions (Vogel, Wester, Larson, & Hackler, 2007). Similarly, those who have sought help previously have been shown to be more likely to do so again than non help-seekers (Goh et al., 2007; Halgin, Weaver, Edell, & Spencer, 1987).

Prior experience of mental illness is likely to have some effect on ability to identify and seek help for that illness (e.g. Lauber et al., 2003), as well as reducing stigma. This suggests that the role of prior experience on attitude towards help-seeking and help-seeking behaviour need to be further examined.

2.2 Aims of this study

The aims of this study are therefore to:

- Examine whether differences exist between men and women in attitudes toward seeking help for psychological complaints.
- Determine whether social support, personality, mental health locus of origin, gender-role conflict are useful in explaining the psychological help-seeking behaviour of men.
- Ascertain whether a gender difference exists in prior help-seeking from psychological services.
- Elicit reasons for lack of help-seeking in those who identify significant psychological issues.

On the basis of past research (discussed above), it is hypothesised that:

1. Males will report less prior help-seeking from a professional source than females.
2. Gender-role conflict scores (GRCS) will be higher for males than females.
3. Restrictive emotionality (as measured by the GRCS subscale RE) will be correlated with openness to experience (as measured by the Quickscales).
4. Males will express a more negative attitude towards seeking professional psychological help than females (as measured by ATSPPHS-S).
5. Higher GRCS scores will be associated with more negative ATSPPHS-S scores.

2.3 Method

This study was conducted using undergraduate students of the University of Adelaide. An internet-based or paper-based survey was completed by participants which investigated social support, personality, gender-role conflict, mental health locus of origin, attitudes towards seeking psychological help, and the role of the theory of planned behaviour in psychological help-seeking.

A pilot study was conducted using paper and pencil questionnaires. The study proper was then conducted online via the University's website. Additional paper versions of the survey and envelopes were also available. The University of Adelaide Ethics Committee granted approval for this study prior to commencement. An information sheet (see Appendix A) preceded completion of both the battery online and the paper version. The information sheet specified that participation was voluntary, the survey was expected to take approximately 30 minutes to complete, that participants were free to cease involvement at any time, and any identifying information recorded would be stored separately to responses.

2.3.1 Participants

The pilot study was conducted using a snowball sample of 34 participants in which initial participants were asked to recruit further participants from their acquaintances. This was undertaken in order to investigate the appropriateness of the length, items and scales included in the battery. Following the pilot study, minor grammatical, layout and ordering changes were undertaken to improve comprehension and ease of completion.

The main study was then conducted using 601 first and second year psychology students from the University of Adelaide who volunteered to participate in exchange for course credit. Both male and female students were eligible to participate and there were no exclusion criteria. Written information sheets were distributed to all potential participants in either computerized or paper form. Consent was considered to be given by the individual's completion of the survey. In the first year of the project (2007) 397 participants completed the survey (including those in the snowball sample). A further 239 took part in the second year.

2.3.2 Plan and Design

The assessment battery (included in Appendix B) consisted of the following measures:

Attitudes Toward Seeking Professional Psychological Help Scale – Short Form

(Fischer & Farina, 1995). This includes 10 statements which are ranked on a 4-point Likert scale. For items 3 and 8 wording was changed from “psychotherapy” to “counselling” in order to make the questions less intimidating to young people. Items expressing positive help-seeking attitudes (items 1, 3, 5, 6, and 7) were coded 1, 2, 3, 4. Items expressing negative

help-seeking attitudes (items 2, 4, 8, 9, and 10) were reverse scored (coded 4, 3, 2, 1). Lower scores therefore represent more positive attitudes toward professional psychological help seeking. Scores range from 10 to 40.

Gender-Role Conflict Scale (O'Neil et al., 1986). This is a 37-item scale on which respondents are asked to answer items on a 6-point Likert scale (6 = strongly agree, 1 = strongly disagree). Three items which referred to sexual behaviour were deleted due to irrelevance to this study and ethical considerations. Slight modifications in wording were made to encompass female participants within this measure (e.g. "Being physically stronger than other men is important to me" was modified to "Being physically stronger than others is important to me"). Scores could range from 34 to 204, with higher scores indicating greater gender-role conflict.

Mental Health Locus of Origin Scale (Hill & Bale, 1980). This scale consists of 20 items designed to assess participant's beliefs about the etiology of psychological problems. Participants are asked to mark answers on a 6-point Likert scale (1= agree and 6= disagree). High scores indicate "endogenous" beliefs that highlight biological factors. Low scores indicate "interactional" beliefs which focus on "interactions between an individual and the social environment" (Hill & Bale, 1980, p. 150). Scores could range from 20 (interactional extreme) to 120 (endogenous extreme) with midpoint 70. Six extra questions relating to mental health locus of origin were included to determine their validity.

Quick Scales (Brebner, 2003). This instrument consists of 30 items designed to assess five personality factors, namely Extraversion, Neuroticism, Openness to Experience, Conscientiousness, and Agreeableness. Subscales consist of six items corresponding to each

of these factors. Respondents were asked to mark their answers on a seven point Likert scale (1 = not at all and 7 = extremely). Subscale scores could range from 7 to 42.

Experience of Distress and Help-Seeking. Questions regarding prior experience of mental illness (in themselves or someone close to them), psychological distress, help-seeking and source of help utilised were also included. Those who identified that they had experienced significant distress but did not seek help for this were asked to explain their reasoning in a short written answer.

2.3.3 Methodology

Responses to the survey were analysed using Statistical Package for the Social Sciences (SPSS) software, version 15. Tests such as correlations, comparisons of means and standard deviations through t-tests, ANOVAs, ANCOVAs and factor analysis were used to determine which variables had an influence on help-seeking behaviour.

Responses to qualitative questions were analysed using thematic analysis using the approach of Braun and Clarke (2006) in order to identify, analyse and report patterns or 'themes' within the data. A theme is described as representing a pattern of response within the data collected (Boyatzis, 1998); a good theme will capture something valuable in the data.

Although some researchers characterise thematic analysis as a tool which can be used within wider qualitative methods of investigation such as grounded theory (Boyatzis, 1998; Flick, 2006), others such as Braun and Clarke (2006) argue that thematic analysis should be

considered to be a method in its own right. This study was undertaken using the approach developed by Braun and Clarke.

The qualitative analysis was conducted from an inductive or ‘data-driven’ perspective. That is, coding and theme development was undertaken according to the concepts within the data and not imposed from previous research or theory. This inductive approach was chosen due to the exploratory nature of the investigation. Further, semantic themes (those which are explicit or at the surface level of responses) were examined. The short answer nature of questions prompted the level of analysis, as the small amount of information provided would make it difficult to accurately identify latent (underlying) themes.

Thematic analysis can be employed from a number of epistemological perspectives. Here a contextualist approach was adopted which can be seen as sitting between the two poles of essentialism and constructionism. Analysis stemming from this contextualist standpoint does not suppose that the way that these individuals responded is ‘fact’, nor that their reports are completely constructed by experiences which are unique. It proposes that responses lie somewhere in between these two. As Braun and Clarke (2006) explain, the contextualist stance “acknowledge[s] ways individuals make meaning of their experience, and, in turn, the ways the broader social context impinges on those meanings, while retaining focus on the material and other limits of ‘reality’” (p. 81). Thus whilst each participant’s own experiences shape their response, the patterns across responses suggest that these experiences are similar. The premise of thematic analysis (used in this analysis) is that such similarities in ways of responding may be important in attempting to understand the reasons young people identify for not seeking help.

It must be further noted that although the qualitative analysis is data driven, the researcher played an active role in identifying and labelling themes across the data set. As such, themes have not ‘emerged’ from the data on their own, but were noted and pursued by the researcher. Themes identified were triangulated for suitability and consistency by another researcher with experience in thematic analysis. Any differences in coding were discussed and themes agreed upon.

A total social contact score was derived from combining scores within item 6 (contact with wife or female partner, mother (including in-law), sister(s), daughter(s), one female friend, a few female friends, husband or male partner, father (including in law), brother(s), son(s), one male friend, a few male friends). Scores on contact with a few female friends and a few male friends were each tripled to reflect the amount of social contact this item infers (i.e. “a few” rather than “a couple”).

Total Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) score was calculated by totalling responses on each item. Items 2, 4, 8, 9, and 10 were negatively scored.

2.4 Results

The sample consisted of 635 participants, the majority of whom were first year university students (74%) or other undergraduates (second year or above, 14%) at the University of Adelaide in 2007 or 2008. Eighty-nine percent of participants were aged 16-24 years, 6 percent 25-34 years, and 5 percent over 35 years. Most participants were single (87%, married or de facto 12%). Participants described the highest level of education that they had achieved as completing high school (82%), a university degree (9%), or a TAFE course (6%).

This study was conducted twice over a two year period. The first group consisted of 396 participants who took part in 2007; the second consisted of 239 participants in 2008. A chi square test confirmed that no significant difference in gender existed between these samples ($\chi^2 (1, N = 635) = .00, p = 1.00$). Very small differences in age and occupation existed across year of completion groups; however, small cell sizes precluded statistical analysis. This was difference was due to the inclusion of pilot survey participants in the 2007 group which consisted of an older, largely non-student sample.

Total social contact was assessed in order to provide an indication of a participant's social interaction and subsequent opportunity for others to prompt them to seek help. Social contact scores ranged from 1 to 14 with an average of 7.9 contacts ($SD = 2.66$). Men reported an average on 8.11 different weekly social contacts ($SD = 2.72$) and women 7.84 ($SD = 2.64$). However, the difference across genders was non-significant.

2.4.1 Experience of Distress, Help-Seeking and Help Sought

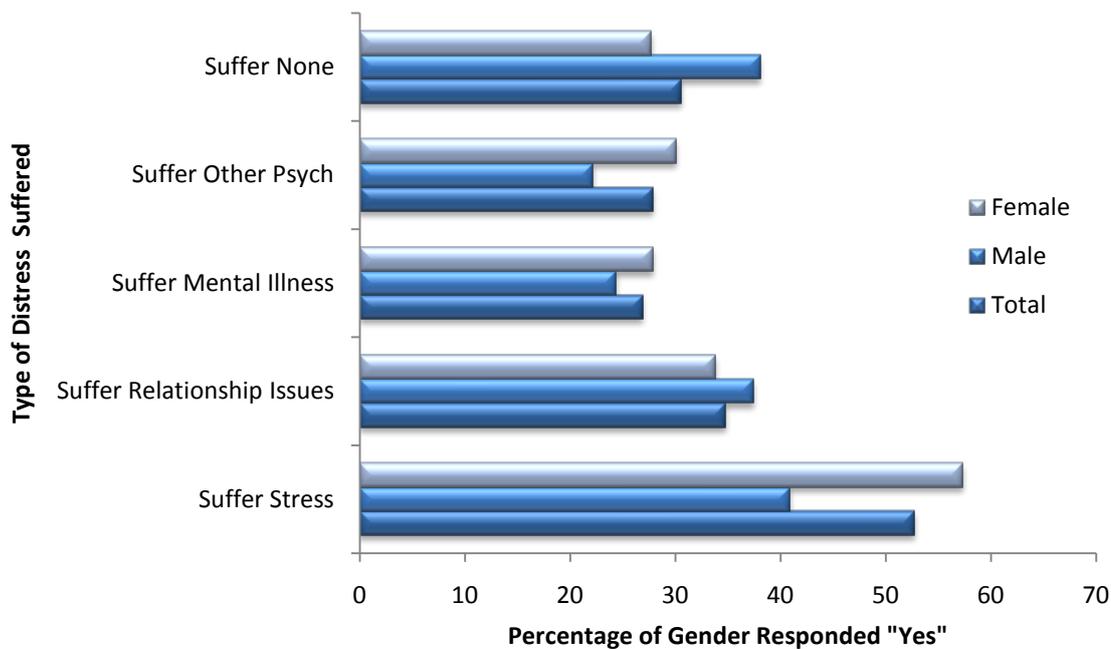
Participants' experience of significant psychological distress, seeking help and source of help sought were examined. More than half of participants reported having previously suffered significant stress, roughly a third had suffered from relationship issues and slightly under a third from no significant distress. Twenty-seven percent of participants indicated that they had suffered from "mental illness" (due to brevity this item did not specify type or severity).

Experience of distress was investigated by gender using chi square analysis. Results showed that women reported that they had suffered stress ($\chi^2 (1, N = 635) = 13.06, p < .001$)

significantly more than men. Men reported having suffered from no substantial psychological distress ($\chi^2 (1, N = 635) = 6.00, p = .01$) significantly more than women (see Figure 1).

Figure 1

Experience of Psychological Distress by Gender

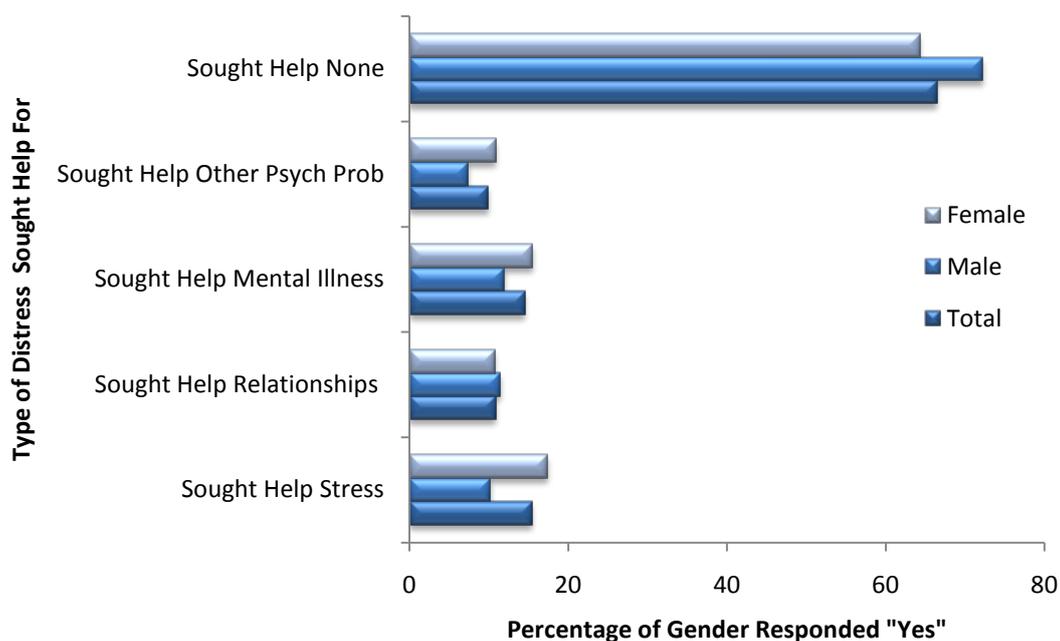


Prior help sought for the same issues was also examined and the results are presented in Figure 2. The contrast between responses presented in Figure 1 and Figure 2 highlights that help-seeking behaviour was low despite experience of significant psychological distress.

Results showed that women reported that they had sought help for stress more than men ($\chi^2 (1, N = 635) = 4.52, p = .03$), and that men reported having sought no psychological help significantly more than women ($\chi^2 (1, N = 634) = 7.43, p < .01$).

Figure 2

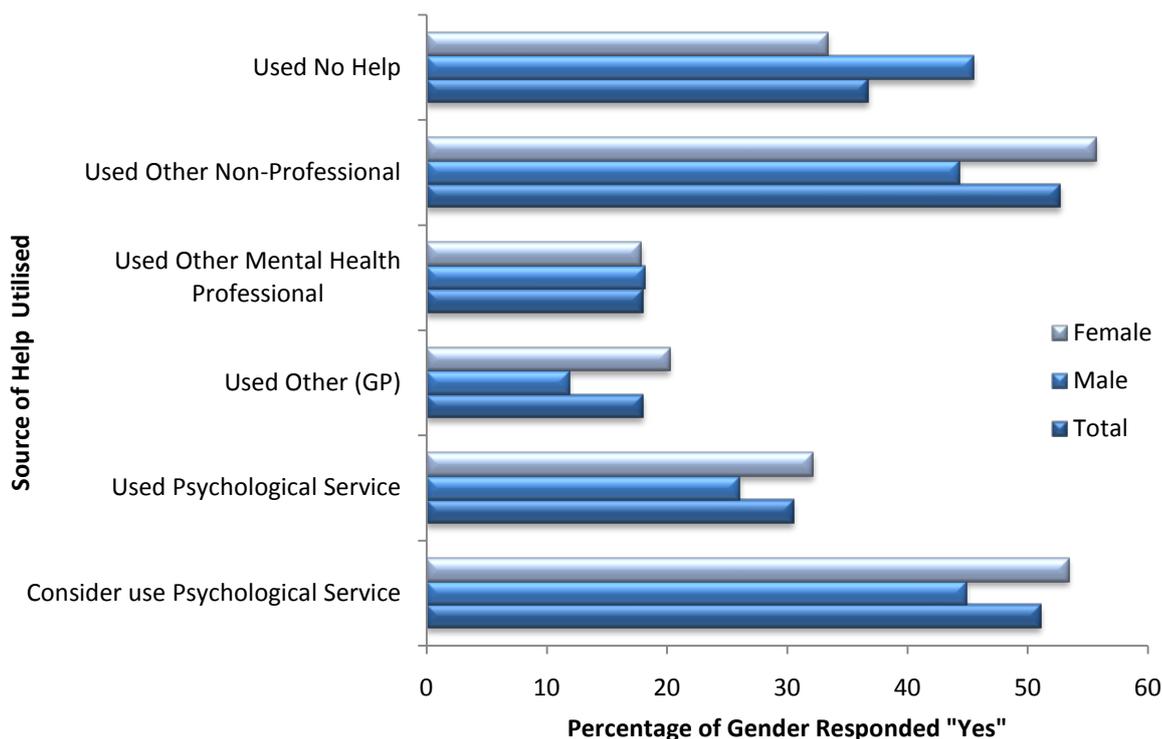
Experience of Seeking Help for Psychological Distress by Gender



Hypothesis 1, that men would report less prior help-seeking from professional sources than women, was tested using chi square analysis. Results showed that women used professional services such as a GP for psychological distress more than men ($\chi^2 (1, N = 634) = 5.49, p = .02$). However, there was no gender difference in use of mental health professionals ($\chi^2 (1, N = 634) = .007, p = .93$). The hypothesis was therefore partially supported. Chi square analysis further indicated that women sought help from non-professional sources significantly more than men ($\chi^2 (1, N = 634) = 6.38, p = .01$). Responses by gender are presented in Figure 3 (for details see Appendix C).

Figure 3

Source of Help Sought by Gender

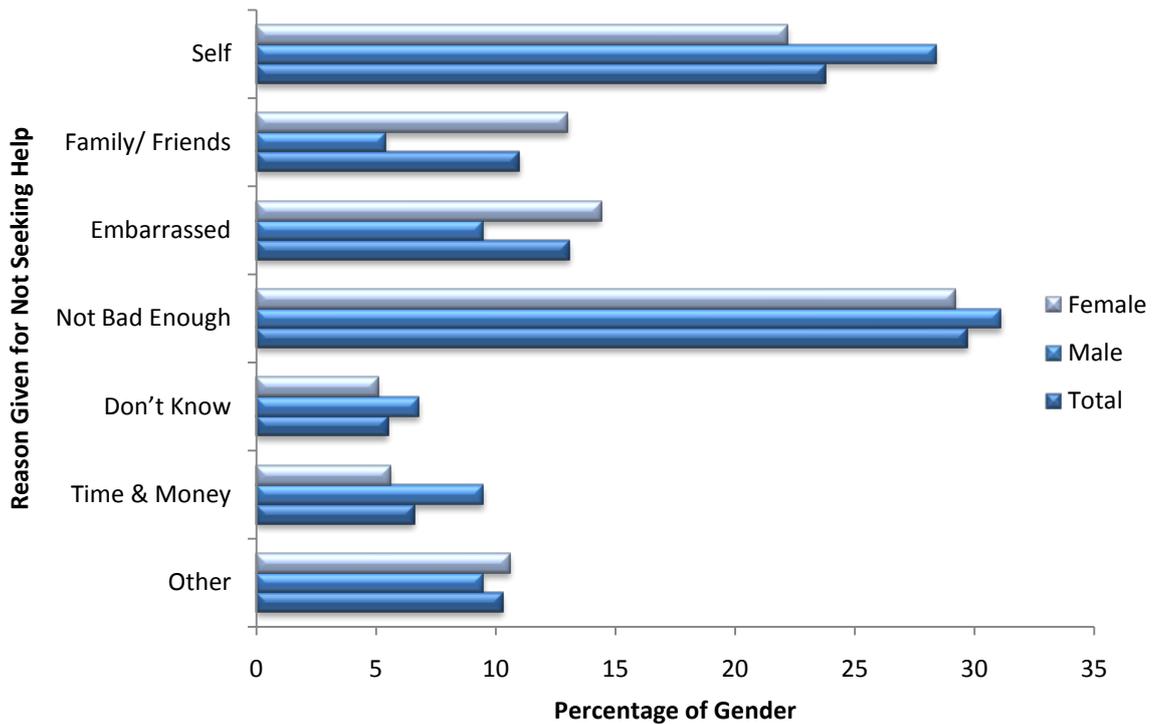


Whilst almost 30 percent of participants indicated that they had suffered from mental illness, only 14 percent had sought help for this concern. Those participants who indicated that they had suffered any kind of significant psychological distress but had not sought any kind of help were asked to report a reason for this ($n = 290$). Each response was coded for only one theme; therefore, when two responses were given the first was recorded. The majority of respondents (30%) indicated that they felt that their problem was not bad enough to require intervention. Remaining participants stated that they tried to deal with the problem themselves, that they were too embarrassed to seek help, talked to family and friends about their problem, did not have the time or money to seek help, didn't know where to seek help or gave various reasons coded as 'other'. Chi square analysis could not be performed to investigate response according to gender due to small cell counts. However, Figure 4 shows that women nominated both talking to family and friends and embarrassment as reasons for not seeking help more than men. Conversely, men were more likely than women to report

either that the problem was not serious enough to seek help, they dealt with the problem themselves, or didn't have the time or money to seek help.

Figure 4

Reason for Not Seeking Help (Despite Suffering Distress) by Gender



Participants were asked to indicate whether they had some previous experience of mental illness in themselves or someone close to them. Almost two thirds of participants had some prior experience of mental illness, with the proportion slightly higher for women than men. However, chi square analysis showed that this difference was not significant ($\chi^2 (1, N = 634) = .96, p = .33$).

2.4.2 Gender-Role Conflict

Total gender-role conflict comprised of the total score on the *Gender-Role Conflict Scale* (GRCS). Scores ranged from 44 to 195 with an average of 114.83 ($SD = 21.56$). Higher scores indicate higher levels of gender role conflict for both total and subscale scores.

Hypothesis 2 proposed that GRCS would be higher for males than females. An ANOVA was undertaken in order to investigate this hypothesis. There was a statistically significant difference between genders on total GRCS [$F(1, 633) = 15.30, p < .001$]. Men were found to have higher average gender-role conflict ($M = 120.18, SD = 23.11$) than women ($M = 112.78, SD = 20.60$). Hypothesis 2 was therefore supported.

Hypothesis 3, that restricted emotionality (RE) would be correlated with openness to experience, was not supported ($r = -.07, p = .07$). Other correlations were analysed to explore the relationship between GRCS and personality factors (see Table 1). RE showed correlations with extraversion, neuroticism, conscientiousness and agreeableness. Results indicate that as extraversion and agreeableness increased, RE, RAB and total GRCS decreased. Conversely, as neuroticism increased RE, RAB, SPC, conflict between work and family (CWF) and total GRCS increased. GRCS total score was found to be correlated with personality factors extraversion, neuroticism and agreeableness, but not with openness or conscientiousness. These results indicate that high neuroticism is associated with high gender-role conflict, and that high extraversion and agreeableness are related to low gender-role conflict.

Table 1

Gender-Role Conflict Subscales and Personality Correlations

	Extra	Neuro	Open	Consc	Agree
GRCS	-.14**	.25**	-.16	.02	-.16**
	.000	.000	.682	.588	.000
SPC	.11**	.11**	.08	.20**	-.15**
	.006	.005	.051	.000	.000
RE	-.27**	.25**	.72*	.13**	.15**
	.000	.000	.071	.001	.000
CWF	-.09*	.29**	.07	.00	.03
	.022	.000	.063	.999	.376
RAB	-.26**	.11**	-.16**	-.11**	-.16**
	.000	.007	.000	.008	.000

Sig at the <.05* or <.01** level, N = 635

It can be seen in Table 2 that mental health locus of origin (MHLOO) was correlated with total GRCS and each subscale except CWF. Negative correlations demonstrated that interactional beliefs regarding mental health locus of origin were associated with higher total GRC, SPC, RE and RAB.

Table 2

Gender-Role Conflict Subscales and Mental Health Locus of Origin Correlations

	GRCS	SPC	RE	CWF	RAB
MHLOO	-.22**	-.20**	-.15**	.02	-.26**
	.000	.000	.000	.547	.000

Sig at the <.01** level, $N = 635$

To investigate the relationship between GRCS and previous experience of distress, independent samples t-tests were performed. Results are presented pictorially in Figure 5. Analysis indicated that those who had suffered from substantial stress ($M = 118.30$, $SD = 21.99$) had higher GRCS than those who had not ($M = 110.96$, $SD = 20.41$; $t(633) = -4.34$, $p < .01$, $\eta^2 = .03$). This was also the case for subscales SPC, RE and CWF.

Similarly, t-tests demonstrated that those who had previously suffered from substantial relationship issues experienced significantly higher GRCS ($M = 117.38$, $SD = 22.76$) than those who had not ($M = 113.47$, $SD = 20.80$; $t(633) = -2.19$, $p = .05$, $\eta^2 = .03$). This was also the case for the CWF subscale.

T-tests showed that GRCS was again higher for those who had suffered from mental illness ($M = 119.35$, $SD = 20.48$) than those who had not ($M = 113.17$, $SD = 21.73$; $t(633) = -3.23$, $p < .01$, $\eta^2 = .01$). RE and CWF were also significantly higher for those who had previously suffered from mental illness.

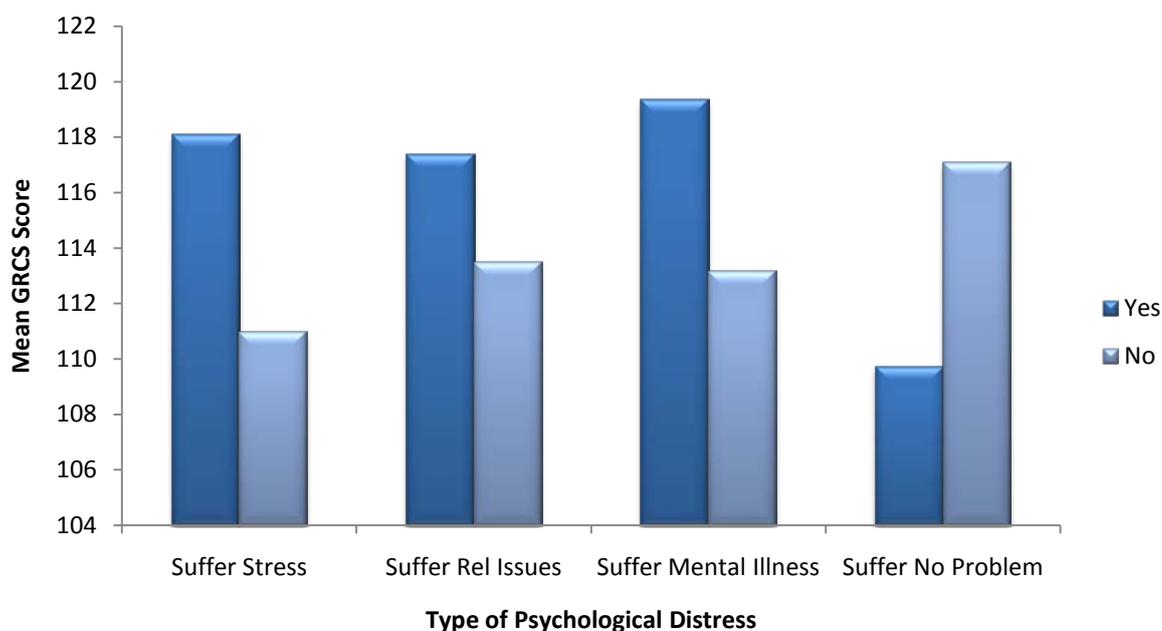
Of total GRCS and subscales only CWF significantly differed across previous experience of substantial psychological problems. CWF was higher for those who had suffered psychological problems ($M = 4.03, SD = .98$) than for those who had not ($M = 3.42, SD = .89$), $t(633) = 7.38, p < .001, \eta^2 = .01$.

GRCS was found to be significantly greater for those who had suffered from any kind of substantial psychological distress ($M = 117.08, SD = 21.60$) than for those who had not ($M = 109.72, SD = 20.62$); $t(633) = 4.01, p < .001, \eta^2 = .02$. SPC, RE and CWF were also greater for those who had experienced some kind of substantial psychological distress than for those who reported that they had not.

For detailed results of these analyses see Appendix D.

Figure 5

GRCS by Prior Psychological Distress



Independent samples t-tests undertaken on experience of seeking help, services used and experience of mental illness items showed that of GRCS and all subscales only conflict between work and family (CWF) returned significant results on almost all of these items. Details can be found in Appendix E.

GRCS varied across previous consideration of using a psychological service ($t(632) = 2.69, p < .01, \eta^2 = .01$). Means showed that those who had considered using a psychological service had higher GRCS ($M = 117.09, SD = 20.81$) than those who had not ($M = 112.50, SD = 22.13$).

One-way between-groups ANOVAs were performed to determine whether GRCS subscales differed across reported reasons for not seeking help despite identifying substantial emotional distress. The first of the analyses showed a significant result for RE [$F(6, 283) = 2.47, p < .05, \eta^2 = .05$]. Post hoc analysis using Tukey's HSD indicated that a statistically significant difference existed between those who responded that they relied on family and friends ($M = 3.20, SD = 1.23$) and those who stated that they were too embarrassed to seek help ($M = 3.91, SD = .81$). Means suggest that those who revealed they were too embarrassed to seek help had higher levels of RE than those who talked to family and friends.

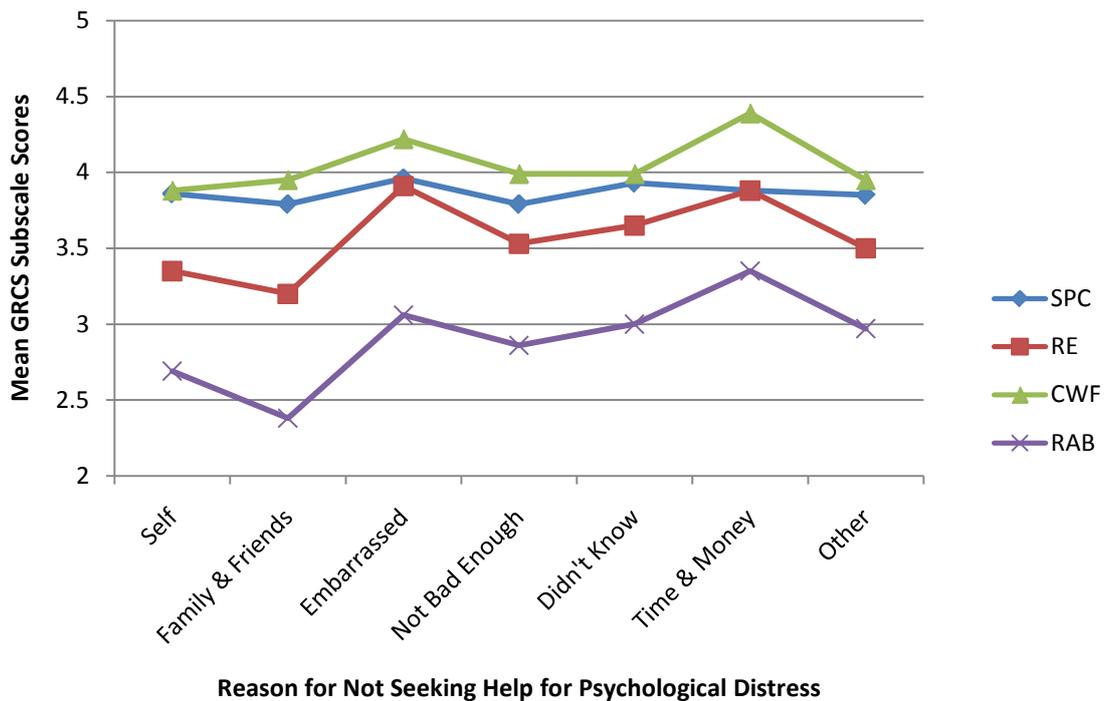
A second ANOVA showed significant differences in RAB across reasons given for not seeking help [$F(6, 283) = 2.66, p = .02, \eta^2 = .05$]. Post hoc analysis using Games-Howell indicated that a statistically significant difference existed between those who responded that they relied on family and friends ($M = 2.38, SD = .91$) and both those who either stated that they did not have the time and money ($M = 3.35, SD = .88$) and were too embarrassed to seek help ($M = 3.06, SD = .89$). Means show that those who stated either that they were

embarrassed or did not have the time and money to seek help experienced greater RAB than those who talked to family and friends.

Further analyses showed no significant differences in SPC [$F(6, 283) = .24, p = .961$], CWF [$F(6, 283) = 1.08, p = .372$], or total GRCS [$F(6, 283) = 2.06, p = .06$] across reason given for not help-seeking. Figure 6 illustrates response patterns regarding reason given according to GRC scores. Only those who indicated that they had suffered substantial psychological distress but had not sought help for this concern were asked to respond to this item ($n = 290$). Although SPC and CWF showed less variation across reason given for lack of help-seeking than the other subscales, each represented a greater source of internal unrest than RE or RAB (as indicated by higher scores).

Figure 6

Reason Given for Not Help-Seeking by Mean GRCS Subscale Score



2.4.3 Attitude Toward Seeking Professional Psychological Help

Scores on the short form of the Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS-S) ranged from 10 to 37 with an average of 22.23 ($SD = 5.40$). Lower scores indicate more positive attitudes toward seeking psychological help.

In order to investigate Hypothesis 4, that ATSPPHS would be more positive for women than men, an independent samples t-test was conducted. Results showed a significant difference ($t(633) = 5.87, p < .001$) between average scores for men ($M = 24.20, SD = 5.42$) and women ($M = 21.47, SD = 5.2$). The effect size of this statistic was moderate ($\eta^2 = .05$). This indicates that men had more negative attitudes towards seeking professional psychological help than women, supporting the hypothesis.

Pearson's r correlations were conducted to investigate Hypothesis 5, that GRCS would be associated with negative ATSPPHS. The results for GRCS and subscales are shown in Table 3, and indicate that as GRCS, SPC, RE and RAB increased ATSPPHS scores (indicating more negative attitudes) also increased, supporting the hypothesis.

Table 3

ATSPPHS and GRCS Correlations

	Total GRCS	SPC	RE	CWF	RAB
ATSPPHS	.20**	.08*	.27**	-.01	.22**
	.000	.040	.000	.821	.000

Sig at the <.05* or <.01** level, $N = 634$

T-tests were conducted to explore the relationship between ATSPPHS and experience of seeking help. The outcomes showed that ATSPPHS was more positive (as indicated by lower scores) in those who had previously sought help for any kind of distress (see Figure 7) or had some experience of mental illness (see Figure 8). Similarly, results showed those who had considered using a psychological service, used a psychological service, or any other professional had more positive attitudes towards seeking psychological help than those who had not. Those who had sought no help had more negative attitudes towards seeking psychological help than those who had sort some kind of psychological intervention in the past. Findings are illustrated in Figure 7 and Figure 8. For details see Appendix F. Results indicate that experience of psychological help-seeking is associated with more positive attitudes regardless of type of distress or source of help (except non-professional source).

Figure 7

ATSPPHS by Help-Seeking for Psychological Distress

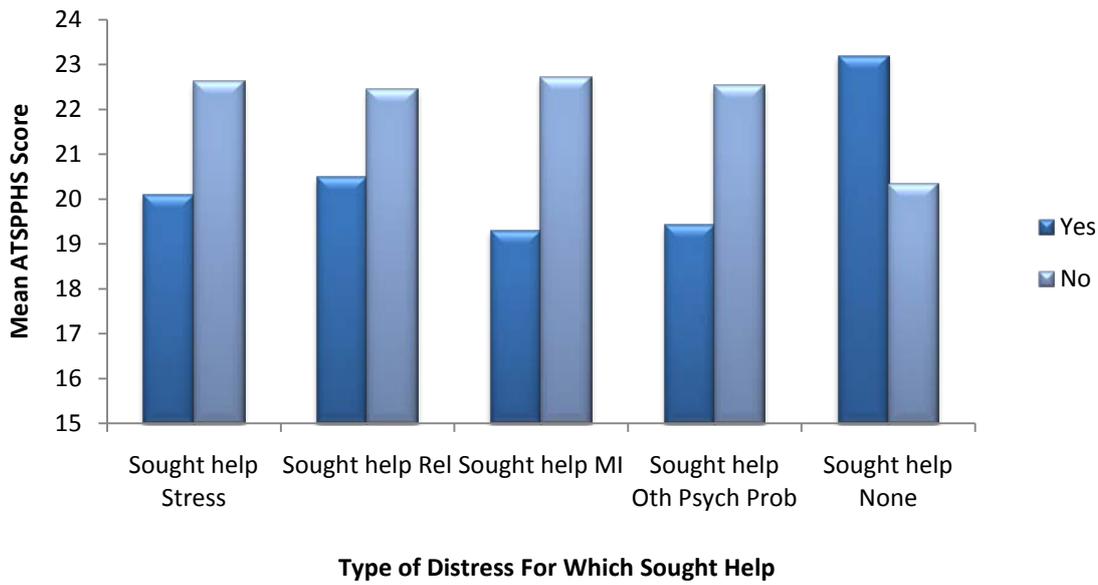
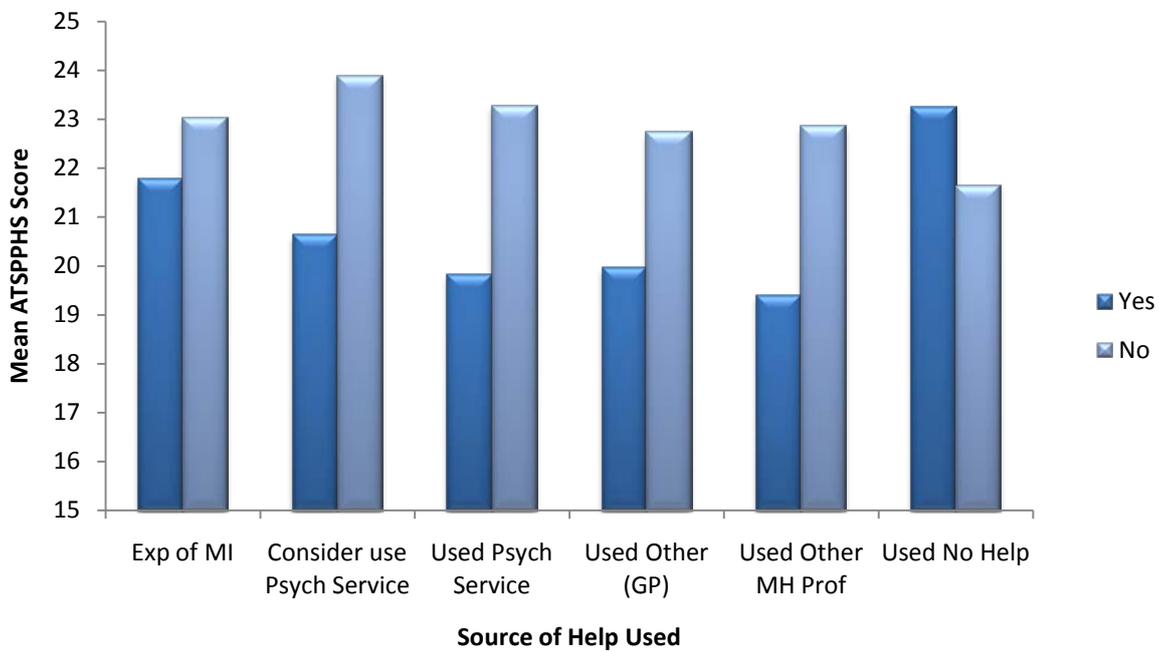


Figure 8

ATSPPHS by Source of Help Utilised



2.4.4 Personality

Extraversion

An independent samples t-test was undertaken to determine whether any difference in extraversion existed across genders. The result was non-significant ($t(633) = .771, p = .44$).

Pearson's r correlation showed that extraversion had a small association with social contact ($r = .23, p < .001$). This suggests that those higher in extraversion reported greater weekly social contact than those with lower extraversion.

Independent samples t-tests showed that extraversion was significantly different across groups for some items referring to experience of distress, help-seeking and type of service used, although this was not consistent across items. Extraversion was higher for those who had not previously suffered from stress or mental illness, had not suffered significant psychological distress, and had not sought help for mental illness. Extraversion was also higher for those who had used a service coded as 'other' for their distress (such as a GP) than for those who had not. Items significantly different in extraversion are presented in Figure 9.

Figure 9

Experience of Distress and Help-Seeking by Extraversion



A one-way between-groups ANOVA showed extraversion to have some impact on the reason participants gave for not seeking help despite identifying a need [$F(6,283) = 2.28, p = .04$]. The effect size of this statistic was small ($\eta^2 = .05$). Post hoc analysis using Tukey's HSD showed that differences in extraversion exist between those who reported that they managed their problem with the help of family and friends ($M = 29.81, SD = 5.98$), and both those who were too embarrassed to seek help ($M = 25.45, SD = 6.63$), and those who didn't think their problem was bad enough ($M = 25.55, SD = 5.61$). Means indicate that those who talked to family and friends were higher in extraversion than those who were embarrassed or believed their problem was not intense enough to seek help.

Neuroticism

Pearson's r correlation results showed an association between neuroticism and social contact which bordered on significance, although the correlation itself was quite small ($r = -.078, p = .05$). This suggests that those with higher neuroticism reported slightly less social contact than those with lower levels.

An independent samples t -test was performed to determine whether differences in neuroticism existed between genders. The result was significant ($t(633) = -3.91, p < .001$), but the effect size was small ($\eta^2 = .02$). Means show that women ($M = 23.01, SD = 6.07$) reported higher neuroticism than men ($M = 20.89, SD = 6.30$). This was consistent with *Quickscales* norms.

Independent samples t -tests showed that neuroticism varied significantly across groups on almost all items regarding experience of distress, experience of help-seeking and service utilised. Appendix G provides details of the analyses. Neuroticism was significantly higher for those who had suffered any kind of significant psychological distress (see Figure 10), as well as for those who had sought help for stress, relationship issues or mental illness (see Figure 11).

Figure 10

Experience of Distress by Neuroticism

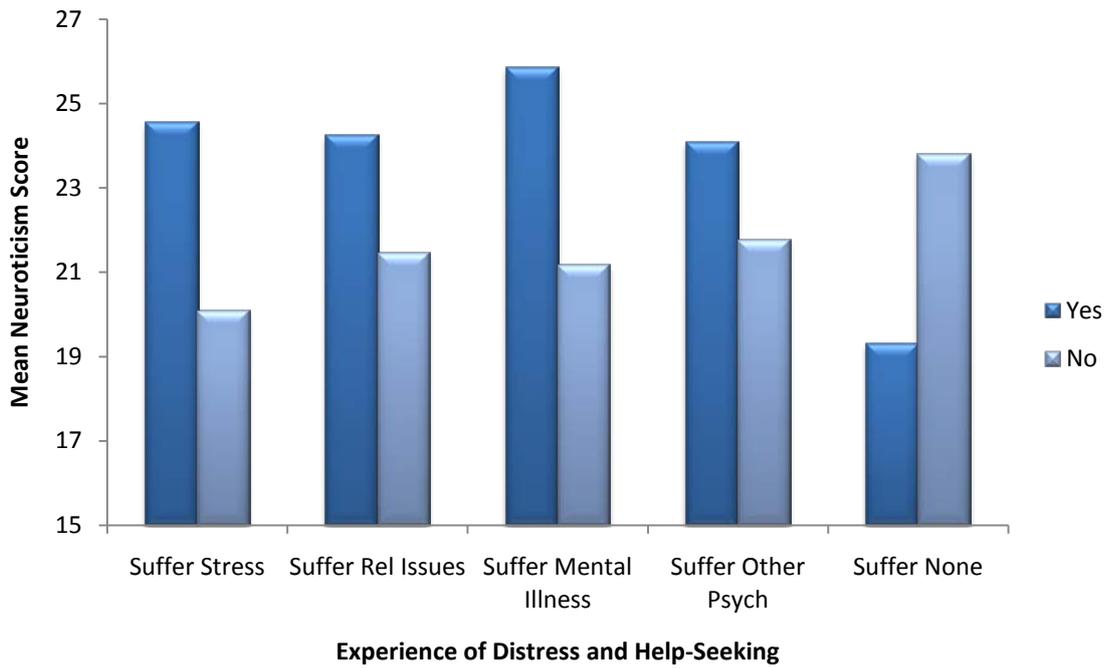
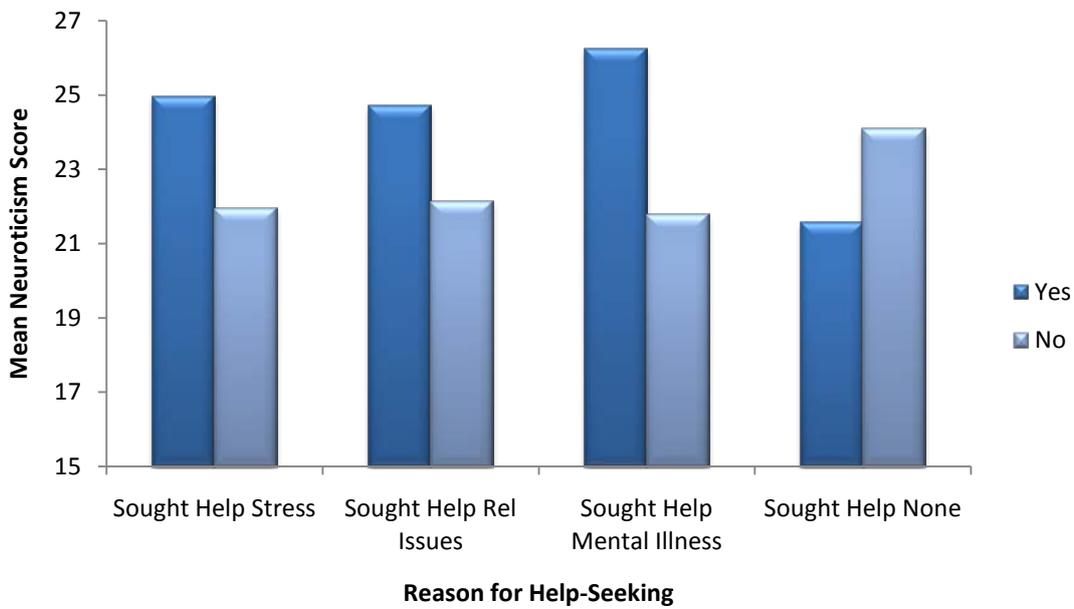


Figure 11

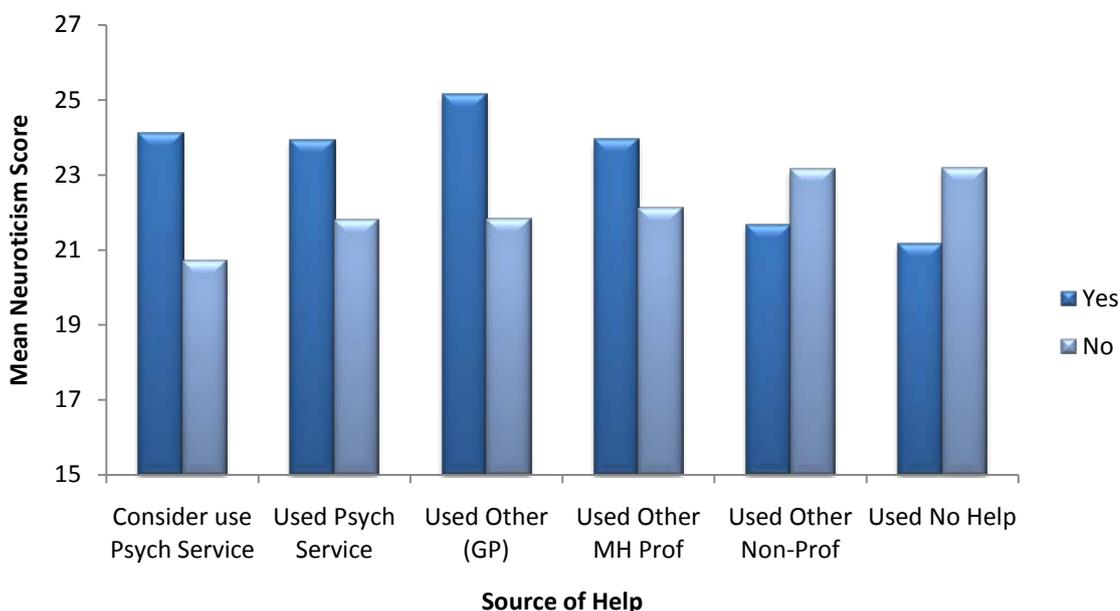
Reason for Help-Seeking by Neuroticism



Neuroticism was also higher for those who had considered using or had used a mental health service. Neuroticism was lower for those who had utilised non-professional sources such as friends and family. Figure 12 illustrates results for those items which returned significant results.

Figure 12

Help Sought by Neuroticism



A one-way between-groups ANOVA was undertaken to investigate differences in neuroticism across reasons for not seeking help despite identifying need. A significant difference was present across groups [$F(6,283) = 4.73, p < .001$]. The magnitude of this difference was moderate ($\eta^2 = .09$). Post hoc analysis using Tukey's HSD showed statistically significant differences between those who reported that they did not seek help because they were too embarrassed ($M = 26.87, SD = 5.66$) and those who dealt with their problem themselves ($M = 22.22, SD = 6.19$), talked to family and friends ($M = 21.25, SD = 4.91$) and thought their problem wasn't bad enough ($M = 23.28, SD = 5.04$). Differences further existed between those who stated they did not have the time and money to seek help ($M = 26.37, SD$

= 8.47) and both those who talked to family and friends and those who didn't think their problem was bad enough to require intervention. Means show that neuroticism was higher for those who stated that they didn't have the time and money or that they were too embarrassed to seek help.

Openness to Experience

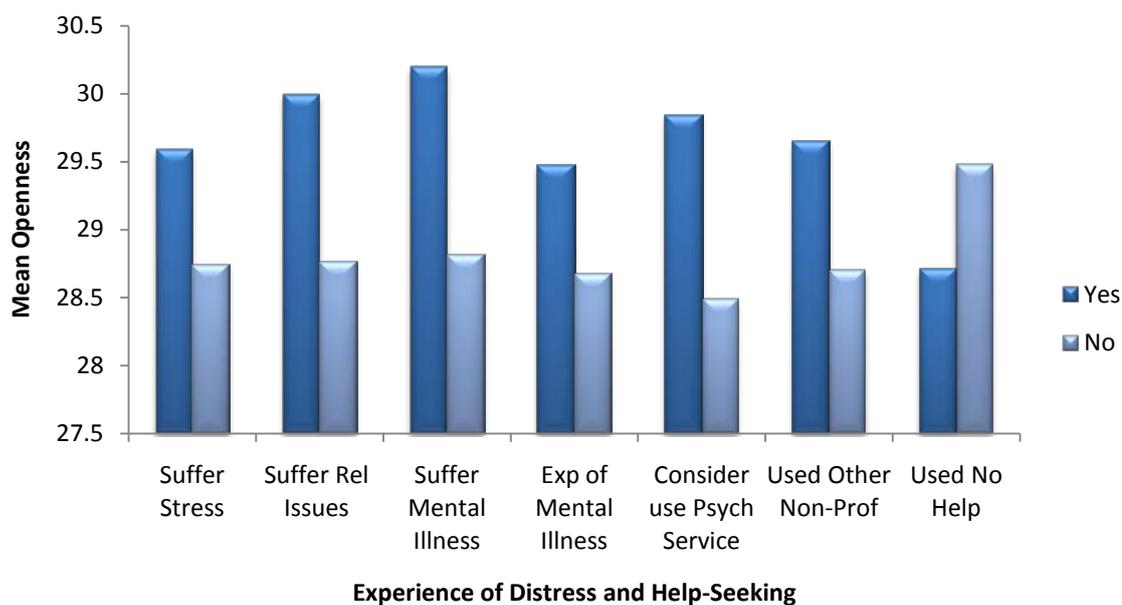
Pearson's r correlation results showed that openness had a small association with social contact ($r = .10, p = .01$). This suggests that those with higher levels of openness to experience reported slightly more weekly social contact than those with lower openness.

An independent samples t -test showed no significant difference in openness to experience across gender, ($t(633) = -1.64, p = .10$).

A series of independent samples t -tests were undertaken to determine the effect of openness to experience on experience of distress and source of help. Those who reported having suffered from stress, relationship issues and mental illness had higher levels of openness. Similarly, those with some personal experience of mental illness, who had considered using a psychological service, had used non-professional sources of help (such as friends and family), and who had utilised some kind of help also exhibited higher levels of openness. Figure 13 illustrates the significant differences in openness across responses to these items. Detailed statistics are included in Appendix H.

Figure 13

Experience of Distress and Help-Seeking by Openness



Agreeableness

A Pearson's r correlation showed that agreeableness was slightly associated to social contact ($r = .09, p < .05$). This suggests that those with higher levels of agreeableness reported slightly more weekly social contact than those with lower levels of agreeableness.

An independent samples t -test showed that differences existed across gender on agreeableness, ($t(633) = -2.96, p < .01$). However, the effect size was small ($\eta^2 = .01$). Means showed that women ($M = 28.07, SD = 4.06$) had higher levels of agreeableness than men ($M = 26.99, SD = 4.34$).

Independent samples t -tests were performed to investigate the role of agreeableness on experience of distress, help-seeking and source of help. The only significant difference in agreeableness was for the item considered using a psychological service. Those that had

considered this had higher levels of agreeableness ($M = 28.10$, $SD = 4.16$) than those who had not ($M = 27.43$, $SD = 4.16$); however, the effect size was small ($t(632) = 2.03$, $p = .04$, $\eta^2 = .01$).

Conscientiousness

An independent samples t-test found a difference in conscientiousness between genders ($t(633) = -2.97$, $p < .01$), however, the effect size was small ($\eta^2 = .01$). Women ($M = 29.42$, $SD = 5.32$) reported significantly higher conscientiousness than men ($M = 28.05$, $SD = 4.94$).

Independent samples t-tests were performed to investigate the role of conscientiousness on experience of distress, help-seeking and source of help. Results showed that those who had sought help for psychological problems (not otherwise specified) had higher levels of conscientiousness ($M = 30.60$, $SD = 5.24$) than those who had not ($M = 28.87$, $SD = 5.12$). This difference was significant ($t(633) = -2.5$, $p = .01$) although the effect size was small ($\eta^2 = .01$).

Those who had considered using a psychological service ($M = 29.54$, $SD = 5.28$) reported higher conscientiousness than those who had not ($M = 28.51$, $SD = 5.18$). Again this was significant ($t(632) = 2.42$, $p = .02$) but with a small effect size ($\eta^2 = .01$). Those participants who had previously used a psychological service also had higher levels of conscientiousness ($M = 29.85$, $SD = 5.52$) than those who had not ($M = 28.67$, $SD = 5.10$; $t(631) = 2.58$, $p = .01$, $\eta^2 = .01$).

2.4.5 Mental Health Locus of Origin

An independent samples t-test was performed to investigate whether gender had any association with mental health locus of origin. The result was significant ($t(633) = -4.08, p < .001$). An eta squared calculation indicated that this statistic had a small effect size (.03). Means showed that men had significantly greater interactional beliefs regarding mental health locus of origin ($M = 57.95, SD = 9.56$) than women, who had more endogenous beliefs ($M = 61.72, SD = 10.72$).

A t-test was also used to explore the role of experience of mental illness on beliefs about locus of origin. Again the result was significant ($t(633) = 3.84, p < .001$), with a small effect size ($\eta^2 = .02$). Means showed that those who had experience of mental illness ($M = 61.86, SD = 10.45$) had more endogenous beliefs about its origin than those who had no experience of mental illness ($M = 58.55, SD = 10.39$), who had more interactional beliefs.

Correlations were performed in order to investigate the association between MHLOO and ATSPPHS. Results showed a small correlation ($r = -.23, p < .01$). The negative correlation indicates that interactional MHLOO beliefs are associated with more negative attitudes towards seeking psychological help, whereas endogenous beliefs are associated with more positive attitudes.

2.4.6 Preference for Indicating Distress

A one-way between-groups ANOVA was performed to determine whether a relationship existed between ATSPPHS and responses to the item “I would feel more comfortable indicating my distress on a form than having to come out and say it”. The result

was statistically significant [$F(3, 631) = 18.90, p < .001$] with a moderate effect size ($\eta^2 = .08$). Post hoc analysis using Tukey's HSD revealed significant differences in ATSPPHS scores between those who agreed ($M = 23.81, SD = 5.13$) or partly agreed ($M = 23.22, SD = 5.10$) with the statement and those who partly disagreed ($M = 21.24, SD = 5.13$) or disagreed ($M = 19.78, SD = 5.45$). Means indicate that those with more negative attitudes towards seeking help are more likely to prefer to indicate their distress on a form rather than stating it verbally.

One-way independent samples ANOVAs were undertaken to explore the relationship existed between total GRCS or subscales and the item "I would feel more comfortable indicating my distress on a form than having to come out and say it". Table 5 shows that total GRCS and each subscale were significantly associated with this item. The ANOVA investigating SPC was found to violate the assumption of homogeneity and thus a Kruskal-Wallis test was undertaken for this subscale. The result was also significant ($H(3, N = 634) = 9.78, p = .021$). Mean rank scores indicate that those who agreed with the statement had the highest score on SPC and that those who responded that they partly disagreed had the lowest. This result, along with those presented in Table 4, reveal that higher levels of gender-role conflict and subscales were associated with preference to indicate distress on a form rather than verbally.

Table 4

ANOVA Results for Preference to Indicate Distress on Form and GRCS and Subscales

	<i>F</i>	<i>p</i>	η^2	Yes <i>M</i>	Yes <i>SD</i>	No <i>M</i>	No <i>SD</i>
GRCS	13.55	.000**	.07	118.90	21.74	109.53	20.16
RE	20.65	.000**	.10	3.84	.81	3.72	.80
CWF	5.25	.001**	.03	3.94	.97	3.72	.94
RAB	9.74	.000**	.05	2.92	.98	2.53	.94

Sig at the <.05* or <.01** level, *N* = 634

An ANOVA investigated the role of conscientiousness on preference for indicating distress on a form. Results indicated a significant interaction [$F(3, 631) = 3.76, p = .01, \eta^2 = .02$]. Tukey's HSD post hoc analysis showed a difference between those who partly agreed ($M = 28.18, SD = 5.33$) and those who partly disagreed ($M = 29.98, SD = 4.66$). Means indicate that those who were less conscientious preferred to indicate distress on a form rather than stating it verbally.

Extraversion, neuroticism and agreeableness were found to violate the assumption of homogeneity of variance and therefore Kruskal-Wallis tests rather than ANOVAs were undertaken to investigate the interaction of these variables and preference for indicating distress on a form. Results for extraversion ($H(3, N = 635) = 14.11, p < .01$) and agreeableness ($H(3, N = 635) = 9.67, p = .02$) were significant. Mean rank scores for extraversion showed that it was highest for those who disagreed that they would prefer to indicate distress on a form and that this decreased in a linear manner so that those who agreed with the statement reported the lowest extraversion score. For agreeableness, mean rank scores showed that those with the highest score reported that they partly agreed that they

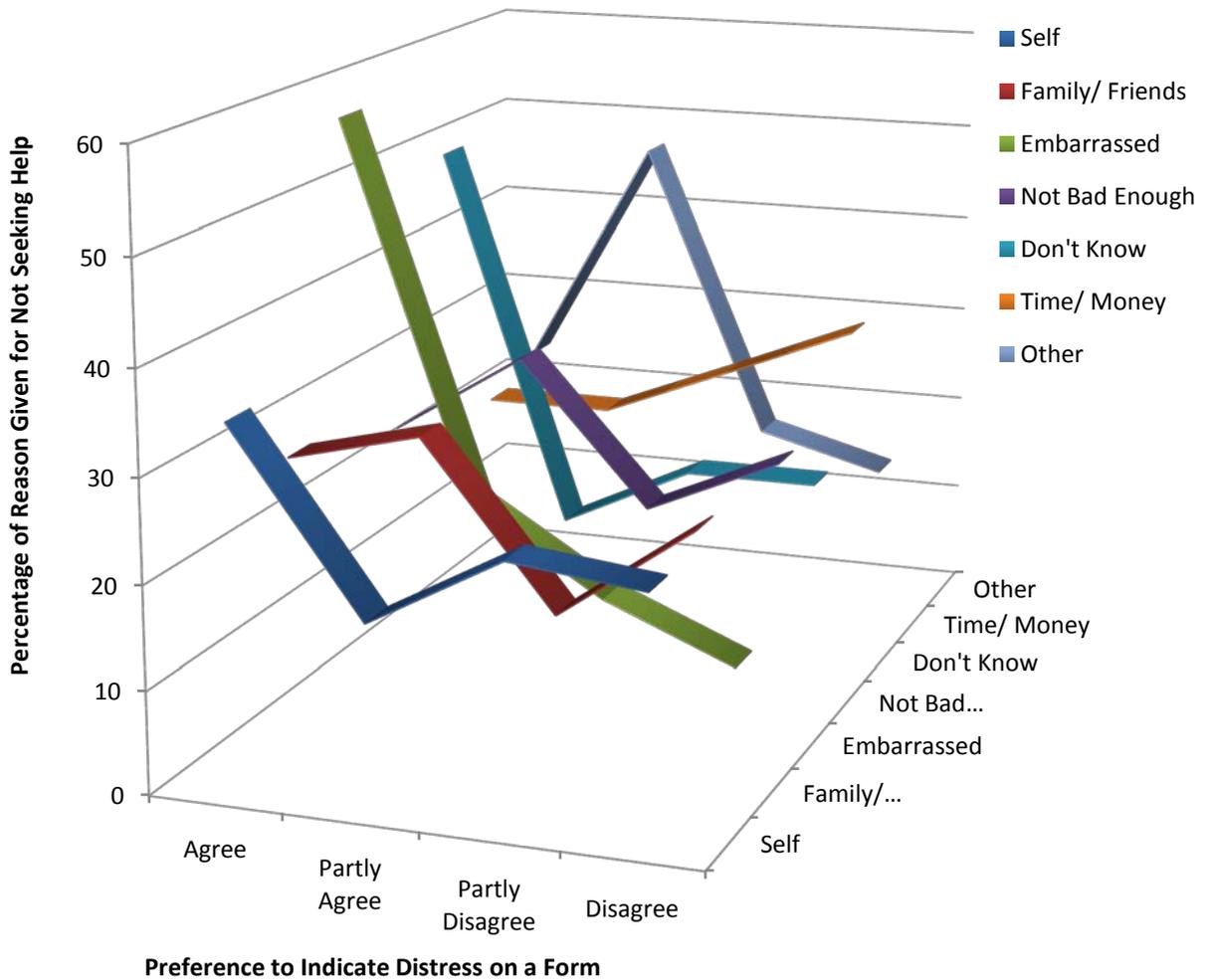
would prefer to indicate distress on a form, followed by those who disagreed, agreed and finally partly agreed. These results indicate that those low on extraversion and agreeableness would most prefer to indicate distress on a form rather than stating it verbally.

A one-way between-groups ANOVA showed that mental health locus of origin varied across preference for indicating distress on a form [$F(3, 631) = 2.93, p = .03, \eta^2 = .01$]. Post hoc analysis using Tukey's HSD showed a significant difference in MHLOO between those who responded that they agreed ($M = 58.97, SD = 10.88$) and those who disagreed ($M = 62.27, SD = 11.16$). MHLOO scores increased in a linear manner across agree, partly agree, partly disagree and disagree. This indicates that those who reported a preference for indicating their distress on a form rather than having to state it verbally had more interactional beliefs regarding mental health locus of origin, and that these beliefs became more endogenous beliefs as preference decreased.

Preference for using a form was also investigated according to the reason given for not seeking help despite having suffered substantial psychological distress. It can be seen in Figure 14 that those who reported that they had not sought help previously because they were embarrassed were most likely to agree that they would prefer to indicate their distress on a form rather than state it verbally. Very few in the 'embarrassed' group disagreed. Almost half of those who indicated that they didn't know where to seek help agreed that they would prefer to use a form to communicate their distress. Those who gave their reasoning as a lack of time or money were least likely to prefer to use a form. For further details see Appendix I.

Figure 14

Preference for Indicating Distress on a Form by Reason for Not Seeking Help



2.5 Discussion

This study investigated gender-role conflict, attitude toward psychological help-seeking, personality, and experience of psychological concerns and help-seeking in a sample of university students. As such, participants in this study were likely to have better than average cognitive abilities, and many may have had higher socio-economic backgrounds than a community sample, among other features.

2.5.1 Prior Help-Seeking

Hypothesis 1, that males would report less prior help-seeking from professional sources than females was partially supported. Prior use of a professional service that was not specifically psychological (such as a GP) was greater for females than males; however, there was no significant difference across other sources of professional help. The hypothesis is therefore partially supported. This finding follows recent work by Judd, Jackson, Komiti, Murray, Fraser, Grieve and colleagues (2006) who found that women sought help from GPs and mental health professionals twice as often as men. In their study of rural Australians, a third of participants in a community sample indicated that they had previously sought help for psychological problems. In the current study less than 15 percent had done so; however, approximately half of those who indicated that they had suffered from mental illness had sought help for this.

Women in the current study also reported that they had sought help from non-professional sources such as family and friends more than men. This is consistent with research which suggests that women have greater social support than men (Antonucci & Akiyama, 1987). Findings of this study showed that men had a slightly higher number of social contacts each week than women, however, their perception of support received from these contacts was not assessed. Women reported suffering more stress as well as seeking help for that stress than men. Men, on the other hand, were more likely to report that they suffered from no psychological distress and had used no help. This denial of emotion and lack of help-seeking behaviour is consistent with the hegemonic masculine role which requires men to be sturdy and reliable, not suffering from psychological concerns (Connell, 2005).

The results partially support research which has found that women seek psychological help more frequently than men (Anderson, 1995; Andrews et al., 2001; Jorm, 1995; Madianos et al., 1993; Morgan et al., 2003; Oliver et al., 2005; Parslow & Jorm, 2000; Vasiliadis et al., 2005; Wrigley et al., 2005).

2.5.2 Gender-Role Conflict

Hypothesis 2, that gender-role conflict (GRC) scores would be higher for males than females was supported. The subscales restricted emotionality (RE) and restricted affectionate behaviour (RAB) were also found to be significantly more important to men than women. However, no gender difference was apparent in subscales success, power, competition (SPC) or conflict between work and family (CWF). Whether the CWF scale tests something which remains unique to men has been questioned (Heppner, 1995); one recent study found no gender difference (Zamarripa, Wampold, & Gregory, 2003). The same could be true of the SPC subscale. The findings of this study suggest that cultural changes in Western society since the development of the GRCS, such as greater involvement of women in paid employment in addition to within the home, may have had some effect on the appropriateness of this scale. Whilst conflict between work and family is a significant issue in men's lives, this is perhaps a conflict which is not exclusively experienced by men. Therefore a scale such as the GRCS which purports to test how closely men ascribe to traditional male roles may need to also take into account the changing roles of women in order to remain pertinent.

The sample used in this study will no doubt have some effect on responses to both of the SPC and CWF subscales of the GRCS. Firstly, university students are by definition high achievers academically. Therefore, it follows that success is somewhat important to them. Secondly, students new to university (i.e. in first year) are bound to have difficulties

managing the workload. Thus, one might expect that responses to these subscales may be different to a broader population. Thirdly, the sample are of a young age and therefore unlikely to be as troubled by work and family conflicts than older populations. The GRCS has been established as a reliable and valid measure (see Thompson & Pleck, 1995, for review). However, it may benefit some consideration of the issues raised by societal change.

Hypothesis 3, that restricted emotionality (RE) would be associated with openness to experience, was not supported. RE has previously been shown to be associated with openness (Tokar et al., 2000). However, of all five personality factors, RE was most closely associated with extraversion, followed closely by neuroticism. As RE increased, extraversion decreased, and conversely for neuroticism. Overall GRCS was most closely associated with neuroticism; as one increased so did the other.

Neuroticism has been reported as a marker for vulnerability to mental illness (ten Have et al., 2005). In the current study neuroticism was found to be associated with gender-role conflict, including all the GRCS subscales. Therefore in this study neuroticism was associated with the conflict provoked in individuals by restrictive emotionality, restricted affectionate behaviour, conflict between work and family and a focus on success, power and competition. Extraversion and agreeableness were also associated with GRCS.

These findings provide evidence that GRCS is associated with personality. However, this research is unable to determine causation. Therefore it is unclear whether neuroticism causes gender-role conflict, whether the reverse is true, or if causation occurs in both directions.

A preference for indicating distress on a form rather than stating it verbally was reported by those who reported high GRC (or only high RAB). This finding is aligned with Brownhill, Wilhelm and colleagues' (2003) proposal that men be given a prompt list to complete whilst waiting to see a GP which would aid in the identification of embarrassing or concealed concerns. Other results of this study indicate that those participants who engage in restricted emotional and affectionate behaviour and who previously needed psychological support but did not seek it were unlikely to report talking to family and friends and likely to state that they were too embarrassed to seek help. Shapiro (1983) noted that people are more likely to accept help if it is offered rather than requested. This implies that using a prompt list would both allow men to see seeking psychological help as normative and to be offered help rather than request it. An offer of help on a GP triage form may present men with a pathway to care which can be accessed without presenting a challenge to the man's masculinity. In fact, no gender difference existed in responses to this item; more than half of men and women reported that they partly agreed or agreed that they would prefer to use a form to indicate their distress than be required to state it verbally. Individuals who do not wish to discuss their problems with others can become isolated with mental health concerns which tend to increase in severity over time. Therefore the use of a paper and pen based 'triage' system in primary health care services such as that proposed by Brownhill and colleagues should be investigated further. However, those with lower levels of education than participants in this sample may not be as willing to read and complete a form in health interactions. Such issues would benefit from further research.

High levels of GRC were associated with having previously suffered significant stress, relationship issues or mental illness. Similarly, total GRC and CWF were associated with consideration of using a psychological service. These findings support research which has

shown GRC to be related to poor psychological well-being (Sharpe & Heppner, 1991), stress (Good et al., 1996), depression and anxiety (Blazina & Watkins, 1996; Cournoyer & Mahalik, 1995). However, prevalence of psychological distress did not translate into use of services. These individuals therefore clearly represent those in the service gap of requiring psychological services but not accessing them (Stefl & Proseri, 1985).

2.5.3 Attitude Toward Seeking Help

Hypothesis 4, that males would express a more negative attitude towards seeking professional psychological help than females was supported.

Negative attitude towards help-seeking will logically impact poorly on men's help-seeking intentions (Deane et al., 1999) and behaviour (Judd et al., 2006). In this study a gender difference was found within a sample which, being tertiary educated, would be expected to have more positive attitudes towards professional psychological help-seeking (ATPPHS) than the general population (Fischer & Cohen, 1972; Goh et al., 2007; Jeweler-Bentz, 2003). This provides further support for the common finding that negative attitudes toward seeking help are pervasive among men (Ang et al., 2004; Hao & Liang, 2007; Judd et al., 2006).

ATSPPHS was associated with seeking help from a GP, psychological service or other mental health professional. However, it was not associated with seeking help from a non-professional source. It has previously been demonstrated that both men and women prefer to seek help from informal sources (Komiti et al., 2006). Such previous literature and the results of this study suggest that participants differentiate between formal and informal sources of help.

Those who had sought any kind of help for psychological concerns in the past had more positive attitudes towards the behaviour than those who had not. Similarly, those who had experience of mental illness personally or through someone close to them also held more positive attitudes towards seeking professional psychological help than those who had no such experience. These findings are in line with previous research which has shown that exposure to mental illness and prior help-seeking are associated with more positive attitudes to help-seeking (Halgin et al., 1987). However, other authors have reported that perceived quality of prior therapy also affects attitude to help-seeking (Deane et al., 1999). The current study did not assess perceptions of therapy quality due to concerns regarding the length of the survey as well as the personal nature of the questions (under circumstances where participants gained course credit for survey completion).

As this study has demonstrated that men seek less help than women and prior experience with help-seeking is associated with more positive ATSPPH, an opportunity to improve the attitudes of men is likely to commonly be missed. Further, more positive attitudes are associated with greater help-seeking behaviour. This can therefore be seen as a circular process which can exclude men. If advances are to be made in rates of service utilisation by men such opportunities to influence men's attitudes towards help-seeking should be further investigated.

Hypothesis 5, that higher gender-role conflict scores would be associated with more negative attitudes toward seeking professional psychological help was supported. Results indicated that as GRC intensified ATSPPHS became more negative. High gender-role conflict has been reported to be associated with negative ATSPPHS in a number of studies (Berger et al., 2005; Good & Wood, 1995; Simonsen et al., 2000; Wisch et al., 1995). These findings

indicate that the traditional male role is associated with negative attitudes towards seeking professional psychological help. This traditional or hegemonic masculine role has been described as incompatible with help-seeking (Addis & Mahalik, 2003). As Rochlen (2005) noted, the traditional male role encourages men to avoid emotional expression, weakness, vulnerability and dependence. He reported that seeking psychological help contradicts such values in that help-seekers are expected to expose their vulnerabilities, express emotion and to depend upon others. Indeed, studies have shown that many men believe it is admirable not to seek help for mental illness but to try to cope alone (Komiti et al., 2006). Therefore the correlation between GRC and ATSPPHS was expected.

Of interest was the finding that those who held more negative ATSPPH reported a preference for indicating distress on a form rather than stating it verbally. This suggests that perceptions regarding the act of disclosure may act as a barrier for those with negative views of help-seeking. Those with high gender-role conflict also reported a preference for the use of a form. These results generate further questions regarding why these preferences might exist and what other ways they may be satisfied. If discomfort in the process of disclosure can be minimized it is possible that this may have some effect on help-seeking behaviour. Future research investigating such issues is recommended.

The mental health locus of origin scale investigated participants' beliefs regarding the origin of mental illness. Interactional beliefs were associated with high levels of total GRC, SPC, RE and RAB, and more negative attitudes toward seeking professional psychological help. More endogenous beliefs were associated with low GRC, positive attitudes to seeking help and prior experience of mental illness in self or someone close. Men in this study were shown to have more interactional beliefs about mental health locus of origin and women more endogenous beliefs.

These results are consistent with those of Cooper, Corrigan and Watson (2003) who reported that individuals who view people with mental illnesses as responsible for their disorders (interactional beliefs) are less likely to seek help than those who do not hold such beliefs. Further, Jorm, Christensen and Griffiths (2005b) found that a large proportion of the community believed that mental illness is caused by personal weakness, although such beliefs have reduced over time. Greater education regarding mental illness has been shown to reduce the tendency to blame people for their disorders (Cooper et al., 2003). Thus, such education could help to improve men's attitudes towards mental illness and help-seeking behaviour.

2.5.4 Psychological Distress

Psychological distress in this study was defined as having suffered from major stress, relationship issues, mental illness or other significant personal problems. Forty-six percent of the participants in this study indicated that they had previously suffered substantial psychological distress for which they had not sought help. This is similar to the finding of Wrigley, Jackson, Judd and Komiti (2005) who reported that 43% of rural Australians in their sample had at some time wanted or needed to seek help for a mental health concern but had not done so. Almost a third of participants in the current study reported that they had suffered from mental illness (self-reported and not further defined). Of this group less than 15 percent had sought help for this concern.

Those who reported that they had suffered from substantial psychological distress but had not sought help for this concern were asked to clarify the reason. Participants primarily indicated that they believed the problem was not bad enough to seek help followed by the explanation that they dealt with it on their own. Prior success of self-reliance in dealing with problems was beyond the scope of this study. However, past success may have some bearing

on the tendency to use the strategy of self-reliance rather than seeking professional help. The responses given by participants in this study were different from those elicited by Wrigley and colleagues (2005). In that survey almost half of participants reported that they were too embarrassed to seek help, followed by the lack of knowledge of where to seek help from.

Gender differences were apparent in reasons given for not seeking help. Women in this study were more likely than men to report that they discussed their problem with family and friends or were too embarrassed to seek help. This was in line with earlier research which has shown that men and women prefer to seek informal rather than formal help (Komiti et al., 2006) and are embarrassed to seek professional help (Barney et al., 2006; Wrigley et al., 2005). Men were more likely than women to report that they dealt with a problem on their own or did not have the time or money to seek help. This finding is consistent with those studies which have shown that men believe in dealing with depression alone and have more positive expectations of the outcomes of this strategy than do women (e.g. Jorm, Kelly et al., 2006). Further, this may reflect men's attitude toward spending money on a service they may regard negatively. If men do not value professional psychological help the cost may become a secondary barrier rather than an initial one. Subsidies for psychological treatment costs for men or education that they can be reimbursed (through the Medicare system in Australia) may address the cost barrier but are unlikely to affect attitudes regarding the value of seeking help.

2.5.5 Clinical Implications

When considering implications for clinical practice, the results regarding preference to indicate distress on a form rather than verbally are of particular interest to mental health professionals. Those who held the most negative attitudes toward help-seeking (i.e. those high

on gender-role conflict, low on conscientiousness, extraversion and agreeableness, and who held interactional beliefs about the origins of mental illness) indicated a preference for the use of a form. Similarly, those who reported that they had not sought professional help for previous substantial psychological distress because they were embarrassed or did not know where to seek help also indicated a preference to record distress in written form.

The results suggest that mental health professionals need to consider the role that written forms could play in facilitating disclosure and client comfort. It may be that such non-interactional disclosure can encourage more individuals who suffer from psychological distress to seek professional intervention. For example, forms completed on the internet or posted prior to appointments, or even sent in conjunction with emails requesting appointments, may remove some of the initial embarrassment experienced by individuals. This could also offer professionals an opportunity to indicate to clients that their concerns are serious ('enough' to seek help).

2.5.6 Strengths and Limitations

The sample used in this study was one of convenience. Participation of first and second year psychology students allowed for a large sample size but brought with it limitations. Firstly, contact with the discipline of psychology has been noted to promote favourable attitudes towards help-seeking (Morgan et al., 2003). In line with this, students of psychology and other arts courses have been shown to hold more positive views of help-seeking than those in other fields (Fischer & Cohen, 1972; Jeweler-Bentz, 2003). Therefore it is likely that ATSPPHS scores were higher among the sample utilised by this study than across a wider university or community. Secondly, the majority of participants were aged between 16 and 24 years, consequently results may not be generalisable to a wider age range.

In particular, scores on the GRCS subscale success, power and competition may be higher than in other populations due to the competitive nature of the tertiary environment. Similarly, the subscale conflict between work and family is unlikely to be as significant for this sample as for those who are older or married.

Participants in this study gained course credit for their involvement, although participation was voluntary. Participants who self select for a study on psychological help-seeking may be more communicative and open to help-seeking than non-responders. Further, the study was conducted using online self-report measures and cannot reveal participant motives.

This study required participants to recall seeking help, and to identify such help as directed at a mental health concern (rather than simply discussing a problem). Therefore there may have been recall issues for some participants. However, the large proportion of participants who identified that they had previously suffered significant distress suggests that this was not a substantial problem in this study.

Despite the above limitations this study identified significant gender differences in gender-role conflict and attitude toward seeking professional psychological help. The sample size was substantial, suggesting that the results are likely to be representative of first and second year university students at metropolitan Australian universities.

2.6 Conclusion

In this study men were shown to report less psychological distress, seek less psychological help, display higher gender-role conflict, hold more negative attitudes towards

help-seeking, hold more interactional beliefs about the origins of mental illness, and report greater preference for dealing with psychological problems alone than women. These results highlight a number of factors which are likely to impede men's psychological help-seeking behaviour, however, further research examining the ability to identify mental illness, knowledge of sources of assistance, and beliefs regarding treatment effectiveness may reveal more issues relating to the help-seeking process. In addition the results suggest that the utilisation of written forms on which to express psychological distress need to be further examined.

CHAPTER THREE

Study Two: Mental Health Literacy

3.1 Introduction

The purpose of this study was to assess mental health literacy. The ability firstly to identify a mental health concern, and secondly to choose an appropriate source of help, is central to help-seeking and effective treatment. This study investigated ability to identify mental illness, beliefs about treatment effectiveness, help-seeking recommendations and likelihood of future help-seeking behaviour in a sample of young people.

The concept of health literacy has been utilised in health literature for the past 30 years (Parker, Baker, Williams, & Nurss, 1995). It has been described as the cognitive and social skills needed to understand, access and utilise information which leads to good health practices (Nutbeam, 2006). Studies on health literacy suggest that around 100 million people in the developing world are functionally illiterate (Kickbusch, 2001), resulting in an inability to source and access services, satisfactorily understand information received and communicate needs. Such difficulties need to be considered when developing public health and educational programs. The term ‘mental health literacy’ was first coined by Jorm and colleagues (1997) who defined it as:

knowledge and beliefs about mental disorders which aid their recognition, management or prevention. Mental health literacy includes the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments, and of professional help available; and attitudes that promote recognition and appropriate help-seeking (Jorm et al., 1997, p. 182)

The seminal paper by Jorm, Korten and colleagues (1997) used vignettes of depression and schizophrenia to assess the mental health literacy of more than two thousand Australians. Vignettes were presented in both male and female versions alternated randomly; however, gender of character was only found to be associated with very minimal differences in response and data was therefore pooled across gender.

Findings from this study indicated that mental health literacy among the Australian public is low. Both Lauber, Nordt and colleagues (2003) and Suhail (2005) found mental health literacy to be lower in Switzerland and Pakistan respectively than Jorm and colleagues did in Australia. These results indicate that mental health literacy seems to be consistently low across countries.

Jorm and colleagues further reported that mental health literacy regarding schizophrenia is lower than that for depression. Diagnoses applied to the depression vignette included stress, a physical disorder, a personal or employment related problem, a problem with not being active or social enough, along with a mental health problem. Diagnoses attributed to the schizophrenia vignette included a mental health problem, depression, a physical disorder and 'has a problem'. Depression can be seen as characterised by many in Jorm's sample as a minor problem to do with employment stress or a lack of social interaction. Despite the abnormal nature of behaviour associated with psychotic illness, only a minority of this sample were able to identify schizophrenia. These findings and those of Lauber and colleagues (2003) and Suhail (2005) suggest that the majority of the population would be unable to identify depression or schizophrenia in themselves or those around them. An inability to identify a concern as a mental health disorder may delay or prevent psychological help-seeking.

The majority of participants in Jorm and colleagues' original study (1997) indicated that seeing a GP would be most helpful for depression, followed by seeing a counsellor. Only half of respondents thought that a psychologist or psychiatrist would be helpful for depression (less than suggested a friend or telephone counselling). Counsellors and GPs were also interventions most commonly rated as being helpful for schizophrenia, although psychiatrist and psychologist had higher helpfulness ratings for this group than for depression.

In similar studies on mental health literacy by Goldney, Fisher and colleagues (2001), less than ten percent of participants (some of whom suffered depression) reported believing that seeing a psychiatrist, and even fewer that seeing a psychologist or taking prescribed medication, would be helpful for depression. Angermeyer, Matschinger and colleagues (2001) found that Germans primarily recommended non-professional help for depression, closely followed by expert help, and for schizophrenia overwhelmingly recommended expert help followed by a large margin by non-professional help. Pakistani respondents most commonly recommended a psychologist for depressive symptoms and a GP for schizophrenia (Suhail, 2005). Oliver, Pearson and colleagues' (2005) study showed a preference for informal help-seeking (friends and relatives) across gender among Britons. (Importantly, one quarter of the respondents to this study indicated that they would not seek any help.) Cotton, Wright and colleagues (2006) found Australian men to be less likely than women to recommend the services of a general practitioner or psychologist for psychosis.

These findings indicate that participants recognise a difference between depression and schizophrenia which prompts them to recommend different sources of help for each. Participants tend to recommend more general sources of help for depression and more professional sources for schizophrenia. Participant responses suggest that most would

recommend GPs and counsellors as their first contact with mental health services. Whilst seeking help from a GP may enable the individual to be referred for psychiatric assessment and support or to obtain pharmacological treatment, it is of concern that participants in this study believed that counsellors would be a useful source of help for schizophrenia. This reveals a significant lack of understanding of the severity of the illness and treatment needs.

Jorm (2000) hypothesised that mental health literacy would influence people's symptom management activities, that is, their behaviours in response to mental health disorder. His research findings showed that the Australian public viewed environmental factors as more important than biological factors in the development of mental disorder. Jorm posited that this belief regarding locus of origin of mental illness could have significant implications for help-seeking behaviour. For example, Angermeyer, Matschinger and colleagues' (2001) showed that a large proportion of participants in their study thought that being morally weak could cause depression or psychosis. One can envisage that if an individual believes that a mental concern is brought about by their character they would be unlikely to seek help because they may see little ability to change.

Research has also shown gender differences in mental health literacy. For example, Kessler, Brown and colleagues (1981) found that women are consistently able to recognise and label experiences as mental health problems more than men. Similarly, Cotton, Wright and colleagues (2006) found that men were significantly less literate than women with respect to depression. Men were also more likely to under-report the prevalence of mental illness than were women. When interpreting the symptoms of psychosis there was a low level of literacy with no significant difference between genders. However, in the age bracket of 18-25 years, men displayed significantly less awareness of psychosis than women.

A lack of mental health literacy has been shown to be associated with a delay in help-seeking (Thompson et al., 2004). Therefore lack of mental health literacy can have implications for the severity of symptoms experienced and disability suffered in line with such delay. Mental health literacy, then, can be seen to play a significant role in the identification and treatment of mental illness in the community.

3.2 Aims

The aims of this study were as follows:

- To examine levels of mental health literacy in a sample of young people.
- To examine the role of gender on mental health literacy.
- To examine beliefs about effectiveness of mental health interventions.
- To explore help-seeking recommendations for mental illness.
- To explore future help-seeking intentions.

On the basis of past research such as that discussed above, the hypotheses for this study were:

1. Mental health literacy regarding depression will be lower for men than women.
2. Mental health literacy regarding schizophrenia will be lower for men than women.
3. Mental health literacy will be higher for depression than schizophrenia.
4. Respondents to the depression vignette will recommend help-seeking from a non-professional source.
5. Respondents to the schizophrenia vignette will recommend help-seeking from a GP or psychiatrist.

3.3. Method

This questionnaire was completed online at the same time as those measures discussed in chapter two. Psychology students at the University of Adelaide along with participants from the pilot sample, numbering 635 in total, completed the questionnaire.

The *Mental Health Literacy Questionnaire* (adapted from that created by Jorm et al., 1997) was part of the battery discussed in chapter two (Appendix B). This measure was designed to test participant knowledge of mental illness and was presented in survey form. Two vignettes of individuals with depression and schizophrenia developed by Jorm and colleagues were presented. These were as follows.

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or to have a bath. Her parents also hear her walking about her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

These vignettes were each followed by the questions “What, if anything, would you say is wrong with John/ Mary?”. Participants were then presented with eleven interventions and asked to indicate whether each individual intervention would help, harm or make no difference to John and Mary’s problems. Participants were further asked to recommend the treatment which they believed would most help the problem and to give a reason for this choice. The final items were designed to measure how likely it would be that each problem would be resolved if John or Mary undertook the intervention recommended, how long this might take and how likely it was that the participant would undertake the course of action they recommended if they had John or Mary’s problem.

3.3.1 Methodology

Qualitative responses were coded using thematic analysis as described by Braun and Clarke (2006, see chapter two for description). Where extracts of participant responses are presented these are verbatim and therefore include grammatical and spelling errors.

Quantitative analysis using t-tests, ANOVAs, and chi square was again conducted using SPSS version 15.0. Exploratory quantitative analysis was also conducted using data discussed in chapter two pertaining to level of weekly social contact, experience of mental illness, gender-role conflict and attitude towards seeking professional psychological help.

3.4 Results

3.4.1 Identification of Depression

Mental health literacy responses were coded to reflect themes derived from thematic analysis of the corpus of qualitative responses to short answer questions. For the depression vignette (John) the themes and a description of data included within them were:

<u>Depression:</u>	any comment referring to depression or depressed
<u>Stress:</u>	stress, tension, work problems
<u>Mental Problem:</u>	mental or emotional problem (specified or unspecified), incorrect diagnoses of mental disorder
<u>Sleep Problem:</u>	sleeping disorder or problem, insomnia
<u>Bad patch:</u>	something wrong but doesn't specify mental illness (e.g. "has problems", "is unmotivated", "sad", "lonely", "worried", "low self-esteem", "midlife crisis" etc.)
<u>Other:</u>	anything not coded under other themes, (e.g. "family" or "relationship problems", "don't know", suggestion regarding what to do rather than diagnosis etc.)

Eighty percent of participants correctly identified depression, 6 percent suggested that John was going through a 'bad patch', whilst another 6 percent gave answers such as sleep, relationship or medical problems. Five percent reported that John was stressed, often stating that this was due to work problems, and 3 percent responded that he had a 'mental problem'.

Analysis using chi square showed no statistically significant difference in diagnosis responses across data collection groups (2007/2008) for John's diagnosis ($\chi^2 = (4, N = 625) = 4.11, p = .39$) after combining the variable 'sleep problems' with the "other" category.

Hypothesis 1 stated that mental health literacy regarding depression would be lower for males than females. Chi square analysis showed a statistically significant gender difference in diagnosis attributed to the John vignette ($\chi^2 (4, N = 603) = 17.46, p < .01$). Women identified depression at a rate of 83 percent; with men only 67 percent (see Figure 15). The hypothesis that mental health literacy regarding depression would be lower for men than women was therefore supported. Men were more likely to respond that John was going through a bad patch or make 'other' responses (11% each respectively) than were women (5% each respectively).

Exploratory analyses were further conducted to elicit any associations present between diagnosis given to John and a number of variables discussed in chapter two. A one-way between-groups ANOVA found a difference in social contact between diagnosis for John [$F(1,4) = 3.83, p = .01$]. The magnitude of this difference was small ($\eta^2 = .04$). Post hoc analyses using Tukey's HSD found there to be a statistically significant difference in social contact between those correctly identifying depression ($M = 8.14, SD = 2.46$) and those diagnosing John with stress ($M = 6.39, SD = 3.56$). This indicates that those able to diagnose depression experienced higher weekly social contact than those who diagnosed John with stress.

A quantitative variable was created by dichotomising diagnoses attributed to John into correct (i.e. identified depression) and incorrect (other responses). This variable was then

analysed using an independent samples t-test to determine whether attitude towards seeking professional psychological help was related to diagnosis for John. The result was significant ($t(248.13) = 4.02, p < .001$), although the effect size was small ($\eta^2 = .02$). Means showed that those participants who identified that John had depression ($M = 21.81, SD = 5.50$) held more positive attitudes towards seeking professional psychological help than did those who diagnosed John with other problems ($M = 23.72, SD = 4.75$).

Chi square analysis was used to investigate whether previous experience of mental illness (yourself or someone close to you) had any effect on diagnosis attributed to John. The result was significant ($\chi^2 (5, N = 625) = 18.69, p < .01$). Of those participants who correctly identified depression in John, 68 percent indicated that they had some personal experience of mental illness. Sixty-one percent of those diagnosing John with stress, 53 percent of those diagnosing him with a mental problem or as going through a bad patch, 46 percent of those responding with answers coded as 'other', and 20 percent of those diagnosing John with a sleep problem indicated some experience with mental illness.

3.4.2 Identification of Schizophrenia

Thematic analysis was performed using responses to the second vignette (Mary) according to the method described by Braun and Clarke (2006). The themes elicited from this analysis were as follows.

<u>Schizophrenia:</u>	any comment referring to schizophrenia
<u>Symptom description:</u>	description of symptoms, (e.g. "psychotic episode", "paranoia", "hallucinations", "delusional", "imagining things" etc.)
<u>Incorrect diagnosis:</u>	any specific diagnosis of mental illness other than

	schizophrenia, (e.g. "anxiety", "eating disorder")
<u>Mental Problem:</u>	any general reference to mental illness, (e.g. "crazy", "psycho", "having a breakdown" etc.)
<u>Emotional Problem:</u>	any reference to an emotional problem (e.g. "stress", "frustration", "upset", "no motivation", "unfulfilled" etc.)
<u>Other:</u>	anything not coded under other themes, (e.g. "don't know", "lonely" etc.)

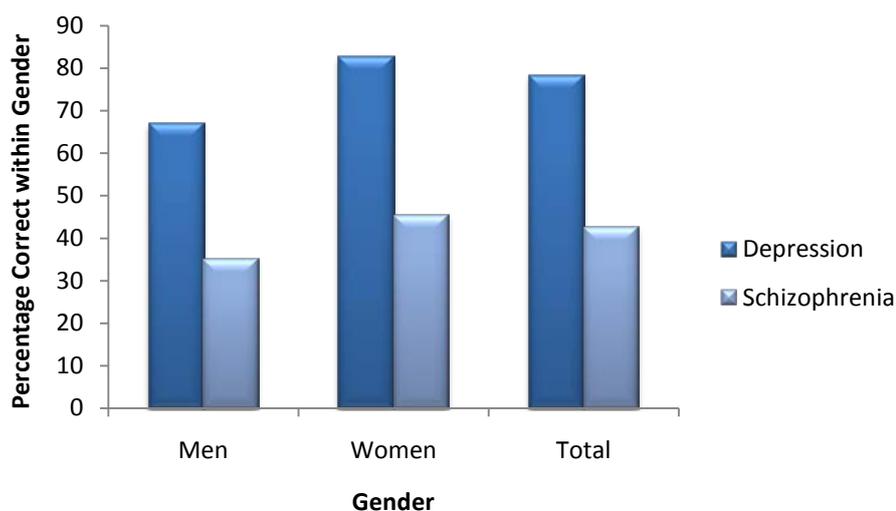
Forty-four percent of participants correctly identified schizophrenia. Eighteen percent described the symptoms without attributing a label to the problem, and 18 percent reported that Mary had a 'mental problem'. Twelve percent of participants gave an incorrect diagnosis (e.g. eating disorder, anxiety disorder), 5 percent suggested Mary had 'emotional problems', and 5 percent gave responses coded as 'other' (i.e. 'don't know', 'relationship problems' etc.).

Hypothesis 2 stated that mental health literacy regarding schizophrenia would be lower for men than for women. Chi square analysis determined a statistically significant difference in diagnosis between genders in response to the Mary vignette ($\chi^2 (5, N = 621) = 29.42, p < .001$). As displayed in Figure 15, women (46%) were more likely than men (35%) to correctly identify schizophrenia. Men (11%) were much more likely than women (2%) to respond in ways coded as 'other' or describe symptoms (men 21%, women 16%), whilst women were more likely to make incorrect diagnoses (men 7%, women 14%). The hypothesis that men would have lower mental health literacy regarding schizophrenia than women was supported.

Further analysis found that 52 percent of those participants who identified depression also identified schizophrenia. In the opposite direction, of those who identified schizophrenia, 94 percent also identified depression. Hypothesis 3 stated that participants would identify depression at a higher rate than schizophrenia. As shown in Figure 15, 80 percent of participants identified depression whilst only 44 percent identified schizophrenia. Therefore the hypothesis that mental health literacy would be higher for depression than schizophrenia was supported.

Figure 15

Gender Differences in Recognition of Depression and Schizophrenia



Chi square analysis (using a manipulated diagnosis variable which combined ‘lonely’ with ‘other’ responses in order to circumvent small cell size) showed a significant difference across participant groups in 2007/2008 for Mary’s diagnosis ($\chi^2 (5, N = 621) = 20.02, p = .001$). Results showed that more 2008 participants (52%) identified schizophrenia than 2007 participants (39%). Conversely, more 2007 participants described Mary’s symptoms (22%) when asked to diagnose her than did 2008 participants (12%).

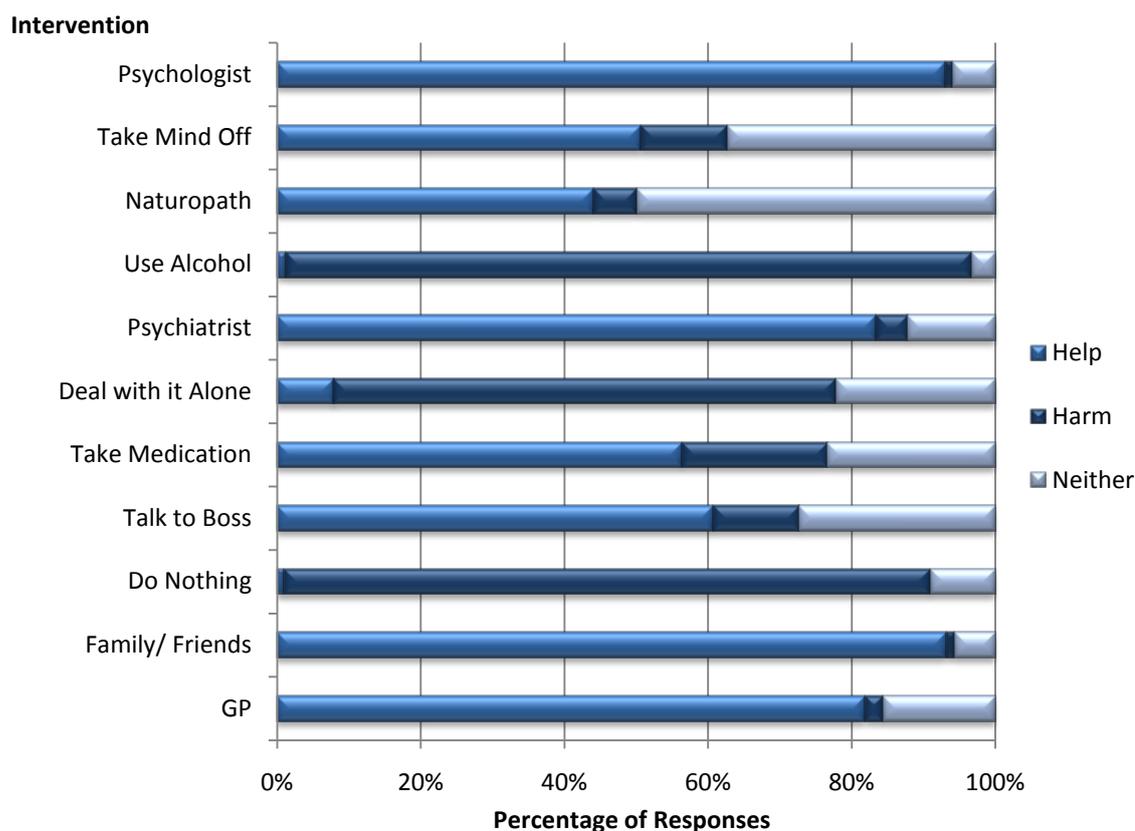
An independent samples t-test using the dichotomised schizophrenia variable (1 = correct diagnosis, 2 = incorrect) found that attitude toward seeking professional psychological help had some impact on Mary's diagnosis ($t(633) = 4.08, p < .001$). An eta squared calculation showed that this statistic had a small effect (.03). Those that correctly identified schizophrenia were shown to have a more positive attitude towards seeking professional psychological help ($M = 21.23, SD = 5.52$) than were those who did not identify Mary's problem as schizophrenia ($M = 22.97, SD = 5.19$).

3.4.3 Perceptions of Intervention Effectiveness for Depression

Participants were asked to indicate whether they felt that eleven particular interventions would “in themselves help, harm, or neither help nor harm” John with his problem. The results are presented in Figure 16. Participants overwhelmingly reported that seeing a GP, talking to family and friends or his boss, or seeing a psychiatrist or psychologist would help John. Whilst the majority of participants reported that the interventions taking medication and doing something to take his mind off would help John, a large proportion of responses to each item were distributed across both neither and harm responses. Most participants indicated that doing nothing, dealing with it alone, or using alcohol to soothe himself would harm John. Seeing a naturopath was the intervention most frequently reported as likely to neither help nor harm John.

Figure 16

Intervention for Depression Outcome Beliefs



Participant beliefs regarding the likely outcome of interventions were also investigated according to diagnosis attributed to John. Chi square analysis could not be undertaken due to the low cell count on a number of items. Whilst each diagnosis followed the pattern of help, harm or neither help nor harm presented above, some variations in proportions of participants making each response were evident. Responses according to diagnosis for interventions with more variable response patterns are presented below.

Figure 17 indicates that those who reported that John was suffering from stress were most likely to believe that talking to his boss would help the problem, whilst those who thought he was going through a ‘bad patch’ were most likely to think this would make no difference to him.

Figure 17

“Talk to his Boss” Outcome Beliefs according to Diagnosis attributed to John

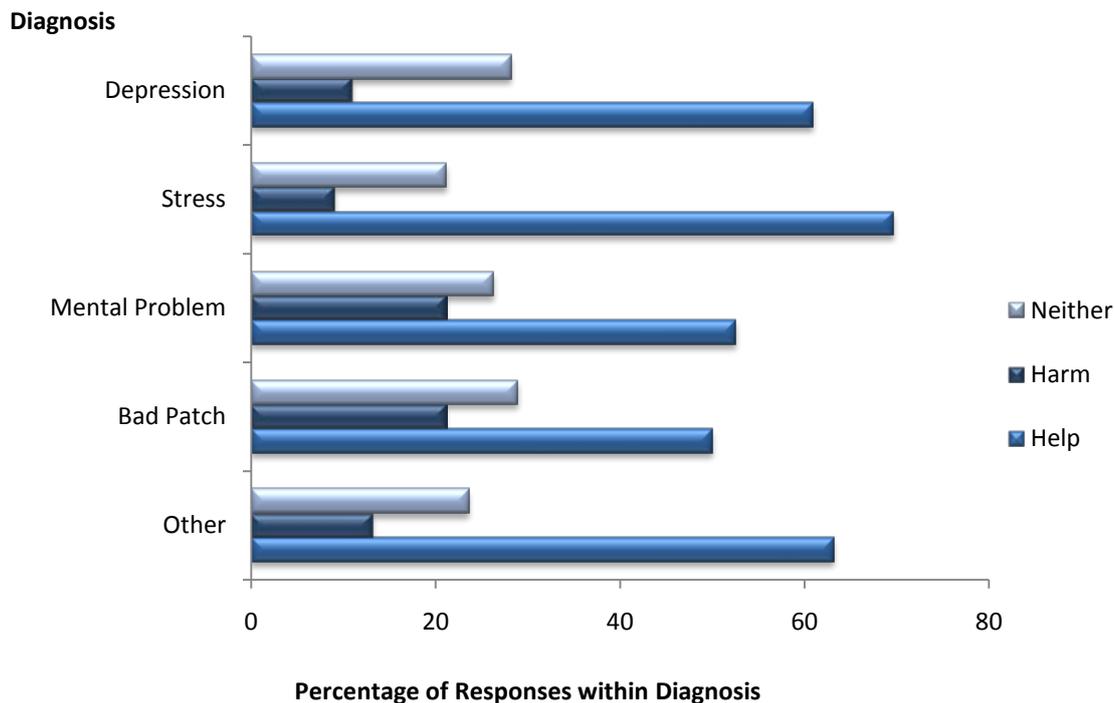


Figure 18 shows substantial variance in responses across the intervention variable ‘take prescribed medication’. The graph shows that those who made responses coded as ‘other’ (which included diagnoses of sleep problems) were most likely to believe that taking prescribed medication would help John, followed by those who diagnosed him with depression. Interestingly, of those who indicated that John had a mental problem, over a third thought that taking medication would harm him. Those who reported that John was going through a bad patch were most likely to believe that medication would have no effect.

Figure 18

“Prescribed Medication” Outcome Beliefs according to Diagnosis attributed to John

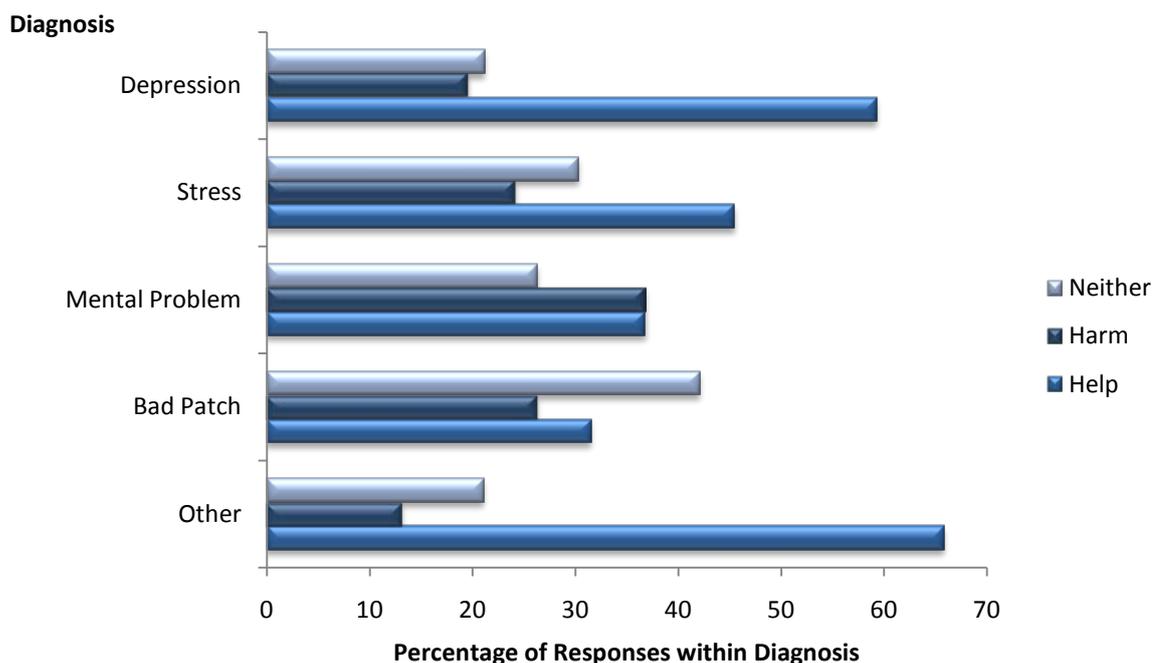


Figure 19 displays the common response that seeing a psychiatrist would help John. Those who identified that John suffered depression were most likely to report that this intervention would help him. However, almost 40 percent of those who reported that John suffered from a mental problem indicated that a psychiatrist would make no difference to his problem.

Figure 19

“Psychiatrist” Outcome Beliefs according to Diagnosis attributed to John

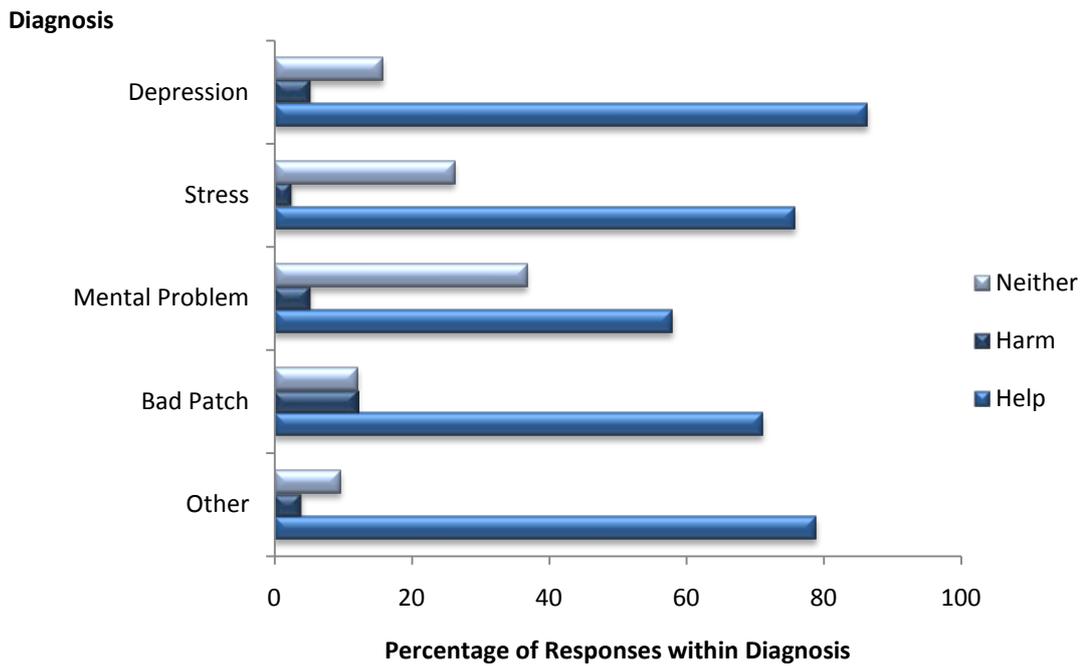
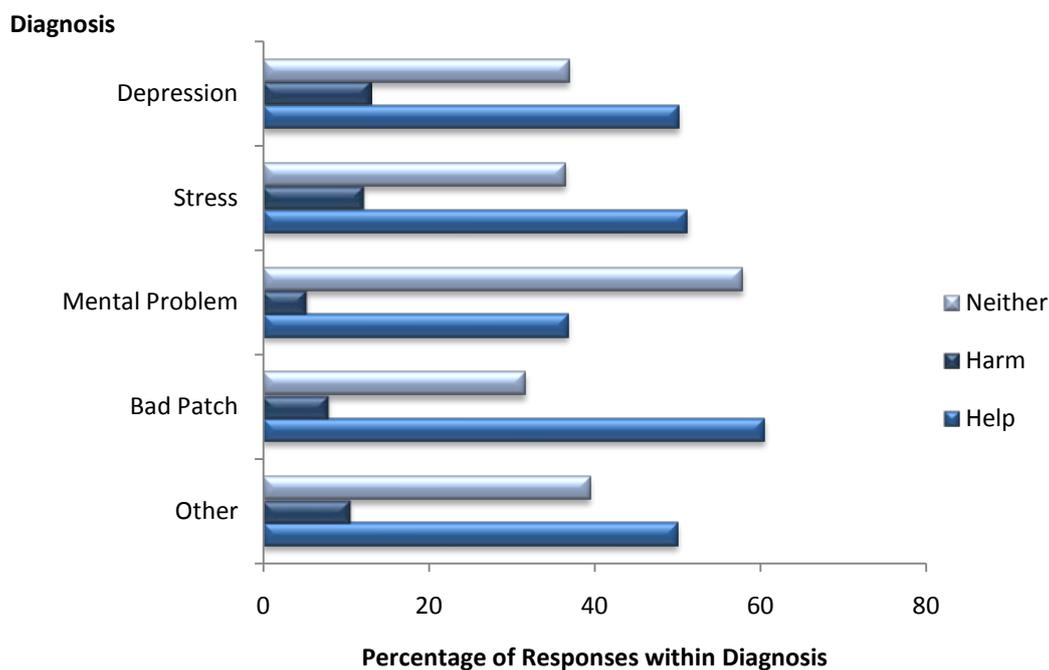


Figure 20 displays the variation in beliefs regarding the outcome if John did ‘something to take his mind off the problem’. Well over half of those who reported that John was going through a bad patch indicated a belief that taking his mind off it would help, which was the most of any diagnostic group. Those who diagnosed John as suffering from a mental problem were most likely to state that taking his mind off it would have no effect on John’s problem.

Figure 20

“Take Mind off Problem” Outcome Beliefs according to Diagnosis attributed to John



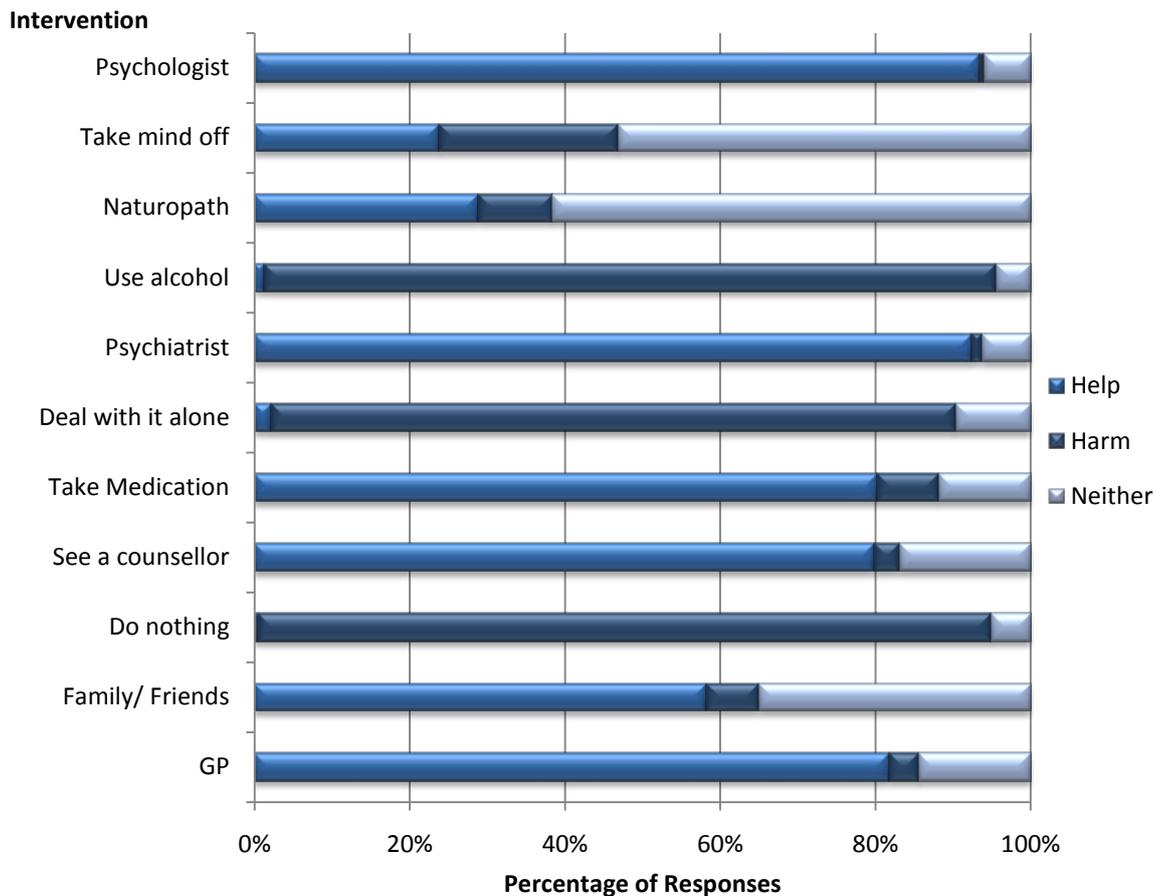
Between 82 and 95 percent of participants in all diagnosis groups indicated that seeing a psychologist would help John.

3.4.4 Perceptions of Intervention Effectiveness for Schizophrenia

As was the case with the depression vignette, participants were asked to indicate whether they felt that eleven particular interventions would in themselves help, harm or neither help nor harm Mary (who suffered schizophrenia). The results are presented in Figure 21. Participants overwhelmingly reported that seeing a psychologist, psychiatrist, GP, taking prescribed medication and seeing a counsellor would help Mary. The majority of participants indicated that doing nothing, using alcohol or dealing with the problem alone would harm Mary.

Figure 21

Intervention for Schizophrenia Outcome Beliefs



Participant beliefs regarding the likely outcome of interventions were also investigated according to diagnosis attributed to Mary. Chi square analysis could not be undertaken due to the low cell count on a number of items. Broadly, responses were similar across diagnoses. However, variations in proportions were evident across some diagnoses, indicating that beliefs regarding effectiveness of intervention may be affected by perception of the problem. For example, Figure 22 shows that those who diagnosed Mary with emotional problems were most likely to report that talking to family and friends would help. Conversely, those that identified schizophrenia were most likely to indicate that this would have no effect on Mary's problem.

Figure 22

“Talk to Family/ Friends” Outcome Beliefs according to Diagnosis attributed to Mary

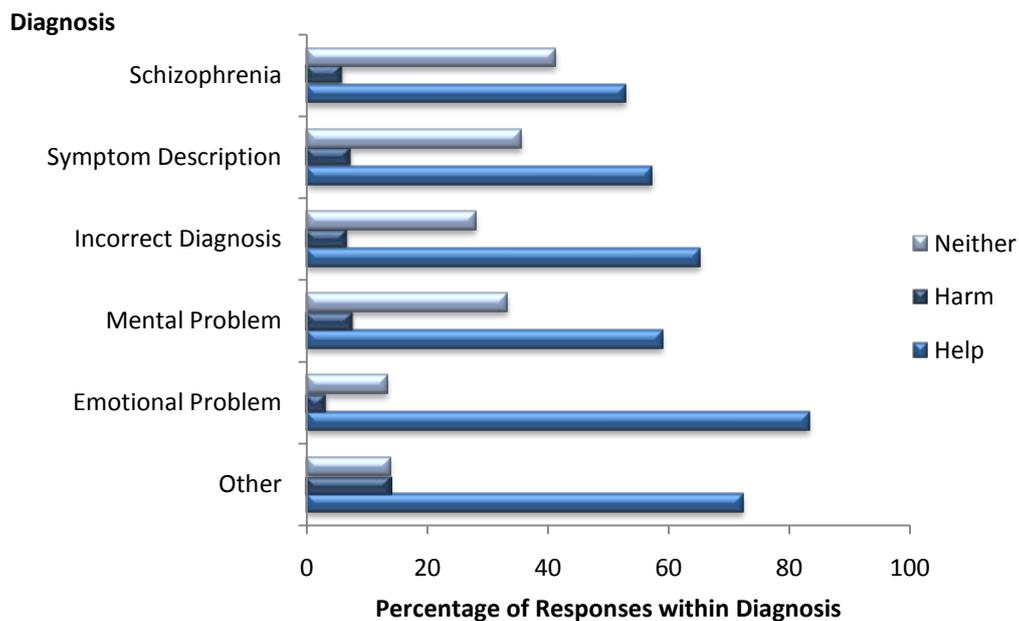
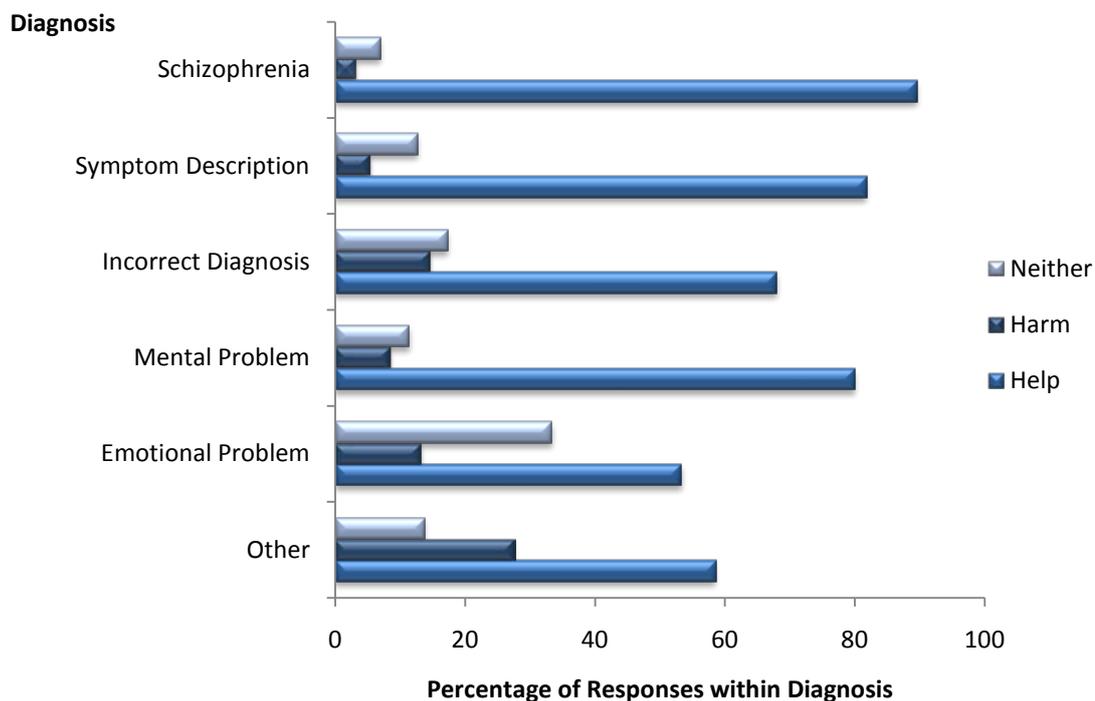


Figure 23 demonstrates that a high proportion of those who correctly identified schizophrenia believed that taking prescribed medication would help Mary. A third of those who reported that Mary was suffering an emotional problem believed that medication would make no difference. Almost a third of those who made responses coded as other indicated that taking medication would harm Mary.

Figure 23

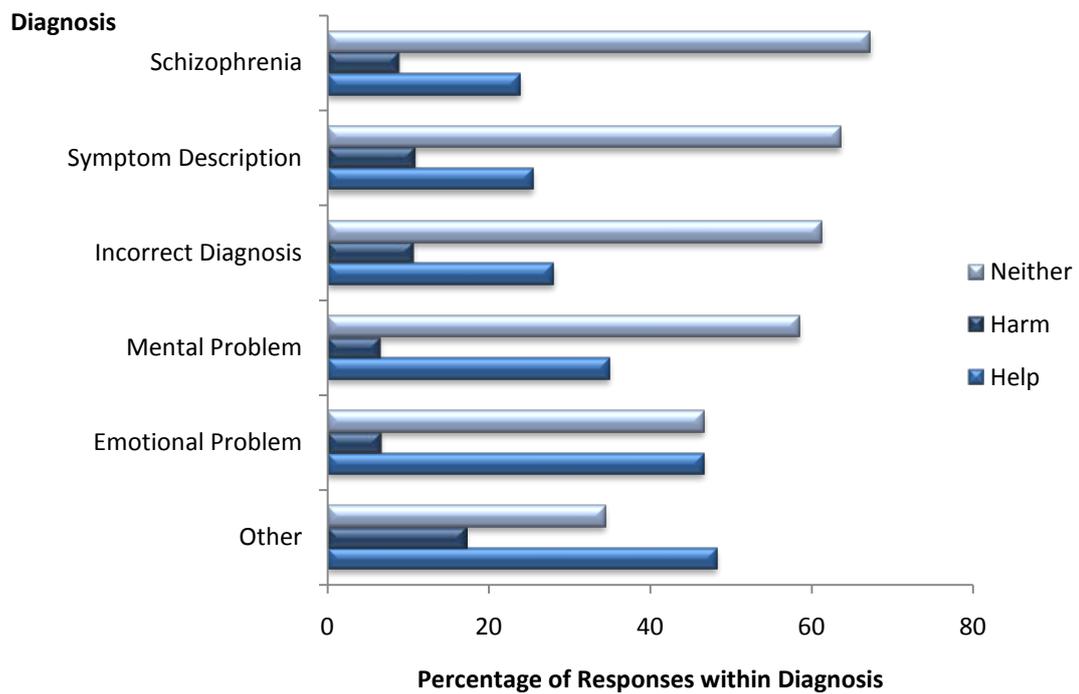
“Prescribed Medication” Outcome Beliefs according to Diagnosis attributed to Mary



As indicated in Figure 24, almost half of participants who made diagnoses coded as ‘other’ believed that seeing a naturopath would be helpful to Mary. Conversely, roughly two thirds of those who correctly identified schizophrenia indicated that this intervention would make no difference to Mary’s problem.

Figure 24

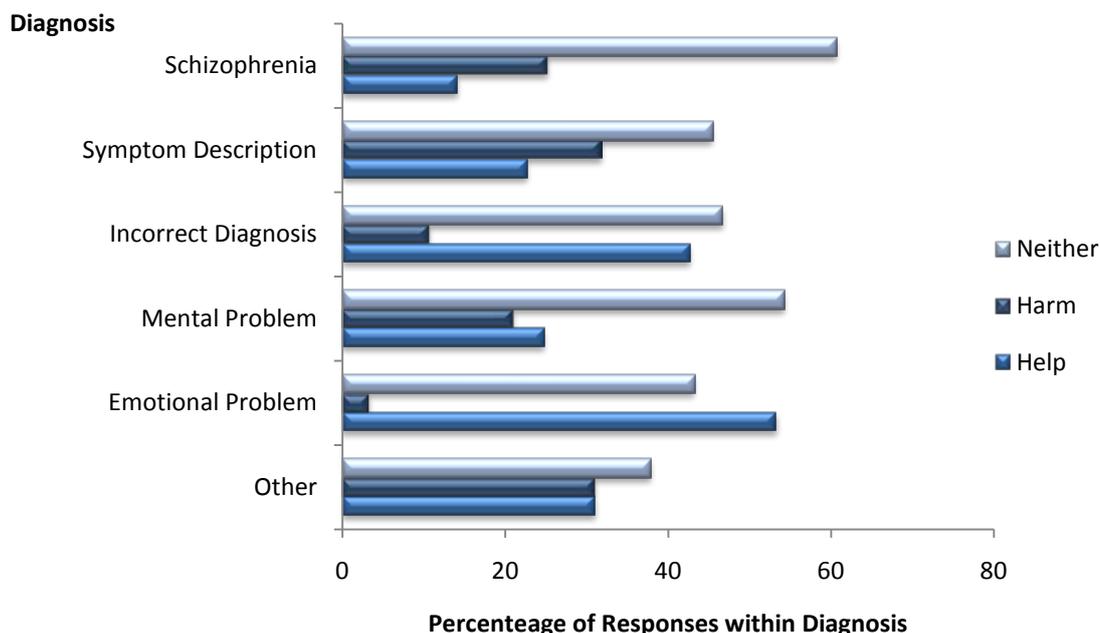
“Naturopath” Outcome Beliefs according to Diagnosis attributed to Mary



The proposition that Mary might ‘do something to take her mind off her problem’ returned variable responses. Figure 25 shows that those who diagnosed her with emotional problems thought that this intervention would help, whereas those who diagnosed schizophrenia were more likely to report that taking her mind off it would have no effect.

Figure 25

“Take Mind off Problem” Outcome Beliefs according to Diagnosis attributed to Mary



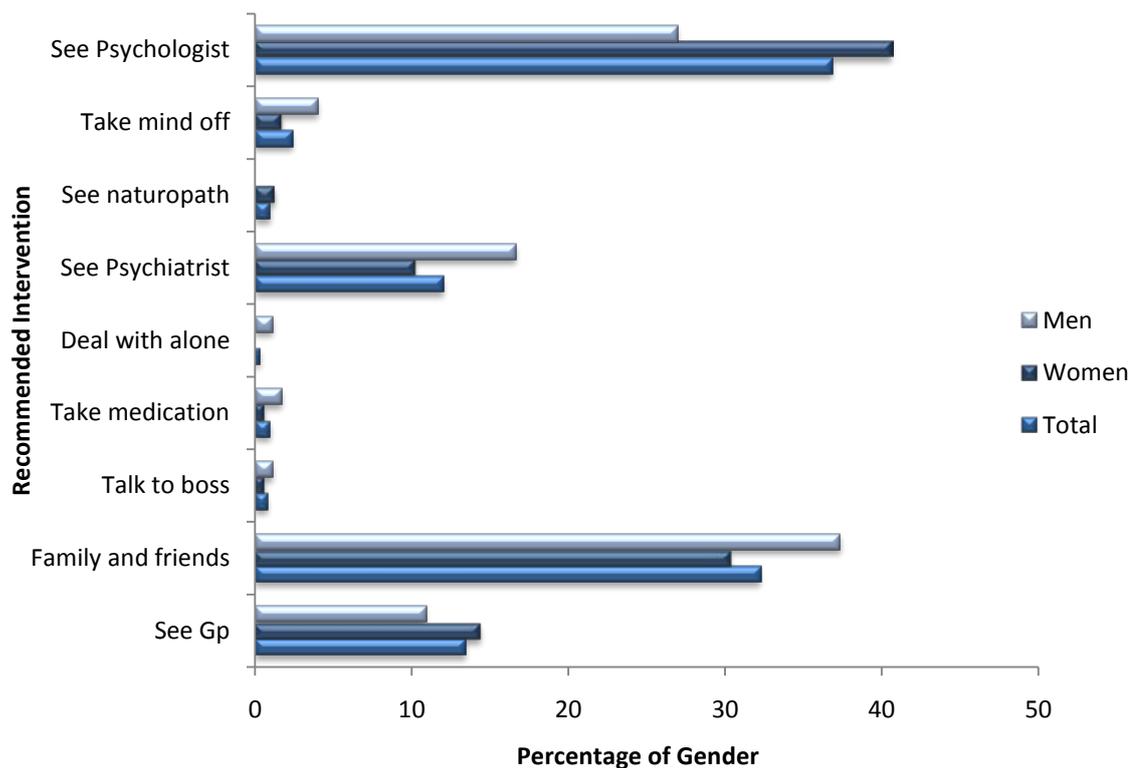
3.4.5 Recommended Intervention for Depression

Hypothesis 4 stated that respondents would recommend John seek help from a non-professional source. As shown in Figure 26, overall participants reported that the intervention that would most help John was to see a psychologist (37%) followed by talk to family and friends (32%). Therefore this hypothesis was not supported.

Chi square analysis was undertaken to determine whether recommendation for John was affected by gender. Only the four most common responses (GP, Family and Friends, See Psychiatrist, See Psychologist) were used in the analysis due to the small response numbers for other categories. Results showed that gender differences across these recommendations of intervention for John were statistically significant ($\chi^2 (3, N = 598) = 13.75, p < .01$). Figure 26 indicates that men most commonly recommended seeking help from family and friends. Women most frequently suggested John see a psychologist.

Figure 26

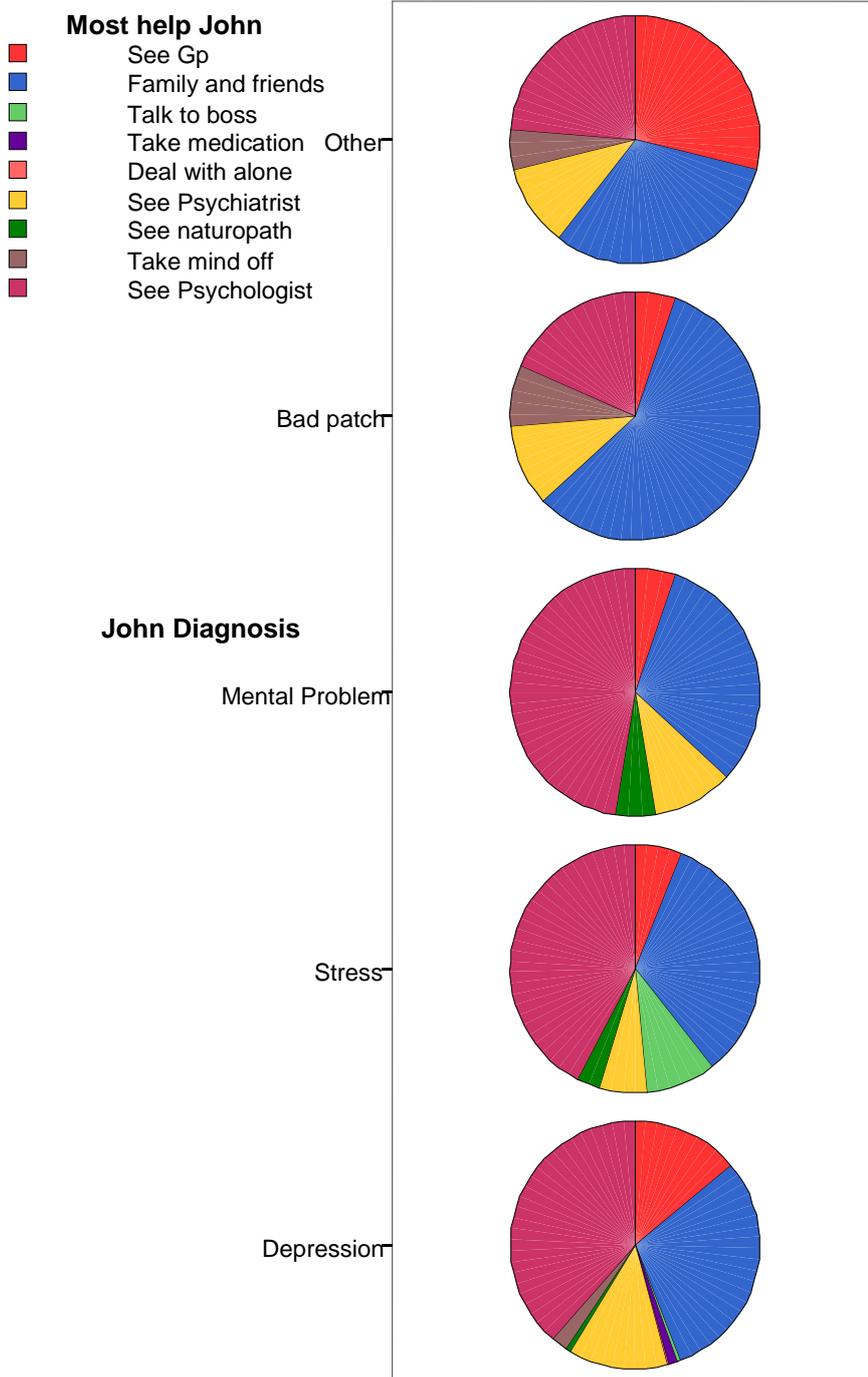
Recommended Intervention for Depression by Gender



Recommendations of the intervention that would most help John were found to vary according to what participants believed to be the problem. Figure 27 presents recommended interventions according to the diagnosis given to John. Of those that identified John as suffering from depression, stress or a mental problem, the most common recommendation for intervention was to see a psychologist, followed by talking to family and friends. Those who diagnosed John with a sleep problem most commonly recommended that he see a GP, whereas participants who described John as going through a bad patch or made responses coded as ‘other’ most frequently suggested that John talk to family and friends.

Figure 27

Intervention Recommended for Depression by Diagnosis Attributed to John



A one-way between-groups ANOVA suggested that social contact had some impact on recommendation regarding what would most help John [$F(1,8) = 2.45, p = .05$]. However,

this magnitude of this difference was small ($\eta^2 = .03$). Tukey's HSD post hoc analysis found that differences existed in social contact between those participants who recommended John see a psychologist ($M = 7.39$, $SD = 2.86$) and those who recommended he talk to family and friends ($M = 8.27$, $SD = 2.51$). A significant difference in social contact was also present between those who recommended seeing a psychologist and those who suggested John see a psychiatrist ($M = 8.49$, $SD = 2.50$). Those who recommended John talk to family and friends or see a psychiatrist had greater weekly social contact than those who advised that he see a psychologist.

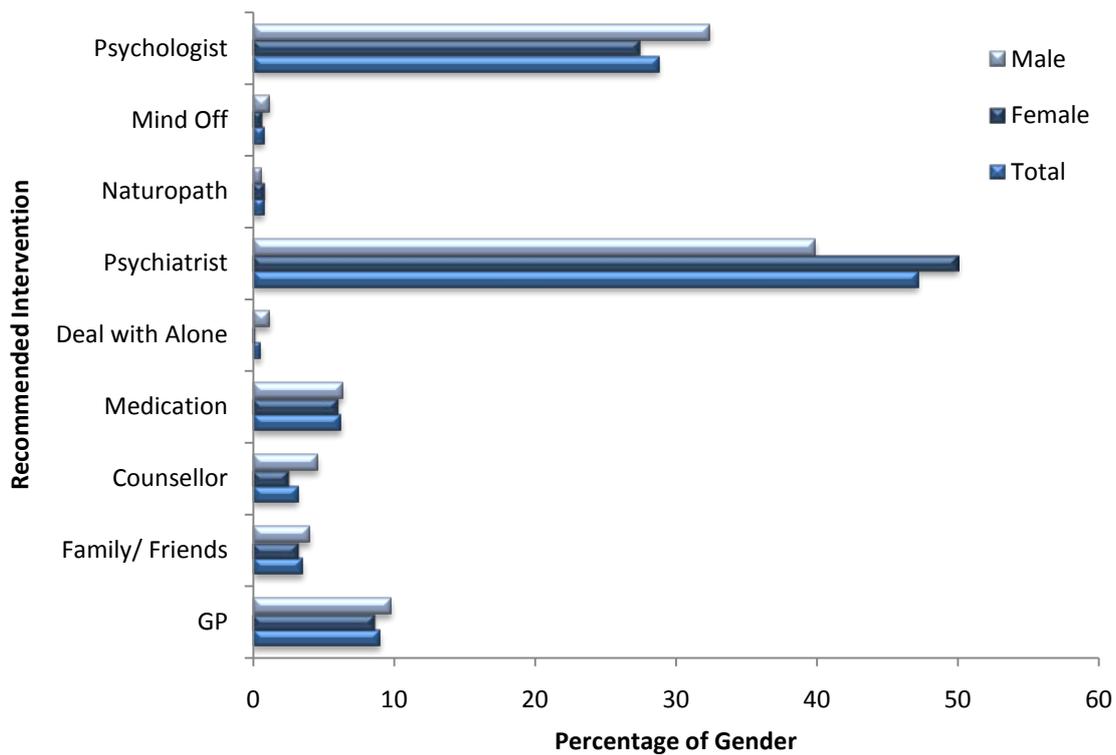
3.4.6 Recommended Intervention for Schizophrenia

Hypothesis 5 stated that respondents would most commonly recommend that Mary seek help from a psychiatrist or GP. The intervention reported as most likely to help Mary was to see a psychiatrist, followed by psychologist. The hypothesis was therefore supported. Details are presented in Figure 28.

Chi square analysis (using only the five most common responses due to the small response numbers for other categories) was performed to determine whether recommendation for Mary was affected by gender. Results showed no significant gender difference in recommendations of intervention for Mary ($\chi^2 (5, N = 618) = 5.75, p = .33$, see Figure 28).

Figure 28

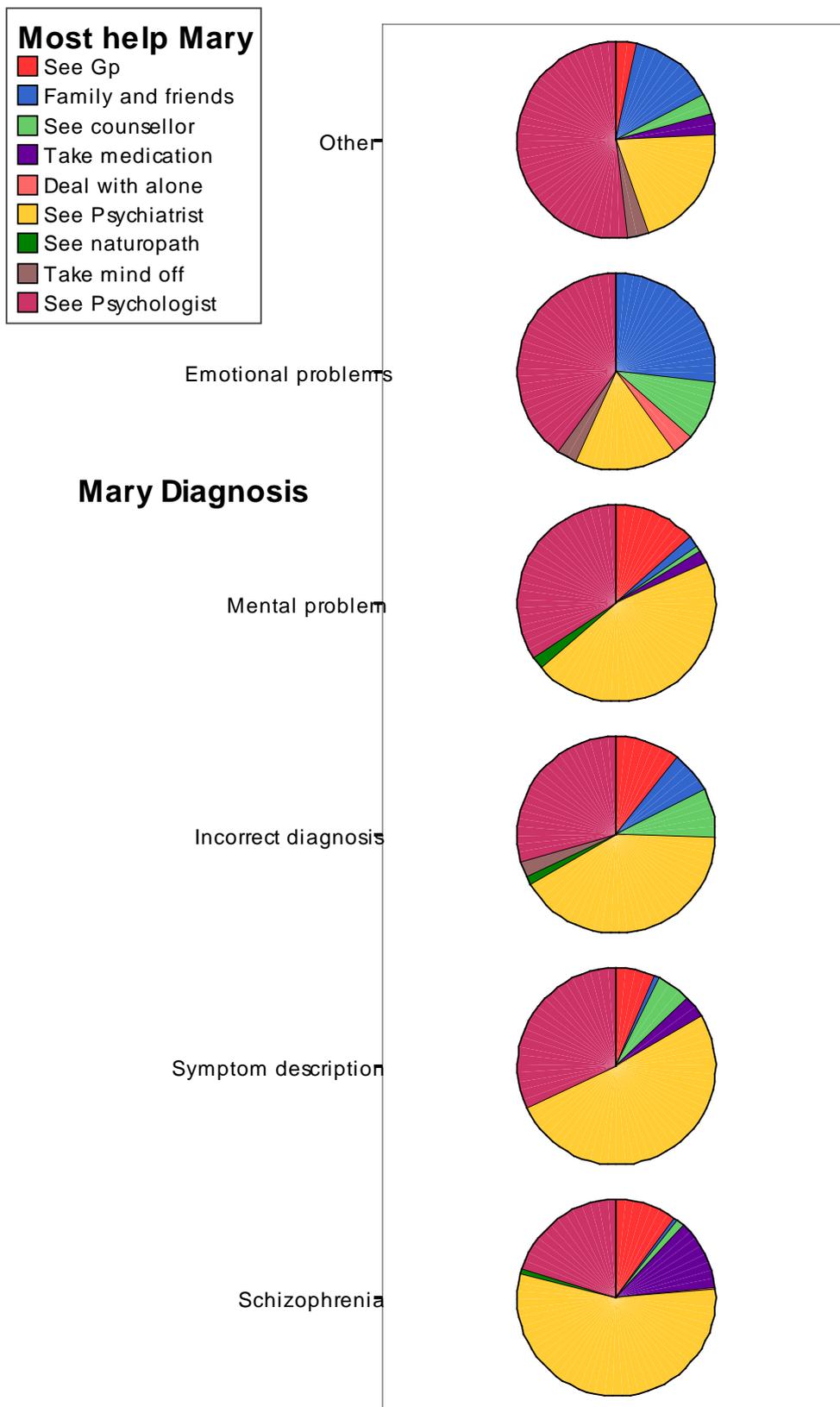
Recommended Intervention for Schizophrenia by Gender



Recommendations of intervention for Mary by diagnosis are shown in Figure 29. Of those who identified Mary as suffering from schizophrenia, described her symptoms, made incorrect diagnoses or reported that she suffered from a mental problem, the most common recommendation for intervention was to see a psychiatrist, followed by psychologist. Those who indicated Mary had an emotional problem equally suggested that she see a psychiatrist or talk to family and friends, and those who made diagnoses coded as ‘other’ recommended that Mary see a psychologist followed by psychiatrist.

Figure 29

Recommended Intervention for Schizophrenia by Diagnosis Attributed to Mary



3.4.7 Reasoning for Recommended Intervention for Depression

After indicating which intervention they believed would most help John, participants were asked to explain why they chose a particular intervention by short written answer. Qualitative responses were coded into themes using the thematic approach discussed by Braun and Clarke (2006). The first of the themes elicited from responses was ‘familiarity and support’ which incorporated comments referring to either comfort with the intervention, John’s knowledge of others or others’ knowledge of John, or alternatively encouragement from others. This theme included the following responses:

Extract 1

He would feel more comfortable with people he knew and trusted (Male)

Extract 2

Family will always support you (Male)

Extract 3

His family would know more about him, maybe this could help find out what’s the matter (Female)

The theme ‘professional’ incorporated responses referring to the qualified nature of the practitioner, their expertise or training. Examples of comments coded under this theme include:

Extract 4

A psychologist is trained to help people like john with their problems (Female)

Extract 5

Psychologists have expertise in that field. They'd know the right plan of action to follow. (Male)

Extract 6

Talking to a professional can aid because they are qualified to deal with this type of problem (Female)

The theme 'medication' encompassed any response that mentioned medication, including those that argued either for or against its use. Answers coded under this theme include:

Extract 7

Better track record than psychiatrists, no need for medication (Male)

Extract 8

Able to prescribe medication as well as provide therapy (Female)

Extract 9

Therapy and medication = good for depression (Male)

The 'refer' theme encompassed responses that suggest that the intervention could be a first step or a point from which John can be directed on to other interventions. Examples of comments coded under this theme are:

Extract 10

Boss can relieve stress in the workplace and refer him for professional help (Male)

Extract 11

Family and friends may help John through his problems, or they could refer him to a psychologist (Female)

Extract 12

GP could do an initial assessment and then either treat the person or make the appropriate referral (Male)

Other participants indicated that they chose a particular intervention because it was the 'best choice' or most likely to be useful to John. Responses coded under this theme included:

Extract 13

Provides the best results- cognitive behaviour therapy (Female)

Extract 14

This field is most capable of helping someone with a severe mental disorder (Male)

Extract 15

Most likely to help solve the issue of depression, best understanding of human psychie [sic] (Male)

A number of participants returned responses which did not fit under any of the above categories. These responses did not refer to any consistent themes and therefore were coded as 'other'. Examples of comments coded under this theme are:

Extract 16

Its worked for me in the past (Female)

Extract 17

A psychologist would be able to listen to him and find out what problem he has (Female)

Extract 18

It sounds as though John has an unresolved issue which is embodying itself in a depressed state (Male)

Extract 19

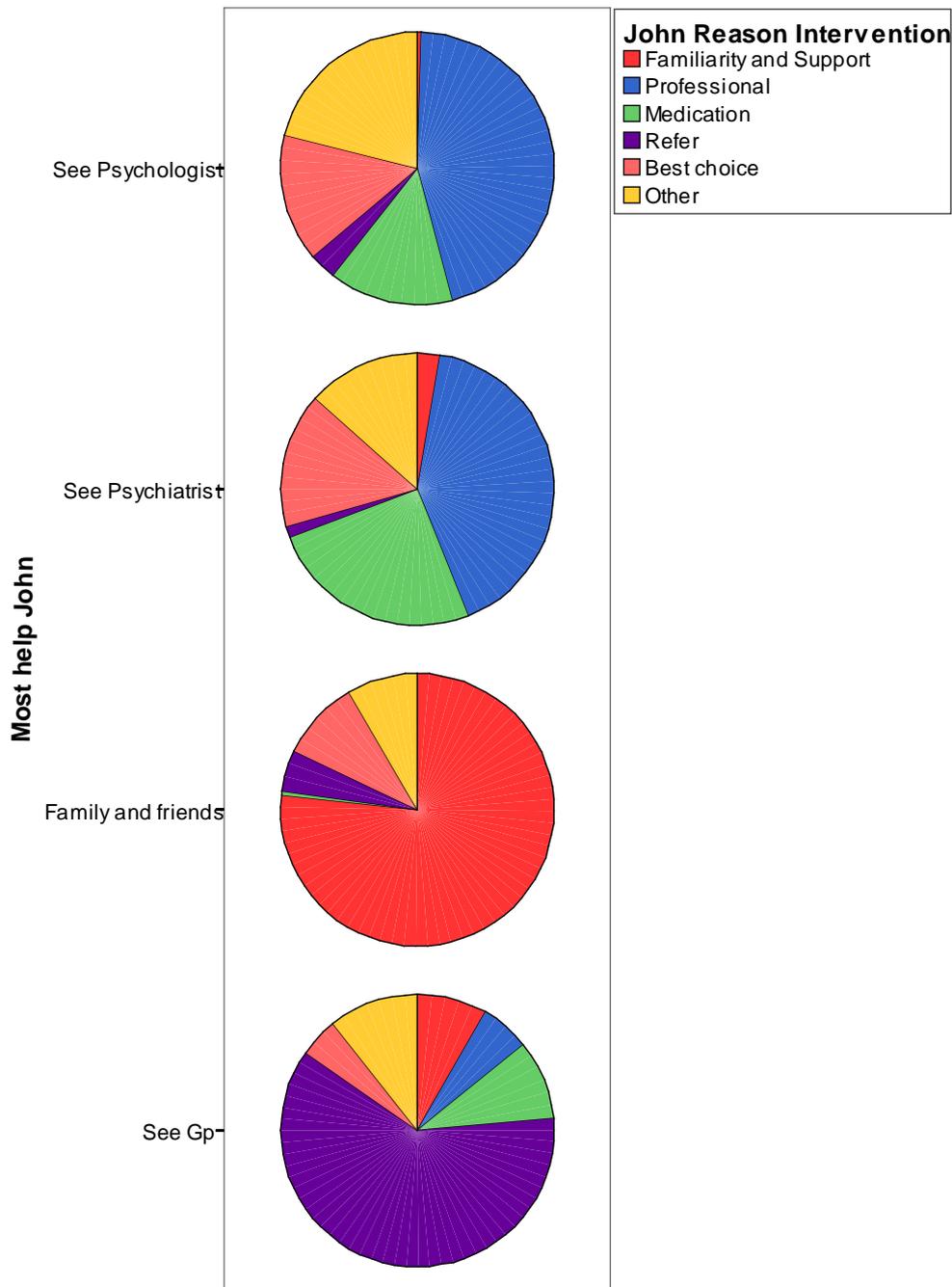
Activity and success will distract and potentially correct the problem (Male)

The majority of participants reported that their reason for recommending a particular intervention for John was familiarity and support (27%). The next most common response was professional (23%), followed by other (17%) refer (12%) and best choice (12%). The least frequent theme reported was medication (10%).

Reasons participants gave for choosing an intervention varied according to the action they had recommended. Chi square analysis could not be performed due to the low cell count for a number of variables; however, Figure 30 presents reasons for recommendations by recommended intervention. Results indicate that those who recommended family and friends did so largely because this intervention would be familiar and provide support. Those who advised that John should see a GP commonly reported that they did so because this practitioner could refer, whilst those who directed John to a psychiatrist or psychologist noted their professional nature. Of those who suggested John see a psychologist and reported that their reasoning was based on medication, the majority (82%) stated that the attraction to this intervention was that a psychologist could treat John without medication. Conversely, those who recommended John see a psychiatrist for reasons of medication stated that they chose this professional because he or she could prescribe pharmaceuticals.

Figure 30

Reason for Recommendation for Depression by Intervention Recommended

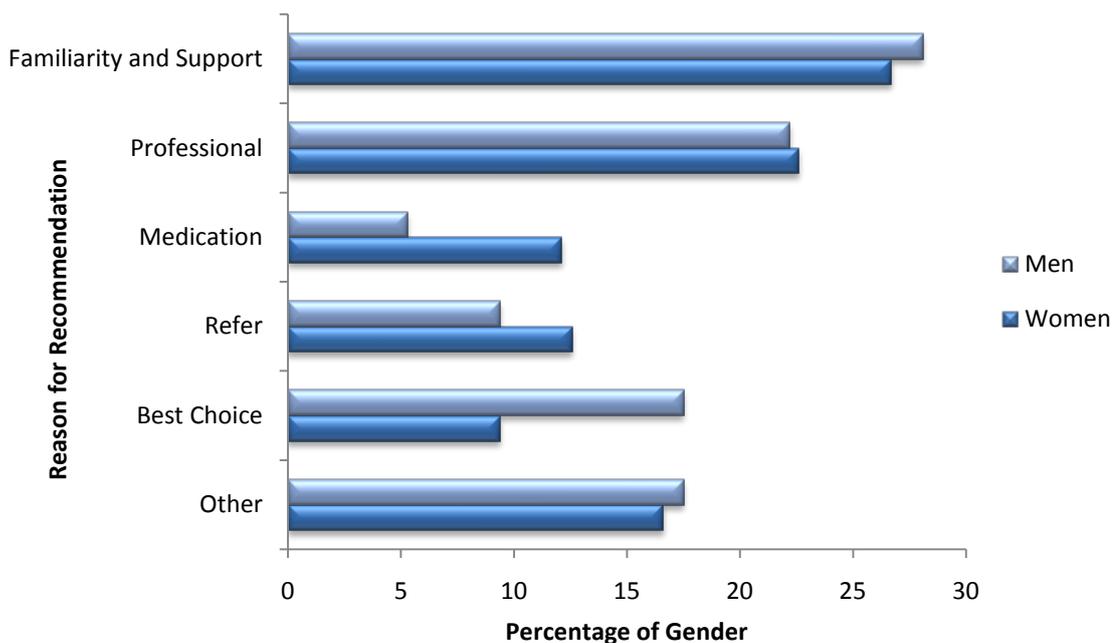


Chi square analysis was undertaken to investigate gender across reason given for recommending a particular intervention for John. The result was significant, ($\chi^2 (5, N = 617) = 13.92, p = .02$). Whilst both genders most commonly reported their decision was based on familiarity and support, men were more likely to state that their reasoning was that the

intervention was the best choice, whilst women were more likely to make reference to medication. Gender differences in reason for suggesting an intervention are displayed in Figure 31.

Figure 31

Reason for Recommendation of Intervention for Depression by Gender



An ANOVA was undertaken to determine any differences in ATSPPHS across reason given for intervention advised for John. However, a significant Levene statistic indicated that the assumption of homogeneity of variance was violated. Therefore a Kruskal-Wallis test was performed to complete this analysis. The result was significant ($H(7, N = 617) = 65.28, p < .001$). Pair-wise comparisons using Mann-Whitney tests revealed that significant differences existed between familiarity and support and a number of reasons including professional ($Z = -6.54, p < .001$), medication ($Z = -5.03, p < .000$), refer ($Z = -6.22, p < .001$), best choice ($Z = -4.17, p < .001$), and other ($Z = -2.73, p = .006$). Descriptive statistics are presented in Table 5. Means suggest that those who indicated that their recommendation was based on familiarity and support held the most negative attitude towards seeking professional psychological help.

Table 5

Descriptive Statistics for ATSPPHS by Reason for Recommendation for John

Reason	<i>n</i>	<i>M</i>	<i>SD</i>
Familiarity and Support	167	24.80	4.84
Professional	139	20.95	4.63
Medication	63	20.57	5.69
Refer	72	20.24	4.91
Best choice	72	21.58	5.32
Other	104	22.89	5.87
Total	617	22.27	5.40

3.4.8 Reasoning for Recommended Intervention for Schizophrenia

After indicating which intervention they believed would most help Mary, participants were asked to provide a short written answer to explain why they chose this particular intervention. Again, qualitative responses were coded using thematic analysis. Themes included ‘experience’ which incorporated responses referring to the knowledge, expertise or professional nature of the practitioner involved in the intervention. This theme included such responses as:

Extract 20

Trained to deal with this sort of thing and diagnosing the problem (Male)

Extract 21

Because professionals have the most experience with mental illnesses
(Female)

Extract 22

They're psychiatrists. Their job is to handle crazies. (Male)

The theme 'assess, treat or refer' encompassed responses which made reference to the process of evaluating the problem or assigning a diagnosis and then either undertaking treatment or referring clients. Examples of comments coded under this theme are:

Extract 23

Because Psychiatrists can assess the problem and prescribe medicine if applicable (Female)

Extract 24

GP can refer to appropriate professional (Female)

Extract 25

Mental illness, GP could refer her to have her condition properly diagnosed (Male)

Some respondents suggested that 'medication' was the reason for their choice of intervention. Any answer referring to medication, a medical condition or the requirement of medical attention was coded under this theme. Examples include:

Extract 26

It sound [sic] as if her situation is bad enough to need supervision and medication (Female)

Extract 27

She requires medical assistance (Male)

Extract 28

More likely to be a medical problem rather than a psychological one (Female)

Other participants pointed to the need for both ‘medication and counselling’. Due to the large number of responses including reference to both medication and therapy or counselling (or strongly alluding to this), this theme emerged separately to medication alone. Examples of comments coded under this theme are:

Extract 29

Able to prescribe medication as well as provide therapy (Female)

Extract 30

They can help her sort through her problems, and are able to prescribe medication if she needs it (Female)

Extract 31

Mary is mentally ill and needs medication and counselling, psychiatrist best equipped [sic] to handle this (Male)

Responses that made reference to the severe nature of Mary’s problem were coded under ‘serious’. Examples of the comments included under this theme follow.

Extract 32

Because she needs very serious help (Female)

Extract 33

Because Mary seems to be losing her mind, and needs some serious help.
(Male)

Extract 34

She has some serious problems that need help and may need more intervention than just talking. (Female)

Responses that indicated a particular intervention was chosen because it would be the most useful were coded under the theme 'help'. Any comment which made reference to this course of action, offering the best help for the problem, was included. Examples are:

Extract 35

If it is a mental illness, a psychologist would be able to help her the best
(Female)

Extract 36

Best choice (Male)

Extract 37

A psychiatrist would be able to give her the help she needs in the best possible way. (Female)

A number of responses did not fit under any of the major themes described above. These were coded as 'other'. A substantial proportion of comments were included in this theme, but these were not consistent in subject. A few examples are:

Extract 38

She wouldn't be afraid of a friend, and a friend would find it easier to alliviate [sic] he[r] fears. (Male)

Extract 39

Because she needs to confront the issues that are causing her behaviour.
(Male)

Extract 40

Someone she can freely talk to and not be looked on as crazy. (Female)

Extract 41

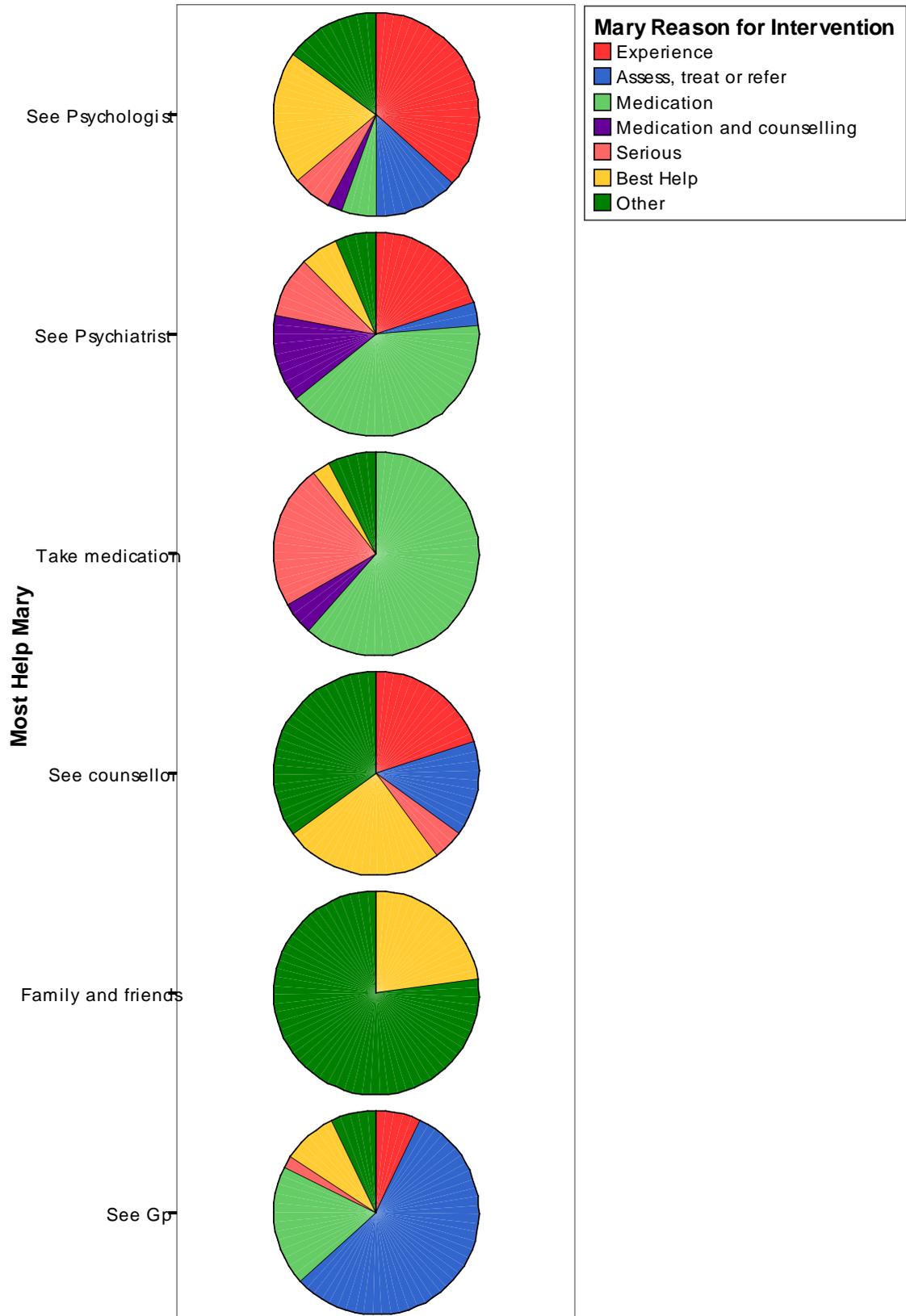
There is something wrong with her mind (Female)

The most common reason given for the recommendation of an intervention for Mary was medication (26%), followed by experience (21%). Less common reasons given were those coded as other (13%), best help (12%), assess, treat and refer (11%), serious nature of the problem (8%) and medication and counselling (7%).

Chi square analysis investigating reason for recommendation and recommended intervention could not be performed due to low cell counts. However, Figure 32 displays the substantial variation in reason for recommendation given by participants according to the diagnosis they attributed to Mary. Those who recommended Mary see a psychologist most commonly cited experience as their reasoning, whilst those who recommended she see a psychiatrist or take medication reasoned that medication would be of most use. Interestingly, of those who recommended Mary see a psychologist and gave their reasoning as medication or medication and counselling, the majority stated that a psychologist could prescribe pharmaceutical treatment. Of those who recommended a GP, the most common reasoning was that this intervention would provide an opportunity for assessment, treatment and referral. Those who thought that counselling or family and friends would be the most useful to Mary most frequently gave reasons coded as 'other'.

Figure 32

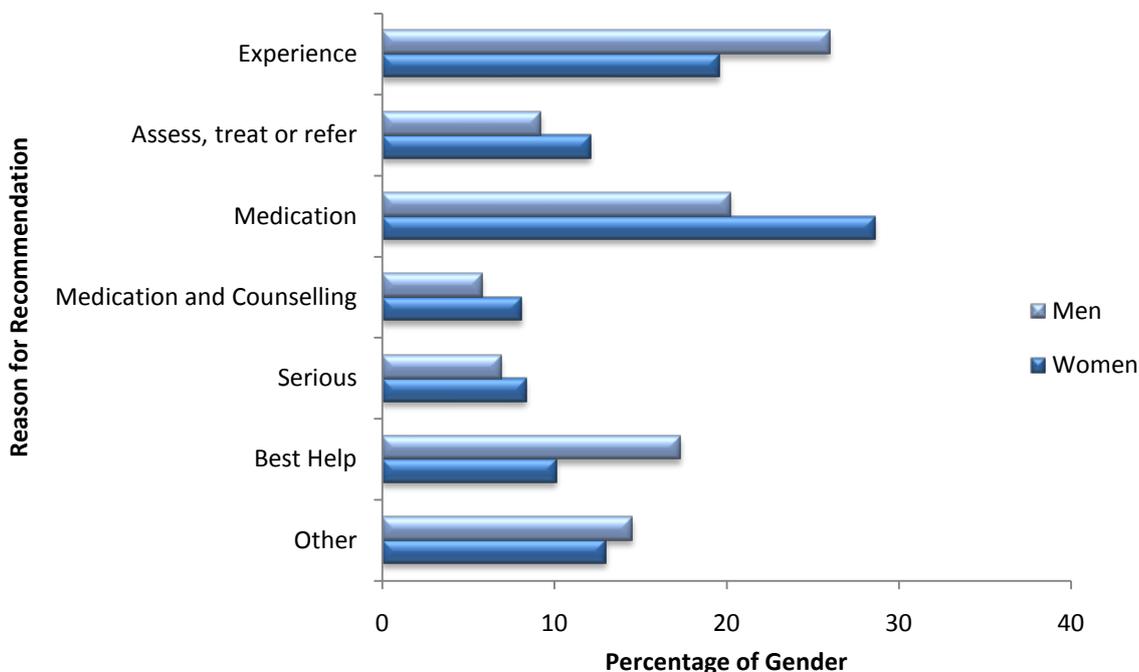
Reason for Recommendation for Schizophrenia by Intervention Recommended



Chi square analysis was conducted to determine whether any differences were present across gender in reasons given for intervention recommendations for Mary. The result was significant ($\chi^2 (6, N = 627) = 13.51, p = .04$). Results show that men were more likely than women to report that they chose a particular intervention either because the worker had experience, the intervention represented the best help, or give responses coded as other. Women were more likely to report that they had chosen an intervention based on medication. Detailed results are shown in Figure 33.

Figure 33

Reason for Recommendation of Intervention for Schizophrenia by Gender



A one-way between-groups ANOVA was conducted to investigate the interaction between ATSPPHS and reason for recommending a particular intervention for Mary. The result was significant [$F(6, 620) = 5.63, p < .001$], with a small effect size ($\eta^2 = .05$). Tukey's HSD post hoc analysis showed differences in attitude between 'medication and counselling' and 'experience', 'assess, treat, refer', 'serious', 'best help', and 'other'. Differences were

also present between medication and both best help and other. This indicates that those who recommended medication and counselling had the most positive attitude toward seeking professional psychological help. Descriptive statistics are presented in Table 6.

Table 6

Descriptive Statistics for ATSPPHS by Reason for Recommendation for Mary

	<i>n</i>	<i>M</i>	<i>SD</i>
Experience	134	22.61	5.27
Assess, treat or refer	71	22.39	5.14
Medication	165	21.27	5.70
Medication and counselling	47	19.19	5.25
Serious	50	22.64	4.54
Best Help	76	23.64	4.89
Other	84	23.69	5.40
Total	627	22.25	5.41

3.4.9 Likelihood of Following Recommendation for Depression

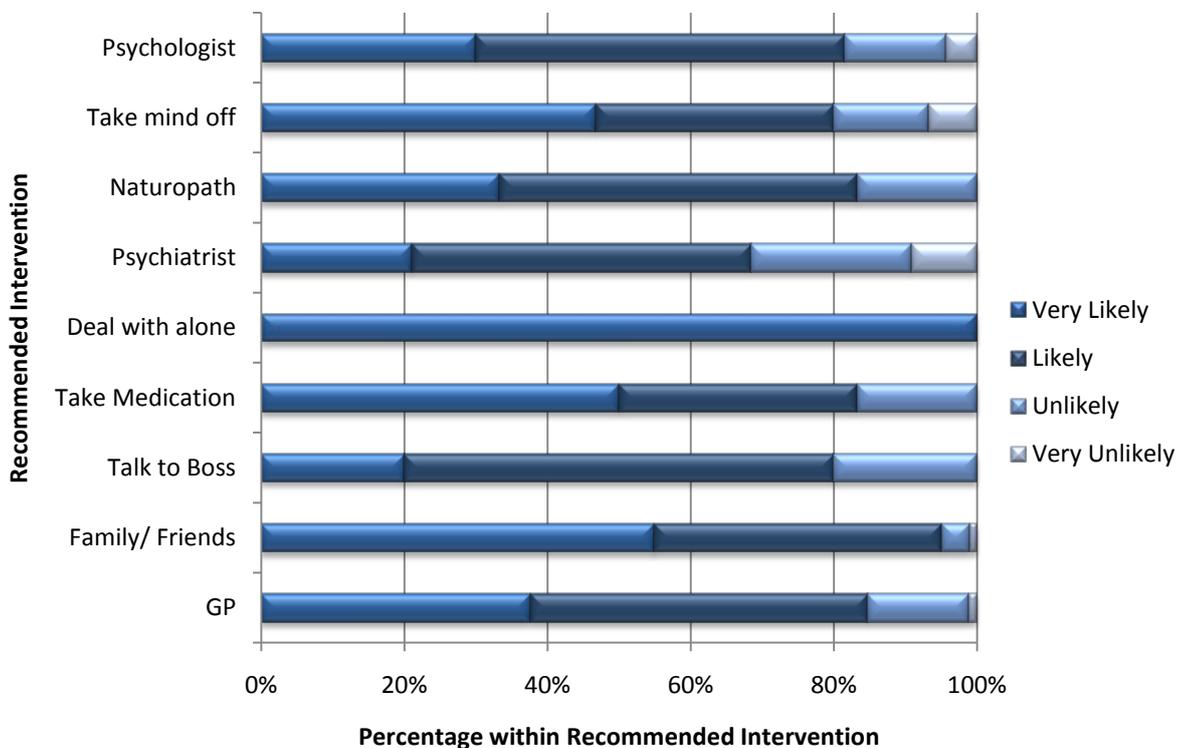
Participants were asked, “If you had John’s problem, how likely is it that you would take the course of action you suggested above?”. Thirty-nine percent of participants indicated that it was very likely they would follow their own advice regarding intervention, 46 percent stated that it was likely, 12 percent that it was unlikely and 4 percent that it was very unlikely. Chi square analysis showed no statistically significant difference in response across gender ($\chi^2(3, N = 633) = 2.05, p = .56$).

Of those who correctly identified depression, over 16 percent said that they were unlikely or very unlikely to follow their own recommendations (see Appendix J for more detail). This was greater than the 11 percent of those who did not identify depression from the vignette that reported that it was unlikely or very unlikely that they would follow their own recommendations if they had John’s symptoms.

Likelihood of taking the action recommended was further investigated according to intervention recommended. The results are presented in Figure 34. Surprisingly large proportions of those who recommended John see a psychiatrist or psychologist stated that it was unlikely or very unlikely that they would follow these courses of action if they were in his position.

Figure 34

Likelihood of Following Advice for Depression by Intervention Recommended



3.4.10 Likelihood of Following Recommendation for Schizophrenia

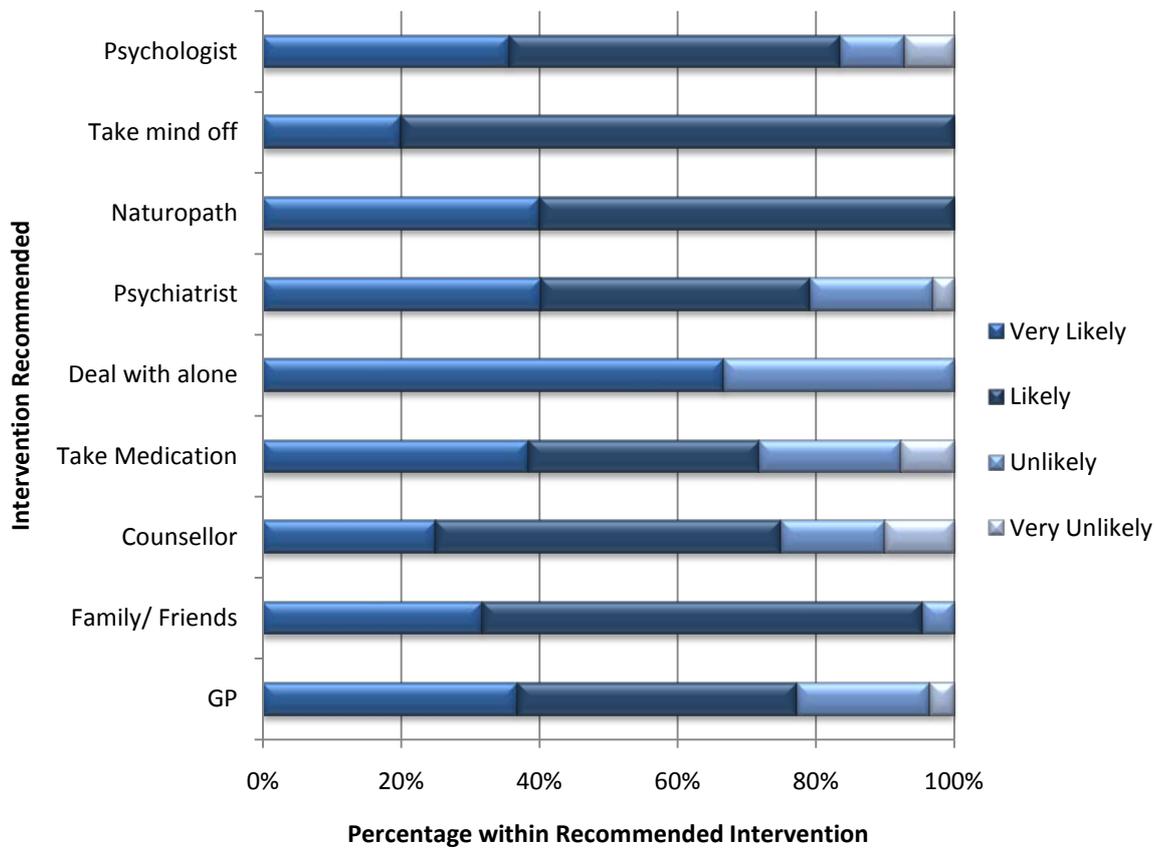
Participants were asked to rate the likelihood they would follow the action they recommended for Mary if they were experiencing her problem. Overall 38 percent responded that they were very likely to take the action they recommended, 43 percent indicated that this was likely, 15 percent that it was unlikely and 5 percent that it was very unlikely. Chi square analysis showed that there was a statistically different response pattern between men and women ($\chi^2 (3, N = 632) = 9.13, p = .03$). Women had a greater tendency to state that it was very likely they would follow their own recommendation (39%) than men (35%). Men more commonly stated that it was very unlikely they would follow their own recommendation (9%) than did women (3%).

Twenty percent of participants overall, indicated that they were unlikely or very unlikely to take their own advice regarding Mary's problem (see Appendix K for more detail). This proportion rose to 23 percent among those who did not identify Mary's problem as schizophrenia, and fell to 15 percent among those who identified schizophrenia.

Likelihood of following own recommendation of intervention was analysed according to which intervention was advised. Again, surprisingly large proportions of those who recommended Mary see a psychiatrist or psychologist indicated that they were unlikely or very unlikely to follow their own advice if they had Mary's problem. This was also the case with recommendations Mary see a GP, take medication or see a counsellor. Results are presented in Figure 35.

Figure 35

Likelihood of Following Advice for Schizophrenia by Intervention Recommended



3.4.11 Beliefs Regarding Improvement from Depression

Participants were asked “If John undertook the course of action you suggested above, how likely do you think it is that his problem would improve?”. The majority of respondents reported that it was likely (65%) or very likely (23%) John’s problem would improve. Eleven percent of respondents were unsure whether John would improve. Those most sure that John would improve were those who recommended that he see a naturopath or take medication. Chi square analysis indicated no statistically significant gender difference across responses ($\chi^2(4, N = 633) = 6.06, p = .19$).

Participants were also asked “If John took the course of action you have suggested, how long do you think it would take for his problem to improve?”. Results showed that the majority of participants believed it would take John months to improve (48%), followed by weeks (42%), days (7%) and years (3%). Chi square analysis found no difference across genders ($\chi^2 (2, N = 612) = 5.32, p = .07$).

Time to improve was also investigated according to diagnosis attributed to John. Chi square analysis could not be undertaken due to low cell counts across a number of responses. The majority of those who diagnosed John with depression, a mental problem, sleep problem or a bad patch believed it would take him years to improve, whereas those who diagnosed John with stress or other problems indicated that improvement would take weeks.

3.4.12 Beliefs Regarding Improvement from Schizophrenia

Participants were asked to indicate how likely they thought it was that Mary would improve if she took the action they had suggested. Fifty-three percent of participants believed that it was likely and 24 percent very likely that Mary would improve with intervention, whilst 23 percent were unsure. Those who suggested that Mary take her mind off the problem or talk to family and friends were the most sure she would improve, whilst those that recommended Mary see a naturopath or take medication were most unsure.

Participants were also asked how long they believed it would take for Mary to improve if she took the course of action they had recommended. Results showed that the majority of respondents thought improvement would take months (58%), followed by years (21%), weeks (19%), days (2%) and never (0.5%). Chi square analysis of gender differences

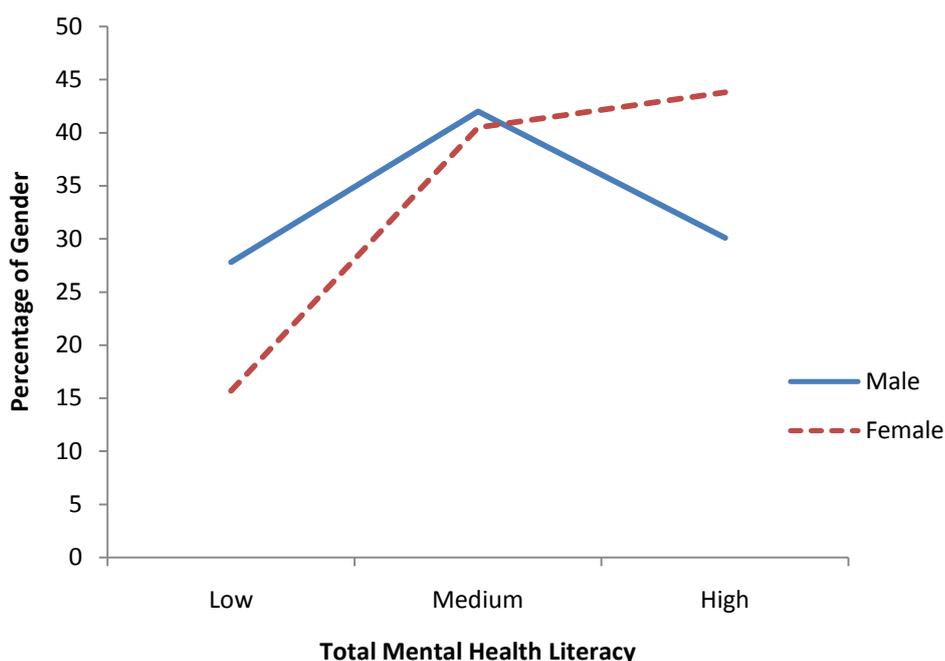
or diagnosis across estimated time to improve could not be undertaken due to low cell counts. However, of those who recommended that Mary talk to family and friends, the majority thought it would only take her weeks to improve, with days the subsequent highest response.

3.4.13 Mental Health Literacy Interaction with Other Variables

A total mental health literacy variable was created by combining the two dichotomised depression and schizophrenia variables so that 0 = low mental health literacy, 1 = medium and 2 = high. This total mental health literacy variable was used in analyses to examine any interaction between mental health literacy and other variables analysed in the previous chapter. Firstly, chi square analysis found that a significant difference existed in total mental health literacy across genders ($\chi^2 (2, N = 635) = 15.88, p < .001$). This reflects gender differences in the identification of depression and schizophrenia presented earlier. Results displayed in Figure 36 indicate that women had higher mental health literacy than men.

Figure 36

Level of Mental Health Literacy by Percentage of Gender



A one-way between-groups ANOVA was conducted to investigate the relationship between total mental health literacy and attitude towards psychological help. A significant difference between groups was found [$F(6, N = 634) = 11.81, p < .001$], with a small effect size ($\eta^2 = .04$). Post hoc analysis (using Tukey's HSD) showed a significant difference in ATSPPHS scores between both low ($M = 23.73, SD = 4.66$) and high ($M = 21.06, SD = 5.49$), and medium ($M = 22.66, SD = 5.41$) and high mental health literacy groups. There was a linear relationship between these variables; those with high mental health literacy had the most positive attitude towards seeking professional psychological help, and as mental health literacy decreased attitudes became more negative.

Chi square analysis showed a statistically significant difference in experience of mental illness between groups on total mental health literacy ($\chi^2(2, N = 635) = 16.74, p < .001$). Cell frequencies indicated that previous experience of mental illness is associated with high mental health literacy. For those who neither identified depression or schizophrenia, only 50 percent reported personal experience of mental illness compared with 64 percent of those with medium mental health literacy (either identified depression or schizophrenia) and 71 percent of those with high mental health literacy (identified both depression and schizophrenia).

3.5 Discussion

3.5.1 Knowledge of mental illness

Eighty percent of participants correctly identified depression from a vignette. Other responses included stress, sleep problems and that he was going through a bad patch, indicating that those participants who did not recognise depression generally characterised the

problem as reasonably mild. Overall 82.5 percent of participants indicated that John suffered from a mental concern.

Men recognised depression less frequently than women, supporting hypothesis 1. This is consistent with findings of a recent study by Cotton and colleagues (2006) who found that women identified depression at much higher rates than men. The factors contributing to this difference are unclear. Socialisation into traditional gender roles encourages women but not men to engage in personal conversations with peers, including discussion of emotional concerns, and perusal of health literature such as that included in women's magazines (Courtenay, 2000b; McKinlay, 2005). This can be seen to generate exposure to and receipt of mental health information and thus increased knowledge by women but not by men. This is one possible explanation for gender differences in ability to recognise depression. Whilst this study was able to determine that a difference in mental health literacy for depression exists between genders, future research could contribute more to understandings of possible causes of this difference.

The ability to recognise depression was associated both with more positive attitudes towards seeking professional psychological help and previous experiences of mental illness in oneself or someone close. It is logical that exposure to mental illness is likely to increase mental health literacy, if not from the experience itself, then possibly from associated information gathering. This result supports findings by Angermeyer and Matschinger (1996) that exposure to mental illness improves an individual's attitude towards mental disorder. However, it stands in contrast to other literature which demonstrated that neither experience of depression (Goldney et al., 2001) nor prior contact with mental health services (Goldney et

al., 2002) improved mental health literacy. Therefore there may be other factors which restrict learning or retention of information surrounding mental health.

Ability to identify depression was associated with higher reported social contact. Greater social interaction could denote an increased chance of exposure to discussions regarding the psychological concerns of others. Alternatively, it could be the case that those who seek wider social contact are independently more mental health literate than those with narrower social interactions. Social support has been shown to be a protective factor against psychological distress (Murray et al., 2007; Wester et al., 2007) and a facilitator to help-seeking (Vogel, Wester, Larson et al., 2007). However, this research did not assess perceptions of support gained from social contact, but rather social contact itself. Although one might infer that greater support is likely to be available to those with greater social contact, this may not always be the case.

As was the case with depression, men were found to be less likely to identify schizophrenia than women, supporting hypothesis 2. This finding stands in contradiction to previous work which has shown no gender difference in ability to identify psychosis (Cotton et al., 2006; Lawlor et al., 2008). However, findings that women are more psychologically-minded than men (Shill & Lumley, 2002) could be seen as predictive of this result.

Overall less than half of participants identified schizophrenia. This finding is particularly concerning due to the nature of this sample. Students enrolled in psychology are likely to have greater knowledge of mental illness than wider samples. Secondly, the age group of this sample is at risk of first episode of mental illness. Therefore, the inability of the majority of this sample to identify schizophrenia from a vignette does not bode well for the

likelihood of understanding the seriousness of the condition or treatment opportunities.

However, a further 18 percent of participants specifically indicated that the vignette depicted a mental problem.

Those who correctly identified schizophrenia had a more positive attitude towards seeking professional psychological help. This finding is consistent with the assertion that improved mental health literacy can improve attitudes towards mental illness and improve help-seeking by reducing associated stigma (Wrigley et al., 2005).

Despite the concerns surrounding the low identification rate of schizophrenia in this study, recognition of both depression and schizophrenia was higher than in previous research. Identification rates for depression have previously been reported at between 19 (Suhail, 2005) and 39 percent (Jorm, Christensen, & Griffiths, 2005a), where here identification was eighty percent. Reported identification rates for schizophrenia have been shown to vary from 5 (Suhail, 2005) to 27 percent (Jorm et al., 2005a), but in this study 44 percent diagnosed it correctly. As mentioned, higher identification rates in this study are likely to reflect the sample involved. Whereas previous studies have generally used community samples, here participants were enrolled in a university level psychology course. Therefore, this sample is likely to have greater knowledge of mental health issues than the general public.

Mental health literacy was higher for depression than schizophrenia, supporting hypothesis 3. Almost twice as many participants were able to identify depression than schizophrenia. The first year psychology course in which participants were enrolled was changed between the two years in which this study was conducted. This meant that the 2008 cohort had undertaken a block of lectures on mental health, including the DSM-IV

classification system prior to their involvement in this research, where the 2007 cohort had not. It was expected that this greater education would impact on diagnoses attributed to the vignettes presented. However, whilst identification of schizophrenia increased significantly across groups (39% in 2007 to 52% in 2008), there was no such difference in the identification of depression. This is likely to be due to the high rate of diagnosis of depression.

Lauber and colleagues (2003) investigated participant abilities to determine whether vignettes of depression and schizophrenic described an illness or a crisis. Using these parameters 74 percent of participants identified schizophrenia as an illness but only 40 percent recognised depression as an illness. Therefore participants in that study were able to identify the significance of the problem in the case of schizophrenia, but perhaps the boundaries between personal concerns and mental concerns were more blurry when it came to depression. However, the findings of Lauber and colleagues are in opposition to those in this study which asked participants to indicate what problem, if any, they believed was present.

3.5.2 Beliefs Regarding the Outcome of Interventions

Investigation of beliefs about the effectiveness of various interventions for the first vignette (depression) indicated reasonably consistent beliefs across participants regarding whether an intervention would help, harm or neither help nor harm. Participants reported that seeing a GP, psychiatrist and psychologist, talking to family/ friends and his boss, taking medication, and doing something to take his mind off the problem would each help John's problem. Doing nothing, dealing with it alone, and using alcohol to soothe himself were seen as likely to harm John's problem. Seeing a naturopath was thought to have no effect. The

response most frequently reported as likely to help John was talking to family and friends, closely followed by seeing a psychologist.

However, responses varied slightly according to the diagnosis attributed to John. For example, those who diagnosed John with stress were most likely to report that talking to his boss would help. Those who made responses coded as 'other' (including a number who stated that John suffered from sleep problems) were the group most likely to state that medication would help. Those who identified depression were the group most likely to report that seeing a psychiatrist would help, whilst more than a third of those who noted that John suffered a mental problem thought that this intervention would make no difference. More than half of those who reported that John was going through a 'bad patch' thought that taking his mind off it would help the problem.

Beliefs regarding likely outcomes of interventions for the second vignette (schizophrenia) were also reasonably consistent. Participants reported that seeing a psychiatrist, psychologist, GP, counsellor, take medication, talking to family and friends would help. Conversely, doing nothing or doing something to take her mind off it were each reported as likely to harm Mary. Seeing a naturopath was reported by most participants as likely to make no difference to the problem. Seeing a psychologist was the response most frequently indicated as likely to help, followed closely by seeing a psychiatrist.

Again, responses varied slightly according to the diagnosis attributed to Mary. For example, those who reported that Mary suffered from an emotional problem were most likely to state talking to family and friends would help. Those who identified schizophrenia were most likely to indicate that medication would help and that seeing a naturopath would have no

effect on the problem. Conversely, almost half of those who diagnosed Mary with ‘other’ problems thought that a naturopath would help Mary. Of those who indicated that Mary had emotional problems more than half reported that doing something to take her mind off it would assist her with those problems.

The investigation of outcome beliefs for interventions according to diagnosis highlights the importance of mental health literacy in seeking treatment for problems. The results discussed above show that the label that one attributes to a problem has some effect on what treatment is considered to help. If one sees the problem as primarily a physical one (e.g. sleep problem) then the treatment sought will follow accordingly (i.e. sleeping medication from a GP). Similarly, if depression is seen as stress then individuals may wait for a stressor to pass or modify their workload rather than seek professional help. Of concern are responses such as those given by participants who labelled Mary as suffering from an emotional problem. The majority of this group believed that taking one’s mind off it would help the problem presented in the vignette of schizophrenia. This disorder is serious and can have dangerous consequences if not adequately treated. Similarly, depression can increase in severity over time if not treated and can have fatal outcomes. The psychology students in this study are likely to have greater knowledge of depression and schizophrenia as well as possible treatments than those in the general community. Therefore the finding that a proportion of this group would consider ultimately ignoring the symptoms of schizophrenia, and indeed believe this will be of some use, is of significant concern. Adequate and appropriate treatment is unlikely to be attained if individuals are unaware of the problem at hand. Improvements in mental health literacy would facilitate suitable help-seeking (Wright, Jorm, Harris, & McGorry, 2007).

3.5.3 Interventions Regarded as Most Useful

Previous research investigating mental health intervention has been criticised for the use of rating scales as in ‘real-world’ situations individuals are required to make decisions regarding the source from which they seek help (Reidel-Heller, Matchinger, & Angermeyer, 2005). Therefore, this study asked participants to indicate which intervention they believed would most help the problems presented in vignettes.

Participants did not primarily recommend help-seeking from a non-professional source for the depression vignette, therefore hypothesis 4 was not supported. The most common recommendation of intervention for John was that he sees a psychologist. Recent research has found that people generally recommend informal help for depression (Angermeyer, Matschinger, & Riedel-Heller, 1999; Angermeyer et al., 2001; Komiti et al., 2006). However, other literature has reported that seeing a GP (Jorm et al., 2005a) or mental health professional (Reidel-Heller et al., 2005) is recommended for depression. As the current study is not consistent with the majority of this research the nature of the sample (psychology students) is likely to have had some impact. The association of the students in this sample with psychology may encourage them to recommend a psychologist as the intervention most likely to help the problem.

Further investigation of recommended intervention according to gender showed that men primarily recommended talking to family and friends, whilst women most commonly recommended John see a psychologist. Therefore, men in this sample recommended that help for depression be sought from the lay system.

In response to the second vignette, participants most commonly recommended that help for the schizophrenia be sought from a psychiatrist, supporting hypothesis 5. Almost half of respondents recommended that Mary see a psychiatrist, with the second highest response psychologist. This finding was consistent with research which has reported that mental health experts were recommended by participants as the best treatment for schizophrenia (Angermeyer et al., 1999, 2001; Reidel-Heller et al., 2005). This more specialised recommendation could be seen to reflect the more serious nature of the symptoms described in the schizophrenia vignette as opposed to that of depression. No gender difference was present across recommendations of the intervention most likely to help Mary.

Angermeyer and colleagues (2001) have suggested that schizophrenia may be seen as inexplicable and therefore as more in need of professional help than depression, which may be seen as an extension of normal feelings of sadness. This would predict that participants would be more likely to assess that the behaviours associated with schizophrenia indicated a mental illness than those associated with depression. Recommendations that a psychologist be sought for the treatment of depression and a psychiatrist for the treatment of schizophrenia lend some support to this position.

Jorm and colleagues (2005a) reported that participants in their study recommended the individual in the schizophrenia vignette see a counsellor. However, only twenty-seven percent of participants in that study identified the problem present as schizophrenia. It is logical to assume that had the problem been accurately diagnosed by a greater number of participants the most commonly recommended intervention may also be different. In the current study less than half of participants were able to identify schizophrenia; however, a greater proportion indicated that Mary suffered from mental concerns.

The interventions recommended as most useful in this study are inconsistent with previous research. Thompson and colleagues (2004) studied past psychological help-seeking behaviour and determined that the GP was the primary point of contact for more than two thirds of participants. Kovess-Mastety and colleagues (2007) investigated help-seeking intentions and found that over half of participants would primarily contact a GP regarding psychological concerns. It is possible that recommendations participants made for the individuals described in the vignettes were affected by the hypothetical nature of the situation or the problem being experienced by third person. Therefore this study included an examination as to the likelihood that participants would personally utilise advocated interventions (see p. 119).

3.5.4 Reasons for Recommending Intervention

Participants indicated why they recommended a particular intervention for each vignette. Reasons given for advocating an intervention for depression in order of most frequently used were: familiarity and support, professionalism, medication, referral, best choice and other. Reasons given varied according to which intervention was recommended for John (see Figure 30, p. 110). For example, those who recommended that John see a GP most commonly stated that they did so because this source could refer John to other services where appropriate. Alternatively, those who recommended seeing a psychologist or psychiatrist primarily cited the professional standing of these sources of help.

Reasons reported for recommending an intervention for schizophrenia (in order of most frequent) were: medication, experience, other, best help, assess/treat/refer, serious, and medication and counselling. Again, reason for recommendation varied according to the

intervention advised (see Figure 32, p. 117). For example, those that recommended a psychiatrist most frequently gave their reason as medication, those who recommended a psychologist primarily reported their reason as experience, and those who recommended a GP stated that this source of help could provide referral where necessary.

For each of the vignettes women reported medication as the reason for their recommendation more commonly than men. Men referred to an intervention providing the best help or being the best choice more than women in response to both vignettes. In response to the schizophrenia vignette, men were also more likely than women to indicate that they recommended an intervention due to the experience of the source of help.

Reasons given for recommending an intervention are important in understanding decisions around help-seeking. Results show that particular interventions are sought for different reasons. Those who are confident in their assessment of the problem may seek experienced, professional help to address the problem from the outset (such as a psychiatrist), whilst those who are unsure may seek help from sources that they recognise can assess the problem and refer for further treatment where necessary (such as a GP).

3.5.5 Beliefs Regarding the Likelihood of and Length of Time for Improvement

Beliefs about the likelihood of and length of time for improvement for the problems presented in the vignettes reflect participant understandings of the course of mental illnesses. For the depression vignette almost two thirds of participants believed that the problem would improve if the course of action they recommended was followed. Those most sure that the problem would improve were those who advocated that John take prescribed medication or

that he see a naturopath. Participants were most likely to indicate that it would take months for the problem to improve. However, a large proportion of participants (most frequently those who reported that the issue was stress or a problem coded as ‘other’) indicated that improvement would take weeks.

The majority of participants thought that it was likely that Mary’s problem (schizophrenia) would improve if she took their advice, although the proportion was substantially less for schizophrenia than depression. Those who were most sure that the problem would improve were those who recommended that Mary do something to take her mind off the problem or talk to family and friends. Almost a quarter of participants were unsure if schizophrenia would improve if the intervention they recommended was sought.

Most participants thought that improvement from schizophrenia would take months. A troubling finding was that a third of those who recommended Mary talk to family and friends believed that she would improve within days due to this intervention. This result demonstrates the need for improvements in mental health literacy, even for those in this sample who are likely to have greater understandings of mental health than the general population. The belief that schizophrenia will improve within a very short time frame without professional intervention clearly shows a lack of understanding of the seriousness of this disorder and the likelihood of increasingly negative outcomes without professional intervention.

Again, conceptions of the problem at hand affect beliefs about the likelihood of improvement and the length of time that this may take. If participants believe that seeing a naturopath for depression or talking to family and friends for schizophrenia are very likely to improve the problem it is likely that they will undertake this course of action, especially as

these interventions do not require the labelling of a problem as severe or as mental illness and therefore resist the associated stigma. However, the delay in appropriate professional help-seeking associated with these sources of help could result in increased chronicity and negative consequences for the individual. Increasing understandings about mental health, likelihood of improvement and course of illnesses would combat such delay and promote appropriate help-seeking.

3.5.6 Likelihood of Following Own Recommendation of Intervention

Mosher (2002) found that people have a tendency to recommend a higher level of intervention for others than themselves, and this was especially the case for men. Accordingly, recommendations of most useful interventions for mental illnesses in this study were studied according to relationship to help-seeking intention. Participants were asked to indicate how likely it would be that they would follow their own recommendation of intervention if they suffered from each of the problems presented. Sixteen percent of participants indicated that they would be unlikely to follow their own advice if they had John's problem. Those who identified depression were less likely to take their own advice regarding the intervention they recommended than those who made other diagnoses.

In response to the second vignette, 20 percent of participants indicated that they were unlikely to follow their own advice for schizophrenia. Those who correctly identified schizophrenia were more likely to follow the intervention they recommended than those who made other diagnoses. Men were three times less likely than women to follow their own advice for schizophrenia, supporting findings of gender differences by Mosher (2002).

Almost a third of those who suggested John see a psychiatrist and almost a fifth of those who recommended he see a psychologist would not do so if they suffered from his problem. Of those who recommended that Mary deal with the problem alone, a third would not follow this course of action (although the group size was very small). Almost thirty percent of those who recommended that Mary take prescribed medication would not follow their own advice. These results reflect findings of earlier studies which have consistently reported a lack of psychological help-seeking among community samples (Andrews et al., 2001; Jorm, 2000; Mojtabai et al., 2002; Vasiliadis et al., 2005). Whilst mental health literacy must clearly play a role in the process of help-seeking for psychological concerns, these findings indicate that there must also be other factors at play. These may include notions of stigma associated with the diagnosis or with psychological help-seeking. Further research into real-world experiences of psychological help-seeking could illuminate some of these issues.

3.5.7 Associations between Mental Health Literacy and Other Variables

Attitudes towards seeking professional psychological help were more positive among those with high mental health literacy than with low. Similarly, experience of mental illness in self or someone close was associated with higher mental health literacy. It could be implied from these findings that experience with mental health improves ones knowledge of the topic and that knowledge of mental health has some interaction with attitudes towards help-seeking. Thus, efforts increase to mental health literacy could also improve rates of psychological help-seeking.

Women had higher levels of mental health literacy than men. This finding is not surprising given a wealth of research which suggests that men tend to resist talking about the emotional concerns with others and are likely to deny symptoms of mental illness in

themselves (Cook, 1990; Kilmartin, 2005; Mahalik et al., 2003; Seidler, 1997). There is clearly room for improvement in mental health literacy, especially for men.

It should further be noted that some participants displayed disrespectful attitudes towards people with mental illnesses. For example, a number of responses labelled the individuals presented in the vignettes as ‘crazies’ or stated that they were ‘mental’. Despite presumptions that the sample of psychology students used would attribute less stigma to mental illness than a wider community sample, these responses clearly demonstrate that some participants stigmatised the individuals depicted. This provides some evidence for the pervasive nature of stigma associated with mental illness and the challenge that exists to diminish it. The emergence of stigma in participant responses prompts the question as to whether this is a contributing factor to the resistance observed to seeking psychological help, and perhaps whether its role is as significant as that of mental health literacy.

A lack of mental health literacy can have serious implications for individuals who experience mental illness. As shown in the results of this study, if a problem is not considered to be a significant mental concern then appropriate intervention would not be sought. However, illiteracy has further complications in the help-seeking process. As Brownhill, Wilhelm and colleagues note (2003) when seeking help individuals are required to disclose information regarding their concern in a way that conveys to a lay person or professional that the problem is indeed one of mental disorder in order to receive the appropriate treatment. The finding that men are less able to identify both depression and schizophrenia from vignettes than women suggests that it is men that are most at risk from mental health illiteracy.

Whilst mental health illiteracy, including an inability to recognise mental illness, negative help-seeking beliefs and intentions, may act as barriers to appropriate treatment for mental health concerns, this study did not investigate barriers to help-seeking per se. Before concluding that improving mental health literacy will have some impact on psychological help-seeking, some effort needs to be made to determine whether this is central to the underutilisation of services, or whether separate or related factors are of greater importance. Secondly, a focus particularly on the perceived barriers that exist for men would be useful in providing a basis from which interventions intended to improve the mental health literacy of men could be created.

3.6 Conclusion

Lack of knowledge about mental illness and available treatment is a significant factor in delay of help-seeking (Thompson et al., 2004). Delays in help-seeking can increase the chronicity of the concern and associated negative outcomes (Compton, Goulding, Broussard, & Trotman, 2008). It is heartening therefore to see evidence that mental health literacy can be improved (Jorm, 2000; Jorm, Barney et al., 2006). However, better understandings of help-seeking and the factors that affect it (such as the role of stigma) would be useful in determining how best to approach increasing mental health literacy.

CHAPTER FOUR

Study Three: Help-Seeking Behaviour

4.1 Introduction

As discussed in chapter three, mental health literacy refers to beliefs and knowledge about mental disorders, their identification and treatments (Jorm et al., 1997). It has been demonstrated that there is a lack of mental health literacy amongst the Australian community, including poor understandings of mental health treatments and available resources (Goldney et al., 2001). Research suggests that in order to seek professional support individuals must not only identify the problem but believe that it is sufficiently severe to justify seeking help (Galdas et al., 2005) and is amenable to help (Gross & McMullen, 1983). As such, decisions to seek help rely on mental health literacy and available research suggests that lack of knowledge may significantly impede help-seeking.

Knowledge about mental health also affects individual judgements about other people who suffer from mental illnesses. For example, research has shown that those who attribute mental illness to biological causes have been shown to be more willing to interact with someone with a mental illness than those who believe mental illness stems from individual causes such as a person's 'bad character' (Martin, Pescosolido, & Tuch, 2000). Further, conceptions of mental illness continue to be bound up in notions of violence and dangerousness (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Such judgements may be affected by an individual's actual contact with people with mental disorders (Angermeyer & Matschinger, 1996) although whether this interaction is causal is unknown (Jorm & Oh, 2009).

It has been reported (Phillips, 1964) that there is a tendency for individuals to judge men with mental illnesses more negatively than women even where the illness is the same. In addition, research has shown that men with disorders which are considered atypical to their gender role (such as depression) are considered more favourably than those who exhibit symptoms of gender typical disorders (e.g. alcoholism, Wirth & Bodenhausen, 2009). However, since men with mental illnesses are considered to be more dangerous (Schnittker, 2000) and are treated less favourably than women (Farina, 1981), it follows that individuals are more willing to interact with women with mental illnesses than men (see Jorm & Oh, 2009, for review).

Barriers to men seeking help have been discussed in chapter one. These can be located within a broad framework of the approach / avoidance conflict (as discussed by Kushner & Sher, 1989). Approach / avoidance describes the conflict between incentives to seek help, such as psychological distress and the possibility of reducing such distress, and motivation not to seek help, such as fear of stigma (Vogel, Wester, & Larson, 2007).

Avoidance factors have been noted to include structural factors such as cost (Schober & Annis, 1996), time (Kierans, Robertson, & Mair, 2007), and transport (Stefl & Prospero, 1985). However, attitudinal factors have been demonstrated to dominate considerations of help-seeking (Thompson et al., 2004). These factors include stigma (Corrigan, 2004; Corrigan & Watson, 2002; Judd et al., 2008; Narikiyo & Kameoka, 1992; Vogel, Wade et al., 2006), lack of knowledge of available services (MaGPIe Research Group, 2005; Thompson et al., 2004; Timlin-Scalera, Ponterotto, Blumberg, & Jackson, 2003), concerns about confidentiality (Gorman et al., 2007), believing a problem will improve without intervention (Outram, Murphy, & Cockburn, 2004), fear of emotion (Kids Help Line, 2003; Vogel,

Wester, & Larson, 2007), lack of confidence in the source of help (Rickwood et al., 2005), and the traditional masculine gender role (Davies, McCrac, & Prank, 2000; Kierans et al., 2007; Mansfield, Addis, & Courtenay, 2005; Timlin-Scalera et al., 2003).

The traditional masculine role has been described as incompatible with help-seeking (see chapter one). For many men seeking help implies inadequacy that one has not been able to deal with the problem independently (Gross & McMullen, 1983). Therefore, men who do seek help tend to anticipate receiving negative reactions from others (Wills, 1983) which evoke embarrassment (Shapiro, 1983). Indeed, men have been shown to perceive more stigma associated with the 'mental illness' label (Judd et al., 2008) and to be more embarrassed about seeking help than women (Gonzalez et al., 2005). Men may feel uncomfortably vulnerable in seeking help as doing so requires them to relinquish control (Merton, Merton, & Barber, 1983). They may also feel shame that they have failed to ascribe to the masculine expectations of strength and self-reliance (Gorman et al., 2007). Those men who hold beliefs more consistent with the traditional masculine role have been shown to experience more shame from such events (Thompkins & Rando, 2003).

Whilst many avoidance factors have been identified, fewer approach factors are evident in the literature. The factors that have been identified include confidentiality (Timlin-Scalera et al., 2003), mental health literacy (Wright et al., 2007), supportive social influences (Rickwood et al., 2005), beliefs about normativeness (Rochlen & Hoyer, 2005), and severity of symptoms (Issakidis & Andrews, 2006).

4.2 Aim

The aim of this study was to investigate young people's understandings of mental illness, barriers to help-seeking for physical and mental concerns and their views on men's mental health.

4.3 Method

A questionnaire consisting of short answer questions was completed by 239 participants. The participants were enrolled in a first year psychology course in 2008 and received course credit for their participation. Sixty-seven of the participants were male and 172 female. The University of Adelaide Ethics Committee granted approval for this research prior to its commencement. Participants were informed via information sheets that participation was voluntary, they could cease involvement at any time, and that any identifying information would be stored separately from responses.

The survey consisted of a short questionnaire discussing beliefs around mental illness and asking for written responses. The questionnaire began with a paragraph defining mental illness and was followed by nine short answer questions. An introductory paragraph defining mental illness was followed by the questions below.

Mental illness is a broad term which has been described as any of a variety of conditions characterized by the impairment of an individual's thinking, emotions or behaviours. It is used to describe many conditions such as mood, anxiety disorders, schizophrenia etc and can affect every part of a person's work, relationships and leisure.

1. Reading the above, is this what you previously understood mental illness to be?
2. If not, what did you understand by this term?
3. How would you characterize men with mental illnesses?
4. How do you think you would recognize a mental illness in yourself?

5. What would you do about it?
6. A lot of research suggests that men don't seek help for things (like physical or mental health concerns) as much as women. What do you think are the things that stop men from seeking help?
7. What things (if any) might stop you from seeking help for physical health problems?
8. What things (if any) might stop you from seeking help for mental health problems?
9. What do you think would make men more comfortable in seeking help for mental health problems?

Themes were elicited from responses to each question individually using thematic analysis as discussed by Braun and Clarke (2006). Extracts are included in results in order to provide examples of responses. These are replicated verbatim and therefore are commonly sentence fragments which may include grammatical errors.

4.4 Results

4.4.1 Comprehension of terms

The first question asked "Reading the above, is this what you previously understood mental illness to be?". This and the second item "If not, what did you understand by this term?" yielded no usable results. Participants agreed that the paragraph correctly described their own understanding of mental illness. The small minority who did not agree reported that they did not realise that the definition of mental illness was so broad.

4.4.2 Characterisation of Men with Mental Illness

Participants were asked “How would you characterize men with mental illnesses?”.

The themes which emerged from responses were: ‘in denial’, ‘weak’, ‘no different to women’, ‘mentally ill’, and ‘symptoms’ (with sub-themes ‘severe’, ‘anxiety/depression’, and ‘general’). Each is discussed in turn.

The theme ‘in denial’ was employed at a higher rate by females than males. Responses were included if they made reference to men rejecting the proposition that he may have a mental health concern. Examples of responses coded under this theme are:

Extract 42

often deny it and avoid confronting it (Male)

Extract 43

you wouldn't know because men don't like to talk about their problems
(Female)

Extract 44

don't say is sick (Female)

It is intuitively sensible that men employed this theme less than women, as the theme's content implies that men do not admit to others that they are suffering mental distress or are in need of support. A number of female respondents also reported that men seek help less often than women for mental health concerns. This lack of help-seeking was also referred to by male participants, but at a much lower rate.

The second theme that emerged contributes to understandings as to why men may deny mental health problems. A small number of male participants reported that they felt men with mental illnesses were inadequate. Examples of responses which were coded under the theme 'weak' include:

Extract 45

a bit soft (Male)

Extract 46

somewhat weaker than other men (Male)

Extract 47

either mentally weak, or having experienced massive trauma eg. war
(Male)

No female respondents employed this theme; however, two female participants made the following statements regarding how they would characterise men with mental illness.

Extract 48

the same as women with mental illness, I would not judge them as weak
(Female)

Extract 49

...They are as valuable and as normal and as human as everybody else,
and are not weak or feeble-minded (Female)

Whilst these participants position themselves in opposition to the belief that mental illness implies a weakness in men, their statements indicate that they are aware that others might hold this perception. By drawing upon this theme the participants invoked the beliefs

and stereotypes which they intended to express that they opposed. Despite the intention, the very use of such terminology can be seen to reinforce the stereotype that mental illness is equated with weakness. If this stereotype was not considered by these participants to be pervasive it could be expected that they would not have made reference to it. However, no women considered that men with mental illness were weak. Male participants did evoke this stereotype and none of them challenged it in response to this item.

The majority of participants indicated that they considered men with mental illness to be no different to women. This was considerably more evident in the responses of women.

Extract 50

Gender makes no difference in mental illness (Male)

Extract 51

I don't think there's a difference between men and women's characteristics when they have a mental illness (Female)

The intention of respondents utilising this theme was clearly to express gender equality. In their use of this theme participants may have indicated that they personally do not see men with mental illnesses in a different light than women. On face-value this stance seems to be a liberal one. However, by stating that gender makes no difference in mental illness, participants discounted fundamental differences in the experiences of men and women in terms of what it is to be male or female and suffering a mental illness. Discounting gender differences reflect that which has historically existed through health and mental health services and has been to the detriment of men. If gender did not make any difference, prevalence of mental illness, suicide, alcohol and drug use, help-seeking, and recovery rates

would be common across genders. Participants who employed the theme ‘no different to women’ are ostensibly drawing upon the gender equality framework, the long-established but flawed paradigm which upholds the female experience of mental illness and assumes that the male experience is similar. Recent research on men’s mental health shows that this assumption is detrimental to men whose needs are not met by generalist services, assessment and treatment tools aimed primarily at women.

Over a third of participants reported symptoms as characteristic of men with mental illnesses. These were categorised into three sub-themes, severe symptoms, symptoms of anxiety and depression, and general symptoms. Severe symptoms were reported with similar frequency by both genders, and were the most frequently utilised of the three sub-themes of symptoms. Examples that made reference to severe symptom responses include:

Extract 52

Someone suffering from delusions/ hallucinations (Male)

Extract 53

Men who engage [sic] in activities that are harmful to others in a negative way, or harmful to themselves (Male)

Extract 54

crazy (Female)

Extract 55

they could become violent and more aggressive [sic] or competitive than usual (Female)

These comments reflect an assumption that men with mental illnesses are generally severely affected. Some comments suggest that men with mental illnesses are dangerous and even violent. Severe symptoms such as these can be seen as located within the traditional male role which is associated with strength, dominance, and aggression. This perception of dangerousness of men with mental illness increases the stigma for men with mental health concerns.

Some participants reported symptoms characteristic of men with mental illness which indicated problems with depression or anxiety. Examples of those responses coded under this sub-theme include:

Extract 56

sad (Male)

Extract 57

Depressed (Male)

Extract 58

Lazy, unmotivated, unable to move on from major events in their life
(Female)

Extract 59

Unsociable, unemployed, sensitive (Female)

Other participants reported symptoms that were deemed to be more general. These included:

Extract 60

Not think the way the normal do (Male)

Extract 61

Struggling (Female)

Extract 62

Appear unable to cope or function on a day to day basis (Female)

Each gender utilised the sub-theme of severe symptoms more commonly than other symptoms. General symptoms were also reported more commonly than symptoms relating to depression or anxiety. Women were slightly more likely than men to report depressive symptoms, whereas men were slightly more likely than women to report general symptoms.

4.4.3 Recognising Mental Illness

Participants were asked how they thought they would recognize a mental illness in themselves. Themes that emerged from responses included: 'other people', 'change', 'general symptoms', 'depressive symptoms', and 'wouldn't recognise'. Gender differences in response to this item were substantial.

Male respondents most commonly utilised the theme that they would recognise that they had a mental illness because they would be told by other people. Considerably fewer female respondents employed this theme. Examples of responses coded under 'other people' include:

Extract 63

when I am told I am acting unusual by those around me (Male)

Extract 64

I didn't, friends did, I had no idea why I was feeling the way I did and acting the way I was (Male)

Extract 65

Someone would tell me (Male)

Extract 66

with help from family and friends (Female)

Responses by female participants implied interaction and discussion with others. Male participants commonly reported that other people would tell them there was something wrong with them in factual language, whereas female responses used terminology which evoked a more collaborative process. For instance, female responses used terms such as 'consulting', 'advice', 'noticing', 'asking if I'm ok', whilst male responses used terms such as 'indications', 'told', 'inform', and 'seriously suggested I needed help'.

Women were much more likely than men to report that they would recognise that they had a mental illness due to a change in their thinking or behaviour. Examples of responses coded under 'change' include:

Extract 67

If I acted out of the ordinary (Male)

Extract 68

Feeling different to usual, possibly physical factors such as sleep pattern change or appetite [sic] change (Female)

Extract 69

not being myself for a prolonged period of time, different behaviours (Female)

Women employed the theme of change as their most common response to this question. Fewer men utilised this theme. Change in behaviour and thinking were the most common uses of this theme, although a number of participants suggested that ‘not feeling themselves’ would indicate to them that they had a mental illness.

Similar rates of men and women employed the theme ‘general symptoms’. These symptoms were reported by participants as probable indications that they had a mental illness. These included:

Extract 70

Feelings of uneasiness, unusual emotions or intensity of emotions for me (Female)

Extract 71

not being in control of what I do (Male)

Extract 72

When my life can't work properly, I shall know (Female)

Extract 73

distancing myself from people (Female)

Many of the responses coded under general symptoms were vague. Others made reference to intensity of emotion or specific symptoms such as hallucinations or increased anxiety.

Some respondents made clear references to depression in their comments. These responses were coded under the theme 'depressive symptoms'. Women were twice as likely to employ this theme as males. Examples of responses coded under depressive symptoms are:

Extract 74

If I felt constantly down all the time or if it was affecting my daily activities
(Male)

Extract 75

feel sad (Male)

Extract 76

if i found everything uninteresting, stopped caring about my wellbeing, felt sad and moody and maybe cried a lot w/out any specific reason, started self-harming (Female)

Extract 77

Depressed mood most of the time, losing interest in things I usually like to do, decreased appetite, decreased social interaction (Female)

As can be seen from these examples, female responses generally contained more detail than those by males. The rate at which females made reference to symptoms of depression rather than those indicative of other disorders suggests that they may associate depression with a mental illness to which they might be prone. On the other hand, male participants were much more likely to report general symptoms rather than those that could easily be classed as

symptomatic of depression. Again, this could be because they do not see depression as an illness that they are likely to experience.

A small number of female participants indicated that they would not know if they had a mental illness. No male participants gave this response. Examples of responses coded under the theme 'wouldn't know' are:

Extract 78

I don't think you can, you will have no notion (Female)

Extract 79

Very hard to self diagnose (Female)

Extract 80

I probably wouldn't unless it was something obvious like not eating, throwing up after eating (Female)

Male respondents reported that they were not sure how they would recognise that they had a mental illness. However, none of them suggested that they might be suffering from one and not know. This may reflect a lack of awareness or distancing from mental illness by men. An example of this follows.

Extract 81

I don't think I will have mental illness (Male)

The participant cited above indicated that he is unwilling to contemplate experiencing mental illness. The reasoning for this participant's stance cannot be determined. However, it

is possible that the positioning of mental illness as outside the defined boundaries of hegemonic masculinity could play some role in this man's response. Mental illness is labelled as incompatible with hegemonic masculine ideals. Therefore a question which asks the participant to indicate how he would know that he had a mental illness concurrently asks him to consider the extent to which he ascribes to the hegemonic definition of the male role. The response above could be seen to reaffirm the participant's membership in a paradigm of hegemonic masculinity which was challenged by the very question at hand.

4.4.4 Managing Mental Illness

Participants were asked what they would do about mental illness if they suffered from one. Themes which emerged from responses included: 'deal with it myself', 'seek help', 'get professional help', 'get informal help', and 'nothing'. Each is discussed below.

A quarter of male participants indicated that they would deal with mental illness themselves. Only a small number of female participants employed this theme. Examples of data coded under 'deal with it myself' follow.

Extract 82

Depends on what it was. Maybe deal with it myself until it gets too out of hand (Male)

Extract 83

Try to deal with it on my own (Male)

This finding is consistent with earlier research which suggests that the belief one can manage the problem on their own or that it will go away eventually is the most frequent

reason given for people not wanting to seek help (Morgan et al., 2003) or dropping out of treatment (Vasiliadis et al., 2005).

Most respondents who utilised this theme indicated that they would initially try to deal with it on their own, but included secondary intentions if the first route failed. For example:

Extract 84

Attempt to do something about it myself, and if that didnt [sic] work, seek help (Male)

Extract 85

At first I would probably try and snap myself out of it, but if it began affecting everyday activities, I would hopefully tell someone (Female)

Extract 86

Solve it self first, if not help then seek for professional help (Male)

The common nature of this structure signifies that many participants are aware this course of action may not be successful and therefore a second option may be required. However, the emergence of this theme also poses new questions. How would participants know that their attempt to solve the problem on their own had failed? How long would participants try to deal with the problem alone before seeking help? Studies have shown that people with non-psychotic mental health issues on average wait six months before receiving mental health care (Steel et al., 2006). The response of men is further associated with both delay and failure to make contact with mental health services (Wang et al., 2005). The tendency for people, especially men, to attempt to deal with a problem alone is likely to contribute to this delay.

Some participants noted they would seek help if they thought they had a mental illness. Almost half of all participants indicated they would seek ‘professional help’, less would seek ‘informal help’, and fewer again would seek help of some kind (but did not specify source). Slightly more males than females suggested they would seek professional help. Data coded under this theme made reference to professionals, general practitioners, psychiatrists, psychologists, other mental health professionals or interventions (e.g. medication, therapy etc.). The types of responses coded under ‘professional help’ were:

Extract 87

seek mental guidance from a trained professional (Male)

Extract 88

See a GP first then a Psychologist (Male)

Extract 89

seek professional help (Female)

Female participants most commonly reported they would seek help from a psychologist, whilst male participants most frequently reported they would see a GP for mental health concerns.

Informal help was referred to by substantially more females than males. Data coded under this theme included responses such as talking to family and friends. Examples of responses coded under ‘informal help’ are:

Extract 90

Id struggle to admit it, but if I did, I would seek help from family and friends
(Male)

Extract 91

speak to family and friends, most probably my friends first (Female)

Some participants indicated that use of informal help might precede professional help.

Extract 92

...I would talk to a close friend of family member and get them to come
with me when I went to see a professional (Female)

Extract 93

Talk to family, friends, and if it didn't get better, a psychologist (Female)

Extract 94

Talk to my mum, maybe get help from psychologist if she thought I needed
it (Female)

A smaller number of participants reported they would seek help for mental illness but did not specify what form this would take. Of those comments coded under the theme 'seek help', slightly more were made by male than female participants. The most common response was the first listed below. Other examples are also presented.

Extract 95

seek help (Male)

Extract 96

depending on the situation, if I was really worried, I would seek help (Male)

Extract 97

ask people for advice (Female)

Extract 98

try to talk to someone about it if I built up the courage (Female)

A small percentage of respondents indicated they would not do anything about a mental illness if they thought they had one. Females employed this theme more frequently than males. Some respondents stated they would delay trying to manage their mental illness by not do anything about the problem until it became serious. Others noted they would not do anything at all. Examples of data coded under the theme 'nothing' follow.

Extract 99

I feel sad a lot now and I'm not doing anything, so probably nothing
(Female)

Extract 100

I would like to say that I would seek professional help, and I would advise others to do so... but when push comes to shove, I don't think I would seek that help (Female)

Extract 101

Ignore it until I had to face it (Female)

Extract 102

brew on it.... If it got bad ask for help (Male)

The utilisation of the theme ‘nothing’ indicates that barriers to seeking help exist for these respondents. One of the comments presented above indicates that the respondent would recommend that others seek help, but would find it hard to do so herself. Possible reasons for this were targeted in later questions.

4.4.5 Barriers to Help-Seeking for Physical Concerns

Participants were asked what might stop them from seeking help for physical problems. Themes which emerged from responses were ‘embarrassment’, ‘seriousness’, ‘fear of outcome’, ‘resources’, and ‘nothing’. The most common of these themes was embarrassment for men and resources for women. Each theme is discussed below.

A large number of participants of both genders indicated they might not seek help for physical problems due to embarrassment. Responses referring to shame, pride, weakness, or not wanting others to know about the problem were each coded under this theme because the crux of all these responses was a concern regarding embarrassment. Examples of the types of responses coded under ‘embarrassment’ follow.

Extract 103

My reputation (Male)

Extract 104

I'm shy or embarrassed [sic] to talk about problems with unknown people
(Male)

Extract 105

I might be too embarrassed about my problems (Female)

'Embarrassment' was a theme utilised by more men than women. Roughly half of the male responses coded under this theme made reference to concerns about others knowing about the problem, whilst the remainder highlighted that embarrassment might stop them from help-seeking. Within female responses almost all used the term embarrassment, and only a small minority made reference to concerns about the perceptions of others. This gender difference suggests that for women the embarrassment surrounding seeking help arises from within (i.e. judgement by the self) whereas for many men embarrassment arises from concern over external assessment (i.e. judgement by others).

A smaller number of participants indicated they may not seek help for physical problems if the problem did not seem serious enough. More female than male participants employed this theme. Responses coded under 'seriousness' included:

Extract 106

The thought of it being something relatively insignificant and a waste of the doctor's time (Male)

Extract 107

Doubt as to whether it's serious enough to seek help (Female)

Extract 108

Thinking that it will probably fix itself (Female)

The emergence of this theme supports findings which suggest that in some cases individuals only view help-seeking as legitimate when, and if, the problem crosses some perceived threshold of severity (Addis & Mahalik, 2003). In the first comment above, the

participant expresses concern that he would be misusing resources if the problem was not severe enough. Here the respondent seems to articulate a perception that his position is less privileged than the doctor whose time he may waste if he presents a trivial concern. Although this is not stated as clearly in any other responses, the concern that problems weren't 'serious enough to see a doctor' and that the respondent may be 'over-reacting' were frequent. This raises the question as to how and where the line of severity is drawn, or what constitutes distressed 'enough'.

Some participants noted they would not seek help due to a fear of what might happen if they did. This 'fear of outcome' was a much more common response for men than women, although overall, it did not account for a large number of responses. Some examples of responses coded under this theme are:

Extract 109

The fear of finding out something is worse than I thought it would be
(Male)

Extract 110

The fact that it may be quite bad and that I may need an operation/
injection!! (Male)

Extract 111

Fear of what condition I might have (Female)

In this instance participants indicate a preference for ignorance rather than confronting their fears that the problem may be significant or require unwanted intervention. The emergence of this theme is an interesting comparison to the last. Whereas those who used the

theme 'seriousness' were concerned that their problem was not severe enough to warrant intervention, those employing this theme were concerned that their problem would be deemed so severe that further intervention would be required. This theme reflects earlier work by Kushner and Sher (1989) in which fears about possible treatments were shown to inhibit help-seeking, and Howerton, Byng and colleagues (2007) who found that men did not seek help for mental health concerns for fear of being labelled mentally ill or having to deal with the problem once it was diagnosed.

Female respondents were more than twice as likely as males to make reference to a lack of time or money as a reason they may not seek physical help. References to 'resources' by males were mostly in reference to financial cost of intervention, whereas for women time was the most common resource identified. A substantial proportion of female respondents mentioned both time and money in their answers. Some of the responses coded under resources were:

Extract 112

if I couldn't afford to go and see a doctor or afford treatment I wouldn't get it (Male)

Extract 113

being too busy or not having enough money (Female)

Extract 114

cost, convenience, time (Female)

Time and cost are probably particularly salient themes for this sample as they are first year university students. This group are generally financially and in some instances time poor. However, this does not explain the significantly greater use of this theme by women than men. It may be reflective of the tendency of female participants to use more than one theme in their response, whereas male participants most often only made reference to one. Thus, a number of responses by females which were coded under resources were also coded under other themes (e.g. embarrassment).

Lastly, some participants indicated that there would be no reason that they would not seek help for a physical concern. This theme was employed by a slightly higher proportion of male than female respondents. The vast majority of responses simply stated 'nothing' or 'none'. A few elaborated.

Extract 115

Nothing. Learned to go to a GP even if its [sic] a minor problem (Male)

Extract 116

At my age now, nothing. (Female)

Extract 117

Nothing, if the problem really made my life difficult (Female)

Nothing was the second most common theme used by male participants (after embarrassment), and the third most common for females. This suggests that although barriers to help-seeking for physical problems certainly exist, they are perhaps not salient for all.

4.4.6 Barriers to Help-Seeking for Mental Health Concerns

Participants were asked what might stop them from seeking help for mental health problems. Major themes which emerged from responses were: ‘stigma and embarrassment’, ‘identification’, ‘fear of outcome’, ‘self reliance’, ‘resources’, ‘seriousness’ and ‘nothing’.

Close to half of all responses regarding reasons for not seeking help for mental health concerns made reference to stigma or embarrassment. Little gender difference was evident. Responses coded under ‘stigma and embarrassment’ encompassed references to embarrassment, shame, and perceptions of others. A similar theme emerged from responses surrounding reasons for not help-seeking for physical health problems. However, whilst that theme was dominated by embarrassment, this also included significant references to stigma and a fear of what others might think. Roughly half of responses by both genders discussed the role of stigma and the judgement of others. Examples of this include:

Extract 118

Fear of others knowing. Fear of public perception towards me (Male)

Extract 119

People may treat me differently and may not want to associate with me
(Male)

Extract 120

Embarrassment, the risk of other people finding out (Female)

Respondents were concerned about how other people would ‘view’, ‘evaluate’, ‘judge’, ‘respond to’ or ‘think about’ them if they knew that the respondent suffered from a mental illness. The discomfort referred to in this theme is ‘embarrassment [as to] what other people would think of me’. This embarrassment is located publicly, as in the first comment above. Here it is not the problem itself or its treatment that is presented as a barrier to help-seeking; it is the fear of ramifications for the participant if the ‘public’ were to uncover his problem. In each of these responses mental health concerns are presented as a shameful secret. It is the fear of exposure or being marked as mentally ill that acts as a barrier.

Secondly, participants indicated that a lack of identification may stop them from seeking help for mental health concerns. These responses discussed either an inability to tell that one had a problem or a denial of the problem to oneself. Examples of comments coded under this theme follow.

Extract 121

If I was unsure if there was actually a problem or if I am just overthinking [sic] things, I may be hesitant to seek help. (Male)

Extract 122

...uncertain whether its a real problem or not that is happening to me
(Female)

Extract 123

admitting I have a problem (Female)

Participants suggested it might be difficult for them to tell that what they were experiencing was a mental health concern, and further whether it was significant enough to

seek help. Further, participants noted it would be difficult for them to admit to themselves and others that they had a problem. Considering the significant references to stigma discussed previously, it is perhaps unsurprising that respondents would be reluctant to label their problems as mental health concerns and thus to indicate their membership to a socially undesirable group.

As was the case for physical illnesses, a small number of participants noted that ‘fear of outcome’ might stop them from help-seeking for mental health concerns. In line with the finding in the case of physical illness, this theme was utilised by more males than females. However, the proportion of participants that employed this theme was small. Examples of comments coded under fear of outcome include:

Extract 124

The possibility of having to undergo counselling or being admitted to a mental institution (Male)

Extract 125

I worry that I might find out I was seriously ill – sometimes ignorance is bliss i.e. not knowing could be easier to cope with (Male)

Extract 126

fear of what the “help” might be – fear of drugs being pushed on me (Female)

These comments echo Dew, Morgan and colleagues’ (2007) finding that fear of what consequences may follow operates as a barrier to disclosing mental health concerns to a GP. Apprehension that control would be relinquished to others was a common anxiety throughout

comments coded under fear of outcome. This can be seen in the first and last comments above. A frequent idea was that once someone knew about the problem the participant would be forced into some intervention, be that therapy, medication or institutionalisation. A number of participants revealed a fear that they would be given medication which may either produce unwanted side effects or not have any effect at all.

‘Self reliance’ was a theme used much more frequently by men than women. Responses reflecting a desire to deal with problems alone and without the help of others were coded under this theme. Some examples of the responses coded as self reliance follow.

Extract 127

The need to feel I am able to handle my own problems, without help from professionals (Male)

Extract 128

Shoulder all youre [sic] own burdens and become stronger because of it (Male)

Extract 129

...perceived idea that seeing a counsellor is giving up on something I could solve myself (Female)

Participants conveyed a perception that they should deal with problems on their own. Seeking help can be seen as a failure to cope alone, as in the case of the last comment. As Ducat notes, men express a “denial of dependency” (2004, p. 53) by remaining self-sufficient and independent rather than asking others for help. This reliance on oneself in the face of a challenging personal problem is consistent with traditional notions of masculinity. Therefore the emergence of this theme, predominantly utilised by men, was reasonably predictable given

the literature on men and the role of hegemonic masculine values in problem appraisal and help-seeking behaviour. However, that self reliance was a significant theme in this data, and one that was employed substantially more by men than women, lends support to the notion that adoption of the traditional masculine gender role has substantial implications for the help-seeking behaviour and mental health of men.

‘Resources’ was another theme which emerged as a reason for not seeking help for both physical and mental concerns. Again, this theme was utilised by substantially more females than males. By far the most commonly reported resource was money, but time was also mentioned. Examples of responses coded under resources are:

Extract 130

Money – high cost of treatment (Female)

Extract 131

Lack of time, cost, accesability [sic] and opening hours that are convinient [sic] to me (Female)

Extract 132

Money, money, money, mon-ey...MONEY (Male)

Financial cost is again presented as a prohibitive factor in help-seeking. However, it is unclear whether these participants have knowledge of costs or whether these comments are based on assumptions. A free counselling service is available to students at the university at which this study was conducted. Public mental health services are also provided through the Australian government. Furthermore, a limited number of clinical psychology sessions are

available through GP referral at no cost through the Better Outcomes in Mental Health Care Initiative (see Morely et al., 2007 for discussion). The accessibility of free mental health services was therefore very good at the time this study took place. This suggests that either these participants were not familiar with their options for mental health intervention, or that they would choose to engage either with private services or none at all.

A small number of female participants made reference to concerns about ‘seriousness’ in their comments. No male participants did so. This gender difference reflects the use of seriousness in response to barriers to seeking help for physical health concerns, although in that case a smaller number of men also employed the theme. Responses coded under seriousness included the suggestion that the problem may not be severe enough to seek help. Examples of comments follow.

Extract 133

...thinking I am dramatizing my condition (Female)

Extract 134

Sometimes I feel my problems may be too minor or hormonal (Female)

Extract 135

thinking that the problem was not serious enough... (Female)

In the examples above female participants indicate a concern that their problems are too trivial or insignificant to warrant seeking help. That male participants did not have the same concerns is revealing. This suggests that it is not the severity of the problem which prohibits men from help-seeking for mental concerns, despite some indicating that this may be

a barrier to seeking help for physical problems. The men in this sample reported identifying the problem in the first place, a preference for self-reliance, concern over stigma, fear of possible outcomes, and a lack of resources as more significant barriers. In the context of help-seeking literature this is not surprising. Gender role research would suggest that men often do not consider help-seeking due to the implications that this has for his traditional masculine self-construct. Thus within this paradigm stigma and self-reliance would be most salient.

As was the case for physical health problems, some participants stated there was 'nothing' that would stop them from seeking help for mental health concerns. The vast majority of comments coded under this theme simply stated 'nothing'. Two exceptions were as follows.

Extract 136

Since accepting help for mental health problems, it would now take a severe failure in my cognitive abilities and ability to reason to stop getting it
(Male)

Extract 137

I have no problem seeking help for my mental state as I am used to seeking help from counsellors (Female)

These comments suggest that, at least for these individuals, seeking help is easier if one has done so previously. Perhaps this prior experience goes some way to eliminating fear of stigma or outcome, makes the ideal of self reliance less salient, and provides information on symptoms of illness and cost of services as well as indications of how intervention can help.

4.4.7 Barriers to Men Seeking Help

Participants were asked to consider why men might seek help for both physical and mental concerns at lower rates than women. The following themes emerged from responses: ‘perception of weakness’, ‘stigma and embarrassment’, and ‘lack of emotional expression’.

By far the most common response to this question was related to ‘weakness’. Two thirds of male and almost three quarters of female participants reported this theme as an explanation as to why men are likely to seek help less than women. Data coded under weakness referred to traditional masculine stereotypes which suggest that to admit to needing help is a sign of weakness and that men should instead be ‘strong’. Examples of this include:

Extract 138

Social stereotypes about men. They shouldn't let things get to them like woman [sic], its [sic] a sign of personal weakness (Male)

Extract 139

Too proud; a view that men should be self-reliant, stoic and strong; a view that talking about emotions makes them seem gay (Male)

Extract 140

Admitting there is something wrong, I think it makes them feel less manly (Female)

Extract 141

There is a stereotype that men are not masculine if they get sick, especially when it comes to mental health (Female)

The responses coded under this theme reflect the constrained nature of hegemonic masculinity and the difficulty for men in engaging in behaviour which is positioned outside its paradigm. The repetition of ideals of strength, stoicism, self-reliance and an unemotional nature suggest respondents are very well versed in this stereotype. The labelling of behaviours which do not follow the hegemonic ideal is similarly well-known, with many participants reporting that men who seek help may feel, or be deemed by others to be, weak, emasculated or homosexual.

Corresponding with the labelling of men with mental illness as weak, roughly a quarter of participants suggested that men would be embarrassed by seeking help and the stigma associated with help-seeking. This theme was employed equally across genders. Examples of responses coded under 'stigma and embarrassment' include:

Extract 142

Embarrassment/ shame to admit something is physically or mentally wrong
(Male)

Extract 143

Thinking that their peers would not approve of them (Male)

Extract 144

Mostly the same thing that would stop women from seeking help. Fear, embarrassment, not realising they need help (Female)

A number of responses which made reference to embarrassment and stigma also noted that these stem from stereotypes and perceptions of weakness. Many suggested that men would be embarrassed to seek help for fear of what others might think of them. This indicates

that not only are the boundaries of hegemonic masculinity well understood by both men and women, but that the ramifications of participating in behaviour unsanctioned by this paradigm are also common knowledge amongst this sample.

A small number of responses discussed men's 'lack of emotional expression' as a reason for their non help-seeking. Data coded under this theme made reference to men not being open, not talking about or being in touch with their feelings. For example:

Extract 145

Men generally do not express themselves as much as women, so it's a bit hard for them to talk about their problems with psychologists/ psychiatrists
(Male)

Extract 146

Keep more quiet about emotions (Female)

Extract 147

Embarrassment, awkwardness expressing emotion to both males and females (Female)

Lack of emotional expression has been a common theme throughout literature on men (Eisler & Blalock, 1991; Good et al., 1989; Levant, 1995; O'Neil, 1981; Robinson, 2002; Seidler, 1997). The emergence of this theme is therefore not unexpected. However, there is a substantial disparity in its use across genders, with females twice as likely to discuss men's lack of emotionality as male participants.

Considering the content of this theme, it is perhaps not surprising that women utilised it much more frequently than men. Many comments regarding men's difficulty in communicating emotion were coupled with reports that expressing emotion would result in embarrassment. The ability to convey emotion is generally seen as the realm of women. Similarly, a lack of emotional expression is positioned centrally within hegemonic masculinity. A move by a man to express emotion can thus be seen as positioning himself outside the hegemonic masculine script and therefore as vulnerable to stigma and embarrassment. When one weighs this potential for distress against the known distress caused by the illness, it is understandable that a man would choose the known (and probably to some extent perceived to be manageable) internal distress over what he could perceive as exposing himself publically to potential ridicule.

4.4.8 Increasing Men's Comfort in Help-Seeking for Mental Health Concerns

Participants were asked to record any thoughts on what may make men feel more comfortable to seek help for mental health concerns. The diversity of responses across genders was greater for this item than any of those discussed above. Themes which emerged from responses were: 'educate', 'change stigma', 'normalise', 'ensure anonymity', 'services for men', and 'don't know'.

A common theme amongst responses was to increase education about mental health. A greater proportion of male than female participants utilised this theme. Most responses coded under this theme referred to information, understanding or awareness. Examples of the type of comments coded under 'education' are:

Extract 148

Provide them information on the benefits of seeking help for mental health problems (Male)

Extract 149

Increased general awareness of symptoms of mental illness and helpful treatments (Male)

Extract 150

Through education, allowing people to know that there is help out there for men and women (Female)

Educating the public and increasing their awareness about mental illness was presented by a number of participants as a pathway to increased acceptance of the mentally ill and help-seeking. Some participants indicated that those who had more information about mental illness and its treatment would be less embarrassed and more likely to engage with professionals. As seen previously, the fear of unknown consequences of help-seeking is a barrier for some. If information about help-seeking and treatment were more widely available and understood, perhaps it would be less challenging for men to undertake the behaviour.

Similarly, a third of women and a much smaller proportion of men indicated that if we could somehow change the stigma surrounding mental health that men may feel more comfortable seeking help for these concerns. This theme encompassed the stigma associated with behaviours which do not follow limiting traditional notions of masculinity (i.e. help-seeking seen as weakness), as well as that which is associated with mental illness itself. Comments coded under 'change stigma' include:

Extract 151

Reducing the stigma associated with mental illness and making it more socially acceptable to seek help (Female)

Extract 152

Divorcing mental illness from weakness (Male)

Extract 153

Changing society's view of how men should behave (Female)

As some participants indicated, significantly changing the stigma associated with mental illness or extending the behavioural repertoire sanctioned by traditional masculinity would be difficult. A handful of participants noted that the likelihood that any change could be made to stigma was small. However, as can be seen by the emergence of stigma as a barrier to physical and mental health help-seeking, as well as in response to this item, the stigma associated with seeking help for mental health concerns is a significant problem.

One way participants suggested that stigma be challenged was to 'normalise' help-seeking for men. Substantially more female than male participants employed this theme. Indeed, few male participants mentioned normalising behaviour. Responses commonly suggested that role models would be useful to alert men to the fact that they would not be the first man to seek help for such concerns, and that men that they respect have done so before. Some responses which utilised this theme were:

Extract 154

Maybe to let them know there are many men out there going through the same thing and that it is completely acceptable for them to have these feelings (Female)

Extract 155

Having male sports stars etc admitting to receiving help for mental health problems (makes it more socially acceptable) (Female)

Extract 156

Other men also seeking help, for example well known people who are otherwise consistent with how a man should behave (Male)

Comments on the need to normalise men's help-seeking reflect the ideas present in the 'change stigma' theme. There is clearly a perceived barrier surrounding what behaviour is deemed acceptable for a man. Here a predominantly female group suggested that providing men with instances of seeking help, role models who have done so, and illustrations of the positive ramifications of receiving help may help to combat the stigma associated with the behaviour. In the last comment above a male participant indicated the need for traditional men to be shown to be normalising the behaviour so that the role model himself is not discounted.

The responses coded under this theme reflect an acute understanding of the boundaries of hegemonic masculinity and the need to challenge these if help-seeking is to be accepted by both society and individual men. Normalising behaviour seems to be an avenue by which stigma could be changed.

A greater proportion of men than women made reference to the theme 'ensure anonymity'. Responses coded under this theme reflected a need for confidentiality in help-seeking. Male respondents especially seemed to imply that anonymity is not generally afforded to those who seek help, and therefore indicated that this would need to change in order for men to feel comfortable seeking help. Examples of responses coded under this theme follow.

Extract 157

Discreet measures (Male)

Extract 158

Extreme confidentiality, easy access out of site [sic] of people that may judge them (Male)

Extract 159

Private, anonymous, individual psychological health care (Female)

In using this theme respondents indicate they are aware of the stigma surrounding both mental health and help-seeking for these concerns. Participants who recommended anonymity proposed a solution which would allow men to seek help despite the stigma. Where others suggested that stigma be changed or suggested ways of reducing it, this group took a more pragmatic approach which seems to accept that stigma exists and will be difficult to alter.

However, comments coded under this theme generally implied that confidentiality would be something new and a way to modify existing services. This may reflect a lack of information about the services available or the process of seeking help. Some participants

indicated that an anonymous phone line would be useful. Free, anonymous counselling specific to men is already available seven days a week for Australian men (Mensline Australia). So whilst it is clear that anonymity is a concern for men in particular, information dispersal is perhaps the key to making men more comfortable in seeking help. If men were aware of the Mensline for example, or the confidentiality afforded by any professional service, their concern may be less significant.

Some female participants made suggestions about the provision of psychological services specifically for men. No male participants gave responses which used this theme. 'Services for men' included recommendations that male friendly services be developed, often with the further suggestion that male workers may make male clients more comfortable. Comments coded under this theme include the following:

Extract 160

Someone who dealt only with men and the issues that they have – probably feel more comfortable talking to a male (Female)

Extract 161

If there was a "men only" clinic (Female)

Women's health clinics are familiar to many. However, services provided solely for men are quite rare in Australia. Only female participants suggested that men's clinics may make men more comfortable in seeking help. The reason for this is unclear. It may be that women may have been exposed to gender specific services, or simply have knowledge of their existence, whilst men have not. Conversely, it could be the case that men do not believe that the availability of a gender specific service would make them feel any more comfortable,

although literature shows that male oriented services have positive outcomes for men (Kierans et al., 2007).

Some participants indicated their belief that men may feel uncomfortable initiating discussion about mental health concerns and therefore may need a less intimidating way to disclose their distress.

Extract 162

Being able to write it down instead of doing it in person (Female)

Extract 163

Less talking, probably more likely to use questionnaires that rate their need to seek help (Female)

The female participants cited above made a link between lack of emotional expression and the difficulty in seeking help. These participants offer a way to seek help without challenging men's restricted emotionality, at least initially. This theme is reflective of Brownhill's (2003) proposal that a mental health survey be used by GPs to prompt those men who have difficulty in verbalising their distress.

4.5 Discussion

A number of the themes that emerged from this study, including denying the problem, the perception that it is weak to seek help, self-reliance, and a lack of emotional expression are consistent with traditional scripts around masculinity. This supports a wealth of earlier research which highlights the negative impact of hegemonic masculinity on men's health and help-seeking (e.g. Addis & Mahalik, 2003; Blazina & Watkins, 1996; Courtenay, 1998,

2000b; Galdas et al., 2005; Good et al., 1989; Good et al., 2004; Good et al., 1996; Good & Wood, 1995; Heppner & Heppner, 2008; Levant, 1995; Mahalik, Cournoyer, DeFrank, Cherry, & Napolitano, 1998; O'Neil et al., 1986; Pleck, 1981; Rochlen, Blazina, & Raghunathan, 2002). Such studies, along with the themes ascertained through this research, indicate that men are restricted by the stereotype that they should be strong, independent and free of emotion. Mental health concerns challenge these narrow traditional expectations and men with these concerns must either depart from the masculine 'norms' defined by the traditional male role or find some way to negotiate a place for mental illness within them. Negotiation within such limited boundaries is difficult.

The emergence of the traditional male role as a significant factor in participant discourse around mental health suggests that this hegemonic masculinity is both seen as restrictive for men by female participants and experienced as restrictive by males.

4.5.1 Perceived Gender Differences

Despite consistent reference to the traditional male role, many participants indicated that they believed that no gender difference exists when it comes to mental illness. Whilst this standpoint could be seen to uphold ideals of equality, it dismisses the experiences of men with mental illnesses. Indeed, it is this standpoint that assumes that general mental health services meet the needs of men. Service utilisation rates suggest that this is not the case. Therefore, the idea that there is no gender difference in the experience of mental illness can be seen to contribute to the continuing subjugation of men's health needs. Further, this stands in opposition to the emergence of numerous themes in the current study which reflect the importance of hegemonic masculinity in men's experience of mental health.

The contrast between participants on one hand, identifying the problematic nature of the expectations of the traditional male role, and on the other, stating that there is no gender difference in mental health is striking. The theme of no gender difference can be seen to reflect the vast majority of current real world practice in mental health. Whilst many agree in theory that significant barriers exist for men in identifying mental illness and accessing services, historically little has been done to address this in practice (Lumb, 2003). As such, this finding highlights an important contradiction which is present in many current health policies. The importance of equality is not to be discounted, however, there are situations in which gender is significant and must be managed as such. There is a wealth of information which suggests that men's mental health is one of these conditions. This contradiction between theory and practice should be addressed if men's engagement with services and mental health is to be improved.

Gender differences regarding mental illness are demonstrated across the themes which have emerged in this study. Findings indicate that men with mental illnesses are expected to be severely ill and dangerous. For example, both men and women characterised men with mental illness as exhibiting severe symptoms such as violence and those associated with psychosis. Such symptoms have been found to evoke much more fear and be considered more unpredictable and dangerous than those of other disorders (e.g. depression, Angermeyer & Matschinger, 2003). In line with this, research indicates that men with mental illness are rated as more dangerous (Schnittker, 2000) and are more strongly rejected than women with the same problems (Farina, 1981; Phillips, 1964). Despite the iniquitous nature of such characterisation and the intense stigma attached to men with mental illness as a result, the research (e.g. Angermeyer & Matschinger, 2003; Farina, 1981; Phillips, 1964; Schnittker, 2000) indicates that the descriptions given by participants in this research were unfortunately not unusual.

Participants in this study were not asked how they would characterise women with mental illness. Such investigation could contribute to understandings of perceived gender differences.

4.5.2 Recognising Mental Illness

Women in this study reported symptoms of depression to be indicators that they had a mental illness at roughly twice the rate of men. Epidemiological surveys have found that men suffer depression at lower rates than women (Australian Institute of Health and Welfare, 2007; Bijl, Ravelli, & van Zessen, 1998; Henderson, Andrews, & Hall, 2000; Kessler et al., 1981), however, other research suggests that men's lower service use and lack of acknowledgement that they are suffering distress confounds these statistics (Branney & White, 2008; Kilmartin, 2005). The perception of depression as a female disorder is exhibited in participant responses in this research. In practice depression is the second highest cause of illness and injury burden in South Australian men (SA Dept. Health, 2008).

It has been asserted that depression is more likely to be considered abnormal for men than women (Jones & Cochrane, 1981), due to the perceived inconsistency of its symptoms with traditional masculine behaviours (Rosenfield, 1982; Warren, 1983). Some suggest that men are therefore more likely to deny the problem (Tudiver & Talbot, 1999), report less symptoms (Angst et al., 2002) and not seek help in order to distance themselves from perceptions of femininity (Brownhill, Wilhelm, Barclay, & Schmied, 2005).

In the case of this study it may be the case that men simply do not consider that they may be vulnerable to depression. Men may mentally distance themselves from this concern due to the inconsistency between the feminised role of the depressed and the traditional male

role into which men in Western culture are socialised (Warren, 1983). Literature is divided on actual responses to male depression. Some suggest that gender incongruent mental illness (i.e. depression in men) is more likely to yield favourable reactions from others than gender congruent mental illness (i.e. alcohol abuse, Wirth & Bodenhausen, 2009). Wirth and Bodenhausen (2009) suggest that whilst the perception of stigma may result in men with depression denying the problem and not seeking help, if they did seek help the reaction would be more positive than they might expect. Conversely, others found that behaviour associated with mental illness that was inconsistent with gender roles engendered more negative reactions from others (Phillips, 1964). The societal response to men seeking help for mental illness remains unclear, perhaps due to the varied nature of individual responses. This in itself may present a barrier to men seeking psychological help.

Perhaps the most unexpected finding of this survey was that male participants would rely on others to tell them they had a mental illness. Whilst female participants also utilised this theme, they did so at substantially lower rates. Men's reliance on others is reminiscent of Seidler's proposition that men tend to have an "externalised relationship to the self" (1997, p. 11), or distance themselves from their own emotion. He suggests that this distancing from feeling is a way for men to separate themselves from the feminine, and therefore reinforce their own masculinity. It follows that if a man did not allow himself to connect with or monitor his emotional self he may need others to convey to him if and when this becomes problematic.

Earlier literature signals that men tend not to engage with their problems (e.g. Addis & Mahalik, 2003; Branney & White, 2008; Hamilton, 2006; Kleinke, Staneski, & Mason, 1982). Despite the overwhelming evidence that men seek help less than women for mental health

concerns, Kessler, Brown and colleagues (1981) found that once a mental health concern was recognised no gender difference in help-seeking existed. These authors proposed that the difficulty for men is in problem recognition. This is in accordance with the notion that men rely on others to intervene in these situations and are unlikely to identify the problem alone. The difficulty for men with mental illnesses who have not sought help could be that no one has yet intervened. In the case of those men who are isolated or do not have people in their life willing to intrude on their personal concerns, this reliance could mean that the problem becomes chronic before it is recognised or that it is never identified.

The importance of the role of others in men's mental health has been highlighted by authors in such work as "Why won't he go to the doctor?" (Mansfield et al., 2003), "Who influence men to go to therapy?" (Cusack et al., 2004), and "My Wife Ordered Me To Come!" (Seymour-Smith, Wetherell, & Phoenix, 2002). Some have suggested that social support is the most important predictor of men's mental health (Lock, 1989). This is endorsed by findings from studies which have found that 96% of men are influenced by others to seek help (Cusack et al., 2004) and that men are almost three times as likely as women to be influenced in help-seeking (Norcross, Ramirez, & Palinkas, 1996). Women have been shown to have larger social networks and receive support from multiple sources (Antonucci & Akiyama, 1987), whilst men tend to rely solely on their spouse (J. Smith et al., 2006), and both seek out and receive less social support than women (Butler, Giordano, & Neren, 1985). Tudiver and Talbot (1999) demonstrated that men gain the majority of their support from their female partners and a minority from their male friends. As Dr. Murray Drummond commented, "the majority of men who do get help ... [for mental illness]... do so because there's a significant female in their lives – a mother, sister or partner – who goes to a clinic to seek assistance" (quoted in Hamilton, 2006, p. 109). These authors suggest that the person in the role of 'other' tends to be a female.

Whilst the role of others has previously been identified as significant in men's help-seeking, the emergence of it here suggests that others may become involved earlier than many authors have previously proposed. Literature has commonly discussed 'others' as having a role in decisions about help-seeking. In this case male participants noted that other people would initially bring a mental health concern to their attention. This places a substantial burden of responsibility on those close to men to be watchful for any signs of distress and to discuss them if they arise.

Research has previously shown that men commonly try to avoid thinking about their problem by keeping busy and keeping their mind off it. As Krugman states, "Ultimately, the best way to conceal vulnerability is to conceal it from oneself" (1995, p. 95). Individuals sometimes conceal their illnesses from others in order to distance themselves from the stigma associated with mental health problems (Corrigan, 2004). This poses the question, what happens when either the problem is not recognised or dialogue is not initiated by others? A lack of intervention may delay or possibly prevent help-seeking. The ramification of this is likely to be an increase in the severity of the problem. This is concerning considering that mental illness has been found to manifest in men as symptoms such as unstable interpersonal relationships, drug and alcohol use, aggression, and even suicidality (Brownhill et al., 2005). Men's tendency to keep busy in order to avoid the problem has been shown to have some positive effects. For example, Nolen-Hoeksema (1987) found that men's tendency to respond to feelings of depression with behaviour improves mood and decreases the length of the episode. However, in other cases the use of avoidant, numbing and escape behaviours can result in the concealment of the problem from others and subsequently a permanent lack of detection.

Men's reliance on others to perceive mental health concerns and raise it with them is problematic. Those who expect that others will tell them if they have a mental illness deny their own accountability in monitoring their psychological health. By stating 'someone would tell me' these men distance themselves from the feminised realm of emotion and mental health in general, reinforcing a barrier which once established must be difficult to challenge. It also places significant responsibility on those surrounding men to detect and discuss problems where they arise.

In contrast to this predominantly male belief that others would tell them if they had a mental illness, women most commonly reported that they would recognise mental illness because something about them had changed. Changes in thoughts, emotions and behaviours were described by participants as indicators. A handful of women also reported that they probably would not know that they had a mental illness. No male respondents used this theme, although this could be seen to be implied through their discussion of reliance on others. The contrast between relying on others and noticing a change in one's self indicates that gender differences exist across experience of mental illness. Although many participants made initial statements to the contrary, this is consistent with recent literature on men's health.

The literature further suggests that attention influences perception of symptoms (see Bishop, 1994, for review). That is, where one attends to a physical feeling or emotion that symptom is more easily recognised than when one is distracted or not focused on the feeling. Thus, if men are not focused on their emotional experiences (as socialised and predicted by gender role expectations) they are less likely to note problems than those who do attend to such things (women). There is a perception among the public that the majority of men are

unable to recognise when they have problem for which they need help (Timlin-Scalera et al., 2003). This view is supported by research which showed men as less able to identify mental illness than women (Kessler et al., 1981), and less psychologically minded (Shill & Lumley, 2002). Without appropriate contemplation it is improbable that one could identify mental illness in oneself. Decisions about help-seeking behaviour primarily rely on a perception of need (Shapiro, 1983). Therefore, a lack of identification would prevent help-seeking.

4.5.3 Managing Mental Illness

Despite the complexities of determining when mental illness exists, participants of both genders most commonly reported that they would seek professional help if they had a mental illness. The subsequent most common responses differed across gender, with the second preference of males to deal with it themselves and of women to get informal help. These responses reflect both gender role stereotypes and previous findings of help-seeking research which has shown men to be stoic and self-reliant (Jorm, Kelly et al., 2006) and women to discuss their problems with their friends and family (Angst et al., 2002). Seeking professional help is not consistent with the traditional male role. It was therefore unexpected that a large proportion of male participants (indeed, a greater proportion than of female participants) employed this theme. Further, this finding stands in opposition to much research which suggests that this response does not reflect male attitudes toward help-seeking (Addis & Mahalik, 2003; Courtenay, 1998) or real world behaviour (Andrews et al., 2001; Henderson et al., 2000; Vasiliadis et al., 2005). It is possible the use of this theme by male participants may reflect social desirability responding, or that those involved were enrolled in psychology courses and are therefore likely to hold more positive views about psychological help than a more varied population (Jeweler-Bentz, 2003). Further, this response could highlight the sometimes substantial gap between intention and behaviour (see Ogden, 2000,

for discussion). As one participant indicated in her response, saying that one would seek professional help and actually doing so are very different.

A small number of participants indicated that they would not take any action if they had a mental illness. This response is particularly concerning because the age group of this sample is at risk for experiencing a first episode of mental illness. Further, as mentioned, the sample used in this study is likely to have a better understanding of mental health and more positive attitudes towards seeking help than the general population given their enrolment in psychology course. This implies that attitudes to seeking help of those in the general population will be even more negative. A few participants disclosed that they had previously or currently experienced symptoms of mental illness and had not taken any action. It is these individuals, described by Stefl and Prosperi (1985) as in the service gap of being in need of help but not seeking it, that would most benefit from an intervention that could diminish barriers to help-seeking.

4.5.4 Barriers to Help-Seeking

Barriers to seeking help for physical or mental health concerns were similar. Common themes included embarrassment, perception of seriousness, fear of outcome, lack of resources and none. When considering help-seeking for mental health concerns, participants further discussed barriers associated with not being able to identify mental illness and stressed the role of stigma in generating embarrassment.

Whilst both genders indicated concerns that their physical problem might not be serious enough to warrant seeking help, only female participants made reference to seriousness regarding mental problems. This finding demonstrates a greater tendency by female

respondents to contemplate help-seeking for mental health concerns. The concerns reported by male participants indicate that there is something substantially different about physical and mental concerns for men which manifests in distinctively masculine obstacles. Whilst in the case of physical problems men consider what the effect of seeking help might be (e.g. embarrassment at being told that the problem is nothing serious), mental health concerns do not seem to be considered in the same way. Applying Prochaska and DiClemente's (1982) stages of change model to findings in this study, men's mental health can be located in the pre-contemplation stage (i.e. prior to thinking there is a problem which needs to be addressed), whereas physical concerns may generally exist in the contemplation stage (i.e. considering whether to take action). This could reflect an avoidance style of coping for mental health as compared to an approach style for physical health (Leventhal, 1970; Leventhal & Diefenbach, 1992).

Concerns about seriousness pose the question, who and what determine when and if the problem is significant 'enough'? In the case of mental health it would be logical that those with greater mental health literacy may establish this artificial boundary at a less critical stage than those with lower mental health literacy due to their increased understanding of the problem and its treatment. It may be that some individuals never consider problems to be so serious that they seek help for them, and that this is the major barrier to their help-seeking. Without knowledge of how the boundary of appropriate severity is established, this process seems quite arbitrary. Further, there is a possibility that one might mentally establish a level of severity at which one will seek help, only to revise this boundary once the problem reaches such seriousness. Indeed, this seems quite likely if the individual feels uncomfortable seeking help. Mental health literacy may help to establish reasonable limits on what is 'serious enough'.

Literature suggests that some men use chronicity as an indicator of legitimacy. For example, Heifner (1997) found that men commonly described being forced to attend hospital emergency departments by police, paramedics or family members, and that few had discussed their depression with primary health care workers. Being compelled by others to seek help can be seen to legitimise the action as it serves as an indicator that the mental health concern is severe. For a man to be escorted by police to an emergency department not only indicates that the individual legitimately suffers from a serious problem, but that the man had made some attempt at self-reliance and that it is only after that has failed that he has been forced to consider intervention. This can be seen to uphold the masculine gender role whilst allowing the man to legitimately seek help. However, it should be noted that again in these instances it is not the man who decides that the problem is serious 'enough'. These men rely on others to identify the problem and to take action.

It may be that the reliance on others reported by participants in this study is founded on this want to seek intervention only if the problem will be seen as significant. This would reflect the concern expressed that professionals might think that their time was being wasted because the problem was unimportant. Therefore reliance on others could in fact reflect a pathway to decision making. This would allow a man to check firstly that the problem is so severe that others notice it, and secondly, that it is so bad that others believe he should seek help. This process would reassure a man that his problem was serious 'enough' whilst providing some legitimacy to his help-seeking. A man prompted by others is able to report to the professional 'my wife [or other referrer] sent me' and as such confirm his masculinity by indicating that it was not his intention to seek help.

To worry about the relative seriousness of a problem demonstrates that one has recognised that a problem exists. If one does not identify the problem as mental illness and also believe that seeking help will have some positive effect, then help-seeking will not occur. The emergence of the theme 'identification' for mental but not physical concerns has significant implications. Firstly, this suggests that participants understand that mental illness may be difficult to recognise, more so than physical illnesses. Secondly, lack of identification has consequences for help-seeking. As Jorm, Barney and colleagues (2006) attest, a lack of appropriate identification of mental disorders may lead to delay in help-seeking or inappropriate help-seeking.

The barrier of identification is supported by earlier work. Despite a plethora of research demonstrating gender differences in help-seeking behaviour, it has been speculated that no gender difference is present once individuals recognise that a mental health problem exists. Kessler, Brown and Broman (1981), for example, propose that disproportionate rates of help-seeking across gender are likely to be a result of difficulties in problem recognition. Whilst much research has shown that negative attitudes towards seeking help significantly impact on such behaviour (e.g. Deane et al., 1999; Fischer & Farina, 1995; Hoyt, Conger, Valde, & Weihs, 1997; Komiti et al., 2006; Mackenzie et al., 2006; Rickwood et al., 2005), attitudes are only relevant once the individual has identified that there is a problem which may need some intervention. Therefore, problem recognition or identification can be seen to present a substantial barrier at an early stage of the help-seeking process.

Stigma represented another barrier to help-seeking for mental health concerns identified by participants in this study. Stigma has been conceptualised as a mark or label that ties an individual to undesirable characteristics (Goffman, 1963) and results in discrimination

(Link & Phelan, 2001). It has been shown to be especially salient for those with mental illnesses (Dinos et al., 2004) and to impede mental health help-seeking behaviour (Wrigley et al., 2005). Stigma therefore presents a pervasive and dangerous barrier to psychological help-seeking.

Perceptions that seeking help is not a normal way to manage mental illness (Addis & Mahalik, 2003), and concerns that others will respond negatively (Barney et al., 2006) contribute to the stigma associated with this behaviour. Individuals try hard to fit in with stereotypes of 'normal' behaviour in order to be accepted by those around them. Behaviours which are not perceived to be 'normal' (and are therefore stigmatised) are avoided. Mental health help-seeking is not only a stigmatised behaviour in itself but acts as a signifier that the individual seeking help is a member of an undesirable group. In this sense help-seeking makes the individual "visible" (Goffman, 1963, p. 48). Where individuals strongly wish for their membership to the categorical group 'mentally ill' to remain invisible, help-seeking is unlikely to occur.

Stigma presents a significant and well-documented barrier to psychological help-seeking and recovery (Barney et al., 2006; Chew-Graham, Rogers, & Yassin, 2003; Cooper et al., 2003; Corrigan, 2004; Han et al., 2006; Hocking, 2003; Hoyt et al., 1997; Jackson et al., 2007; Narikiyo & Kameoka, 1992; Sims, 1993; Stefl & Prosperi, 1985; Vogel, Wade et al., 2006). Men in particular have been shown to be more likely than women to feel personally discredited by mental illness (Judd et al., 2008) and suffer more severe stigma than women with mental illness (Farina, 1981). Its role in men's help-seeking, as indicated in this study, should not be discounted.

The emergence of the theme 'fear of outcome' indicates that anxiety regarding what help-seeking might involve also serves as a barrier to appropriate use of services. It is also reflective of research which has shown that people are hesitant to seek help for fear of possible outcomes (Dew et al., 2007). For example, Howerton, Byng and colleagues (2007) found that male offenders feared being given a diagnosis, the stigma associated with such a diagnosis, and were worried that finding out what was wrong would necessitate doing something about it. Similarly, Vogel, Wester and Larson (2007) reported that people avoided seeking help so that they would evade the distress they perceived to be associated with it. Other research has purported that treatment fearfulness is greater for women than men, despite men seeking substantially less help than women (Kushner & Sher, 1989). These authors emphasise that whilst fear of treatment may represent a barrier to help-seeking, other factors must also be at play.

A few of the participants in this sample mentioned that they were frightened that they would be institutionalised if they sought help regarding mental health concerns. These participants may be less anxious about seeking help if they were informed of the likely outcomes and treatments for mental illnesses. Better education for youth to improve their mental health literacy could alleviate such fears and break down the fear of outcome barrier to mental health help-seeking.

It is concerning to see the common reference to the prohibitive nature of the cost of health services as presenting such a barrier to seeking physical and mental health intervention. The emergence of this theme stands in contrast to research by Thompson, Hunt and Issakidis (2004) which found evidence structural barriers such as cost and availability of services were relatively unimportant in an Australian sample.

The emergence of cost as a barrier to help-seeking is puzzling. Australia has a free healthcare system available for both physical and mental health which is not difficult to access. Further, the university at which this research was conducted provides free GP and counselling services on campus to students. Therefore one must question whether participants were unaware of such free services or whether they would for some reason rather forgo appointments than attend bulk-billed services. It seems likely that lack of knowledge about the services available plays a significant role. Again, it is likely that education regarding help-seeking pathways, treatment opportunities and outcomes would provide these young people with a greater understanding of their options and may go some way to reducing this obstacle of resources.

Participants reported that stigma and embarrassment, perception of weakness and lack of emotional expression were to blame for men's lack of mental health intervention. Whilst stigma and embarrassment emerged as barriers for both genders in seeking help for physical concerns, perceptions of weakness and restricted emotion only emerged in responses to this item. Very few male participants made comments about weakness in the previous questions regarding one's own help-seeking for physical and mental concerns. However, two thirds of them indicated that traditional male stereotypes which deem help-seeking as weakness were likely to stop men from doing so. This number increased to two thirds of women. In comparison only a quarter of participants of either gender described embarrassment or stigma as a barrier to men seeking help. Clearly, then, it is the traditional notions of masculinity and their incompatibility with seeking help that is seen as most prohibitive for men.

Whilst this finding is in one sense nothing new, the pervasiveness of this response and the consistency across genders suggest that focus should be placed on this barrier if men's psychological help-seeking is to be improved.

4.5.5 Facilitating Men's Help-Seeking

In line with this are participant recommendations as to how men can be made to feel more comfortable in seeking mental health support. Each of the themes which emerged from this item in some way addressed the notion of hegemonic masculinity and recommended its limited parameters be widened. Participants suggested that education, changing stigma, normalising help-seeking, ensuring anonymity and providing male oriented services would make men more comfortable seeking help. These recommendations only loosely reflected facilitators to psychological help-seeking identified in research by Rickwood, Deane and colleagues (2005). These authors reported that emotional competence, positive past experiences of help-seeking, mental health literacy, and supportive social influences were each associated with greater help-seeking for psychological concerns. However, gender differences were not addressed in that research. It seems clear that greater stigma for men with psychological concerns produces different barriers to counter in order to facilitate men's help-seeking. As such, greater anonymity and normalising of the behaviour may be more significant in improving services for men than they would be for women.

Male preferences for confidential or anonymous services fall in line with findings that men try to solve their mental health concerns on their own (Jorm, Kelly et al., 2006; Mahalik, 1999). Researchers have suggested that more self-help information be made available so that men trying to solve their own problems have greater resources (Banks, 2004; Harland, Barclay, & McNamee, 2006; Oliver et al., 2005). Others have confirmed men's preference for

forms of intervention that do not require face to face counselling (Rochlen, Land, & Wong, 2004). Expressions of the need for confidential and anonymous services could easily be dismissed with the statement that services already aspire to offer these criteria. However, what has historically been available to men has not been appropriate, as evidenced by their lack of uptake of services (Banks, 2004). New ways of providing services and information should be considered in order to improve men's chances of seeking and receiving appropriate intervention (Rochlen & Hoyer, 2005).

Education about mental health, including the high lifetime prevalence of mental health concerns among men, treatment modalities and likely outcomes would increase self-identification and give men more control. Changing stigma around male mental health concerns, whilst difficult, would allow men to seek help without fear of negative appraisal from themselves or others. Normalising men's help-seeking would see stigma around this behaviour diminish as it is no longer marked as aberrant.

Jorm, Barney and colleagues (2006) noted that stigma is a significant barrier to help-seeking and determining ways in which to reduce it remains a challenge. These authors argue that increasing mental health literacy may decrease stigma. This assertion is supported by findings that education about mental health (Brockington, Hall, Levings, & Murphy, 1993) and contact with people with mental illness (Angermeyer & Matschinger, 1996; Link & Cullen, 1986) reduce stigma. However, this is not always the case. For instance, it has been demonstrated that mental health workers often have very stigmatising attitudes towards the mentally ill (Rao et al., 2009). Therefore, as Jorm and colleagues argue, there is a need to monitor population knowledge, attitudes, help-seeking behaviour and mental health in

conjunction with an effort to illuminate men's mental health issues and provide widespread education.

The *Real Men. Real Depression.* campaign in the United States was the first large scale mental health promotion undertaken with the objective of disseminating information on depression in men (Rochlen, McKelley, & Pituch, 2006). The campaign featured "hypermasculine" men discussing their experiences of depression and seeking help (Rochlen, Whilde, & Hoyer, 2005, p. 190). The intention of the campaign was to increase mental health literacy and confront "the stigma that tough guys can't seek help" (National Institute of Mental Health, 2003a, p. 1). The project was designed to educate the public, combat stigma and normalise mental health help-seeking for men. The NIMH provided resources on depression in men via public service announcements, brochures, a website, telephone, and email which allowed individuals to seek information anonymously. Therefore this campaign, which was deemed to have surpassed expectations of distribution (Rochlen et al., 2005), addressed the majority of the themes arising from participant suggestions regarding improving men's help-seeking for psychological problems. A similar promotion in Australia, also including methods for anonymous referral to male-oriented services, would be likely to achieve similar success.

In Australia *beyondblue*, the national depression initiative, also launched a campaign which specifically targeted at men with depression (*beyondblue*, 2006). Television, radio and print sources were utilised to display advertising which featured the catchphrase 'Men do get depression', along with images of a man in a suit discussing alcohol use, another in a shirt and tie discussing stress, a football player, an Aboriginal man and a farmer. As was the case with the American campaign discussed above, these are stereotypical images of strong, successful

men aimed at challenging the stereotypes of men with mental illness. Posters featured images coupled with quotes, such as a farmer stating 'I didn't want people to think I was weak. I'm a man and men don't get depression'. This hyper-masculine male directly challenges gender role expectations. Another poster featured an image of a man and wife with the quote 'He'd changed. He wasn't himself anymore. I didn't know what to say or do...I felt helpless'. Clearly this advertisement is aimed at those 'others', women in particular, around men who are relied upon to identify mental illness and take some action. This campaign accounts for a number of the themes raised in this study. However, a formal evaluation of this work has yet to be published.

The barriers to help-seeking identified in this study support findings of earlier work. For example, in an Australian study Rickwood, Deane and colleagues (2005) investigated young people's help-seeking for mental health concerns. These authors found that barriers to help-seeking included lack of emotional competence, negative attitudes and beliefs about help-seeking and fear of stigma. Outram, Murphy and Cockburn (2004) found that barriers to Australian women seeking help for psychological distress were thinking they should cope alone, thinking the problem would get better by itself, embarrassment, believing no help available, not knowing where to go for help, and fear of what others might think. Findings of this research reflect the themes determined by both of those studies, suggesting that they can be generalised to wider Australian populations than university samples.

4.6 Conclusion

Participants in this study identified the traditional male role as significant in men's experience of psychological concerns and subsequent help-seeking. Results demonstrated a tendency to characterise men with mental illnesses as suffering from severe problems, and as

dangerous and frightening. Female participants believed that they would notice the symptoms of mental illness in themselves, whilst male participants reported that they would rely on someone to tell them that they had mental concerns. This finding stressed the importance of the role of women in men's mental health.

Embarrassment, perception of problem severity, fear of the outcome of help-seeking and a lack of resources were identified as barriers to help-seeking for both physical and psychological concerns. Barriers to seeking help for mental concerns also incorporated an inability to identify a problem and the stigma associated with mental illness.

Participants suggested that education, changes to existing stigma and the normalisation of help-seeking for psychological concerns among men could facilitate greater utilisation of mental health services by men. In line with such recommendations, the findings of this study could be useful in the development of educational and promotional materials, including campaigns such as those developed by *beyondblue* and the NIMH.

CHAPTER FIVE

Study Four: Practitioner Experiences of Men's Psychological Help-Seeking

5.1 Introduction

Psychological disorders have been described as under-diagnosed in Western countries (Karlsson, 2000). Some authors suggest that less than half of mental illness is recognised (Goldberg & Huxley, 1992). Compounding this is the finding that psychological disorder is more likely to go unnoticed in men than in women (Karlsson, 2000).

Eighty-two percent of Australians (Britt, Miller, Knox, & al, 2002) and New Zealanders (MaGPIe Research Group, 2005) will see a General Practitioner (GP) in a one year period. This number is slightly higher amongst those who meet the criteria for mental disorder (Issakidis & Andrews, 2006; Meadows, Liaw, Burgess, Bobevski, & Fossey, 2001). The GP is usually the first point of contact for Australians seeking psychological help (Hight, Hickie, & Davenport, 2002; Steel et al., 2006; A. Thompson et al., 2004). However, studies have found that only between a third (Komiti et al., 2006; Meadows et al., 2001) and slightly less than half (Jorm, 2000; Madianos et al., 1993) of those with mental illness seek help for their psychological concerns. These statistics suggest that treatment of mental illness would more than double if those in need of care sought help.

Of those who do seek help the substantial majority are women (see Moller-Leimkuhler, 2000, for review). Indeed, two thirds of people receiving outpatient mental health treatment in Australia are female (Issakidis & Andrews, 2006). On average it takes around six months for those who seek psychological help to do so, and this is not moderated by symptom

severity (Steel et al., 2006). This delay suggests that factors other than the illness itself are at play.

Perhaps not surprisingly, belief in a GP's ability to help predicts psychological help-seeking from these practitioners (Steel et al., 2006). Jorm, Korten and colleagues (1997) note that many people perceive GPs to be more helpful for mental health problems than psychiatrists and other mental health professionals. This may explain why GPs are the most common first point of contact in mental health. Some authors have found that GPs only refer a small percentage of patients with psychological concerns to mental health services (Goldberg & Huxley, 1992; Ustun & Sartorius, 1995). Whilst this is of concern to some authors, others note that the patient's own reluctance to be referred may also be a factor in this decision (Rost, Humphrey et al., 1994).

An individual's own GP is preferred for discussing psychological concerns (Lester, Tritter, & Sorohan, 2005). This preference may be well founded as studies suggest that continuity of care and previous knowledge of a patient increases the likelihood that a GP will identify psychological disorder (Bushnell, 2004; MaGPIe Research Group, 2005).

Some authors (Parslow & Jorm, 2000) have reported no difference in rates of help-seeking across rural, remote and metropolitan area of Australia. However, more recent work by Caldwell, Jorm and Dear (2004) has found that people living in non-metropolitan areas visit general practitioners less than those in metropolitan areas. Likewise, people in these areas also have less contact with GPs for mental health reasons than their metropolitan counterparts. These authors note that despite having less contact with GPs, large regional areas see greater numbers of antidepressants prescribed and dispensed than capital cities.

Caldwell and colleagues posit that this may indicate either the tendency of rural individuals to travel to their closest major centres for this type of endeavour, or an over-reliance on medication by GPs in these areas.

The Department of Health and Ageing recently reported that there is a shortage of GPs in rural and remote areas of Australia (2008). This is exacerbated by a substantial increase in the management of mental health by GPs across rural and metropolitan Australia in recent times. This rise has been especially significant in rural areas where management rates increased thirty percent from the period 1990-1991 to 2000-2001; rates of metropolitan GP contacts increased by thirteen percent over the same period (C. M. Harrison & Britt, 2004). The considerable differences in increases were reported despite little difference in prevalence of mental illness across locations (Judd et al., 2002). Considering the recent discussion by Caldwell, Jorm and Dear (2004) presented above, these findings suggest that although rates of GP mental health contact may have increased in the last 15-20 years, a large proportion of mentally ill individuals do not seek help.

Other recent research has shown that men seek help less than women, even in rural areas (Judd et al., 2006). It has also been argued that in rural areas the stigma associated with seeking mental health treatment is greater than the stigma associated with the mental illness itself (Rost, Smith, & Taylor, 1993). However, other authors purport that stigma does not influence lifetime help-seeking behaviour for mental health treatment (Judd et al., 2006). Stigma is certainly a concern for both GP and patient. For example, one study reported that GPs may intentionally fail to record mental health concerns in a patient's file in order to avoid labelling the individual and to manage this stigma (Karlsson, 2000).

Some authors contend that GPs only detect a minority of psychological disorders in patients (Karlsson, 2000), and that they are especially likely to overlook or deny symptoms in men (Brownhill et al., 2003). Indeed, gender has been found to influence diagnoses of patients even when the clear-cut diagnostic criteria are fulfilled (Loring & Powell, 1988). For instance, GPs have been found to correctly identify depression in significantly less men than women who met the DSM-IV criteria (Potts et al., 1991).

GPs have also been found to be aware of or act upon psychological disorder in women more than men (Borowsky et al., 2000). If, as countless authors suggest (e.g. Courtenay, 1998; Cusack, Deane, Wilson, & Ciarrochi, 2006; Ducat, 2004; Kraemer, 2000; McVittie & Willock, 2006; Rutherford, 1992; Seidler, 1997; Vogel, Wester et al., 2006), men express less emotion and distress than women, these findings indicate that they are also less likely to seek help and to be diagnosed by their GP.

Both patient and GP characteristics can affect recognition of mental illness (Sorgaard, Sandanger, Sorensen, Ingebrigtsen, & Dalgard, 1999). Identification of mental illness can be affected by patients' coexisting medical problems (Borowsky et al., 2000), past psychiatric history, race, social problems (Odell, Surtees, Wainwright, Commander, & Sashidharan, 1997), personality (Sorgaard et al., 1999), etiological beliefs regarding mental illness (Goldstein & Rosselli, 2003), patient belief that mental health problems should not be discussed, patient concerns about their relationship with their GP (MaGPIe Research Group, 2005), patient concerns about wasting the GP's time (Barry, Bradley, Britten, Stevenson, & Barber, 2000), reluctance to admit their problem (Shay, 1996), embarrassment, belief that they can cope on their own, and belief that there is nothing the GP can do to help (Cape & McCulloch, 1999).

Similarly, a GP's approach to mental health (Cape & McCulloch, 1999) and confidence in their ability to diagnose and treat mental illness have been shown to increase the likelihood of making correct mental health diagnoses (Bushnell, 2004; Dowrick, Gask, Perry, Dixon, & Usherwood, 2000). A study by Browne, Lee and colleagues (2007) found that almost thirty percent of GPs lacked confidence in identifying mental illness in patients. Research also suggests that whilst ninety-five percent of GPs stated that they are confident in initiating antidepressants, fewer are confident in providing psychotherapy.

Prior training and an interest in mental health has been found to significantly increase GP confidence in dealing with mental illness (Browne et al., 2007). According to the literature (e.g. Dowrick et al., 2000), increasing GP confidence should subsequently increase their ability to diagnose and treat psychological disorders. These findings promote GP education as paramount to appropriate identification and treatment of mental illness.

An in-depth study by Dew, Morgan and others (2007) in which GP patients were interviewed found that barriers to the disclosure of 'stress and worry' to GPs included fear of consequences, lack of encouragement by health professionals, being a burden or whingeing, lack of trust, stigma, belief that the GP cannot help or that GPs only deal with physical problems, resilience or self-reliance, bottling it up, lack of awareness or denial, limited consultation time, money, gender and culture. Conversely, categories facilitating disclosure were: a sense of control over consultation, encouragement from the GP to disclose, trust in the GP, the worry being associated with physical problem (e.g. sleep difficulties), a view that it is a GP's job to deal with mental health problems, reached the point of breaking down, the provision of informal surroundings for the appointment.

Recent research on mental health literacy has found that large numbers of Australians cannot recognise specific mental disorders or distress (Highet et al., 2002; Jorm, 2000). Further, mental health literacy has been positively associated with a more optimistic attitude towards help-seeking (Fox, Blank, Rovnyak, & Barnett, 2001), faster (Thompson et al., 2004) and greater levels help-seeking (Cotton et al., 2006). Whilst GPs rely on patients to self-disclose mental health concerns, doing so requires some knowledge of psychological disorder or mental health literacy. Brownhill, Wilhelm and colleagues (2003) and Gorman, Buikstra and others (2007) note that men in particular often do not have the level of knowledge of mental illness that is required to identify it in themselves or others. Thus low levels of mental health literacy can be seen to impact negatively both on help-seeking and the likelihood of diagnosis among men. Although attempts have recently been made to improve men's mental health literacy (such as the development of the 'Real Men. Real Depression.' campaign in the United States, National Institute of Mental Health, 2003b), there is still much work to do on this front.

Research on symptom attribution suggests that the way that an individual describes their illness in their contact with professionals is bound to affect the ability of those professionals to identify psychological disorder. Symptom attribution has been found to play a significant role in the negotiation of diagnosis between patient and practitioner, with different attribution styles found to be strongly associated with differences in detection rates of depression and anxiety by GPs (Kessler, Lloyd, Lewis, & Gray, 1999).

Individuals can be seen to attribute their symptoms in one of three ways; 'psychologising', 'somatising' or 'normalising'. Psychologisers have been described as those who attribute their symptoms to psychological causes. This group has been found to report

higher levels of distress and were more likely to believe that symptoms reflected a psychological problem than somatisers or normalisers (Bower, West, & Hann, 2000). Further, the association between psychologising and diagnosis is proportional, that is, the stronger the tendency of patients to make psychologising attributions, the more likely it is that they will receive a psychological diagnosis (Kessler et al., 1999). Psychologisers are the most likely of the three attributional styles to be diagnosed with psychological disorder (Kessler et al., 1999) and there is agreement amongst researchers that psychologisers are likely to be female (Greer, Halgin, & Harvey, 2004).

Somatisers tend to attribute their symptoms to physical concerns. Individuals with this attribution style have been characterised as less likely to consult a GP about psychological symptoms because they have an unsympathetic view of mental illness (Bridges, Goldberg, Evans, & Sharpe, 1991). Some authors suggest that most somatisers are men (Greer et al., 2004).

Kessler, Lloyd and colleagues (1999) found normalising to be the most commonly employed attribution style. Normalising involves patients accounting for symptoms or minimising the role of symptoms and associated distress. As such, the GP may be left with the impression that symptoms are explicable and not due to mental illness. Patients using normalising attributions have been found to be less likely to be diagnosed with psychological disorders (Greer et al., 2004) and the stronger the tendency to use normalising attributions the less likely to be diagnosed (Kessler et al., 1999). Whilst some authors suggest there is no gender difference in the utilisation of normalising attributions (Greer et al., 2004), other studies have shown the majority of men to be normalisers (Kessler et al., 1999).

These findings provide a possible explanation for the lack of help-seeking and mental health diagnosis in men, since research on symptom attribution suggests that men are less likely than women to receive a psychological diagnosis due to their style of attribution.

These concerns are amplified by research by Brownhill, Wilhelm and colleagues (2005) that argues that the very symptoms that men suffer are likely to be different to those of women. These authors and others (e.g. Cochran, 2001; Cochran & Rabinowitz, 2003; Hart, 2001) propose that whilst depression is commonly associated with those symptoms that women tend to experience, namely tearfulness, emotionality, expressions of helplessness and passivity, behaviours commonly associated with males such as aggression, violence, drug and alcohol abuse and suicide are likely to be signs of 'masked depression'. As this term suggests, this refers to depression in males that remains undiagnosed due to a lack of the 'right' symptoms. Brownhill and colleagues propose that the combination of oblique symptoms and non-psychologising attribution style indicate that even if men did present to a GP the practitioner may have little chance of detecting existing psychological disorder.

Available research almost unanimously asserts that men commonly do not seek help for mental distress when it is needed (Addis & Cohane, 2005; Cusack et al., 2004; Rochlen & Hoyer, 2005). Much of this is attributed to the role of hegemonic or traditional masculinity in establishing barriers for men in accepting a mental health diagnosis and seeking help (e.g. Berger et al., 2005; Good et al., 1989; Wisch et al., 1995). Although the influence of gender role will not be further examined here, it must be noted as a significant context influencing the behaviours and attitudes of men.

The perceptions of those who work most closely with men with mental disorders can be useful in understanding the issues and concerns involved in these men seeking help. However, the beliefs and attitudes of professionals working with men with psychological concerns is yet to be fully explored (Smith et al., 2006). Available research will be briefly discussed below.

There has been some conjecture that professionals' attitude toward mental illness and expectations of patients can influence their perception of health and illness. Broverman, Broverman, Clarkson and colleagues (1970) examined the characteristics that clinicians valued in adults as reflective of health. The authors noted that abstract notions of health tend to be influenced by the greater societal value of masculine stereotypic characteristics rather than by lesser valued feminine characteristics. Clinicians highlighted independence, self confidence, ambitiousness, logic and objectivity, lack of emotionality, never crying, not easily hurt, and not at all excitable in minor crises as features of a 'healthy' man. Whilst this research has been criticised on methodological grounds (Stricker, 1977), regard for these characteristics in men has not changed in over thirty-five years (Seem & Clark, 2006), suggesting that traditional roles of masculinity remain somewhat rigid.

Conversely, clinicians valued talkativeness, gentleness, ability to easily express tender feelings, awareness of the feelings of others, neat in habits, and a strong need for security as signs of 'healthy' women. Recent research replicating the Broverman study, which used clinicians-in-training rather than qualified clinicians, suggests that small changes have occurred in characteristics valued in women over time. The 'healthy' woman now exhibits those features listed above as well as some additional traditionally masculine attributes, including 'independent' and 'enjoys a challenge' (Seem & Clark, 2006).

These studies argue that clinicians (and clinicians in training) perceive characteristics of health to be moderated by gender. That is, clinicians use different criteria to judge health in men and women. This is likely to have some bearing on rates of diagnosis of psychological disorders. Whilst traditionally masculine characteristics such as independence and lack of emotionality can be seen as beneficial in some instances (e.g. war, emergency services etc.) if these features remain unwavering they could be detrimental by operating as barriers to help-seeking and treatment. Further, if clinicians set the parameters of 'health' so that maladaptive masculine behaviours are encompassed by them, the likelihood of identifying psychological disorder in men may be reduced.

In further research on practitioner attitudes, Werrbach and Gilbert (1987) interviewed therapists regarding their perceptions of male clients. Practitioners in that study described men as resistant to engaging with emotion due to fear of becoming vulnerable. Similarly, men were described as sometimes ceasing therapy prematurely in order to avoid anxiety provoked by developing a dependence on the therapist. All participants noted that male clients wanted to engage in problem solving ('cognitively orientated') therapy, a theme which has since been supported by a number of other authors (e.g. Robertson & Fitzgerald, 1992; Wisch et al., 1995). Some practitioners involved with this research suggested that men externalised the responsibility for problems and attempted to portray themselves as tough, autonomous, and in control of emotion. All participants commented that they had found women to be more emotionally open and available to psychotherapy than men, something they attributed to men's socialisation.

Werrbach and Gilbert argue that in order to work with male clients the therapist must investigate socialisation factors which produce these uncomfortable feelings and withdrawal

behaviours. They suggest that the role of the therapist is to “assist [men] in coming to self definition that is consistent with their needs and goals rather than those imposed on them by society” (1987, p. 565).

The MaGPie Research Group (2005) in New Zealand recently studied GPs’ perceptions of the barriers that exist to the provision of mental health care. The GPs surveyed reported that reluctance of patients to seek mental health help, costs and concerns about confidentiality were significant barriers to mental health treatment. GPs further proposed that they could increase the identification rates of psychological disorder in patients by spending more time in consultation with them and conducting better interviews.

Smith, Robertson and Houghton (2006) conducted thematic analysis on data from a focus group conducted with general practitioners and a medical school professor on men’s attitude towards help-seeking for mental health concerns. The themes identified were used to develop a short questionnaire on practitioner attitudes to specific interventions, which was posted to a large sample of GPs. Themes derived from the focus group included ‘Male socialisation process’ (men are stoical), ‘Influence of stigma’ (physical problems are okay but psychological ones are not), ‘Ignorance of the consultation process’ (lack of knowledge) and ‘Possible ways forward for engaging men’ (normalising counselling). The participants involved proposed that men’s adherence to the traditional male role and lack of mental health literacy were significant barriers to them seeking psychological treatment. The study recommended that health services be encouraged to include mental health screening as part of men’s yearly physical, in the hope that this would help normalise talking about mental health and seeking help for mental health concerns.

Whilst there has recently been an increase in research on men's health, how best to improve current inequitable gender differences in seeking and accessing mental health care remains unclear. Practitioners can provide valuable information concerning the barriers to help-seeking and types of presentation of mentally ill men. Further, many have suggestions regarding how to increase help-seeking for psychological concerns based on their own experiences. The studies discussed above have identified a number of avenues of interest in examining the role of gender in psychological help-seeking and diagnosis, including clinicians' gendered perceptions of health, male clients' cognitive orientation to treatment and avoidance of emotion. However, relatively little research has been undertaken examining different practitioner perspectives of mentally ill men. This reflects a substantial shortfall in the literature on men's psychological help-seeking.

GPs are often the first point of call for men with psychological concerns. Mental health practitioners may also be an initial psychological contact for men, although more generally work with them to overcome their difficulties. Despite the extensive experience these practitioners have with both men and women with mental illnesses, few studies have explored their observations of men with psychological concerns. Mental health practitioners are well placed to provide objective information on these issues involved in seeking help and receiving mental health treatment. It is believed that by encompassing the perspectives of both general and mental health practitioners a broader understanding of the issues can be developed.

Whilst some studies have examined mental health concerns in rural areas and made comparisons between rural and metropolitan areas, practitioner perceptions of issues specific to men have not been fully explored. Authors publishing recently in this area have called for

further investigation into the role of psychological and attitudinal factors in mental health help-seeking (Jackson et al., 2007), suggesting that this subject is both topical and timely.

The identification of factors affecting men's help-seeking for mental health services could provide a solid basis for improvement of existing structures or the development of new services and pathways to care appropriate for the needs of men. Research encompassing the perspectives of both mental health and general practice professionals regarding the psychological concerns of men would provide an extensive understanding of the issues involved. Further, a comparison of rural and metropolitan practitioner experiences could increase our knowledge of issues relevant to men with mental health concerns.

This study investigates practitioner experiences of men seeking psychological help. It will extend preliminary research undertaken by Smith and colleagues (2006). This research will contribute to the findings of these authors by determining whether South Australian practitioners share similar concerns to those in the United States. Further, it will identify any differences in practitioner observations across rural and metropolitan areas. This research will determine whether earlier findings regarding practitioner perceptions of characteristics of health (Broverman et al., 1970), male resistance to emotion (Werrbach & Gilbert, 1987), male preference for cognitively oriented therapy (Robertson & Fitzgerald, 1992), GP perceptions of barriers (MaGPIe Research Group, 2005) and facilitators (Dew et al., 2007) to help-seeking are raised as relevant to a rural or metropolitan modern Australian context.

5.2 Aim

To determine the issues that rural and metropolitan mental health and general practitioners in South Australia consider important in men's experience of mental illness and help-seeking for psychological concerns.

5.3 Method

This study was undertaken using a questionnaire developed in consultation with mental health and general practitioners and from general themes found in the literature on men's mental health; for example, gender differences (Vogel, Epting, & Wester, 2003), recognition of mental illness (Gorman et al., 2007), referral (Seymour-Smith et al., 2002), barriers and facilitators to help-seeking (Dew et al., 2007). The questionnaire was used to survey practitioners on their experiences of men with mental health concerns.

The questionnaire began with three demographic questions encompassing profession, gender, postcode of main practice and professional experience in rural areas (*yes* or *no*). The remaining nine questions were in short answer format. The questions included:

1. Do you think differences exist between men and women in how they recognize that they have a mental health issue? If yes, in what ways?
2. Do you think men's attitudes to psychological help are different to those of women? If yes, in what ways?
3. How are the majority of men with mental health concerns referred to you (e.g. self-referred, GP, spouse, work colleague)? In what ways, if any, does this differ from how women with mental health concerns are referred to you?

4. What factors do you think may make men less likely to seek help for mental health problems?
5. What factors do you think may make men more likely to seek help for mental health problems?
6. What do you think could be done to increase men's help-seeking for mental health problems?
7. What issues, if any, do you think are of particular importance for rural men with mental health concerns?

Responses to two further questions were not addressed by this study as it was considered that these did not substantially contribute to the current discussion (see Appendix L).

5.3.1 Participants

A pilot study was undertaken using three practitioners (one rural GP, one rural mental health worker and one metropolitan psychologist) in order to investigate the appropriateness of questions. During this consultation it became clear that the original wording of question four was slightly confusing and as a result this was modified. Discussions with pilot participants resulted in the development and inclusion of two questions. Ethics approval was granted by the University of Adelaide Ethics Committee prior to the commencement of this study.

The survey was posted to eighty rural and one hundred metropolitan (greater Adelaide-based) general practitioners in South Australia in mid 2007. Rural general

practitioners were identified through the Mid North, Yorke Peninsula and Eyre Peninsula Divisions of General Practice. Metropolitan general practitioners were selected by gender (fifty male, fifty female) from high and low socio-economic areas across several areas of the city using the yellow pages. The same system was used to select one hundred metropolitan based psychologists (fifty-three male, forty-seven female) from high and low socio-economic areas. Sixty-two mental health professionals (psychologists, social workers, mental health nurses and mental health workers) working as part of the Rural and Remote Mental Health Service of South Australia were identified through this service. In total one hundred and eighty-one GPs and one hundred and sixty-two Mental Health Professionals were invited to participate. Three surveys sent to GPs were returned as undeliverable.

Potential participants were mailed an information sheet, survey and a reply paid envelope for its return (see Appendix L). Of the posted surveys, sixty-six were returned completed (response rate 19.5%). Rural general practitioners returned fourteen surveys, and metropolitan general practitioners eighteen, for a total of thirty-two. Fourteen rural Mental Health Professionals and twenty metropolitan psychologists returned completed surveys for a total of thirty-four.

5.3.2 Methodology

Qualitative methodology was chosen for this study due to the nature of the phenomenon examined (attitudes and beliefs). Thematic analysis, as discussed in chapter two (Braun & Clarke, 2006), was utilised to identify patterns or ‘themes’ within the data. An individual’s responses could have been coded under more than one theme (e.g. where one

individual referred to three different themes within one answer); however, there was exclusivity in that the same part of a response was only to be coded under one theme.

The researcher initially read through all responses in order to become acquainted with the data. Responses were then grouped together under each question and read through again a number of times with the researcher making notes of possible themes and interesting findings. Codes were then developed for each possible theme under each question. These codes were modified, removed and added to as analysis progressed. Responses to each question were initially analysed independently, and the analysis is presented according to this structure. After analysis of each question was complete the themes identified were examined to determine any patterns common across questions. Extracts of participant responses are included to provide examples of comments. Each is followed by a description of the participant's gender, location and occupation.

5.4 Results

5.4.1 Demographics

The majority of respondents were male (62%). Similar numbers of general ($n = 32$) and mental health practitioners ($n = 34$) participated. Table 7 shows that fewer rural ($n = 28$) than metropolitan ($n = 38$) practitioners completed the survey in each occupation group. The group least represented was female rural GPs, with male metropolitan GPs the group with the most participants.

Table 7.

Participant Demographics

Gender	General Practitioner			Mental Health Practitioner		
	Metropolitan	Rural	Total	Metropolitan	Rural	Total
Male	12	10	22	11	8	19
Female	6	4	10	9	6	15

Table 8 indicates that mental health workers were more likely than GPs to have experience working in rural areas. The majority of male metropolitan mental health workers (psychologists) and half of male metropolitan GPs stated that they had professional rural experience. Of a total of thirty-eight metropolitan respondents, twenty had rural experience, seventeen did not, and one participant failed to complete this question.

Table 8.

Percentage of metropolitan respondents with experience practising in a rural area

Gender	GP	Psychologist	Total
Male	50%	80%	64%
Female	33%	44%	40%

5.4.2 Beliefs regarding gender differences in recognition of mental health issues

Question one asked practitioners “Do you think differences exist between men and women in how they come to recognize that they have a mental health issue? If yes, in what ways?”.

A substantial majority of respondents felt that differences do exist between men and women in how they recognise that they have a mental health issue. Metropolitan GPs were the group least likely to believe that differences exist between genders, with rural GPs the most likely (although the disparity between these groups was not large). Gender of practitioner had little effect on belief that differences exist between genders in how individuals come to recognise that they have a mental health issue. Nonetheless, responses by rural GPs suggested that they more strongly held the belief that differences exist for men than their metropolitan counterparts. This may indicate, at least from the perspective of general practitioners, that differences in men and women in the recognition of mental health issues may be more significant in rural areas.

From the outset of analysis there was an obvious divide between comments in response to this question regarding women and men. As such the first thematic categorisation of responses centred on gender. Within responses referencing women, themes of ‘awareness of mental health’ and ‘disclosure’ were evident. Themes associated with men included ‘won’t admit problem’, ‘externalise problem’, ‘delay seeking help’ and ‘maladaptive coping methods’. The most commonly used theme, used by almost half of participants, was that men ‘won’t admit problem’.

Female and male practitioners were equally likely to mention that men ‘won’t admit problem’. Male participants also commented on women’s ‘awareness of mental health’ at the same rate; however, few female practitioners utilized this theme. Although the source of this difference remains unclear, one possibility is that women may be less conscious than men of both their tendency to discuss and gather knowledge about mental health and the distinction of this behaviour from that of men.

The themes identified from responses to question four are analysed below, followed by a discussion of the dichotomised nature of gender.

Women

Responses to question four which described the thoughts and behaviours of women were collated and coded together as one dataset. Major themes found to be associated with women in the way that they recognise that they have a mental health issue were ‘disclosure’ and ‘awareness of mental health’.

Disclosure

Responses coded under disclosure encompassed discussions around women’s attitude towards talking about and seeking help for their mental health concerns. This theme was equally likely to be utilised by male and female practitioners. Rural mental health practitioners most commonly employed this theme, followed by metropolitan GPs.

The use of adjectives to describe women’s attitude towards talking and seeking help indicate practitioners’ beliefs. Respondents typically used terminology such as ‘willing’ and ‘happy’ to describe women in these situations. This suggests an attitude of openness on behalf of women to discussing their problem with others. An example of this follows.

Extract 164

Women are usually happier to talk about emotional problems (Female rural GP)

Participants noted the importance of women's relationships with others in disclosing their concerns. It was suggested that women are readily able to discuss issues with friends and family and therefore gain input from others as to the nature of the problem and what they might do about it. In many instances this was contrasted with the experiences of men. For example:

Extract 165

[women have] More resources because they can talk about some of the issues with friends and family (Male metropolitan GP)

Practitioners described women as acknowledging problems and feeling free to discuss them with their friends or general practitioners. Some responses were delivered with an absence of reference to men (e.g. 'women talk with other women'), whereas others used comparative language (e.g. 'women usually happier to talk...'). These constructions imply that men do not have the same attitude as women, that is, they are often unwilling to talk about emotional problems or are not comfortable doing so.

Awareness of Mental Health

Roughly a quarter of participants noted that women were aware of their own emotions and of mental health in general. Mental health workers were more likely than general practitioners to employ this theme. Considerably more male than female practitioners made reference to women's awareness of mental health. As mentioned above, it is possible that this reflects a level of unconsciousness in women as to their gathering of knowledge of mental health and subsequent lack of recognition that this may be different for men. All comments referring to a good awareness of mental health concerns mentioned women, none men.

Practitioners commonly noted that women paid attention to their own inner experiences. This was conveyed through statements regarding women's awareness or being 'in touch' with their emotions. An example of such a comment is:

Extract 166

Women are more aware of their feelings and emotional problems... (Male metropolitan Clinical Psychologist)

Similarly, women were portrayed as having knowledge that their concerns may reflect a mental illness prior to seeking help. Participants praised women's insight and ability to identify changes in their own mental state. For example:

Extract 167

Women can usually say they have a mental illness... (Male metropolitan GP)

Again, these characteristics were presented in comparison to those of men. Where women were described as in touch with their emotions, men were seen as avoiding such introspection. These comparisons are discussed later in this analysis.

Men

Major themes associated with men recognising that they have a mental health issue were: 'won't admit problem', 'externalise problem', 'delay seeking help', 'maladaptive coping methods'.

Won't Admit Problem

Almost half of participants expressed that in their experience men won't admit they have a problem. Male and female practitioners were equally likely to draw upon this theme. General practitioners (rather than mental health practitioners) most commonly employed the notion that men won't admit a problem. This could be a reflection of the primary nature of GP contacts whereas a proportion of clients seen by mental health professionals may have already admitted a problem and been referred to them.

Men were characterised by practitioners as very reluctant to admit that they have a mental health issue. Responses commonly proposed that men are hesitant and unwilling to think about their own concerns let alone discuss them with others (see following extracts). Participants suggested that men are slow to accept their problems and likely to ruminate on them. Many respondents used the word 'deny' in their remarks. Examples of comments coded under this theme include:

Extract 168

They do not admit their problem is serious enough to need outside help
(Female metropolitan Psychologist)

Extract 169

Men sometimes minimise their problem – even when seeking help... (Male metropolitan Psychologist)

The reported tendency not to admit to problems generates uncertainty as to whether men admit the problem to themselves but not to others or whether this denial is an outward

expression of the emotional struggle occurring within men. That is, perhaps men deny their problems even to themselves. Extract 170 discusses this.

Extract 170

Men understand their mental health issues, just don't access services.

(Male rural GP)

Men's reluctance to acknowledge their problems and denial of a need for mental health treatment was depicted as problematic by almost half of the all practitioners surveyed. It is therefore clear that men's reluctance is a significant concern in promoting help-seeking for psychological problems.

Externalise Problem

Approximately one fifth of participants employed the theme 'externalise problem' in relation to men. Male practitioners utilised this theme slightly more than did female practitioners, and mental health more than general practitioners. This theme refers to the attribution of problems to sources external to the person (rather than internal). This included mental health concerns being considered or presented as physical problems, being recognised only when external changes occur (e.g. in finances etc.), an external orientation to treatment and so forth.

Participants suggested that men are more likely to consider there to be a problem when external changes occur rather than changes in their own emotions and experience. Comments noted that practical changes such as financial difficulties or increases in coping behaviours (e.g. alcohol use) were likely to indicate to men that there was a problem. Similarly,

respondents proposed that men focus on external aspects of their mental health concerns. For example, a number of participants expressed a tendency for men to attend a service presenting with physical symptoms rather than psychological ones. This is illustrated in the extracts below.

Extract 171

Men tend to focus on physical symptoms (Female rural GP)

Extract 172

Men tend to identify as a physical issue and present to GP 'feeling unwell'
(Male metropolitan Clinical Psychologist)

It could be argued that this propensity to externalise mental health concerns may result in the inability of a general or mental health practitioner to diagnose psychological difficulties.

Men were further characterised as locating the source of their difficulties externally. For example, one psychologist noted that men see other people as causing problems rather than acknowledging their own role.

Extract 173

In general many men see their 'problems' (if in fact they do see them as 'problems') as caused externally rather than intrapersonal difficulties, i.e. they see others who must change. (Male metropolitan Psychologist)

Lastly, respondents referred to men's preference for treatments which follow this external trend. That is, men were depicted as preferring treatment which is goal-oriented rather than emotion-oriented. Practitioners suggested that men favour problem solving

approaches rather than those which require them to be introspective. This was contrasted with the proposition that women favour an approach that concentrates on their inner experience.

For example:

Extract 174

men focus more on the problems they are experiencing and want ways to solve them. Women focus more on their feelings about problems they are experiencing and want to talk about their feelings. (Female metropolitan Psychologist)

Delay Seeking Help

Substantially more women than men referred to men delaying seeking help. Mental health practitioners were more likely to utilise this theme than general practitioners. Data coded under this theme referred to men waiting to seek help or others prompting men to seek help (as this suggested that there must have been a period of time when men had not done so on their own).

Respondents commonly referred to men delaying their help-seeking until some kind of crisis or intervention. Men were described as battling on, fighting through, holding on until something insurmountable occurred. The end of this battle was often characterised as some kind of breakdown: of relationships, a physical collapse or an emotional inability to continue without help. Examples of such comments include:

Extract 175

Men tend to "hold on" "keep going" until they are in crisis. (Male rural Mental Health Nurse)

Extract 176

Men do not seek help until emotional issue spills over (Male metropolitan Psychologist)

Maladaptive Coping Methods

A small number of practitioners observed that men use maladaptive coping mechanisms (such as violence, alcohol and drug use) in their struggle to recognise and resolve their mental health concerns. The majority of responses coded under this theme came from metropolitan GPs. Interestingly no metropolitan mental health practitioners employed this theme. Female participants were significantly more likely to mention maladaptive coping methods than were males.

Participants noted that men try to cope with 'bottled up' emotion through maladaptive means. For example:

Extract 177

Take it out on drinking, drugs etc (Female metropolitan GP)

The majority of responses made reference to men's use of alcohol in order to deal with issues that they were trying to ignore. Others mentioned drugs, anger or aggressive tendencies. Practitioners never referred to women as utilising such maladaptive methods; rather, they suggested that this was a masculine trait.

Gender

Many respondents used a comparison technique to demonstrate the ways in which men and women differ in how they recognise that they have a mental health issue. That is, respondents commonly created a dichotomy, stating 'women are like this, men are like that'. These statements commonly presented diametrically opposed behaviours: for example 'men externalise, women internalise'.

Some participants used language to imply variance between genders by using constructions such as 'women are more...' or 'men take longer...'. This structure allowed the respondent to overtly comment on only one gender but to simultaneously imply that the same was not true of the other gender. Similarly, some comments took the form of a statement about behaviours. These responses were almost exclusively statements about men, taking the form 'men are X' or 'men do X'. The survey question specifically asked about differences between men and women. It is therefore reasonable to suggest that respondents utilising either of these answer structures were referring to the other gender as referenced in the question, rather than intentionally avoiding comment.

Most of the responses to this question can be seen to dichotomise the behaviours and attitudes of men and women. Common dichotomies are presented in Table 9.

Table 9.

Gendered Attitudes and Behaviours in Professional Accounts

Men	Women
present physical symptoms	present psychological symptoms
closed	open
silent	talkative
slow to recognise	psychologically minded
require external intervention	self-aware
hold out until crisis	quickly ask for help

There were clear differences in the way practitioners characterised men and women recognising mental health problems. These differences almost exclusively followed stereotypical notions of gender roles, suggesting that all women are open with emotion and that all men find emotional expression difficult.

Discussion

The identified themes of women's disclosure and awareness of mental health in opposition to men's unwillingness to admit to a problem, externalising the problem, delaying seeking help and using maladaptive coping methods, support previous research on gender roles that suggests that women are generally socialised to express and men to suppress emotion (Ducat, 2004; Kraemer, 2000; Rutherford, 1992; Seidler, 1997). However, the descriptions of gendered help-seeking behaviour are possibly overstated. In most cases participant responses were presented as comparisons between the behaviours of men and women, i.e. women X, men Y. Using such constructions may influence participants to overstate the homogeneity of help-seeking behaviour. The position that almost all participants

took was that women are more aware of and willing to disclose mental health concerns than men. Certainly not all women would recognise a mental health issue and immediately disclose this to someone close to them and/ or seek help. Similarly, not all men would exhibit behaviours which coincide with the practitioner descriptions discussed above.

One proposition arising from analysis of GP and mental health practitioner comments regarding gender differences is that characteristics associated with women (talkativeness and the ability to express emotion) are valued in psychological help-seeking. Researchers Broverman, Broverman and colleagues (1970) and Seem and Clark (2006) suggested that such attributes were employed by clinicians as indicators of women's health. Conversely, characteristics reported by those authors as valued signs of health in men were presented as problematic by participants in this study (i.e. independence, lack of emotionality etc.). In this study behaviours associated with femininity were valued as useful in help-seeking, whilst those associated with masculinity were considered problematic.

If, as Broverman, Broverman and colleagues (1970) and Seem and Clark (2006) argue, practitioners use different criteria to judge the health of men and women, is it reasonable to use the same criteria for judging mental health across gender? Authors such as Brownhill, Wilhelm and colleagues (2003) argue that the same standards should not be applied across genders because men experience mental illness differently from women and even show significant variation in symptoms.

The themes which have emerged in this analysis support those identified elsewhere. Practitioners in this study commented that men lack the mental health awareness of women (Brownhill et al., 2003; Cotton et al., 2006), are resistant to admitting they have a problem

(Smith et al., 2006) and likely to minimise (Kessler et al., 1999) and externalise symptoms (Werrbach & Gilbert, 1987) if they do present to care. Service providers should attempt to reduce the delay in men seeking help which would likely affect rates of alcohol, substance use, aggression and even suicide as men have a lesser need for coping methods due to receiving professional treatment. They should also note the stated dichotomy between the behaviour and attitudes of men and women and consider whether current services do or can address the needs of both genders.

5.4.3 Beliefs regarding gender differences in attitude towards psychological help

Question two asked participants “Do you think men’s attitudes to psychological help are different to those of women? If yes, in what ways?”.

Almost all participants believed that men’s attitudes to psychological help are different to those of women ($n = 60$). Of those that did not believe a gender difference exists, more were male than female. All female GPs believed there is a difference in male and female attitude towards psychological help, as did all female rural mental health practitioners.

That rural male GPs were the least likely to note a gender difference in attitudes to psychological help was striking. The choice of GPs in rural areas is limited. Further, there are many more male GPs in country South Australia than females (Hordacre, Howard, Moretti, & Kalucy, 2007). Research has shown that GP attitudes towards mental health affect diagnosis (Cape & McCulloch, 1999). This may suggest that a GP who believes that no gender difference exists in patient attitude to psychological help may negatively influence the patient’s ability to collaborate with them and indeed to obtain diagnosis and treatment. In the

case of rural men who have is little choice of GP, even a small number of male general practitioners holding such a belief could be significant.

Respondents were asked to clarify the ways they thought men and women's attitudes differed. Themes identified from their answers included 'expectation of self-reliance', 'rejection of weakness' (utilised by almost half of participants), 'men are reluctant', 'women emotional, men practical' and 'changing attitudes of men'. Mental health practitioners were more likely to refer to each of the identified themes than were general practitioners.

Male practitioners were more likely than females to draw on the themes 'rejection of weakness', 'men are reluctant' and 'changing attitudes of men'. Female practitioners were more likely to identify 'expectations of self-reliance' and 'women are emotional, men are practical' than were male practitioners.

Expectation of Self-reliance

Participants commented that men perceive there to be expectations that they are self-reliant and in control. These practitioners commented on men's internalised belief that they 'should', 'ought' or 'need' to fix their own problems without intervention from others. Slightly more mental health practitioners than general practitioners made reference to this theme. Respondents were equally likely to use this theme despite their rural or metropolitan location. For example:

Extract 178

...they ought to be able to fix it themselves. (Male metropolitan Psychologist)

Extract 179

Men, more commonly feel that they should be able to manage the mental health issues on their own without help. (Female rural GP)

Comments discussing the expectation of self-reliance communicate values of hegemonic masculinity (Connell, 2005). Within this paradigm men are expected to conform to characteristics of strength and independence. The hegemonic male does not need help from anyone because he is competent and capable.

Rejection of Weakness

Almost half of responses included references to men's rejection of weakness. Mental health practitioners were slightly more likely to utilise this theme than general practitioners. This theme is similar to the last in that men were characterised as managing their own masculinity by portraying and enacting behaviours consistent with hegemonic values. If a male was to seek psychological help this could be seen as 'failing' to be strong and self-reliant, and in that way displaying a weakness in his personality.

Practitioners noted that seeking help was seen as a weakness, failure, or incompetence, and men rejected this. Some made reference to men seeking to feel or seem strong or tough. However, the majority constructed their answer as a rejection of the unwanted rather than an adoption of the wanted. Comments indicated that men distance themselves from seeming 'whoosey' (sic), feminine, weak or a failure by seeking help. Examples of comments included under this theme are:

Extract 180

Seeking psychological help is seen as a character flaw; a weakness in the personality structure (Male rural Clinical Psychologist)

Extract 181

They think it is feminine to cry and show feelings (Female metropolitan GP)

Both this theme (rejection of weakness) and the previous (expectation of self-reliance) exist in opposition to help-seeking for psychological concerns.

Men are reluctant

Some respondents referred to men's reluctance to admit they have a problem and/ or to seek help. More mental health practitioners made use of this theme in their response than did general practitioners. This included somewhat more metropolitan than rural practitioners who suggested that men were reluctant to disclose a problem.

As was the case in responses to question one, men were characterised by participants as denying any problem or that they needed help. The reluctance of these men was sometimes characterised by concern about the judgement of others, reservation due to discomfort, or reflective of the belief that intervention is only required as a last resort. A large proportion of data coded under this theme simply stated that men don't want to seek help and did not provide further explanation. Examples of comments referring to men's reluctance include:

Extract 182

Men don't like conflict – put head in sand – women confront the problems.
(Male metropolitan Psychologist)

Extract 183

In general men are reluctant to seek help for anything. (Female rural Psychologist)

An image of the reluctant male client who rejects weakness and suffers under expectations of self-reliance is an emerging theme.

Women are emotional, men are practical

Some respondents made comments reflecting the theme that women are emotional and men are practical when it comes to mental health. This can be seen to reflect themes previously identified around gender differences in recognition of mental health concerns. More mental health than general practitioners utilised this theme, however, location of practitioner made little difference. Responses coded under this theme included references to women's tendency to talk about or identify their feelings, as well as men's difficulty with emotion and preference to focus on practical orientations.

As was the case in responses to the last question, participants described men as poor communicators who are hesitant to talk about their problems. Men were described as more focused on outcomes and practical changes than discussing the problems themselves. This was contrasted with women who were implied to be focused on the problem and wished to discuss this with others. Practitioners suggested that men were pragmatic, wanted things to be

fixed in a short amount of time and were unlikely to be happy with being asked to talk about the problem because they simply wanted practical changes to solve it. For example:

Extract 184

men don't believe talking helps. Need to be more practical. (Female metropolitan GP)

In contrast, descriptions of women portrayed them as more collaborative and interactive with the practitioner. An example of this comparison is:

Extract 185

Women are happy to talk talk talk men want to do and act. (Female metropolitan GP)

These practitioner perspectives of men and women's conflicting orientations around mental health suggest that gender differences in attitudes towards psychological help are significant and may impact not only on the male's help-seeking, but also on treatment and recovery should help-seeking occur.

Changing attitudes of men

A number of participants described men's attitudes as 'changing'. This referred to changes in the attitudes of men in general over the years as well as changes in attitude within individuals over the course of their illness. Little difference existed between groups (mental health practitioners and GPs or rural and metropolitan practitioners) in the use of this theme.

Some practitioners noted that men's attitudes towards seeking psychological help had become increasingly positive over the years. These comments suggested that in the past men were less likely to seek psychological help than they are today, or that they are now able to express their need more clearly. For example:

Extract 186

...over the past 5 years I have noticed more men presenting in an upfront way i.e. I'm an alcoholic or I'm depressed. Women continually vocalise these issues quicker than men. (Male rural GP)

Other participants noted that men's attitudes tend to change once they are in contact with mental health services. An example of this follows.

Extract 187

...Usually happy once they attend. (Male metro Psychologist)

Extract 187 suggests that after becoming engaged in therapy a man's cognitions change to be more in concordance with the behaviours he is enacting. This could be seen as a balancing of cognitive dissonance (Festinger, 1957), or simply as men gaining a better understanding of psychological issues.

Discussion

The majority of practitioners believed that differences exist between men and women's attitudes to psychological help. Responses described men's attitudes to psychological help as more negative than those of women, as has been the case in previous

research. The themes identified suggest that hegemonic masculinity, a practical orientation and a tendency to transform over time separate the attitudes of men from those of women.

Psychological research suggests that attitudes are significant influences on behaviour (e.g. Conner & Heywood-Everett, 1998; Fedaku & Kraft, 2002; Skogstad et al., 2006). For example, the theory of planned behaviour (TPB, Ajzen, 1980) posits that behavioural, normative and control beliefs ultimately predict behaviour. That is, beliefs about the behaviour (whether it improve a situation), the normative nature of the undertaking the behaviour (whether others would undertake the behaviour or support people undertaking it) and control (what control one has over the behaviour) predict behavioural intention. Further, TPB theorises that intention is the best predictor of behaviour. In this instance, if men's attitudes are influenced by understandings of masculinity that prize self-reliance, regard seeking psychological help as admitting weakness, and associate it with shame and discomfort, theory such as TPB warns that it is unlikely that these men will seek help. The emergence of such attitudes supports previous research (Smith et al., 2006) and suggests that these are significant issues for men.

Consistent with the previous findings of Werrbach and Gilbert (1987), practitioners in this study asserted that whilst women are happy to discuss their emotions and problems, men want a focus on practical, goal driven, quick changes in therapy. The role of service providers is to acknowledge the possibility of this difference in orientation and respond to it by providing services appropriate to each gender. By offering therapy that addresses men's favoured approach and making this known through advertising and education, it is possible that men's attitude toward psychological help could be improved.

The themes identified regarding gender differences in attitude towards psychological help suggest that in order to change men's attitudes we may need to challenge their understandings of masculinity, to broaden the repertoire of behaviours considered 'acceptable' as well as to educate men to confront their own reluctance to discuss mental health. This engagement of men in a dialogue around mental health and psychological help-seeking may prompt the process of change in attitudes which the theme 'changing attitudes of men' indicates may already be slowly occurring.

5.4.4 Referral factors

Question three asked participants "How are the majority of men with mental health concerns referred to you (e.g. self-referred, GP, spouse, colleague)? In what ways, if any, does this differ from how women with mental health concerns are referred to you?".

GPs indicated that the most common referral source for male clients with mental health concerns was self referral. Not surprisingly, mental health practitioners reported that GPs were their most common source of male client referral. Both GPs and mental health practitioners noted that spouse was also a relatively common source of referral. More metropolitan than rural GPs noted the role of spouse in referral for men. A few mental health practitioners identified that their clients were referred from the workplace, the hospital or forensic system. All participants responded to this question, although fewer made further comments regarding gender differences ($n = 44$). Some participants indicated that no gender difference existed in referral source, whilst a further few did not respond to this question.

Women self refer

Roughly half of respondents indicated that women are likely to 'self-refer'. Similar numbers of mental health and general practitioners suggested that women self-refer to their services. Substantially more female practitioners than male practitioners responded in this manner. A small difference was also found to exist between locations, with more metropolitan than rural practitioners making reference to this theme.

No reference was made to men self-referring. Practitioners described women as 'much more likely' than men to refer themselves to a GP or mental health professional for psychological concerns. Some participants commented that women were more likely to have discussed their issue with friends or family. Another noted that women were more likely to come alone rather than with their spouse. An example of comments coded under this theme is:

Extract 188

[women] usually ring me for an appointment directly, whereas men rarely do (Female metro Psychologist)

Data coded under this theme was highly homogenous. Each of the responses coded under this theme suggested that women were more likely to self-refer than men. This suggests that this theme reflects the experience of many GPs and mental health practitioners and is therefore likely to be generalisable to a larger population.

Men are prompted

In contrast to the theme of women self-referring, men were characterised as being prompted by others to seek help. This group of respondents noted that men's spouses or partners commonly refer them to GPs and mental health services. Substantial differences were noted in the use of this theme in terms of occupation and location. General practitioners were more likely than mental health practitioners to note that men are prompted to attend their services. Rural practitioners were considerably more likely than their metropolitan counterparts to refer to this theme.

A number of participants used language which reflected resistance from men to follow prompting. Comments included descriptions such as 'pushed', 'dragged', 'pressure' and 'urged', suggesting that the men involved are reluctant to follow the advice provided. Indeed, this language suggests that the men are actively defiant and unwilling to attend. This refusal to seek help is presented as likely to continue until men are 'dragged' to a service or a crisis occurs. An example of comments coded under this theme is:

Extract 189

Most men are referred by their spouse. Others say when they come in "I'm here because my wife sent me" (Male rural GP, interview)

The emergence of this theme implies that men may not take responsibility for their own mental health, preferring to lay the impetus for seeking help with others. Again, this theme consisted largely of data referring to men and not women. Whilst a few comments existed referring to women, these were consistently in opposition to those of men. Women were described as sometimes referred by family or friends, but such instances were presented

as evidence that they had discussed their issues with these people. Women were also characterised as attending at lower levels of dysfunction (i.e. accessing services when they are not dramatically ill). Men, on the other hand, were portrayed as unlikely to discuss their mental health with anyone other than their spouse or mother.

Discussion

Themes identified here suggest that significant differences exist in the way men and women are referred to GPs and mental health practitioners for psychological concerns. Further, amongst practitioners that believe differences do exist in referral source between genders, there is much agreement as to the form of those differences. Most of these practitioners suggested that women are more likely to self-refer whereas men required a prompt to seek psychological help.

It is likely that men's reluctance to seek help would benefit from education regarding mental health disorders and treatment. However, the themes identified in this data suggest that publicly acknowledging the role of women, family and friends around men with psychological problems and making this more visible is likely to both give these (often female) prompters confidence in intervening and improve outcomes for men. As has been suggested by Cusack, Deane and colleagues (2004), improving the knowledge of those close to men in terms of when and where to go for help could facilitate increased help-seeking for men.

5.4.5 *Barriers to men seeking psychological help*

Question four asked participants “What factors do you think may make men less likely to seek help for mental health problems?”.

Themes that emerged from data discussing factors which may make men less likely to seek help were ‘masculine expectations’ and ‘fear of expressing emotion’. The ‘masculine expectations’ theme encompassed sub-themes of ‘socialisation’, ‘self-reliance’, ‘rejection of weakness’ and ‘work role’. ‘Fear of expressing emotion’ comprised of the sub-themes ‘hesitancy to engage with emotion’, ‘stigma’ and ‘denial’. Overall participants were most likely to refer to ‘masculine expectations’.

Masculine expectations

As has been the case in responses to earlier questions, participants identified a number of themes associated with masculinity that may make men less likely to seek help for mental health problems. In this case these included the sub-themes ‘socialisation’, ‘self-reliance’, ‘rejection of weakness’ and ‘work role’. The most commonly utilised sub-themes were ‘rejection of weakness’ and ‘socialisation’, with ‘work role’ the least frequently employed. Each sub-theme is discussed in turn.

Socialisation

Data coded under socialisation reflected concepts of society, community, stereotypes, acceptability and gender. Many participants discussed the notion of men being brought up not to engage with their feelings or to talk about particular topics. Substantially more mental

health than general practitioners utilised this sub-theme. The group that identified the role of socialisation most frequently was metropolitan mental health practitioners.

Practitioners implied that the kind of masculinity in which men in Western society are socialised is incompatible with help-seeking. References were made to stereotypes, gender and unacceptability of operating outside the boundaries of hegemonic masculinity. For example:

Extract 190

Not cool! Not seen as 'acceptable' health issue for a man (Female rural GP)

Participants clarified that societal expectations regarding masculine behaviours were internalised through cultural conditioning. Men were described by practitioners as enacting expectations, norms, ideals, roles, and stereotypes reflecting the dominant paradigm of masculinity. Respondents suggested that these concepts stemmed from society, family, culture, history, community, or the Australian context. For example:

Extract 191

Gender conditioning/ stereotypes (Female metropolitan Psychologist)

The responses coded under this theme argued that socialisation informed by hegemonic masculinity is an obstacle for men in seeking help for mental health problems.

Self-reliance

Data coded under self-reliance reflected a want, need, or expectation of independence, of not relying on others or the belief one 'should' be able to deal with one's own problems. Similar rates of response were recorded for all groups. Examples of comments coded under self-reliance include:

Extract 192

Notion that men are 'supposed' to be strong, independent and self-sufficient (Male metropolitan Psychologist)

Extract 193

Men must be strong and silent and bear it (Male rural GP)

As mentioned earlier, the desire to be autonomous was noted as existing in opposition to help-seeking behaviour.

Rejection of Weakness

Concepts of strength and frailty were coded under the sub-theme weakness. Many practitioners made use of these notions in their answer. Metropolitan mental health practitioners were considerably more likely than other groups to discuss this sub-theme.

The rejection of weakness has arisen as a theme in response to previous questions. As discussed above, men were portrayed by participants as distancing themselves from judgements of weakness by denying the need for help. Clearly such attitudes impact on the likelihood of help-seeking, as indicated in the following responses:

Extract 194

Construction of help-seeking as weakness (Female metropolitan GP)

Extract 195

They see it as 'weak' and not their role. Rather abuse substances or suicide (Male metropolitan Psychologist)

Practitioners suggest that men consider mental health to be something which should remain undiscussed. In Extract 195 the worker is suggesting that men would prefer to undertake maladaptive coping methods consistent with the traditional male role rather than seek psychological help. Participants indicated that to require help within this hegemonic masculine paradigm is to be deemed vulnerable and inadequate. Help-seeking is not endorsed as behaviour enacted within traditional masculinity. Therefore in order to protect one's status as a strong male, help-seeking and the associated helplessness are rejected.

Work Role

A small number of participants felt that men's work roles may make them less likely to seek psychological help. Data which referred to income, work, time or routines were included under this sub-theme. Rural mental health and metropolitan general practitioners were most likely to draw upon work themes in their response. Metropolitan mental health practitioners were the least prone to mentioning the work role. Men were much more likely than women to make reference to this sub-theme.

Some participants located suggestions about the restrictive nature of work within a masculinity framework. These respondents noted that men were required to fulfil the role of the provider and thus not to take time off to seek psychological help. For example:

Extract 196

Love for their families, seeing their income earning as a linchpin for the family. Not wanting their family to suffer. (Male rural Social Worker)

Other practitioners made similar comments by suggesting that men did not have time available for help-seeking. Sometimes practitioners made it explicit that this was due to work commitments, whilst others implied this was the case.

Extract 197

Too busy – work, life (Male metropolitan GP)

Fear of expressing emotion

Men were characterised by participants as fearful of expressing emotion. Practitioners utilised sub-themes reflecting beliefs that men were ‘hesitant to engage with emotion’, concerned about ‘stigma’ and commonly ‘denied’ that they have a problem. Whilst each of these categories can be influenced by the others, it is pertinent to highlight the features of these categories individually. The interaction between the groupings is emphasised by locating denial, stigma and hesitancy to engage with emotion as sub-themes under the broader theme of ‘fear of expressing emotion’. Each sub-theme is discussed in turn.

Hesitant to Engage with Emotion

Some respondents made reference to communication as a barrier to men seeking help for mental health problems. Rural mental health practitioners utilised this sub-theme the most and metropolitan general practitioners did so the least.

Responses were coded under this sub-theme commented on men's emotional awareness, difficulty engaging with their own emotion or discussing this with others. Practitioners suggested that men were poor at identifying their own emotions and acknowledging them, even to themselves. Observations by participants included that men felt uncomfortable, fearful, and unaccustomed to communicating their feelings. Some respondents simply stated that men do not discuss these things, whereas others focused on a lack of interpersonal support or understanding about mental health that they see as negatively affecting men. Examples of such comments include:

Extract 198

Not used to telling others about thoughts and feelings (Male rural Mental Health Nurse)

Extract 199

Emotional retardation (Male metro GP)

Extract 200

Less support networks among men. Less communicative – system structure is based on talking... (Female rural GP)

These comments suggest that practitioners have experienced their male clients' hesitancy to engage in dialogue regarding mental health. Further, these remarks propose that this hesitancy makes men less likely to seek help for mental health concerns. If men are unwilling to engage with their emotions and see seeking help as a process through which they are expected to discuss them, it is could be expected that they would choose not to seek help.

Stigma

Some respondents employed the sub-theme of stigma in their comments. More mental health than general practitioners mentioned stigma, as did slightly more females than males. Data coded under this sub-theme made reference to stigma, concerns about the attitudes of others or concerns regarding one's own self-image or self-esteem.

More than half of the responses coded under this sub-theme simply stated that stigma made men unlikely to seek psychological help without providing any further explanation. For example:

Extract 201

Perceived stigma (Female rural GP)

The remaining data made reference to the attitudes of the work colleagues, the community, society and other men as stigmatising to individuals with mental illness. Men's pride, self-esteem and social standing were noted as being placed in jeopardy if they sought psychological help. One practitioner noted that concerns about confidentiality were significant, and another argued that men are scared of the social ridicule that would follow if confidentiality was broken. He wrote:

Extract 202

Fear of social ridicule if others find out they have been to a counsellor
(Male metro Psychologist)

These comments suggest that men are concerned about the consequences of stigma surrounding mental health and that this is a substantial barrier to them seeking help.

Denial

Denial is another theme which has reoccurred throughout this analysis. In response to this question some practitioners suggested that denial of mental health problems is likely to make men less likely to seek help. Rural mental health practitioners most frequently made reference to this sub-theme, with other groups drawing upon it at similar rates.

Data coded under denial reflected a refusal to admit a problem existed, attempts to diminish the size or impact of the problem, a lack of insight or denial. Examples of comments coded under this theme include:

Extract 203

The belief that the problem will go away (Male metro Psychologist)

Extract 204

Men tend to downgrade their problems (Male rural GP)

Denial can be seen as a tactic applied by men in order to avoid attending to their issues. This could reflect avoidance not only of the problem itself, but of the negative affect with which it is no doubt associated. In this way denial can be seen as the evasion of attending to or the expression of emotion.

Discussion

The themes which emerged from responses to question four (“What factors do you think make men less likely to seek help for mental health problems?”) suggest that men try to live up to expectations of hegemonic masculinity and are fearful of expressing emotion.

Practitioners suggested that these characteristics impede men's help-seeking for mental health problems.

Definitions of hegemonic masculinity provide very narrow guidelines as to what behaviours are 'acceptable' for a man. Practitioners frequently referred to the restrictive nature of this paradigm. Notions of problematic socialisation implied that had men been brought up differently they may have better attitudes towards seeking psychological help. Most participants indicated a belief that men are taught not to be the sort of person that asks for help. This was reflected in the sub-theme of self-reliance, where men felt that they 'must' be independent and 'should' not rely on others. Respondents noted that help-seeking had been constructed for and by men as a behaviour which indicated weakness. As such men worked to reject this label, actively trying to adopt the opposite quality of strength. Adopting these features of strength and independence carries over into the valuing of the work role. Practitioners signified the importance of the male role as provider by submitting that men do not have time to seek help, or that to do so may impact on their family's finances.

Practitioners suggested that the role of masculine expectations in the decision for men to seek help for mental health concerns is significant. The number and content of the sub-themes identified demonstrates that it is likely that much work will need to be undertaken in order to break down this barrier to men's help-seeking.

Similarly, fear of expressing emotions encompassed a number of obstacles to men seeking help. It was noted earlier that intervention should encompass not only why men are hesitant to engage with their emotions, but what service providers can do to facilitate this process. Men's hesitancy is likely to be caught up in notions of the 'rules' of hegemonic

masculinity and the association of mental health with 'weakness'. This would locate the focus of change in transforming men's very ideas about what it is to be male. Whilst this is likely to be an important avenue to pursue, the role that services have in changing men's attitudes and behaviours should not be disregarded. Men's expectations of the requirement to express emotion in therapy could perhaps be modified through wider dispersal of information. Further, it may be the case that some practitioners are emotion-focused in therapy with men that are fearful of this style. Therapists might need to use a more practical, goal oriented style to better match this fear of emotion that participants described.

Practitioners further noted that men were concerned about stigma and the social consequences of seeking help. Perhaps in response to this and their fear of expressing their own emotions, participants noted that it was common for men to deny their problems.

When considering the sub-themes which have emerged from this data, the low rate of men seeking help for mental health concerns is not surprising. According to the practitioners surveyed, to engage in help-seeking would suggest that a man may leave himself open to criticism as being feminine, dependent, weak, unsupportive of his family, and to being ridiculed. These barriers are each significant and robust; together they seem overwhelming.

5.4.6 Facilitators to men seeking psychological help

Question five asked participants "What factors do you think may make men more likely to seek help for mental health problems?".

Three major themes emerged from responses to this question. The most common of these was 'education', followed closely by 'support from others'. A theme suggesting that men seek help as a 'last resort' was also identified by a number of participants. Mental health practitioners were most likely to use the theme of last resort, whilst GPs primarily used the themes education and support from others. Little gender difference existed across use of themes.

Education

Data coded under education referred to education, information, and media campaigns intending to increase knowledge, mental health literacy or normalising mental illness. Almost half of participant responses referred to the theme of education. Metropolitan mental health practitioners were the group most likely to refer to this theme in their response. Only very minor differences in the use of this theme existed across gender and professional.

Some comments stated that education was likely to make men more likely to seek psychological help without giving any further explanation. Others suggested that education through schools and the media could increase the likelihood of men seeking help. These participants referred to utilising television, internet and print media in media campaigns and public announcements. Some respondents suggested that information be presented at men's health nights, in social group settings and public forums. For example:

Extract 205

Education via media from birth – school. Men's health night where realised not weakness to seek help (Female rural Social Worker)

A number of practitioners recommended the use of role models such as sporting figures stars and politicians to normalise mental illness. The intent behind the use of celebrities and other avenues of education is to normalise and de-stigmatise psychological concerns. One example of this follows.

Extract 206

More campaigns on TV, radio, magazines, internet. Word of mouth. More celebrities owning up to mental health problems. (Male rural GP)

References were made to the Australian government's depression initiative *beyondblue* which is perhaps the most visible mental health organisation in Australia. Some practitioners suggested that more programs like those produced by *beyondblue* would be useful, whilst others commented that they believed this approach had been particularly successful in the past. For example:

Extract 207

Public (preventative) primary health campaigns (e.g. Beyond Blue) local consciousness-raising health information projects (Male rural Clinical Psychologist)

All of the means of education mentioned in the data referred to broad, population level dissemination. Ideas about media campaigns dealt with men on a group level.

Support from others

Practitioners identified support from others as an important facilitator to men seeking psychological help. Metropolitan GPs were the most likely of all occupation/ location groups

to utilise this theme, whilst rural GPs were the least likely. Little difference existed across gender or occupation.

Data coded under support from others referred to intervention by or relationships with friends, family or practitioners. Respondents discussed the role of practitioners, friends and family as essential to men seeking help. The role of women was specified by a number of participants, sometimes referring to men's partner, spouse, or mother as well as other men. An example of such a comment is:

Extract 208

Existing relationship with health professional. Guidance from female in life
(Male metro GP)

Language such as 'approachable', 'supportive', 'good rapport'/ 'relationships', 'respect' and 'trust' was prominent throughout data coded under this theme. Support from others refers to a number of positive aspects of men's interactions. These responses emphasise the role that others and men's relationships play in their behaviours. Practitioners noted that the modelling of others, support and encouragement to seek help is significant in men's decision to seek help. Some highlighted the role of practitioners themselves in remaining open to diagnosis and referral of men for mental health concerns, along with the importance of remembering to ask specifically about troubles in this area. For example:

Extract 209

Supportive family and friends...GPs who ask about mental health as a matter of course, not waiting for this to be raised (Female rural Trainee Psychologist)

Again, mention was made of the need to normalise both interaction with the practitioner and mental health help-seeking in general. Participants noted the role that the encouragement of friends and family had in making help-seeking acceptable to men.

Last resort

The final theme that emerged from responses to this question was that of help-seeking as a last resort. In data coded under this theme, men were described by some practitioners as seeking help only when no other option was available to them. Considerably more mental health practitioners than GPs employed this theme. Metropolitan mental health practitioners were the most likely of all groups to refer to last resort; males were more likely to do so than females.

Responses coded under the theme 'last resort' referred to crisis, legal, relationship, work or other significant life problems or suicidal ideation. These comments portrayed men seeking help as having tried other ways of coping which had failed and that help-seeking from a professional meant that they were out of options. Men's help-seeking from a professional was seen by these practitioners as only utilised as a last resort rather than something which was accessed freely. Comments coded under this theme suggested that in the case of seeking help as a last resort something was blatantly wrong that the male could no longer ignore, conceal from others or cope with alone. An illustration of the types of comments coded under this theme is presented below.

Extract 210

Last resort when all avenues of self-preservation exhausted. (Female rural Mental Health Nurse)

Practitioners who utilised this theme suggested that for many men the only sign that would make them seek help was the development of some kind of external crisis. Many referred to actual or threatened loss of relationship or employment or legal problems. For example:

Extract 211

Threats by spouse e.g. to leave the relationship. Job security is affected by the problem. Any other external factor (e.g. financial, social etc) impact
(Female metro Psychologist)

These responses suggested very practical changes in a man's life that may serve as indicators that they could not continue on their own. However, the notion that psychological help is a last resort for men is worrying. Where men only consider seeking help when their relationships break down, they lose their job or become suicidal there may be no opportunity to prevent such occurrences by earlier intervention.

Discussion

The frequent use of the theme 'education' and the similarity of data within it suggest that there is a reasonably high level of agreement that education is likely to improve men's help-seeking for psychological problems. This can be seen to reflect and support findings in the literature that suggest that higher levels of mental health literacy are associated with greater help-seeking behaviours (Jorm et al., 1997). Despite only one participant using the phrase 'mental health literacy', the use of 'education' in the data can be seen as commonly referring to the concept by mentioning a knowledge and understanding of the signs, symptoms and prevalence of mental illness as well as a familiarity as to where to seek help.

As mentioned in the analysis of the 'education' theme, practitioner proposed interventions were focused at a population level. It is significant that this finding was unanimous amongst those who discussed how education could be disseminated. This may be reflective of themes identified earlier in this chapter. That is, practitioners' beliefs that men are uncomfortable discussing mental illness and much prefer externalised problems and modes of treatment. However, when considering the themes that have emerged so far, one must ponder whether this kind of arm's length education would be useful for the type of man who denies that he has a mental health issue. Respondents clearly believed that men do not acknowledge, perhaps even to themselves, that they have a psychological problem. Therefore one might question whether this type of individual would pay attention to information that he believed was not applicable to him.

Maintaining this suggestion that interventions surround men rather than target them is the emergence of the theme 'support from others'. In a similar way to the earlier finding that men are commonly prompted to seek help, this theme suggests that the relationships between men and their practitioner, friends and family are crucial to a man's decision to seek help. This theme can be seen to locate impetus for help-seeking with those surrounding men rather than with the men themselves.

If this theme of support from others is combined with the previous one regarding education, it would seem that this education may need to be concentrated on the women around men who are in need of mental health services. This supports earlier work by Cusack, Deane, et al. (2004) which highlights the central role that women take in the help-seeking behaviours of men.

Research showing that men are slow to acknowledge mental health problems and to seek help (Lee & Owens, 2002) supports the suggestion by practitioners that men seek help only as a final option after others are exhausted. The theme of men seeking help only as a 'last resort' is also reflective of previous findings in this chapter. The theme of denial was earlier determined from practitioner responses. The theme identified here supports the notion that men are likely to initially deny the need for psychological intervention. In responses to this question participants have suggested that, possibly after an initial period of denial, men will only seek help as a last resort when some kind of crisis occurs.

One could argue that this kind of conceptualisation is reflective of the view that hegemonic masculinity and gender-role conflict are inhibitive for men in psychological help-seeking. Where a man initially denies he has a problem, eventually circumstances change in a way that allows him to acknowledge that he cannot continue on his own. This theory would suggest that the level of functional impairment by the time of crisis is such that the male feels that his concerns are obvious and as such will not be judged negatively by others. In this way the male could feel justified in his help-seeking and believe that others will see his help-seeking as legitimate. 'Legitimate entry' has been described as gaining access to mental health services in a way that causes the least possible damage to the masculine identity (Heifner, 1997). Certainly if a male delays help-seeking until there is a need obvious to others he is likely to preserve some masculine identity because he will have legitimised his need for services.

As mentioned above, if men wait until crises occur and then seek help as a last resort, the chance to engage in preventative intervention and save much distress is severely hindered. Many international studies support this notion of men seeking help as a last resort, if at all

(e.g. Griffiths, 2004). Suicide rates for men are four to five times those of women across western countries (Goldney, 2006), suggesting that these men are not receiving appropriate (if any) care. If there is some way to intervene earlier in the development of men's mental illness this may have some impact on these disturbing statistics.

5.4.7 Improving men's psychological help-seeking

Question six asked "What do you think could be done to increase men's help-seeking for mental health problems?".

An overwhelming majority of practitioners identified the theme of 'education' in response to this question. A smaller number of practitioners made reference to service issues.

Services

Some participants made reference to service issues as factors which could increase men's help-seeking for mental health concerns. Considerably more mental health than general practitioners applied this theme. Further, more rural than metropolitan practitioners suggested that service issues might have some influence. Little gender difference existed in utilisation rates of the 'services' theme. Within responses coded under 'services', the sub-themes of 'access', 'gender specific services' and 'practitioner approach' were identified. Each is discussed in turn.

A small number of participants proposed that issues to do with service 'access' such as cost, opening hours and the like could be changed to increase men's use of services. Financial

issues were central to this notion. Practitioners suggested that reducing the cost of services would mean that they were more accessible to men. Examples of such comments include:

Extract 212

Reducing costs (easier access, less financial costs, more availability etc)
(Male metro Psychologist)

Other respondents argued that gender specific services are needed for men. Comments coded under this sub-theme discussed men's groups, treatment and services as distinct from those aimed at women. Practitioners suggested that programs such as men's health days or nights, male friendly information and services would be useful in making mental health more accessible for men. For example:

Extract 213

More programs like men's shed etc (Female metro GP)

One respondent suggested that having too few male workers in the area of men's health was an issue. He reported:

Extract 214

I believe we need men/ working with men. There are just too many women involved in Men's Health and not enough qualified men. National problem.
(Male rural Mental Health Nurse)

In making statements advocating for gender specific services practitioners indicate that there must be intrinsic differences in the health behaviours of men and women.

A small number of participants discussed the centrality of practitioner approach in increasing men's help-seeking for mental health concerns. This included comments regarding men's perception of workers. For example:

Extract 215

By having well know [sic] contact people who they think are OK (Male rural Mental Health Nurse)

Others proposed that practitioners should increase familiarity with mental health by ensuring to ask explicitly about concerns in this area when seeing male clients, encouraging men to share their experience or seek help. An example of this is:

Extract 216

Increase identification of men at risk during routine consults (Female metro GP)

Participants referred to the need for practitioners to be more 'open' with discussions about mental illness and providing an environment where men feel safe to disclose. One suggested that the role of the worker in the interaction was to give the man 'permission' to talk about his problems.

This idea that practitioners authorize a man to discuss mental health difficulties is supported by previously identified themes regarding men's hesitancy to discuss problems, concerns about stigma, and perceptions of weakness. It follows that if male clients see their practitioners as respected people who are comfortable with emotion and who not only openly

sanction but actively seek discussions around mental illness, this could be interpreted by men as permission to disclose their own troubles.

Education

Most respondents indicated that ‘education’ was likely to make men more likely to seek psychological help. The group that most commonly cited education as important was metropolitan mental health practitioners, with rural general practitioners and rural mental health professionals equally least likely to identify the role of education. Female practitioners made reference to education considerably more than did male practitioners.

The theme ‘education’ encompassed notions of ‘how to educate’ and ‘what to educate about’. Half of the participants in this study commented upon ways in which information could be dispersed that they believed would make men more likely to seek psychological help.

As was the case for question five, a number of participants simply stated ‘education’ to indicate that this was central to increasing men’s help-seeking. However, most went on to elaborate. Of these more specific responses, there was a clear differentiation between those who made a case for the use of media and those who discussed other types of educational programs.

Practitioners referred to media in terms of advertising, or specific types of media including television, radio, internet campaigns. Practitioners focused on type of advertising

(i.e. positive, directed at men), campaigns (i.e. national, through *beyondblue* (2006), on television, radio, internet) that they believed would be useful. For example:

Extract 217

More public forums, media exposure etc (Female rural GP)

The focus of these responses is at a population level. Practitioners who argued for the effectiveness of media use seem to suggest that making men's mental health more visible may increase help-seeking. Participants who mentioned other forms of education tended to focus on more of a community level. For example:

Extract 218

Increasing education/ awareness at work and in social group settings
(Male rural Social Worker)

This type of response provided quite variable data. Some practitioners suggested that education take place in social, sporting, or informal settings, whilst others made a case for school or work environments. In both of these cases practitioners contend that education should be implemented at a more local level than those referring to media campaigns.

The majority of practitioners who utilised the theme 'education' made suggestions about what type of education that they believed would be useful for men. This included specific suggestions about skills, strategies and knowledge that could be imparted, along with combating stigma, normalising mental illness and providing men with role models.

Skills which were highlighted for development by men included communication, conflict and stress management, and knowledge about the signs and symptoms of mental illness. The majority of responses which proposed a focus on education referred to knowledge about mental health and normalising of mental illness. Respondents stated that men needed to be educated about the prevalence of mental illness as well as the likely symptoms and prognosis.

Comments which proposed the need to normalise mental illness underlined the need to convey to men that this is an ordinary concern. Responses called for the communication of the message that ‘we are all’ struggling to cope with stress in our lives and that ‘everyone’ is at risk of collapsing under the pressure. In order to normalise mental health disorders, practitioners suggested both that societal attitudes and stigma be addressed. A handful of remarks included references to changing society and community attitudes. One example of this is:

Extract 219

More supportive attitude, non critical and non-judgemental from society and medical people (Female metropolitan GP)

Further, a number of participants made specific references to de-stigmatising mental illness. These participants argued that there is a need to sanction help-seeking through normalising rather than pathologising mental illness.

Extract 220

Giving them permission to present with psychological symptoms with no stigma, and to repercussions on employment. (Male rural GP)

Participants argued that men should be made aware of both the common nature of psychological disorders and some specific points. These include the length of mental disorder (i.e. that it may not be permanent), the clarifying the process of help-seeking and treatment, discussing the (possibly limited) role of medication, and confidentiality of interactions and treatment. One practitioner advised that men be given a 'map' of problems and what to do about them as a means of providing information

This proposed need for improved mental health literacy amongst men may reflect practitioners' beliefs that some men may have unrealistic ideas about mental illness, the prospects for recovery and the types of treatments available. A significant number of those making reference to type of education suggested that raising awareness amongst males would improve their help-seeking for mental health concerns.

One practitioner noted the importance of educating those around men. As was discussed in responses to question three, partners and friends often influence men to seek help. A male psychologist working in the metropolitan area suggested that education should focus on these important sources of information and referral around men. He noted that by improving the mental health literacy of those around men we might both improve their accessibility of information and increase their likelihood of seeking help.

Similarly, participants documented the need for ongoing education for general practitioners regarding mental health. These comments suggested that in order to encourage men to discuss their problems general practitioners need to be well informed about the issues involved. One of the participants went further, implying that general practitioners sometimes

(perhaps unintentionally) collude with male patients by adopting their 'she'll be right' attitude and conform to the expectations of masculinity which have been discussed previously.

Another way that practitioners recommended that education be dispersed was through the use of role models. A number of participants referred to the use of exemplars of acceptance and help-seeking for mentally ill men. Responses were coded under this sub-theme if they mentioned celebrities, sports stars, personalities or role models in conjunction with concepts of mental illness and/ or education.

Practitioners proposed that men in the public eye who admit they have mental health problems are valuable in improving men's help-seeking. Responses suggest that these men are role models for others and give men the sense that it is acceptable to acknowledge mental illness. The types of men discussed as role models included sporting figures, television and film personalities, public figures and celebrities. Some respondents named individuals who have taken part in informational campaigns about mental illness in the past, including Gary MacDonald (entertainer), Jeff Kennett (former politician), Ken Eustice (former footballer) and Kenneth Branagh (British actor). No gender neutral comments or references to women were made in data coded under role models. This may suggest that practitioners believe that there is something different about male role models than female ones which make them more valuable in reaching men.

One rural general practitioner referred to another kind of role model. It is notable that this individual was the only one (at least in response to this question) to make reference to a role model other than a public figure. This practitioner suggested that role models exist within the family, not just within the media. He revealed that he actively suggests to his male

patients that they provide a role model for their children by bringing their sons to the doctor with them. The GP noted that with this practice boys grow up seeing their strongest role model (their same sex parent) in contact with health services. In this way interactions with the health system are normalised rather than pathologised. He reported:

Extract 221

I suggest when men come in to see me that they bring their son along in the same way that they come with their mothers, so that they see that men do go to the doctor. I think that kids learn by example, so to see that, and to grow up with it, they feel more comfortable. (Male Rural GP, interview)

Role models are presented as examples of men at once being both masculine and successful along with having a mental illness and seeking help for their concern. This presents men with evidence that contradicts the boundaries of hegemonic masculinity. If men respect the male role model they may be forced to consider their attitudes around what role mental illness plays in a man's identity.

Discussion

In response to the question what is likely to improve men's help-seeking for psychological concerns, practitioners overwhelmingly responded with discussions regarding education. Almost a third also referred to service issues.

It seems that practitioners believe that improving access to services (including opening hours and costs), providing gender specific services for men and attending to practitioner approaches could improve men's help-seeking. These are interventions that could be undertaken irrespective of men's historical reluctance to engage with mental health services.

As such it may be useful to carry out these changes in service factors and evaluate any changes in men's experiences.

The most common response to this question was to do with education. Practitioners suggested ways of educating men, through directed campaigns in the media or men's health nights and men's groups. As noted earlier, focus on media campaigns is directed at a population level. It could be argued that this approach does not take into account the heterogeneity between men. A focus on the wide dispersal of information may not target men specifically enough that they will pay attention. As has also been identified in responses to earlier questions, men tend to deny that they have a problem. If they are denying the issue to themselves as well as others, viewing broad media campaigns about mental health may not seem relevant to them. If men do not see the relevance of the information presented it is unlikely that they will be attentive or be prompted to take any action. This suggests that the content and implementation of media campaigns should be carefully considered so that the focus remains on those in most need. Otherwise those men most in need of information may not consider it relevant to them and not pay attention.

The theme of education emphasized the need for mental illness to be normalised and de-stigmatised. Participants also highlighted the function of role models in modelling and sanctioning help-seeking behaviour for men. Many noted that public admission by male celebrities that they have suffered from mental illness gave men permission to admit to their own concerns whilst maintaining a masculine self-image which otherwise may have been challenged. The proposal that role models may positively influence men follows earlier work which advocates for the use of recognisable public figures or men that the public can relate to in promoting the message that other men do seek help (e.g. Rochlen & Hoyer, 2005). This

approach has been utilised in the United States' *Real Men. Real Depression.* campaign and received encouraging feedback from evaluators (Rochlen et al., 2005) as well as by Australia's *beyondblue* (2006).

These themes highlight ideas for improving men's help-seeking identified by those actively working with mentally ill men. Whilst the service factors and education may not seem to establish substantially new pathways to connecting with men, details within these themes reflect directions in which positive moves can be made. These include making small changes in service delivery, aspects to consider when approaching population based media strategies, the importance of familial as well as celebrity role models in admitting and seeking help for mental illness, and the continuing need for mental health literacy education.

5.4.8 Issues of importance for rural men

Question seven asked "What issues do you think are of particular importance to *rural* men with mental health concerns?". Four themes were identified in response to this question. The theme 'service factors' was mentioned substantially more than others, followed by 'confidentiality' concerns, 'work factors' and 'isolation'.

Data were examined according to experience in rural practice. No noticeable difference existed between themes employed by metropolitan practitioners with experience in rural areas and those without. Further, no significant difference was found in the types of statements coded within each theme according to rural experience.

Responses by practitioners currently in rural practice were significantly more likely to make reference to 'service factors' than their metropolitan counterparts. Metropolitan practitioners were more likely to utilise the three other themes identified. Rural practitioner responses tended to be longer than those of metropolitan participants. These comments were generally directed towards the clarification of one or two themes. They did not contain references to a higher number of themes than those comments made by metropolitan practitioners.

Service factors

Rural participants in particular were likely to mention 'service factors' as of importance for rural men with mental health concerns. Rural GPs were more than twice as likely to discuss service factors as any other theme. Many respondents made reference to this theme, with similar rates across gender.

Responses reflected the belief that there is a significant lack of services available to rural men. Comments centred upon the lack of accessibility of services, long waiting lists, a deficiency of choice of practitioner or service. Participants noted that there was a lack of GPs in rural areas, along with few psychiatrists. For example:

Extract 222

1. Access to appropriate support and intervention. 2. Lack of psychiatrists (there seem to be a lot of them in Eastern suburbs of Adelaide!!) [high socio-economic area] (Male rural GP)

Others pointed out the absence of availability of services out of work hours and the difficulty coordinating counselling. The initial difficulty in finding appropriate help was noted to be compounded by the problem of a lack of local services. Some respondents suggested that men were unlikely to travel long distances to access services.

Choice of services was another topic raised by practitioners. Respondents argued that in some cases the need for choice was important, such as where GPs were unlikely to refer to mental health services, or other reasons. An example of such a comment is:

Extract 223

Lack of choice of helping professionals – GP may not “believe” in mental health, may be related to Social Worker (Female rural Trainee Psychologist)

Inability to choose practitioners in rural situations may have ramifications regarding the gender of workers. Some men and women may feel more comfortable discussing personal matters with a practitioner of a certain gender. In areas where access to services is limited preferences may not be satisfied. A female worker suggested that this may be a problem for some men:

Extract 224

Sex of worker: male worker more of a challenge sometimes? (Female rural Social Worker)

Practitioners further observed that the problems exist in both attracting workers to rural areas and in keeping them there. For example:

Extract 225

Trust and constancy – Graduates in Country Health tend to be a revolving door. Come in inexperienced and leave back to metro with some experience. This is an ongoing problem. (Male rural Community Mental Health Nurse)

Confidentiality

A moderate number of respondents drew upon the theme of ‘confidentiality’. Female practitioners were considerably more likely to utilise this theme than were male practitioners. Women were more likely to employ the theme of confidentiality than any other in response to this question.

Participants conveyed widespread concern regarding a lack of confidentiality in rural areas. Most responses simply stated ‘confidentiality’ or ‘anonymity’ as issues of unease for rural men with mental health concern. Others clarified that anxiety centred on the lack of anonymity available in the country due to the tight knit nature of communities. For example:

Extract 226

everyone knowing everyone’s business (Female metropolitan Psychologist)

Extract 227

...the fear that others will talk/ gossip which frequently happens with country towns (Male metropolitan Psychologist)

There was much homogeneity within responses coded under confidentiality. Combined with the common nature of this response, this suggests that practitioners generally believe that concerns around confidentiality are a significant issue for rural men.

Isolation

Participants noted that 'isolation' is likely to be a critical issue for rural men. Practitioners discussed segregation, loneliness and lack of social support in their comments about the remote nature of the rural lifestyle. A number of respondents combined discussions of isolation with other problems related to it such as lack of opportunities to make friends, form relationships, find employment or establish a role in the community. The following practitioner noted a further lack of diversity in attitudes and opinions.

Extract 228

I think the relative isolation on properties and limited social networks involving men with more heterogeneous views/attitudes (Male rural Clinical Psychologist)

Another discussed the ramifications of loneliness and isolation.

Extract 229

...much more likely to blow their brains out under a tractor than go seek help. More isolated. (Male metropolitan Clinical Psychologist, interview)

A few responses coded under isolation refer to the subsequent difficulty for men to discuss their concerns with others. If men do not wish to talk about psychological concerns, or there seems to be no-one available to talk to, they may be left to their own devices. Without

anyone to whom they can disclose their problem, it is understandable that men could become consumed by it and see no way out. This is clearly a dangerous slope for distressed, isolated men.

Work factors

One third of participants identified ‘work factors’ such as finances, unemployment, drought and other stressors as central to the experience of rural men. Female respondents were more likely to utilise this theme than were male respondents. Of interest was that slightly more metropolitan than rural participants employed the theme of work factors in their response.

Comments discussed stress around unemployment and the limited opportunities to gain work. The following extract is an example of these observations.

Extract 230

Work availability: if employed, higher risk (apparently) of losing job if MH issues (Female rural Social Worker)

Financial issues were also central, noted as affecting both those without a job and those trying to make ends meet through a difficult farming period. There were many references to the drought and subsequent lack of income. Examples of such comments include:

Extract 231

...drought/ debt etc are very imp (Female metropolitan GP)

Extract 232

Stress – of farm issues e.g. crops, rain, wheat/ meat prices... (Female metropolitan Psychologist)

Practitioners reported that there is pressure for men to fulfil ‘responsibilities’ by maintaining their role as a worker and providing financial support to their families. An example of a comment making reference to such pressure follows.

Extract 233

Drought, self worth, self-blame (e.g. the farm has been in the family for generations – until me) (Male rural GP)

Work factors were presented by participants as substantial in rural men’s lived experience. Mental illness and help-seeking can be seen as separate to this pressured lifestyle in that even in discussion which is ostensibly about mental illness, there is very little mention of psychological concerns when discussing work factors.

Discussion

Rural practitioners in particular were likely to mention service factors as issues of concern for rural men with mental health concerns. Factors included problems with accessing services and a lack of staff that stay in the area long term. Practitioners (especially females) thought that men would be particularly concerned about a lack of confidentiality in rural areas. They expressed the belief that it is difficult to keep such things private in a small town. Respondents further suggested that isolation and lack of support were inhibitive for mentally ill men, who may not have anyone to discuss their problems with even if they were willing to do so.

Also significant in the minds of practitioners was the work role. Observations included that the stress over employment, finances and providing for the family weighed heavily on the shoulders of men in rural areas and that these would have a substantial impact on their mental health.

Of interest was that rural practitioners were most likely to refer to service factors whilst metropolitan practitioners discussed isolation issues. Such differences in perspective suggest that if policy is made from a metropolitan perspective without adequate consultation with rural stakeholders, important information may be overlooked. In response to this question practitioners suggested that it is services themselves which are of significant importance for men with mental disorders. Such data should stress to policy makers and service providers their own potential role in making appropriate mental health services available to rural men.

5.5 Discussion

This investigation found that an overwhelming majority of practitioners felt that differences exist between men and women in how they recognise they have a mental health issue. Further, almost all practitioners surveyed believe that men's attitude toward psychological help is different from that of women. Participants noted that whilst women generally self-referred for mental health treatment, men were commonly prompted by others. Masculine expectations and a fear of expressing emotion were thought to be barriers to men seeking psychological help. For rural men in particular service issues such as a lack of staff, problems with access and waiting lists, concerns about confidentiality, isolation and work factors were identified as significant.

Practitioners identified education, support from others and seeking help as a last resort as likely to facilitate help-seeking. Further, they proposed that improvements in services and education could increase men's help-seeking for psychological concerns.

5.5.1 Masculine Gender Role

Practitioners of both genders, professions and from both rural and metropolitan locations characterised men as greatly influenced by gender role expectations. Responses to a number of questions utilised concepts of masculinity and associated roles. The quantity and content of responses utilising these expectations indicated that the impact of the hegemonic masculinity paradigm on men is immense. Practitioners discussed the role of socialisation into a paradigm of hegemonic masculinity in the attitudes and behaviours of men with mental illness (seen in analysis of question four). The expectations of society were described as rigid and following defined 'rules' about the behaviours that men should and should not engage in. These 'rules' were explicit in the majority of the themes elicited from practitioner responses. These included the expectation of men to be self-reliant and not in any way dependent on others (questions two and four). Dependence on others can be seen as implicit in the process of help-seeking. In asking for help one is actively violating the attribute of independence. As such, this feature of hegemonic masculinity is problematic for the help-seeking process.

Men were further depicted as denying (question four) or being unwilling to admit they have a problem (question one). Further, practitioners described men as hesitant to engage with emotion (question one) and reluctant to seek help (question two). These themes can also be seen to reflect the features of hegemonic masculinity and the findings of much literature on men's mental health (e.g. Cusack et al., 2006; Vogel, Wade et al., 2006). In fact authors such as McVittie (2006) posit that men's reluctance to seek help can be seen as an indication of the

ongoing negotiation of their masculine identity. By not acknowledging problems or seeking help for them men could be argued to be attempting to prevent a challenge to their traditional masculine persona. Hegemonic masculinity prescribes that men should be strong and independent. In practitioner responses men are portrayed as rejecting weakness and ascribing to the value of strength (questions two and four) by renouncing behaviours which they believe portray them as vulnerable (i.e. admitting that they have a mental health problem). Respondents noted that men associated admitting to a mental health problem with confessing to a weakness in their character. To be strong is constructed in the traditional masculine identity as stoic and independent. As discussed previously, this trait of hegemonic masculinity is positioned in opposition to the requirements of help-seeking which require the admission of a problem. Indeed, both stoicism (Judd et al., 2006) and adoption of hegemonic masculine values (Berger et al., 2005; Good et al., 1989; Wisch et al., 1995) have been found to be associated with low levels of help-seeking.

Practitioners indicated that expectations of self-reliance, denial of weakness and emotionality informed men's attitudes to psychological help-seeking. Relying on one's self rather than others reflects what Ducat (2004) describes as a "denial of dependency" (p.53). In this context help-seeking can be seen as an admission of the need to depend on others. This need presents a challenge to the traditional masculine role.

Understanding the role that traditional masculinity plays in the lives of men with mental illness may go some way to explaining the notion that even when presenting to the doctor men are likely to normalise their symptoms (Kessler et. al. (1999), also see question one) and may refuse to be referred for treatment (Rost, Humphrey, & Kelleher, 1994). Similarly, the high value placed by men on their role as worker and provider for the family

reflects the regard in which this role is held within traditional masculinity (question four). Thus, refusing to jeopardise this role by taking time off to visit a doctor or mental health professional can be seen as entirely consistent with the performance of hegemonic masculinity (question six and seven).

5.5.2 Clinical Implications

Practitioners indicated beliefs that women are at ease with discussing emotion whilst men were not, and that men instead preferred practical orientations to treatment (see question two). The identification of this theme supports previous findings that suggest that a goal-oriented, practical approach to therapy is preferred by men (Werrbach & Gilbert, 1987; Wisch et al., 1995). Research by Robertson and Fitzgerald (1992), for example, found that men who scored highly on ratings of traditional masculinity responded negatively to traditional counselling but positively to descriptions of mental health interventions that were more consistent with masculine socialisation (i.e. self help materials, workshops etc.). This suggests that operating a wide range of services that include self-directed or goal-focused opportunities may offer men more incentive to undertake help-seeking behaviour.

Men were further characterised as externalising their problems (question one) or locating the responsibility with other people or things. For example, men may discuss the physical symptoms associated with their mental illness rather than the psychological ones (Greer et al., 2004), or may blame their partner for relationship issues (Werrbach & Gilbert, 1987, also see question one).

The reported tendency for men to keep a cognitive distance from psychological concerns is critical in the assessment and treatment of men. Those practitioners who identify and attempt to address this distance by trying to persuade resistant men to engage with their emotions could be met with opposition. Therapists should be aware of the possibility that men may approach therapy with what Shay (1996) calls an “a priori stance of anti-alliance” (p. 505). Instead of challenging the attitudes and behaviours of resistant men, Shay argues therapists should respect the position of men and recognise that they feel this way for good reason. Men are socialised in Western cultures to believe that they should not feel and certainly should not express emotion, so that some authors suggest that many men are left “emotionally illiterate” (Rutherford, 1992).

The overwhelming propensity of practitioners to make reference to hegemonic masculinity in this research provides evidence that its role for men needs to be recognised by professionals. In Western society the hegemonic masculine identity and repertoire of behaviours associated with it provide very strict boundaries around what behaviours are acceptable for a ‘real’ man and those that are not. Asking men to engage in behaviours outside of the repertoire of hegemonic masculinity, indeed, in *opposition* to this repertoire, necessarily challenges the very identity of the individual as a man both internally and socially. Therefore, practitioner understanding of the role of men’s likely socialisation into a paradigm of traditional masculinity and perhaps the adoption of a goal-oriented treatment style may make men feel more comfortable in seeking help and treatment as well as improving outcomes.

Practitioners discussed many of the behaviours sanctioned by hegemonic masculinity as barriers to men accepting their mental illness and seeking treatment. Whilst practitioner awareness of the pervasive nature of gender expectations would be useful with individuals,

ultimately it is ideas about 'real' masculinity both in society and individuals that need to be contested in order to begin to diminish the influence of perceptions of masculine behaviour.

5.5.3 Education

Respondents advised that one way to challenge the role of hegemonic masculinity, as well as men's lack of help-seeking generally, is through education (questions five and six). Importantly, this was a theme employed by the majority of participants. In informing men about the common nature, symptoms and locus of origin of mental illness along with where to seek help and treatment strategies (in short, mental health literacy), practitioners imply that men will suffer less anxiety about the unknown, their own role in the development of the problem and what to do about it. Higher levels of mental health literacy have been shown to be associated with more positive attitudes towards mental health services (Fox et al., 2001), faster (Thompson et al., 2004) and higher levels of help-seeking (Cotton et al., 2006). Thus, improving men's mental health literacy through education may be successful in improving the likelihood of men seeking psychological help and of them doing so more quickly.

Nevertheless, practitioners and policy makers must be careful to consider how a resistant male might view media campaigns or educational information. If a man denies that he has a psychological concern (identified as likely by many practitioners) it is possible that general mental health campaigns will not make much of an impression. Whilst practitioners recommend that education is fundamental to improving men's help-seeking, they also provided opinion as to what information should be included and how this is presented to men.

Within practitioner recommendations of education, normalising mental illness and help-seeking was particularly encouraged. Many practitioners noted that the use of relevant role models for men would be valuable (question six). It was implied that if men were able to see others that they considered to be ‘manly’ as sufferers of mental illness who sought help for their problems, this would challenge rigid notions of masculine behaviour. A number of respondents advised that the use of footballers or celebrities as role models in this sense would provide men with significant evidence that masculine men can seek help and retain their manly status, encouraging them to challenge their own beliefs. This approach has been employed recently in the *Real Men. Real Depression* campaign (Rochlen et al., 2005) with some effect.

Practitioners clearly considered men to be likely to respond very differently to mental health concerns than women. In light of this it is important to consider the information and services which are currently available and reflect upon how applicable they can be to both experiences concurrently. It seems apparent that if men and women experience psychological distress and help-seeking quite differently a single approach is likely to only suit one gender. A lack of appropriate services may contribute to a lack of help-seeking by the overlooked gender, and commentary suggests that this disregarded gender is male (Porche, 2007).

5.5.4 Strengths and Limitations

Whilst the findings above shed light on practitioner experiences of men with psychological concerns, some limitations exist and these must be discussed. Firstly, the self-selected nature of participants may be a limitation to this research. Although it cannot be substantiated, it is likely that those who chose to participate did so due to an interest in this area. Therefore, the themes identified from responses received in this study may not be

indicative of those that might emerge from the responses of practitioners who do not have a particular interest in this topic. However, it may also be argued that practitioners who chose to participate and do have an interest in men's health may also be well placed to be included in research of this kind (e.g. because they may be more frequently exposed to men's mental health issues as practitioners). Nevertheless, the diverse professions and locations included in this investigation account for a number of different perspectives on men's psychological well being. Further, the consistency in ways of responding to each question suggests that there are similar issues amongst professionals working in different areas, with different roles and with different clients.

Secondly, critics may argue that the observations of practitioners may not represent a 'true' account of how men respond to mental illness. However, this analysis was conducted under a contextualist method which presumes that what practitioners have to say both has some element of 'reality' and yet acknowledges that it is shaped by the social processes surrounding individuals. Therefore, whilst the themes identified cannot necessarily be said to be a 'true' account of practitioner experiences, they achieve what they set out to which is to describe the attitudes and beliefs of practitioners who have experience working with men with psychological concerns.

Despite these limitations this study has investigated an area of research which has not been fully explored previously. The experiences of mental health and general practitioners are valuable in considering the real world event of men suffering from mental health concerns. As such, professional experiences of men's psychological help-seeking are able to better inform understanding of this topic.

5.6 Conclusion

The major themes that emerged from this study suggest the following. There are implicit conditions regarding ascribing to a traditional male role which make help-seeking for psychological problems different for men than for women. Men tend to distance themselves from their problems, have difficulty engaging with emotion and may seek help only as a last resort. Knowledge of mental health issues affects men's experience, as does the support they have from others. Men are concerned about the identity that comes with categorizing themselves as suffering from mental illness. There are a number of service issues that compound these themes to produce an environment which is not conducive to men seeking help.

Much practitioner discussion centred upon the role of hegemonic masculinity which is enacted through societal expectations and somewhat difficult to alter on a large scale. However, service and education improvements were also substantial themes and are those which practitioners and policy makers are most able to address.

CHAPTER SIX

Study Five: Male Consumers of Mental Health Services

6.1 Introduction

As noted in studies presented so far, men seek help for psychological concerns less than women, but recent research suggests that this is not necessarily due to lower prevalence (Boynton, 2004). Research examining men's psychological help-seeking in the past decade has examined factors which may be relevant to a discrepancy between prevalence and help-seeking by men. Much of this research has been explorative and has used qualitative methods (Shepard, 2002). In particular, research has considered the experiences of men as consumers and non-consumers of mental health services. Areas of focus have included factors which facilitate or impede men's help-seeking behaviour.

Low mental health literacy has been identified as impeding men's help-seeking behaviour. For example Gorman and colleagues (2007) found that a large proportion of men are unable to recognise that the problems they suffered could be diagnosed by professionals as depression. This finding is corroborated by other studies that suggest that both men and women have difficulty identifying (Cornford, Hill, & Reilly, 2007) and communicating mental health concerns (Emslie et al., 2007). Men have also been shown to be poorer than women in identifying ill-defined experiences of distress as emotional problems (Kessler et al., 1981). An inability to identify mental illness when it arises is problematic as it would prevent any consideration of help-seeking. However, it has been noted that knowledge alone does not predict service utilisation (Green & Pope, 1999).

Consumers of mental health services (that is, those who use these services) have identified concerns about the stigma associated with mental illness as well as feelings of shame and embarrassment as prohibitive to help-seeking (Gorman et al., 2007; McColl, 2007; Wrigley et al., 2005). In rural populations the difficulty in achieving anonymity when help-seeking has also been determined as problematic (Crawford & Brown, 2002). Research has also shown that men's expression of depression symptoms may differ from that of women (for example, including aggressive behaviour and lacking tearfulness, Johansson et al., 2009; Kilmartin, 2005) which may result in a failure to diagnose where appropriate (Rochlen et al., 2009).

A number of authors have conceptualised men's reluctance to seek psychological help as an effort to negotiate their masculinity (McVittie & Willock, 2006). More specifically, to suffer from a psychological concern is inconsistent with hegemonic notions of masculinity which require men to be strong, stoic and invulnerable. In such a construction mental illness is portrayed as a personal weakness (Chew-Graham et al., 2003). Further, seeking help is incompatible with traditional descriptions of masculinity which exalt self-reliance and independence. Therefore seeking psychological support can be seen as presenting a considerable challenge to the masculine identity of men (Davies et al., 2000).

Levant (1990) noted four major factors that impede men from seeking psychological assistance. He proposed that each of these is related to societal expectations of behaviour associated with the male gender. Levant observed that men have difficulty in admitting the existence of a problem, asking for help, identifying and processing emotion, and that they fear intimacy. This is consistent with other research which suggests that hegemonic expectations that men do not discuss personal information with others (Heifner, 1997), express emotion (J.

Harrison et al., 1995) or involve themselves in health behaviours (Kierans et al., 2007) are likely to leave men isolated with few resources in order to deal with psychological distress. Men have also been reported to primarily try to solve their problems alone (Jorm, Kelly et al., 2006; Warren, 1983; Yorgason, Linville, & Zitzman, 2008). Often it is only when such attempts fail that the individual will seek professional intervention (Manthei, 2006). Some attempts to escape from symptoms or problems may include the use of alcohol or other substances (Brownhill et al., 2005).

A number of studies have examined the factors which may hinder psychological help-seeking behaviour. However, few have investigated these factors from the perspective of men who have previously sought help for mental health concerns. Biddle, Donovan, Sharp and Gunnell (2007) interviewed 23 young people with mental distress who had or had not previously sought help for this. These authors proposed that help-seeking constitutes a circular process in which understandings of mental health, meanings attached to seeking assistance and treatment are particularly significant. The help-seeking was hypothesised as a 'cycle of avoidance' in which the validity of psychological concerns was established in part by the act of seeking assistance for them. Biddle and colleagues propose that this cycle offers a better reflection of the experiences of their participants than the nomination of 'barriers' to help-seeking, which they describe as superficial representations of complex issues.

In a study of 33 general practice patients in New Zealand by Dew and colleagues (2007) respondents identified multiple factors which they considered would impede their own or others' disclosure of mental health concerns. This sample included men and women and slightly more than half had discussed psychological issues with their GP. However, it is unclear whether only those who had discussed psychological concerns experienced distress,

what proportion of those who had disclosed their concerns were male or whether themes identified varied across gender or disclosure. Factors likely to inhibit help-seeking identified included fear of the consequences, lack of encouragement from health professionals, being a burden, lack of trust, stigma, the belief that general practitioners cannot help, self-reliance, denial, limited consultation time, money, different expectations of genders, and cultural views on responses to illness. Conversely, respondents identified the following factors as likely to facilitate disclosure: sense of control over consultation, encouragement from the GP, trust in the GP, association with a physical problem, belief that GPs address mental problems, reached the point of breaking down, and less formal surroundings.

Other studies have reported that young people identify lack of emotional competence, negative attitudes and beliefs about help-seeking, and fear of stigma as barriers to seeking help (Rickwood et al., 2005). Similarly, a review of research by Vogel, Wester and Larson (2007) found that help-seeking avoidance was related to stigma, treatment fears, fear of emotion, anticipated utility and risk, social norms and self esteem. In addition, research has shown that Australian women reported that believing that they should be self-reliant, believing the problem would improve, embarrassment, not knowing where to go for help, and fear of what others might think were barriers to psychological help-seeking (Outram et al., 2004)

A number of studies have highlighted the importance of social support in assisting men to seek help (Rickwood et al., 2005; Wester et al., 2007). Gorman and colleagues (2007) interviewed men from rural Queensland in order to investigate helpful factors in coping with emotional difficulties. The study showed the importance of talking about the problem, and feeling needed by others in men's ability to manage their psychological concerns.

Level of distress has also been associated with help-seeking, with research demonstrating that those experiencing higher levels of distress are more likely to seek help (Judd et al., 2006; Koopmans & Lamers, 2007). Research which has reported that men are likely to seek help once they are no longer able to cope and have reached a time of crisis verifies this (Brownhill et al., 2005; Strike, Rhodes, Bergmans, & Links, 2006).

Some research suggests that conceptions of health and illness are entwined with the understanding and performance of gender (McVittie & Willock, 2006). Indeed, it has been argued that “gender is a key cultural variable and central mediator of experience in men’s lives” (Sinclair & Taylor, 2004, p. 390). Therefore identifying how gender influences the acknowledgement of mental health problems and help-seeking for these concerns is of utmost importance if improvements are to be made to service uptake. Furthermore, the consumers of mental health services have been recognised as able to offer unique insight into impediments to psychological help-seeking (Judd et al., 2002).

Despite the existence of much important research on men’s help-seeking, gaps in the literature remain. In particular, men’s ability to identify a particular concern as a mental health issue that may require help has not been fully explored. Limited research in this area has studied mental health literacy. However, the lived experience of men recognising and acknowledging mental health concerns remains vague. As problem recognition is the first step in the help-seeking process this is identified as a significant issue. Further, studies investigating barriers to help-seeking have often used community samples. In such research barriers to help-seeking identified may be hypothetical rather than those which have proven problematic for individuals. Lastly, existing studies have commonly utilised samples

consisting of participants in one geographical region (although Rost et al., 1993, provide an exception). The current study attempts to address these gaps in existing literature.

6.2 Aim

The aim of this study was to determine the processes or factors that current and past male consumers of psychological services consider important in recognising a need for and accessing psychological help.

6.3 Method

6.3.1 Participants

The participants for this study were referred from or were attending mental health services including the Centre for the Treatment of Anxiety and Depression, the University of Adelaide Counselling Centre, the Mental Illness Foundation of South Australia (MIFSA) or a previous study on this topic. Rural participants were referred through MIFSA, rural mental health services, disability services, consumer groups and an article in a local paper calling for men to participate in a study on psychological help-seeking.

Criteria for involvement specified that participants needed to be male, aged 18 years or older and have attended more than one session with a mental health professional (including general practitioner) for support with mental health concerns. Those who expressed interest were interviewed at the service through which they were recruited, the University of Adelaide, or another appropriate setting in their rural area. One interview with a remotely located participant took place by phone.

A total of 18 men participated in this study, 10 from the metropolitan area and 8 from rural areas. Participant ages ranged from 26 to 64 years, with a mean of 47 years ($SD = 13.07$). Episodes of contact with mental health services ranged from five times to over 35 years. Ten participants indicated that they suffered from depression, four of whom reported co-morbid anxiety. Other diagnoses included anxiety ($n = 1$), bipolar disorder ($n = 4$) and schizophrenia ($n = 1$). Two participants did not disclose diagnoses but one discussed paranoia and mania, and the other spoke of substance use.

Eight participants were either married or in a relationship at the time of the interview. Others indicated that they were divorced ($n = 4$), mentioned previous de-facto relationships ($n = 5$), or did not discuss intimate relationships in the interview ($n = 1$). Although ethnicity was not specifically examined, one participant identified himself to the interviewer as Aboriginal and another as Chinese. One metropolitan participant reported that he was homeless at the time of the interview.

Rural participants were recruited from across South Australia. The Department of Health and Ageing's Accessibility/ Remoteness Index (ARIA) indicates that participants resided in areas classified as highly accessible (relatively unrestricted accessibility of some goods, services, and opportunities for social interaction), accessible (some restrictions) and highly inaccessible (very restricted access).

6.3.2 Interview Protocol

Interviews were semi-structured. Where they had not already indicated an answer, participants were asked the following questions.

- How did you come to recognise that you had a mental health issue?
- When you first recognised the illness, did you think about getting help? If so, did you know how and where to seek help? Or how did you get this information?
- Did you feel any reluctance to seek help? If so, why?
- How do you think that seeking help might be different for males than for females? Why do you think that men do not seek help at the same rates?
- Were there any major barriers to you getting help?
- What barriers are there to other men seeking help?
- Did you discuss your problems with others? E.g. friends or family?

6.3.3 Methodology

Interviews took between forty five minutes and two hours, with the majority lasting approximately one hour. Interviews were transcribed verbatim and analysed using thematic analysis (Braun & Clarke, 2006, as described in chapter two) in order to elicit common themes associated with men considering and accessing psychological services. The interviews covered particular questions and the interviewer followed particular comments of interest and not others. Therefore transcripts reflect co-authored conversations.

6.3.4 Ethical Considerations

Written information sheets were distributed to all potential participants. Consent forms were completed by participants prior to taking part in discussions with the interviewer (see Appendix M). Ethics approval for this study was obtained from the University of Adelaide Ethics Committee prior to participant recruitment.

Involvement in this study was purely voluntary and the results remain confidential. Basic demographic data (age, number of therapy sessions attended) was collected for statistical purposes. Psychological services sourcing participants for this study were not informed of individuals who chose to participate.

Participants were free to decline to answer specific questions or cease the interview at any time. Identifying information such as names and services attended was removed in the transcription process and digital recordings destroyed after analysis was completed.

A list of appropriate resources was provided to all participants upon completion of the interview. Any participant experiencing distress as a result of involvement in this research would have also been encouraged to seek help from their treating psychological clinician. No participant expressed such distress.

Extracts from interviews are included as evidence of particular themes. Due to confidentiality reasons extracts are labelled with a code which identifies the participant. This code refers to the location of the participant (M = metropolitan, R = rural) and the participant number (i.e. M5). Where comments by the interviewer are included this is indicated by "I:" and comments are italicised. Extracts are labelled chronologically to improve readability. Excerpts of transcripts may in some instances have minor details omitted to improve readability. Themes are presented in this results section and explored in greater detail in the discussion.

6.4 Results

Themes are presented in three sections. The first two of these sections address crucial parts of the help-seeking process, the identification of the problem and consideration of what to do about the problem. The third section addresses participant perceptions of gender differences in the experience of psychological concerns.

6.4.1 Problem Recognition

Identification of problem is the first step in the process of solving that problem. Therefore, participants were encouraged to discuss how it was that they were able to identify that they had a psychological concern. Men in this study discussed three ways in which they first identified the problem. Some immediately ‘knew what was happening’, others thought ‘something wasn’t right’, and the remainder reported that they ‘didn’t know’ what was happening for a long time.

Symptoms of mental illness play a significant role in the ability of individuals to recognise that a problem exists. A large proportion of participants in this study reported that they suffered from depression. The major theme which emerged in exploring symptomology was therefore ‘describing depression’. Manner of acknowledgement and descriptions of depression are each discussed in turn.

Acknowledgement of Problem

Participants were asked how they came to realise they had a psychological concern.

Three ways of responding which emerged were labelled as themes: 'knew what was happening', 'something wasn't right' and 'didn't recognise'.

A very small number of participants indicated that when symptoms arose they quickly understood that they were experiencing psychological concerns associated with mental illness. Only participants from metropolitan areas made such comments. Examples of comments reflecting the theme 'knew what was happening' follow.

Extract 234

I think I knew, from probably day one really, that it was, ah, a mental issue.

(M16)

Extract 235

I knew from what I'd read I have depression (M10)

These comments clearly indicate an understanding that the concerns these men were experiencing were psychological. This demonstrates high mental health literacy. However, the majority of respondents reported that their mental health literacy at the time of their first concern was much lower than that of men who utilised this theme.

The most common response to inquiry as to how participants came to realise they had a mental health concern was that 'something wasn't right'. This was the case for both metropolitan and rural participants. Some participants reported that they knew that they had a

problem but seemed uncertain as to what it was specifically. An example of comments coded under the theme ‘something wasn’t right’ follows.

Extract 236

...after those few days I said “there’s something wrong here” (R2)

Many of the participants who drew upon this theme described an understanding that their experience was other than ordinary. These men frequently used terminology that referred to normality and located their own experience as distanced from it.

Extract 237

It just gradually hit me, you know “hang on, that’s not, that’s not right”... I recognised that “hang on, this isn’t good” (M1)

Extract 237 indicates that the man had a notion of what was usual or normal and positioned his own experience in opposition to this. This construction implies that the recognition of something ‘wrong’ is dependent upon an awareness of what is ‘right’. In some cases participants explicitly described the behavioural norm to which they compared their own experience. This involved assessing their own problems against the experiences of other people. Examples of such comments include:

Extract 238

I suppose it was because I saw myself as being unhappier than other people...I didn’t feel it was right, that that just didn’t seem to be normal, I don’t know... yeah, I measured myself a lot against others and it didn’t seem to be the same (M8)

Extract 239

I still felt that I was sort of different from other people where moods and that sort of thing was concerned. I hadn't really even identified moods at that point. It was more the feelings of not fitting in (M9)

Some participants reported that they did not recognise that they had a psychological concern at all. These men commonly indicated that they first acknowledged that they may be suffering from mental illness once they were engaged with mental health services. This engagement was often involuntary or due to a crisis. Participants in all locations utilised this theme but use was more frequent in interviews with rural men. Examples of comments coded under the theme 'didn't recognise' include:

Extract 240

...well I can't remember ever thinking about psychological problems [prior to hospitalisation] (M5)

Extract 241

I didn't realise I was actually, it's funny it just sort of sneaks up on you, you don't realise you're crook until you are right in the middle of it. (R18)

Several participants indicated that this lack of recognition of mental illness was likely to be the same for other men. Those who made such statements could be seen as normalising a lack of mental health literacy for themselves and others by presenting this as a pervasive trait among men. For example:

Extract 242

Most men will not even recognise they have a problem. (M6)

Extract 243

...they're not necessarily going to know what the problem is themselves when they contact you. (M17)

One participant in this study reflected that his inability to recognise the problem was the reason he had not sought help. This man suggested that had he realised that it was possible to live differently he may have sought help sooner.

Extract 244

It wasn't something where I knew there was a better way, kind of thing. Because I think if I did I would have been going after that (M1)

This participant inferred that the lack of understanding that what he was experiencing was a treatable disease acted as a significant barrier to him seeking psychological help. Thus, increased mental health literacy may have seen this man seek help while his depression was at a lower level of severity.

Describing Depression

Participants were not specifically asked to discuss their symptoms. Despite this, many symptoms were identified when participants discussed their general experience of mental illness. Participants in this study identified with a number of diagnoses. However, many were assigned only to a small number of men and the symptoms disclosed were not determined to be beneficial to this discussion. (For example, symptoms of psychosis are readily identifiable and men are unlikely to present in a strikingly different manner to women.) 'Describing depression' was distinguished as an informative theme in the context of this research investigating issues of gender, illness identification and service use.

In considering the transcripts of men diagnosed with depression a number of paths of investigation emerged. Of particular interest was that only two participants in this study discussed experiencing sadness despite ten having received a diagnosis of depression. Both of these men lived in a metropolitan area. Their comments were:

Extract 245

...all I can remember is that feeling of inadequacy, the feeling of sadness, chronic, you know, 50 year sadness is pretty sad (M5)

Extract 246

I also felt that I was very much more engaged in my head than other people, that I was sadder, that I was...yeah, I didn't have that job to be, that joy of life that other people seem to have (M8)

Two rural men further described their state of mind at times as 'misery' and 'down'. Whilst this terminology implies sadness it was not overtly discussed by the majority of participants. Some stated they had been depressed without elaborating on the meaning of this term or referring to negative moods.

The symptoms which were commonly described by men with depression in this study were: disinterest, lack of motivation, insomnia, fatigue, anger, stress, changes in behaviour such as withdrawal from social interaction and difficulty completing work tasks to one's usual ability. Many of these were behavioural symptoms. The following extract comes from a man describing his experience.

Extract 247

I was getting stressed, so that what I was doing was just basically withdrawing. So withdrawing, kind of social function, a-nd it got to the point where I would just figure out the latest minute that I could get up to go and do work and then just come home and just go back into my room and just repeat kind of thing... all my life was, it was just sleep, lie there, go to work and repeat kind of thing. (M1)

This man expressed that his symptoms consisted mainly of stress, withdrawal, lack of interest and motivation. Whilst these are common symptoms of depression, of interest is the lack of reported negative feeling. Accounts of other men were similar. Examples include:

Extract 248

I was stuck in a rut and didn't want to feel like getting up to work (R13)

Extract 249

I was also getting um, bad-tempered, irritable, edgy...having difficulty sleeping, arguing with my partner all the time, over silly things. And ah, just feeling tired out. (M16)

As in Extract 247, these men discussed behavioural symptoms and a loss of interest. Whilst these descriptions could be seen to make reference to negative mood ('disinterested', 'stuck', 'irritable') none of them discuss sadness, a criteria of the DSM-IV diagnosis of depression (American Psychiatric Association, 2000). Even where men described times of crisis or particularly bad episodes of their illness it was rare for sadness to be mentioned, although a few accounts did mention psychological distress. An example of this follows.

Extract 250

I just spiralled...down the gurgler... [later]...I don't think I was [pause] functioning apart from breathing, at that stage. (R14)

One man presented his own account of depression as reflective of men's general experience. His comment below can be seen as demonstrating an attempt to both convey his experience and to normalise his symptoms as common amongst those who suffer from the illness.

Extract 251

... you want to apply for a job in Alaska, because you've check-listed all of the other criteria, you don't have to eat much, you don't have to sleep much... you go for periods where you don't go out... you just, like I say you lose interest in things and people. You dwell, you live in the past...All sorts of things that you used to do really well and now you, you find yourself turning into Ozzy Osbourne, which is not good, it's not a good look [laughs] (M6)

This participant's final sentence further indicates a tendency to use humour when discussing his experience. This allows the man both to distance himself from the concerns he suffered and to minimise the impact that depression had on his life. In this way the use of humour can be seen as a face-saving activity, one intended to establish the role of its author as in control.

6.4.2 What to do about the problem? Avoiding or Accepting

Once a problem is identified individuals move to a new phase of the help-seeking process; what to do about the problem. Participant responses to psychological problems

broadly fitted into the major themes ‘avoiding’ and ‘accepting’ the problem. Both of these major themes encompassed a number of sub-themes. Those who avoided their problem discussed ‘delaying’ help-seeking, ‘denying’ the problem, and the ‘reasons for avoidance’. Those who accepted the problem referred to facilitators to seeking help as ‘being prompted’ and help-seeking as a ‘last resort’. Each theme is discussed in turn.

Avoiding

The majority of interviews undertaken for this study included descriptions of men’s avoidance of psychological problems. Men commonly discussed ‘delaying’ seeking help and ‘denying’ the problem existed. The following themes were identified as reasons given for avoidance: ‘others worse off’, ‘fear’, ‘lack of knowledge’, ‘stigma’, and ‘masculinity’. Each is discussed in turn.

Delay & Denial

The majority of men in this study spoke of delaying seeking help; in many instances this was associated with denying the problem. Some men indicated that they denied the problem even to themselves. For example:

Extract 252

I didn’t want to think about the fact I had mental illness, didn’t want to associate with that because I wanted to be ok (M8)

Extract 253

I probably didn’t want to face it or put a name to it at that time...Didn’t want to face up to it... “Oh, she’ll be right” (R13)

Other participants reported that they deferred their help-seeking for some time.

Examples of such comments include:

Extract 254

It took me um it took me about a year actually. After I decided that I needed to do something. It still took me a year to do something about it.

(M7)

Extract 255

So, when I first knew about it eight or nine, when I actually did something about it, sixteen, when I was forced at sixteen (M17)

Delay and denial were normalised by several participants as generally ‘what men do’. Of interest was that more participants discussed other men’s denial of the problem than other men delaying help-seeking. Examples of comments coded under this theme include:

Extract 256

Most men refuse to really acknowledge it (M6)

Extract 257

Probably because men hide a lot of that stuff behind grog (R18)

Extract 258

“Oh, nah...I’m fine”...men perceive themselves as, you know... they think that they don’t need it but they do (R2)

The focus on denial may suggest that the men in this study identified this as the significant barrier to accessing help. Denial could also be the reason for delayed help-seeking,

thus the majority of participants may have focused on the source of the problem. The problematic nature of men's denial of health and mental health issues was discussed by a few men who indicated the ramifications of such behaviour were often extremely harmful. For example:

Extract 259

"I'm alright, I'm okay, it's just that I think I'll hang myself tomorrow." (R14)

In some instances the denial of psychological concerns may be undertaken by more actors than just the sufferer. A number of participants referred to types of collusion with others in the denial of mental health concerns. Their comments underline the role of expectation and normalisation in such denial. Some men reported that their workmates, friends and family participated in the denial of their own mental health concerns. Examples include:

Extract 260

I had one close friend, and he was also my boss at work...We used to say when I had one of these massive attacks...that I had a migraine, and I'd go off (M15)

Extract 261

Mum...didn't want to sort of admit herself that maybe her son was mentally ill....Mum's reaction was sort of "Well everybody has moods and some people are more moody than others" (M9)

One participant (cited below) indicated that he denied such problems even to the general practitioner who monitored his illness and medication. This was despite the GP

explicitly stating to the participant that he was the professional that the participant should talk to regarding concerns around his mental illness.

Extract 262

I: Do you tell him when you aren't doing well?

Not about the stuff I'm telling you...I just forget about it and do small talk about footy or something. Reassure him and myself. (R2)

In this statement the man indicates that he denies real psychological concerns to that person whose role it is to address these concerns. If this man is uncomfortable sharing information about his illness with this professional it seems unlikely that he would share it with others. The implication here is that it is the role of the patient to set the mind of the professional at ease and to convince them that there is no cause for concern.

Reasons for Avoidance

Participants utilised a number of themes whilst justifying attempts to avoid problem recognition and help-seeking. These included that 'others worse off', 'fear', 'lack of knowledge', 'stigma', and 'masculinity'.

Others worse off

A number of men in this study utilised a theme in which other people with mental illnesses were considered to be 'worse off'. Of interest is that a much higher proportion of men from metropolitan than rural areas commented that others were worse off than themselves. In some instances these comments seemed to be presented as justification for the

participant's own lack of help-seeking or recovery. Other responses appeared to position the participant as 'better off'. An example of such a comment is:

Extract 263

...cousin had mental breakdown and never returned to work, I didn't want to end up like [name]. ...Feel sorry for people who have had it all their life. I think their degree of depression is much greater than mine. (M16)

Some participants suggested that the fact that other men were worse off made them feel better. For example:

Extract 264

I...developed an awareness that other people are dealing with this, dealing with a lot more, puts it in perspective (M8)

However, it was noted that comparing one's own problems with others who are worse off could result in delayed or no help-seeking as individuals justify to themselves that their own concerns are not worthy of seeking professional input.

Extract 265

I'm okay and they're struggling some of them... some of them are really bad (M15)

In men who are already predisposed to delaying help-seeking or denying their own problems it seems likely that the latter outcome might contribute to these reservations.

Fear

'Fear' was a theme which reflected a major reason for denying mental health concerns and delaying help-seeking for men in this study. Comments indicated that participants were fearful of possible help-seeking outcomes, however, the outcome feared varied across participants. Many men in this study discussed initially experiencing fear of seeing mental health professionals. For example:

Extract 266

I mean it's always that fear of vulnerability that, you just don't know something and what are you going to do to yourself by taking it up? (M8)

Another concern raised about seeking help was the possibility of discovering that something is actually wrong. This could be considered a fear of being diagnosed, particularly of being diagnosed with a severe mental illness. Fear of 'having something' seemed to have acted as a barrier to help-seeking for a number of men in this study, and went some way to explaining men's resistance to seeking help. One participant explained this:

Extract 267

..to almost say "Ah, there's something wrong in my life...and I don't know what to do"...it would be counter-intuitive I think to most people to go "oh, okay, yeah, that's the problem". It would be that's what they're afraid of, what they'll do almost anything to get away from (M1)

Apprehension in the men in this study stemmed not only from the possibility of being diagnosed with a mental illness, but fear of the unknown consequences which may stem from

'having something'. In some instances, such as in the extract below, men indicated concern that they could be hospitalised against their will.

Extract 268

...thinking "maybe I'm just crazy" and, you know, "they're going to lock me up" (R12)

Fear of medication was another concern raised by participants. Some men indicated that they worried about the outcomes of taking medication. For example:

Extract 269

Especially starting medications. You've always got the expectation of "When's it going to kick in? What's it going to be like? How's it going to feel? Is it going to change my personality? You know. (R13)

Men in this study also feared being judged as unmanly. The role of masculinity will be addressed in depth shortly. However, it was mentioned as a source of fear for men considering seeking help. For example, one man (cited below) conveyed a conscious desire to occupy the traditional category of masculinity. More than simply explaining his desire to be located within a hegemonic framework, this participant accounted for alternate masculinities from which he wanted to distance himself. He discussed his fear that suffering from a mental illness would locate him within a category of masculinity which he found undesirable.

Extract 270

Blokes are just sort of ... down this path of, yeah, I know where blokes are. I mean, on that side are wusses, on that side are wankers, so I'll just sort of stroll down this, this middle line, sort of thing. And um, you're scared of... of being lumped into one of those...it's like, the tribe up this side, with

all their shaved, shaved legs and riding bicycles and doing weights in the gym...then there's my team that are just average sort of blokes strolling down the middle. And then there's all of these, I suppose you could actually interchange some of the wankers into the wusses...you don't want to be part of either of those, is what I'm saying. And you sit down a normal bloke thing, and ah, it's a bit of a shock when you find out that you might be one of those that you've been calling a wuss. And you might end up in that tribe over there. Nobody wants to end up in a tribe that they don't like... ...That's why blokes don't want to go and see, or find it difficult to see professionals, because they don't want to be lumped somewhere else (R14)

When this participant stated 'I know where blokes are' he suggested that he understands that there are different types of masculinity and is able to identify which are located in each category. The man noted that 'his' group lies between the 'wusses' and 'wankers' and is the 'normal bloke' group. He stated that it is confronting to acknowledge mental illness because he considers this a characteristic of the 'wuss' group, and is resistant to being allocated to a group other than 'normal'. Indeed, this participant advised that fear of relocation to an undesired group may stop men seeking help.

Another participant indicated a fear that a professional may uphold traditional masculine values and belittle an individual for seeking help when it was unwarranted. He reported:

Extract 271

You run the risk of maybe having a professional say "Oh just get some balls will you? Just be a man and have a bit of backbone" and so you're sort of worried that you might cop those sorts of comments which you've had from other men and other environments where, you know, you're just expected to sort of tough it out (R12)

Men in this study identified fear of being diagnosed, of the unknown consequences of diagnosis, of medication, and of being judged unmanly as creating barriers to the acknowledgement of, and to seeking help for, a psychological concern.

Lack of Knowledge

A 'lack of knowledge' regarding available sources of treatment was a theme identified as a barrier to help-seeking by participants. Some men indicated that they lacked knowledge regarding how to address their problem once they identified that it existed. A number of men reported that they sought help from the only source of which they were aware. In most cases this was a general practitioner, such as for the man cited below.

Extract 272

..,other than my sort of emotional state I didn't have a need for a GP...I just didn't go in there often. And I would not have known where else to go
(R12)

Despite the statement that he had no need for a GP, the man cited in Extract 272 indicated that this was the only source he knew. Such lack of knowledge amongst men was normalised by a number of participants who utilised this theme. In the following extracts 'ignorance' is positioned as the standard experience of men (and sometimes women), allowing the participants to establish themselves as ordinary.

Extract 273

People just don't know. You know which, I can understand that. I didn't know either [laughs] (R2)

Extract 274

I think men, most men are pretty ignorant, you know. (M6)

Lack of knowledge could function as a substantial barrier to help-seeking. Further, if men see one professional and do not receive adequate support they may not be aware of other sources of help.

Stigma

‘Stigma’ associated with mental illness was a common theme throughout the interviews with men in this study. Whilst not all accounts used the same terminology, the underlying worry regarding stigma was clear. For example, in the following extract the participant reflected on feeling labelled by his illness.

Extract 275

...I was in [hospital] and I thought I was mad, I thought other people would see me, would think I was mad as well. You know? And that was a huge thing. That was, ah, that shame in that, that was a lot of shame, a lot of guilt. Sort of, being marked, being marked for life by that sort of stuff. (M8)

In other accounts men reflected upon previous experiences where stigmatisation has occurred. One man reported that he encountered stigma after telling a work supervisor of his psychological concerns.

Extract 276

...eventually I told her...And suddenly you know she just fussed over me then. You know, I'd come in and I was tired or grumpy and she said "Oh, you feeling alright?...You're not having a breakdown?" And I used to think

"What?!" I said "I'm allowed to be tired or grumpy sometimes without having a mental breakdown" and it was just, I thought "Well shit, you just can't tell people about it" (M16)

This participant indicated that he had previously disclosed his problem to another but that the outcome left him unwilling to do so again. Here the stigma is not only perceived but acted upon by another. A number of participants discussed ramifications of the stigma of mental illness, such as being avoided. Some men discussed efforts they made to contain information about their own problems in order to manage the reactions of others. An example of this follows.

Extract 277

I hide a lot of it, to people I'm just normal. Because of that stigma...I don't want to be seen as someone who's nutty...I just cover it up, and people just think "oh, normal" (R2)

Here the participant presents his psychological concerns as disguisable and states that he actively tries to mask them in order to fit in. This was reflected in the comments of other men who signified that they did not discuss their psychological concerns with others because this would call their membership of a 'normal' group into question. Discussion regarding this topic was described as unacceptable. Reference to this was made much more frequently by rural than metropolitan men. Examples include:

Extract 278

...in small country towns people don't come out with mental illness, in my mind (R11)

Extract 279

You don't have these problems. You certainly don't tell any of your mates, um, because you're bananas (R14)

These comments imply that the simple discussion of mental health may locate an individual in an out-group even without the disclosure that they did suffer from a mental illness themselves. The desire to keep information from others in order to avoid stigma was not limited to strangers in the community. A number of men indicated that they did not discuss their concerns with their friends or family. For example:

Extract 280

Oh...all along I don't, I didn't tell this to my own children, about my depression. I don't want to affect them. Is, is a stigma to me...having somebody suffering from mental illness is a stigma. (M10)

The excerpt above provides an example of 'self-stigma', or an internalisation of the stigmatising societal attitudes to create a negative attitude towards the self (Corrigan & Watson, 2002). Self-stigma is pervasive and almost inescapable for those individuals who attribute it to themselves. In this way self-stigma may be more detrimental to individuals than perceived stigma or stigmatising behaviours of others.

Despite the common appearance of stigma throughout the interviews as a barrier to seeking help or disclosing the problem to others, a minority of men indicated a belief that stigma associated with mental health was changing for the better. An example of this is:

Extract 281

You can talk about going to see a psychologist now, people don't think "Oh god, he's a nutcase!" [laughs] Some do, but. (M16)

Masculinity

As discussed earlier (see chapter one), hegemonic masculinity refers to the traditional notions of masculinity such as strength, independence, self-reliance, and lack of emotionality. Such characteristics of hegemonic masculinity were frequently discussed across interviews. For example:

Extract 282

I think that, that stiff upper lip thing and the macho man, Australian man thing...is a hard thing not to do, and especially when you've got kids, you know. (R18)

The participant cited above indicated that he found it difficult to resist upholding traditional notions. Conversely, others reflected upon finding it difficult to uphold a traditional masculine persona in the face of mental illness. An example of this is:

Extract 283

...the shame is from a belief that as a man I should be totally in control. That, yeah, I control my existence, my mind, my life really.... So when I have a sense that I'm not actually meeting that standard, erm, I have a sense of being a failure. And there's shame attached to being a failure....And the guilt...that I haven't been able to do it (M8)

Whilst Extract 283 discusses difficulties in ascribing to hegemonic masculinity, these comments stop short of presenting such notions as problematic. Some participants did indicate that conforming to traditional masculinity was limiting, especially in the context of a need for professional intervention. An example of this follows.

Extract 284

...they think that they can deal with it themselves, you know. It's that stupid macho thing. (M6)

The majority of comments made reference to the concept that men rejected experiences which positioned themselves as vulnerable because this was opposed to the traditional notion that men are strong. Examples of these include:

Extract 285

Men don't want to show any weaknesses really. That's in our nature. (R2)

A few participants labelled suffering from mental illness and talking to others about the problem as weak. An example follows.

Extract 286

... it's a sign of weakness almost. It's like being impotent almost, like, among blokes...you know, if you're head is not together, you're a nut. (R18)

The participant cited above likened suffering from mental illness to lacking power or as being weak. This perception was widespread amongst participants and was claimed to be

amongst the communities referred to in interviews. Hegemonic masculinity seemed to be prized amongst participants, although many portrayed its notions as problematic when they encountered emotion or were required to engage in therapy covering personal topics.

The majority of men reported that Western societal expectations of men are that they are not emotional. This information was generally presented as evidence of the difficulty men have in acknowledging to themselves that they have a mental health concern, disclosing these concerns to others and seeking professional help. Men often relayed messages that they received growing up which taught them that emotion was inappropriate. For example:

Extract 287

“ANZACs don't cry! Just get on with it son” (M5)

The excerpt above refers to ANZACs (Australian and New Zealand Army Corps soldiers) as models of traditional masculine values. These men are customarily seen as loyal to their mates yet strong, unemotional, and independent. In Extract 287 the participant indicated that he was taught to measure himself against this stereotype of masculinity and subsequently that emotion was not a characteristic which was admired. Indeed, he noted that interactions with his family often encouraged him to be independent and ‘get on with it’ rather than seeking support from others. Participants commonly reported that their caregivers encouraged men to be impassionate and independent. It is therefore unsurprising that some participants normalised their own discomfort with emotion as a typically masculine reaction. An example of this follows.

Extract 288

...I felt very uncomfortable. Like most men do in those sorts of situations, showing their feelings. I'm a typical bloke in that way I suppose (M7)

The participant cited above clearly constructed his own position as that of a typical male. He further presented inexpressiveness as natural within this 'normal' male persona. Many men depicted 'typical blokes' in similar ways.

There was a general recognition amongst participants that men are expected to be inexpressive. Despite acknowledgement by some that this is impractical and has adverse ramifications for men, the characteristic was nevertheless cited by almost all men in this study. The account presented below is an example from a man who discussed his personal challenge to seek help for his mental health problem regardless of the contradiction to traditional masculine values.

Extract 289

It's hard to go in to a GP...and say, you know, "I think I've got depression"...it was everything I had not to just burst into tears at the, at the time, so it's, yeah, quite confronting. But I really was at a point where I felt like I, I really couldn't sink much lower, I, it almost didn't matter anymore that, you know, someone might see my crying or, you know, in a compromised sort of position. (R12)

In this extract the participant relayed the importance of concealing his emotion in his first help-seeking interaction. He disclosed how difficult he found it to present the desired impression, seemingly that of strength and control as consistent with traditional masculine

values. Here the participant reported having managed his masculinity by attempting to control emotion that he perceived as indicative of weakness.

For some of those who are unable or unwilling to express emotion or seek help substance use may offer a (maladaptive) coping method (Brownhill, 2003). More than half of participants discussed using substances or other men doing so in order to manage feelings which were socially unacceptable to express. Most men who discussed substance use indicated that they had previously engaged in this behaviour and many labelled it 'self-medicating'. For example:

Extract 290

...yeah, I was drinking. I was drinking too much. I was self-medicating with alcohol was what I was doing (M16)

A number of participants indicated the belief that other men were likely to use substances, alcohol in particular, in order to deal with psychological distress. For example, the man cited below reported that many men with mental health concerns use alcohol as a coping mechanism because it is socially acceptable.

Extract 291

Go down the pub and have a couple of beers. Get pissed....Now, that's the alternative for medication for most men. Is beer, you know? Because, everybody drinks, you know. And if he drinks and he gets a bit silly, well, you know. (M15)

Here alcohol is seen as an outlet for men which would not draw unwanted attention. Substance use was thus presented as legitimate amongst men, leaving any psychological concern to remain undetected. Substance use is constructed as behaviour consistent with traditional masculine characteristics.

Accepting

A few men reported that they accepted that they were suffering from a psychological problem and sought help for this concern quickly. However, many men utilised themes which indicated that they were 'prompted' into action by another person and/ or that seeking help was undertaken as a 'last resort'. A small number of men indicated that they considered that 'masculinity' could be a facilitator to help-seeking. Each of these themes is discussed.

Prompted by others

For many men in this study 'prompting from others' served as a facilitator to seek professional psychological help. The source of this prompt varied, but the majority of men indicated that encouragement came from their wife or partner. For some men this persuasion was presented as an ultimatum. An example of comments coded under this theme is:

Extract 292

...it was my partner at the time was saying "You've got to see someone. That's it." You know. "I won't be with you for much longer if you won't see someone." So you get down to that nitty gritty [laughs] and of course if you want to stay in the relationship you'll do it, you know. ... And I asked my partner at the time, you know, "Well, where should I go? Who should I see? I don't know!" and she said "Well go see a doctor". (R13)

In Extract 292 the man's partner introduced the topic of help-seeking. The conversational pattern represented between the participant and his partner can be seen to follow the course of prompt, admission of lack of knowledge, direction. This may be a pattern which is followed in other interactions between men and those who prompt them to seek help. In this example it is unclear whether the participant implies agreement by asking for further information or uses this as a stalling tactic by raising the reasons he would not seek help. Not knowing where to seek help is likely to establish a barrier to help-seeking. In the example above, the role of others is shown to be important in providing the information which is otherwise lacking.

In another example (below) a participant indicated that his wife served as important support in interactions with professionals due to the hindrance of his anxiety symptoms.

Extract 293

When we got onto the doctor and she came along. So I'm only able to say a certain amount of things to the doctor, and she had her say. And that's when they got things going... I can only say so much and then she can have her say so I can have a break. She wanted to come today but she had too much work going on. She wanted to say, she might have said things....

I: a bit different?

She wanted to come. (R4)

Here the actions of the prompter were to facilitate interactions associated with help-seeking. There is an implication that without his wife's input the man may not have received the treatment he needed. He noted further that his wife had wished to attend the interview for this study, presumably as she felt her perspective or ability to convey information was

different from that of her husband. Another rural participant attended his interview for this study with his wife. Her input was included as it was acknowledged that her support and prompting played a significant role in her husband's mental health and treatment. In the comment below she highlighted the role of women in men's help-seeking.

Extract 294

...what the professionals have got to do, is to get at the wives and get the wives to smack the husbands across the back of the head to get them to do something [laughs]. No, that's, that may sound funny but that's pretty much it, isn't it? Really. Because left to your own devices you don't have any, when you hit, hit the bottom. (Wife: R14)

This woman described the lack of motivation associated with depression as a barrier to help-seeking. She indicated that men who have 'hit the bottom' benefit from input from others. However, not all participants looked favourably upon women prompting men to seek help. One participant who noted that this was problematic is cited below. This was the only case of a participant reporting a negative response to prompting from others.

Extract 295

...her expectation of him might be to seek counselling. Then he's going to be resentful. He's going to go to counselling with tickets on it. You know. "I haven't got laid for a week. So I've to go to counselling now to try and get laid..."...I don't know...It's really finding your own, it's just finding your own way. You can't drive someone to it. You really can't. (M17)

The participant cited above indicated a belief that prompting a man who is resistant to help-seeking will not be useful. He implied that men have to desire help for it to be effective.

It was not just partners of men that served as prompts to seeking professional help. Workplaces, media and friends were also cited as crucial in the persuasion to seek help. Prompters often provided very practical support. For example:

Extract 296

...people knew that I was [pause] there was something wrong. So, ah, I was persuaded to go to hospital with them. (R18)

Extract 297

...two of my other housemates kind of encouraged me to go to a doctor and actually helped me with, you know, "yes, this is the doctor I go to", kind of thing. "Just go there, call up, visit"... I think, I mean that was the trigger like I mean that was the...yeah, it needed that practical, "Do this", you know. (M1)

In Extract 297 the participant indicated that he required functional information about how to seek help, not only that his friends recommended that he do so. This is reflective of comments by men whose partners had prompted them to seek help (e.g. Extract 292).

Last Resort

Almost half of the men in this study indicated that they did not seek help until the problem developed to a level of such severity that they felt they had no choice. This was conceptualised as a breaking point at which seeking help became a last resort.

In some instances men stated that at the time they sought help they felt it was impossible to function without some intervention. Although a number of men reported that they sought help as a last resort, the severity of their crisis varied. Some discussed a knowledge that they could not continue in life on their own. For other participants the

understanding that they could not continue meant the consideration of suicide. This notion was much more distinct for some participants. For example:

Extract 298

I thought "I've got to do something otherwise..." otherwise what I don't know [laughs] (M16)

Extract 299

The first time I sought any sort of help, um was just, I think I just reached a point of absolute misery and I had, ah pretty much made up my mind to take my life. Erm, a-nd, it was a bit of a last resort to just, I went and saw a GP....at the time the alternative was go down this road or basically die...I kind of felt like it was my last shot at things. (R12)

One participant discussed an attempted suicide (rather than help-seeking) as his last resort.

Extract 300

I can't really remember what was going through my head at the time, whether it was a cry for help. I certainly didn't know that they [pills] wouldn't kill me, so it was just sort of a last ditch effort. (M9)

Like denial and delay, seeking help only as a last resort was normalised as a standard response for men. For example:

Extract 301

Most men refuse to really acknowledge it unfortunately until something pretty big happens and it's right in their face and they've got to go "Oooh shit" you know (M6)

Seeking help as a last resort was both common among men in this study and presented as common amongst men in the wider community. The comments presented indicate that where men reach this point and still feel unable to seek help the consequences could be lethal.

Masculinity

Whilst most men in this study conceptualised masculinity as a significant barrier to help-seeking, this was not always the case. A few participants utilised masculinity as a prompt to psychological help-seeking. In one instance looking after one's mental health was presented as a method of self-reliance, and therefore as consistent with the traditional masculine role. The consequence of mental illness in this framework is that one will become dependent on others. As dependency stands in contradiction to hegemonic masculine ideals, seeking help is presented as the avenue which is most consistent with masculinity. The following comment reflects this argument:

Extract 302

You have to realise that if you don't keep yourself healthy that you're only a burden to everybody else....If I don't keep myself healthy...then I'm only going to be asking somebody else, you know, what they can do for me
(M15)

Another participant drew upon hegemonic ideals to argue that worrying about what others think is weak and unmanly.

Extract 303

...there will be stigma attached to it...But it's nothing you can't handle.
"You're a big boy now? Or you're worried what other people will think

about you?" I mean, some people are really worried about what other people think. I'd rather get my shit together personally. (R14)

This participant presents being a 'grown up' in opposition to being concerned about others perceptions. Self-doubt does not fit with traditional masculine characteristics. Concerns about the judgements of others can be seen as self-doubt which, although likely to be associated with psychiatric concerns such as depression, does not fit with traditional notions of masculinity. Being 'grown up' evokes attributes such as independence and control which are consistent with masculine expectations. Further, the participant indicates his own masculinity by stating his position regarding this dichotomy. He states that he is unconcerned about what others think about him, presumably because he is a mature, traditional man.

The preceding excerpts are of interest because traditional masculinity has generally been seen as a barrier to help-seeking. Each of these men present an argument that it is possible to utilise traditional masculine values as prompts to seeking help.

6.4.3 Gender Differences

Participants were asked to comment on any differences that they believed existed for men with mental health concerns as opposed to women. Most men in this study indicated a belief that women 'network' and discuss their concerns whilst men do not. A small number of men reported that they thought this was due largely to social 'expectations' of women as opposed to men. Each of these themes is discussed.

Networks and dialogue

Many men in this study stated that an individual's social 'network' and willingness to discuss one's personal concerns was the major gender difference in the experience of mental illness and help-seeking. All of those who utilised this theme indicated that women had social networks and relationships that allowed them to access support and to engage in dialogue regarding their concerns. Participants noted that this was a particular strength for women as it provided not only an opportunity to gain information specific to the problem at hand, but also support and a sense of collaboration and connectedness with others. Men said that this outlet was lacking for men whose relationships with others involved more superficial conversation and no prospects of discussing this topic. Participants reported that men would not speak of their own concerns. For example:

Extract 304

I think women, even before they get to that horrible place where they have to see someone...they have what's called a 'network', they have girlfriends. Men tend to, if they do have stuff they tend to keep it inwardly, they don't share it with their friends or their mates... (M6)

This participant went on to explain how this 'network' specifically works for women.

Extract 305

women... do have a sort of support network, you'll go out for coffee and cake or something...I don't know, probably like a *Sex & the City* scenario where you just tell each other what ticks them off or what this week had happened and stuff like that. Men, on the other hand, they go down to the pub and just talk crap. Watch the football, bitch about the wife [laughs] whatever and then go home...women...a lot more comes out of it and it's a lot more helpful, and therapeutic I think (M6)

In Extract 305 the participant indicated a belief that the ‘network’ and associated support that he sees women involved in is beneficial for their mental health. He further reflected that men’s interactions tend to be superficial and less ‘therapeutic’. Other men mirrored this conception of the gendered differences in interactions. An example of this is:

Extract 306

I hear the women say “Oh dah dah dah”, “Oh dah dah dah” you know and they go on and on and on and they relate to each other and they sort of get to a point where they are both telling each other everything. We got on with it and “Ah, well.” That’s it. “Port [football team] didn’t do too well.” That’s exactly how the conversation goes. (M5)

In this sense Extract 306 seems to exhibit a crucial gender difference in terms of mental health. Open interactions between women such as that described can lead to the exchange of information, the giving and receiving of support and a feeling of connectedness among contributors. The more restricted interactions between men that were described offer no opportunity for such outcomes. Thus, where men’s and women’s communication with others follows this pattern there is likely to be a significant difference between the information and support received.

Expectations

Participants commonly utilised a theme of societal ‘expectations’. They suggested that expectations of men and women differed and this had ramifications for the experience of mental illness and psychological help-seeking. For example:

Extract 307

...most women they're brought up...with an awareness that they can talk to other people about things, that the sharing of feelings is quite acceptable...a lot of blokes just don't have...they don't have the belief that you can sort of talk things through. I mean, if you've got a problem with another bloke you're more likely to have a fight with him or something (R12)

In Extract 307 and other comments gender difference in emotional expression was presented as a social expectation internalised by both men and women. Another participant indicated a belief that these expectations were shared by some professionals who are dismissive of the mental health concerns of male patients due to these gendered expectations. He stated:

Extract 308

I think even the medical profession are accustomed to sitting and listening to the whole day of women with depression problems and maybe expect more of the men (M5)

In the comment above depression is presented as weakness which is inconsistent with the traditional male role. In this example the hypothetical doctor attempts to manage the patient's masculinity by dismissing the mental health concern and directing the focus of the interaction towards something considered to be more compatible with hegemonic masculinity.

A few participants further discussed the role of social expectations within services provision. For example, a rural participant noted the lack of services for men other than those directed at male perpetrators of violence. He reported:

Extract 309

...there are women's groups, and there are in fact men's groups but they seem to be orientated towards situations of domestic violence...I've picked up this brochure about this men's group, and it had sentiments to the effect of, you know, making, or "turning men into safe members of society"...so I felt like I was already labelled, purely by my gender, that yeah, "This is an unsafe person. We need to fix you" (R12)

This participant reported seeking a support group for men with mental health concerns. He said that he was unable to find one which focused on the experience of mental illness but a group that focused on domestic violence was available. In Extract 309 the participant noted the expectation that accompanies the creation of groups such as the one he came across and similarly may prevent the establishment of a group such as the one he sought. This expectation seems to be that men seeking psychological support will be perpetrators of domestic violence.

6.5 Discussion

This study investigated the experiences of male consumers of mental health services. Interviews yielded a number of themes of interest regarding how men recognised that they had a problem, decided what to do about the problem and perceived that gender affects the experience of mental illness. Results will be discussed according to each of these areas.

6.5.1 Recognition of Problem

A number of participants indicated that they did not recognise that they suffered from psychological concerns until some kind of crisis occurred. This was also normalised by

participants who reported that this was a common occurrence among men. This supports earlier research which found that most men don't recognise when they have a psychological problem (Timlin-Scalera et al., 2003) and that their perceptions of the severity of disorders vary significantly from professional opinions (Prior, Wood, Lewis, & Pill, 2003). Therefore men's inability or lack of desire to identify mental health concerns is problematic.

The majority of men in this study stated that they knew they had a problem because 'something wasn't right'. This implied that perceptions of what is 'normal' were central to problem identification. In order to determine what is normal (and therefore label their own experience) men who utilised this theme could be seen as undertaking a process of social comparison (Festinger, 1954; Wills, 1983). This process could have either a positive or negative outcome in terms of help-seeking. Firstly, due to the generally scarce discussion of personal issues between men (as described by Bergman, 1995; Cook, 1990; Pasick, 1990; Perlick & Manning, 2007) it is likely that such comparison would be based on limited information. That is, because men commonly deny rather than discuss their psychological discomfort (as identified by participants in this study) it is likely that hidden psychological concerns exist for many men. As such, outsiders may perceive men as mentally healthy when this is not necessarily the case. Therefore utilising such observation as a basis for decisions regarding the normality of one's own mental health is flawed and likely to produce erroneous perceptions. This is likely to result in an upward social comparison.

When utilising perceptions of others as the basis for one's own help-seeking decisions, many outcomes could eventuate. Men may consider that other men do not experience the problems they do and thus feel isolated, unmanly and unwilling to disclose their own distress. Conversely, perceiving one's own problems as unique may serve as a prompt to help-seeking

for significant concerns. Men who consider that other men do experience the same problems but do not seek help for them would seem more likely to conform than to seek help themselves where this may seem an uncommon behaviour.

Secondly, if individuals compare themselves to other men who suffer from significant and visible mental illness they may engage in a downward social comparison. A judgement of 'normality' made on the basis of this information may again be flawed as the source of comparison is in a more negative position. If men use this group as a basis of comparison they may be uplifted by the consideration that others are worse off. Conversely, they may feel as though their own experiences are minor in comparison and therefore unworthy of help-seeking. In this study men were found to utilise the theme that 'others are worse off' in order to justify their own lack of help-seeking. The belief that a problem may not be serious 'enough' to seek help was also highlighted by participants in chapters two and four.

Social comparison can therefore be seen as a double-edged sword in considerations of psychological concerns and help-seeking. In order to counter its possibly detrimental effects improvements to mental health literacy should be considered on a number of fronts. Firstly, mental health knowledge could be improved to the point where men can identify when something is wrong. This would reduce the need to engage in social comparison and thus erroneous beliefs about the mental health of others would become less influential. Secondly, increasing understanding about the widespread nature of psychological concerns in men and concurrent societal silences surrounding the topic would furnish men with more information which may affect social comparisons with others. Thirdly, knowledge of the various symptomatology associated with different disorders would allow men to make more appropriate comparisons (i.e. rather than with someone suffering a psychotic episode when

his own concern is low mood). Lastly, increasing the public's understanding that there is no threshold of severity that must be reached before one can legitimately seek psychological support seems of utmost importance. Many men in this study normalised low mental health literacy amongst men; if it can be broadly increased positive effects in terms of identification of illness and help-seeking should occur.

6.5.2 Describing Depression

Depression symptomatology described by participants was consistent with that which has been termed 'masculine depression' (Kilmartin, 2005), 'hidden depression' (Brownhill, 2003; Brownhill et al., 2005), or 'masked depression' (Hart, 2001). Authors such as Hirshbein (2006) argue that the DSM-IV criteria for depression are based on the female experience as it is women that most commonly present and are treated for depression. The symptoms and experience of depression may be substantially different for men than women and as such the standard feminised assessment criteria may not be applicable to men (Hart, 2001). The DSM-IV criteria for a diagnosis of depression include features such as feelings of sadness, tearfulness and feelings of worthlessness (American Psychiatric Association, 2000) which numerous authors hypothesise may not be expressed as part of men's experience (Warren, 1983). Symptoms likely to be present in male-type depression include anger, antisocial behaviour, work-related problems and substance use (Brownhill et al., 2005; Kilmartin, 2005; Kleinke et al., 1982). Such differences in symptomology should be considered when developing methods of education which are either aimed at or intend to address men.

Men in this study illustrated their accounts with behavioural symptoms such as social withdrawal, lack of motivation (especially regarding work), along with being irritable and angry rather than discussing negative mood or emotion. These symptoms may not be

perceived as related to depression or may not reach clinical significance using the standard DSM-IV criteria. The findings of this study suggest that at least a proportion of men with depressive illness do not seem to conform to the standard assessment criteria. As such there is likely to be some value in assessing men for 'masculine depression' rather than only standard criteria or assessment tools which may under or misdiagnose those that do seek intervention (Breland & Park, 2008; Cochran & Rabinowitz, 2003).

Professionals should be aware that vague descriptions of problems from both genders, but by men in particular, may hide significant concerns. A failure by the practitioner (general or mental health) to further investigate such presentations may contribute to men's under diagnosis, especially in the case of depression. The language men use may be vague and not lead professionals to the true problem. Greater discussion and gentle probing may be required in order to gain an understanding of the underlying concern. This has implication for the training of all professionals who work with men, particularly general practitioners and mental health professionals.

The proportion of responses in this study which discussed low mood may in part be due to a lack of questioning on this topic. However, it may also be the case that limited emotional expression, or alexithymia, may play a role. Alexithymia is defined by Levant as "the inability to identify and describe one's feeling in words" (1995, p. 238). Men have higher levels of alexithymia than women (Levant, Hall, Williams, & Hasan, 2009). Indeed, Levant (1995) proposed that due to socialisation in hegemonic masculinity a certain level of difficulty with emotion was common in men. However, emotional distress is a common component of conceptions of mental illnesses such as depression (American Psychiatric

Association, 2000) . Therefore the lack of discussion regarding emotions associated with psychological concerns in these interviews was striking and unexpected.

6.5.3 What to do about the problem: Avoiding

Avoidance of acknowledging psychological concerns was a major theme throughout interviews conducted for this study. Men described ‘denial’ of any problem and ‘delay’ of help-seeking. Many participants presented these themes as customary behaviours amongst men, thus positioning their own behaviour as both average and ascribing to masculine norms. Denial and delay of help-seeking were also identified in previous studies in this research (see chapters four and five) and in the literature (Banks, 2004; Dew et al., 2007; Levant, 1990; Tudiver & Talbot, 1999; Vanheusden et al., 2008; Wang et al., 2005) as significantly impacting the psychological treatment of men.

In some instances denial may be more problematic than delay. Those who delay may intend to later seek help if the problem is not resolved, and this may have been successful in the past. However, denial may result in no intervention being sought despite the unresolved nature of the problem. Thus, denial and delay should be considered separately when developing strategies to address men’s help-seeking behaviour.

In this study participants isolated a number of reasons for engaging in denial and delay. These included perceptions that others were worse off, fear, lack of knowledge of sources of help, stigma and the constrictive nature of traditional masculinity.

'Fear' of the unknown is likely to present a significant barrier to help-seeking for both women and men. It was identified earlier in this research (see chapter four) and in the literature (Davies et al., 2000; Dew et al., 2007; Gott & Hinchliff, 2003; Howerton et al., 2007; Kushner & Sher, 1989; Outram et al., 2004; Rickwood et al., 2005) as a barrier to seeking help for mental concerns. Specific apprehensions described within this theme were fear of being diagnosed, of the ramifications of diagnosis (e.g. hospitalisation, medication), and fear of being judged as unmanly.

Where a concern remains undisclosed the individual is not challenged to take action. Disclosing a problem in some sense makes it 'real' as it exists outside the individual. Disclosure is therefore likely to be associated with fear of unknown consequences, be they diagnosis, medication or even hospitalisation. At the very least disclosure leaves one vulnerable to input from others. Societal expectations on men have historically required them to distance themselves from such positions. Therefore embracing vulnerability is contrary to characteristics such as strength and independence which men have been socialised to adopt. In light of this it is likely that for many men actively assuming a vulnerable position is psychologically difficult.

For those who have little experience in surrendering control or relying on others vulnerability may provoke a defensive attitude. One ramification of this for illness identification in primary care could be that if a man senses that the professional will judge him negatively if he discloses mental health concerns the man may instead attempt to manage the way he is viewed (by the professional and himself) rather than reveal what he may consider a weakness.

Further implications exist for those who do make it to therapy. Men may attend treatment in a defensive stance, vigilant for signs that they may be personally challenged or that they become too dependent upon the therapist (Shay, 1996). This is likely to be especially true for those men who ascribe to traditional notions of masculinity. These men are generally uncomfortable in positions in which they feel disempowered (see Connell & Messerschmidt, 2005; Courtenay, 2000a for discussion). Those men who are gender-role conflicted have been shown to perceive therapists as more powerful than with low gender-role conflict (Blazina & Marks, 2001). Such power dynamics in therapeutic interactions have been described as obstacles to help-seeking for traditional men (Blazina & Watkins, 1996). Thus, allowing men experiences of control in therapy may help to alleviate defensiveness and resistance to attendance. Providing information to men about expectations of therapeutic interactions, types of therapy, and likelihood of change may help to reduce anxieties regarding psychological help-seeking (Scheyett & McCarthy, 2006). If practitioners are aware of such issues and this is achieved early in therapy men may feel less vulnerable and therefore defensiveness could be alleviated.

‘Lack of knowledge’ regarding where to seek help was another theme which served as a barrier to men’s help-seeking. It was noted that help was sought primarily from GPs, but that participants indicated that they would not have known where else to go. This emphasises the importance of the first help-seeking interaction. If men do not receive the required support they may firstly be discouraged by this failure to address the problem, but secondly may not know where else to seek help. Any attempt by men to seek help should therefore be treated as though it may be the only attempt made (Strike et al., 2006). Practitioners should be careful to probe for extra information and determine whether deeper issues exist rather than simply that with which a man presents. This may especially be the case when considering symptoms of masculine or masked depression, as discussed earlier.

'Stigma' has been a theme identified throughout this research as problematic for help-seeking (see chapters four and five) and was again present in accounts of men in this study. Stigma is conceptualised as a mark that ties an individual to a negative characteristic (Goffman, 1963). Link and Phelan define it as the co-occurrence of labelling, stereotyping, separation, status loss, and discrimination (2001). In the excerpt above the participant discusses perceived stigma (Barney et al., 2006), or the belief that others will judge him poorly. Participants in this study discussed the effect of perceived stigmatising attitudes of others, tangible stigmatising attitudes of others and self-stigma. Literature on the topic suggests that stigma is one of the biggest challenges in attempts to increase help-seeking for mental health problems (Barney et al., 2006; Corrigan, 2004; Dinos et al., 2004; Stefl & Prospero, 1985; Vogel, Wester, & Larson, 2007; Wrigley et al., 2005). Individuals who are worried that others will think negatively of them if they seek help and thus identify themselves as suffering from psychological concerns (perceived stigma) or will feel negative about themselves for this behaviour (self-stigma) will often refrain from undertaking help-seeking in order to avoid such negative opinion (Corrigan & Watson, 2002). In this sense attempts to avoid stigma can be conceptualised as attempts to maintain a particular identity or to 'save face'. This may be particularly important for men as stigmatising attitudes regarding mental illness have been shown to be more negative for men than women (Farina, 1981). Happily, some participants did note beliefs that stigma surrounding mental health was decreasing and discussions on the topic were becoming more acceptable. It is hoped that with time and education this will continue.

The constrictive nature of the traditional 'masculine role' was identified by all men as significant to this discussion. Hegemonic masculinity was described by participants as it has been in the literature as comprising of strength, emotional inexpressiveness, control, independence, competitiveness and success as an income earner. Some participants identified

the problematic nature of honouring such unfeasible notions of what constitutes a man. However, many discussed the ramifications of suffering mental illness in light of these notions but did not indicate a desire to challenge the paradigm. Mental illness was labelled as a weakness, as a personal shame or failure, and men who expressed emotion associated with this as feminine.

Admitting to psychological concerns has been constructed as likely to be considered a weakness in men by participants across three studies (see chapters four and five) and in previous literature (Chew-Graham et al., 2003; Davies et al., 2000; Kuehn, 2006; McVittie, Cavers, & Hepworth, 2005; Wang, Fick, Adair, & Lai, 2007). Mental illness is sometimes perceived as indicating or deriving from a weakness of character (Calhoun et al., 1974; Goldstein & Rosselli, 2003). This opinion has been found to be held by more men than women (see chapter two). It is not surprising then that those who hold such beliefs would wish to deny that they suffer from mental illness rather than draw attention to it by discussing it with others. Within the traditional masculine role help-seeking is considered weak as it necessitates a reliance on another rather than the self (Ducat, 2004). Therefore seeking help for psychological concerns could result in additional perceptions of weakness assigned both to the problem and the action undertaken. For those who consider that their masculine identity may be under threat by the problems they are experiencing (which are inconsistent with the hegemonic role), identity management is likely to be a foremost consideration. Seeking help under such conditions creates a significant threat to one's masculinity. Thus, many men would vehemently deny a problem and disregard treatment options as they attempt to assert an image consistent with traditional societal expectations. However, some men in this sample interpreted self-reliance as implying that they should take care of themselves, and that this included their mental health. This use of self-reliance as an impetus to seek help should be

considered in future educational strategies and similarly has implications for those who work with traditional men.

Emotional expression was also constructed as incompatible with masculinity in results of this study and those presented earlier (chapters four and five). Men's socialisation generally excludes understandings of how emotion can be articulated and exchanged. This is problematic, especially for men who suffer from psychological distress. Within the hegemonic paradigm emotionality is associated with femininity. Therefore, for men experience of emotion can be seen as challenging to their masculine identity. One participant discussed the extreme effort it took not to cry in front of his GP (see Extract 289, p.320). He reported that despite experiencing overwhelming distress and suicidal ideation he found it of utmost importance that he maintain a masculine image and not be 'compromised' by displaying emotion. This extract provides valuable insight into the barrier that hegemonic masculinity presents to men's help-seeking. If men engage in behaviour which attempts to manage other's perceptions of them at a time when they are in complete psychological agony then they are likely to both engage in this behaviour to a greater extent and to be more successful at presenting a facade of well-being and control at earlier stages of distress. Educational strategies which highlight possible differences in depression symptomology in men may help to reduce such reluctance.

Therapeutic intervention which encourages men to dispute the constrictive notions of hegemonic masculinity has been advocated in order to address such restriction of emotion (Sinclair & Taylor, 2004). Men who are able to contest socially accepted characteristics of masculinity and are introduced to new ways of expressing emotion are likely to then experience less conflict in undertaking therapy and thus have greater potential for gains.

Avoidance of emotion can be problematic as other methods of expressing distress are often sought. For some men in this study substance use provided an outlet for emotion which was otherwise deemed unacceptable. A number of men normalised this as a coping mechanism among men as it offers a method by which one can escape problems and remain consistent with the masculine role.

Many of the reasons men did not acknowledge their problem or seek professional help identified in this study reflected those documented in the literature. For example, Dew and colleagues (2007) identified fear of consequences, stigma, concern that one would be seen as whingeing, lack of awareness and gender issues as barriers to disclosing mental health concerns to general practitioners (along with others) for both men and women. This suggests that these are widespread, significant issues which should be addressed through educational programs for the general public and specific training for general and mental health practitioners in order to increase psychological help-seeking behaviour.

6.5.4 What to do about the problem: Accepting

Facilitators to help-seeking identified by participants were being 'prompted by others', seeking help as a 'last resort' and interpreting 'masculinity' as a prompt to health care. Wives and partners were identified as important prompts to men seeking and receiving help. This supports findings of chapter four that men rely on others to tell them they have a problem which requires help, as well as those of chapter five where practitioners identified that men are prompted to seek help, often by their partners. The significance of prompting by third parties in psychological help-seeking has been reported by other researchers. For example, Vogel, Wester, Larson and Hackler (2007) found that 75 percent of those who had sought psychological help had been encouraged by someone else to do so. Norcross, Ramirez

and Palikas (1996) reported that men were more than twice as likely as women to be prompted to seek health care by a member of the opposite sex. Having someone in whom one can confide (such as a partner) has been described as a protective factor for depression in older men (Miller et al., 2006). Therefore the emergence of the theme 'being prompted' in this study is supported by the literature and is likely to be to a significant facilitator to men's psychological help-seeking. Promotion of men's mental health should encompass those around men, particularly partners and mothers, along with sporting clubs and workplaces through occupational health and safety information.

Despite the seemingly pervasive nature of women monitoring the health of men, expectations that this will occur are problematic. Such expectations construct men as unaccountable for their own health behaviour and are therefore disempowering (Lyons & Willott, 1999). Further, placing the responsibility for men's health on women is a substantial and burdensome demand on women. It has been argued that the role of women in facilitating help-seeking extends much further than simply prompting men to seek help. Seymour-Smith and Wetherell argued that in interactions women give men an "interactional gift" (2006, p. 118) by introducing emotion and difficult aspects of illness which men commonly neglect to discuss. When this occurs men do not need to express such things. The authors note that when others raise such aspects of illness the masculinity of the men remains unchallenged, yet the emotion or problem can still be addressed. In this way women can be seen as complicit in maintaining hegemonic masculine practices such as lack of emotional expression.

There are also implications for therapeutic outcomes based on this finding. It may be the case that for many men help-seeking is a means of satisfying the wants of others, that is, those who prompt them. Theories of help-seeking (such as that by Shapiro, 1983) may not

take this into account. In these cases seeking help may be a source of contention and the men may have negative attitudes towards therapy. This creates a challenge as to how therapists can offer these men something that they deem useful enough to continue to attend appointments. It may be beneficial to be able to distinguish these men 'attending under duress' and tailor service delivery so that it involves them and they can see some benefit.

This is not to suggest that encouraging men to seek help is detrimental. As has been shown throughout this research and others (Seymour-Smith et al., 2002; Tudiver & Talbot, 1999), being prompted is a significant facilitator to men seeking help. Social support has a number of effects on those who suffer psychological distress. These include the mitigation of psychological stress, the provision of support, referral to professional sources of help and the communication of norms regarding help-seeking (Gourash, 1978). Those who prompt men to seek help can therefore be seen as undertaking important functions of social support.

A second facilitator identified by men in this study was help-seeking as a 'last resort'. This was consistent with the findings of Dew, Morgan and colleagues (2007) and elsewhere (Banks, 2004; Fleming, 2007; Hamilton, 2006; Strike et al., 2006) that 'reaching a point of breaking down' serves as a facilitator to help-seeking. Similarly, doctors and mental health professionals surveyed in chapter five identified a belief that many men would not seek psychological help unless they considered they had no other choice. Men who utilised this theme indicated that they had struggled to go on without intervention but reached a point where they felt they had to seek help 'or basically die'. A number of men stated that they did not seek help until they stood on the precipice of a life-changing event. For some this was a partner's threat to leave, for others it was the contemplation of suicide. If men fear being told that their problems are not serious enough to seek help (see chapters four and five) or being

judged as unmanly (see p. 312) they might unconsciously delay help-seeking until such a time that no-one can deny the severity of the problem. This is reminiscent of Heifner's (1997) finding that some pathways to services may be considered by men to be 'legitimate', or consistent with hegemonic masculine ideals.

Lastly, masculinity was utilised by a small number of men as a facilitator to help-seeking. These participants utilised traditional masculinity and its values of strength and self-reliance to argue that taking care of one's self was a man's responsibility and to fail to do so would render him dependent on others or indicate that he was scared of what others would think of him. The use of masculinity in this way was of interest. Whilst its rigid expectations are noted as commonly problematic for men, the use of such notions could be considered in future educational and media campaigns.

The two major facilitators to help-seeking that men identified from their own experiences were extreme. Being prompted by others suggests that a problem has become so significant that it is not only visible to others but they feel they should raise the issue. For some men in this study this involved a warning that their relationship would cease unless help was sought. Similarly, men disclosed that they considered suicide before they sought external help. These are crucial events which drove men to seek help. It is hoped that with increased mental health literacy men may not wait until problems become this chronic before seeking professional intervention. Whilst seeking help as a last resort is consistent with the traditional masculine role, the use of masculinity as a prompt to help-seeking should be explored in future research.

6.5.5 Gender Differences

Participants believed that gender differences existed in the experience of mental illness and help-seeking. Participants considered that differences existed in gendered societal expectations of men and women as well as women's greater use of their social network and dialogues around mental health.

Men noted that societal expectations of women were that they commonly suffered from psychological distress and would seek help from professional sources when needed. On the other hand men were expected not to suffer from distress and to cope with any challenges alone. These societal expectations are in line with hegemonic descriptions of masculinity and femininity. Such constructions can be seen as limiting to both men and women in terms of sanctioned behaviour. Those who stray beyond such constrained characteristics are likely to be stigmatised and categorised outside of their traditional gender group (see Donaldson, 1993, for discussion). Thus, the traditional masculine gender role can again be seen as constricting men's help-seeking behaviour.

Research has noted that social participation and support is an important predictor of psychological wellbeing (Murray et al., 2007). Further, women have been shown to have wider social networks (Antonucci & Akiyama, 1987) and gain more support from these than men (Pasick, 1990). Men in this study portrayed women as able to discuss concerns with other women in their social network, receive advice and information and feel connected with others. In contrast men described their own interactions with other men as superficial and lacking the connectivity present for women. Such descriptions help to account for findings that stigma is lower for women who know someone who has suffered from mental illness than

those who have not, but that the same is not true for men (Wang et al., 2007). The current findings suggest that this may be the case because men spend less time discussing personal problems with others (O'Neil, 1981) and therefore would have less opportunity for opinions to be modified. Further, women have more opportunities through media sources (such as women's magazines) to gain information regarding mental health than do men. The inclusion of such information in men's media may help to address this inequity.

For those traditional men who do seek help there is an opportunity for therapists to encourage men to acknowledge their emotion and to communicate it in interactions with others. If traditional men are able to discuss both their own and others' personal concerns to a greater extent they are likely to gain more information, have their own concerns normalised to some extent, and to feel better supported by their own network. This is especially important for those men whose relationships end, due to men's tendency to rely solely on their partner for emotional support (Tudiver & Talbot, 1999). In the case of those men who have been given an ultimatum by their partner to seek therapy or cease the relationship, the prospect of being left alone to cope with their emotions may be a very real one. If a man does not regard emotional expression as a legitimate outlet such crises can lead to substance use and abuse, as discussed in this study and earlier (see chapter five).

6.5.6 Strengths and Limitations

A strength of this research is that it has explored the lived experiences of men with mental health concerns. Therefore the themes identified are not hypothetical in nature but likely to reflect real issues that the men involved have personally faced. Further, the participant age range (26 to 64 years) allowed the study to address issues relevant to men across different times of their lives. The sample included men from both rural and

metropolitan areas in order to identify similarities and differences in themes identified across regions. Importantly, this research explored the process of problem identification rather than only barriers to help-seeking. Focus on the help-seeking process has been a limitation of previous research as difficulties identifying a problem will necessarily affect help-seeking decisions. That is, if one does not recognise a problem no help will be sought. The experiences of men who have suffered from mental health concerns and sought help are particularly useful as these men have confronted barriers which exist to psychological help-seeking and found a way forward.

One limitation of this study is that it is likely to miss what O'Brien and colleagues call "the strong and silent type" (2005, p. 514), that is, men who are unwilling to discuss their personal concerns and do not seek therapy. These types of men are unlikely to identify themselves as participants in this kind of research. Therefore, the knowledge of those men who had sought help and were willing to discuss their experiences was valuable, albeit stemming from a slightly different perspective. However, those who did participate in this study were able to examine their mental health histories with a young female researcher. Few men seemed to have difficulty doing so, which may be a result of having attended professional psychological services previously. As Emslie and colleagues (2006) noted, this shows "that (some) men (at some times) can and will talk" about their emotions and experiences of mental illness (p. 2255).

6.6 Conclusion

It is acknowledged that individual differences exist between all men and that generalisations are unlikely to reflect experiences of individuals. However, men in this study were generally unable to identify personal problems as likely to be related to mental health.

Men described symptoms of depression more in line with ‘masked’ or masculine depression than standard criteria. Participants admitted to denying their psychological concerns and delaying help-seeking, often until such a time as they felt they had no option. They also portrayed such behaviour as normal amongst men. Men identified the motivations for denial and delay as believing others were worse off, fear, lack of knowledge of sources of help, stigma and in particular the constrictive nature of traditional gender roles. Gendered expectations of men and women, along with the greater social support received by women were presented as productive of significant inequalities in the experience of mental illness. The role of women in prompting men to seek help was highlighted.

Such findings provide greater understandings of the experience of men with mental illness. This could lead to improvements in mental health education such as utilising self-reliance as a motive for help-seeking and publicising gender differences in symptoms of depression, and service provision, such as developing specific services for men without the expectation that they are perpetrators of violence, which in turn could result in greater engagement of men with mental health services.

CHAPTER SEVEN

Summary

The aim of this research was to examine the barriers that exist to the identification of mental health concerns among men and to their seeking appropriate professional treatment. The studies in this thesis highlight that men's experience of mental health and help-seeking is likely to be somewhat different to that of women. Young men and women, general practitioners, mental health practitioners, and adult male consumers of mental health services participated in this research and provided insight into relevant issues for men's mental health.

This chapter summarises the results and implications of this research.

Study One: Gender-Role Conflict and Attitude Toward Help-Seeking

The first study investigated the impact of prior experience of psychological distress, gender-role conflict, mental health locus of origin, personality and gender on attitudes to psychological help-seeking. A survey was completed by 635 men and women. Results indicated that negative attitude towards help-seeking was associated with high gender-role conflict, low scores on the personality variables conscientiousness and agreeableness, and high scores on neuroticism. Interactional beliefs regarding the origin of mental illness were associated with more negative attitudes toward help-seeking and high gender-role conflict. Men experienced greater gender-role conflict than women and held more negative attitudes toward psychological help-seeking. Male participants also held more interactional beliefs regarding the origin of mental illness, whilst women held more endogenous beliefs. These findings suggest that professionals from whom men seek psychological support are likely to

be faced with an a priori stance of negativity. This study established significant associations between interactional mental health locus of origin and gender-role conflict as well as negative attitudes toward help-seeking. Findings contribute to existing literature on the pervasively negative effect of gender-role conflict on men's help-seeking behaviour.

Study Two: Mental Health Literacy

The second study examined the mental health literacy of young people using vignettes of depression and schizophrenia. Variables of interest included recommended sources of treatment, beliefs about treatment outcomes, likelihood of seeking help and gender differences. Results showed that mental health literacy was high regarding depression but significantly lower for schizophrenia. Participant recommendations of the best source of treatment for the individual presented in the vignette of depression varied according to the diagnosis given, although the most common advice was to see a psychologist. Comparable recommendations for schizophrenia were to see a GP or counsellor, and did not differ across diagnosis. Mental health literacy for both depression and schizophrenia was lower in men than women. Men were also more likely to recommend informal sources of help (such as talking to family and friends) for depression whilst women were more likely to advise seeking professional intervention. Further, a number of participants stated that they were unlikely to follow their own advice if they suffered from the described disorders. Men were three times less likely than women to follow their own advice regarding source of treatment for schizophrenia. If men are unable to identify mental illness or unwilling to seek professional help when needed (such as when experiencing symptoms of schizophrenia) then appropriate treatment may not be attained. Increasing the mental health literacy of the community may begin to address this concerning finding.

This study contributes to our understanding of the role of gender in the experience of psychological concerns. Men were identified as possessing lower mental health literacy than women. Further, even where men acknowledged the need for specific intervention they were less likely than women to follow this recommendation. These findings enhance existing understandings by indicating that knowledge alone does not predict men's help-seeking behaviour.

Study Three: Help-Seeking Behaviour

The third study in this thesis investigated barriers to seeking help for both physical and mental concerns. Two hundred and thirty-nine university students completed surveys which described how they would characterise men with mental illness, identified barriers to men seeking psychological help, and gave suggestions for improving men's help-seeking. The majority of participants indicated that they would seek help from professional (men) or informal (women) sources if they experienced psychological concerns, although some men responded that they would prefer to deal with mental illness themselves. A major barrier to help-seeking for both physical and mental concerns identified by both men and women was embarrassment. Inability to identify a problem as a mental illness was further specified as likely to impede help-seeking. The majority of participants believed that perceptions of weakness would prevent men from seeking psychological help and that education could change this.

Of particular interest were responses regarding how participants would know if they suffered from a mental illness. Whilst women suggested that they would notice a change in their thoughts and behaviour, men reported that other people would tell them. The findings of this study contribute to previous research by indicating that an inability to identify

psychological concerns, embarrassment and fear of being perceived as weak may impede men's help-seeking behaviour. Thus, it seems that barriers to seeking help may be attitudinal and consequently amenable to change.

Study Four: Professional Experiences of Men Seeking Help

Study four examined the experiences of general practitioners and mental health professionals regarding men with mental illness and their psychological help-seeking. Surveys of rural and metropolitan practitioners were undertaken to examine professional views on this topic. Results indicated that both male and female professionals believed differences exist in the way that men and women recognise mental health issues. Many participants identified women's tendency to disclose and awareness of mental health in comparison to men's denial of the problem, delay to help-seeking and tendency to engage in maladaptive coping methods (such as alcohol or drug use). Professionals noted that traditional expectations of masculinity (such as self-reliance, rejection of dependence and vulnerability, lack of emotional expression, and underlining the role of worker) decreased the likelihood that men would seek professional help. Women were commonly described as self-referring to professionals whilst men were referred to as requiring prompting by others. Participants believed that education, increasing access to services, providing gender specific services and goal-oriented therapy would increase psychological help-seeking by men.

A number of the themes identified in the comments of doctors and mental health professionals reflected those documented in earlier studies. This suggests that themes such as the role of masculinity, denial of problems, rejection of weakness, the role of others in prompting men are indeed of significance in considering the barriers to service use which exist for men. This study presented general practice and mental health professionals'

experiences of men with mental health concerns. The findings contribute to the field by highlighting issues of particular concern which should be considered when addressing this population either therapeutically or through educational campaigns.

Study Five: Male Consumers of Mental Health Services

Study five explored men's experiences of mental illness and psychological help-seeking through in-depth interviews which were undertaken with rural and metropolitan men who had sought professional assistance. This study aimed to highlight the factors men considered important in recognising and accessing psychological help.

Findings indicated that when first experiencing psychological concerns, most men in this study knew 'something wasn't right' but were unable to specify what was wrong. Participants normalised the denial of psychological concerns and delayed help-seeking. Reasons given for denial and delay were fear, lack of knowledge regarding available treatment sources, stigma, and particularly the constrictive nature of traditional masculinity, including rejection of weakness, and emotional inexpressiveness. Participants described symptomatology in ways consistent with 'male-type' depression, indicating that expression of symptoms for this disorder is likely to be different to those commonly reported by women. Facilitators to help-seeking were identified as being prompted by others (such as wives or friends), doing so as a last resort, and unexpectedly, the traditional masculine role. A small number of participants utilised the traditional male value of self-reliance as an impetus to seek help and thus care for themselves.

Participants also discussed perceived gender differences in the experience of mental illness and help-seeking. Gendered societal expectations of what men and women 'do' were reported as restrictive for men and exclusionary of help-seeking behaviours. Men in this study also described the social networks of women as more supportive than those of men and that subsequent dialogue between women was more valuable than 'superficial' conversations between men. The findings of this study present a rich narrative of the experiences of men ranging in age from 26 to 64 years, from rural and metropolitan locations, who have experienced mental health concerns and have been able to address these. Such experiences and the themes identified in this study are valuable in developing understandings of the field of men's mental health and developing ways of improving the well-being of men. In particular, men's lack of knowledge of symptoms of mental illnesses and sources of help, delay to seeking help, and reliance on prompting by others should be considered when developing strategies to address men's help-seeking behaviour.

Clinical Implications

Research on men's mental health help-seeking has consistently made three general recommendations to improve men's psychological treatment; firstly, the acknowledgement of the influence of the masculine role on clients, secondly, its influence on therapists, and thirdly, the direct examination of this influence in therapy (e.g. Mahalik et al., 2003). The findings of this research are discussed in light of these suggestions.

1. Acknowledge the influence of the masculine gender role on the client

A number of researchers have argued that therapists should acknowledge the influence of the masculine gender role on male clients (Chuick et al., 2009; Mahalik, 1999; Mahalik et

al., 2003; Scher, 1990; Tremblay & L'Heureux, 2005; Wester & Lyubelsky, 2005). The findings of research in this thesis highlight a number of issues which could be considered in this context. Firstly, men may have a low level of mental health literacy (study two). In practice, this suggests that some men are likely to be unclear as to the nature of their problems even when making initial contact with services or entering therapy. Secondly, if men make incorrect assumptions about their problems then they may seek unsuitable interventions (study two). That is, if a man believes his insomnia is biologically based he may seek medical intervention for this. Further, he may be unlikely to spontaneously present psychological symptoms in the subsequent consultation with a GP unless asked directly (study four).

The results of this research indicate that men who suffer from depression may present with symptoms consistent with male-type depression rather than those which fit neatly into the DSM-IV criteria (study five). Male-type symptoms may be combined with personal uncertainty as to the nature of the problem (that is, low mental health literacy, study two). This could make accurate conceptualisation of the problem difficult for professionals. Further, men may prefer informal help-seeking (study two) and have a poor attitude towards seeking professional psychological help (study one). They may be unlikely to seek or be resistant to help (study one, three, four, five) even where they consider the intervention to be the most useful source of assistance (study two). Such men may experience feelings of failure that they have not been able to solve the problem alone (chapters three and five) and feel vulnerable if they are not in control (study four). In practice these men may present as resistant to therapy, and defensive or challenging to the therapist (Good, Thomson, & Braithwaite, 2005).

The results of studies three, four and five indicate that men are likely to have denied their mental health problem and delayed help-seeking prior to their first contact with mental

health professionals. This may occur due to beliefs that the problem is not sufficiently severe to seek help (studies one, two, three and five), fear of the outcome (studies three and five) or fear of the stigma associated with mental illness (studies three, four and five). Many men are also likely to be embarrassed to be seeking help (studies one and three). Delay in help-seeking can result in increased levels of illness. Indeed, many men may attend services only as a last resort in a time of crisis (studies four and five). Therefore, general practitioners and therapists should be conscious of addressing the presenting needs of men in initial consultations. If a man feels challenged or dismissed on the first occasion he does seek help he may not return or seek out another avenue for support (Strike et al., 2006).

In some instances men may rely on others (such as wives or friends) to tell them that something was wrong (study three) and to prompt them to seek help (study four and five). This highlights the important role of others in helping men to understand their own mental health and in supporting them to gain professional support. These understandings can also contribute to the process of therapy. Some men may benefit from the therapist highlighting issues which arise in a concrete manner, rather than assuming that the client has made particular connections between issues independently. All clients, but particularly men who have been hesitant to engage with services, will benefit from continued encouragement from the therapist regarding progress and attendance.

The hegemonic masculine role prescribes that men are strong, self-reliant and emotionally inexpressive (Connell, 2005; Donaldson, 1993; Ducat, 2004; Kraemer, 2000; Levant, 1995; Pleck, 1995; Rutherford, 1992; Seidler, 1997). Seeking help may be seen as inconsistent with such values and is therefore likely to be resisted by many men (studies one,

three, four and five). For men who closely ascribe to such characteristics the process of help-seeking is likely to challenge their masculine identity.

2. Acknowledge the influence of the masculine gender role on the professional

Therapists and other mental health professionals need to address the influence of gender roles in their own life and practice (Robertson & Fitzgerald, 1990). Socialisation is a powerful and comprehensive process which often occurs unmarked. As such, individuals develop expectations of individuals based upon a myriad of factors, not the least of which is gender. However, these are not always productive. Therefore in order to be aware of how personal expectations may influence therapy, a professional should independently consider (and sometimes challenge) their own beliefs.

Therapist expectations that clients will fit the hegemonic masculine role, be breadwinners, strong, emotionally inexpressive and self-reliant are problematic both for the therapist and client. Further, therapists might consider male clients as likely to have severe symptoms (study three), use substances as an emotional outlet (study four) or to be weak because they have been unable to manage alone (study three, four and five). Therapeutic relationships should follow the lead of the client rather than be shaped by the expectations of the therapist. Therefore, where such expectations exist these should be considered.

Findings of research such as this may broaden therapist understandings of the experiences of male clients. However, this information could paradoxically lead to new expectations of male clients, such as that they likely to deny psychological problems (studies three and four). The intention of this research is to provide information which can contribute

to better understanding of the role of gender on experiences of mental illness. It is hoped that these findings can be incorporated into a greater appreciation for the restrictive nature of gender roles and how these can affect an individual's access to and progress within therapy (Heppner, 1995). Therapists therefore should utilise this information in informative rather than prescriptive ways. That is, let it inform practice rather than shape it.

3. Address the masculine gender role in therapy

Studies one, two, three, four and five have demonstrated that the hegemonic masculine role is problematic to men's mental health and help-seeking. Societal expectations about what a man is and does are exclusive of disclosing mental health concerns and psychological help-seeking. The findings presented in this thesis therefore support arguments made by previous research that the masculine role should be explicitly addressed in therapy (Allen & Gordon, 1991; Heppner & Heppner, 2001; Pasick, Gordon, & Meth, 1990; Rabinowitz & Cochran, 2008; Sinclair & Taylor, 2004). It is also recommended that therapists and clients acknowledge feelings of loss of control and identity (Cornford et al., 2007), focus on losses experienced across the lifespan related to gender constraints (Cochran, 2001), normalise discussion of emotion (Mahalik et al., 2003) and utilise group formats where men are encouraged to share emotions without judgement from others (see Blazina & Marks, 2001, for discussion). Mahalik (1999) has also identified cognitive distortions that men are likely to hold (to a greater or lesser extent) based on the values of hegemonic masculinity. Although the masculine role may be more or less prescriptive and inhibitive for individual men, the findings of this research indicate that addressing the role expectations of gender play in the lives of individuals is important for all clients.

The results of this research suggest that modifying treatment modalities to those which are consistent with a traditional male role is likely to be well received by men who are gender-role conflicted. Modalities which are not consistent with masculine values may be associated with early cessation by those men who are uncomfortable. Recommendations as to therapeutic approaches which are best suited to engaging reluctant men have also been made in a number of studies. To begin, a clear structure of therapy and explanations of the purpose of particular activities, such as homework assignments in cognitive behavioural therapy (CBT), have been identified as effective (Tremblay & L'Heureux, 2005). Some research has suggested that men prefer action-oriented or other alternatives to supportive individual therapy (study four, Ogrodniczuk, 2006). Wisch, Mahalik and colleagues (1995) noted that the focus on skill development in CBT is consistent with a goal-oriented style. Others have recommended a psycho-educational (Levant, 1990; Robertson & Fitzgerald, 1992) or psychodynamic approach (Pollack, 1995).

General practice and mental health professionals who participated in this research identified avenues which could be utilised to address the restrictive nature of the masculine role outside therapy (study four). Education, the provision of gender-specific services for men and better access to services (such as outside working hours) were seen as ways forward in men's mental health. Detailed explanations of the non-judgemental nature of mental health consultations and concretely indications of what this means should be publicised (i.e. workers will appreciate that you came to see them, they do not think you should have been able to cope with your problem alone). Further, public education should include the message that GPs expect patients to tell them personal concerns that they would not tell other people, that GPs are commonly privy to such concerns and are well-versed in the best interventions.

Conclusion

The beliefs, attitudes and experiences of young people, professionals and men with mental health concerns were identified and collated in this research in order to generate a better understanding of the atmosphere surrounding men's mental health. A number of themes were common throughout the studies undertaken for this research, many of which were consistent with previous literature on men's mental health and help-seeking. These included men's negative attitude towards psychological help-seeking (Ang et al., 2004; Goh et al., 2007; Hao & Liang, 2007; Leaf & Livingstone Bruce, 1987), low mental health literacy (Cotton et al., 2006; Thompson et al., 2004), stigma (Corrigan, 2004; Howerton et al., 2007; Stefl & Prosperi, 1985; Vogel, Wester, & Larson, 2007; Wrigley et al., 2005), denial of the problem (Levant, 1990; Tudiver & Talbot, 1999; Vanheusden et al., 2008), delay of help-seeking (Galdas et al., 2005; Wang et al., 2005), and the importance of the role of others in men's mental health (Lyons & Willott, 1999; Norcross et al., 1996; Seymour-Smith & Wetherell, 2006; Seymour-Smith et al., 2002). However, this thesis has identified each of these themes across a range of samples, including youth, professionals and adult men with psychological concerns in rural and metropolitan areas. It therefore provides evidence that these themes are seen as significant and pervasive across ages, locations and professions.

Each of the themes identified can, in essence, be traced to the pervasive and constrictive nature of traditional or hegemonic masculinity. The major themes which have emerged throughout this research reflect attempts by men to manage and maintain values and behaviours consistent with the hegemonic masculine role. It is acknowledged that the hegemonic male role is, in some instances, adaptive and valuable. However, the inconsistency of this role with the acknowledgement of psychological distress and involvement in help-seeking behaviour can result in harm to men's health. Therefore, this thesis advocates that

masculine gender role expectations of clients and therapists be both considered and explicitly discussed in the psychological treatment of men.

The findings of this research provide evidence that men with psychological concerns experience barriers to help-seeking upheld by themselves, their local communities, and the wider society. The recommendation of this thesis is that its findings are utilised in future mental health service development and planning, public health research and campaigns, by general practitioners, therapists, and to educate individuals around men so that it may contribute to improvements in mental health education and service provision, greater engagement of men with mental health services, and in so doing, enhance the well-being of men.

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APPENDICES

- A. Participant information sheet and List of available services
- B. Survey Battery
- C. Chi Square results: Source of Help Sought by Gender
- D. T-test results: GRCS by Prior Experience of Distress
- E. T-test results: GRCS by Experience of Seeking Help and Service Utilised
- F. T-test results: ATSPPHS by Experience of Help-Seeking and Service Utilised
- G. T-test results: Neuroticism by Experience of Seeking Help, Service Utilised and Experience of Distress
- H. T-test results: Openness to Experience by Experience of Distress. Experience of Help-Seeking and Service Utilised
- I. Preference for using Form by Reason Given for not Help-Seeking
- J. Likelihood of Following own Recommendation by diagnosis given to John
- K. Likelihood of Following own Recommendation by diagnosis given to Mary
- L. Practitioner Information Sheet and Survey
- M. Consumer Information Sheet, Consent Form and List of Available Services



Seeking Psychological Help Study

Thank you for your interest in this study looking at attitudes to help-seeking.

About this Study: My name is Nicole Bevan and I am conducting this research as part of my PhD with the School of Psychology at the University of Adelaide. This project aims to determine what predicts an individual's decision to seek help. In particular, we are interested in help-seeking for mental health issues (stress, relationship issues, grief, depression or other mental disorders). But anyone can take part in this research, whether you have experience in seeking this kind of help or not. We are interested in attitudes, which means that it doesn't matter whether you have actually thought or done anything about seeking help in the past, but what your feelings are about the questions we pose.

Participation: Involvement in this project consists of completing a questionnaire online or in paper and pencil format. Some paper format questionnaires are available from the Psychology Office, or please feel free to contact me (details below). Completion of the questionnaire will generally take less than 30 minutes. (Please note that the online questionnaire is conducted over a few pages for ease of completion.)

If you choose to take part but change your mind once you have started, you can cease completion of the questionnaire at any time. Your participation in this project will be kept confidential, and any identifying details (e.g. student number) will be stored separately from completed questionnaires.

Please note that you are free to withdraw from the project at any time. It is not expected that there will be any adverse effects of participation in this research. However, information will be provided regarding where to seek further support should any issues arise.

To take part, go to www.psychology.adelaide.edu.au/expts/seekhelp.html

Extra measures (these are not requirements of participation): Those participants who are able are requested to voluntarily ask their father and/or grandfather to complete the same measures. Paper versions of the questionnaire and reply paid envelopes are available from the Psychology Office for this purpose. Alternatively, fathers and grandfathers can also complete the questionnaire online at www.psychology.adelaide.edu.au/expts/seekhelpparent.html

Those able to complete this extra measure are requested to do so. Measures from different generations will give the researchers an idea of any inter-generational differences in help-seeking. These extra measures are not a requirement of participation in this research; however, your help would be appreciated.

Ethics of Study: This project has received Ethics approval from the School of Psychology (Approval Number 06/109). However, if you have concerns or questions about this study, please contact either Nicole Bevan on 8303 3101 (or nicole.bevan@adelaide.edu.au), project supervisor Dr. Aspa Sarris (8303 6144) or chair of the Psychology Research Ethics Committee, Dr. Paul DeFabbro (8303 5744).

Thank you for your interest in this study.

Nicole Bevan

Psychological Help

If you or anyone you know suffer from depressed mood, relationship issues or other concerns, please don't feel like there's nothing anyone can do to help. There are many services and private practitioners who provide help for these and other problems. In most cases getting help will not cost anything as government services are provided under Medicare. Services provided by private psychologists are now also subject to Medicare benefits, although payment of the gap between this refund and the service fee is generally required.

Your doctor can refer you to a local psychological service. GPs are often the first port of call for people seeking psychological help, so they have a lot of experience in this area and can talk with you about what to do. A few other sources of help are listed below.

www.lifeline.org.au or call to speak anonymously with a counsellor on 13 11 14
(24 hours, 7 days)

Men's Line Australia 1300 789 978 Information, support and referral (24 hours, 7 days)

Emergency Mental Health Service SA 13 14 65 (24 hours, 7 days)

Local mental health numbers are available in the **white pages** under "mental health services".

www.beyondblue.org.au (particularly related to depression)

www.reachout.com.au (particularly related to youth)



Seeking Psychological Help Study

This is a voluntary survey. Information you provide will be kept confidential.
If you are a 1st year Psychology student please enter your student number in the top right hand corner. No course credit will be given if no number is recorded.

Please answer all questions as truthfully and as best you can. Some questions may seem repetitive, but please try and answer each as if they were the only one. When you have completed the survey please **return it to the Psychology office as soon as possible**. Thank you for your interest in this study

- What is your age? 16-24 25-34 35-44 45-54 55-64 65+
2. What is your gender? Male Female
3. What is your marital status?
 Single
 Married/ De facto
 Separated/ Divorced
 Widow or Widower
4. What is the highest level of education you have achieved?
 Did not finish high school
 High school
 TAFE course
 University Degree
 Postgraduate Degree
5. How would you best describe your occupational level?
 1st Year Uni
 Other Undergraduate
 Postgraduate
 Employed
 Unemployed
 Retired
6. Which of the following people do you have contact with at least once a week? *Please indicate all appropriate.*
- | | |
|--|--|
| <input type="checkbox"/> Wife/ Female Partner | <input type="checkbox"/> Husband/ Male Partner |
| <input type="checkbox"/> Mother (incl. in law) | <input type="checkbox"/> Father (incl. in law) |
| <input type="checkbox"/> Sister(s) | <input type="checkbox"/> Brother(s) |
| <input type="checkbox"/> Daughter (s) | <input type="checkbox"/> Son(s) |
| <input type="checkbox"/> One Female Friend | <input type="checkbox"/> One Male Friend |
| <input type="checkbox"/> A few female friends | <input type="checkbox"/> A few male friends |
- The following statements relate to how you feel about psychological help. Please indicate the one answer that best describes your response by placing a tick (✓) in the appropriate box.*
7. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.
8. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts. Agree
 Partly Agree
 Partly Disagree
 Disagree
9. If I were experiencing a serious emotional crisis at this point in my life, I'd be confident that I could find relief in counselling. Agree
 Partly Agree
 Partly Disagree
 Disagree
10. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help. Agree
 Partly Agree
 Partly Disagree
 Disagree
11. I would want to get psychological help if I were worried or upset for a long period of time.
 Agree
 Partly Agree
 Partly Disagree
 Disagree
12. I might want to have psychological counselling in the future. Agree
 Partly Agree
 Partly Disagree
 Disagree
13. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help. Agree
 Partly Agree
 Partly Disagree
 Disagree
14. Considering the time and expense involved in counselling, it would have doubtful value for a person like me. Agree
 Partly Agree

- Partly Disagree
 Disagree

15. A person should work out his own problems; getting psychological counselling would be a last resort. Agree
 Partly Agree
 Partly Disagree
 Disagree

16. Personal and emotional troubles, like many things, tend to work out by themselves. Agree
 Partly Agree
 Partly Disagree
 Disagree

The following statements relate to the University Counselling Service offered by Adelaide University. Please indicate the one answer that best describes your response by placing a tick (✓) in the appropriate box.

17. I would contact the University Counselling Service or another psychological service if I had a problem or concern for which I needed assistance. Agree
 Partly Agree
 Partly Disagree
 Disagree

18. I know where and how to contact the University Counselling Service should I choose to do so. Agree
 Partly Agree
 Partly Disagree
 Disagree

19. I have concerns that my attendance and/or details of the concerns I take to the University Counselling Service will become part of my University file. Agree
 Partly Agree
 Partly Disagree
 Disagree

20. It is important for the University to provide a Counselling Service for students. Agree
 Partly Agree
 Partly Disagree
 Disagree

21. I believe that using the University Counselling Service would have a negative effect on my future career prospects. Agree
 Partly Agree
 Partly Disagree
 Disagree

22. My fellow students would support me choosing to use the University Counselling Service. Agree
 Partly Agree
 Partly Disagree
 Disagree

23. The location of the University Counselling Service is convenient for me. Agree
 Partly Agree
 Partly Disagree
 Disagree
 I don't know where it is

24. My lecturers would support my use of the University Counselling Service. Agree
 Partly Agree
 Partly Disagree
 Disagree

25. I believe that the University Counselling Service is effective in its ability to help solve work, personal and emotional problems. Agree
 Partly Agree
 Partly Disagree
 Disagree

26. The University Counselling Service is accessible to me. Agree
 Partly Agree
 Partly Disagree
 Disagree

27. If another student were having personal problems, I would recommend they see someone through the University Counselling Service or another psychological service. Agree
 Partly Agree
 Partly Disagree
 Disagree

28. I believe that University Counselling Service staff always act professionally. Agree
 Partly Agree
 Partly Disagree
 Disagree

29. Using the University Counselling Service is helpful to students. Agree
 Partly Agree
 Partly Disagree
 Disagree

30. I would be embarrassed to use the University Counselling Service or another psychological service.

- Agree
 Partly Agree
 Partly Disagree
 Disagree

31. I would feel more comfortable indicating my distress on a form than having to come out and say it.

- Agree Disagree

32. If I made up my mind to see someone from the University Counselling Service or another psychological service I would definitely go.

- Agree
 Partly Agree
 Partly Disagree
 Disagree

33. I currently struggle or have previously struggled with the following: *Please indicate all appropriate.*

- Major Stress (e.g. due to workload, career, finances)
 Relationship Issues (e.g. major strain, divorce etc)
 Mental Illness (e.g. anxiety, depression etc)
 Other Significant Personal Problems (i.e. not above)
 None of the above

34. I have sought help or are currently seeking help with the following: *Please indicate all appropriate.*

- Major Stress (e.g. due to workload, career, finances)
 Relationship Issues (e.g. major strain, divorce etc)
 Mental Illness (e.g. anxiety, depression etc)
 Other Significant Personal Problems (i.e. not above)
 None of the above

35. If you answered yes to any of the issues in Q33. and did not seek help, please explain why.

36. Someone close to me does or has suffered from mental illness. Agree Disagree

37. I have considered using the University Counselling Service and/or another psychological service.

- Yes (uni service)
 Yes (other service)
 Both (uni & other)
 No

38. I have previously used the University Counselling Service. Yes No

39. I have sought help for stress, relationship issues or mental illness from other sources.

- Yes, GP
 Yes, Mental Health Professional
 Yes, non professional source (e.g. friend)
 No

The next few questions are about your personality. Please choose the one response which is closest to your usual feelings or behaviour by placing a tick (✓) in the appropriate box.

1. How lively, outgoing, and extraverted are you?

- Not at all
 Slightly
 Less than most
 Moderately
 More than most
 Very much so
 Extremely

2. Do you get anxious, worried or frightened?

- Not at all
 Slightly
 Less than most
 Moderately
 More than most
 Very much so
 Extremely

3. Do you easily accept new ideas, different values, or views of what is aesthetically pleasing?

- Not at all
 Slightly
 Less than most
 Moderately
 More than most
 Very much so
 Extremely

4. How often do you make sure you know what to expect, what will need to be done, and how to be sure you get something right? Not at all

- Slightly
 Less than most
 Moderately
 More than most
 Very much so
 Extremely

6. Do you think most people are honest, well-meaning and can be trusted?

- Not at all

- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

6. How much do you prefer meeting people rather than reading, studying, or being at home?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

7. Do you often feel moody, low spirited, and negative about yourself?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

8. How imaginative, intellectually enquiring, and interested to try new things are you?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

9. How often are you organised, well-prepared, and ready for most situations?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

10. How often are you careful not to be too direct, or blunt, in case the truth hurts someone?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

11. How sociable, friendly, and relaxed are you with other people?

- Not at all

- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

12. Do you feel lonely or unhappy, or a bit left out of activities you would like to be a part of?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

13. How open-minded, flexible in your attitudes, and interested in other cultures are you?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

14. How often are you conscientious, careful, and trustworthy? Not at all

- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

15. How often do you consider other people's wishes, feelings, or their need for help?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

16. How active, quick and responsive are you?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

17. Are you an easily-affected, sensitive person whose feelings are easily hurt?

- Not at all
- Slightly
- Less than most

Moderately More than most Very much so Extremely

18. How easily moved, and affected by, or sensitive to beautiful things are you?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

19. How often do you feel motivated, looking to achieve some goal, or working to high standards?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

20. How difficult to you find it to be a little bit deceitful to manipulate things to your own ends?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

21. How easily can you tell jokes, or give your opinion, when you are the centre of attention?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

22. Do other people make you flustered, take you for granted, or try to push you around?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

23. How often do you want to go to new places, join new groups, or try novel forms of recreation?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

24. How often do you put things in order of importance, and pace your efforts, in order to finish what you start?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

25. Are you mostly modest, and somewhat retiring, rather than telling others of your successes?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

26. How much do you like being at large, noisy parties with lots of people you've never met?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

27. Do you have difficulty deciding, reacting to, or coping with unexpected events that demand an immediate response?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

28. How often do you imagine having new experiences, or things that you would like to happen, or events involving you that probably will not turn out like that?

 Not at all Slightly Less than most Moderately More than most Very much so Extremely

29. Do you plan ahead, consider all the possibilities, and think of what the best outcome would be?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

30. How often do you feel sorry for, and willing to help someone who is poor, very old, or disabled?

- Not at all
- Slightly
- Less than most
- Moderately
- More than most
- Very much so
- Extremely

The next section is about what people might do about problems. Please read the story before answering the questions below.

John is 30 years old. He has been feeling unusually sad and miserable for the last few weeks. Even though he is tired all the time, he has trouble sleeping nearly every night. John doesn't feel like eating and has lost weight. He can't keep his mind on his work and puts off making decisions. Even day-to-day tasks seem too much for him. This has come to the attention of his boss, who is concerned about John's lowered productivity.

1. What, if anything, would you say is wrong with John? *(Please be as specific as possible.)*

The following is a list of things John might do about his problem. Please indicate whether you think each item *in itself* would help, harm or make no difference (neither) to John's problem.

2. See a General Practitioner (GP).
 - Help Harm Neither
3. Talk about it with family/ friends.
 - Help Harm Neither
4. Do nothing.
 - Help Harm Neither
5. Talk to his boss.
 - Help Harm Neither
6. Take prescribed medications.
 - Help Harm Neither
7. Try to deal with it alone.
 - Help Harm Neither
8. See a psychiatrist.
 - Help Harm Neither
9. Use alcohol to soothe himself.
 - Help Harm Neither

10. See a naturopath.

- Help Harm Neither

11. Do something to take his mind off it.

- Help Harm Neither

12. See a psychologist.

- Help Harm Neither

13. Of the above, which one item do you think

would MOST help John? *(Please write the corresponding question number.)* _____

14. Please explain why you chose this intervention. _____

15. If John undertook the course of action you suggested above, how likely do you think it is that his problem would improve?

- Very Likely
- Likely
- Unsure
- Unlikely
- Very Unlikely

16. If John took the course of action you suggested, how long do you think it would take for his problem to improve?

- Days
- Weeks
- Months
- Years
- Never

17. If you had John's problem, how likely is it that you would take the course of action you suggested above? Very Likely

- Likely
- Unlikely
- Very Unlikely

Mary is 24 and lives at home with her parents. She has had a few temporary jobs since finishing school but is now unemployed. Over the last six months she has stopped seeing her friends and has begun locking herself in her bedroom and refusing to eat with the family or to have a bath. Her parents also hear her walking about her bedroom at night while they are in bed. Even though they know she is alone, they have heard her shouting and arguing as if someone is there. When they try to encourage her to do more things, she whispers that she won't leave home because she is being spied upon by the neighbour. They realise she is not taking drugs because she never sees anyone or goes anywhere.

18. What, if anything, would you say is wrong with Mary? (*Please be as specific as possible.*)

The following is a list of things Mary might do about her problem. Please indicate whether you think each item *in itself* would help, harm or make no difference (neither) to Mary's problem.

19. See a General Practitioner (GP).

Help Harm Neither

20. Talk about it with family/ friends.

Help Harm Neither

21. Do nothing.

Help Harm Neither

22. See a counsellor.

Help Harm Neither

23. Take prescribed medications.

Help Harm Neither

24. Try to deal with it alone.

Help Harm Neither

25. See a psychiatrist.

Help Harm Neither

26. Use alcohol to soothe herself.

Help Harm Neither

27. See a naturopath.

Help Harm Neither

28. Do something to take her mind off it.

Help Harm Neither

29. See a psychologist.

Help Harm Neither

30. Of the above, which one item do you think would MOST help Mary? (*Please write the corresponding question number*) _____

31. Please explain why you chose this intervention.

32. If Mary undertook the course of action you suggested above, how likely do you think it is that her problem would improve?

Very Likely
 Likely
 Unsure
 Unlikely
 Very Unlikely

33. If Mary took the course of action you suggested, how long do you think it would take for her problem to improve?

Days
 Weeks
 Months
 Years

Never

34. If you had Mary's problem, how likely is it that you would take the course of action you suggested above?

Very Likely
 Likely
 Unlikely
 Very Unlikely

Please indicate whether you think the sentences below about mental illness are true or false.

35. Mental illness is always biological and genetic.
 True False

36. Mental illness is always the result of stress.
 True False

37. People get mental illnesses because they aren't able to cope as well as everyone else.
 True False

38. Once you have a mental illness you are stuck with it for life. True False

39. You would definitely know if you had a mental illness. True False

The following questions are also about mental illness. Please indicate the one answer which best suits your response.

40. Eventually medical science will discover a cure for psychosis. Agree
 Partly Agree
 Unsure
 Partly Disagree
 Disagree

41. The cause of most psychological problems is to be found in the brain. Agree
 Partly Agree
 Unsure
 Partly Disagree
 Disagree

42. If the children of schizophrenics were raised by others people without mental illness they would probably grow up to be mentally healthy.
 Agree
 Partly Agree
 Unsure
 Partly Disagree
 Disagree

3. Mental illness is caused by some disease of the nervous system. Agree
 Partly Agree
 Unsure
 Partly Disagree
 Disagree

Appendix B

44. Some people are born mentally unstable and are almost certain to spend some part of their lives in a mental hospital. Agree

- Partly Agree
- Unsure
- Partly Disagree
- Disagree

45. Most people suffering from mental illness were born with some kind of psychological deficit.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

46. Some people are born depressed and stay that way.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

47. Everybody's system has a breaking point and those of mental patients are probably weaker.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

48. The mental illness of some people is caused by the separation or divorce of their parents during childhood

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

49. Being hot-blooded is the cause of mental illness in some people. Agree

- Partly Agree
- Unsure
- Partly Disagree
- Disagree

50. More money should be spent on discovering healthy methods of child rearing than on determining the biological basis of mental illness.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

51. Some people are born with the kind of nervous system that makes it easy for them to become emotionally disturbed.

- Agree

- Partly Agree
- Unsure
- Partly Disagree
- Disagree

52. Your choice of friends can have a lot to do with your becoming mentally ill. Agree

- Partly Agree
- Unsure
- Partly Disagree
- Disagree

53. Although they usually aren't aware of it, many people become mentally ill to avoid the difficult problems of everyday life. Agree

- Partly Agree
- Unsure
- Partly Disagree
- Disagree

54. Some people are born with a slightly greater capacity than others to commit suicide later in life.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

55. Many normal people would become mentally ill if they had to live in a very stressful situation.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

56. Mental health professionals probably underestimate the extent to which brain damage is responsible for mental illness.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

57. When a group of people are forced to live under extremely stressful conditions, the ones who crack under the strain are likely to be the ones who inherited a psychologically weak disposition.

- Agree
- Partly Agree
- Unsure
- Partly Disagree
- Disagree

58. The kind of nervous system you were born with has little to do with whether you become psychotic.

- Agree
- Partly Agree
- Unsure

- Partly Disagree
 Disagree

59. The cause of many psychological problems is bad nerves.

- Agree
 Partly Agree
 Unsure
 Partly Disagree
 Disagree

The final section relates to how you feel about some work, health and personal topics. In each case please indicate the one answer which best suits your response.

1. Moving up the career ladder is important to me.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

2. I have difficulty telling others I care about them.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

3. Verbally expressing my love for others of my gender is difficult for me.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

4. A feel torn between my hectic work schedule and caring for my health.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

5. Making money is part of my idea of being a success.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

6. Strong emotions are difficult for me to understand.

- Strongly Agree
 Agree

- Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

7. Affection with others of my gender makes me tense.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

8. I sometimes define my personal value by my career success.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

9. Expressing feelings makes me feel open to attack by other people.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

10. Expressing my emotions to others of my gender is risky.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

11. My career, job, or school affects the quality of my leisure or family life.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

12. I evaluate other people's value by their level of achievement and success.

- Strongly Agree
 Agree
 Partly Agree
 Partly Disagree
 Disagree
 Strongly Disagree

13. I worry about failing and how it affects my doing well.

- Strongly Agree

Appendix B

- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

14. I have difficulty expressing my emotional needs to my partner.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

15. Finding time to relax is difficult for me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

16. Doing well all the time is important to me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

17. I have difficulty expressing my tender feelings.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

18. Hugging others of my gender is difficult for me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

19. I often feel that I need to be in charge of those around me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

20. Competing with others is the best way to succeed.

- Strongly Agree
- Agree
- Partly Agree

- Partly Disagree
- Disagree
- Strongly Disagree

21. Winning is a measure of my value and self-worth.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

22. I often have trouble finding words that describe how I am feeling.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

23. I am sometimes hesitant to show my affection to others of my gender because of how others might perceive me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

24. My needs to work or study keep me from my family or leisure more than I would like.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

25. I strive to be more successful than others.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

26. I do not like to show my emotions to other people.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

27. My work or school often disrupts other parts of my life (home, health, leisure).

- Strongly Agree
- Agree
- Partly Agree

- Partly Disagree
- Disagree
- Strongly Disagree

28. I am often concerned about how others evaluate my performance at work or school.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

29. Being very personal with others of my gender makes me feel uncomfortable.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

30. Being smarter or physically stronger than others of my gender is important to me.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

31. People of my gender, who are overly friendly to me, make me wonder about their sexual preference (men or women).

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

32. Overwork, and stress, caused by a need to achieve on the job or in school, affects/ hurts my life.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

33. I like to feel superior to other people.

- Strongly Agree
- Agree
- Partly Agree
- Partly Disagree
- Disagree
- Strongly Disagree

If you would like information on the end results of this study, OR would like to be part of further research on this topic, please indicate which in one or both of the boxes below and enter your details.

This information is voluntary.

Name: _____

Email address: _____

***Address:** _____

***Phone number:** _____

(*not required if email address entered)

Please indicate the purpose for which you are providing this information.

- Results
- Further research

Thank you very much for your participation.

Chi Square Results for Gender by Source of Help Utilised

Source of Help Utilised	Percent of		<i>df</i>	<i>N</i>	χ^2	<i>p</i>
	Males	Females				
Psych Service	26.1	32.2	1	633	1.9	0.017
Other (GP)	11.9	20.3	1	634	5.49	0.019
Other Mental Health Professional	18.2	17.9	1	634	0.00	1.00
Other Non-Professional	44.3	55.9	1	634	6.38	0.012
None	45.5	33.4	1	634	7.43	0.006

T-Test results for GRCS by Prior Experience of Distress

Distress Experienced	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Suffer Stress	633	-4.34	0.00	118.30	21.99	110.96	20.42
Suffer Relationship							
Issues	633	-2.19	.02	117.38	22.76	113.47	20.79
Suffer Mental Illness	633	-3.23	.01	119.35	20.48	113.16	21.73
Suffer Other Psych							
Problem	633	-1.70	0.08	117.17	22.12	113.92	21.30
Suffer None	633	4.01	0.00	117.08	20.62	109.71	21.60

T-Test results for GRCS by Experience of Seeking Help

Experience of Seeking							
Help	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Sought Help for Stress	633	-.52	.61	115.87	24.33	114.64	21.04
Sought Help for							
Relationship Issues	633	.87	.38	112.70	23.39	115.09	21.34
Sought Help for Mental							
Illness	633	-.73	.47	116.35	19.98	114.58	21.83
Sought Help for Other							
Psych Problem	633	.08	.94	114.62	22.02	114.85	21.53
Sought Help for None	633	.47	.64	114.54	21.80	115.40	21.12

T-Test results for GRCS by Service Utilised

Service Utilised	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Psych Service	631	-1.24	.22	115.57	22.14	113.27	20.23
Other (GP)	632	.42	.67	114.09	23.15	115.03	21.22
Other Mental Health Prof	632	.21	.83	114.47	18.29	114.95	22.23
Non-Professional Source	632	-.09	.93	114.94	20.32	114.78	22.90
Used None	632	-.28	.78	115.18	22.52	114.69	21.01

T-Test Results for ATSPPHS by Experience of Help-Seeking

Help Sought For	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Stress	633	4.31	0.00	20.09	5.33	22.61	5.33
Rel Issues	633	2.86	<.01	20.48	5.51	22.44	5.35
Mental Illness	633	5.77	0.00	19.29	5.28	22.72	5.26
Other Psych Prob	633	4.42	0.00	19.41	5.16	22.53	5.34
None	633	-6.35	0.00	23.18	5.15	20.34	5.40

T-Test Results for ATSPPHS by Source of Help Utilised

Service Utilised	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Psych Service	631	-7.68	0.00	19.84	5.48	23.28	5.03
Other (GP)	632	5.06	0.00	19.96	5.39	22.73	5.27
Other Mental Health							
Prof	632	0.551	0.00	19.39	5.25	22.86	5.23
Non-Professional							
Source	632	1.77	0.08	21.88	5.48	22.64	5.28
Used None	632	-3.65	0.00	23.25	5.09	21.65	5.49

T-Test Results for Neuroticism by Experience of Distress

Experience of Distress	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Suffered Stress	633	-9.64	0.00	24.52	5.89	20.08	5.69
Suffered Rel Issues	633	-5.53	0.00	24.24	6.07	21.45	6.05
Suffered Mental Illness	633	-8.92	0.00	25.84	6.08	21.17	5.76
Suffered Other Psych	633	-4.25	0.00	24.08	6.36	21.78	6.02
Suffered None	428.5	9.5	0.00	19.3	5.21	23.8	6.11

T-Test Results for Neuroticism by Experience of Seeking Help

Experience of Seeking							
Help	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Sought Help Stress	633	-4.47	0.00	24.96	5.96	21.96	6.14
Sought help Rel Issues	633	-3.29	0.00	24.72	5.95	22.14	6.18
Sought help Mental							
Illness	633	-6.57	0.00	26.23	6.02	21.78	6.00
Sought help other	633	-0.73	0.46	22.97	6.27	22.36	6.20
Sought no help	633	4.91	0.00	21.58	6.01	24.09	6.25

T-Test Results for Neuroticism by Source of Service Utilised

Service Utilised	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Used Psych Service	631	4.03	0.00	23.93	6.43	21.8	5.97
Used GP	632	-5.28	0.00	25.16	6	21.84	6.08
Used Other MH Prof	632	-2.87	0.00	23.94	5.68	22.11	6.26
Used Non-Prof Source	632	-3.02	0.00	23.14	6.24	21.66	6.06
Used None	632	4.01	0.00	21.16	6.02	23.18	6.18

T-Test Results for Openness to Experience by Experience of Distress

Experience of Distress	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Suffered Stress	632.33	-2.26	0.02	29.59	5.04	28.74	4.37
Suffered Rel Issues	633	-3.14	0.002	29.99	4.97	28.76	4.57
Suffered Mental Illness	633	-3.31	0.001	30.2	5.11	28.81	4.56
Suffered Other Psych	633	-1.91	0.06	29.76	4.60	28.96	4.79
Suffered None	633	2.88	0.004	28.37	4.35	29.54	4.88

T-Test Results for Openness to Experience by Experience of Seeking Help

Experience of Seeking							
Help	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Sought Help Stress	633	-0.43	0.66	29.38	4.5	29.15	4.80
Sought help Rel Issues	633	-0.35	0.72	29.38	5.11	29.16	4.71
Sought help Mental							
Illness	633	-1.66	0.10	29.95	5.3	29.06	4.64
Sought help other	85.44	-0.35	0.73	29.35	3.83	29.17	4.84
Sought no help	633	-0.13	0.89	29.2	4.63	29.15	4.99

T-Test Results for Openness to Experience by Service Utilised

Service Utilised	<i>df</i>	<i>t</i>	<i>p</i>	<i>M</i> Yes	<i>SD</i> Yes	<i>M</i> No	<i>SD</i> No
Used Psych Service	631	1.59	0.11	29.63	4.87	28.98	4.69
Used GP	632	0.28	0.78	29.09	4.65	29.23	4.76
Used Other MH Prof	632	-0.94	0.35	29.58	4.83	29.12	4.72
Used Non-Prof Source	632	-2.55	0.01	29.65	4.68	28.7	4.77
Used None	632	1.98	0.048	28.71	4.75	29.48	4.72

Preference for Using a Form by Percentage of Reason Given for not Seeking Help

Reason for Not Seeking Help	Agree	Partly Agree	Partly Disagree	Disagree
Self	34.8	17.4	24.6	23.2
Family/ Friends	28.1	31.3	15.6	25
Embarrassed	57.9	21.1	13.2	7.9
Not Bad Enough	24.4	32.6	18.6	24.4
Didn't Know How	50.0	12.5	18.8	18.8
Time & Money	21.1	21.1	26.3	31.6
Other	23.3	46.7	16.7	13.3

Likelihood of Following own Recommendation by Diagnosis given to John

Diagnosis	Very Likely	Likely	Unlikely	Very Unlikely
Depression	38.5	45.2	12.9	3.4
Stress	42.4	42.4	6.1	9.1
Mental Problem	26.3	63.2	10.5	0.0
Sleep Problem	20.0	70.0	10.0	0.0
Bad Patch	47.4	47.4	5.3	0.0
Other	42.9	42.9	7.1	7.1

Likelihood of Following own Recommendation by Diagnosis given to Mary

Diagnosis	Very Likely	Likely	Unlikely	Very Unlikely
Schizophrenia	47.2	37.3	12.9	2.6
Symptom				
Description	29.1	45.5	20.0	5.5
Incorrect Diagnosis	21.3	56.0	16.0	6.7
Mental Problem	40.0	40.0	16.2	3.8
Emotional Problem	30.0	50.0	10.0	10.0
Lonely				
Other	30.4	43.5	13.0	13.0



Men's Psychological Help Seeking

Practitioner Information Sheet

My name is Nicole Bevan and I am conducting this research as part of my PhD with the School of Psychology at the University of Adelaide. I am seeking assistance for a study which looks at men's help-seeking for psychological services.

Aim: This project aims to find out what factors influence men in their recognition of mental disorder, decision to seek help and experience of psychological intervention. Men currently seek psychological help at far lower rates than women. By determining what factors might impede men in seeking help it is hoped that we can improve rates of men's help-seeking. Increased early intervention should result in improved quality of life, lower levels of chronicity, improved relationships, lower job stress, and importantly, a lower suicide rate.

Participation: Involvement simply consists of completing the brief survey enclosed. We are looking for GPs and mental health practitioners to be involved in this study. The questions relate to your experience of men in psychological services, including issues you see as important, factors you see as good or bad etc. No personal questions will be asked, and if you do not wish to answer any particular question you do not have to do so. A prepaid return envelope is included for your convenience.

Participation in this study is entirely voluntary and you can cease involvement at any time. Your participation in this project will be kept confidential, and no identifying details will be required. If you choose to participate you may elect to be informed of the results of this study: to do so simply return a separate piece of paper or business card with your survey detailing your email or postal address. Those surveys returned with requests for outcome information will be separated immediately from identifying information, which will be stored separately.

Ethics: The results of this study will help identify how to make seeking psychological help easier for men. This study has been approved by the School of Psychology Ethics Committee, University of Adelaide (approval number 06/42). However, if you have concerns or questions about this study, please contact either Nicole Bevan on 8303 3101 (or nicole.bevan@adelaide.edu.au), project supervisor Dr. Aspa Sarris (8303 6144) or chair of the Psychology Research Ethics Committee, Dr. Paul DeFabbro (8303 5744). If you have any further questions please contact me (Nicole Bevan) via the details above. Thank you for your interest in this study.

Nicole Bevan
PhD Candidate,
School of Psychology
University of Adelaide
North Tce, Adelaide, 5000



Practitioner Survey

Please write on the reverse side of the paper (indicating which question) if you need more room to respond. Please also feel free to add any further comments on the reverse.

1. What is your profession? (e.g. GP, specialist Doctor, Social worker, Psychologist, Counselor)

2. What is your gender? Male Female

3. What is the postcode of your main practice? _____

Have you had experience practicing in a rural area (if not currently)? Yes No

4. Do you think differences exist between men and women in how they recognize that they have a mental health issue? Yes No If yes, in what ways? _____

5. Do you think men's attitudes to psychological help are different to those of women? Yes No

If Yes, in what ways? _____

6. How are the majority of men with mental health concerns referred to you (e.g. self-referred, GP, spouse, work colleague)? _____

In what ways, if any, does this differ from how women with mental health concerns are referred to you? _____

7. What factors do you think may make men less likely to seek help for mental health problems?

8. What factors do you think may make men more likely to seek help for mental health problems?

9. What do you think could be done to increase men's help-seeking for mental health problems?

PTO

10. Are there times of year when you see more (or less) men with mental health issues? Yes No

If Yes, what times are there increases or decreases, and why do you think this is? _____



Men's Psychological Help Seeking

Consumer Information Sheet

Are you male?

Have you attended more than one session with a mental health professional?

We need your help!

Thank you for your interest in this study which looks at men's help-seeking for psychological services. My name is Nicole Bevan and I am conducting this research as part of my PhD with the School of Psychology at the University of Adelaide.

Psychological problems can be difficult to recognise. When you do know something is wrong it can be confusing to know what to do about it. Even when you know exactly where to go and who to see, it takes real guts to seek help. This can be especially true for men who are brought up to feel that they should be able to cope on their own.

This project aims to find out what factors influence men in their decision to seek help for psychological concerns. By determining what factors might stop men from seeking help we can help to tailor a system which suits them, making it easier for men to seek help and improving their mental health.

We are looking for men to be involved in this study who are of any age over 18 years and have attended more than one session with a mental health practitioner. Involvement simply consists of an interview which may take up to an hour and may be recorded with your permission. Participants will be asked questions relating to their experience of seeking help (i.e. did you find it difficult, did you know where to go, was there anything that held you back?). No particularly personal questions will be asked during the interview, and if there is anything you do not wish to answer you do not have to do so.

Participation in this study is entirely voluntary. If you choose to take part but change your mind once you have started, you can cease involvement at any time. Your participation in this project will be kept confidential, and identifying details will be removed when any audio recording is transcribed. Contact information of participants will be stored separately from interviews and recordings will be destroyed after they are transcribed.

The results of this study will help identify how to make seeking psychological help easier for men. If you choose to participate you may elect to be informed of the results of this study. This study has been approved by the School of Psychology (Ethics Approval number 07/56). However, if you have any concerns regarding the ethics of this research, please contact the researcher via details below, project supervisor Dr. Aspa Sarris (8303 6144) or Chair of the Psychology Research Ethics Committee Dr. Paul Delfabbro (8303 5744).

If you would like to be involved simply do one of these three things. Either

(1) Complete the attached consent form and mail it to:

“Nicole Bevan, Men's Help Seeking Study, School of Psychology, University of Adelaide, South Australia, 5005” or

(2) Email nicole.bevan@adelaide.edu.au, or

(3) Call Nicole Bevan on (08) 8303 3101.

If you have any questions regarding this study, please contact me via the details above.

Thank you for your interest in this project.

Nicole Bevan, PhD Candidate

Consent Form

I, (*please print name*) consent to take part in the research project entitled:

Seeking Psychological Help Study

I acknowledge that I have been provided with and have read the Information Sheet and am satisfied that I understand my role and what will be asked of me in this research.

My consent is given freely.

I understand that although the results of this study may help to improve the quality of services available to men, my involvement may not be of any direct benefit to me.

I understand that my involvement in this project will be kept confidential and identifying information will be removed when the interview is transcribed. I agree that whilst the information I provide may be included in published material, I will not be personally identified in any way.

I understand that I am free to withdraw from this project at any time and to do so will not affect the psychological services provided to me in any way.

I declare that I have read the information sheet provided and am comfortable with proceeding with the interview. I have further read and agree with the points above on this form.

Signed (*please sign*)

The..... *day of*..... 2008 (*date*).

Contact Information

This information will only be used to arrange participation in the research detailed above. It will be kept confidential. Providing this information does not signify any obligation to participate.

Name.....

Phone

Best time/day to contact by phone.....

Email.....

Post.....

Preferred method of contact (if you have one).....

Please complete at least one method of contact.

Available Services

Thank you for your participation in this research on men's mental health. Your experiences are valuable in determining how we can improve services for men.

Discussing psychological issues can sometimes affect you, even if you don't realise it at the time. We do not envision that this research will make participants distressed. However, if you feel that involvement has impacted negatively on you, please contact a mental health professional or your local GP for support. For some people this may be your case manager, but if you are not currently under mental health care, the services below may be of use to you.

- ☎ Your local GP
- ☎ www.lifeline.org.au or call to speak anonymously with a counsellor on 13 11 14 (24 hours, 7 days)
- ☎ **Men's Line Australia** 1300 789 978 Information, support and referral (24 hours, 7 days)
- ☎ **Adelaide Emergency** Mental Health Service (ACIS) 13 14 65 (24 hours, 7 days)
- ☎ **Rural Emergency** Mental Health Service 1800 182 232 (24 hours, 7 days)
- ☎ **Emergency Department** of your local hospital
- ☎ www.beyondblue.org.au (particularly related to depression)
- ☎ www.reachout.com.au (particularly related to youth)

Local mental health numbers are available in the **white pages** under "mental health services".