Understanding Men’s Mental Health:
Gender Relations and Mental Well-Being

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To Lisa, Emma and Mathew, my lifelong friends.
Abstract

Men’s mental health has remained understudied and undertheorised. Much of the early research on men’s mental health comes from large scale quantitative studies focusing on gender differences in mental illness. It is only in recent years that the influence of gender as a social construct has become the focus for researchers interested in men’s mental health, particularly depression.

This study uses a life history method underpinned by gender relations theory to explore how men’s everyday social practices can help or hinder mental well-being. Life history interviews were undertaken with fifteen New Zealand men aged between twenty and forty years based in the Wellington area. The interviews explored participant’s emotional lives, work lives, family and social relationships, and how they engaged with their mental health on a day-to-day basis. Gender relations theory was used to examine the complex interplay between masculinity and mental health within each man’s life story. Individual theorised life histories were written up for each participant. Four of these are presented in this thesis. A collective analysis was then undertaken using all fifteen life histories and similarities and differences in patterns of social practice were examined across all participants.

The findings illustrate the diversity in men’s social, emotional, work, help-seeking and mental health promoting practices and highlight not only the ways in which these can hinder or help men’s mental well-being, but how men are active agents in constructing masculinity through these social practices. Whether a man pursues a hegemonic pattern of masculinity, remains ambivalent or embodies a resistant masculinity, his social practices have varying costs and benefits to his overall mental health. Finally, this study argues for the need to address cultural ideals of masculinity in order to support and promote men’s mental health.
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Statement of Participation

I have published one paper from my doctoral research (included in the appendices), co-authored with my supervisors. The findings from the qualitative metasynthesis have been integrated into Chapter 2. I was responsible for the design, carried out the search strategy, completed the synthesis and drafted the full paper for publication. My co-authors contributed to reviewing study titles for inclusion in the metasynthesis and assessing the quality of the included studies using the Critical Appraisal Skills Programme criteria for qualitative studies. Anonymous reviewers also provided helpful comments.
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Chapter 1

Introduction

*Good mental health is much more than simply the absence of mental illness. It is easy to think of men who have a diagnosable mental disorder as being in poor mental health. There are countless others, though, whose state of mental well-being is severely hampering their ability to live a happy, well-balanced and fulfilled life who will never be offered (or seek) professional help.*

(Conrad & White 2010, p. x)

Men’s health researchers, Conrad and White point to a salient issue in regards to men’s mental health. That is, mental health is not simply the absence of mental illness but also the presence of mental well-being. To promote and build men’s mental health therefore we must do more than just offer treatments to those who have sufficiently deteriorated and experienced mental disorder, we must also create supportive living and working environments in order to support men’s mental well-being. It is this quote that sparked my interest in men’s mental health and left me wondering who are the “countless others” that Conrad and White are referring to.

This doctoral study evolved from my research interests in mental health and suicide research and my curiosity about what is it about being a man in contemporary New Zealand that could enhance or diminish mental health, and lead some men, but not others, to experience mental illness and engage in suicidal behaviours. This latter point is of particular significance given New Zealand’s continually high rates of suicide in men (Ministry of Justice, 2016).
The first strand of research from which this study evolved was my work within the mental health sector exploring the integration of publically funded mental health care services into primary health care settings, namely general practice (Collings et al., 2010; McKenzie, Collings, & Rees, 2013). This work arose from a need to provide New Zealand based evidence about how to support service provision and policy development within the rapidly evolving primary mental health care sector. This work highlighted the significant lack of funded psychological services in New Zealand for those experiencing mild or moderate severity depression or anxiety.

While funders and planners within regional health services began to prioritise addressing inequalities in access to these services for specific ethnic groups and those living in areas of high deprivation, there was no consideration of gender inequalities in accessing these services. This is surprising given we know that men consistently visit general practitioners less than women (McKinlay, Kljakovic, & Mc Bain, 2009; Ministry of Health, 2016) and are underreported in population statistics on depression and anxiety (Ministry of Health, 2016; Scott, Oakley Browne, & Elisabeth Wells, 2010). This left me wondering whether there was an underlying assumption that New Zealand men are less likely to experience mild to moderate depression and anxiety compared to women and are therefore generally healthy in terms of their everyday mental health.

The second strand of research from which this study evolved was my work in suicide research (Collings et al., 2012; Suicide Mortality Review Committee, 2016). I started to further question the assumptions we have in New Zealand about men’s mental health given the consistently high rates of male suicide. Through my involvement in research exploring the feasibility of setting up a Suicide Mortality Review Committee in New Zealand, I became acutely aware of the complexity of men's social lives in relation to mental illness and suicide. Moreover, understanding this complexity is hampered by the fact that the data needed to elucidate the social issues that can put men at increased risk of suicide is not currently collected in New Zealand. Despite attempts to further our understanding of suicide through the establishment of a Review Committee, we still do not have the means to go beyond
the simple reporting of suicide statistics at a population level (Suicide Mortality Review Committee, 2016). While the rate of suicide in men has slowly decreased since 1998, when it reached the highest rates on record, suicide rates continue to remain disproportionately higher among men (Ministry of Justice, 2016). The continually high rates of suicide in men, and a lack of data with which to explore in more depth the social issues in men's lives, further suggests that in the New Zealand context we need to consider researching men's mental health and increased suicide risk from an alternative perspective. One that does not rely solely on suicide or mental illness statistics.

This thesis looks further upstream at men's mental well-being. I argue that to further our understanding of men's mental health we need to do more than just offer treatments to men who may be diagnosed with mental illness or who may seek professional help, we must also look upstream at supporting men's engagement with their own mental health and well-being. However, to do this we need to understand the lived realities of men in relation to their everyday overall mental health.

While there is a paucity of research in New Zealand that examines men's mental health, or indeed men's health more generally (Neville, 2008; Rhys & McCreanor, 2009), the international research has seen men's mental health become a major area of research focus in its own right (see Hoy, 2012; McKenzie, Jenkin, & Collings, 2016 for reviews). This body of research has drawn attention to men's under reporting of depression and using qualitative research methods has demonstrated the diverse ways in which men experience and cope with depression (e.g. Brownhill, Wilhelm, Barclay, & Schmied, 2005; Chuick et al., 2009; Emslie, Ridge, Ziebland, & Hunt, 2006; Korner et al., 2011; O'Brien, Hart, & Hunt, 2007; Oliffe, Galdas, Han, & Kelly, 2012; Oliffe et al., 2010; Ramirez & Badger, 2014).

While this research has undoubtedly provided valuable insights in men's personal experiences, coping strategies and help-seeking behaviour for depression, it does not provide us with much scope for exploring how to build men's mental well-being. In other words, the focus on mental illness limits the questions we can ask about
promoting and maintaining good mental health. This study addresses this gap in the research by examining the mental health of men who do not have a diagnosable or self-reported mental illness, but whose state of mental well-being may be hampering their ability to live a happy and fulfilling life (Conrad & White, 2010).

The third strand of research from which this doctoral study evolved was my work in health inequalities and public health, and an awareness of the lack of understanding of gender in a large proportion of the mental health research. Indeed, in my own research exploring inequalities in mental health I would often add “sex” as a variable in my epidemiological analysis, assuming the meaning of any finding of a sex difference to be self-evident and requiring little explanation. While I was able to show, for example, that unemployment, deprivation and financial hardship were significant determinants of inequalities in mental health outcomes (e.g. Mckenzie, Imlach Gunasekara, Richardson, & Carter, 2014); or that becoming a parent for the first time was related to better mental health (e.g. Mckenzie & Carter, 2013), my findings could not tell me why these differences or associations might exist in the first place or how they came about. Instead, I was left to speculate on the possible reasons.

The health sociologist Toni Schofield (2015) argues, that while the social determinants of a health approach can amply demonstrate robust associations between sex and health outcomes, it leaves largely unanswered the question of what exactly produces the “causes of the causes” or how causation actually operates (p. 13). I became acutely aware of the limitations of quantitative epidemiological research. I soon realised that if I wanted to understand how men and women’s social lives impacted mental health outcomes, then I had to move beyond statistical associations and the positivist paradigm towards qualitative research, which has the potential to yield rich insights into people’s lives, perspectives and practices in relation to health and the social contexts in which they emerge.

Prior to embarking on this PhD I had not studied gender theory, or the sociology of health and illness, in a formal academic setting. I was intrigued to learn what an explicit gender perspective could add to a study of men’s mental health. My journey
as a novice gender researcher started with a conversation with a man who worked at the Mental Health Foundation who was particularly interested in my ideas around exploring men’s stories in relation to mental health. It was through this conversation that I connected with Jo River, who was to become my PhD supervisor. With her guidance and extensive knowledge of gender relation theory, I gained confidence to embark on my journey towards becoming a gender and health researcher.

I started reading the work of Raewyn Connell (2009, 2012; Connell & Messerschmidt, 2005) and immediately found myself questioning my own assumptions about gender. I began to “see” gender in my social world in ways I had not noticed before. I became acutely aware of gender stereotypes in New Zealand. For example, advertising for beer, building materials and sport often involves the stereotype of the New Zealand man as strong, unemotional and a pioneer. The “kiwi male” is associated with rugby and outdoor masculine activities, such as grilling meat on a barbeque or riding quad bikes. I started to struggle with these ideas, because the stereotype matched very few men I knew – particularly men who talked with me about their feelings and mental health concerns. Connell (2009) states that while noticing the existence of the gender order is easy, understanding it is not. Determined to understand more, I pushed on and came to appreciate Connell’s theoretical framework of gender relations (Connell, 1987, 2005).

Connell’s explanation of gender as a social practice represents a theoretically sophisticated way to conceptualise gender. Gender is understood as multi-dimensional and embraces the emotional relations, social relations, economic relations, power relations and symbolic relations that operate simultaneously between men and women, and among men and women at the individual, community, institutional and society-wide levels (Connell, 2009, 2012). This relational approach to gender is concerned with the everyday social practices in which gender is constructed. This includes the social practices men use to enact masculinity or masculinities (Connell, 1995, 2005).
This thesis is underpinned by Connell’s framework of gender relations. At the centre of it is an exploration of what hinders or helps the mental well-being of men who do not have a diagnosable or self-reported mental illness. In other words, those men whose mental well-being may be hampering their everyday enjoyment of life. The study is framed by a broad question: How do the social practices of men promote or block mental well-being? To answer this question I undertook a life history study of fifteen New Zealand men using a gender relations approach to explore how men’s everyday social practices influence their mental health.

1.1 Outline of the thesis

This thesis unfolds over the following nine chapters. In Chapter 2, I introduce the literature on men’s mental health and explore the various ways that men’s mental health has been studied within different disciplines specifically in regards to gender. The aim of the chapter is to provide context for where this study sits in relation to existing theoretical and empirical research, and to examine gaps in current research on men’s mental health. I end this chapter arguing for a gender-relations approach to examining men’s mental health and a broader conceptualisation of mental health, beyond mental illness.

In Chapter 3, I outline the existing methodological challenges in the men’s mental health research in terms of using gender relations theory and describe how I addressed these using a life-history methodology. Following this I describe a scoping exercise carried to help define the scope of the study. Chapter 3 also details the research methods used to collect and analyse the accounts of the fifteen participants.

In Chapter 4, I present the life history case studies of four of the participants in this study. Each case study illustrates one of the four patterns of masculinity and mental health identified in this study. These comprised hegemonic, ambivalent, marginalised and resistant masculinity.
In Chapters 5 through to Chapter 9, I present the themes identified from the collective analyses across the fifteen participants’ life history cases. These themes include men’s emotional practices (Chapter 5), men's social support and connectedness (Chapter 6), men’s work-related practices (Chapter 7), men’s help-seeking and engagement with health professionals (Chapter 8) and men’s health-promoting strategies (Chapter 9).

Finally in Chapter 10, I draw conclusions about men’s mental health as it relates to masculinities and mental well-being. The findings are discussed in the context of existing research. After examining the strengths and weaknesses of the study, I consider the implications of the research for practice, and policy and recommend areas for further research.
Chapter 2

Prevailing approaches to researching men’s mental health

2.1 Introduction

Historically, men's mental health and mental illness has not been a topic of major academic research or clinical interest in its own right. This is due in part to the dominant focus within mental health research on women's higher reported rates of diagnosed mental disorders (Riska, 2009). Within psychiatry, the traditional and dominant discourse in perspectives of mental health and illness, the dominant focus on women can be traced back to the nineteenth century, when, for example, hysteria was linked to female biology (Busfield, 2010). It was not until the 1960s and 1970s that feminist researchers began to criticise the fact that women were more likely to be identified as mentally disordered than men (Rogers & Pilgrim, 2010).

Phyllis Chesler (1972) in her classic Women and Madness was one of the first to argue that a double standard existed in terms of mental illness because women, not men, were more likely to be deemed mentally ill. Likewise, Pugliesi (1992) argued that issues such as substance abuse, violence and emotional problems in men were not historically subjected to the same degree of research or clinical interest because they were not perceived to hold the same degree of “mental disorderedness or weakness” as female mental illness, such as depression (p. 62). Consequently, men's mental health and illness has remained under researched in comparison to women's (Riska, 2009).

For the researcher interested in men's mental health, there is a diverse range of literature to draw on from the United Kingdom (UK) and Northern Europe, Canada, United States (US), Australia and New Zealand. Current knowledge and debate around men's mental health has been influenced by theoretical and empirical
research from psychiatry, psychology, public health, nursing, social sciences and masculinities studies. Reviewing the research on men’s mental health, particularly in relation to men as gendered beings, is not a straightforward task due to the different ways in which gender is understood by researchers. Within the various bodies of literature, there exist different epistemological positions regarding gender, which are often implicit rather than explicit. The way in which gender and mental health are conceptualised by the researcher determines the manner in which men’s mental health is investigated.

This chapter provides a critique of the prevailing approaches and arguments related to researching men and their mental health. It synthesises the major ideas from psychiatry, psychology, social sciences and masculinities studies in relation to current understandings of men’s mental health. It is not an exhaustive review: rather, it focuses predominantly on the implicit or explicit position researchers take regarding gender in their work. While there are corresponding concerns and debates about how mental health and illness are conceptualised in the literature (see Busfield, 2010; Rogers & Pilgrim, 2010), this is not the focus of this thesis. This chapter ends by locating this study within the current literature.

### 2.2 Sex differences and depression – Psychiatry

Some of the best-documented sex-difference data on rates of mental illness between males and females comes from the psychiatric literature. Large-scale epidemiological surveys of mental disorder, such as the National Comorbidity Survey in the United States, have provided a wealth of data on rates of mental disorder (e.g. Kessler, 2010; Kessler et al., 2005; Kessler et al., 2005). Psychiatric researchers view mental illness as caused by underlying biological pathways and use diagnostic categories, such as those from the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2013) to determine the prevalence and rates of mental disorder within both clinical and non-clinical populations. While psychiatric surveys suggest that there is no difference in overall
rates of mental disorder between males and females, they do suggest differences in particular types of mental disorder (e.g. Angst et al., 2002; Kessler, 2000; Kornstein et al., 2000; Piccinelli & Wilkinson, 2000).

The most consistently reported sex difference in the psychiatric literature, first reported by Weissman and Klerman (1977) over forty years ago, is the finding that females have almost twice the prevalence rates of major depressive disorder compared to males (e.g. Angst et al., 2002; Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993; Kornstein et al., 2000; Marcus et al., 2005; Romans, Tyas, Cohen, & Silverstone, 2007; Scheibe, Preuschhof, Cristi, & Bagby, 2003; Schuch, Roest, Nolen, Penninx, & de Jonge, 2014; Weissman et al., 1993). More specifically, the 2:1 female-to-male ratio for depression is taken to be a reliable finding across Western countries (e.g. Eaton et al., 2012; Romans et al., 2007; Schuch et al., 2014) including in New Zealand (e.g. Bushnell et al., 2003; Oakley Browne, Wells, & Scott, 2006), despite the use of different psychiatric classification tools and interview methods.

Social scientists on the other hand have challenged this view, demonstrating that the sex difference in depression is not a universal finding (e.g. Dagher, Chen, & Thomas, 2015; Van de Velde, Huijts, Bracke, & Bambra, 2013). For example, in a cross-national comparison of 25 European countries, Van de Velde et al. (2010) reported minimal sex differences in prevalence rates of depression in a number of countries including Ireland, Slovakia and Finland. This suggests there are important cross-cultural differences that may influence the prevalence of mental disorder in males and females that have been overlooked by psychiatric researchers.

Likewise, Dagher et al. (2015) have demonstrated how sex-difference rates in major depression in the United States changed over the course of the global economic recession. While there was no reported sex difference in depression in the two years prior to the recession, or during the recession (2008–2009), there were significant sex differences in the two years after the recession. These patterns are further complicated by studies showing variations in the relationship between sex differences and mental illness by unemployment status (Artazcoz, Benach, Borrell,
& Cortès, 2004), socio-economic status (Lorant et al., 2003) and ethnicity (Weich et al., 2004). With odds of mental illness greater in unemployed men, those with low socioeconomic status and ethnic minorities. Collectively, these studies bring in to question the traditional psychiatric view that the sex difference in depression is universal, and suggest that wider social and cultural influences on men’s and women’s mental illness are at play.

While psychiatric epidemiological studies typically report females’ preponderance for reporting depression, rates of mental illness in males are largely overlooked in sex difference studies. Yet, males reportedly have a higher prevalence of substance use disorders, anti-social behaviour and personality disorders (Eaton et al., 2012; Kessler et al., 2005; Kessler et al., 1997; Marcus et al., 2005) and are over-represented in rates of suicide (Canetto & Sakinofsky, 1998; Schrijvers, Bollen, & Sabbe, 2012). As discussed in the opening of this chapter, the continued focus on women’s over-representation in particular psychiatric diagnosis has left men’s mental health and illness comparatively understudied, not only within psychiatric research but also within the mental health literature more broadly (Riska, 2009).

Despite these widely reported sex differences in depression, the reasons for it remain poorly understood (Möller-Leimkühler & Yücel, 2010; Parker & Brotchie, 2010; Piccinelli & Wilkinson, 2000). One of the main explanations in any discussion of sex differences in mental illness within the psychiatric research is whether the data are an artefact of the measurement instruments used to detect mental illness, or the differential reporting of symptoms by females (e.g. Parker & Brotchie, 2010; Romans et al., 2007; Salokangas, Vahtera, Pacriev, Sohlman, & Lehtinen, 2002; Smith et al., 2008).

For example, Romans (2007), using a national epidemiological survey of Canadian adults, reported that the sex differences in major depressive disorders were due to females’ increased reporting of particular symptoms such as “increased appetite”, “loss of interest” and being “often in tears” (2007, p. 907). She argues that women have a greater tendency to cry more readily and intensely than men in response to distress, so are more likely to report crying as an indicator of depression. However,
she is unable to provide evidence to substantiate her claim and leaves us with questions regarding males' emotional responses to distress and depression.

More recently, the emphasis on females’ higher prevalence rates of depression has been challenged by a minority of psychiatrists who argue that men's lower rates of reported depression may be explained by male-specific depressive symptoms not picked up by traditional diagnostic criteria (e.g. Azorin et al., 2014; Martin, Neighbors, & Griffith, 2013; Möller Leimkuhler, Heller, & Paulus, 2007; Stromberg, Backlund, & Lofvander, 2010; Winkler, Pjrek, & Kasper, 2006). Rutz (2001; 1995) postulated a male depression syndrome characterised by substance abuse, aggressive behaviour, and “acting out” or “outbursts” of anger (2001, p. 126). He hypothesised that this male depression syndrome explained the apparent paradox between males’ high rates of suicide but low rates of reported depression. Since this time, studies have attempted to demonstrate the existence of a male depression using psychiatric scales, such as the Gotland Male Depression Scale, designed to capture these male symptoms (e.g. Möller-Leimkühler & Yücel, 2010; Möller Leimkuhler et al., 2007; Sigurdsson, Palsson, Aevarsson, Olafsdottir, & Johannsson, 2015; Stromberg et al., 2010).

In this vein, Martin et al. (2013) showed that when traditional measurement criteria for depression are supplemented with male depressive symptoms, not only is it possible to detect more males with depression, but also sex differences in depression disappear. Using two new scales designed specifically to capture these male symptoms, Martin reported that males and females meet the criteria for depression in equal proportions. However, she is unable to explain why being male may account for the expression of different depressive symptoms to females. Instead, she speculates that males respond with more aggression, anger and risk-taking behaviour when depressed, because they are taught to withhold their emotions; but she is unable to provide evidence to support this claim.

While these studies point to significant issues for men’s mental health and illness, the epidemiological sex difference data cannot explain why or how such differences come about, nor explain variations in mental illness outcomes among men as a
group. As such, studies tell us very little about men’s mental illness in terms of gender or differences among men. Men’s mental illness, or more specifically depression, is understood only in terms of the margin of difference in rates, and the prevalence of risk of mental illness between males and females. Consequently, researchers are left to speculate on the possible reasons for the reported differences. Gender-relation theorists have criticised this sex-difference approach because of its “taken-for-granted belief” that men and women are simply two distinct biological groups (Schofield, Connell, Walker, Wood & Butland, 2000). As Connell (2009) argues, health researchers often report the presence or absence of sex differences with little consideration for the nature of gender or the meaning of differences between men and women.

An interesting study by Brownhill et al. (2005) has demonstrated that sex differences in depression may not be as straightforward as psychiatric researchers assume. Moving away from measuring male depressive symptoms using quantitative psychiatric classification tools, Brownhill explored men’s reporting of depressive symptoms in their own words. Using focus groups with men and women, she asked them to discuss their experience of being “down in the dumps” (2005, p. 922). This is one of the criteria for depressive disorder used in the DSM-IV (American Psychiatric Association, 1995). While both men and women described experiencing similar physical and emotional symptoms reflecting standard diagnostic criteria, such as loss of interest in pleasure, changes in appetite, weight or sleep, or feelings of worthlessness, they differed in how they reported or expressed their depression. Brownhill coined the term “the big build” to describe how men expressed their depression as a “constrained trajectory of emotional distress” (2005, p. 929), where emotions are initially suppressed but later released in the form of aggression, violence, and on occasion deliberate self-harm. Women, on the other hand, reported expressing emotions early on by crying and seeking help from others.

Brownhill’s study is important because it suggests it is not simply the case that there is a “male type” depression, as suggested by Rutz and others, but rather, men
themselves can actively hide their emotional distress. However, Brownhill is unable to provide evidence why men might suppress or express particular emotions differently from women. Instead, she is left to speculate, suggesting that traditional notions of masculinity may lead men to constrain their emotional distress. Equally problematic is the fact that men and women in her study are constructed as single cohesive groups, with Brownhill arguing that one emotional trajectory is “common to men” (2005, p. 926). In doing so, she assumes men are a homogenous group whose experiences are viewed as being all the same, and as being different to all women’s experiences. This assumption is contested by masculinities scholars, who argue that men are not a homogenous group with the same risk of and experience of health and illness (Connell, 2000; Schofield, 2010).

2.3 The male role, masculinity and mental health – Psychology

Psychologists trying to understand the relationship of men to their mental health have relied on the notion of the male gender role and theories of socialisation. This approach was influenced by popular works such as David and Brannon’s The Male Sex Role (1976), which arose in response to feminist critiques of traditional gender roles within the sociological literature in the 1960s. Brannon (1976) is credited with identifying the underlying principles that define the male gender role, or masculine ideology (Levant, 1996; Levant, 1992; Thompson, Pleck, & Ferrera, 1992). This includes particular male role expectations, such as rejecting feminine qualities, restricting emotions, not showing weakness, being self-reliant, independent, heterosexual and taking risks. Thereafter Harrisons’ (1978) influential paper Warning: the male sex role may be dangerous to your health brought to the attention of psychological researchers the hazardous influences of male role expectations on men’s psychological health. These arguments remain core to the large body of psychological research on masculinity and mental health.

These explanations rely on theories of gender socialisation, which assume that men are “socialised” into the male gender role as a culturally defined standard for male
behaviour, including how men should think, feel and behave (Levant, 1996; Pleck, 1981, 1995). This theory of gender socialisation draws heavily on the sociological construct of male and female sex roles, which dominated sociological accounts of gender from the 1940s, and was subsequently taken up by psychologists in the 1970s (Smiler, 2004). Parsons, a major supporter of sex-role theory, contended that male and female role expectations were socially learned and internalised during childhood through a process of “socialisation”, where boys are taught to be instrumental or task-orientated and girls to be emotional or expressive (Parsons & Bales, 1955). However, since this time sex-role theory and the notion of socialisation as an account of gender have been widely criticised by sociologists (e.g. Carrigan, Connell, & Lee, 1985; Connell, 1987; Messner, 1998; West & Zimmerman, 1987).

In their highly influential paper *Towards a new sociology of masculinity*, Carrigan, Connell and Lee (1985) outlined the development of sex-role theory and explained how feminist, gay and pro-feminist scholars questioned the adequacy of sex-role theory as a means of understanding gender. One of the major criticisms was the idea that the sex-role framework assumes the male and female sex roles are “learnt, acquired or internalised through a single, passive process” (Carrigan et al., 1985, p. 578). In other words, it assumes that all men are socialised to conform to a single male role. Connell further states that role socialisation collapses the concept of gender into a “biological dichotomy” (Connell, 2009, p. 59), because it assumes that the male and female role flow directly from biological sex. Consequently, sex-role theory and socialisation, like the sex-difference approach, remains an essentialist way of thinking about gender, as it is unable to separate sex from gender. Despite these criticisms, sex-role theory and socialisation remain the focus of much of the psychological research on men’s mental health (e.g. Addis & Cohane, 2005; Addis, Mansfield, & Syzdek, 2010; Beaglaoich, Sarma, & Morrison, 2014; O’Neil, 2013; Thompson & Bennett, 2015).

Based on this idea of the male gender role, researchers have developed numerous theoretical and psychological scales and measures with which to assess this
socialised male role (Cochran, 2010; Whorley & Addis, 2006). See, for example, the “Conformity to Masculine Norms” scale (Mahalik et al., 2003) or the “Gender Role Conflict Scale” (O’Neil, 2008, 2013). Researchers employ these scales and measures in quantitative, correlational studies in order to demonstrate the links between the male role and men’s attitudes toward help-seeking (e.g. Berger, Levant, McMillan, Kelleher, & Sellers, 2005; O’Loughlin et al., 2011; Pederson & Vogel, 2007; Tsan, Day, Schwartz, & Kimbrel, 2011; Vogel, Heimerdinger-Edwards, Hammer, & Hubbard, 2011; Vogel, Wester, Hammer, & Downing-Matibag, 2014; Wahto & Swift, 2016; Yousaf, Popat, & Hunter, 2015). Studies have also demonstrated correlations between aspects of the male role and men’s increased risk of alcohol abuse (Monk & Ricciardelli, 2003), suicide (Granato, Smith, & Selwyn, 2015), depression (Berger, Addis, Reilly, Syzdek, & Green, 2012) and poor psychological well-being (Alfred, Hammer, & Good, 2014).

A significant limitation of this body of work is that the use of quantitative instruments, such as the Gender Role Conflict Scale (O’Neil, 2008), requires participants to rate their endorsement of fixed, simplistic ideologies, such as restricting their emotions, using simple self-reported questionnaires, and does not include any observation of men’s actual behaviour or gender practices (Hearn, 1994). In other words, the socialised male role, or masculinity, is understood as a singular construct composed of a set of attributes or characteristics that men possess in varying degrees. However, it fails to adequately tell us the things men “do” in daily life in relation to their mental health.

For instance, in a study of male college students’ attitudes towards seeking professional psychological help, Tsan et al. (2011) demonstrate a correlation between increased emotional restriction (measured using the Gender Role Conflict Scale) and negative attitudes towards help-seeking. This was particularly the case for men who scored higher on measures of “restrictive emotionality” and “restricted affectionate behaviour between men”. Tsan suggests that the disclosure of personal experiences and the expression of feelings required within a psychotherapeutic interaction goes against the gender role expectations of men to
restrict their emotions. Yet, beyond describing correlations between psychological measures of attitudes or willingness to seek help, this study cannot tell us about men’s actual help-seeking practices or what they actively do in relation to seeking help. Tsan finds the sex-role theory and measures of gender role socialisation inadequate to distinguish between the social expectations of men’s behaviours and what men actually do in everyday practice.

Similarly, Wester, Christianson, Vogel, and Wei (2007), in their exploration of social support and psychological distress, report that lower levels of social support in males can be accounted for by their increased restriction of emotions and restricted affection between males. That is, social support between men is limited because of the socialised male gender role, which in turn leads to greater levels of psychological distress. Wester et al argue that for men, seeking support or discussing emotions with other men conflicts with messages men receive about the importance of emotional restraint, particularly around other men. Yet what remains unclear is what men’s actual social support networks or social relations with other men look like, or the ways in which men do seek or mobilise social support when they need it. As Carrigan et al. (1985) state, role theory does not describe the actually “concrete reality of people’s lives” (1985, p. 578). Wester’s study tells us very little about men’s social support or its relation to mental health, aside from the fact it may be related to emotional relations among men.

Akin to the sex-difference approach, studies examining the male gender role have also failed to account for the differences among men. Psychological researchers present men as a homogenous group and assume that psychological health effects simply flow from conforming to the male role. Tsan and Wester position all men as reluctant help-seekers, with few avenues for social support. They are unable to inquire further into the differences among men because, as Connell (2009) argues, gender socialisation positions all men as passive learners of a socially prescribed role. Consequently, the socialisation framework is unable to tell us about those who resist and do not conform to the gender role as defined by the dominant culture.
For example, those men who do seek help from health professionals, or those men who build supportive relationships with other men.

It is not the case that all psychological researchers ignore the reality of people's lives. An interesting study by Rochlen et al. (2010) demonstrates some men do seek help and treatment for depression. Moving away from measuring gender role socialisation with psychological scales, Rochlen used focus groups with 45 men aged 24 to 64 years to explore how men talked about aspects of the male role in relation to depression and seeking treatment. A number of men in this study talked about their own experiences of seeking professional help and the benefits they received from treatment. This study is important because it suggests it is not simply the case that there is a singular masculinity or male gender role which all men adhere to, but rather, men themselves can go against male role expectations and seek help. However, Rochlen is unable to explore further why some men go against the male role expectations to be self-reliant. While his study points to diversity among men in terms of their depression-related experiences, Rochlen finds role theory inadequate to explain this diversity among men's help-seeking.

While the majority of this body of research relies on convenience samples of white, heterosexual, middle-class, male undergraduate students (Whorley & Addis, 2006) some researchers have started to explore more diverse groups of men in terms of ethnicity and sexuality (e.g. Bingham, Harawa, & Williams, 2013; Hammond, 2012; Iwamoto, Liao, & Liu, 2010; Li, Pollitt, & Russell, 2016; Mincey, Alfonso, Hackney, & Luque, 2015; Szymanski & Ikizler, 2013). In a recent study, Szymanski and Ikizler (2013) explored the relationship between male role expectations, heterosexist discrimination and depression in gay and bisexual males, using an on-line survey. Yet, beyond describing the correlations, Szymanski and Ikizler find quantitative measures of gender-role conflict inadequate to inquire further into why males who self-identify as gay or bisexual may experience discrimination and increased risk of poor mental health. Likewise, Hammond (2012) reports an association between everyday racial discrimination and increased depressive symptoms in African American males. However, Hammond finds role theory inadequate to explain how
African American men's experience of racial discrimination is linked to an increased risk of depression, or why this relationship actually exists.

Carrigan et al. (1985) argue that the sex-role framework, as a way of understanding masculinity, is so theoretically flawed it should be rejected, especially because it does not acknowledge the power relations which exist within gender as a social structure (Connell, 1987) – in particular the power relations between men and women, and among men, such as among heterosexual and homosexual men. In terms of men's mental health, Szymanski and Ikizler find sex-role theory inadequate to inquire into the power relations in gay and bisexual men's experiences of heterosexist discrimination.

While it has been argued by some researchers that this body of literature provides clinicians working with men a means of understanding gender within their therapeutic treatment with men (e.g. Addis, 2008; Cochran, 2005; Kilmartin, 2005; Rochlen, 2005), it remains a limited and problematic way of conceptualising masculinity. Addis and Cohane (2005) have noted how psychologists interested in men's health have remained isolated from epistemological and methodological developments and debates in the analyses of gender within the social sciences and sociology. Consequently, psychological researchers have been slow to move away from their reliance on outdated sex-role theory, and to embrace contemporary gender theories from the perspectives of social constructionists, or gay and pro-feminist scholars. As I will demonstrate later in this Chapter, these contemporary perspectives offer a way of conceptualising gender that moves away from theorising masculinity in terms of sex difference and passive socialisation into the male role, towards theorising gender as socially constructed and relational (Connell, 1995; Connell & Messerschmidt, 2005).
2.4 Gender differences, social factors and mental health –

Social Science

The social epidemiological literature has produced the largest single body of research on gender differences and social factors in mental health. This body of work has raised valuable questions about how the social world influences the determinants of mental health. For instance, the link between social factors such as marital status (e.g. Strohschein, McDonough, Monette, & Shao, 2005), social support systems (e.g. Fiori & Denckla, 2012; Grav, Hellzén, Romild, & Stordal, 2012), employment and occupation (e.g. Offer & Schneider, 2011; Strandh, Hammarstrom, Nilsson, Nordenmark, & Russel, 2013) and mental health. Furthermore, in contrast to the traditional psychiatric research, discussed in section 2.2, social scientists have tended to focus on measures of non-specific psychological distress (Kessler et al., 2002) or screening measures to detect symptoms of mental illness, such as depression or anxiety, rather than dichotomous measures of diagnosable mental disorder as assessed by the DSM (American Psychiatric Association, 2013).

Oakley’s classic text *Sex, Gender and Society* (1972) is credited with establishing acceptance within the social sciences for a distinction between sex and gender. The term “gender” is commonly used in the mental health literature to indicate the social production of differences between men and women, whereas the term “sex” remains the biological difference between males and females (Rosenfield & Mouzon, 2013; Rosenfield & Smith, 2010). However, while most social science researchers consider gender a social factor, and wish to understand men and women’s health in relation to social and cultural aspects, they tend to use the term “gender” when in fact they are examining sex-difference mental health data (Aneshensel, Phelan, & Bierman, 2013; Horowitz, 2010). As such, gender, like sex, is viewed as a binary category, which though not determined by biology, is still linked to biological sex (Busfield, 2010). Most researchers do not explicitly draw on gender theory: rather, they speculate on how their sex-difference findings relate to gender practice.
For instance, there are a number of studies that support the idea that men’s mental health suffers more from the experience of unemployment than women’s does (e.g. Artazcoz et al., 2004; Strandh et al., 2013). Artazoc et al. (2004) used epidemiological data to link unemployment status to sex-differences in mental health, measured using the General Health Questionnaire, a screening device for measuring psychological problems. She reported a significant gender difference in the effects of unemployment on mental health, in particular that unemployed males had poorer mental health than unemployed females. Yet, without drawing on any gender theory, Artazoc is left to speculate that this difference may be due to men’s lower involvement in family responsibilities, which means that if they lose their job, they cannot successfully replace it with family as an “alternative source of meaning in their life” (2004, p. 87). There is an implicit assumption that being male is somehow connected with paid employment outside the family home, whereas being female is associated with looking after families within the home. Consequently, differences in men’s and women’s mental health are assumed to result from this opposite and complementary division of labour.

This finding is further complicated by studies that report unemployed females experience similar or worse mental health than unemployed males (e.g. Drydakis, 2015; Hammarström, Gustafsson, Strandh, Virtanen, & Janlert, 2011). For example, Drydakis used longitudinal labour market data covering the period of the global financial crisis (2008–2013), when unemployment rates in Greece doubled. He reported that women were more negatively affected by unemployment in relation to their mental health status than men. Drydakis speculates this is because women are more likely to experience job insecurity, financial debt, social isolation, poor housing and discrimination in comparison to men. Yet he provides no evidence by which we can evaluate this claim. These contradictory findings in terms of gender differences in the relationship between unemployment and mental health are echoed throughout the literature (e.g. McKee-Ryan, Song, Wanberg, & Kinicki, 2005; Paul & Moser, 2009).
Many of these social epidemiological studies draw on theoretical frameworks about the causal mechanisms between social determinants and health to interpret their sex-difference data (Berkman, Kawachi, & Glymour, 2014). See, for example, the stress model, which draws on psychological theories (Wheaton, Young, Montanzer, & Stuart-Lahman, 2013) and suggests stressors, such as unemployment, trigger a psychological stress mechanism that affects ill-health; and the economic deprivation model (Avendano & Berkman, 2014) which argues that changes in family income produced by unemployment can reduce the ability to build wealth, which in turn reduces access to resources relevant for health. Yet without the explicit use of a social theory of gender, researchers are unable to theorise the links between gender, social determinants such as unemployment, and mental health.

However, it is not the case that social scientists with an interest in mental health have completely overlooked gender theory. Some social researchers draw on sex-role theory, introduced in the previous section 2.3. This theory, which dominated sociological accounts of gender from the 1940s, assumed that men and women were socialised into male and female sex roles through a process of “socialisation” in childhood (Parsons & Bales, 1955). In the 1970s, Gove and Tudor (1973; 1984) applied sex-role theory and Parsons’ socialisation argument to studies of mental illness in order to explain women’s higher rates of mental disorders. As a consequence, the social science literature, like the psychiatric literature, became predominately focused on explaining women’s over-representation within psychiatric diagnosis (Rogers & Pilgrim, 2010).

Gove and Tudor used sex-role theory to build their argument that marriage was more beneficial for the mental health of men compared to women (Gove, 1972). Their rationale was that marriage for women was more inherently stressful because it left them economically dependent on their breadwinner husbands. On the other hand, marriage was deemed more advantageous to men because men found purpose and fulfilment in paid employment while also having their needs met at home (Gove, 1972; Gove, 1984). It is only in the last decade that social researchers have begun to question Gove’s assumptions in terms of who benefits
from marriage (e.g. Simon, 2002; Strohschein et al., 2005; Strohschein & Ram; Umberson, Thomeer, & Williams, 2013; Williams, 2003). However, researchers do not question the underlying assumption in sex-role theory that men and women are simply two categorical groups with complementary social roles (Carrigan et al., 1985).

Strohschein et al. (2005), using four years of longitudinal data, reported no gender differences in levels of psychological distress from moving into or out of marriage i.e. divorced, separated, widowed or remarried over the short term, but significant differences over the longer term. Strohschein interprets this finding using sex-role theory, arguing that over time, men's mental health recovers quicker than women's because their social role as a breadwinner and financial provider is more protective in terms of health. In contrast, women's social role as the carers of children expose them to more economic hardship. Yet, there are also studies which challenge this idea, showing that divorce, widowhood and remarriage is more harmful for men's mental health than women's (e.g. Hewitt, Turrell, & Giskes, 2012; Hiyoshi, Fall, Netuveli, & Montgomery, 2015; Symoens, Van de Velde, Colman, & Bracke, 2014). Despite these contradictory findings, researchers continue to rely on the binary notion of social roles, with men as breadwinners and women as homemakers and carers of children. However, they are unable to adequately explain why men's and women's position in society may have different consequences for mental health or what happens to men who do not fulfil the role of breadwinner.

The masculinity theorist Kimmel (2011) argues that the model of breadwinner and homemaker, popularised in the mid-nineteenth century, has become outdated as it no longer represents the social reality of men's and women's economic situations. Similarly, Connell (2005) has described how the traditional division of the housewife and breadwinner is being challenged in contemporary developed countries. Historical changes in the gender order, that is the gender arrangements within society, have occurred through an increasing emphasis on neo-liberal policies in the labour market, which have blurred the boundary between family and economy. As Connell notes, the idea of “family” being women's sphere and “work”
being men’s sphere is now in a state of “flux” (2005, p. 370). This is evidenced by recent data that shows in Western countries an increasing number of men stay at home to care for children, while the number of women engaging in paid work outside the home in steadily increasing (Chesley, 2011; OECD, 2011). However, researchers using the notion of social roles to interpret sex-difference data on mental health frequently overlook such changes in domestic arrangements.

Sex-differences studies, interpreted through a sex-role framework, also overlook the social mechanisms that link men’s and women’s lives. Strandh et al. (2013), in their examination of unemployment and psychological distress in Sweden and Ireland, report significantly higher rates of distress among unemployed males in Ireland. They argue these findings are a consequence of women’s participation in the labour market being encouraged in Sweden, but discouraged in Ireland, leading to Irish men having a greater “need” for employment (2013, p. 661). However, Strandh overlooks the fact that most men are able to participate more extensively in paid work outside the home because women undertake more of the family and household responsibilities (Connell, 2005).

Connell (1987) argues that the gendered division of labour is a source of social power relations, and influences how men and women interact in their everyday lives. However, as discussed earlier, sex-role theory overlooks power relations between men and women because it views them as “separate but equal” groups with complementary roles (Carrigan et al., 1985, p. 559). As such, Strandh is unable to inquire further into the social or power relations between men and women and leaves us with questions whether unemployed men’s poorer mental health is a consequence of men’s greater need for employment, or social expectations for women to take on the domestic unpaid work in the home.

Social scientists have demonstrated the benefits of social connections and supportive relationships for buffering the impact of stressful or traumatic life experiences on mental health (e.g. Andrea, Siegel, & Teo, 2016; Åslund, Larm, Starrin, & Nilsson, 2014; Dalgard et al., 2006; Grav et al., 2012; Kleiman, Riskind, & Schaefer, 2014; Maulik, Eaton, & Bradshaw, 2010; Panagioti, Gooding, Taylor, &
In terms of men's social support, quantitative studies consistently report that men have fewer social ties and smaller, less dense and supportive social networks in comparison to women (e.g. Almquist, Östberg, Rostila, Edling, & Rydgren, 2014; Dalgard et al., 2006; Fiori & Denckla, 2012; Fuhrer & Stansfeld, 2002; Kikuzawa, 2016; Liebler & Sandefur, 2002; Matud, Ibáñez, Bethencourt, Marrero, & Carballeira, 2003; van Daalen, Sanders, & Willemsen, 2005; Wagner, Dichter, Mavandadi, Klaus, & Oslin, 2016). However, these studies tell us little about the diversity in men's social support networks, or why men's social supports might differ from women's.

Fiori (2012), using epidemiological data from a longitudinal study of middle-aged adults, examined the relationship between different types of social support and sex differences in depressive symptoms. Males who provided instrumental support to family members, such as financial aid and informational support, reported better mental health. In contrast, females who received emotional support reported better mental health. Fiori draws on the idea of gender socialisation to interpret her findings. She suggests that instrumental support is more important for men because they are socialised to express traditionally male behaviours, such as providing for their families, unlike women, who are socialised to “need and give” emotional support (2012, p. 429). Yet, she provides no evidence by which we can evaluate her claims. There is an underlying assumption that men do not need emotional support in the same way as women. Fiori finds sex-role theory and the notion of socialisation inadequate to inquire further into the gendered nature of men's everyday social or emotional relations with others, or the social and relational context in which they occur.

This instrumental and emotional dichotomy is one of the leading ideas in sex-role theory and also a widespread belief in popular culture Connell (2005). However, by relying on the idea that men and women have opposite and complementary social relationships, Fiori is unable to account for differences among men when she interprets the relationship between social support and mental health. In fact, almost 30% of men in her study (n=964) reported that they had provided emotional support.
support to their friends and family, and over a third reported they needed emotional support. The sex-difference approach treats men and women as separate homogenous groups and therefore obscure patterns of similarities and differences among men and women (Schofield et al., 2000). As a result, beyond reporting the margin of difference between men’s and women’s social support networks (both size and type), studies such as Fiori, relying on the difference approach interpreted using role theory, tell us little about the diversity in men’s social support networks or how men go about seeking or mobilising social support from others.

2.5 Qualitative research in men’s subjectivity and mental health – men’s health studies

Within the social sciences there also exists a smaller body of research employing qualitative research methods to examine men’s subjective experiences of mental health and illness (see Hoy, 2012; McKenzie et al., 2016 for reviews). This research has arisen in response to the large body of quantitative sex-difference studies, where explanations for men’s lower rates of depression have followed indirectly from the efforts to explain women’s higher rates (Riska, 2009). While this body of social literature considers gender a social factor, most researchers do not explicitly draw on social theories of gender.

The value of lay knowledge, or people’s own interpretations of their experiences of health and illness in everyday life, has been well-established within social research over the last thirty years (e.g. Bury, 1982; Charmaz, 1983). In the case of mental health and illness, Rogers and Pilgrim (1993, 1997) first demonstrated the value of qualitative research methods for exploring the lay knowledge of people with mental health problems. Shortly after this, studies specifically exploring men’s lay perspectives of mental illness, namely depression, soon started to appear in the literature (e.g. Heifner, 1997; Ritchie, 1999; Robertson, 1998). Researchers in this genre of social research argue that qualitative methodologies illuminate aspects of
men’s experiences not captured by quantitative methods, definitions or measurement strategies (Chuick et al., 2009).

Studies have highlighted the diversity in men’s mental illness experiences, mainly depression, and provided insight into the subjective emotional aspects of men’s mental health (e.g. Brown et al., 2012; Bryant-Bedell & Waite, 2010; Liang & George, 2012; Patterson-Kane & Quirk, 2013; Ramirez & Badger, 2014). By way of example, Bryant-Bedell and Waite (2010) explored the experiences of men aged between 35 and 65 years who self-identified as being diagnosed with major depressive disorder. Many men in this study described feelings of loneliness, sadness, distress, hopelessness, being overwhelmed, and at times crying. Contrary to claims in the psychiatric literature that men experience a male-type depression characterised by anger, aggression and irritability, this study suggests men embody and express diverse emotions, including crying. Furthermore, some men explained that while they wanted to express their feelings to loved ones, and seek emotional support, they did not know how to talk about their feelings, or felt embarrassed to do so. This particular finding is similar to Liang and George’s study (2012), where some men reported a desire to talk to family and friends about their personal difficulties, but had few or no people in their close social networks with whom they trusted to share their feelings.

While these studies draw attention to the difficulties some men experience in their emotional relations, without engaging in more sophisticated social theories of gender researchers are unable to theorise why men might struggle to talk to other men and women about their feelings, or how their emotional practices may affect their social relations with others. On the other hand, some masculinities scholars have explicitly linked men’s emotional practices to gender, arguing that the social display or expression of particular types of emotions is highly gendered and controlled (e.g. Cleary, 2005, 2012; Connell, 2009; Frosh, Phoenix, & Pattman, 2002; River, 2014). They argue that boys and men learn the importance of concealing particular emotions viewed as socially feminine, and displaying emotions viewed as socially masculine, in an effort to keep their emotional lives distinct from female
emotional expression (Connell, 2000; Kimmel, 2011). This clearly has implications for understanding the gendered nature of men’s mental health and emotional distress.

Researchers have also provided insights into the mental health experiences of specific groups of men (e.g. Brown et al., 2012; Griffith, Ellis, & Allen, 2013; Hudson, Eaton, Banks, Sewell, & Neighbors, 2016; Isaacs, Maybery, & Gruis, 2013; Lindsey & Marcell, 2012; Ward & Besson, 2013). For example, Brown et al. (2012) draw attention to indigenous perspectives of depression that are specific to the experience of colonisation, loss of culture, and social and economic disadvantage in Aboriginal men in Australia. They interpret men’s experiences of depression using Aboriginal constructs of well-being and in terms of spirituality. While Brown’s study points to important cultural and social stressors on indigenous men’s mental health, without a substantial theory of gender he is unable to theorise how ethnicity interacts with gender, and why being a marginalised indigenous man might place a man at greater risk of poor mental health.

Likewise, researchers have highlighted the impact of racism and discrimination on the mental health of African-American men (e.g. Griffith et al., 2013; Hudson et al., 2016; Lindsey & Marcell, 2012; Ward & Besson, 2013). Taken together, these studies document a diversity of social and cultural determinants of men’s depression and mental health related problems. Yet, they are unable to explain how being a man of particular race, ethnicity or cultural background influences his everyday experiences of poor mental health.

McAndrew and Warne (2010) have drawn attention to the detrimental impact of internalised homophobia on gay men’s long-term mental health. For example, some men talked about the practice of “passing” as heterosexual in order to prevent their sexuality being challenged by others, which in turn compromised their mental well-being. The authors suggest that men’s internalisation of heterosexual societal beliefs and stereotypes about homosexuality may explain the increased risk of mental health problems and suicide in gay men. However, without the use of a social theory of gender their account leaves us with questions regarding the wider
gendered social context of gay men’s lives and the social power relations between homosexual and heterosexual men. In contrast, River (2014), in her gender-relations analysis of men who engaged in suicide, highlights a more complex picture. Gay men in her study who engaged in non-fatal suicide did so because their homosexual orientation had left them subordinated within the gender order.

Schofield et al. (2000) argue that studies that do not consider the social relations between men and women present “a startling and unrealistic separateness between men and women’s worlds” (p. 25). This has been the case for the sex-difference research discussed in previous sections of this chapter and the qualitative work discussed here, where men’s social worlds are treated as though they are disconnected from women’s social worlds. An example of this is Fletcher and St Georges’ (2010) study exploring how men manage their emotional distress and seek support while separating from their female partners and resolving child-access issues. While Fletcher describes how men seek practical and emotional support from family members, and formal help from health professionals, he overlooks the fact that men’s and women’s daily lives are, as Schofield et al. (2000) state, “inextricably intertwined” (p. 251). Given that the focus of this study is men who are resolving child custody issues, it is surprising we are told nothing about men’s social or emotional relations with their former partners and mothers of their children. As I argue in the following section, to fully understand men’s mental health we need to explore men’s health in the context of their social and gendered interactions with other men and women.

2.6 Gender relations and men’s mental health – Masculinities studies

There is a small body of qualitative social research on men’s mental health that uses gender-relations theory to explore the relationship between masculinities and men’s depression (e.g. Coen, Oliffe, Johnson, & Kelly, 2013; O’Brien et al., 2007;
Oliffe et al., 2012; Oliffe et al., 2010; Oliffe et al., 2013), suicidal behaviour (e.g. Cleary, 2005; Oliffe, Han, Ogrodniczuk, Phillips, & Roy, 2011; Oliffe, Ogrodniczuk, Bottorff, Johnson, & Hoyak, 2012; River, 2014) and mental health-related help-seeking practices (e.g. River, 2016; Roy, Tremblay, & Robertson, 2014). This body of literature embraces more recent developments in the fields of gender studies and sociology, that reject essentialist accounts of gender which fail to account for the diversity among men, and the power relations both between men and women, and among men and women (Connell, 1987, 1995; Schofield et al., 2000).

Gender-relations theory was articulated by the Australian sociologist, Raewyn Connell, in her influential book *Gender and Power* (Connell, 1987). In their discussion of the development of gender-relations theory, Carrigan et al. (1985) argue that pro-feminist scholars who were focused on developing a more critical theory of masculinity were influenced by the extensive critiques of sex-role theory by feminist and gay scholars in the 1970s and 80s. Unlike sex-role theory, gender-relations theory does not assume men and women are passive victims of a socially prescribed sex role, nor does it view gender as being fixed by social roles. Rather, gender-relations theory is a contemporary understanding of gender as a combination of dynamic social practices and social relations (Connell, 2012; Schofield et al., 2000).

Connell states that gender is a structure of social practice that is organised in everyday life in relation to reproductive bodily differences (Connell, 1995). From a gender-relations perspective, gender is about *how* the reproductive distinctions between bodies are brought into play through social practice, or the things people do in everyday life (Connell, 1987, 2005, 2009). In other words, gender is not a set of characteristics or traits, which men and women possess, nor is it a fixed set of norms that are socialised or internalised. Rather, gender is something that is produced and reproduced through everyday social practices (Connell, 2009). Furthermore, health consequences are produced not as a side effect of these social practices but in the making of gender itself (Connell, 2012).
Gender is also about the sets of social relations between men and women, and among men and women – a system of relations which Connell terms the “gender order” of a society (Connell, 2009, p. 73). Importantly, these overall patterns of gender relations are historical and subject to change over time (Connell, 2003). From this relational perspective, gender is viewed as the way in which social practices are organised, whether it is in an individual’s personal life, in social interaction with others or on the larger global scale (Connell, 2000). Connell’s theories of masculinities are part of this larger system of gender relations.

Connell and Messerschmidt (2005) argue that one pattern of masculinity, “hegemonic masculinity”, is socially privileged and legitimises a hierarchy of gender relations among men and other masculinities, as well as between men and women. Connell in her book *Masculinities* (2005) defines hegemonic masculinity as “the configuration of practice which embodies the currently accepted answer to the problem of the legitimacy of patriarchy which guarantees (or is taken to guarantee) the dominant position of men and the subordination of women” (2005, p. 77).

While only a small number of men may actually enact hegemonic masculinity, other men position themselves in relation to it and, as such, the hegemonic pattern of masculinity has the power to dominate other men and subordinate women (Connell & Messerschmidt, 2005). Indeed, as Connell and Messerschmitt (2005) note, the idea of a hierarchy of masculinities grew out of homosexual men’s experiences of violence and discrimination from heterosexual men.

Over 15 years ago, sociologists advocated for a gender-relations approach to men’s health and illness policy, practice and research (Schofield et al., 2000). Since this time, gender-relations theory and in particular theories of masculinities have offered health researchers a promising way of moving beyond seeing men’s health problems as the inevitable consequence of a socialised role or a set of gender norms, but as something that is influenced by the social practices and resources that men use to configure gender (Connell, 2009, 2012). In contrast to the singular male role defined by sex-role theory, a gender-relations perspective views the social relations between men and women and among men and women as having implications for
health and illness outcomes (Sabo & Gordon, 1995; Schofield, 2010; Schofield et al., 2000).

While gender-relations theory has allowed health researchers to provide fascinating new insights into the diverse relationships between masculinities and men's mental health, the empirical research has come up against some theoretical difficulties. Bottorff, Olliffe, Robinson, and Carey (2011) suggest this is due to a lack of conceptual clarity in the health research literature about how to integrate and apply a relational theory of gender. Consequently, men's health researchers exploring mental health often grapple with analysing and interpreting men's narratives using a gender-relations perspective.

For example, in one of the earliest studies exploring masculinities and men's depression, Emslie et al. (2006) used secondary data from interviews with people about their experiences of health and illness. They demonstrated how some men used values, or ideals, associated with hegemonic masculinity in their narrative accounts of recovering from depression. For example, some men framed their recovery as a “heroic struggle” where they remained “in control” and “one of the boys” (2006, p. 2251). Other men legitimised their pursuit of less masculine activities, such as creative activities like writing, crafts and art, as a positive point of difference from other men. These findings are interesting because they draw attention to the differences among men in terms of health-related practices. They also highlight how men can use or resist discourses associated with dominant forms of masculinity in order to bolster their masculine status during their recovery from depression.

However, Emslie's study does not fully engage with Connell’s concept of hegemonic masculinity as a configuration of social practice or the things men do in relation to the gender order (Connell & Messerschmidt, 2005). Rather, Emslie focuses only on discursive practices, which is more in line with Wetherell and Edley's (1999) concept from discursive psychology, which views hegemonic masculinity as a subjective position in discourse taken up by men in particular contexts. Connell and Messerschmidt (2005) argue that discursive perspectives are limited in
understanding gender, because they acknowledge only what they call the “symbolic
dimension” of gender (p. 842). For example, how people interpret their lives
through the gendered meanings in discourse, language, dress and the media
(Connell, 2009). Gender-relations theory, on the other hand, views gender as multi-
dimensional, established through discursive and non-discursive practices such as
paid work, family relationships, and emotional and social relations with others
(Connell, 2009). Without a more explicit consideration of the other dimensions of
gender, Emslie’s analysis of the gendered aspects of men’s recovery from
depression remains limited. She is unable to tease out how men actually embody
or contest these hegemonic ideals through their everyday social practices and in
their social relations with others.

In their focus group study of Scottish men, O’Brien, Hunt, and Hart (2005) provide
fascinating insights into why some men are reluctance to seek help for their health,
both physical health and depression. The majority of men in O’Brien’s study
endorsed the hegemonic ideal that men should not seek help and expressed a desire
to remain “strong and silent”(p. 514). There were however some examples where
men challenged this view and sought help from medical professionals for
depression and physical illness. Interestingly, this was often among men who had
prior illness experiences, such as cancer or long standing depressive illness. While
O’Brien does not explicitly present this as a pattern of masculinity which resists
hegemonic masculinity; she does describe these instances as exceptions to the
norm.

While O’Brien’s study offers important insights into the relationship between
hegemonic masculinity and men’s accounts of depression, it leaves us with
questions about suitable research methods. O’Brien reported that within the focus
groups themselves there was strong resistance from participants to discuss or
explore issues related to depression from their own personal experiences. As
Courtenay (2000) argues the denial of depression, a condition constructed as
feminine (Warren, 1983), is one of the ways in which men can demonstrate
masculinity and avoid assignment to a lower-status position compared to other
men and women. Indeed O’Brien suggests that perhaps the way men talked about their health within the focus groups, among other men, may be a means of demonstrating hegemonic masculinity and may not reflect their “actual” practice (p. 507). This leaves us with questions whether focus groups, as method of data collection, limited O’Brien’s collection and analysis of men’s narratives, or as Oliffe (2015) suggests the inductive\(^1\) nature of this type of research limits the analysis and interpretation of the power relations, which are key to understanding hegemonic masculinity and multiple patterns of masculinity.

Some health researchers have moved away from focusing solely on men’s health beliefs and behaviours in relation to depression to explore men’s health-related practices in relation to men’s paid and unpaid work (e.g. Coen et al., 2013; Oliffe, Kelly, Bottorff, Johnson, & Wong, 2011; Valkonen & Hänninen, 2013). Courtenay (2000) argues that institutional structures such as the work place and the health care system have a “profound influence” on men’s health (p. 1394). Yet it is not the case that these structures are simply imposed on men, like the socially prescribed male role discussed earlier; rather, men are active agents in their own social practices, including their work-related and health practices. Thus, when men reproduce traditional gender divisions in labour, and sustain institutional structures that support the receipt of privileges that flow from preserving such structures, men are not only engaging in social practices that can undermine health but also enable men to acquire power and status in society (Courtenay, 2000). In other words, men’s pursuit of the hegemonic pattern of masculinity through paid work and traditional gender divisions of labour not only enables them to maintain their masculine status but has implications for their mental health.

A recent study by Valkonen and Hänninen (2013) has demonstrated how men’s diverse work-related practices can have implications for men’s depression. Through interviews with 24 Finnish men with depression, aged in their forties, Valkonen and Hänninen demonstrate how men’s pursuit of hegemonic masculinity

\(^1\) Inductive research here refers to approaches that use detailed reading of raw data to allow concepts, themes, patterns or theory to emerge from the data in order to understand the phenomenon being investigated (Bourgeault, Dingwall, & de Vries, 2010).
through paid work outside the home can have adverse consequences for men’s mental and physical health. For instance, long work hours, a loss of balance between personal and work lives and a loss of social networks due to work commitments contributed to depression for many men in this study. Some men were more ambivalent in terms of hegemonic masculinity and wanted more involvement in the care of their children or were dissatisfied with their pursuit of paid work. This also had consequences for exacerbat ing men’s depression.

While Valkonen and Hanninen’s study offers fascinating insights into the work-related practices of men in relation to depression, and how men position themselves in relation to hegemonic masculinity, it becomes somewhat confused in its concept of hegemonic masculinity. The authors refer to “character traits” of masculinity including strength, rationality and competence (p. 165). A lack of conceptual clarity around masculinity means Valkonen and Hanninen merge the concept of the male sex role with masculinity as a social practice and do not see how this contradicts Connell’s concept of hegemony masculinity. Furthermore, their study leaves us with questions about men’s social relations with other men and women. Despite providing interesting and long excerpts of narrative from men’s interviews which point to men’s interactions with female partners, children and other men, the authors do not include these aspects of men’s social relations in their interpretation. Consequently, they overlook how gender relations are implicated in men’s depression.

The workplace and men’s paid work is not the only setting of gender interactions which have major implications for men’s health, families are another important setting (Schofield et al., 2000). In a recent study, Oliffe et al. (2011) provide fascinating insights into the dynamics of heterosexual gender relations within the context of men’s depression. Using interviews with 26 Canadian couples, they examined the emotional, work and power relations within men and women’s intimate relationships. For example, some couples “traded places” in terms of their gendered domestic relations (p. 777) and men embodied a subordinate pattern of masculinity due to their diminished ability to engage in paid work outside the home.
as a result of their depression. While taking up non-paid domestic work at home helped some men to manage their depression, it also had implications for their emotional and sexual relations with their partners, due to changes in the power dynamics within their relationship.

For example, some women became frustrated by their partner's perceived inability to manage his depression and resisted being the nurturer and caregiver for him. In contrast, other couples maintained their traditional gendered arrangements at home, with men engaging in masculine paid work, such as engineering and forestry, despite their ongoing depression. While this enabled couples to ensure men “pass[ed] as being well”, despite their depression (p. 780), it had consequences for their romantic relationships. Some men became more reliant on their partners for emotional support in private, while others engaged in more alcohol and drug use, creating conflict in their relationships and putting the mental well-being of their partners at risk.

In identifying these multiple patterns within gender relations, (Oliffe et al., 2011) offer a new understanding of the relationship between masculinities and men’s mental health: one in which men's everyday work-related practices and their social and emotional relations with women have implications for men's mental health. This study leaves us with questions regarding men’s emotional and social relations with men and women outside of their heterosexual relationships. For instance, it would be useful to know more about men who do not have female partners to rely on for support, or men who mobilise social support from their wider social networks or male friends.

While this body of literature has provided new and important findings in regards to masculinities and men’s depression, there has been less focus on other aspects of men’s mental health, namely mental well-being or distress (Ridge, Emslie, & White, 2011). Robertson (2007) was one of the first men’s health researchers to question the growing qualitative empirical work on men’s physical ill-health and chronic disease experiences and the absence of a comparable body of work on men’s “health and well-being” experiences. Drawing on focus groups and in-depth interviews
with men in the northwest of England (including gay men and disabled men), Robertson examined the relationship between masculinities and men’s social practices in relation to health and well-being. His study provides one of the most comprehensive explorations of the relationship between masculinities and men’s “health and well-being” to date.

Robertson’s study points to the implications of men’s relationship and emotions for well-being. For instance, men’s intimate sexual relations with partners and social relations with family and friendships can both support and hamper men’s well-being in a multitude of ways. Further, Robertson argues that men’s emotional investment in social relationships are often, but not solely, instrumental and focused on activities rather than talking about feelings. This study offers new insights into the complex relationship between masculinities, men’s social relations and health and well-being. It also raises important points about the distinction between health and illness. There was uncertainty among some men in this study about when a “minor mental health” issue such as feelings of depression or anxiety actually represented a mental illness and required professional help (Robertson, 2007, p. 114).

A recent study by Lomas, Cartwright, Edginton, and Ridge (2013) is one of the few studies to explicitly draw attention to the relationship between masculinities and men’s mental well-being. Using interviews with thirty men recruited through local meditation centres, the authors illustrate how men can be active agents in their own emotional practice, and in doing so can manage and support their own mental well-being. For many men in this study, their participation in a collective meditation community enabled them to resist hegemonic masculine emotional practices, which in turn proved beneficial for their mental well-being. For example, within these meditation groups men shared their personal difficulties and emotional distress with other men, openly expressing emotions viewed as socially feminine. Nevertheless, men found it challenging to embody these alternative emotional practices in everyday life, outside of these “safe” community spaces (2013, p. 198).
Lomas’ study offers insights into the mental health of men who, as Conrad and White (2010) suggest in the opening quote of this thesis, may not have a diagnosable mental illness, but whose state of poor mental well-being is severely hampering their everyday life. While Lomas did not specifically sample men who had experienced mental health problems, many participants described experiencing distress and depression in the past. Consequently, Lomas is able to offer a broader understanding of the gendered experiences of men who are not just coping with, or managing mental illness, but actively trying to engage with their mental well-being. Lomas’ study, alongside Robertson’s (2007), provides a promising new direction in masculinities and health research that moves away from focusing solely on ill health.

However, Lomas’ study leaves us with questions about the heterogeneity of men’s emotional and social practices in relation to mental well-being. Why exactly did men experience this conflict between the private and public expression of particular emotions, and were there men who managed to negotiate this tension and maintain this more open emotional practice outside of these meditation communities? What other ways did men actively engage in mental health promoting practices aside from meditation?

### 2.7 Positioning the current study

As outlined in Chapter 1, this thesis uses a gender-relations approach to examine the everyday social practices of New Zealand men in relation to their mental health. It builds on the work of masculinities and men’s health researchers such as Oliffe, Robertson and Lomas by using Connell’s gender-relations theory to theorise the links between men’s gendered social practices and mental health. However, it deviates from the dominant focus on depression within the men’s mental health literature and focuses on a broader conceptualisation of mental health that is more than illness and includes mental well-being.
The term “mental health” has no clear or consistent meaning within the literature (see Aneshensel et al., 2013; Horowitz, 2010; Rogers & Pilgrim, 2010). Therefore, it is important to clarify from the outset the meaning of mental health which underpins this study. For many people, the term “mental health” means only something to do with mental illness or having a mental health problem, while for others, the term “mental health” is seen as a more acceptable substitute for “mental illness”, and used as a synonym (Pilgrim, 2009). To complicate matters more, our understanding of what constitutes mental health is likely to be influenced by the culture that defines it, and may have different meanings depending on socio-cultural beliefs about health and illness, and can vary by time, place, culture and social context (Barry, 2009; Kovess-Masfety, Murray, & Gureje, 2005; Rogers & Pilgrim, 2010).

However, the positive aspects of mental health have also been increasingly recognised by researchers (e.g. Barry, 2009; Keyes, 2002; Keyes & Michalec, 2010). Social and psychological researchers have been studying “something positive” in the domain of mental health for over fifty years through the study of subjective well-being (Diener, Lucas, & Oishi, 2002; Jahoda, 1958; Keyes, 2006). While there are various theories and a range of constructs relevant to understanding the “positive” side of mental health, Barry (2009) argues there are some common underlying aspects to most definitions. These include dimensions of emotional well-being in terms of developing positive affect and happiness, psychological well-being in terms of the development of abilities to manage life and maximise one’s own potential, social well-being in terms of relations with other and society, physical well-being in relation to physical health and spiritual well-being which is linked to a sense of meaning or purpose in life (Barry, 2009, 2013; Huppert, 2005; Vaillant, 2012).

In this study I wanted to focus on the social and gendered aspects of men’s lives which promote mental well-being among men who do not have a mental illness, as well as what hinders mental well-being and leaves a man at risk of mental illness.

In order to bring together mental illness and the positive aspects of mental health, or mental well-being I draw upon Keyes concept of complete mental health (Keyes,
This concept incorporates both dimensions of mental illness and mental well-being by integrating the traditional continuum of mental illness, from illness symptoms through to no symptoms, with a second complementary continuum minimum to maximum mental well-being (see Figure 1).

Figure 1: A model of complete mental health (adapted from Keyes, 2013, p. 17)

This concept acknowledges that mental health is subjective, dynamic: can include varying degrees of both mental illness and mental well-being and can change over a person’s life. Some men may experience high levels of mental well-being with no symptoms of mental illness, while other men may experience low levels of mental well-being but not meet the criteria for a diagnosed mental illness.

This broader notion of complete mental health can help us to understand that the absence of mental illness does not necessarily imply the presence of mental well-being or good overall mental health; and that people can and do languish with low emotional, social and psychological well-being without having a mental illness. It also responds to Conrad and White’s (2010) call for a wider understanding of men’s mental health presented in the opening of this thesis. Going forward I use the term
mental health in this thesis to refer to this complete dynamic state of mental health. I also use the terms mental illness and mental well-being.

2.8 Conclusion

This chapter has provided a critical review of existing bodies of literature focusing on men’s mental health. It has demonstrated how little we know about the gendered lives of men in relation to their mental health. It also highlights how current knowledge and debate around men’s mental health and illness has arisen from several bodies of distinct but related areas of research. Furthermore, depression has received more research attention than any other area of mental health.

Psychiatric researchers using the sex-difference framework have focused predominantly on explaining females’ higher prevalence rates of depression, leaving explanations for men’s mental illness largely out of focus. The majority of this research presents males and females as two separate biological groups and ignores any differences among men. It also largely ignores the social aspects of men’s lives, and being male is positioned as a risk factor for a “male-type” depression. Yet, the research offers little insight into why men might be at a higher risk of a male-type depression. Brownhill’s account suggests there is more to men’s lower rates of reported depression than being biologically male: rather, men may hide their emotional distress and express it in different ways to women.

The psychological research has relied on the notion of the male gender role and theories of socialisation to explain sex-differences in mental health outcomes and men’s attitudes to help-seeking. Masculinity is understood as a set of characteristics or traits, which all men are socialised to possess in varying amounts. By viewing the male gender role as a singular and largely problematic construct, psychological researchers are unable to account for men’s actual social practices and what they “do” in relation to their mental health.
The social epidemiological literature has produced the largest single body of research on gender differences and social factors in mental health and illness. Sometimes researchers speculate on reasons for the observed sex differences in mental health outcomes. However, many social researchers draw on sex-role theory, which assumes that men and women are two categorical groups that fulfill two distinct social roles. These assumptions are seldom based on a comprehensive understanding of gender: rather, researchers often rely on ideas and stereotypes that are also widespread in popular culture.

Qualitative social research on men’s subjectivity and mental illness has provided new insights into the experiences of various population groups of men. This body of work moves beyond a homogenous account of men to draw attention to the differences among men and the diverse social influences on mental illness. Yet, it remains limited by its inability to theorise the links between masculinity and mental health, due to a lack of explicit gender theory.

In contrast, men’s health researchers using gender relations and theories of masculinities have demonstrated the strength of a contemporary gender analysis. This approach provides researchers with the means to theorise the links between masculinities, aspects of men’s social lives and men’s mental health, accounting for issues of agency and structure. Researchers have provided insights into the complex relationship between men’s mental illness and social institutions such as work and family, and pointed to the importance of men’s social relations. However, there is a need for greater understanding around men’s mental well-being from a gender-relations perspective. In this study, I specifically aim to explore issues related to men’s emotional lives, work lives, family and social relationships, and how men engage with their mental well-being. I will also examine the relationship between masculinities and men’s mental health.
Chapter 3
Methodology and Methods

3.1 Introduction

The small but growing body of research on masculinities and men’s mental health discussed in the previous chapter demonstrates the value of Connell’s framework of masculinities, as well as qualitative research methods for examining men’s mental health practices and illness experiences. This approach has given researchers a means to go beyond understanding mental health problems as the inevitable consequence of being male, or adopting a socially prescribed male role, and instead demonstrated how men’s mental health is influenced by the social practices and resources men use to construct masculinities (Connell, 2012).

This chapter focuses on the methodological considerations and choices made to explore the relationship between men’s social practices and mental health in this study. In the first section, I build on the methodological considerations in masculinities and mental health research raised in Chapter 2. In the second section, I discuss how I addressed these methodological challenges by using a theorised life-history approach. The third section describes a scoping exercise undertaken to inform aspects of the study design. Following this, I describe the research process, including the recruitment of men, conducting interviews and the gender analyses of men’s narratives.
3.2 Methodological challenges for a gender-relations study of men’s mental health

This study explores New Zealand men’s everyday social practices and how these impact on men’s mental health and well-being. Although social practices are at the core of Connell’s gender-relations theory, as outlined in Chapter 2, health researchers often have difficulties in identifying men’s social practices in their empirical research. There appears to be two reasons for these difficulties, which are closely related. One is that health researchers struggle in applying Connell’s gender theory to the analyses and interpretation of their qualitative research findings. The second is a lack of clarity about suitable data collection methods that can enable men’s narratives to be collected in a way that allows the relationship between gender and men’s health to be fully theorised. These difficulties reflect the fact that this field is an emerging area of health research and there is no substantive body of empirical research that explicitly links qualitative work on men’s narratives of health and illness to gender as a social structure (Robertson, Williams, & Oliffe, 2016).

It has been over fifteen years since Schofield and colleagues (2000) called for an explicit gender-relations approach to researching men’s health and illness experiences. A gender relations approach, they argue, provides a way of understanding how the social relations between men and women, and among men and women, contribute significantly to health. However, there is a lack of empirical health research which explicitly uses gender relations theory. Bottorff et al. (2011) suggest this is because there is a lack of conceptual clarity in the health research literature about what gender relations are and how researchers can use or apply gender-relations theory in their work. As highlighted in Chapter 2, researchers often do not fully appreciate that Connell theorised masculinities as configurations of social practice structured by gender relations, and not simply “a character typology” (1995, p. 76).
In this thesis, I argue that to fully understand the relationship between masculinities and men’s mental health we must take an explicit gender relations approach. This requires moving away from viewing Connell’s theory of masculinities as typologies, categories or character types, and instead see seeing masculinities as part of the wider gender relations of contemporary society (Connell, 2005). Gender relations are concerned with the everyday social practices in which gender (masculinities and femininities) are enacted, such as paid labour, domestic labour and childcare, sexuality, social relationships and the sites in which these practices occur, such as families, the workplace and neighbourhoods (Connell, 2009).

As discussed in Chapter 2, Oliffe et al.’s (2011) study is one of the few to explicitly use a gender-relations framework to research men’s mental health. Their study draws attention to the gender relations between men and women in terms of emotional relations, work relations and power relations, and their implications for men’s depression and men’s intimate relationships with women. A gender-relations approach has been successfully used in other areas of men’s health, including men’s smoking (Kwon, Oliffe, Bottorff, & Kelly, 2014), men’s sexual health (Oliffe et al., 2013), prostate cancer, and diet (Mróz & Robertson, 2015).

In their review of published studies using gender relations to explore health-related behaviours, Bottorff et al. (2011) note that even when health researchers do employ a gender-relations approach, discussion is often lacking around how particular data collection methods have been used to capture gender relations. As such, it is difficult to know how the use of interview guides and specific interview questions have allowed researchers to identify and carry out a gender-relations analysis. Likewise, many researchers do not consider how their choice of qualitative data collection method and inductive analytical approach may have limited their ability to capture gender relations or theorise the relationship between masculinities and men’s mental health outcomes. This lack of transparency in how a researchers’ choice of data collection and analysis fit with the chosen theoretical framework can, as Patton argues, undermine the qualitative rigour of the research (2002). As an
example, Valkonen and Hanninen (2013) in their study of men’s depression discussed in Chapter 2, offer little explanation of the way in which their choice of data collection and analyses influenced their ability to theorise the links between masculinity and depression. While their conceptual clarity around masculinity is somewhat confused, it is hard to know whether their qualitative interview method or narrative analysis has limited in any way their ability to theorise the links between multiple patterns of masculinity and men’s experiences of depression.

Finally, Robertson et al. (2016) have recently argued the need for research approaches and methods within men’s health research that can explicitly identify and understand men’s changing and contradictory social practices. That is, research methods that can identify the dynamic and diverse patterns of everyday social practices which men move in and out of within different social contexts. While Robertson et al. argue that research designs and procedures within health studies should be closely linked to conceptual understandings of masculinities, they do not go as far as discussing what these research designs and approaches might look like.

To move beyond these methodological challenges, I sought a research method that would explicitly fit with my chosen theoretical framework of gender relations. In particular, I wanted a method that would allow me to elicit rich information about men’s everyday social practices, identify the contradictions and ambiguities in men’s configuration of social practices, and allow me to theorise the links between masculinities and mental health. In my search, I turned to the work of masculinities scholars, including Raewyn Connell, James Messerschmidt and Michael Messner. I subsequently chose the life-history method, which, in conjunction with gender-relations theory, has been a key approach to masculinities research for a number of years.
3.3 Life-history methodology

In this section, I discuss the life-history methodology that underpins the design of this study. I offer clarity regarding my methodological choices, in particular demonstrating coherence in the choice of research method and theoretical framework used to collect and interpret men’s narratives.

3.3.1 A brief history

In the life history is revealed, as in no other way, the inner life of the person, his moral struggles, his successes and failures in securing his destiny in a world too often at variance with his hopes and ideals.

(Clifford Shaw, *The Jack-Roller*, 1966, p. 4)

The life-history method aims to capture and document a person’s life, or the salient experiences in a person’s life, as narrative, through the telling and recording of one’s life (Plummer, 2001). In his book *Documents of Life* (Plummer, 1983, 2001), Plummer provides a comprehensive account of the development of the life history approach and its scope and flexibility as a research method within social research. As particular aspects of the development of the life-history method are relevant to my study, I discuss these first.

Life-history method has been used within sociology for many years, providing researchers with a way of understanding and theorising about the everyday lives of people. A number of famous works, associated with the Chicago school, helped to fuel interest in what Harrison (2009) refers to as the “micro-analyses” of social life and the lived experience (p. xxii). A classic example is the now famous study *The Polish Peasant* by sociologists Thomas and Znanecki, conducted in the 1920s, examining the autobiographical accounts of Polish migrants in Chicago (Plummer, 2001). Their study is credited with inspiring a genre of social research using life
history methods to explore and theorise the experiences of people’s lives and the
social context in which they are situated (Connell, 2010). Sociologists continued to
publish influential studies in the 1960s and 70s, and by the 1980s life-history
research was practised more widely by other disciplines within the social sciences.

Plummer (2001) describes how life-history methods, like the Chicago school of
sociology itself, underwent change, critique and debate over the years. This debate
is beyond the scope of this thesis, however, Connell (2010) argues that the most
important transformation of life-history methods came not from within sociology
but from within psychology. She notes how Freud, the founder of psychoanalysis,
established the use of life histories as a therapeutic tool and would create case
studies based on patient’s narratives in which he related the current pathology of
the patient to the whole of an individual’s life.

However, it is the work of the famous philosopher Jean-Paul Sartre (1968) which
Connell credits with influencing the use of the life-history method in her
masculinities research (see Connell, 1995; 2010). Sartre, adapted Freud’s approach
and developed a method of analysis that provided a way of reading a life story,
moving backwards and forwards and linking events in a person’s life to the wider
social context (Plummer, 2001). In her now famous study, Masculinities, Connell
(1995) used Sartre’s progressive-regressive method of analysis to demonstrate
how masculinities are “configurations of practice” that unfold as trajectories
through time. Connell calls these trajectories “projects” or patterns of agency
(2010, p. 68).

In Masculinities, Connell used focused interviews and strategic sampling, to collect
the life histories of four small groups of Australian men for whom she argued the
construction of masculinity was under pressure. This included young working class
men without jobs, men connected with the gay community, men who were part of
the environmental movement and men working in professional or middle class jobs.
Through this work, Connell established the “theorised life history”: that is, life
history used in conjunction with gender relations, as a way of linking men’s
narratives to social structures, including gender and social class (Connell, 1995).
This methodology enabled Connell to examine the diverse ways in which masculinity was constructed by men in her study and identify the contradictions and tensions which arose in men’s masculine projects.

Since this time, the life-history method used in conjunction with gender-relations theory has become a key research method used by masculinities scholars in various disciplines. Other noteworthy studies, aside from Connells include Messerschmidt’s (2000) *Nine Lives*, which provides fascinating insights into the lives of adolescent male perpetrators of sexual and assaultive violence. Using the theorised life-history approach Messerschmidt was able to examine how the social context of boy’s lives led to their trajectory of becoming violent and theorised the links with masculinity. Likewise, Donaldson and Poynting (2007) in *Ruling Class Men* provide intriguing insights into the everyday lives of wealthy and powerful men and reveal the complex interplay between gender and class relations among men at the top.

More recently, the theorised life-history approach has been shown to be of value in research on masculinities and men’s health. In their study of masculinities and obesity in Australian men, Fisher and Chilko (2012) illustrate how the male body is integral to men’s construction of masculinity. In particular, they show how men’s body weight can influence the power dynamics within their social relations with other men, and influence their intimate relationships with women. Similarly, River (2016) in her study of masculinities and men’s suicide, examined men’s diverse and help-seeking behaviour and dynamic interactions with health services using life history interviews and gender relations theory. Together, these studies provide evidence of the validity of the theorised life-history method for analysing men’s lives.

### 3.3.2 The life history as a method

In this study, I use the theorised life-history as a method of collecting and analysing men’s narratives. I chose the theorised life-history approach for this study first and foremost because it provides an explicit framework for analysing gender within
mens’ accounts. It would allow me to theorise the links between masculinity, the social context of men’s lives and mental well-being. Additionally, life history research allows the issue of intersectionality, such as the intersection between gender, social class, sexuality and ethnicity, to be examined (Connell, 2010). The importance of intersectionality, or the way in which masculinities intersect with other social determinants of health to create health inequalities between men has been highlighted in the men’s health research (Evans, Frank, Oliffe, & Gregory, 2011; Griffith et al., 2013)

The key to this theorised life-history approach is the application of Connell’s structural method analysis using the four substructures of gender. These are: power relations – the overall subordination of women and dominance of men; production relations – the gender division of labour; emotional relations – the practices that shape emotional desire or attachment; and symbolism – the symbolic expression of gender through language, gesture and dress (Connell, 1995, 2009). These four aspects of gender represent an analytical framework that can be used to locate gender and social practice within the life stories of the men interviewed. I come back to this point in the research methods section 3.5.4, where I discuss how I analysed my data.

There were other aspects of life history research which made it a suitable approach for this study. The life-history method is a very flexible method of data collection. Plummer (2001) outlines the merits of different types of life stories, including the long and the short story; the comprehensive, topical or edited story; or the naturalistic, researched and reflexive story. In this study, I chose to collect topical, short and researched life histories from men. The topical life history, unlike the comprehensive life story, does not aim to grasp the entirety of a participant’s life story, rather it focuses on particular areas of an individual’s life (Plummer, 2001). Consequently, it provided me with a means of focusing on particular aspects of men’s lives, which the mental health literature has highlighted as being important for mental health. Furthermore, a short life history can involve a single interview rather than multiple interviews over a prolonged period of time. This is often
preferable in qualitative research on sensitive or personal topics, such as men’s intimate lives, because one-off encounters can potentially reveal more sensitive information than multiple encounters, due to the “anonymity” of the encounter (Dickson-Swift, James, & Liamputtong, 2008, p. 35). Lastly, a researched life history collects a story which does not naturally occur, rather a sociological life history is made apparent through the research itself (Plummer, 2001).

The life-history method allows for the collection of men's narratives within the context of their entire lives, from their earliest memories to the point at which they are interviewed. While the participant tells their life story in the present, the story they give ranges over their past (Plummer, 2001). This approach was ideal for this study as it provided me with the means to explore how both past and present experiences in men’s lives may influence their mental health. This is in line with Lohan’s (2007) call for integrating a life-course perspective in men’s health which acknowledges that a man's health status at any given age reflects not only contemporary circumstances but the embodiment of prior life circumstances. In a life-history interview this is made possible through a process known as “cross-referencing” (Miller, 2000, p. 74). This is where the participants’ recall of prior life events is facilitated by the interviewer, who helps the participant to move back and forth in their story, making linkages between the past, through the present and into the future.

### 3.3.3 Researcher subjectivity and reflexivity

The importance of researcher subjectivity and reflexivity is well recognised in qualitative research, particularly when influenced by a pro-feminist perspective, as is the case in masculinities research (Pini & Pease, 2013; Robertson, 2006). As a researcher, I engaged in an on-going process of reflexivity throughout the research process (Alvesson & Sköldberg, 2009; Finlay, 2002; Haynes, 2012). In doing so, I drew on literature incorporating the reflective experiences of researchers carrying out life-history research e.g. De Chesnay (2015) and women researchers doing
gender research with men e.g. Pini (2005). Here I discuss the aspects of subjectivity relevant to my life-history research and in section 3.5.3 of this chapter, I discuss reflexivity in the context of my role as a women interviewing men.

Within life-history research, researcher subjectivity and reflexivity are important for rigour and transparency and are addressed by the notions of credibility and dependability (Atkinson, 1998; Cole & Knowles, 2001; Plummer, 2001). The notion of credibility requires researchers to consider what they accept as truth in the data they collect. Life-history research rejects the notion that there is an absolute and objective truth and acknowledges that it is the subjective reality of the story at the time of telling that is the truth (Denzin, 1989) – particularly as no two researchers will collect the same life history from a participant. Likewise, if you were to collect a participant’s story on two separate occasions, they would not be the same constructed story. Consistent with this notion of credibility, I accepted that I could never have full access to knowledge about another person’s life, or get a simple, real truth about life through a life story. As Plummer (2001) notes, while some aspects of a life story may not be factually correct, they are told from a point of view which has its own truth at the time of being told. Thus, the life histories collected in this study are the truth at the time of being told by the participants.

The notion of dependability requires researchers to acknowledge that the researcher, the participant or the research relationship itself can influence the construction of a life history. Life-history methods have come under scrutiny from post-modernists such as Denzin (1989) who argue that life-history researchers attempt to produce objective accounts of people’s life stories without acknowledging their own part in the interpretation and co-construction of the life story. Yet, the stories told by participants are rarely told in a chronological order, therefore it is the researcher with their own theoretical lens and interpretations, not the participants, who are tasked with organising the structure of the life-history text within the research (Atkinson, 1998; Plummer, 2001). Thus, it must be understood that the final accounts of participants’ life histories presented in this thesis are not their life stories as told exactly by them during the interview. Rather,
the participants’ narrative and the theoretical gender relations framework are woven together to create the final story (Connell, 2005). In this respect, they are my interpretation of their original accounts, reconstructed using gender-relations theory.

3.4 Exploring the context for the research

When I embarked on this doctoral research, there were few discussions on men’s mental health within New Zealand that drew on concepts of gender and masculinity. Therefore, I began this research with a scoping review of the existing empirical qualitative literature on men’s mental health (see McKenzie et al., 2016 - Appendix A). While this review informed the conceptual framework of my study in terms of using gender-relations theory and focusing on a broader concept of mental health, it told me little about how similar research might be conducted in the New Zealand setting.

Given the aim of this study was to explore how the everyday social practices of New Zealand men influence mental well-being, not just mental illness, an important aspect of the research design was to identify a population of men who would provide the most relevant, comprehensive and rich information (Holliday, 2002; Lewis, 2003). Prior to finalising the design of this study, a brief scoping exercise was undertaken to address the practicalities of carrying out this research in the local New Zealand setting and to help me gain a deeper understanding of the current context of men's mental health.

3.4.1 Scoping exercise

In this scoping exercise I used key informant interviews, a method commonly used in health and policy research to help researchers identify aspects of their research design, or gain a greater understanding on a topic, from individuals who possess an intimate knowledge of the subject (Casswell, 2003; Whittaker, 2012). I identified three different groups of professionals who could provide me with a range of
perspectives on men’s mental health issues in the local New Zealand context. These included mental health practitioners who had knowledge and experience of engaging with men (e.g. general practitioners, clinical psychologists, and counsellors in mental health care); health promoters with knowledge of promoting population mental health (from non-government organisations -the Mental Health Foundation and the New Zealand Cancer Society); and those working within non-profit social organisations who had knowledge and experience of working with different groups of men (from the Canterbury Men’s Centre and the Wellington men’s homeless shelter).

Key informants were initially contacted via email and meetings were arranged either in person or using Skype (for ethics, information sheet and consent form see Appendices B, C and D). Scoping interviews with nine key informants took place over a two-month period. The interviews were structured using a topic guide which allowed the free flow of ideas and discussion (see topic guide in Appendix E) (Liamputtong, 2013). These topics included key informants’ understanding of lay and professional perspectives of mental health, topics from the empirical literature on men’s mental health, including men’s formal and informal help-seeking, social support, barriers and opportunities for promoting men’s mental health and cultural stereotypes. As the intention of these interviews was to assist with research design and further my own understanding, it was decided not to analyse the interviews: instead, written notes were taken to assist me in reflecting on the discussions. Next I discuss three issues raised by this scoping exercise relating to my study design: defining the setting and population, strategies for recruitment and interviewing men.

3.4.2 Defining the setting and identifying a population

The findings from these early key informant interviews provided useful and interesting suggestions for thinking about the setting and population group for this research. In particular, given the qualitative nature of the study, how to define a
small “grouping” of men who could provide rich information in terms of their everyday social practices and mental well-being (Holliday, 2002, p. 45).

While all key informants suggested different groups of men for whom mental illness is a priority, for example male farmers who report higher rates of suicide (Beautrais, 2017), elite sportsmen (Rice et al., 2016), new fathers (Paulson & Bazemore, 2010) and particular ethnic groups of men (Brown et al., 2012; Bryant-Bedell & Waite, 2010) who may be more at risk of mental illness, there was a general consensus that men in the local community could provide relevant and rich information about mental health in their everyday lives. As one key informant described it, “asking the man on the street”. Furthermore, key informants suggested excluding men from the study who had accessed secondary mental health care services, that is hospital-based services for diagnosed severe mental illness. The argument being that by excluding these men, it would more likely to capture the lay perspectives of men who have not been exposed to the medical discourse of mental illness through contact with medical professionals (Pill, Prior, & Wood, 2001).

Others suggested focusing the research on men born in New Zealand in order to provide greater insight into the problems with cultural and gendered stereotypes of New Zealand men. For example, gender portrayals in the New Zealand media continue to frame men using a singular dominant masculine stereotype of the “Kiwi bloke” as big, strong, hard, rugged and tough (Dudding, 2009; Yates, 2015). However, this perpetuating image of the New Zealand male is based on the history of the Pakeha² male as a pioneer and settler in a colonised country, first described by Jock Philips in the 1980s (Philips, 1987) and arguably no longer reflects contemporary New Zealand. Key informants suggested that by focusing on men born in New Zealand, it may provide a greater insights into the contemporary lives of New Zealand men, including indigenous Māori men and the impact this outdated yet enduring stereotype has on men’s lives.

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² Pakeha is a term for a white New Zealander as opposed to a Māori New Zealander.
Finally, a number of key informants suggested focusing this research on men aged in their twenties and thirties because this age group of men are often “invisible” in terms of their overall health. This point is supported to some degree by evidence that men in this age group have low rates of enrolment with primary health care providers and low rates of health service utilisation (Johnson, Huggard, & Goodyear-Smith, 2008). Yet this age group of men are clearly “visible” in high rates of suicide (Ministry of Health, 2016). I believed there was merit in focusing on this age group in my research.

3.4.3 Strategies for recruiting men into health research

The key informant interviews left me somewhat uncertain about how to recruit men into this study. While the majority of key informants believed that recruiting participants, particularly younger men, from the community setting would be possible using public advertisements, the literature on men’s health and illness has highlighted particular challenges with recruiting men into research (e.g. Brown, 2001; Bryant, Wicks, & Willis, 2014; Oliffe & Mróz, 2005; Yong, 2001). For instance, Oliffe and Mróz (2005) suggest men do not tend to volunteer for health research studies by responding to public advertisements and are best recruited via social networks, acquaintances and partners.

In contrast, River (2014) reported no problems recruiting men who had engaged in non-fatal suicide into her interview study, using advertisements placed in local newspapers. Similarly, O’Brien (2006) recruited men with diverse experiences of ill health into a focus group study using advertisements and leaflets placed around a university campus, among other methods. These studies suggest the challenges with recruiting men may depend on the social context and the topic being researched. These contradictory findings suggested to me it would be worthwhile trialling a recruitment strategy using advertisements.
3.4.4 A Pākehā woman interviewing men

I was curious whether key informants believed there were issues with my role as a Pākehā woman interviewing men, including Māori men. Māori researchers have raised concerns with regards to the appropriateness of non-Māori researchers working with indigenous Māori people (Health Research Council, 2010). The key informants did not perceive this to be an issue for this research. In fact, a Māori health promoter suggested my Scottish background and accent could be advantageous, as it positioned me as an outsider to the research. In other words, my culture was a point of difference, which could help rather than hinder the collection of men’s narratives.

My main concern was ensuring that the research procedures were respectful and culturally appropriate in terms of collecting the lay perspectives of any Māori men who came forward. Therefore, I consulted with a Māori mental health researcher prior to finalising the research design to provide advice on the cultural appropriateness of the research. Consultation with the Ngā Tahu Research Consultation Committee was also undertaken to ensure the research acknowledged the health needs of Māori.

Interestingly, a number of key informants assumed that simply being a woman would be advantageous to the research process, because women are perceived as “good listeners”. However, feminist researchers would disagree and argue that this belief reinforces stereotypes and social expectation of women as empathetic listeners (e.g. Arendell, 1997; Pini, 2005). Feminist researchers also argue there are specific methodological issues with women interviewing men, in particular the extent to which the research encounter is illustrative of and embedded in gendered power relations (e.g. Arendell, 1997; Gailey & Prohaska, 2011; Golombisky, 2006; Horn, 1997; Lee, 1997; Pini, 2005; Sallee & Harris, 2011).

For example, Arendell (1997) in her reflections of interviewing divorced fathers, describes how men enacted masculinity and asserted their beliefs in male superiority by taking control of the interview through instructing and questioning
her; expressing sexist and misogynist opinions; and describing hostile behaviours toward women. In doing so, she argues men relegated her to a subordinate role during the interview process. Arendell’s discussion suggests that not only do the gender dynamics within research interviews with men require negotiation by the interviewer, but there also needs to be consideration of how this relationship influences the collection of men’s narratives.

Within the masculinities literature, some researchers have also noted how male participants can shape their interview responses in an attempt to align themselves with the researcher (e.g. Sallee & Harris, 2011; Williams & Heikes, 1993). For example, Sallee and Harris (2011) in their study of men’s university education demonstrated how men who were interviewed by a woman presented themselves as opposed to patriarchy, whereas men who were interviewed by a male researcher emphasised their heterosexuality and dominance over women.

There have been fewer reflexive accounts by researchers conducting studies of men’s health (Robertson, 2006). In his study of masculinities and men’s health and well-being, Robertson (2006) reflects on his role as a male researcher interviewing men, and describes how he often found himself mentioning his own children in interviews to “reassure” curious participants about his sexual identity (2006, p. 313). Reflections such as these highlight the fact that gender dynamics in the interview interaction can occur between men as well as between men and women.

Finally, most key informants believed that in order to be successful, the research encounter needed to involve trust and rapport building. In particular, being authentic and using non-academic language was highlighted as an important approach for engaging men to talk about their personal lives. This is in line with the literature on qualitative in-depth interviewing, which emphasises the need for rapport building and trust between interviewer and interviewee (see Dickson-Swift et al., 2008; Green & Thorogood, 2004; Liamputtong, 2007; Seidman, 2013). This can include strategies such as mirroring participants’ language, be they men or women (Green & Thorogood, 2004; Liamputtong, 2013).
3.4.5 Summary of the scoping exercise

The key informant interviews raised a number of methodological issues for consideration in finalising the design of this research, including defining the research setting and identifying the population for study. My reflections on this scoping exercise and subsequent reading of the sociological literature emphasised a particular need for reflexivity in regards to the issue of a woman doing research on men (e.g. Golombisky, 2006; Pini & Pease, 2013; Sallee & Harris, 2011).

Pini (2005) suggests the need to be critical and reflexive about “who is asking whom about what and where?” in qualitative studies where the gender of the interviewer and interviewee differs (p. 204). In other words, as a woman researcher I had to reflect not only on my gender but on my own social position, as well as that of the men I interviewed and the broader social context in which the research took place. This was part of my on-going process of reflexivity throughout the research process, and an awareness of how my role as the researcher and my relationship with those being researched could influence the research process (Alvesson & Sköldberg, 2009; Finlay, 2002; Haynes, 2012). While I could have engaged a male interviewer to carry out the interviews for me, as a doctoral researcher, I wanted to understand first-hand the gendered nature of research interviews. I continue to detail this process of reflexivity as I discuss my research methods in the following section.

3.5 Research methods

3.5.1 Participant selection and recruitment

This aim of this study was to investigate the social practices and mental health of a group of New Zealand men in the context of their everyday lives using a life-history method underpinned by gender-relations theory. Life-history research does not target large and representative samples from which to draw generalisations (Cole & Knowles, 2001; Messerschmidt, 2000). Rather, the goal is to gain an in-depth understanding of men’s configurations of social practice and their implications for
men’s mental health. As such, I used a purposeful sampling procedure to fit with the theorised life-history method and deliberately selected “information-rich cases” for studying in depth (Patton, 2002, p. 230). Initially I aimed to recruit fifteen to twenty participants aged between twenty five and thirty four years, born in New Zealand, who had never accessed secondary mental health care services.

The recruitment of participants in this study was achieved using advertisements placed in the local community, inviting men to participate. A number of advertisements were designed displaying different social, outdoor and sporting activities in an attempt to appeal to a diverse range of men (see Appendix J). Given the uncertainty of this recruitment strategy, as discussed earlier, advertisements were trialled in three public locations over a two-week period. This included a public community notice board, a library notice board and a café. During these two weeks, I received five inquiries from potential participants; however, three of these did not fit the selection criteria as they had previously used secondary mental health care services for severe diagnosed mental illness.

At the end of the two-week trial, I removed the advertisements and reflected on the contact I had had with interested individuals and the wording of the advertisements. I decided to amend the wording from “What does mental health mean to you?” to “How do you get through the stuff that life throws at you?”. My justification for these amendments was that as discussed at the end of Chapter 2, the term “mental health” is often synonymous with mental illness (Rogers & Pilgrim, 2010). Since three out of five study inquiries came from men who had a history of using secondary mental health care services for severe mental illness, I considered that using the phrase “mental health” implied the study had a clinical and mental illness focus. Given the focus of this study was on recruiting men who had a broader range of mental health, in particular mental well-being experiences, I felt that removing any reference to mental health would make the study more appealing to men who had never experienced severe mental illness – thereby helping to recruit a broader range of perspectives.
The revised advertisements were placed in a variety of locations over a three-month period. The timing of the placements was staggered to control the pace of recruitment. Advertisements were located in a variety of public locations around the city including cafes, libraries, community and public notice boards, bars, shops (e.g. a bicycle shop, a surf shop), gyms, swimming pool complex and recreation centres. The advertisements included my contact email address and a designated study phone number that participants could call or text. Recruitment progressed swiftly and I quickly began to receive texts and phone calls from men who were interested in participating in the study.

One month into recruitment I decided to widen my initial sampling frame from men aged between twenty-five and thirty-four years to include those aged twenty to forty years. This was partly because I received a number of inquiries from men who were interested in taking part, but were outside the original age bracket by three to five years. Given the arguably sensitive nature of the research topic and suggestions in the literature that men are difficult to recruit for health topics, I did not want to turn these men away. However, I also began to feel that given this was an under-theorised area of research which have never been conducted in New Zealand, such as tight age restriction was probably unnecessary. Due to practical reasons of retrieving and replacing existing advertisements and time constraints on the study, the age range stated on the advertisements was not amended.

During the recruitment phase, I screened all potential participants who responded to the study investigation through email and telephone conversations. I sent prospective participants a copy of the information sheet, which included details of the study (Appendix G) and a list of mental-health-related support services (Appendix I). In these exchanges, I asked for details on their prior use of mental health care services. For those participants who confirmed they had used secondary mental health care services for a severe mental illness, I provided a full explanation as to why they did not meet the inclusion criteria for the study and thanked them for coming forward. For those that met the inclusion criteria, I discussed further details of the personal nature of the interview. This
communication was important, because it prepared participants for the interview and gave them space to withdraw their offer to participate if they wanted to.

The University of Otago Human Ethics Committee granted ethical approval for this study and subsequent changes to the participant inclusion criteria (Appendix F).

3.5.2 The interview process

Meeting the men
The final sample consisted of fifteen men aged between twenty and forty years living in the local area. Interviews were set up at a time and location suitable for the participant, with all participants expressing a preference to come to the university. Rapport building began from my first encounter with the men. On hearing my Scottish accent, participants often initiated conversation, asking where I was from and telling me about their links to Scotland. This would often lead to a conversation about their time spent travelling or visiting Scotland. These initial conversations were helpful in setting the relaxed tone of the interview.

Prior to gaining consent (Appendix H), I discussed the personal nature of the interviews with participants and ensured there was an opportunity for them to discuss concerns or ask further questions about the research. I explained that if the interview entered an unanticipated and uncomfortable area, or if there was a topic which they did not wish to discuss, participants could pause the interview process at any time, or tell me that they did not wish to answer a question, or talk about a particular issue. None of the men I interviewed refused to answer questions.

I also gave participants a printed copy of the list of mental-health-related support services (Appendix I) and explained the reasons I was providing this. I encouraged and reassured participants that if they felt they needed to talk to someone after the interview, then they should consider contacting these support services. In addition, I explained to each participant that I was not a clinician or a qualified mental health professional but a doctoral researcher, and therefore could not offer any clinical
advice or help. However, if they had concerns I could provide them with information on how to seek further assistance. Dickson-Swift et al. (2008) note that some people might volunteer to take part in research hoping for therapeutic outcomes, rather than a desire to simply tell their story. To avoid confusion around the nature of the interview I felt it was important to make not only the purpose of the interview clear, but my role in the interview.

After discussing these issues and obtaining consent, I invited each man to introduce himself to me in whichever way he wanted to. While some provided detailed introductions about themselves, others were more hesitant and asked me what information I would like to know. I encouraged men to talk freely and provided some suggestions. A brief summary of each participant is provided here to help the reader to become acquainted with the fifteen men. Pseudonyms have been used.

Adam is in his late twenties and is in a relationship with a women who has a young daughter. He grew up in a major city in New Zealand in a middle-class family and has one brother. He went to university and currently works in a government department. He saw an advert for the study in the city library. Adam reported that he had never experienced any problems with his mental health.

Liam is early forties and divorced with two children under the age of fifteen. He currently has a girlfriend. Liam grew up in rural New Zealand with one sister. His parents were migrants from Europe. He went to university and is currently unemployed and starting up his own business. He saw an advert for the study in the local swimming pool complex while his children were at swimming lessons. Liam report that he had never experienced any problems with his mental health.

Nathan is early twenties and currently a university student. He has a girlfriend but they do not live together. He is an only child whose parents separated when he was young, and his father went to prison. He saw an advert for the study at his local gym. Nathan reported previous issues with recreational and prescription drug use and had engaged in non-fatal suicide.
Ben is in his late thirties and has been married for over ten years. He has two children under the age of five. He grew up in a rural farming community with three brothers. He went to university and is currently working for a large national corporate company. Ben reported that he had never experienced any issues with his mental health.

Zac is in his early thirties and lives with his female partner and they are expecting their first child. He grew up in a middle-class family in rural New Zealand with two brothers and a sister. He went to university and currently works in a government department. Zac reported experiencing depression throughout his twenties and had accessed counselling services.

Thomas is mid-twenties and currently a university student studying law. He also works part-time in hospitality. He has a girlfriend whom he lives with. He saw an advert for the study posted on a café noticeboard. Thomas reported that he had never experienced mental health problems.

Jacob is early twenties and reported he is gay but currently not in a relationship. He went to university and currently works in marketing. He grew up in a small rural town, the youngest of three boys. Both his parents were on sickness benefits, unable to work due to chronic health issues. He saw an advert for the study in a sports shop. He reported experiencing depression and anxiety for a number of years and had accessed psychological services.

Ritchie is mid-twenties and recently divorced. He grew up in a middle-class family, one of four children. He is a works as manager within sport and recreation and is responsible for overseeing a large team. He went to university as a mature student. Ritchie reported that he had never experienced mental health problems.

Max is mid-twenties and lives with his girlfriend. He grew up in a middle-class family with two sisters. He went to university and currently works as a lawyer. He saw an advert for the study in his local gym. Max reported experiencing problems with his mental health and had seen a therapist.
Cameron is late twenties and has a girlfriend. He grew up in rural New Zealand with two sisters. He went to university and currently works as a Community project coordinator in sport and recreation. He saw an advert for the study circulated through his workplace. Cameron did not report experiencing issues with his mental health.

Dylan is late twenties and currently single. He grew up in a middle-class family with one sister. He went to university and now works in commerce within the private finance sector. He saw an advert for the study at his local gym. Dylan reported that he had struggled with his mental health and had sought counselling.

Kieran is early thirties, Māori and lives with his partner. They are expecting their first child. He grew up in a working class family with two sisters. He went to university in his mid-twenties and currently works as a policy analyst for a government department. He saw an advert for the study at his local gym. He reported having problems with alcohol use at university and had accessed counselling.

Steve is early thirties and divorced. He is not currently in a relationship. He grew up in a small town and had one brother. He went to university and currently works as a civilian in a desk job for the New Zealand Defence Force. Steve reported that he had never experienced issues with his mental health.

Ethan is late thirties, has been married for over ten years and has two children under the age of ten. He has two half-brothers from his mother’s second marriage. Ethan is a self-employed artist and works from his home studio while also caring for their two children. He heard about the study through a friend. Ethan reported that he had experienced some mental health issues during his recovery from cancer in his early twenties.

Peter is late twenties and currently single. He grew up in a Christian, middle-class family in a rural town. He has five sisters. His parents separated when he was fourteen. He went to university and currently works in information technology in
a government department. Peter reported experiencing depression, problems with drug use and had accessed professional help.

**Conducting the life-history interviews**

The interviews took the form of a semi-structured conversation. I began each interview with a general opening question, asking participants to tell me something about themselves. Participants often began with information about where they were from, their jobs and their family. I then picked up on the topics participants talked about and used these to guide the interview towards these issues in more depth.

I did not use specific interview questions; rather, I identified areas of interest to guide my questioning. The use of a topic guide in interviews with men has been shown to be an effective way of collecting men's life histories (Connell, 2005). My topic guide included areas of interest identified from the empirical literature on men's mental health and my scoping exercise with key informants. The guide covered different areas of men's lives in relation to mental health and provided me with a more flexible, less directive approach than a structured interview schedule.

The life-history topics used in the interviews were as follows:

- Family relationships: emotional relationships, family divisions of labour
- Friendships, romantic relationships, social connections, leisure activities
- Education and paid/unpaid work history: education level, occupation, domestic work, interactions with peers and colleagues
- Significant life events: significant people involved, help-seeking behaviours (friends/professional/community organisations), management strategies
- Managing and maintaining mental health and well-being: activities to promote mental well-being, life satisfaction, wishes for the future
Consistent with the flexibility of the life-history method, the order in which topics were covered was individual to each interview allowing participants to tell their own life story, in their own words, and on their own terms. As the interview continued, I used probing questions and prompts to draw out further information from participants and clarify issues, whilst asking questions around topic areas that had not been covered. I used a "circling-back strategy" when it appeared that participants did not seem ready to talk forthrightly about an issue (Holstein & Gubrium, 1995, p. 17). For example, on two occasions participants appeared to become upset and struggled to talk about the death of a loved one early on in the interview so I did not pursue it, letting them tell me as much or as little as they wanted. I then made notes and came back to it later on in the interview. On the second attempt participants seemed more relaxed and comfortable talking about these upsetting experiences. I also sought clarification from participants when earlier comments in the interview appeared to differ from comments made later in the interview. This checking for internal consistency in participants' stories is a strategy for improving rigour in life-history research (Atkinson, 1998). According to Atkinson although there are inconsistencies in how life is experienced, participants' telling of a life story should be generally consistent.

During each interview I ensured that I took on the role of an active listener, which is key to a life-history interview (Atkinson, 1998). While I listened to participants' stories, I employed a number of strategies Berg (2001) refers to as the "interviewer’s repertoire" to encourage participants to share the richness and depth of their own life stories (p. 93). For example, throughout the interview I maintained eye contact, ensure my body language was relaxed but attentive, nodded encouragingly, and was responsive and empathetic (Atkinson, 1998; Green & Thorogood, 2004). Also avoided non-verbal cues that suggested disapproval or disagreement and shared laughter with participants (Green & Thorogood, 2004; Seidman, 2013).

I took great care in bringing each interview to a close, to ensure participants did not feel rushed, and were not left feeling distressed, uncomfortable or with unanswered
questions. On a number of occasions, after the digital recorder had been turned off, participants enquired further about my doctoral research or would ask me more about why I had chosen to come to New Zealand. I documented both these informal conversations and my own experiences of the interviews in a reflective journal (Ortlipp, 2008). I would write about my observations of participants and also my own thoughts and feelings during and after each interview. These notes later helped to provide me with context during the long and timely process of analysis.

Interviews lasted from one to two-and-a-half hours. After fifteen interviews, I stopped recruiting and gathering life-history data because I felt I had reached saturation (Bertaux & Kohli, 1984). By the last three interviews, I started to recognise specific elements emerging regularly and no substantially new issues appeared to be emerging from subsequent interviews (Bertaux & Kohli, 1984; Green & Thorogood, 2004). For example, emotional difficulties, social relationships with women, work experiences and career pathways.

Finally, procedures for clinical support during the interviewing period were established to ensure I was provided with a safe avenue to report any emotional distress for both my participants and myself. I reported the distress of one participant to a clinical supervisor, who provided advice and support. I was concerned about the well-being of this man, who had a prior history of non-fatal suicide, and was clearly distressed during the interview. After the interview, I made contact with this man to check on his well-being. One a number of occasions I also discussed my own feelings about the interviews with a clinical supervisor. As Dickson-Swift (2008) and others (e.g. Liamputtong, 2007; Rubin & Rubin, 2005) have noted, entering the intimate lives of others for extended periods of time can be stressful, and the emotional impacts of this type of intensive interviewing, and analysis, can lead to researcher exhaustion and burn-out. This avenue for support was clearly essential given the nature of the research.
3.5.3 Reflections on interviewing men

Consideration of the gender dynamics of the interview process in this study were of particular importance. Yet, many of my reflections were not conspicuously gendered. For example, early on in my interviews, I noted that interview participants could be polite but distant in manner. As a result, I felt uncomfortable asking personal questions early on in the interview. This critical reflection prompted me to make changes to the order in which I introduced the interview topics. Participants appeared more comfortable if I began interviews by asking about more general aspects of their lives, such as their jobs and families, and left more personal, probing questions until later on in the interview, when rapport had been established.

To assist me in this process, I made notes about any potentially sensitive topics briefly touched on by participants early on in the interview and came back to them later on. These topics included significant events, such as the death of a family member or the end of a romantic relationship. I also started using preparatory statements that warned the participant about a particular question, for example by saying “This might be a personal question and you do not have to answer it if you do not want to, but could you tell me about …” (Hutchinson, Marsiglio, & Cohan, 2002). By premising questions in this way, I was able to prepare participants for a potentially sensitive question and offer them an “opt out” (Jepson, Abbott, & Hastie, 2015). I also felt it emphasised the informal nature of the interview and reassured participants that I was aware of the intimate and potentially sensitive nature of some of my questions.

I was surprised by the level of self-disclosure by the majority of participants during the interviews. The study men were willing to share their stories with me and no one refused to talk about a topic or answer a question. There are a number of possible reasons for this level of self-disclosure. Previous research has highlighted how a “one-off” interview relationship can make it easier for people to open up and disclose personally sensitive information (Dickson-Swift et al., 2008). I believe this was likely the case with my interviews. I felt participants were willing to share
private information about certain aspects of their lives because I was a stranger. Since they would never see me again, there were no repercussions for their self-disclosure. There were also a number of study men who told me they had volunteered for the study specifically because they hoped their story might “help” others. This was clearly a motivation for some to disclose.

There were gendered aspects of the interview that facilitated participants’ self-disclosure. Some participants told me during the interview that they had never spoken to anyone about many of the aspects of their personal lives that they were sharing with me, particularly not with other men. Arendell (1997) reported a similar aspect to her interviewing, with many men reporting they had never shared their experiences or feelings to such an extent with anyone else because they had not felt safe in doing so, particularly with other men. I believe it was likely the case that a number of men in this study disclosed their experiences and feelings in great detail because they saw me as an empathetic, female listener.

For example, one participant told me at the end of the interview that he had enjoyed it because he felt “more confident opening up in this sort of setting”. By this, I believe he meant talking to a woman because during the interview he had described his difficulties in talking to his male friends about his personal life. Similarly, another participant told me that he believed it was “safer” and “easier to solicit sympathy” from a women. I observed this in a number of interviews, where study men positioned women as being the safe and appropriate avenues for disclosing personal details about their lives. These reflections draw attention to the gendered social expectations on women to be empathetic listeners. In being an empathetic listener to these men, I do question whether I reinforced stereotypes of women as listeners. It is possible a male interviewer might not have had the same ease eliciting the diverse stories of emotional difficulties that emerged during my interviews.

Alternatively, the level of self-disclosure by participants in this study could be attributed to my role as a mental health researcher. While I had been clear with participants that I was not a clinician, there is no way of knowing the impact my
status as a researcher in this topic area had on participants. However, I did observe what Dickson-Swift et al. (2008) describes as the “quasitherapeutic” relationship (p. 62). This is where participation in a qualitative research interview can have a therapeutic nature because, like therapeutic interviews, it provides a space to talk, with an empathetic listening person: the uninterrupted opportunity to share a personal story and divulge personal information to another person whose role is to listen and ask questions (Dickson-Swift et al., 2008; Seidman, 2013). Dickson-Swift suggests that people may offer to participate in a research interview hoping for therapeutic outcomes, rather than simply an opportunity to tell their story.

A number of men in this study told me at the end of the interview that they had found the process cathartic. Further, they said they were appreciative of the opportunity to discuss issues that they did not normally spend much time thinking or talking to others about. For example, one participant stated he felt a “sense of relief” in being able to talk to someone. Another told me that while he had never felt the need to use mental health services, he had hoped that by volunteering for the study he might “learn something” about himself. One man told me that it had been good to be able to talk about issues that he had “thought a lot about” but “never actually ever vocalised with someone else”. While it is not possible to know whether participants volunteered for the study hoping for therapeutic outcomes, in the course of my research it became clear that some study men found therapeutic value in the interview process. This is interesting given the aim of this research was not to provide support or advice in relation to mental health. Yet, clearly the process of having someone to talk to about mental health related issues was useful and informative for many of these participants.

The location of the interviews is another factor that may have influenced the level of self-disclosure. While choosing interview locations is often a pragmatic decision, for example, ensuring that participants can easily travel to and find the location, and that it is conducive to private conversation, previous research has suggested that location can influence the interview (Elwood & Martin, 2000). All the men I interviewed expressed a preference to come to the university premises. This
indirectly had practical implications in terms of my own personal safety. Given the busyness of the university buildings and the presence of library staff after hours, I did not feel any extra physical safety measures needed to be put in place while conducting interviews. Manderson, Bennett, and Andajani-Sutjahjo (2006) note that while the use of the interviewer’s workplace privileges them and their research, more public spaces such as cafes or parks can potentially inhibit the discussion of private and emotive topics. I conducted all the interviews in private meetings within the university building. These rooms were located away from busy areas, they were plainly decorated, with nothing on the walls, and simply contained a table and chairs. They also had windows with natural light. I perceived these spaces as relatively anonymous, less formal and less public. The level of disclosure in my interviews may have been influenced by this perception of anonymity.

The university location may have also influenced the power dynamics of the interview process. As a university researcher, I may have been afforded a certain status that may not have been given to me as a woman outside the university setting. In other words, conducting the interviews on a university site may have privileged my position and positioned me as the “expert”. Alternatively, the power dynamics of the interview may have been blurred by my position and gender combined with men’s vulnerability in disclosing intimate details about their personal lives. It is impossible to know whether these interviews would have been different if they were conducted by a man, or in another location. However, the majority of study men had been to university themselves, with some commenting on the familiarity of being in the university setting. Perhaps coming to the university legitimised their decision to volunteer and talk about their personal lives, as it was viewed as taking part in research. Indeed, two men explicitly told me they had volunteered because they knew friends who had undertaken doctoral research.

Nevertheless, my gender did provide some specific challenges during interviewing. For example, on one occasion, a participant flirted with me at the start of the interview, telling me my accent was “very sexy” and how he was attracted to foreign accents. Despite feeling unsettled by these unwanted and unwelcome comments, I
tried to ignore them, however on reflection they put me on edge during this interview. Gubrium and Holstein (2001) argue that flirting, sexual innuendos or remarks on appearance can be one way that some heterosexual men try to reassert control when being interviewed by women. Although some of this behaviour could be construed as innocent and harmless, or a means of relieving tension, it can also be seen as controlling and a way of diminishing a woman’s legitimacy and power as a researcher, thus preserving a man’s control of the situation (Arendell, 1997). This same participant had been very insistent that his story was one that I should hear when he called to enquire about the research. This sort of research encounter has implications for the personal safety of women carrying out research with men. It highlights the need to consider both the practical aspects of personal safety as well as the emotional aspects when conducting sensitive research.

During a number of interviews, I found myself, like Arendell (1997), in a “paradoxical” position as a woman researcher as I had to listen to men devalue and criticise other women (p. 347). She experienced divorced men openly blaming and being critical of women for the high rates of divorce. Likewise, many men I interviewed criticised women they knew and made derogatory remarks referring to ex-wives, girlfriends or female partners as “manipulative”, “a witch”, “lazy”, “defiant”, “emotionally unstable” and “mentally ill”. Although I wanted to say something in response to these derogatory remarks, I held back in order to maintain rapport with the participant, avoiding any expression that would suggest disapproval or disagreement and potentially close down the interview.

On another occasion I listened to a participant describe how many women he had “picked up” and slept with, describing his behaviour as “putting notches on his belt” and women as “suckers for punishment”. I felt angry with these comments, as the participant positioned women as stupid and careless. At the same time, the participant also emphasised that these past encounters had been “consensual”, assuring me he had not taken advantage of these women and no longer acted this way towards women. By adding this, I felt he did not want my disapproval.
However, as a woman these comments made me feel angry and uncomfortable, because by not saying anything I felt I was legitimising their negative views of women and reinforcing their belief of male superiority over women. These interactions highlight the complexity of power relations in women’s research interviews with men, particularly when it involves talking about issues where gender relations are strongly embedded, such as marriage and intimate relationships with women. This raises the question as to what the appropriate responses are to such encounters in the research setting. My answer to this is that I set out to study the personal lives of men and I wanted to hear their own experiences in their own words, therefore I needed to allow them to tell their stories in their own way, whatever the content and style.

Finally, it was not just my gender but also my cultural identity that influenced the quality of the interview data. My Scottish accent was obvious to all participants during our encounter. On a number of occasions, participants were unsure of my knowledge of New Zealand and would ask me if I needed clarification about what they were saying in case I was unfamiliar with a particular issue. I would encourage them to clarify, even if I understood what they were talking about. In other words, my cultural background was not necessarily a disadvantage. Green and Thorogood (2004) argue the more social and cultural similarities there are between interviewer and interviewee, the more likely we are to assume shared meaning. This shared meaning can make it difficult to prompt participants during interviews, such as saying “what do you mean by that?” – because it implies a breach of common understanding (p. 87). In my interviews, participants often did not assume shared meaning and as a result provided their own clarification without me prompting them for it. This only added to the richness of the data.

3.5.4 Data analysis

The life-history narratives in this study were analysed using Connell’s structural analysis of gender relations discussed earlier in this chapter (1987). The analysis
occurred in two stages: the first, an individual level analysis of each participant’s life-history data; the second, a collective analysis across all fifteen participants' life-history data.

In the first stage, I transcribed each recorded interview verbatim. I then created a life history case study for each of the fifteen participants. This involved reading each transcript carefully, documenting a time-line of their personal lives and significant life events, such as going to school, leaving home, overseas travel, going to university, starting and ending relationships, work history and experiences of mental-health-related issues. Then I examined each interview transcript in detail for descriptions that related to Connell’s (2009) four distinguishing dimensions of gender relations in contemporary society: power relations, production, emotional relations and symbolism.

*Power relations* describe the way that power is organised and contested between men and women, and among men and among women in society. Power as a dimension of gender first emerged as central to the concept of patriarchy identified by feminist researchers and the women’s liberation movement (Connell, 1987). Later on, power emerged as a major theme in Gay Liberation writing, where the oppression of gay men was linked to the oppression of women in general (Connell, 1987). This laid the foundations for the analysis of gendered power relations between patterns of masculinity, and the concept of hegemonic masculinity (Connell & Messerschmidt, 2005).

*Production or work relations* are the gendered division, allocation and organisation of labour. For example, there is the division of paid and unpaid labour (housework and childcare), where domestic or home life is defined as “women’s work” and paid work in the economy is seen as “men’s work”. The gendered nature of work practices can be seen through the segregation of the workforce, where certain occupations are understood as socially masculine, such as engineering and mechanical trades, and other occupations are viewed as socially feminine, such as the arts or human service jobs (Connell, 2009).
Emotional relations describe personal emotional attachments to others and include desire, sexuality and sexual relations between and among men and women. These emotional relations form the basis of social relationships and can be favourable or hostile, for example heterosexuality, homosexuality, misogyny and homophobia. Emotional relations are practised in men’s relationships with women and with other men. They can occur in private, such as in the family or romantic relationships, but can also be found in the workplace. One of the key emotional connections in the family is between parent and child. As Connell (2009) notes, the globally hegemonic pattern is where the care and emotional attachment to young children is seen as the realm of women, namely mothers, whereas fathers are viewed as the breadwinners and expected to be emotionally distant.

The final dimension of gender is symbolism, which Connell added to her original structure of relations in later years. Symbolism draws attention to how gender is given meaning through language, the way people dress, gestures and the media (Connell, 2009). An example is found in Willott and Lyons (2012) study who demonstrate how the language of the “blokey bloke” and discourses of beer drinking are used as symbolic expressions of masculinity in New Zealand.

This stage of the analysis was undertaken with an understanding that these four dimensions of gender are not fixed, discrete categories: rather, they are heuristic “tools for thinking” about gender (Connell, 2009, p. 85). These dimensions of gender interweave with each other and are constantly changing. For example, the emotional relations between parents and their children are also connected to production relations through the division of domestic labour. I looked for instances where these aspects of gender overlapped in men’s life histories. Furthermore, as discussed earlier in this chapter gender does not exist as a social structure on its own: it intersects with other social structures, such as class and ethnicity (Connell, 2009). For example, a man may embody a marginalised masculinity because of his ethnicity, sexuality or working class status. Thus, I also looked for instances in men’s life histories where masculinity intersected with other social structures.
My analysis also went beyond gender. I examined each man's narrative for themes identified in the mental health literature, including social support networks, help-seeking behaviour and health-promoting practices. I also documented aspects of men's stories relating to mental illness and mental well-being. As I discussed at the end of Chapter 2, this study was informed by a broad conceptualisation of mental health which acknowledges that individuals with or without a diagnosed mental illness can experience varying degrees of mental well-being. While the men in this study were not explicitly asked about their understanding of mental health as a construct; the presence or absence of mental health related problems was discussed by most men. However, the presence or absence of mental well-being was less clear. I did not assume just because a man talked about the absence of mental illness or mental health relate problems, that he was experiencing good mental well-being. Within each man's stories I examined the links between men's social practices and their implications for helping or hindering men's mental well-being.

A written theorised life history case study for each man was created and ranged in length between 3,000 and 7,000 words, depending on the length of the interview and the level of detail offered by participants. Given that life histories can make participants recognisable through the life-history text (Plummer, 2001), all personal identifiers were removed from transcribed interviews (for example, references to types of paid work were kept intact but references to specific job titles or location of workplaces were made anonymous). Each participant was given a pseudonym for the purpose of confidentiality. These were selected from the list of the top 100 baby names in the year 1999 published by the Births, Deaths, Marriages and Citizenship section of the New Zealand Department of Internal Affairs.

Through carrying out an individual case study analysis of each of the fifteen participants, I was able to keep each participant's narrative intact while going beyond the narrative to analyse men's social practices and construction of masculinity and theorise their links to mental health. I present four of these
theorised life history case studies in Chapter 4 to offer clarity in the construction of the theorised life histories.

In the second stage of the analysis, all fifteen participants’ case studies were analysed collectively. This involved exploring similarities and differences in men’s life history case studies in relation to Connell’s four dimensions of gender: in particular, examining patterns of social practice across the life stories. In addition, I explored the similarities and differences in terms of health-related practices across the participant’s life histories, including help-seeking and health-promoting practices. In doing so, diverse patterns or configurations of social practice in relation to masculinity and mental health were made visible across all fifteen men’s life stories.

Once these diverse patterns were identified, they were grouped into themes which included emotional practices, social relationships, work-related practices, help-seeking and engagement with mental health professionals and health-promoting practices. These themes form the collective findings and are presented in the following findings Chapters 5, 6, 7, 8 and 9. Within these chapters I provide coherent linkages between the interview data and the reported findings by providing verbatim quotations from participants to support my interpretations.

3.6 Conclusion

In this chapter, I have set out my methodological response to current challenges within the masculinities and men’s mental health research. I have discussed the life-history approach I took in this study and argued the coherence between my choice of research method and theoretical gender relations framework for collecting and analysing participants’ narratives.

I have also described a scoping exercise carried out early on to explore the context for the research and how this informed my research design. I have discussed the research methods including the recruitment, data collection and analysis of men’s
stories. Finally, I have sought credibility in the research process through a process of reflexivity and transparency, offering clarity regarding my role in the research process and the co-constructed nature of the life history case studies. The following chapter presents the theorised life history case studies of four of the study participants.
Chapter 4
Life History Case Studies

4.1 Introduction

This chapter presents the life history case studies of Ben, Zac, Kieran and Ethan. These four case studies present a close examination of the links between men's social practices, masculinity and mental health. They were selected from the larger sample of fifteen participants for the following reasons. First, they demonstrate the differences among the men in this study in terms of social practices and gender relations. Second, they highlight the diverse mental health experiences of the men in this study. Finally, the third case study presents a story which is particular to the history of New Zealand and the impact of colonisation on Māori people.

For each life history case study, I present a brief overview of the interview and each man's life course. I then examine men's social practices within the different dimensions of gender explained in Chapter 3. This includes emotional, power and production relations and symbolism. I also examine men's mental health related practices including professional help seeking and mental health-promoting practices.
4.2 Case Study 1: Ben - the costs of pursuing hegemonic masculinity

4.2.1 The interview

Ben is thirty-four years old, married with two young children under the age of five. He has a background in engineering. He reported that he had never experienced a mental health problem. Ben volunteered for the study because he considers himself “quite resilient” and hoped his experience might help others. He came to the university late afternoon and the interview took place in a private office. Ben was dressed smartly and arrived straight from work on his bicycle. When I first encountered Ben, he was on his cell phone having a work related conversation so I stood quietly and waited for him to finish. During the interview, his phone vibrated repeatedly. Ben appeared quiet and apprehensive at first, however as the interview progressed, he relaxed and talked freely. Ben struggled to answer questions at times and told me he was tired and sleep-deprived from being awake during the night with sick daughter. The interview lasted one hour and forty minutes.

4.2.2 Life course

Ben came from a rural farming family. His parents had a traditional division of labour. His father was a dairy farmer and his mother looked after the household and cared for the children. Ben enjoyed his childhood on the farm and the regular tramping and camping trips with his father and three brothers. Ben had fond memories of his childhood until the age of thirteen, when he witnessed the accidental death of one of his brothers.

Because of this traumatic event, Ben’s teenage years were “miserable”. He talked to no one at home or school about his brother’s death and concealed his grief. Despite being incredibly unhappy throughout his high school years, Ben achieved success both academically and in sport and was moved forward a year. After school, Ben went straight to university and was the youngest in his year. Ben left home and
made good friends at university. He described it as “some of the best times” of his life. Ben had not had such good friends since he was at primary school before his brother died.

While at university, Ben met his future wife Lisa at a party. Ben’s first job after leaving university was with the army, which involved travelling overseas. After a number of years, Ben left the army to marry Lisa as she did not want “that life” for their family. When I met Ben, he and Lisa had been together for twelve years and married for six. They have two young children under the age of three. Lisa stayed at home to look after their children while Ben was in full time paid work.

4.2.3 Emotional Practices

Ben learned as a child that it was not okay for boys and men to talk about their emotions, particularly emotions viewed as socially feminine, like crying. As he said “we’re boys, we don’t that”. This practice of concealing emotions was reinforced when Ben experienced the “most significant and worst event” of his life. Ben was thirteen years old when he witnessed the death of his brother, who was hit by a car. Following his brother’s death, Ben was actively discouraged from talking about or expressing his distress both at home by his parents and brothers, and at school by his peers. As Ben described:

It was pretty awkward to be honest, particularly with my peers. You wouldn’t say anything you know. I was at an all-boys’ school and it was like, fuck they would be awkward about the whole situation. My family, I wouldn’t talk to them about it.

Despite Ben’s school friends knowing about his brother’s death, no one was willing to talk about it, resulting in unease among Ben’s school peers. Ben stated that he
would have “liked” to talk to one of his brothers at the time, but it was too “uncomfortable”. Frosh et al. (2002) note how boys’ social relations are filled with fear around the expression of emotions, and that boys will avoid displays of emotional pain or upset, and belittle such displays in other boys, in order to ensure their relations stay within the boundaries of acceptable masculine behaviour. Ben was fearful of transgressing these boundaries of socially acceptable behaviour and concealed his grief and distress from his family and friends (for a discussion of the concealment of socially feminine emotions see Chapter 5).

However, Ben did learn that it was acceptable for “males to talk to girls about stuff, about their feelings”, but only in private, away from the view of other men and boys. Following his brother’s death, Ben corresponded by mail with a female cousin “for some years”. He stated it was “safer” to talk to girls, because not only was it was permitted but it was easier to “solicit sympathy from a girl”. In other words, expressing socially feminine emotions was allowed with girls and women in private, but not with boys and men in public. Masculinities scholars argue that boys and men learn the importance of concealing particular emotions viewed as socially feminine, and displaying emotions viewed as socially masculine, in an effort to maintain their masculine status (Connell, 2000; Kimmel, 2011). Ben had learned that the public expression of particular emotions viewed as feminine, was not a socially acceptable practice for boys and men.

Ben continued this emotional practice of concealment as an adult and would only talk about his feelings in private, mainly with his wife. However, his practice had consequences for his social relations with others, including his own children. As Ben described:

*She [his daughter] just laughs. She has such a joy of life, and just watching her is fun. She was showing me what an airplane does yesterday, and kind of ran around, flapping her arms, and stripped all her clothes off. Disturbingly, I don’t actually feel the same depth of*
emotion about my son, but that’s probably because he’s newer and, you know, he’s just growing on me, but he’s a lovely little boy as well, very smiley.

Ben’s practice of only expressing his emotions with girls and women, and not boys and men, seemed to be having consequences for his emotional connection and relationship building with his new-born son. Ben was continuing the same cycle of emotional non-disclosure between boys and men that he had experienced as a child in his own family. Despite personally suffering for this practice, after the death of his brother, he now seemed to be repeating it with his own son. This would likely have future consequences for his relationship with his son and possibly his son’s own emotional practices.

While Ben seemed comfortable expressing vulnerability with women in private, he was careful to present himself as “strong” and “unsympathetic” in public, particularly around other men. One way he did this was to dismiss and deride other people for expressing their emotions in public. As he explained:

We had this conversation the other day. A few guys have got issues, and they’re upset at the company. I said, “Well, why don’t you just fuck off? You know, you’re choosing to be here, you know, you choose to stay in [city name], you choose to stay in this job.” They probably don’t have anything else and they’re probably frustrated. Maybe I’m not like that, I can move if I want to and they can’t. But sitting there and whining about it isn’t going to do them any good either.

Ben clearly viewed talking about emotions in public as feminine and described men who talked about their personal problems as “whining”. Ben felt entitled to control conversations and disparage other men’s public displays of emotions. Yet, by
presenting himself as heartless and uncaring, Ben risked damaging his social relations with his work colleagues. Ben not only derided men for their expression of emotions, he also derided women for talking about their emotions in public. Ben described how he had already lost his closest female friend for disparaging her public display of emotions and calling her “sensitive”. Ben had dismissed his friends’ desire to confide in him despite the fact he had been happy to rely on her for emotional relations in private. Ben’s story highlights the power that exists in emotional relations among men and between men and women. He felt entitled to dismiss and diminish other people for expressing their emotions because he viewed his hegemonic emotional practice as superior.

While Ben concealed emotions viewed as socially feminine, he was less wary of expressing anger. When Ben could not talk to his family about his brother’s death, or express his emotional distress, he became angry, particularly towards his parents. Plummer (1999) argues that boys will restrain emotions associated with weakness and feminity, but will not restrain anger in the same way because it is seen as more permissible for boys and men. For Ben, expressing anger seemed a more acceptable strategy for dealing with his grief and distress (for a discussion of diverting grief and distress in anger see Chapter 5). Interestingly, during the interview, Ben reflected that now he had children of his own, he wondered if his parents had been “suffering more” than he had realised.

As an adult, Ben remained angry at his parents for insisting he participate in a police investigation over his brother’s death and, as he said, involving him “in bullshit we had no right to be involved in as children”. Ben blamed them for making the situation worse, and insisting he “sit there through this whole fucking thing not wanting to be there”. Ben said if there had been a “slim chance” he might talk to them about his distress and grief, being forced to take part in the investigation “stopped it dead in its tracks”. Ben felt so resentful and angry towards his parents that, as he said, “there’s no way in gods earth I was going to talk to them about it”. Ben continued to have a strained relationship with his parents, particularly his mother who he described as a “bloody dragon”.

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Ben described himself as “positive, unsympathetic and aggressive all at the same time”. It is interesting that Ben described himself as unsympathetic, or emotionally inexpressive, and yet he was less wary of expressing anger. Shields (2002) argues that anger is frequently overlooked as emotionality, particularly in adult men, because it is seen as something that is natural to men. Ben clearly did not see anger as an emotion, rather just something that men do. He particularly valued his aggressiveness and concealment of weak emotions in the public sphere of his work life and viewed it as advantageous to pursuing his career. As he explained:

*I’m free to admit my approach probably isn’t constructive all the time, with all people, but it is with me. If something happened to me, I was having a whine and someone said to harden up, I’d probably either accept it or be really angry and then go away and accept it. But that may not be relevant for other people.*

Ben viewed anger as a more useful strategy than complaining about issues or whining. He appeared to view his approach as superior to others and described himself as someone who responded well to anger and aggression, particularly in the workplace as it pushed him to “achieve more”. Ben’s view echoes what Whitehead (2002) describes as the notion of the ideal working man which pervades organisational culture, that is a man who is aggressive, independent, competitive and unemotional. While Ben’s anger and aggression might help him at work, it had consequences for his social relations, indeed he had already damaged some of his family relations and friendships through his anger and disparaging of other people’s emotions. This not only had implications for his own mental well-being but also for the mental well-being of those around him.
4.2.4 Social Relationships

Ben made a clear distinction between the types of social relationships he had with men and women. As he explained:

_I’ve got hunting mates, I’ve got people I debate with, people I go to the rugby with, I’ve got female friends that tell me about their male problems and I talk about my kids with, what’s going on in my life and in theirs. Shit, I had a mate the other day that got married. He’s in Scotland, and my wife said “I didn’t know he was engaged”. Neither did I. You know, we talk about all this other stuff._

Ben masculinised his social relationships with men by linking his friendships with men to shared interests and activities seen as socially masculine, such as sport and hunting (Wheaton, 2000). These relationships definitely did not involve discussing each other personal lives. On the other hand, his relationships with women involved talking about his family life and personal problems (for discussion of the gendering of social relationships see Chapter 6). Ben “compartmentalised” his social relations and emphasised that he had a “different dialogue” with his female friends compared with his male friends. Ben could talk more openly with women about personal issues than he could with men, and viewed women as “safer” to talk to. By “safer” he meant women were less likely to reject or hassle him in the way he hassled his male friends who attempted to talk about their personal difficulties.

_We [men] do not talk like I’d talk with my wife about these issues. I don’t think males talk about stuff like this, unless other ones do, but not me. If a male talked to me about this, I’d probably hassle them._
In this quote Ben reinforces the stereotype that women talk about their problems, whereas men do not. For Ben, talking about personal difficulties was more acceptable to do with women than with men. He expected women to provide “sympathy” and social support, yet did not expect the same from his male friends. However, Ben still tried to distance himself from his social relationships with women, diminishing them as “just blabber” and claiming it was women who told him their problems and not the other way around. Ben used women for emotional support, but then disparaged this type of support in order to maintain his masculine status.

Ben would also hassle other men who sought emotional support and wanted to talk about their personal problems. When Ben’s brother attempted to talk to him about his marriage problems, Ben was not interested. Instead, he used humour to deflect the conversation, telling his brother he would be able to “shag other birds” and was probably going to “get more [sex] than me”. Ben was clearly uncomfortable with these sorts of conversations and viewed talking about personal problems as something that should not be done between men. Nardi (1992) argues that tension exists in men’s friendships with other men because closeness and intimacy is associated with homosexuality. In Ben’s case, it seems his way of dealing with this tension and his discomfort at the conversation veering into a highly personal and potentially emotional topic was to divert the conversation to joke about heterosexuality. Ben was not interested in providing any emotional support to his brother, which could have implications for the mental well-being of his brother. However, Ben did offer to financially help his brother and offered to look after his children if needed.

Ben’s compartmentalisation of his social relationships has a number of implications for mental well-being. First, his strategy of maintaining a distance from his male friends and relying mainly on his wife for emotional support is risky. In the event something happened to his wife, Ben would be left with few avenues for emotional support. Cleary (2005) has demonstrated how a lack of avenues for men to disclose their personal difficulties and distress can have serious consequences for men in
terms of mental health risks, including suicide. Second, in the event that Ben did turn to his male friends or work colleagues for support, they may be reluctant to offer support or advice given his history of hassling and demeaning other men for sharing their private information.

Furthermore, Ben’s social circle had gradually become smaller as he got older, and he spent less time with his friends. Many of his long-standing male friendships had waned, due to his investment in work and family and he had few opportunities for socialising with his male friends or pursuing his own interests. The increased risk of mental health problems for people with few social ties has been clearly demonstrated (e.g. Turner & Brown, 2010; Turner, Turner, & Beardall Hale, 2014). For Ben, his lack of social connections and distant friendships could hinder his mental well-being.

### 4.2.5 Work related practices

Ben’s middle-class family background provided him with the resources to pursue hegemonic masculinity in terms of his education and paid work. Ben did not want to be a farmer like his father; he did not view it as a “smart thing to do” financially. Ben became an engineer and worked for a large multinational company. He also established traditional domestic arrangements with Lisa. He did not expect his wife to engage in paid work outside of the home because he “earned enough money” to support their family. Ben was happy with this arrangement as it allowed him to pursue his masculine career:

> It’s important that I work for my family, not for me, really. I don’t like my job, I love it. But the main reason is for money, so I explain to my daughter that I need to go to work so I can buy her a birthday cake, or whatever. You know, it’s the motivation, really.
Ben viewed his place in the family as the breadwinner and financial provider, and his wife’s place as the carer of their children. However, pursuing this traditionally gendered arrangement caused conflict for Ben. As he described:

*I'd like to work less, because I travel all the time, almost every week, and that does take up a lot of time and it’s not where I want to be. I want to be with my family in the evenings or in the mornings. But I’m working on that.*

Ben’s desire to be the economic provider for the family conflicted with his desire to be at home, spending time with his wife and children. Long work hours and regular work-related travel away from home meant Ben missed time with his young children. Ben rarely made it home before his children were in bed and left early the following morning. Connell (2005) argues that being career-driven can lead to men “shrivelling emotionally from never seeing one’s children” (p. 378). For Ben, this arrangement was already affecting his mental well-being. During the interview, Ben described how he was “sleep-deprived” as he had wanted to stay up all night with his sick daughter and still go to work the next day.

Ben’s story illustrates how the imbalance between men’s paid work and personal/family lives can have implications for men’s mental well-being and men’s relationships with their children. However, while Ben seemed to be fully aware that his work took him away from his children, he did not question the impact this arrangement was having on his or his family’s mental well-being. Ben viewed his tiredness and missing time with his children as the price he had to pay for being both a provider and father. As he described:

*I want to be a family man. I want to prioritise my children, and my job fits in around that. It’s a good job, I get well paid and that works for*
us; but if that takes me away from them or affects that, then it’s a no brainer, really. If I died and someone was to stand up and say something about me, I’d want it to be them saying I was a good dad, not my work colleagues saying I was a good whatever I do. So that’s where my focus lies in the next five to ten years.

Ben’s narrative demonstrates how his masculine project actually left him feeling torn between prioritising his children and his job because he “loved” his job, but he also wanted to be a “good dad”. Yet, he had no immediate commitment to change his work arrangements, because they provided the financial means for the family’s lifestyle. Connell and Wood (2005) have demonstrated how men who work in large multinational corporations are often subject to heavy demands in terms of their time and energy. This creates difficulties for men who want to be more engaged fathers because the pressure, which results from working longer hours, is expected to be absorbed into family life. This was certainly the case for Ben, whose family absorbed the personal costs of his pursuit of a successful career.

4.2.6 Help seeking and engagement with health professionals

Ben stated he would go to a health professional for a physical health problem, but would never see a professional for his mental health. As he described:

*Myself for physical stuff, you know. I know the risk and the issues and concerns and I’m not willing to spurn technology any more than I’m not willing to drive a car or get in an airplane. It’s a central part of life. But to see a mental health professional – I don’t think so [laughs]. It’s not for, it’s going to sound heartless, but it’s not for people like me. I don’t need that, I can sort things out, at least so far I can and I have.*
Ben clearly viewed himself as independent and self-sufficient, able to handle his own problems without professional help. For Ben, asking for help, particularly for mental health-related problems was clearly a sign of weakness:

To me, it’s about as valid going to a mental health professional for excessive happiness or anger as it is for being miserable. This may be unsympathetic but is it physiological? Maybe people think so, but I think people get sad and they try and medicate it. Maybe their own coping mechanisms aren’t that good, or something?

Ben rejected the medicalisation of issues which he viewed as a “normal part of life”. He believed that people who did seek help for mental health issues were either “medicalising” their sadness or unable to cope with life. Ben was scathing of people who were depressed and questioned whether their reasons were legitimate:

People need to realise that people get sad, that’s gonna happen to everyone, they don’t need to be depressed. I’m unsympathetic if anything towards people because half their issues aren’t real, they’re just normal, they happen in life. You’re gonna start a job and it’s going to be shit because you’re going to be crap at it, and you’re gonna be bottom of the food chain, and you’re going to break up in relationships, and people you care about are going to die, but that’s just life. Sounds like I’m unsympathetic. I probably am, but to the right person, I think that’s needed at times. I’m less sympathetic to things I don’t think are real.
Ben seemed to believe that people had a choice whether they became depressed or not, and did not view depression as a genuine health problem. Ben’s view of mental illness appeared to be influenced by his own experience of loss. To him, the death of a loved one was a “real” issue, relationship break-ups or work related problems on the other hand were not. Ben believed he had coped adequately on his own after his brother’s death and thought others should be able to do the same. However, Ben had not coped that well and his emotional suppression and anger had affected his longer-term relationship with his parents. He had also had a miserable time at school, unable to connect and have close friendships with other boys because of his awkwardness around his distress and grief. Ben clearly overlooked how affected his mental health had been by his brother’s death and argued that events such as these “don’t need to be terminal; it doesn’t need to affect your life”. Yet Ben clearly remains affected by his brother’s death. During the interview, as Ben talked his grief was almost tangible.

Ben was also dismissive of the need to look after his own mental health. He did not believe he needed to pay specific attention to it because he saw himself as “resilient” and therefore not susceptible to mental health problems. Ben stated that his successful career and family, was testament to his resilience in coping and that he had not let the tragic event in his life “stop him from achieving”. However, Ben’s idea of resilience was related more to success and denying the impact of the emotionality of the situation on him. For Ben, not only was seeking support or help for personal difficulties viewed as unmasculine, but having a mental health related problem was a sign of weakness and a lack of resilience.

4.2.7 Mental health-promoting practices

Ben was aware that his long work hours not only cost him time with his family, but also cost him time and connection to the things he enjoyed. Ben had little time for socialising with his friends or for enjoying his hobbies, such as climbing, running and tramping. Research has shown that long, inflexible or unpredictable work
hours, commuting and mandatory overtime have negative impacts on mental well-being by creating conflict and imbalance between the demands of work, family and non-work time (Foresight, 2008). For Ben, the conflict between the demands of paid work and non-work time meant he had little time for the physical and social activities that he enjoyed and that were beneficial for his mental well-being.

Ben’s mental well-being already appeared to be suffering from the emotional exhaustion which Sonnentag, Kuttler, and Fritz (2010) argues can occur if people are unable to detach from high demand jobs and have leisure time away from work. While Ben had plans to address this imbalance in the future, for now he had no commitment to making time for the things he loved and that are beneficial for mental well-being, such as running and outdoor pursuits with friends.

4.2.8 Conclusion: Masculinity and mental health

Ben pursued a hegemonic pattern of masculinity and reproduced the traditional gender division of his parents. He also took on a middle class pattern of masculinity through his university education and a career in engineering. The emotional, social and work practices Ben used to construct hegemonic masculinity had a number of personal costs in terms of his own mental well-being and had potential costs for the mental well-being of those around him.

Ben’s hegemonic emotional practice had a number of implications for his mental well-being. As an adult Ben was still emotionally affected by the death of his brother. His practice of supressing socially feminine emotions had held him back from openly grieving or talking to others about the loss of his brother. Ben maintained a public persona of emotional self-sufficiency but in private relied on his wife for emotional relations. This has implications for her mental well-being, given that she was responsible for the care of their young children and most likely had reduced time for her own mental well-being practices. It was also already impacting on Ben’s emotional connection with his son.
Ben’s hegemonic practice also impacted his social relations. Ben’s anger had already led to a strained relationship with his mother. He also risked damaging social relationships with colleagues, family members and friends through his disparaging of other people’s public displays of emotion and his hassling of other men for talking about their personal issues. This not only had implications for others’ mental well-being but also had repercussions for Ben. If he ever needed to seek support from his friends, they may be less willing given his history of criticising other people’s disclosure of feelings or personal difficulties.

Ben’s pursuit of hegemonic masculinity through paid work and his desire to be the financial provider also created conflict that had implications for his mental well-being. Ben was unable to spend as much time at home with his children as he wanted to and had little time for the physical and social activities he used to enjoy and that are beneficial for mental well-being. Finally, his denial of any need for mental health related support meant that in the event he did experience a problem with his mental health he would be unlikely to seek professional help or informal support. While Ben reported that he had never experienced a mental health problem or a mental illness, his story suggests the social practices he used to construct hegemonic masculinity hindered the social and emotional aspects of his mental well-being.
4.3 Case Study 2: Zac - ambivalence, shame and depression

4.3.1 The interview

Zac is thirty years old and lives with his partner Emma who is expecting their first child. He is a public servant in a large government department. Zac reports experiencing repeat episodes of depression throughout his twenties. He describes these episodes as “troughs” where he felt “really down” and life was a “dark sinister world”. In contrast, his “peaks” were “fleeting moments” of happiness that occurred “every now and then”. Zac saw an advert for the study at his local swimming pool complex and volunteered “out of interest”. We met at the university, after work hours and the interview took place in a quiet room.

Zac was dressed casually and came across as relaxed and confident, if a little shy. Zac listened intently to my questions and provided in-depth answers. At times, there were long silences and I would wait. Sometimes he would pick up his answers and continue to talk; other times there was no more to be said. Zac had an infectious laugh and many times throughout the interview we laughed together. I felt that he was hoping to gain some clarity and understanding of his experience by talking to me, as he appeared less interested when we touched on aspects of his life which were not directly related to his struggle with depression. The interview lasted one hour and ten minutes.

4.3.2 Life course

Zac came from a middle-class family. His parents had a traditional division of labour. His father was a veterinarian and his mother stayed at home to care for the children. Zac was the youngest of four children and described his childhood as “stable and happy”. His parents owned a holiday home by the sea and Zac spent many “happy” summers with his brothers, sister, cousins and friends. In his final year of high school, when Zac was seventeen years old, his mother was diagnosed with cancer. Zac’s family believed she was going to recover, it was a shock when
she suddenly died. As the youngest in his family, Zac was the only one left at home living with his father at this time.

Shortly after his mother’s death, Zac left home and went to university to study politics. While he started a “whole new life” and made new friends, Zac struggled with “waves” of grief at the loss of his mother. This was the start of Zac’s struggle with his mental health, which would continue throughout his twenties.

After finishing university, Zac moved to a new city and landed his first government job. Over the next few years, Zac climbed the career ladder, moving into more senior, well-paid positions. Despite feeling successful at work, Zac continued to struggle with his mental health. Zac eventually met his partner, Emma, through work and after two years together, they bought their first home and are now expecting their first child together.

4.3.3 Emotional Practices

Zac described growing up in a family with a gendered pattern of emotional relations. His mother had a “natural talent” for talking about her emotions, whereas his father was emotionally distant. Zac recalled learning from his older brothers that expressing particular emotions such as crying or sadness was not okay for boys or men. Whenever Zac became distressed or cried, his brothers actively curtailed and discouraged him from expressing these emotions by telling him to “toughen up”, “don’t be a wimp” or stop being “a sissy”. Being a “sissy” was the antithesis of masculinity.

Frosh et al. (2002) refer to this behaviour as the “policing” or “scrutinising” of boys’ masculine identities by others to ensure boy’s conformity to a heterosexual notion of masculinity (p. 176). This policing of emotional expression, causes young boys to avoid displays of particular emotions, for fear of being called gay or effeminate by their peers for overstepping certain ideas about dominant masculinity. For Zac,
the policing by his older brothers taught him that to be masculine required him not to express emotions viewed as weak and feminine.

Zac used symbolism to give gendered meaning to emotionality, using the phrase “mentally tough” to talk about holding in emotions and the word “soft” to talk about the expression of emotions. Being tough or strong was associated with masculinity and Zac believed the ability to suppress emotions was a strength. On the other hand, expressing emotion was associated with softness, femininity and weakness. Zac recalled how he was treated differently to his sister whose expression of “soft” emotions was not kept in line the way his emotions were. Furthermore, she was allowed to receive as much “support and help” as she needed, whereas Zac was expected to be emotionally self-sufficient and deal with his issues on his own. As Zac described:

*I was sort of expected just to toughen up and push on through. I guess my brothers were sort of personality A types, whereas I think me and my sister are more alike and sort of share that depressive side to us. I think at times I felt like I was just expected to be like my brothers and, you know, just be a bit tougher and don’t make too much of a fuss because you’ve got to look after your sister.*

Zac’s quote illustrates how his family expected him to be tough, self-sufficient, stoic and deal with his own problems, unlike his sister, who needed looking after because she was a girl and more delicate. Cleary (2012) notes that family members, especially fathers and male siblings, are important enforcers of masculinity and emotional expression for young men. For Zac, this was certainly the case and in this quote, he draws on symbolic language, referring to his brothers as “personality A types”. In doing so, he positions his brothers’ masculinity as strong and dominant, the opposite of softness or weakness. He and his sister on the other hand, had a “depressive side” or were more open with their emotionality.
Zac took up what he referred to as his family's “subtle signals” and put his emotions away. Yet, these signals were not so subtle. Zac was overtly told by family members not to express his emotions through name-calling and being told that he could cope on his own. Zac became resentful that he was treated differently from his sister. He wanted to have and express his emotions like she did, but was not allowed.

As a teenager, Zac was able to maintain this practice of emotional concealment to some extent; however it had ongoing consequences for his mental health. Zac described feeling “traumatised” when his mother died and he struggled to conceal his grief and distress. Zac wanted to be able to express his emotions but felt ashamed about wanting this more open emotional practice. During the interview, Zac’s voice broke as he talked about how traumatic the death of his mother had been. He was still clearly affected by her loss.

Over the following years, Zac’s mental health deteriorated and he experienced “bouts of depression” which continued throughout his twenties. Zac recalled spending a lot time trying to figure out “why bad things happen” and why he was “suffering” so much. Zac was searching for rational reasons to explain his continued episodes of depression. Many times, he thought, “life could not get much worse”. In trying to understand his suffering, Zac started to question his own emotions and began to reflect on his parent’s emotional practice (for discussion of the questioning of emotional practices see Chapter 5). As Zac explained:

*My Mum was a really excellent communicator and my Dad not so. He’s a lovely man and all that, but just that sort of old school, I suppose. Not talking about feelings, very difficult to engage on that sort of level with my Dad. I often sort of now can see myself, can see my Dad, you know, what I say through my Dad. I just wish my Dad would be more like this and could talk to me more like that. And then, you know, here I am now, sort of I’m being like my Dad. It’s not an easy thing to have that*
skill that my Mum had, to be able to engage with people and solicit, make them feel comfortable on quite difficult topics and things.

Zac started to see he had pursued the traditional masculinity of his father who was unable to talk about the “in-depth emotional stuff” and started to question this emotional practice. What Zac really desired was a masculinity where, as he said, “emotions are more readily available”. Zac clearly admired his mother’s “skill” for emotional expression and began to see the value in talking about his feelings and what he called “soft issues”. Zac could see the problems with his father’s repressed emotional practice and did not want to reproduce the same pattern with his own children; however he was unsure how to change it. As he explained:

*I think I would like to have that [his mother’s] communication with my children. It won’t be the exact same, as there will always be a different dynamic to it, but I’d like not to just leave it to my partner to do it, to be there as well. That’s probably … if I can do that, I’d love to do that. But I do not know. Maybe it’s a skill that I don’t have.*

Zac had a clear need for emotional connection and a desire to have the sort of emotional relations with his children that he had experienced with his mother. However, the difference Zac could see between the way his mother talked about her feelings and his own practice caused him considerable suffering. Zac did not want to be the unemotional, self-sufficient man he felt he was expected to be, but at the same time he felt ashamed for wanting to embody a more open and genuine emotional practice. Despite his shame and continued depression, Zac pushed on against his despair rather than give in to it.

In contrast to the difficulties in his personal life, Zac found his strategy for emotional control worked for him in his job. As he described:
I’m more about what I can do and it’s more a positive phrase. So a technique I use when I’m under pressure is sort of saying “I can do it” “I can do it” “I can do it”. I can do this, I can meet that deadline and convince that person to do this. That’s kind of the work me whereas the personal life me is more laid back and just letting things go. So that’s a lot different to ‘this can’t get any worse’ you know [laughing] and that’s been very useful for me.

This quote highlights the contrasting strategies Zac used at work compared to his personal life. At work, he embraced what he called a positive “can do” attitude, which involved pushing for results, competitiveness and desire. As Whitehead (2002) notes, these emotions serve the masculine ideals of organisational work cultures and are therefore encouraged in the workplace. Yet, Zac ignored the emotionality of these emotions because they are viewed as masculine and allowed in the workplace. However, Zac’s “can do” strategy, which involved denying emotionality, was harder to carry through into his personal life:

Work’s easy in a sense, in that you can work really hard at it and get tangible results. But I think in my private life, personal life, I guess I think of it slightly differently. If I’m having a challenging time mentally, in a darkish place, I’m not trying to solve anything anymore, I’m just more accepting that this is life. It goes up and down, and you may as well enjoy as much as you can. Don’t try and figure it out, cos it probably can’t be figured out. Whatever you are feeling now will pass with time.
When not at work Zac could no longer ignore the emotionality of his situation and tried to apply a more rational (socially masculine) approach to sorting out his emotional issues. He attempted to be more laid back and more accepting that life “goes up and down”. However, the difference between these two worlds of work and private life was a cause of considerable tension in Zac’s life. While he could cope at work by suppressing his emotions, he could not cope with the emotional turmoil in his personal life.

Despite trying to pursue hegemonic masculinity in terms of his emotional practice Zac remained ambivalent. He did not really want to deny and conceal his emotions but at the same time could not actively resist this practice. Perhaps for now his ambivalence was a way of living with the emotions he could not understand and seemed more achievable than overcoming his feelings of shame. This sense of shame for not being able to live up to the masculine ideal of denying his emotions came at a cost for Zac. He continued to live with a sense of bleakness in his life, which blocked his mental well-being.

4.3.4 Social Relationships

Zac had never been able to comfortably talk to his male friends about his sadness and depression and said he found it “really hard”. Zac described one of his “dark periods” when he was feeling really low and how he desperately wanted to talk to someone and reached out to a friend:

I needed to get lots of courage together to tell a friend of mine and I kind of said, “Ah, I think I’m depressed”, and he’s like, “Ah, that’s a shame” [laughs] and it didn’t really go anywhere, you know. It felt like I invested, put myself out there on a limb and built up, had to really sort of build myself up to struggle to get the words out even to say the actual words. And it sort of came out real sort of bland, and it probably
didn’t sound like much but it didn’t really go anywhere. I guess because beyond just saying “I’m depressed” you kind of need to talk about it more than that.

This quote illustrates the effort it took for Zac to disclose his depression to his friend. However, with the response he received, Zac felt it was not safe to go any further and did not push the conversation. Zac was left feeling a deep sense of shame and embarrassment for disclosing his unhappiness and wanting emotional support from his friend. Unfortunately for Zac, this encounter reinforced the messages he received as a child, that disclosing and talking about his feelings to other boys and men was not socially acceptable. Zac stated he was worried his friend thought he was a “prima donna”. This is interesting, because the term has a sense of socially feminine hysteria, where women’s emotions are seen as being out of control. Zac was clearly worried his friend would think he was being overly emotional and feminine. In future, Zac would not break the unwritten boundaries that prevent men from expressing their feelings and would continue to rely on women for emotional support in private.

Without the support and understanding of his friends, Zac continued to suffer with feelings of depression alone and in silence. It was not until he met his partner, Emma, that Zac finally found a safe avenue for talking about his mental health and received the emotional connection he craved. Zac’s, case, like Ben’s, illustrates how women are often relied on by men to be the sole emotional connection and support, because they are unable to have this connection with other men.

4.3.5 Work related practices

Zac’s middle-class family background provided him with the resources to pursue hegemonic masculinity in terms of his university education and career. He was expected to go to university and pursue a respectable career like his father and his
older brothers. After finishing university, Zac moved to the city to find paid work. He joined the public service and had a respectable and well-paid desk job. However, this pursuit became a disappointment for Zac:

It had been a couple of years and I just kind of felt like, you know, I’d gone to university, now working and this was kind of it. I just felt, it didn’t feel like I’d done much with my life. Didn’t feel like I had good friends at that point. Didn’t have a partner. Didn’t enjoy my work or think I was that valuable at work. Could see everyone else around me being very happy and successful, comparatively. I mean, there was no one particular thing, but I guess it was just a collection of all those things at that time in my life where I just felt really down.

Zac became disillusioned by life after university. Despite having a well-paid job, his pursuit of hegemonic masculinity through paid work had not provided the secondary emotional gains he had expected. Without a partner, good friends or a job he really enjoyed, Zac felt unsuccessful compared to those around him. Zac's pursuit of masculinity was not just about paid work; it was also about having a partner and a family. There was a sense that Zac felt he needed a partner to legitimise his masculine project. As a result of this feeling of disillusionment, Zac continued to experience recurring feelings of depression which added to the weight of his unresolved grief.

Despite his despair, Zac continued his pursuit of hegemonic masculinity through paid work. He worked hard to overcome his “severe shyness” through public speaking and moved into more senior job positions in the public service. Zac eventually started to feel he had “conquered” his “self-doubt” and anxiety. He became quietly ambitious and pursued positions which would look good on his curriculum vitae. However, despite his feelings of success at work, Zac remained unhappy in his personal life for many years.
Meeting his partner Emma was a turning point for Zac. Through their relationship, Zac started to receive the emotional gains he had expected from pursuing hegemonic masculinity. Zac stated his life “kicked into gear and moved on”. Zac and Emma bought their first house together and were expecting their first child. Zac had also reached his most senior job position to date. Yet, despite achieving success in both his paid work and in establishing traditional gender relations, Zac’s mental health issues remained unresolved. The divide between his public and private life left him confused and he was unable to resolve his emotional ambivalence.

4.3.6 Help-seeking and engagement with health professionals

Zac first sought help from a counsellor at university when he felt unable to cope with his mother’s death and his father’s subsequent new relationship. Zac described how he became distressed when he came home from university and his mother’s belongings were “put away” in the garage. Zac sought help from a “number of counsellors” during his time at university as he experienced “waves of grief” (for discussion of help-seeking see Chapter 8).

Zac described counselling helpful because he was finally able to “talk to someone” about his personal difficulties. It was also cheap, five dollars a visit, meaning he could afford to pay for sessions himself. Despite seeing the value in professional assistance, Zac still struggled with it. As he explained:

*I did feel ashamed about going to see them and I wouldn’t tell my friends, it wasn’t something I would share with them. I tried to justify it to myself partly along the lines of I don’t have a mother anymore to talk to and the other being if we look back on our society there would have been the priest of the chief, there would have been someone in your social structure where there would have been someone to go and*
talk to. But in this day and age it just happens that you know you pay to go and see someone so it's not that much different.

Zac clearly found seeking professional help and expressing his emotional distress difficult as it went against the messages he had been given as a child to be emotionally self-sufficient. He was acutely aware that he was going against dominant notions of masculinity regarding men’s help seeking and was worried others might see him as “weak” or a “sissy”. Zac rationalised his decision to speak to a professional because seeking professional help for health problems is viewed as a feminine practice (Courtenay, 2000). Zac clearly felt that his friends would not view his help seeking as an acceptable practice for a man and he told no one apart from his sister about his encounters with mental health professionals.

While Zac gained some benefit from talking to counsellors, at the same time he devalued this support and pushed himself to be self-sufficient:

I guess they did help but beyond talking to someone and having them ask probing questions I think ultimately you have to turn yourself around. You can’t sort of offload that to someone and pay them to do it for you. I think for me when I realised that it was only me personally that can do that, once I got my head around that you know that was the most effective thing for me. The expectation is that you take the responsibility on your own shoulders and you are just expected to deal with it yourself.

Zac questioned the value of professional help in addressing his personal issues. Beyond talking about his current situation with someone independent, Zac found these services inadequate in addressing his recurring depression and sadness. While Zac also went to see a GP at university, he was unhappy at being prescribed
antidepressant medication. Zac did not think, “taking a pill would solve your problems” and believed that “only me personally can do that”. Zac clearly struggled with the tension between asking others for help and feeling that he should be responsible for solving his own emotional problems. As Zac said, he wanted to be “the master of his own future” yet he struggled to master his own emotions. Zac did not want to be self-sufficient and unemotional, he wanted to seek help and support from others and he wanted to be able to talk about his grief and be someone whose emotions were as he said “readily available”. However, the deep sense of shame he felt for not being able to cope on his own held him back and his mental health continued to suffer for it.

4.3.7 Mental health-promoting practices

Zac developed his own health promoting strategies when his engagement with mental health professionals failed to provide ongoing relief or resolution to his personal difficulties. Zac described his strategy of relying on his inner resources when he was experiencing low periods:

“I've always felt interested in the world. I've always had this inquisitive side to me which I rely upon and even if you're in that horrible place, I still found I had energy to find out new stuff, even if it was about being unhappy. I think getting through real tough times I'd always be looking at things, thinking about different things, reading books. Yeah, that inquisitive- there must be something new, there must be another layer to this, kind of thing.”

As this quote indicates, Zac had a sense of curiosity and a desire to learn more and make sense of his life. This sort of curiosity and engagement with learning is promoted as a strategy for supporting individual mental well-being (e.g. Foresight,
2008; Mental Health Foundation, 2015). However, while this strategy provided Zac with the means to alleviate his depression and distress to some extent, it had limited benefits for promoting his mental well-being as it did not provide longer-term resolution to the issues that were troubling him. In particular the tensions in his masculine project in regards to his emotional practice.

4.3.8 Conclusion: Masculinity and mental health

While Zac had achieved the conventional form of hegemonic masculinity that his family had expected of him through successful paid work, it was also a source of incredible tension for him. Zac struggled with the contradiction between his successful work life and the unresolved unhappiness and recurring feelings of depression in his personal life. This contradiction resulted from the conflict in his masculine project between the hegemonic practice of being emotionally self-sufficient and his desire for emotional connections with others.

Zac’s ambivalence around his emotional practice had major implications for his mental health. Like Ben, Zac had been unable to resolve the deep sense of loss from his mother’s death and was still emotionally affected by it. He also felt a deep sense of shame for wanting to embody a different masculinity where the expression of emotions was allowed. He struggled to build supportive social connections with his male friends and relied on his female partner for emotional relations. For Zac, both professional counselling and his strategy of engaged learning was not enough to help him resolve his emotional ambivalence, or his recurring depressive episodes. Zac continued to experience symptoms of mental illness and his mental well-being was hindered by the unresolved tensions in his masculine project.
4.4 Case Study 3: Kieran - shifting and reconnecting

4.4.1 The interview

Kieran is thirty-two years old, Māori, lives with his partner Hannah and they are expecting their first child. He works as a public servant in a large government department. He reports experiencing problems with alcohol use in his twenties. Kieran saw an advert for the study in his local gym and volunteered because he was “interested” in research. We met at the university after work hours, and the interview took place in a quiet room. Kieran was dressed smartly in a suit. He was polite, softly spoken and appeared relaxed, listening carefully to my questions before giving considered answers. The interview lasted one and a half hours.

4.4.2 Life course

Kieran grew up in a working-class Māori family, one of three children. His parents had a traditional gender division of labour; his father pursued paid work, while his mother cared for the children. As a child Kieran’s family experienced significant financial hardship and at times, his parents struggled to pay bills and buy food or clothes. There were as Kieran said, “good times” and “not so good times”. As a child, Kieran and his sisters frequently moved around the country for his father to find work, mainly manual labour and factory work. This “nomadic existence” as Kieran called it meant he often had to change schools, leaving his friends behind. Despite this disruption, Kieran did well academically.

After leaving high school, Kieran went straight into paid manual work like his father. For a number of years, Kieran worked in various jobs including furniture removal, labouring and bar work and he had been unsure what do with his life. This changed after Kieran experienced a number of significant events that led him to question what he was doing with his life. Kieran decided to leave his job in hospitality and follow his passion for art. Despite doing well at art school, Kieran was unable to complete his course when a house fire resulted in the loss of an entire years’ worth
of work. Around the same time Kieran’s grandmother, whom he had been close to as a child, died and he attended her funeral which was carried out in customary Māori protocol. Kieran described how not only could be not understand what was being said, as he did not speak te reo Māori language, but he did not understand the cultural protocol. As a consequence of this Kieran began to seriously question his lack of connection to his family’s Māori culture and language.

Motivated by his desire to reconnect with his Māori culture, Kieran decided to go to university and embarked on a double degree in art and Māori Studies. Kieran became fluent in te reo and was the first person in his family to go to university. After university, Kieran did not see himself working in an office but had no choice when the jobs on offer were office-based. He worked as an intern in a government department and later moved into better job positions as his experience increased. Kieran met his current partner Hannah through work. They had just bought their first home together and were expecting their first child.

4.4.3 Emotional Practices

Kieran did not recall emotions being talked about in his family when he was growing up. Every time Kieran had to move school for his father to find work, there was no open discussion about where they were going or why, Kieran recalled simply being told “that’s what’s happening.” His father would encourage Kieran and his sisters to “see the positives of everything” such as making new friends. However, with some of the more “difficult issues” in their family he described his parents as being “closed”. Kieran’s family social class struggle and issues of financial hardship appear to have influenced the emotional relations in their family.

As an adult, Kieran said he was “more inclined to be closed” about his feelings in public but in private, Kieran had established a close and “very deep” emotional connection with his female partner. He wanted his partner to know he was “open” and she could always talk to him about anything. Kieran did not believe that men were any less emotional than women were:
I don’t think the cues are different, I think drawing it out might be different depending on who you’re talking to, men would probably be a bit more inclined to be closed, I wouldn’t say that, I can’t say that for every man but maybe yeah little less wanting to talk about it or maybe they’re just not comfortable talking about it with you or that person. So yeah different in that way but I can only talk from my experiences, but definitely not any less expressive I don’t think. The emotions are still there with whatever they are dealing with, still the same. I think it’s just drawing it out is the challenge.

Kieran believed that men and women experienced the same emotions; rather it was the public display of men’s emotions that differed. Kieran’s view echoes Hochschild’s (1979) theory of emotions: that the acceptability of expressing particular emotions is governed by cultural and social display rules. Kieran pointed to the social expectations on men not to express particular emotions and did not naturalise the difference between men and women’s emotionality like other men in this study. Despite this acknowledgement, Kieran was still reluctant to be open with his own emotions in public. He was clearly aware of these social expectations on men to conform to hegemonic practices of concealing emotions.

For Kieran, becoming a father for the first time had led him to reflect on his own emotional practice and the distant emotional connection he had with his own father. Kieran wanted a closer connection with his own son:

Just a Dad my son can rely on and feel comfortable about coming to talk to about anything and everything. Yeah, no subject is taboo, and just to have that open sort of relationship the same as I have with my partner, to know that I support him and only want good things for him.
The upcoming birth of Kieran’s son had led him to make some commitment to changing his emotional practice, albeit in private. He wanted his son to be comfortable talking to him about “anything”. Research on fatherhood has shown how becoming a father can lead men to reconsider their masculine projects and pursue a masculinity that embodies the masculine ideals of being a caring and protective father (Bottorff, Radsma, Kelly, & Oliffe, 2009). It seems Kieran, through his emotional relations with his partner, had become more resistant to the hegemonic practice of emotional concealment. Kieran wanted to embody a more open emotional practice in order to have a closer emotional connection with his son than he had never had with his father. Kieran’s story highlights how becoming a father can be an opportunity for men to move towards more openness in their emotional practice. If Kieran was able to embody this change in practice it could be beneficial for his mental well-being and the well-being of his partner and son.

4.4.4 Social Relationships

Kieran was cautious about establishing close social relationships with others. His unsettled childhood, regularly moving schools and having to make new friends, had made him very selective about the friendships he established. Kieran described becoming “more reserved” and “private” in his social relations. He learnt to “isolate” himself as a means of protecting himself from relationships that would not last.

As an adult Kieran distinguished between the types of social relationships he had with men and women. He described close social relations with women where he would talk openly about his personal life. For example, he would talk to his sisters if he had a problem “or just felt like talking”. He also placed great importance on communication within his relationship with Hannah and said they always tried to be “open and honest” with each other about what they were feeling. Kieran was clearly respectful of and valued his social connections with women.
On the other hand he described his social relations with men as being more “closed”. Kieran linked this difference to the social rules around men’s public display of emotions, as noted earlier. He believed that society encouraged men to “be strong” and “hide” their emotions, and “sort out their own problems”, rather than rely on support from others, particularly other men. However, Kieran was not entirely closed in his own social relations with men. He had male friends who he would talk to about personal issues “if and when” he needed to, but this was generally done in an indirect way. As he described:

> It would probably only be with a couple of friends, like close friends that I would do that with. Usually, I don’t think I would necessarily go and visit for that specific reason. You know, just having a couple of beers and talking, and then something might come up or they might bring something up, and then I’ll use my example, too. Yeah, just to flesh it out. But it’s not like, it’s neither planned or unless someone might have brought it up somewhere else and then give a text, maybe we should talk about that someone, but pretty fluid, not set.

In this quote Kieran frames his social relations with his male friends as unplanned and causal encounters over a drink, rather than explicitly talking about their personal issues. By framing them in this way, Kieran not only masculinised the context of these social interactions (i.e. mates having a drink in the pub), he also positioned men as not needing structured social support networks. Kieran’s story points to the difficulties of meaningful social relationships between men that involve self-disclosure. Nonetheless these unstructured get-togethers were clearly beneficial for social aspects of Kieran’s mental well-being and he had opportunities to receive and offer support with his male friends.
4.4.5 Work related practices

While Kieran’s parents had left school without qualifications, Kieran completed his school certificate. However, when it came time to leave school, he was given little advice or support on choosing a job or career from his teachers. He was not told that further education or university might be an option. As a result, Kieran had been uncertain what to do once he left high school:

*Because my parents had never been in that environment, I felt I sort of reached a point, maybe near the end of high school, where they couldn’t give me any more advice on that direction. They were always supportive, they would tell me, “do what you want to do”, “be successful in whatever you choose to do”. It was just I had a problem knowing what that was.*

Kieran had felt unable to turn to his parents for advice because of their own lack of opportunities and experience. Instead, Kieran left school and spent a number of years working in manual jobs including furniture removal, labouring, and bar tendering. With little other choice, Kieran followed the same social class project as his father. Kieran described “floundering” in terms of knowing what to do with his life. He did not have any “big ambition or drive” when it came to paid work. He also felt he lacked “the courage to take that step or bigger risk” in terms of changing his personal circumstances. It seems that Kieran’s marginalised social class background had left him with a lack of opportunities and financial support.

After a number of years of working in hospitality, Kieran searched for something that would “ignite passion” in him. Kieran applied for a student loan to go to art school. However, his studies were cut short when he lost all his course work in a house fire. Kieran was forced to leave art school when he could not get any further
funding to continue studying. Around the same time, Kieran’s grandmother died. Her death and attending her funeral was a turning point in Kieran’s life. As he explained:

Being in that environment where they had the tangi\(^3\) and someone coming in to do karakia\(^4\) and that sort of thing and not being able to understand any of it – that was a big trigger. I’m a Māori person, but I don’t even know what’s going on here at the moment or even understand any of it, which I should or I felt I should. That was a big driver to go back to study.

Attending his grandmother’s funeral, conducted in customary Māori protocol, led Kieran to reflect on his lack of connection with his own Māori culture, family, and background. He started to reflect on where he was going in life and developed a desire to reconnect with his culture. Despite both his parents being Māori, few people in his family had spoken te reo. Kieran had not been taught to speak Māori or to understand Māori customs when he was growing up.

Kieran’s story reflects a particular story that is unique to New Zealand. That is a story of colonisation. The social, political, cultural and economic systems of Māori as the indigenous people of New Zealand were significantly and profoundly impacted as a result of colonisation (Reid & Cram, 2005). The loss of connection to Māori culture in Kieran’s family can be linked to both the historical and intergenerational impacts of colonisation on the economic and social position of his parents and wider family (Paradies, 2016; Reid & Robson, 2007). For Kieran, suddenly being immersed in his own culture as an adult and not being able to understand it triggered feelings of disconnection and led him to question his loss of culture. These feelings eventually led to his decision to enrol in a Māori studies

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\(^3\) A tangi is the traditional Māori rites for the dead or a funeral
\(^4\) A karakia is a Māori ritual chant recited using traditional language.
degree at university. Kieran stated that he wanted to “better understand” his both his culture and his language.

Kieran was in his mid-twenties when he became the first person in his family to go to university. Kieran’s degree “opened doors” for him and he now had a well-paid government job. Through tertiary education, Kieran had been able to change his social class. It is likely that the economic resources available to Kieran, such as student loans and educational qualifications, were different to those available to his parents’ generation. They had experienced the harsh economic reforms in New Zealand during the 1980s and 1990s, which led to high unemployment and reduced household incomes particularly among Māori (Ajwani, Blakely, Robson, Tobias, & Bonne, 2003). These impacts can be observed in Kieran’s story, whose family struggled financially and had to move around for his father to find paid work.

Although Kieran had changed his social class project he was now “working in an office building in front of a computer” which was not how he had envisioned his work life. However, his change in class project was important to him given his own childhood experience of financial disadvantage. Kieran said he wanted to provide financially for his family, so that his children would not experience the hardship or sense of “insecurity” that he had felt growing up. As he explained:

*Definitely some of the values I have and what I value comes from my parents as well. It's just my experiences as a child are ones that I would not want for my children; so it's about putting things in place to be able to make sure they are provided for and will never need for anything.*

Kieran’s desire to provide for his children was not about pursuing the hegemonic masculine ideals of being a breadwinner, like other men in this study. Rather it was about ameliorating the financial difficulties and breaking the cycle of poverty that
he had experienced in his own family. Kieran wanted to be able to offer his children a better life and ensure that they could always “rely on him”. Through his education and pursuit of a well-paid, full time government job, Kieran had the resources to provide a different upbringing for his own children. He also described feeling a sense of “responsibility” to financially support his ageing parents, who were suffering poor health and continued to work in manual jobs.

Kieran and Hannah did not want a traditionally gendered division of labour and Kieran did not expect his partner to stay at home and look after their children. Once their son was born, they wanted to balance the paid work and unpaid childcare between them by “doing a split, half and half”. Kieran also wanted to provide a lifestyle for their child that was more achievable if they were both in paid work. However, this could be difficult initially, given Kieran was entitled to only two weeks’ unpaid parental leave and beyond this would be required to use his annual leave entitlement. Once this entitlement was used, without a more permanent change in working hours, Kieran would be forced to take unpaid leave in order to spend more time with his son. This could be prohibitive, given he and Hannah had bought their first house and had a mortgage.

Current parental leave policies in New Zealand make it difficult for men like Kieran who want to spend more time with their children, because in doing so they lose their financial income. O’Brien (2009) has demonstrated how fathers living in countries where parental leaves policies include higher income replacement, and extended leave, tend to spend more time caring for their children than fathers in countries without these policies. She argues these policies have the potential to boost fathers’ emotional investment in and connection with young children, because there is more incentive to take parental leave (O’Brien, 2009). Kieran’s story highlights how a lack of income replacement and extended parental leave in New Zealand limits the time fathers can spend with their new-born babies without making more permanent changes to work arrangements. If Kieran is unable to

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5 Current entitlements in New Zealand mean that men who are not going to be the primary carer of their children and remain in paid work are entitled to only one to two weeks of unpaid partner’s leave (Ministry of Business Innovation & Employment, 2016).
work more flexible hours, it may make it difficult for his partner to return to paid employment. This has consequences for Kieran in terms of his emotional connection with his son, and for their plan of shared parenting. This could block the mental well-being of both Kieran and his partner.

4.4.6 Help seeking and engagement with health professionals

Kieran first sought professional help at university for his heavy drinking. He recognised that he had “trouble” with his drinking and said he struggled to “get a handle on it”. As he explained:

*I think I just saw something on the wall and was like ‘maybe that will be useful just to talk to someone about what’s happening’, just to get another view. I always found the psychological side of things quite interesting too, so it was cool to get a perspective on that too.*

It seems Kieran was aware that men’s help seeking can be viewed as unmasculine, and framed his help seeking as both opportunistic e.g. a chance sighting of an advert offering free services, and a rational search for knowledge, rather than actively seeking professional help. Kieran described how he was interested in psychology and “learning more” about himself. The psychologist had Kieran “lots of tools” to understand his behaviour and helped him to stop “ruminating on things”. Kieran visited the psychologist a number of times and found it extremely helpful in understanding the reasons for his heavy drinking.

Once in full time employment Kieran accessed the employee assistance programme (EAP) at his workplace. EAP is a confidential services funded by some employers to provide practice and psychological assistance when personal or work issues arise that may impact on someone’s ability to do their job or affect their mental
well-being (EAP Services Ltd, 2017). Kieran was able to open up and talk about his personal problems at the encouragement of a counsellor. Again, he positioned this help seeking as a rational and responsible decision to seek independent “advice” and get “another perspective” on his personal and work situation. Johnson, Oliffe, Kelly, Galdas, and Ogrodniczuk (2012) argue that men’s discursive reframing of help seeking, such as talking about help seeking as responsible action, can be beneficial as it enables men to resist dominant ideas that men should not seek help. For Kieran it appears his reframing of help seeking as opportunistic and rational enabled him to resist these hegemonic masculine ideals.

There was no mention in Kieran’s story whether any of the mental health practitioners he engaged with explored the underlying social and cultural issues he described: his feelings of disconnection from his Māori background and the impact of his grandmother’s death. This is important, given Māori and indigenous scholars have demonstrated how historical trauma, or the generational effects of colonial oppression, can lead to cumulative emotional and psychological harm over the lifespan and across generations, such as Lawson-Te Aho & Lui (2010) who describe the link between intergenerational trauma and mental illness and suicide among young Māori men.

4.4.7 Mental health-promoting practices

Kieran had a number of strategies for maintaining his mental well-being. He valued “down time” and the practice of self-reflection:

*I’m quite a reflective thinker so it just gives me time to think. At work I feel you know you’re quite boxed in a focused on what you’re doing or focused on doing things for other people so that time out just helps me expand and branch out a bit more, pull my thoughts back together*
Kieran emphasised the importance of having time by himself due to the demanding nature of his job. He also enjoyed spending time with his partner, watching movies or having “nice dinners” together. Kieran also enjoyed going to the gym to “get rid of a bit of extra energy and get the endorphins going”. Kieran knew the importance of “taking time out” to look after himself and recognising when he was feeling “stressed” and tired. He described how he would become physically unwell if did not engage in these strategies, particularly when his paid work was demanding and his workload was high.

The upcoming birth of his first child would challenge Kieran’s health-promoting practices, as there would be less time for him to spend on his own or with Hannah. His mental well-being could be hindered if he is unable to manage the demands of becoming a parent and finding time for engaging in his own well-being strategies.

4.4.8 Conclusion: Masculinity and mental health

Kieran pursued an ambivalent, marginalised pattern of masculinity. He was not committed to the hegemonic project but nor did he fully resist it. Kieran’s story highlights how the social structure of gender is interwoven with social class and ethnicity. As such Kieran’s masculine project reflects the intersection of masculinity, indigenous ethnicity and the historical process of colonisation in New Zealand. The social practices Kieran used to construct his masculinity included ambivalent emotional and social practices but also the work and education practices of a marginalised masculinity influenced by his family’s subordinated social class and disconnection from their Māori culture.

While Kieran’s disadvantaged socio-economic background impacted his social and emotional relations in childhood and lack of opportunities when he left school, as an adult Kieran was able to change his social class through education and paid work. Kieran’s desire to provide for his family, was not so much about pursuing hegemonic masculinity but more about changing socioeconomic disadvantage he had experienced growing up. He also did not pursue traditional domestic relations
with his partner. Kieran valued emotional connections with others and wanted a
different relationship with his children to the emotionally distance relationship he
had with his father. He resisted idea that men should not seek help and engaged in
strategies to maintain his own physical and mental health. These social practices
were beneficial for his overall mental health.

Kieran’s story not only points to the generational impacts of colonisation on young
Māori men but also to the possibilities that exists for breaking the cycle of
disconnection and socio-economic disadvantage. Reconnecting with his culture
and shifting his social class influenced Kieran’s’ social practices which in turn
benefited his mental well-being. Kieran wanted to ensure his own children
embraced their Māori culture, and he and his partner would raise their children
bilingual, speaking Māori and English. This reconnection to their culture would
certainly have wider positive implications for the mental well-being of Kieran and
his children.
4.5 Case Study 4: Ethan – resistance and connection

4.5.1 The interview

Ethan is thirty-seven years old, married with two children under the age of seven and is an artist. He reported that he had never experienced a mental illness, but had experienced significant issues with his physical health, with a cancer diagnosis in his twenties. Ethan heard about the study through a friend. He came to the university during the day and the interview took place in a quiet room. Ethan was casually dressed and although he appeared a little nervous at first, he talked freely. His answers were often very reflective, and it was clear to me that Ethan had previously reflected on many of the experiences in his life that he shared with me. The interview lasted one hour and ten minutes.

4.5.2 Life course

Ethan started life in a solo parent family and never knew his biological father. When Ethan was a couple of years old, his mother met and married his stepfather. They had a further two children together. Ethan’s parents had a typical gendered domestic arrangement. His stepfather “chased his career” while his mother stayed at home to care for the children. Ethan’s family moved around a lot for his father’s work and he went to four different schools in four years.

When Ethan was a teenager, his mother went back to paid work and opened her own café with the financial help of Ethan’s stepfather. With both his parents working, life became stressful at home. Ethan recalled his parents arguing a lot and his father being aggressive towards his mother. Over the next few years, his mother’s café got into financial trouble and eventually had to be sold. Ethan’s parents separated when he was seventeen.

In his early twenties, Ethan was diagnosed with cancer and underwent extensive treatment. He described this as a significant period in his life. After his recovery from cancer, Ethan went to art school where he met his wife Anna. They have been
married for 15 years. Anna and Ethan lived in a small rural community for a number of years, where they both worked part-time while studying at art school. Eventually they moved to the city, bought a house and had two children together.

After their children were born, Ethan stayed at home to care for them while his wife was in paid work. This was a significant change from the gendered arrangements of his own parents. Ethan continues to be an independent artist, working from his studio at home and teaching part-time at the local art school.

4.5.3 Emotional Practices

Emotions were not talked about in Ethan’s family when he was growing up. However, he recalled learning as a boy that his mother was the person to go to for “emotional support” and he described having a close relationship with her. Ethan never knew his biological father and was not particularly close to his stepfather who was the “financial provider” and could be aggressive and violent at times. Ethan recalled the fear he felt as a child of being threatened with physical discipline both at school and by his stepfather:

It was brutal, you know, there was always that fear. But then it was also at home too, you gonna get whacked. I was never beaten, but you’d get whacked, you know, so there was always a sense of fear. I think it was quite a tough upbringing because I’d pull out the card ‘you’re not my real father’ in the heat of the moment and that would have angered him. There was always that sort of little bit of tension in the family dynamics.

Although emotions were not talked about in Ethan’s family, anger was allowed and embodied through violence. However, as an adult Ethan rejected the aggressive,
emotionally distant form of masculinity that his stepfather embodied. Becoming a father himself was the catalyst for Ethan’s masculine project and he actively made the decision to raise his sons differently from how he had been raised. Ethan did not want his children to experience the sense of fear that he had felt as a child and he would never physically discipline his children or be aggressive towards them.

Ethan also resisted taking on the masculine project of his stepfather in terms of concealing socially feminine emotions. He embodied an alternative resistant masculinity and refused to conceal his emotions from his children. He had a strong emotional connection with them and would regularly sit and talk to his two young sons about their feelings and his feelings. Ethan believed in “letting emotion be part of it rather than suppression”. It was very important to Ethan that he taught his boys that it was “fine to have feelings”. Ethan viewed this openness in emotional relations as necessary for supporting his children’s emotional well-being and development.

Ethan rejected a traditional division of emotional labour and did not locate the emotional work within their family as his wife’s job. Instead, he and Anna shared an emotional life with their children and both took responsibility for the physical and emotional well-being of their children. Ethan described their parenting as a partnership where their communication was “always out in the open” and they tried to keep things “honest”. In other words, they both tried to embody an emotional practice where feelings were openly talked about with each other and with their children. Ethan and Anna were also conscious of ensuring that their conversations “never got heated around children” because they had both experienced arguing and animosity between their own parents.

Ethan’s story highlights how the concealment of emotions is not an inevitable practice for men. Ethan was an active agent who chose not to comply with gendered expectations of men to be emotionally inexpressive. He was also committed to helping his sons be active agents in their own emotional practice and did not just talk to them about their emotions but showed them this embodied emotional practice.
4.5.4 Social Relationships

Ethan had open and supportive social relationships with men and women whom he confided in and talked to about his feelings and his personal life. One of his longest standing male friendships developed after Ethan was diagnosed with cancer in his early twenties. Ethan met Peter and formed a close emotional connection, which he still maintains. Ethan explained how this friendship started:

"I was talking to this guy for a few minutes and it completely changed the perspective of everything after that moment. He just said some beautiful words and that meant it was like "Wow"! I put down the phone. He said cancer will be the best thing that will ever happen to you. It kind of snapped me out of that state. I didn't spend heaps of time with him straight after. For the next six months, it was more just other people who were close to me at the time. But then we became very good friends and we still keep contact."

Ethan’s narrative highlights the impact that a sense of connection with another person can have during a difficult or distressing time. Peter's meaningful words had “snapped” Ethan out of the shocked and distressed state he was in after his diagnosis. This connection grew into a long-lasting close and supportive friendship. Ethan respected Peter not only for disclosing his feelings and personal life, but also for showing him an alternative and positive perspective on getting through his cancer experience. Wenger and Oliffe (2014) have illustrated how this type of unsolicited support, from men who share a similar illness experience, can be a valuable source of help for men in managing their own cancer experiences as it normalises it and reduces feelings of isolation. For Ethan, this was certainly the case with Peter, who offered him an alternative friendship, in which social and emotional connection, confiding and sharing feelings were valued rather than avoided. This social connection was beneficial for Ethan's mental health as he had
an avenue for emotional support and mutual understanding through their shared experience.

Going to art school provided Ethan with further access to supportive and expressive social relationships with other men and women, which he described as “fulfilling”. As he explained:

*Going to art school a lot of things fell into place. I think all the stuff that I experienced with the illness made a lot more sense going there. You know, just meeting the types of people that were there, the free-spirited kind of nature. Being able to let go, play, explore, experiment, sort of brought the child out in me. So maybe that child was sort of, you know had its upbringing, then it was able to come out and just dance and express itself. Doing all those things was crucial and was all part of the healing process. It helped me in making sense of it. So that was pretty special, just feeling “this is good, this is where it should be going”.*

In this quote Ethan links the art community and the people he met with helping him to resist the hegemonic emotional project and learn to be more emotionally expressive and to connect with others. He also links these expressive and supportive social relationships with his cancer recovery and improved mental well-being. Gerschick and Miller (Gerschick & Miller, 1995) in their study of men with physical disabilities demonstrated how men create alternative masculine identities which involve rejecting, or resisting, hegemonic masculinity in order to create closer social networks with others that provide them with a supportive environment. For Ethan, experiencing cancer led him to resist masculine ideals about self-sufficiency and non-disclosure and instead he continued to build open and supportive relationships with other men and women.
During his time at art school, Ethan met another close male friend, Adrian, whom he formed a close friendship with:

You know I’ve got that relationship with my dad and that’s good, were you know he’ll ring up and he wants to find out about how things are going, but because Adrian is quite open about stuff I think that works quite well, he’ll tell me what he’s thinking and how he’s feeling and he also experienced, and had experienced, cancer as well so I think it’s a similar mind set. I think having that, there’s an understanding, he’s faced with what he’s faced but can work through it, so yeah I think a natural sense of going, you’re living an amazing life and you’re staying true to your artistic journey the whole way through. I think it’s quite lovely when you have those people in your life cos they’re very important.

This quote demonstrates the difference in masculinity between his stepfather and his friend Adrian. Where his stepfather was more closed, Adrian embodied a resistant masculinity where openness and emotional expression was allowed and encouraged. Ethan valued this friendship and described it as a “father-son relationship, but a more soulful one”. In other words, it was deeper and more emotionally connected than the type of father-son relationship he had experienced with his stepfather.

Ethan’s story highlights the value of close social relationships between men. His friendships with both Peter and Adrian had shown him what kind of connection was possible between men. Seeing the embodiment of this social practice had been important for Ethan in supporting his own resistant masculinity and building meaningful and supportive social relationships with others.
4.5.5 Work related practices

Ethan recalled his parents did not put any expectations on him in terms of his career choices and gave him the “freedom” and encouragement to follow his own interests. Ethan followed his passion for art and went to art school, later becoming an independent artist with his own studio. Ethan did not pursue traditional men’s work (Connell, 1987), rather he wanted work which embodied his belief about making money “in an ethical or sustainable way”. While Ethan was acutely aware that the time and energy he put into his artwork did not necessarily bring big “financial rewards” this was the trade-off for wanting to align how he earned money with his own “belief system and values”.

Ethan did not want or expect traditional domestic arrangements like his own parents. Instead, when his children were young, Ethan was a “play centre Dad” while his wife was in paid work. He would take his children to play centre and spend time with them and other parents, mainly mothers. Again, this was not socially masculine work. It was important to Ethan to let his children know that “play and spontaneity is a crucial part [of life] and just having fun [was important]”. He described his time at play centre as “valuable” both for himself and for his emotional connection with his children. Ethan and his wife shared the parenting of their two young boys and made every effort to work as a “partnership”.

The financial costs of raising children and having a mortgage meant Ethan eventually had to take on part-time paid work as an art teacher to make ends meet. This created some tension for Ethan because he was no longer able to spend as much time with his children at play centre and could only drop them off and pick them up. He also felt the pressure of external expectations as he explained:

*I think men take on this thing that they’ve got to be that breadwinner support person, and for me that’s a bit of underlying pressure as well. I feel like I’m in the arts and not maybe having as much finances there,*
Ethan felt the pressure of society’s expectations on him as a man to be the main income earner or breadwinner for his family. However, he did not want to be like his stepfather who had continued to “grind away” at his job to “make ends meet”. Ethan was resistant to the traditional idea of being the sole breadwinner, yet at the same time was conscious that he had chosen paid work that was not “well paying” and was aware that others might judge him for this. Ethan felt the tension between his own resistant masculine project and the hegemonic project because to some degree he still measured himself against the hegemonic ideal.

Despite this, Ethan stated he received a lot of “true fulfilment” from his art and from being involved in his children’s lives. Ethan enjoyed his unpaid and paid work, which he found “fulfilling”, brought him a lot of joy and aligned with his own work ethic. When he was not caring for his children or teaching, he would work in his art studio at home. Ethan did not want to lose his “identity” as an artist, but he now juggled his time between childcare, paid work in teaching and his own work as an artist.

4.5.6 Help-seeking and engagement with health professionals

Ethan had a history of engaging with health professionals, due to his history of cancer in his twenties. Ethan had undergone intensive cancer treatment and attended numerous follow-ups with specialists. However, after a bad encounter with his GP who framed his physical health concerns as a psychiatric issue, Ethan was deterred from future help seeking from his doctor.

Ethan said his cancer had led him to experiencing “some mental stuff” he had to deal with and “get through” in relation to his physical health but he did not see this as mental illness. As Ethan explained:
I remember feeling a little lump in my testicle and then that went through a big thing with the urologist here, and it was nothing but it was still me trying to process stuff, almost checking too much because you obviously want to be careful but then it just went through that phase of being too paranoid. I don't think there was any of that beforehand, but afterwards it was my way of dealing with it, my way of coping with it.

The fear and uncertainty that cancer can bring into men's lives has been well-documented (e.g. King et al., 2015; Wenger, 2013). In Ethan's case, he said he had become “too conscious” about his cancer and found it difficult to maintain a balance between looking after his physical health and being “too paranoid”. For example, when he took his children to the doctor he would sometimes get his weight checked or get his “bloods done”. This was Ethan's way of coping with the uncertainty of his cancer survivorship.

On one occasion Ethan went to his GP about some “physical sensations” he was experiencing. While he was concerned this was related to his physical health and history of cancer, his GP related his concern to mental illness and prescribed him antidepressants. Ethan took the medication but began to feel “absolutely awful” and stopped taking them. He said he had not realised at the time that he had been prescribed antidepressants and felt his GP had not explained it properly to him. Ethan “lost complete trust in her” because he felt she was just trying to “mask the problem” rather than address his physical health concerns. Ethan felt angry with this GP for framing his concern as a psychiatric issues rather than a concern related to his experience of cancer. He also started to doubt how helpful his GP was in addressing his needs:
She kind of checked and then went online and did all her research online and I was kind of going ‘what? she just went online, what? I could do that’. That’s how it made me feel.

Ethan started to doubt the benefit of seeking help from his GP. He was deterred from seeking help from his GP again. Wenger (2013) highlights how men’s health-related help seeking does not always lead to the resolution of a problem and can influence a man to seek alternative avenues. This was the case for Ethan who said in future, if he had concerns related to his cancer he would seek specialist help through the hospital and not his GP. Ethan stated he would no longer rely on his doctor but would take “self-responsibility” for his own health.

Ethan’s story highlights how men can resist hegemonic masculine ideals that men should not care about their health or seek professional help (Robertson, 2007). Not only did Ethan take responsibility for his physical and mental health and his interaction with health services, but he also sought informal support when he needed it. These practices supported his mental well-being.

4.5.7 Mental health-promoting practices

Ethan used a number of strategies to engage with his mental well-being or as he called it “thriving”. For instance, he described how he thrived on spontaneity as a way of “living in the present”:

I still like going around the coast and hitch hiking, you know like even though I can drive I still quite like doing that, it keeps that part of it alive like just putting your thumb out and the first person stops and they’re pretty much taking you to the stop you want to go. I love that stuff, the lining up, the belief, even those words that Peter said you
know, “it’s the best thing that will ever happen to you”, sort of like maintaining that philosophy.

It was important for Ethan to make the most of everyday. He wanted to live in the present and there was a sense of gratefulness at being alive. He linked his “philosophy” about life to his prior experience of being diagnosed with cancer. Ethan’s friend had told him it would be the “best thing” that would ever happen to him. Indeed, for Ethan his diagnosis of cancer had been a life-changing event and he was acutely aware of appreciating the small, everyday things in life.

Studies have shown that spirituality, or a “search for connectedness and meaning” can play a role in maintaining or increasing well-being among cancer survivors (Schreiber & Brockopp, 2012; Visser, Garssen, & Vingerhoets, 2010). While struggling with or questioning one’s belief system early in the cancer journey is often associated with lower levels of psychological well-being, longitudinal studies of cancer survivorship have shown this generally resolves over time (Visser et al., 2010). For Ethan his sense of spirituality and clarity around his belief system in terms of how he lived his everyday life, not only supported his mental well-being but benefitted the well-being of those around him, including his partner and children.

Ethan’s story also illustrates how men can go against hegemonic ideals and engage in health promoting practices. Ethan ensured his family maintained a “good diet” and would only eat organic fruit and vegetable. Ethan questioned whether his childhood diet of “fish fingers” and “junk food” had contributed to his cancer. Taking control and responsibility for his own physical and mental well-being and the well-being of his family was important for Ethan.
4.5.8 Conclusion: Masculinity and mental health

Ethan pursued a resistant pattern of masculinity. He rejected the traditional gender division of his parents and the aggressive and emotionally distant hegemonic masculinity of his stepfather and constructed his own masculine project in opposition to this. Through his resistant emotional, social and work practices and taking responsibility for his own “thriving” Dan not only strengthened and maintained his own mental-wellbeing but also those of his children and partner.

While Ethan still experienced daily stresses and on-going physical health concerns, his approach to life had set him up for positive mental health experiences. He chose not to comply with gendered expectations around the concealment of emotions in men. He was also committed to helping his sons be active agents in their own emotional practice and did not just talk to them about their emotions but showed them this embodied emotional practice. He had open and meaningful emotional relationships with his sons and shared the emotional labour with his wife.

Ethan had a supportive network of friends and was an active part of a social community. These friendships involved confiding, sharing and supporting each other and he did not rely on or see women as his only avenue for emotional support. He also did not differentiate between his social relationships with men and women and viewed them both as supportive and expressive. This meant he was able to mobilise social support when he needed it.

Ethan’s story points to the possibilities of men’s part in changing the nature of social relations among men. It took one man to break the cycle and create a meaningful connection with Ethan, and he in turn changed his own social connections with others. Seeing this practice embodied, provided Ethan with the resources to pursue his own resistance of hegemonic masculinity. He continued to establish close and supportive social relationships with other men and women.

Ethan also pursued both paid and unpaid work that allowed him to be more involved in the care of his children and to engage in learning and pursue his passions and interests. Ethan had a clear philosophy about the way he wanted to
live his life and emphasised the key to his mental health was “staying true” to himself and “making the most of your own potential”. Ethan had worked out for himself what was good for his mental health and had pursued this through embodying a resistant masculine project and personal change.

Ethan’s story clearly points to the benefits for mental health of resisting hegemonic masculinity. Yet his story also highlights how this resistance is not without problems. Societal expectations on men can still hinder men’s mental well-being, even when men have chosen not to pursue these particular expectations.
4.6 Summary of the four case studies

In this chapter, I have presented the life history case studies of four of the participants in this study. These cases illustrated four distinct patterns of masculinity among the men in this study and highlighted the tensions and contradictions that can arise in men's masculine projects.

Ben embodied a middle-class hegemonic masculinity in terms of his public work life and private family life. However, this came at a personal cost to his family life and his mental well-being. Zac's middle-class hegemonic masculine project was plagued by ambivalence in terms of his emotional practice. This caused conflict between his private and public lives and a deep sense of shame that contributed to his ongoing feelings of depression and blocked his mental well-being. Kieran reconnected with his Māori culture and shifted his social class position through tertiary education. This was very beneficial in terms of Kieran's mental well-being and his connections with others. Ethan resisted the hegemonic project in terms of work and family life, and as a result experienced fulfilment from his work, greater involvement in his children's care and close and supportive social relationships. These all contributed to supporting and enhancing Ethan's mental well-being.

In the following Chapters 5 to 9, I focus on the major themes that arose from the collective analysis across all fifteen participants life history case studies. Within each theme, I present the various patterns of social practice that arose from the data and link these to implications for men's mental well-being.
5.1 Introduction

This chapter presents the first of five themes which emerged from the collective analysis across the fifteen life history case studies. In this chapter, I explore the emotional practices of the participants. As discussed in Chapter 2, most explanations for men's emotions in the mental health literature have relied on binary notions of gender i.e. sex-roles, and treats men's and women's emotional lives as though they are separate and opposite (e.g. Fiori & Denckla, 2012; Tsan et al., 2011; Vogel et al., 2011; Wester et al., 2007). Researchers uncritically assume that all boys and men are socialised into appearing or being unemotional (e.g. Genuchi & Mitsunaga, 2015; Mahalik & Rochlen, 2006; Martin et al., 2013) whereas girls and women are socialised into being openly emotional.

However, a growing body of contemporary masculinities research has shown that strict divisions regarding emotional practice based on gender are increasingly untenable and men's and women's emotional lives may not be so distinct (e.g. Cleary, 2005; Connell, 2009; Frosh et al., 2002). Rather, it is the social display or expression of particular types of emotions that is highly gendered. Boys and men learn the importance of concealing particular emotions viewed as socially feminine and displaying emotions viewed as socially masculine in an effort to maintain their masculine status (Connell, 2000; Kimmel, 2011). For example, men's reluctance to disclose depression has been linked to the association between femininity and the expression of distress and crying (Emslie et al., 2006; O'Brien et al., 2007).

The diversity in men's emotional practice in relation to their everyday lives and mental well-being has not been examined in detail. In this chapter, I consider the ways in which men express or conceal particular emotions. I also link men's
emotional practices to mental health and consider the ways in which they promote or inhibit men’s mental well-being.

5.2 Emotions viewed as weak and socially feminine

Most men in this study described concealing particular socially feminine emotions such as distress, grief and crying. However, three patterns of concealing emotions were identified across study men’s lives. Some men concealed emotions in all aspects of their lives; some men found safe, often private places to express emotions; and a few questioned their own emotional practices and the concealment of these socially feminine emotions. These three patterns of emotional practice are discussed in turn.

5.2.1 Emotional fortressing

Four men in this study described containing socially feminine emotions in order to present themselves to others as emotionally self-sufficient. These men viewed the practice of emotional containment as an appropriate masculine coping strategy for dealing with difficult and often upsetting events in their personal lives. This pattern applied to Thomas, Steve, Dylan and Adam. For example, Thomas described how he concealed emotions and adopted a public persona:

*I sort of use “emotional fortressing”, not expressing myself to other people. I still know how I feel, as long as you know how you feel, I think you can kind of have whichever exterior you want. But you’ve gotta be able to at least be on a level with yourself because otherwise you’ll never be able to tell yourself anything.*
Thomas viewed his strategy of holding back his emotions, or “fortressing”, as a strength, he could not only control the expression of his internal emotions, he could also prevent others from knowing his true feelings. Thomas used this practice to deal with upsetting circumstances in his personal life, however his strategy had repercussions. For example, when he found out via a text message that, as he put it, a “consensual drunken encounter” with a woman at university had resulted in pregnancy, Thomas was both shocked and distressed. He was not in a committed relationship with her and had not considered that having unprotected sex with a stranger might have such serious consequences. Thomas decided he would deal with this situation on his own and kept the pregnancy a secret from his friends and family. As he explained:

_I was being like “no, I’m the man” or “a man”, I can handle this, it’s fine. [It] probably wasn’t true all the time, even though I can see that that’s not such a great thing these days, like that sort of emotional fortressing, I suppose. But still there’s like benefits to it. It makes you more resilient in a general sense to emotionally traumatising things. I don’t know if it’s unhealthy or healthy, but it definitely just helps to a certain extent._

In this account, it is clear Thomas linked the blockading of emotions to masculinity. Thomas believed that concealing emotions and distress is what men do and required great strength. He also viewed this emotional practice as beneficial because it made him more resilient to negative and emotionally distressing events in his life. Yet at the same time, his description is somewhat ambivalent. Thomas also acknowledged that there were times when he could not handle the pressure of concealing distress and found this emotional concealment quite difficult to do. However, it was also the case that Thomas had not talked to anyone about his personal situation because he found it a “tough thing” to “open up” to people.
Thomas was not only concerned to appear manly, he was also worried that if he told people about the pregnancy he would have to disclose his distress, and he did not want people to see his emotional distress, or his mistake of having unprotected sex and “pass judgement”.

Thomas’ strategy had mixed success. He described this period of his life as “traumatic” but stated that he had never felt “low enough” to seek help from others. Nevertheless, there were “depressing days” where he thought “my life’s shit”. Thomas’ “emotional fortressing” not only had negative consequences for his own mental well-being but his secret keeping from friends and family about having a son, had consequences for his son’s mental well-being who was denied the opportunity to connect with his wider family. Cleary (2005) has described how some men attempt to project a coherent and confident self in front of family, friends, partners and work colleagues in order to maintain their masculine status, but in private their unresolved emotional distress can have significant mental health risks including suicidal behaviour. While Thomas did not describe feeling suicidal, his emotional difficulties and non-disclosure certainly hampered his mental well-being and was putting his overall mental health at risk.

Thomas also used other coping mechanisms that were potentially damaging to his mental health. He became heavily involved in a partying lifestyle and taking drugs as a means of coping with his emotional distress. However, it started to impact on his university studies. As he described

So the partying for one definitely. I also decided that I probably didn’t want to go and finish my law degree because I failed a paper and that meant that I had to repeat it and then it was problematic. So I worked full time for a couple of years to get my head around the whole situation. But it was a very busy job, you are stressed as and I hated it after two years.
It was not only Thomas’s university studies that suffered as a consequence of his partying and drug taking but his mental well-being as he became increasingly stressed and unhappy. Thomas took up paid work in hospitality in order to pay child support for his son whom he described as “estranged” but he did not enjoy his job and found it stressful. Thomas’ use of recreational drugs to manage his stress increased and he described becoming a “habitual pot smoker” and drinking regularly as way of “taking his mind off things”. Lomas et al. (2013) have highlighted men’s use of drugs to ameliorate feelings of distress and cope with emotional difficulties. In Thomas’ case, his use of drugs was a way of coping with things that were “really troubling” him.

Steve also embodied the practice of concealing emotions that are viewed as weak and unmasculine. He described how this practice was something he had done since childhood:

*I think my mother sort of tried to force the topic sometimes, you know, like, would try and get you to talk, and I am quite an introvert, and it sort of made me feel uncomfortable when somebody asked you, “How are you feeling?” Yeah, it was just, I don’t know, you just sort of get on with it, you know. I have always spent my whole life, you know, if you have a problem, why complain about it? You know, do something about it.*

Like Thomas, Steve not only felt uncomfortable talking about his feelings, he also sought to be emotionally self-sufficient and deal with his own problems rather than talk to others. Steve used this practice of emotional containment as a way of coping with upsetting events in his personal life. For example, when he found out his wife was having an affair and wanted a divorce, Steve stated he was devastated. Yet at the same time he did not tell anyone about their separation or how upset he was. As Steve explained:
I was too embarrassed, really. Yeah, failure. I don't like failure, especially because it was something that was completely out of my control. I didn't want people to feel sorry for me. I just wanted it to be over with, and I didn't want to talk about it. It was almost, like, the shame of dealing with. A lot of my family didn't know how to talk to me about it. “Are you ok?” and I am, like, “Yeah”.

Steve did not want to be seen as a failure and so pretended that he was “ok”. He not only concealed his distress but kept the end of his marriage a secret from his friends and family as he felt ashamed. Kimmel (1994) argues that the risk of failure carries with it real fears of being exposed to other men as not being “a real man” (p. 128). Steve not only associated masculinity with concealing distress, but also with concealing failure. In fact, Steve’s parents only discovered he and his wife were separating when they found out Steve’s wife had applied for a job in another city. They questioned him about what was going on but even then, Steve was not prepared to discuss things with his family, despite their offers of support. He was too uncomfortable with this sort of emotional interaction, and his own feelings of failure.

Besides denying any weakness, Steve also asserted his own superiority by diminishing his wife’s emotional needs. As Steve described:

I am not a big person to talk about my feelings, but she, I don’t know, she couldn’t talk to me about anything really. I don’t think I am scary to talk to, but certainly she confides in other guys. You know, likes the attention, I guess. Something that makes her feel important, and have a guy pander over her. After we got married the real her came out. A lazy mixture, that sounds awful but it is the best word to describe her,
Steve’s sense of failure to live up to the hegemonic masculine expectations of the heterosexual married man, led him to reassert his masculinity through not only denying weakness but asserting his superiority over his wife. Rather than question his own contribution to the end of their marriage, and his own practice of concealing emotions, Steve instead criticised his wife’s need for emotional connection. He seemed to feel entitled to belittle her need for an emotional relationship, while positioning himself as the more rational and unemotional one.

While separation and divorce have been shown to have consequences for mental health such as anxiety and depression (Amato, 2010), Steve reported that he did not experience any problems with his mental health and stated that it did not take him long to “get over” his divorce. However, Steve’s assertion was undermined when he admitted feeling unhappy, and missed “knowing that somebody really cares”. While Steve did not report experiencing symptoms of mental illness such as depression, his mental well-being was clearly compromised.

Dylan also embodied the practice of “emotional fortressing” which appeared to reflect the context of emotional relations in his family. While Steve’s family attempted to talk to him about his feelings, Dylan’s family viewed emotions as problematic and wished them to be covered up at all times. Indeed, Dylan said he could not recall emotions ever being talked about as a child. Despite this, Dylan still had strong ideas about the gendered nature of emotions. He believed that women, and mothers in particular, should be responsible for the emotional care in their families. Dylan felt let down by his own mother, who had not been “motherly” or “affectionate”. It is interesting that Dylan, like other participants in this study, presented emotional non-disclosure as a masculine practice, despite them describing women they knew who were not open with their feelings. Instead,
Dylan, and other participants, insisted that there was something unnatural about women being unemotional.

As an adult, Dylan continued the practice of emotional concealment he learnt from his family. When he found out his mother had terminal cancer, Dylan stated he was shocked and distressed but “didn’t know how to deal with it”. Things were made worse for Dylan when he found out his father was having an extra marital affair. Dylan’s parents would not openly discuss the situation and Dylan described how it was “the elephant in the room that everyone knew about but no-one talked about”. Despite his emotional distress, Dylan would not talk about his family's difficulties or disclose his feelings to his family or friends. Instead, like Thomas, Dylan used partying and recreational drugs to “escape” and “cope” with his emotional difficulties. Dylan said he drank “a lot” and “did a lot of drugs” as a way of dealing with his family circumstances.

After his mother died, Dylan maintained his practice of emotional concealment and hid his grief and distress. He told his employer about his mother’s death, but not to share his grief, rather because he “had to” in order to get time off to attend her funeral. Dylan hid his personal difficulties from others because it would require him to disclose and talk about his feelings, which he was not prepared to do.

Dylan’s emotional practice had repercussions for his mental well-being. The unresolved grief from the death of a parent has been associated with poor mental health outcomes as much as six to nine years later (Bylund-Grenklo, Fürst, Nyberg, Steineck, & Kreicbergs, 2016). In Dylan’s case he was unhappy and described experiencing what he called “elements of depression” as a consequence of his unresolved grief. At the time of the interview Dylan stated that “things just haven’t been right” in his life for some time. His mental health was clearly at risk of deteriorating further.

This pattern of “emotional fortressing” illustrates how some men pursue hegemonic masculinity through concealing emotions viewed as weak and socially feminine and maintaining a public persona of emotional self-sufficiency. These
men’s stories also highlight the implications that the practice of emotional concealment can have on mental well-being including distress, unhappiness and feelings of depression.

5.2.2 Private expression in safe places

Six men in this study concealed emotions viewed as weak and socially feminine in public, but found safe places to express emotions in private. In all cases, these men maintained a public façade of emotional self-sufficiency, but sought emotional support in private from women, including girlfriends, wives, sisters and female friends.

For example, Nathan described learning as a child that his mother was a safe place for expressing or talking about his feelings. She would comfort him when he was upset and allow him to cry. His father on the other hand, was emotionally distant and he and Nathan were not close. Instead Nathan felt awkward around his father. As an adult Nathan, continued to rely on women for the private expression of emotions while trying to maintain a public façade of emotional self-sufficiency.

However this strategy of relying on women had limitations. When Nathan left home to go to university he discovered he had no safe places to express his emotions and started to rely on recreational drugs as a way of managing his emotions. Nathan stated that drugs helped him “open up emotionally”. Yet Nathan’s strategy was problematic and he described becoming increasingly distressed after failing in his studies and eventually having to leave his university course. With a lack of safe avenues to turn to Nathan took an overdose of recreational drugs. As he explained:

*I know that in the past when I’ve cried it’s like, I just don’t want people to know that I’m crying, like it makes me feel a certain way. I know that other people hear me. That’s probably part of the reason why I went into the woods, because I knew I was going to cry so much, and I*
did, but I just can't cry around other people. I just won't do it, and that's the thing because I'm so afraid to cry in front of others. I don't know where that comes from.

In this account, it is clear that Nathan was distressed but did not feel safe expressing his emotions, in particular crying, in public. His non-fatal suicide occurred in a remote wooded area where no one would see or hear him cry. Cleary (2005) has described how men's disclosure of emotional distress to others requires a high level of trust. At the time of his non-fatal suicide Nathan clearly had no-one he trusted with his emotions. Nathan's confusion around his emotions continued to have significant impacts on his mental health. At the time of the interview, Nathan became visibly upset while talking about his emotional difficulties.

Nathan eventually found a safe place to express his emotions when he met Julia, his current girlfriend. He described her as the “person I've been closest to and the most honest about myself with”. Nathan clearly felt safe crying in front of his girlfriend, and stated he “trusted” her. However, his strategy of relying on Julia for expressing his emotions was starting to create strain on their relationship. Nathan acknowledged that Julia was becoming upset by his reliance on her and they were starting to have regular arguments. At the time of the interview, Nathan and Julia had argued the night before and she had given Nathan an ultimatum. She insisted he go and see a university counsellor, otherwise she would end their relationship. Nathan's girlfriend clearly no longer wanted to be his sole avenue of emotional support. Nathan's mental well-being was clearly being impacted by his current emotional difficulties and he described feeling increasingly “depressed and unhappy” and was worried he would lose Julia and the “only chance of having a real connection with someone”. Given his prior history of drug use and suicidal behaviour Nathan was also at risk of mental illness.

This pattern of relying on female partners for the expression of prohibited socially feminine emotions was also described Ben's case (Case Study 1, Chapter 4). While
Nathan’s family had viewed mothers as an acceptable avenue for boy’s expression of emotions, Ben’s family viewed emotions as something boys “don’t do” and actively discouraged it. However, Ben learnt that particular emotions were allowed with girls in private. As he said, it was acceptable for “males to talk to girls about stuff, about their feelings”. Ben also stated that it was “safer” to talk to women because it was easier to “solicit sympathy” from women than it was from men.

As an adult Ben was careful to present a public persona of emotional self-sufficiency around his male friends and work colleagues. One way he did this was to dismiss and deride other people for expressing their emotions in public. Ben viewed talking about emotions in public as feminine and described men who talked about their feelings as “whining”. Ben felt entitled to disparage and criticise other men’s public displays of emotions. He viewed his strategy of holding back his emotions in public as “strong” and “unsympathetic” and those who talked about their emotions as being too “sensitive”.

However, in private Ben would talk about his emotions with his wife and his daughter. Yet, he would not do the same with his son. Ben’s strategy of only expressing his emotions with girls and women in private arguably had negative consequences for others. Aside from deriding other men in public, Ben risked curtailing his son’s emotional expression in the way his own emotions had been discouraged as a child. Ben’s reliance on his wife for emotional expression was also risky because in the event he lost her, he would be left with few safe avenues to disclose his emotions. While Ben did not report experiencing any problems with his mental health, his mental well-being was arguably hindered by his refusal to emotionally connect with anyone other than his wife and daughter.

Liam also embodied the practice of maintaining a public façade of emotional self-sufficiency, while seeking emotional support from women in private. Following his divorce, Liam confided in his female friends. Liam described how in private he would have “chunkier” and more “introverted” conversations with women, whereas he viewed men as “stoic” and emotionally restrained. As he explained:
I think woman are more emotional, that relatedness that women seem to have in their brain that most men don’t, the downside of that though, there are lots of upsides, but the downside is that ability to hold what essentially becomes a grudge is a lot more prevalent in women than in men.

Liam naturalises the difference between men and women’s emotional practices by linking them to differences in anatomy. Liam’s view echoes the common sense thinking about gender, that men and women are “naturally” different and opposite in their thinking and emotions (Connell, 2009). It is interesting that Liam, like other participants in this study, framed women as emotional and men as unemotional, despite the fact that he expressed and discussed his own emotions with women in private.

Like Nathan, Ritchie also recalled his mother was the person he would go to for “comfort and cuddles” as a boy. Despite this, emotions were not openly talked about in his family. As an adult, Ritchie maintained a public façade of emotional self-sufficiency. When his wife asked for a divorce Ritchie would not talk to his male friends or family about how he felt, instead he talked to his female colleagues in private. Ritchie discussed his “sadness” with his colleagues and one suggested he consider seeing a doctor for antidepressants. As he explained:

*The other thing she said was, you know, you will go through cycles and you might feel like you have been fine for a long time and then a couple of months’ time you might just drop of the end of a cliff and feel terrible. I said to her at the time I would monitor it, at the moment I am fine but you know, if that does happen or if you see that happening in me then*
Ritchie clearly valued the emotional reassurance he received from his female colleague but downplayed the importance of it. He stated that as long as he could “function and live life to best” then, as he said his “emotional well-being” was fine. Ritchie still tried to maintain a persona of being emotionally self-sufficient. While Ritchie did not report experiencing any problems with his mental health he admitted that he had not been feeling “a hundred percent emotionally”. This was the extent to which Ritchie was prepared to acknowledge the impact his marriage separation had on his mental well-being.

Finally, Cameron also embodied the practice of maintaining a public façade of emotional self-sufficiency, while expressing emotions in private with women. While Cameron would not discuss his feelings with his male friends or family members, he would confide in his female friends. However, this practice was problematic for Cameron in his new relationship. He had expected to be able to express socially feminine emotions in private with his girlfriend Jenny, but she had been less receptive. As Cameron explained:

*I quite often cry at movies, just because it causes an emotional reaction and I like to just get into it, so it’s obviously not out of sadness, it’s out of the empathy for a movie or something. I think she was a little bit shocked because I was crying a little bit. But then I just sort of choked up a little bit as well and I was quite upset and she sort of felt a bit awkward dealing with it, and looked at me a bit weird. Then I sort of started saying “I’m sorry” and I started apologising.*
Cameron had clearly expected to be able to cry in front of his girlfriend in private. However she had been less comfortable with this display of emotion and reacted with shock. Cameron's assumption that all women are okay with the expression of emotion, backfired and he was left feeling embarrassed and ashamed. Cameron and his girlfriend never talked about the incident again. Instead, Cameron felt so embarrassed about it, that he attempted to rationalise his display of emotion by suggesting that “everyone cries” at “that” movie. It is interesting that Cameron had such strong ideas about the gendered nature of emotions given he described both his parents as people who were “more practical rather than digging deeper” into their feelings.

Cameron’s case highlights the impact that women can have on men’s emotional practices. While Cameron wanted to be able to express particular feelings in their relationship, because he viewed it as the socially acceptable place for this display of emotion, his girlfriend was less keen on this idea. Cameron seemed disappointed that his girlfriend was as he said, “not so emotional”, but they were trying to “work on” their emotions in their relationship together. It seems that neither Cameron nor his girlfriend were that comfortable with expressing their emotions.

Cameron’s case also draws attention to the issue some men experience in communicating their emotions. Cameron, like other participants, described that while they were able to explain the “reason” for feeling a particular way, they struggled to name the feeling. As Cameron said, he would become “tongue tied” and use the word “sad” as a catchall, even if it did not describe exactly what he was feeling. This is not surprising given Cameron did not have many avenues for practicing his emotional expression.

This pattern of relying on women in private for the expression of prohibited socially feminine emotions both helped and hindered men’s mental well-being. While for some men their reliance on women provides a significant source of support, there are also risks associated with this. In the event men lose these safe places they are in danger of having no emotional support, putting their mental health at risk, as demonstrated by Nathan’s case. Furthermore, the reliance on women has
implications for the mental well-being of women as also indicated by Nathan’s story. This pattern of practice is also problematic as it reinforces binary notions of men as unemotional and does not address the hegemonic pattern of men’s emotional practice.

5.2.3 Questioning emotional practices

Four men in this study questioned their concealment of emotions viewed as weak and socially feminine. For these men, their questioning of hegemonic emotional practices occurred as a result of distressing and emotionally challenging experiences. While Holmes argues that this sort of personal emotional reflection has the potential to change individual emotional practices (Holmes, 2015), at the time of interviewing these men remained ambivalent in terms of their emotional practices. That is, they had not outright rejected hegemonic ideas about emotional inexpression. Nevertheless, these men’s stories suggest that resolving this contradiction in terms of their emotionality could be beneficial for their mental health. This pattern applied to Max, Jacob, Zac and Kieran.

Max’s story exemplifies this pattern of ambivalence. Max grew up in a household without a typical gender division of labour, or, as he described it, a more “gender equal” household. By this, he referred to the arrangement whereby his father had stayed at home to care for Max and his siblings, while his mother, a doctor, had worked outside of the home full time. As a result of this arrangement, Max said he had a “close” relationship with his father.

Max started to question his emotional practice when his father suddenly became unwell and had what Max described as a “mental breakdown”. Max struggled to comprehend how his father, an “intellectual powerhouse”, could become so unwell, so quickly. Max had always looked up to his father, and started to question what had gone so wrong for him. In search of some understanding, Max started to reflect on how he had been taught to deal with his own emotional difficulties. As he described:
It was okay for me to be emotional, I guess, which was cool, and to show, to talk about my feelings with Mum or Dad if I wanted to, and to be open about that kind of thing. But then, you know, it’s easy with hindsight to kind of look back on these things, but I think I did model a lot off my Dad who didn’t talk, who didn’t express a lot of feelings. He would say “I love you” and he’d be happy talking about emotions. But I’d say one of the things that led to his breakdown was that he didn’t talk about his own emotions.

While Max’s father had encouraged his children to talk about their feelings, he had not embodied the same emotional practice himself. Rather Max’s father had remained more “conservative” with his emotions, and while he had been happy to discuss other people’s feelings, he did not discuss his own. However, the mixed messages Max received as a child, had consequences for his own emotional practice as an adult. As he explained:

*Dad kept a lot of stuff inside of himself, and I notice that as it transpired that is my way of dealing with things as well. I’d be able to talk openly about some things, and maybe even talk openly about what was bothering me, but then also carry stuff quite deeply. I don’t know where it came from. I think growing up I had really prided myself on being emotionally secure. It’s ironic, I guess, that I’d kind of looked down on the image of a stoic male who never talked about his feelings.*

In this explanation, it is clear that Max became confused by the contradiction between the emotional practices he believed he had been brought up to embody, and his actual emotional practice. Max had embodied the same practice of
emotional concealment as his father. However, it was not only his father’s masculine practice that he started to question and see as problematic, but his own. Max wondered whether this practice may have had contributed to his ongoing relationship problems with women as he had made himself “emotionally unavailable” to others.

Max also started to pay more attention to his mother’s emotional practice and admired her more open expression of emotions. As he described:

In the last year-and-a-half I’ve seen the strength of my Mum really, that she wore her heart on her sleeve. She was probably more honest with herself about what was going on, so if something bad happened, she would get upset about it, you know, and if she was angry about something, she would get angry. But equally in the last year-and-a-half she’s had to deal with such incredible strain, and she’s dealt with it in a really honest way and shown a huge amount of strength. I hadn’t applied the same revisionist history to Mum as I had to Dad. But thinking on it now, that was a really positive thing for her.

Max clearly began to view his mother’s more open expression of emotions as a healthier way of coping with stress and personal difficulties than his father’s emotional containment. Max started to believe there was a link between his parents’ different emotional practices and his father’s mental breakdown. For Max, his father’s breakdown had “forced” him to “re-evaluate” his own coping strategies. He became committed to trying to understand his own emotional practice and to be as he said more “honest” with himself and others. Despite this commitment, however, Max remained ambivalent. While he made concessions to speak with counsellors and his mother in private, he did not embody the same practice in public.
Max’s story is interesting because it suggests that being told as a child it is “okay” to express socially feminine emotions is not the same as actually seeing the practice embodied. His father’s contradictory practice led to confusion for Max which impacted on his personal life, in terms of his relationships with women and in his ability to cope with emotionally distressing events. While Max did not report experiencing a mental illness, his mental well-being had clearly been compromised and he described feeling “desperately unhappy” and as though he was “going crazy”.

Similarly, Jacob questioned the hegemonic practice of emotional concealment after the death of his mother. As a child, Jacob had learnt that his mother was the person to go to whenever he needed to “talk it out and cry”. Jacob had a close relationship with his mother and admired and valued her embodiment and expression of socially feminine emotions. Jacob’s mother was the person who “emotionally held our house together”. In contrast, Jacob’s father was “emotionally awkward” and “went along with whatever Mum said”. As Jacob described:

> I always really struggled because my relationship with Mum was really close and strong, whereas with Dad it was always, “Dad’s there, he exists, he’s a father” and I’d often question “Is he my Dad?” It would make so much more sense if he wasn’t my Dad, because there just seems to be, like, zero there – aside from him literally being my father. Like, it doesn’t seem there was ever any emotional bond beyond that. I don’t know what happened there.

This quote illustrates how Jacob felt so emotionally removed from his father that he questioned whether they were indeed related. Jacob resented his father’s lack of emotional connection which appeared to be the consequence of traditionally gendered patterns of emotional labour in his family. Unfortunately, this pattern had major repercussions for Jacob when his mother died by suicide. Jacob described
how his family life changed suddenly from being “loving and supportive” to an “emotionally dead” place to be. Jacob had lost his closest emotional connection.

Jacob’s way of coping with his mother’s suicide and an emotionally repressive household was to hide his distress, grief and fear and embody his father’s practice of emotional containment. As he described:

> It really, really hurt my sense of self to feel as though I had to put on a brave face all the time. I wish someone had said to me, “Be upset, get overwhelmed, really just let it out and be fine with it”. To have someone there who can be, like, “It’s fine, don’t hold it together”.

Jacob put on a public persona at school and among his friends, and would “act like nothing was wrong”. However, in private he would “plummet into a negative head space” and cry in private. Jacob described this period of his life as “horribly depressing”. Perhaps suppressing his emotions in front of others felt like a safer strategy at this time. On reflection Jacob wished that someone had encouraged him to express and talk about his distress and grief. The sudden death of Jacob’s mother not only pushed him towards hegemony in terms of his emotional practice but also led to depression and anxiety. As he explained:

> A lot of my social anxiety stemmed from losing Mum. She was my rock and my support and the one who told me “You’re doing well” and “I’m proud of you” or any of that kind of thing. You know, your reassurance that everything in the world is okay, because Mum’s still there. My social anxiety really, really ramped up when I hit university.
Jacob directly linked the loss of his mother and the loss of their emotional connection to his mental health problems, which started as a teenager and continued into his twenties. Jacob’s social anxiety and questioning of his emotional practices was further influenced by his struggle with his identity as a homosexual man. Although Jacob had “come out as gay” to his friends and family while at university, he stated that he did not feel “ready” for a romantic relationship with another man. Jacob only disclosed his homosexuality to those he knew and trusted. However, he was unable to resolve the tension he felt between the hegemonic heterosexual project and his own need for emotional connections with others. This unresolved tension was hampering Jacob's mental well-being. While he described having “moments of contentedness” in his life, Jacob still struggled with his anxiety, depression and unresolved grief.

This pattern of questioning the concealment of emotions was also present in Zac’s story (Case Study 2, Chapter 4). Zac, like Jacob had also been deeply affected by the death of his mother as a teenager. While Jacob had been encouraged by his mother to talk about his feelings, Zac had been actively discouraged from expressing his emotions by his older brothers. Zac hid his distress and grief over the loss of his mother from his family and friends. However, as an adult Zac started to question this practice of emotional containment and view it as problematic. He believed it had contributed to his on-going periods of depression.

The upcoming birth of his first child had also led Zac to question his emotional practice. Zac described aspiring to a version of masculinity where the “emotions are more readily available”. He stated that he wanted to able to connect emotionally with his children, the way his mother had with him. While the birth of Zac’s child may resolve his ambivalence, in the mean time it was hindering his mental well-being. Given his mental health history, this tension was also placing him at risk of major depression.

Similarly, Kieran (Case Study 3, Chapter 4) was also about to become a father for the first time and described wanting to embody a different pattern of practice to his emotionally distant father. Kieran wanted a close emotional connection with his
son, one where his son could talk to him about anything. Kieran also stated that he wanted to share the emotional labour of raising his children with his partner Hannah. If Kieran was able to embody this resistant emotional practice, it could have benefits for both his own mental well-being and the well-being of his partner and children. However, as highlighted by Max’s story, it may not enough for Zac and Kieran as fathers to just support their sons’ emotions in private; it may require a more publically embodied change in their emotional practice.

This pattern of questioning the hegemonic practice of emotional concealment illustrates how some men desire a different practice: one where emotions are open and expressed. However, these men do not outright reject hegemonic ideas about emotional concealment and so their current practice remains ambivalent which has various implications for their mental well-being.

### 5.3 Expressing socially masculine emotions

While most men in this study described concealing particular socially feminine emotions such as distress, sadness and crying, they were less wary of expressing anger, an emotion viewed as socially masculine. However, three patterns of expressing anger were identified across study men’s lives. Some men openly expressed anger towards others; some men redirected their distress and grief into anger; and a few men rejected the embodiment of anger and aggression.

#### 5.3.1 Anger, blame and entitlement

Six men in this study expressed anger, blame or a sense of entitlement towards women, specifically ex-wives, partners and girlfriends after the ending of a marriage or relationship. This pattern applied to the cases of Adam, Liam, Thomas, Ritchie, Max and Steve.
This pattern is exemplified by Liam who became angry and blamed his wife for their divorce and the loss of his career. Liam described how after his separation he was “forced” to make a “trade off” between his own career and his children. Liam had spent many years pursuing his career internationally with a large global corporation, and had aspirations for early retirement. However, as a result of his separation and subsequent divorce, Liam had to give up his international travelling as it was no longer feasible with having shared parental custody of his children. Liam was angry and blamed his wife for the breakdown of their marriage. As he explained:

“She was like a demanding teenager. When I got divorced, I lost my third child. Life actually got easier after we got divorced. I swear to God it did, life actually got easier, a lot easier. I didn’t have the teenager to worry about. The demanding, constantly there, sulky teenager just disappeared out my life, and that actually helped a lot, which is a terrible thing to say but it’s the truth, so that work-life balance thing, it should have been good, but my life balance was consumed by my wife.

Liam apportioned all the blame for the collapse of their marriage and ruining his work-life balance to his ex-wife. Liam was derogatory about his ex-wife, framing her as a delinquent and emotional teenager who was out of control. He did not discuss his own part in their marriage breakdown; instead he positioned his wife as having the problem and himself as blameless:

*In retrospect, she just wanted children and not necessarily the man that would come with them. I could have been anyone. It wasn’t me, Maybe with a plumber she might have lasted longer but it might have*
been anyone. I don’t think it was a particular reaction to me. I just think once she had the children, that was her world, that was her cocoon, that was all she wanted; and here she has this husband who’s quite driving, quite focused, quite energetic.

Liam felt entitled to diminish his wife’s contribution to their marriage, his career progression and the raising of their children. Despite the many years his wife had supported his career and his job-related travel by caring for their children, Liam continued to criticise her as a mother, a partner and a woman. He also clearly viewed himself as the fitter parent and was angry at the joint legal custody arrangement. Despite his children splitting their time evenly between their parents, he described himself as doing the majority of the parenting.

Prior to his divorce, Liam had viewed himself as highly successful in his career, his finances and his personal life, in terms of his marriage and children. He had been in a position of relative privilege and had felt entitled to the emotional and domestic labour of his wife and to her care and nurturing of their children and their relationship. Their divorce, however, called this status into question. As his wife had been the one to ask for a divorce, she was seen to have failed to meet his demands and expectations as a wife and mother. It seems that this led to Liam becoming bitter and angry towards his wife and he felt entitled to express it.

Liam’s story draws attention to what Connell (1987) refers to as the “shadow” of power relations in emotional relationships (p. 114). It seems Liam’s anger stemmed from what he perceived as a violation of his sense of entitlement to his marriage, family and career. Liam had also been angry about how he had been treated by the courts and his wife in their custody arrangements. He positioned himself as a victim of the “system” which he claimed prioritised women and mothers over men and fathers. Catlett and McKenry (2004) argue that the divorce process and the legal system redistribute power and can lead to a post-divorce family structure where men’s perceived relative position is dramatically altered.
This was certainly the case for Liam, whose response to the changing relations of gendered power and entitlement within his family resulted in him feeling bitter, angry and blaming his wife.

Masculinities researchers have shown the importance of work and career to men’s lives (Collinson & Hearn, 2005), while health researchers have highlighted the connections between unemployment and men’s increased depression and suicide (e.g. Coen et al., 2013; Oliffe & Han, 2014; Oliffe et al., 2011; Valkonen & Hänninen, 2013). In terms of Liam’s mental health, although he was currently unemployed, and unable to find work in his field, he stated that he did not have any issues with his mental health. However, his anger and blame towards his ex-wife arguably had consequences for the mental well-being of his ex-wife and children. He described a strained relationship with his ex-wife, and said his children were often unsettled by moving backwards and forwards between their parents’ homes. While the link between divorce and poor mental health in men and women has been established, research also points to the increased risk of emotional and behavioural problems in children of divorced parents (Amato, 2010). Liam’s emotional practice may be having implications for the mental well-being of his children.

Steve also expressed anger towards his ex-wife because she asked for a divorce. Rather than seeking understanding, he blamed their marriage breakdown on his wife’s character:

_What I sort of found at the time was that she was a real people pleaser._
_You know, she liked whatever I liked, but then after a while, especially after we got married, the real her came out. A lazy mixture. That sounds awful, but it is the best word to describe her: lazy, selfish and emotionally unstable. Yeah, a very different person to who I met, that is for sure. I was really angry because I was, like, I have done nothing wrong and yet you left me for some guy you meet on the internet … and_
Steve framed his wife as the one at fault because she had changed, and she had been ungrateful for what he perceived as him rescuing her from a bad life. Steve criticised her spending of “his money” and stated that after their divorce he was pleased to regain “control” of his own money. Steve did not question their relationship or reflect on his own part in their marriage breakdown. Instead, he positioned himself as blameless and felt entitled to criticise his wife, describing her as “emotionally unstable” and weak. In turn, he framed himself as being a better person, stating that he was not a “quitter”.

Steve’s story is another example of the power relations that exist in the social relations between men and women. Steve enhanced his own masculine status by framing himself as superior for not giving up on his marriage, whereas his wife was belittled and positioned as a failure as a person. Despite having been divorced for a number of years, Steve stated he was still “unhappy with what she did to me”. This continued bitterness about this collapse of his marriage was not ideal for his mental well-being.

Thomas’ case highlights the repercussions that anger and blame towards others can have. As discussed earlier, Thomas had been shocked and distressed when unprotected sex with a stranger resulted in pregnancy. While Thomas used his strategy of “emotional fortressing” to cope with his emotional distress, he did not hide his anger. The lack of contact Thomas now had with his son had partly been the consequence of how he had dealt with the news of the pregnancy. He described being incredibly angry about the situation, questioning whether it had been deliberate and implying he had been tricked. Thomas stated he had been given “no choice or say in the matter”. In Thomas’s view, it was okay for him to be careless and irresponsible, but the woman had to be responsible. It seems his anger pushed her away as he explained:
I don’t really see the kid unfortunately but I mean I’m very much under the impression that he’s well looked after but it’s not really something that I was privy to based on how I felt about it at the time and stuff.

Thomas was aware of the implications of his emotional practice and appeared to have some regrets about the situation and the way he had handled it. Oliffe et al. (2012) have highlighted how men’s outbursts of anger towards family and friends can lead to feelings of guilt and sadness which can heighten depressive symptoms. For Thomas, his anger eventually turned to shame because he could not “get away from the whole estranged thing”. He described having feelings of “self-loathing” about himself, not only because he had an estranged son but because he had kept it a secret from his family for over five years. Thomas’s mental wellbeing was blocked by his sense of shame and the ongoing struggle with his secret. In the meantime, however, Thomas was prepared to “put it on the back burner” because he did not know how to “deal” with it.

These men’s stories draw attention to the consequences of anger in men’s lives. Dominey and Dominet (2010) argue that being able to deal with anger and frustration in a healthy way is essential for achieving a positive state of mental well-being and for not damaging the mental well-being of those around us. For these men, their anger not only had the potential to hinder their own mental well-being but also the mental well-being of those around them.

5.3.2 Redirecting concealed grief and distress into anger

Four men in this study described diverting concealed emotions viewed as socially feminine, such as grief, crying and distress into anger as it was seen as a more acceptable emotion for men. These men had all experienced the death of a family
member as boys and young men, and diverting their distress was a coping strategy. This pattern applied to Dylan, Ben, Zac and Jacob.

As discussed earlier in this chapter, Dylan’s family had a history of not talking about personal issues or emotions. When Dylan found out his father was having an affair, while his mother was dying of cancer, he was told it was “none of his business”. Dylan, unable to express his distress and upset about his family’s situation, redirected his distress into anger towards his father. As he described:

[I am] angry, very angry. I don’t know what would compel someone to do that. Maybe I don’t have enough experience to understand it. It’s not something I would do, it doesn’t make any sense. I’ve thought about it a lot in terms of maybe it’s none of my business and I shouldn’t talk about it. I shouldn’t think about it, but it just bothers me and I’m angry about it.

Dylan clearly struggled to understand his father’s behaviour and felt confused and powerless by the situation. Dylan felt angry that his parents had put him “in the thick of it”. He was also angry at what he saw as his father’s betrayal of their family. Dylan and his sister were expected to accept the situation without question and continue to maintain their secrecy. Dylan’s father did not tell his mother about his affair; it was only when a stranger “left a note” on her car windscreen that his mother found out.

Dylan also expressed anger towards his sister as he felt that given he had been the only one living at home, that he had carried more of the burden of their family secret and his mother’s illness than she had. Dylan had been distressed by his mother’s illness, but felt his sister “did not care” about what he had been through. For Dylan, being angry was more socially acceptable than showing others his upset and distress or talking to his family about how he felt. Dylan’s emotional practice had
consequences for his mental well-being. He and his sister no longer had contact with each other and he continued to have a “rocky” relationship with his father. Dylan directly linked these “fractured” relationships to his poor mental well-being and stated that while his family were important to him because he did not “have anyone else”, these relationships were making him unhappy.

Similarly, Jacob expressed anger towards others after the death of his mother as a teenager. As discussed earlier, Jacob lost the only emotional connection he had after his mother’s death, which seemed to push him towards hegemonic masculinity in terms of his emotionality. In the aftermath of his mother’s death, Jacob coped by suppressing his emotional distress and putting on a “brave face”. With a lack of avenues or opportunities to talk about his distress, Jacob diverted it into more socially acceptable masculine emotions, both at school and at home. As he described:

*The year Mum died was horribly depressing. You know, like, I just really struggled and just ended up being snarky with teachers, and her death kind of at school paid off as being just rude and annoying and I guess I took out my anger on school.*

At school, Jacob expressed his anger towards teachers and classmates, while at home Jacob would get angry and argue with his father. Perhaps this felt like a safer strategy for him in an emotionally repressive situation. However, Jacob’s anger impacted on his relationship with his father, and it took many years for them to repair their relationship. In Jacob’s case this emotional practice of concealing distress and redirecting it as anger hampered his mental well-being and affected his relationships with those around him. His story points to the consequences of this practice for mental health, as he experienced on-going anxiety and depression at university.
Similarly, Ben and Zac (Case Studies 1 and 2, Chapter 4) also experienced the death of a family member as adolescents. Ben witnessed the accidental death of his older brother and rather than express his emotional distress and grief, he redirected them into anger and resentment towards his parents. Ben was particularly angry at being constantly compared to his dead brother. Ben continued his practice of redirecting distress and grief into anger as an adult. However, this practice had implications for his social relationships with friends, colleagues and family members and for his emotional connections with his children. Indeed as adult Ben was still angry towards his mother and described her as “a bloody dragon”.

This pattern of redirecting concealed grief and distress into the more acceptable masculine emotion anger, illustrates how the curtailing of boys and men’s expression of socially feminine emotions, such crying, can have far reaching implications. All four men acknowledged during the interview that they had been angry at the expense of grieving and were visibly upset in talking about these events. For these men, their unresolved grief continued to impact on their mental well-being.

5.3.3 Point of departure: Rejecting anger

Two men in this study rejected the expression of anger or aggression towards others because they did not see it as helpful or necessary. For years, Cameron had watched his father being aggressive on the sports field. He described how his father would “get angry and yell at the refs a lot” whenever they played or watched sport together. However, Cameron stated there was “no reason” for this aggressive behaviour and would often tell his father to “just stop”. He did not believe it accomplished anything, except getting other people worked up. Cameron described how he did not want to be like his father in terms of his aggression because he did not “see the point”. For Cameron, he got more enjoyment out of his sports by not engaging in aggression and anger towards others.
Similarly, Kieran did not express the anger or bitterness that other participants in this study did after the breakdown of their relationships with women. Kieran described how at the end of his previous relationship there had been an “initial period of inebriation” where he wanted “time not to think about it”. However, after this he had a period of being self-reflective, reading books about relationships and as he said “just trying to understand my part in it, and what I could do differently”. Kieran clearly engaged with the emotionality of his situation and attempted to understand his part in the ending of his relationship. He stated that it was not “healthy” to harbour negative feelings about past relationships. This was beneficial for Kieran’s mental well-being and had positive consequences for his current relationship with Hannah who he described having a “very deep emotional” connection with.

5.4 Resisting the hegemonic pattern

One man in this study resisted taking on hegemonic masculinity in terms of his emotional practice and embodied an alternative resistant practice. In Ethan’s case (Case Study 4, Chapter 4), despite growing up in a household with a typical gendered pattern of emotional labour, Ethan chose a different arrangement and did not locate the emotional labour within his family as his wife’s job. He and his wife shared an emotional life with their children, and Ethan not only talked to his young boys about their feelings but also embodied the practice of being more open in expressing his socially feminine emotions around his children and amongst his friends and family.

Ethan also rejected the aggressive masculinity of his stepfather. He actively made the decision to raise his sons differently to his own upbringing, and did not want his children to experience the fear he had felt as a child. He stated he would never physically discipline his children or threaten them in the way his stepfather had threatened him.
Ethan’s story highlights that the concealment and expression of particular emotions is not a compulsory practice for men. Ethan was an active agent who chose not to comply with gendered expectations around the emotional expression in men. He was also committed to helping his sons be active agents in their own emotional practice and did not just talk to them about their emotions but showed them this embodied practice. Ethan’s choice to resist the hegemonic pattern of emotional practice supported his mental well-being through fulfilled and rewarding emotional relations with friends and family.

5.5 Conclusions

Contrary to the mental health literature, which treats men’s and women’s emotional lives as though they are separate and opposite, the findings presented in this chapter demonstrate the diversity in men’s emotional practices and how these practices have diverse implications for hindering or helping men’s mental well-being. Six patterns of emotional practice were identified across study men’s lives.

The pattern of “emotional fortressing” described men’s desire to be emotionally self-sufficient, concealing emotions viewed as weak and feminine in order to ensure their masculine status was not threatened. This concealment was viewed as being emotionally self-sufficient and an appropriate masculine coping strategy for dealing with difficult issues in their personal lives. However, this practice had consequences for mental well-being including distress, unhappiness and feelings of depression.

The pattern of relying on women in private for the expression of prohibited socially feminine emotions both helped and hindered men’s mental well-being. While it provided men with outlets for sharing their emotional lives and seeking support it reinforces expectations on women to be the listeners, carers and providers of emotional support to men. There was also the risk that if their wife, girlfriend or
female friend were no longer available, these men would have no other safe avenues for emotional connection.

The pattern of questioning the concealment of emotions viewed as weak and feminine could be implicated in both helping and hindering men’s mental well-being. For these men, this questioning occurred as the result of experiencing either personal negative life events, including the illness or death of a family member, or positive life events, such as the upcoming birth of a child. As a result of these major life changes, men started to question their own emotional resilience and how they coped with these events. For some their questioning had the potential to push them towards an alternative masculinity where a more open emotional practice could be embodied which would be beneficial for their mental well-being. For others, however this questioning was accompanied by confusion and tension which until it could be resolved hindered mental well-being and led to feelings of unhappiness and depression.

While the majority of men in this study described concealing particular socially feminine emotions such as distress, sadness and crying, they were less wary of expressing anger, an emotion viewed as socially masculine. For some men, they did not see the emotionality in anger and maintained their masculine status by describing themselves as unemotional, while seeing anger as something natural to men. Some men expressed anger specifically towards women, blaming them for relationship problems and marriage breakdowns. This practice had negative consequences for a number of men, who either damaged relationships or were unable to resolve the ill-feeling towards ex-wives and partners. For other men, the pattern of redirecting concealed distress and upset into anger was harmful for men’s relationships with others and could hinder mental well-being. It also put men at risk of mental illness with many men reporting feelings of depression, anxiety, unhappiness, distress and unresolved grief later in life.

Finally, one man in the study actively resisted the hegemonic pattern of emotional concealment, and chose to express and share his emotions with others. Although this is only one story, it highlights how the suppression of emotion is not a given for
men. This man was an active agent in his own emotional practice. His story highlights the benefits for emotional and mental well-being of his determination to change his emotional practice. He had a happy, fulfilled and rewarding emotional relationships with his children, his wife and both male and female friends.
6.1 Introduction

In this chapter, I explore the social relationships and support networks of the participants. In Chapter 2, I argued that the mental health literature has told us little about men’s social support networks or how men go about seeking or mobilising social support when they need it. While the importance of friendships, good social relations and strong supportive networks for supporting mental health has been well documented (e.g. Lehtinen, Ozamiz, Underwood, & Weiss, 2005; Turner & Brown, 2010; Van Lente et al., 2012), the ways in which social support actually sustains or improves mental well-being remains largely unknown (Reblin & Uchino, 2008; Thoits, 2011; Umberson & Montez, 2010). Definitions of social support abound in the mental health literature (see Turner et al., 2014; Umberson & Montez, 2010; Williams, Barclay, & Schmied, 2004) but most include two broad types of support – emotional support which includes emotional sustenance and empathy; and instrumental aid which includes practical assistance or tangible help from others.

Qualitative studies of men’s depression and suicidal behaviour have provided further insight into men’s social support needs, particularly during distressing times, highlighting not only men’s desire to have supportive social relationships, but also the difficulties that some men experience in seeking support (e.g. Bryant-Bedell & Waite, 2010; Cleary, 2005; Coen et al., 2013; Oliffe et al., 2012). In this chapter, I consider the diversity in men’s social relationships with others, how men go about seeking or mobilising social support and how the nature of men’s social support networks hinders or helps mental well-being.
6.2 Differentiating between types of social relationships

Six men in this study described distinguishing between the types of social relationships they had with men and women. These men viewed their social relationships with men as instrumental or based on shared activities, with little disclosure or sharing of personal issues, whereas their social relations with women were seen as being more intimate and based on receiving emotional support. This pattern applied to Liam, Ritchie, Ben, Kieran, Cameron and Peter.

For instance, Liam made a clear distinction between his friendships and social relationships with men and women. As he described:

"I think the conversations with my female friends are quite, how can I put this, they’re definitely chunkier conversations in general than the ones I have with say my friend Peter, but they do tend to be more introverted focus so more feeling, more about relationships more about people. I think guys do jump into the right lets solve a problem kind of thing very easily. I do have a group of my old friends as well, and that’s a different type of conversation. We’ll do a regular poker night, or we’re going to Bill Bailey next week. That’s a boys’ night out, and that’s a constant group of friends that I’ve also had for about 10 or 15 years, I guess but they all come from work; actually, they’ve all worked for me at different points, but that’s a very different thing. I'll confide in my male friends a lot less than in my close female friends."

In this account Liam uses a common stereotype of men as problem solvers rather than expressive talkers or listeners, to describe his social relations with men. In contrast, he describes his social relationships with his female friends as being more in depth, and “introverted”. In other words, his discussions with his women friends involved disclosing and sharing personal issues, such as relationships and feelings.
Liam clearly viewed women as his source of emotional support and men as his source of shared activity or practical problem solving. Both these types of social relationships were beneficial for Liam’s mental well-being and gave him multiple avenues for his different support needs.

Liam’s perspective of his social relationships is interesting because while he described other men as closed and inexpressive, he clearly did not see himself in this way. He overlooked the fact that he enjoyed expressing his emotions and discussing his personal life with women. Walker (1994) argues that men and women often describe their social connections and friendships in stereotypical ways, yet overlook the fact that what they actually do in terms of their friendships does not always match these cultural stereotypes. This was certainly the case for Liam, who maintained the façade that men are “doers” rather than “talkers” in their social relationships, even though he had expressive and emotional relationships himself, albeit only with women.

Liam described his three closest friends as women whom he could “confide in about anything”. Interestingly, Liam had a romantic history with each of these women and therefore had probably already established a level of intimacy and trust with each of them. These friendships were important to Liam, and he described how he valued their supportive nature, emphasising that they were “two-way” friendships that involved “mutual support”. In other words, he provided as much support in these relationships as he received. Liam was clearly not just a problem solver, as he had stereotyped other men; he was also a listener and expressed himself within his social relations in particular social contexts.

Liam had actively maintained his social relationships and support networks over the years and they were clearly beneficial for his mental well-being. Liam did not report ever experiencing a problem with his mental health and described himself as feeling “fundamentally happy about life most of the time”. During and post his divorce, Liam maintained regular contact with his male friends, whom he engaged in regular social activities with but also built on previous and current relationships with women for his emotional relationships. There is evidence to suggest that how
much help and support one has access to, and how easy it is to access this support, has a clear impact on the amount of stress individuals are exposed to (Whiteford, Cullen, & Baingana, 2005). In Liam’s case, it appears he had access to both instrumental and emotional support, which was beneficial for him in terms of his mental well-being.

Similarly, Ritchie described having a wide range of social relationships, including school and university friends, family and work colleagues. When he and his wife agreed to separate, Ritchie did not stay silent about the collapse of his marriage; instead he “messaged everyone” on social media to tell all his social connections, rather than let them “hear it through the grapevine”. However, Ritchie was immensely disappointed by the “lack of concern” shown by his friends. He had clearly expected his old friends to be more supportive than they were. Although Ritchie’s strategy of telling people about his separation though social media allowed him to avoid sharing details about his personal situation face-to-face, it appears to have been limited in providing him with support.

It seems Ritchie had come up against the limits of his social relationships in terms of mobilising support. Ritchie described how some of the people he would have considered really close friends were “absolutely useless”. Despite being unhappy with this lack of response, Ritchie rationalised their lack of support, suggesting they had “busy lives” and “other priorities”. He surmised that many of his old friends had moved on and developed new social groups, whom they spent more time with and were closer to.

With this lack of support from his social networks, Ritchie turned to his work colleagues for support. Like Liam, Ritchie also differentiated between the types of social support he received from women and men. On the one hand, he would have a coffee and talk about his personal difficulties with his female colleagues, whom he described as “upfront and willing” to talk about their personal lives. Ritchie valued the support he received from his female colleagues and appreciated the openness of their conversations. He described them as “supportive” and “reassuring in that emotional sense”. On the other hand, his male colleagues were “the type of mates I
would go for a night out on the town with” or “go for a run together”. In other words, Ritchie’s relationships with women were based around talking and listening, whereas his relationships with men involved shared activities, such as socialising and drinking. These social relationships were clearly beneficial for his mental well-being not only because they offered him emotional and instrumental support, but confiding with others who had been married and divorced help him deal with the shame he felt about being labelled as a divorcee in his early twenties. He stated he would “think twice” about getting married again.

While Ritchie clearly valued the social support his colleagues offered him, at the same time he attempted to downplay the significance of emotional support:

*Going through that [separation] and just talking through all of those things was probably what I needed most during that time, so, yeah, probably much more of a constructive conversation than it was an emotional need and again it probably comes down to me, you know, boys being boys don’t relate, I suppose, communicate at that emotional level – how I am feeling and how I am coping, blah, blah. It was more the constructive side of it that I needed.*

In the above quote Ritchie implies that boys and men do not need to talk about their emotional needs with others by naturalising it as something that “boys being boys” do not do. Ritchie overlooked the fact that his own social relationships did not neatly match these stereotypes, and maintained the façade that men are doers rather than talkers in their social relationships. This was despite the fact he described having social relations with his female colleagues that involved confiding and sharing each other’s personal difficulties and experiences.

In Ben’s case (Case Study 1, Chapter 4) he described how he “compartmentalised” his social relations with men and women. Ben’s social relations with men were
based around masculine interests such as hunting and rugby and did not involve talking about each other personal lives. In fact, Ben would hassle other men who attempted to talk to him about their personal problems. On the other hand, his social connections with women involved talking about “problems” and “kids”.

While Ben discussed his personal life with his women friends, he also separated himself from these social relations by emphasising that it was his women friends who talked to him about “their male problems” and not the other way around. Ben attempted to present himself as self-sufficient and not in need of these types of supportive relationships. Yet, at the same time he clearly viewed his social relationships with women as the “safer” avenue for discussing his personal life and stated it was easier to “solicit sympathy” from a women than a man.

Kieran (Case Study 3, Chapter 4) also emphasised that men tended to be “closed” in their social relationships with other men, but more open with women. However, this was not entirely the case in Kieran’s own social relationships. He described how he would get together with his close male friends, have a “couple of beers” and then “something might come up” that they would “flesh out” and discuss together. While he framed his social interactions with his male friends as unplanned and causal encounters over a drink, they were nonetheless supportive relationships that involved the open discussion of their personal lives. For Kieran, these unstructured get-togethers were beneficial for his mental well-being and maintaining his friendships with other men.

6.3 Difficulties pursuing more open social relationships with other men

Four men in this study described trying to establish more open social relationships with their male friends but experiencing difficulties. This pattern applied to Thomas, Max, Zac and Nathan.
Thomas attempted to seek support from his closest male friend when he was struggling with personal problems. Thomas had been upset when a one-night stand with a woman he did not know very well, resulted in her becoming pregnant (see Chapter 5 for discussion of Thomas’ emotional relations). Thomas decided to approach his best friend for support in dealing with the issue because he was “close enough he could almost be like my brother”. Thomas had expected his best friend to be receptive to the disclosure of his problem and respond supportively; however the conversation did not go as Thomas had planned. As he explained:

*I could tell because we know each other so well, that he was passing a sort of a judgment on me and it was a passive thing for him. But it was just, like, “That’s how it is, man” and then he was sort of, like, “Yeah, yeah”. He sort of understood. Like, you could just see that it was difficult for him to be, like, “Okay, and how does that work?” and I’d be, like, “I don’t know”. So in that sense, I haven’t confided in many other people.*

Thomas appeared to have misread the closeness of their friendship as permission to share his personal life. In fact, his friend seemed uncomfortable with this level of self-disclosure and did not reciprocate by asking more about Thomas’ difficulties. It seems Thomas had transgressed the unspoken limits expected of men’s social relationships by sharing his problems with another man. In turn, his friend appeared to want to maintain their friendship within the confines of hegemonic masculinity and would not engage in discussing Thomas’ difficulties any further. As a result the conversation was closed down. Croezen et al. (2012) have demonstrated a link between negative experiences of seeking social support such as a lack of understanding, belittlement or avoidance of the discussion and poor mental well-being. For Thomas, his experience with his closest male friend not only left him without the support he had been hoping for but also left him feeling judged
and a sense of shame for having disclosed his personal difficulties. Thomas’s mental well-being suffered as he struggled to deal with his secret on his own.

Coen et al. (2013) have illustrated how some men can be put off seeking support or outlets for disclosing their emotional difficulties, if they have had prior experience of men being unwilling or unreceptive to talking about such issues. This often leaves men relying on wives and female partners for emotional support during difficult and distressing times. This was certainly the case for Thomas whose experience with his closest male friend was such a negative experience that it put him off from trying again. As a consequence of this experience, Thomas never confided in his friends again about his estranged son. That is, until he met his current girlfriend, Kate, who was the only person who knew the details of his secret and the one person he relied on for discussing aspects of his personal and emotional life.

Similarly, Max had a difficult experience approaching his closest male friend for support when he was having relationship problems with his girlfriend. Max described feeling confused and hurt when his girlfriend told him she had “developed feelings” for someone else. While he attempted to talk it through with his best friend, the response had not been exactly what Max had expected:

_He said “bro, this is absolute bullshit what she’s doing to you”, like, “let me get this straight- she’s told you she’s got feelings for this other guy and that she’s cuddled with him but it hasn’t gone any further, and then she’s slowly drip-fed you information that it did go far, she’s finding it harder not to talk to him than she thought”. It took me about two months to actually realise, no, you’re probably going to lose her over this. I think he tried to say that to me. He was, like, “Bro, why are you not more angry? You should be spitting tacks over this. Why are you being so reasonable?”_
Max’s friend did offer him support, albeit limited. However, his friend did not seem to want to hear Max out and instead questioned why he was being so reasonable. Max had actually wanted his friend to help him work out how to “salvage” his relationship because he loved his girlfriend. He needed to talk about his hurt and confusion and be listened to. Instead, his friend encouraged him to take up the more masculine response of anger and blame. This is an example of how men can police other men’s masculinity (Frosh et al., 2002). Max’s friend was telling him how he “should” respond in this particular situation, and that did not involve being upset, hurt or repairing his relationship with his girlfriend.

Like Thomas, Max’s friend appeared to be trying to keep their relationship within the confines of hegemonic masculinity. This entailed limiting the sharing of personal problems and responding in an appropriately masculine way. As such, the support Max was offered occurred within the boundaries of what his friend believed was acceptable in terms of discussing, not what Max had wanted to actually discuss. This encounter was not beneficial for Max and only served to reinforce the idea that he should be self-sufficient and handle his own problems. Max did not seek any further support from his friends and put on a front to ensure that he looked like he was, as he said “being a good bloke”. Yet, Max was clearly not coping and described struggling with life, being unable to cope and feeling “desperately unhappy”.

Zac’s story (Case Study 2, Chapter 4) also points to the consequences of pushing the boundaries of social relationships with other men. When Zac attempted to seek emotional support from his closest male friend and confided in him his feelings of depression, his friend was unreceptive and the conversation went nowhere. For Zac, it seems there was a sense it was not safe to go any further with the conversation, and he did not push it. He described being worried that his friend might think he was a “prima donna”. In other words, he was worried his friend might think he was being overly emotional and feminine. As a consequence of this encounter, Zac was left feeling “ashamed” for wanting to discuss his emotional difficulties with his friend. In future, Zac would not step outside the confines of
hegemonic masculinity and would not disclose his personal difficulties with his friends again. Like Thomas, once Zac met his current partner Emma, she became his sole outlet for his emotional difficulties and providing emotional support.

Nathan's case provides further evidence of some of consequences of difficult social relationships between men. Nathan had gone back to university as a mature student but struggled to make any friends, particularly with other men. Nathan described feeling “unable to connect with people” and “really alone”. This was Nathan's third attempt at university and it seems that being older than his university class mates and surrounded by seemingly more successful young men was threatening to him. Nathan said he went to great effort to “hide things” from people he met in social situations. As he said, he “did not want others to find out” that he felt like “such a loser”. As he described:

*It might be uncertainty because I don't know what's going to happen, so they [other men] might be mean or abusive or judge me or not like me. You know, it can easily not be good and it's like ... I'm not willing to risk it.*

Nathan clearly did not feel safe in his social relations with other men. Kimmel (1994) argues that men are under “constant scrutiny” from other men and the risk of being seen as a failure to be a “real man” carries with it the fear of being exposed as someone who does not “measure up” (p. 214). This Kimmel suggests can cause fear, shame and silence among men. For Nathan, his fear of scrutiny from other men at university, led to his avoidance of initiating any friendships. Despite “wanting” to make friends with other men, Nathan said he would actively “avoid” interacting with men in his class or in the hostel where he lived. Nathan's story highlights one of the consequences for men’s social support networks when they feel as if they are failing as an individual. Nathan isolated himself socially from
others on purpose, because of the way he felt about himself and his fear of being judged by other men.

These men’s stories highlight how gendered expectations about how men should behave in their social relationships, particularly with other men, can lead to serious difficulties in men being heard when they do seek social support. These difficulties have significant implications for men’s mental well-being if they are unable to find avenues for support for they need and want them.

6.4 Maintaining independence

Two men in this study described an overriding desire to remain independent and self-sufficient and as a result they downplayed the need for close or supportive social relationships. Despite describing the existence of support networks, including family and friends, these men would not use these social relations for support nor would they discuss or disclose aspects of their personal lives within them.

As an adult, Steve social relationships had dwindled since his days at university when he had “hundreds of friends”. Now he had a “small group” of friends who were spread out overseas and only occasionally met up, mainly for weddings. Steve appeared nostalgic in the way he talked about his old friendships and seemed to miss the connection these relationships had offered him. He reminisced how he had enjoyed the “camaraderie” of his university peers, a description with masculine undertones, suggesting a group of men who were close and spent a lot of time together. However, Steve had been unable to build similar friendships and social connections to those from his university days. Although he organised social events such as a pub quiz and sports events with his colleagues from work, he seemed to have more acquaintances rather than close friends.

Thurnell-Read (2012), in her research on men’s friendships, has demonstrated how changes in men’s lives, such as moving from school to university and to work, can
change men’s friendships as time together becomes less frequent. This was certainly the case for Steve whose friendships had become fewer and more distant both geographically and socially. While his relations and social activities with his colleagues were beneficial for his mental well-being, he would never willingly discuss his personal life with them or ask for support if he needed it.

When Steve and his wife experienced problems with their marriage, he told no-one, including his parents, work colleagues and old friends. He described himself as a “very, very private person”. Even when his wife asked for a divorce and made plans to move out of their marital home, Steve continued to pretend that all was well and kept it a secret, until he was caught out by a visiting friend. As Steve described:

*He [his friend] brought it up, really. He asked, “Are you two sleeping in separate bedrooms now? What the hell is going on?” – and it was pretty obvious what was going on. Again, my parents brought it up, like, after she [wife] got a job in [name of city] and I was staying here. I think they were really suspicious and they knew what was happening, but they knew I would talk to them when and if I wanted to talk. But I didn’t need to.*

Steve believed that demonstrating masculinity required him to be independent and self-sufficient rather than tell others about his personal problems or seek support. Even when his parents became aware that he was experiencing problems with his marriage and questioned him, he would not talk about it. Beyond confirming that he and his wife were separating, Steve did not want to discuss his situation in any detail, despite his parents offering him the opportunity to talk about it if he wanted to.

Some studies suggest the perception of having support available from social relationships may be more important in terms of promoting good mental health
than the actual receiving of support (e.g. Matud et al., 2003; Panagioti et al., 2014). For Steve, it seems that knowing that his parents were there to talk to “if” he wanted to was enough; their support at this time did not necessitate discussing or sharing his personal difficulties. Perhaps for Steve he had a history of feeling supported by his parents and being able to count on them, and maybe this was enough for him in his current personal circumstances. However, it seems it was more important for Steve to maintain the perception that he was independent and could deal with his problems on his own, than to ask others for support:

Yeah like because there is that independence that I have always had since I was a kid you know, looking after yourself and doing what you want to do. I realise from a young age that life isn’t always fair you know, you know and there is nothing you can do about that. If you have got a bad situation I always had, you know, instead of thinking oh poor me it was like what can I do to fix this situation and that is my focus. I don’t really need to talk to anyone about it to get to that conclusion.

Steve pursued independence and self-sufficiency by not telling anyone about his personal difficulties. He wanted to present himself as a man who was strong and could deal with his own issues. Steve emphasised that he was “an independent guy” who would rather, as he said, “try my best to sort it out” than speak to anyone else about his personal problems. He also argued that “a lot of people didn’t know how to talk to me about it” anyway.

Steve was also reluctant to talk to others about his marriage separation because he felt “embarrassed”. He had discovered his wife was having an affair with another man and, as he said, he felt like a “failure” for not being able to maintain his marriage. This was a struggle for Steve, because he did not like failing. He also described being “worried” about what other people would think of him if they knew
his wife was leaving him. Perhaps he felt his masculine status would be questioned and did not want others to view him as weak or unmasculine. As a result of this, Steve continued to conceal his personal difficulties and would not talk to others about his personal circumstances. As he said, he “just wanted it to be over”.

Despite describing his relationship with his brother as “best friends”, Steve would never share details of his personal life or seek support from his brother. As he described:

*We sort of joked with each other that we don’t talk about that sort of thing. After we have had a couple of drinks or something, we might sort of just jokingly say, yeah, “I might be your bro”, you know. We know we love each other; we are just sort of awkward about expressing it, I guess. Certainly, like, when things happen, like when [his sister-in-law’s mother] died. We talk if we need to, just sort of awkward, but I guess it is more me than him, I would say.*

In this quote, Steve seems to suggest that his relationship with his brother did not necessitate disclosure or sharing of personal information; rather, the closeness and supportiveness of their relationship was simply understood. However, Steve’s pursuit of independence and self-sufficiency clearly made his relationship with his brother “awkward” at times because he uncomfortable discussing his personal issues with others. While Steve described their relationship as being “quite honest with each other”, he was not entirely honest or open with his brother and did not discuss his marriage separation with his brother.

For Steve, it seems that the perception of having supportive relationships, even though he would never seek support from them, was enough for him. Furthermore, it allowed him to maintain his masculine independence and position himself as a man who did not need support from his social relationships. While Steve reported
he had never experienced problems with his mental health, his lack of engagement with his social networks after his separation did have implications for his mental well-being. Steve struggled with feelings of being a failure and reported he had been “upset”, “angry” and “unhappy” during this time.

Similarly, Adam seemed content with limited support from his social relationships. Like Steve, he described himself as an “independent man” who would try to deal with his own problems rather than seek support from others. As he described:

I mean, I think for me, it’s like I’ve always put a lot of credence, I guess personal pride, in being independent. I would generally, and it goes for, like, most things in my life, I’ll try and do it myself and then only if I really can’t do it. You know I don’t want to burden other people with my problems if I can just sort it out for myself and deal with it, rather than putting all that need or energy onto something. Like, it’s dealt with and then carry on, everything’s fine, or not. Yeah, so I think it’s just that kinda there’s definitely pride that comes into it, in terms of just trying to deal with it yourself.

In this explanation, Adam aligns his desire to deal with his own problems with being an independent man. He asserts his masculinity by drawing on notions of pride and self-sufficiency. Adam also justified not talking to his friends about his personal problems stating that he did not want to “burden” others. He seemed to view the discussing or sharing of personal problems with others as a weakness and believed that he should shoulder the weight of his own problems. This is exactly what Adam did when he and his girlfriend were having relationship problems. As he described:

I worked in a café and I liked the people I worked with, but I didn’t tell them. Not even with many of my close friends and stuff, I generally
don’t confide about relationship things, and it’s probably just me being a stupid man and I should talk more. So generally that whole period just dealt with it myself and I know that’s probably not the smartest way of dealing with it, but I guess I kinda backed myself as well to be able to handle it. I mean I was going to work and have all these things going on in my head, but just pretending that everything was okay. I don’t think I really talked to many people about it.

Adam links his reluctance to share details about his personal life to demonstrating masculinity, or being a man. In doing so, he naturalises his lack of openness about his difficulties as being something that all men do. There is also an element of performance in Adam’s story. He put on a public persona for his work colleagues and friends, pretending he was coping, when in reality he was not. Interestingly, Adam indirectly linked this practice to his mental well-being. He acknowledged that his coping strategy of “backing himself” and not talking to others was probably not the “smartest” strategy and reflected that this actually had been one of the “roughest times” of his life.

Although Adam tried to avoid anyone knowing about his relationship difficulties, he could not keep it contained. When an argument erupted between Adam and his girlfriend during a social event with friends, she “took off” and Adam was left embarrassed. However, rather than ignore it, a couple addressed the issue and offered Adam the opportunity to talk about it. As he described:

Basically, it was like a big scene, so there wasn’t much else to talk about when that happened. He and his wife were a bit older, they would have been in their early 40s and they’re quite open, well, they’re very open, maybe too open at times.
Despite being offered support from friends, Adam was clearly uncomfortable with the level of openness in their conversations. However, Adam could no longer pretend that everything was alright. Although they tried to “talk things through” and Adam described it as “nice to hear”, he was too uncomfortable with this level of conversation, and did not maintain this social connection or seek any future support from them. Adam’s story demonstrates how social support can be thrust on someone even when they try to avoid it.

When Adam and his girlfriend eventually split up, he reluctantly told his parents. However, unlike Steve’s family, Adam’s parents did not ask him about his relationship difficulties or offer any support. Adam reasoned that this was because his family were not accustomed to talking about or sharing their personal problems with each other. While he appeared to accept this, suggesting it was not done “on purpose” and defending his family by stating they were “not a cold family”, he seemed to be disappointed by this lack of support. He remarked that when he told his parents, there was “not much conversation” about it. Perhaps Adam wanted more of a supportive response from his family.

In terms of social relationships beyond his family, Adam valued friendships that enabled him to engage in outdoors activities, but they were not friendships that involved sharing or confiding personal difficulties. Most of Adam’s friendships were based on activities such as diving, surfing and mountain biking with other men. These echo the instrumental social support networks described in the mental health literature (Fiori & Denckla, 2012; Matud et al., 2003). Adam’s mental well-being clearly benefited from these friendships, and he described the enjoyment and satisfaction he got from taking part in these social activities, especially with friends he had “a lot of history with”. Swain (1989) argues that friendships between men that involve shared activities are often an alternative path to closeness or intimacy. This appeared to be the case for Adam, whose shared activities with other men provided him with instrumental support that was beneficial for his mental well-being as it provided him the opportunity for closeness with his friends that was otherwise difficult to establish due to expectations of masculinity. These social
relationships however did not necessarily provide the kind of social support that allows men to talk about their personal lives or difficulties.

Adam’s discomfort with the notion of talking to other about his personal life was evident through his narrative of a chance encounter with a men’s group while camping outdoors. Adam described how this group of men “talked to each other” about their personal problems while engaging in action orientated outdoor pursuits. Yet he stated that while this may be “beneficial” for some men, it was certainly not for him and he would never ever “invest” his time in in a group like this because he could manage his own issues.

6.5 Creating stronger social connections with men

Two men in this study described supportive social relationships with other men and women based on self-disclosure and sharing of their emotional lives. These social relations were not limited to the activity-based companionship which other men in this study described, but included both instrumental and emotional support. Interestingly, both these men experienced significant events in their lives which appear to have created opportunities for them to build more supportive relationships with others.

As an adult, Jacob established close and supportive relationships with men and women. However, it had not always been like that. Jacob described himself as an “awkward” teenager who “struggled to make friends”. This became even harder when as a fifteen year old Jacob’s mother died by suicide. Jacob never showed anyone into his “home life” and by the time he went to university he was struggling with what he called severe “social anxiety” which stemmed from losing his mother. As a result of this anxiety Jacob “lost confidence” in making friends and was “constantly worrying about what people think of me and what should I be doing now”. Jacob’s social anxiety not only held him back from taking part in social
activities where he could make new friends but stopped him from seeking social relations with others.

This changed when Jacob reached out to his older brother and disclosed his emotional difficulties. Jacob’s brother was very receptive and encouraged Jacob to talk about the loss of their mother and offered Jacob emotional support. Over time Jacob and his brother would have “some pretty in depth conversations” and Jacob felt he could turn to his brother for support whenever he needed to. Jacob described their relationship as follows:

>Very emotionally aware, unlike the stereotype of gruff non-emotional men. I guess more so now that we are adults and have all been through the stuff we have. Me and my oldest brother always had a really close relationship and were able to talk about a lot of things.

In this quote Jacob distances himself from the stereotype of men as unemotional and unable to talk about their emotions. Instead, it seems he and his brother embodied a different masculinity in their relationship, one where the expression of emotions, feelings and supportive relationships between men was allowed. Jacob’s support from his brother helped him to address issues around his own emotional practice and his sexual identity (see Chapter 5 for discussion of Jacobs’s emotional relations). As a result, Jacob started to become surer of both his emotions and his sexual identity and said he was able to overcome the social anxiety that had plagued his years at university.

Jacob’s relationship with his brother encouraged him to seek out supportive social relationships with other men whom he viewed as “emotionally switched on”. For example, he described the friendship he established with his flatmate:
We could both just literally sit there and talk for hours on end about stuff like this, just emotional stuff and what we felt. We could engage, just look at each other in the eye and just be really fired up by what we were talking about. And it wasn’t just “what did you do today?” and “what did you have for lunch?” and “where are you going next weekend?” It was intense, emotional stuff that we could really grip into, like “what do you think about that and why has that upset you?” and I really lock onto those people, that I feel like they look me in the eye and we understand and connect.

Jacob clearly valued social relations with other men that involved openness, emotional connection and the sharing of each other’s personal lives and feelings. Jacob’s increased social connection with men his own age, also had wider implication. Jacob was able to establish a closer relationship with his father, which he had never had before. Although his father did not agree with Jacob’s homosexuality, they were able to discuss it in detail and his father had told him “I love you anyway”. This finding is important, because it highlights how one man’s social practice can promote change in other men’s practice. In Jacob’s case, his increased social connection and deeper supportive relationship with his brother, had led Jacob to create meaningful social relations with other men his own age. However, it also extended to his relationship with his father, who in turn made changes to his own emotional practice and was able to offer Jacob the sort of emotional support he had been unable to offer in the past.

Jacob’s involvement in the gay community provided him with further access to supportive relationships with other men. He described how he related to other men who, like him, “had to deal with a struggle with their identity”. Jacob was able to find male friends who, like him, were willing to transgress the boundaries of male friendships and talk about their feelings and share details of their personal lives. Jacob also had close and supportive friendships with his female friends and work
colleagues. As with his friendships with men, he said he enjoyed being able to “connect” with people who “understood the struggles in life”.

I can sit down and have a coffee with someone and just be totally intrigued and engaged in conversation. Or I can be lying on a beach and I can just hear the waves and see the sun and the sand and the beach. Or tramping somewhere and being inspired by these jagged peaks covered in snow.

It seems that, as an adult, Jacob started to see that emotions and supportive social connections could improve his mental well-being. He described feeling more content with his life. Jacob’s story provides evidence that men can build supportive and expressive social relationships with both other men and women which in turn have benefits for men’s mental health and well-being.

As a young man, Ethan (Case Study 4, Chapter 4) also established closer social relationships with other men. Ethan’s experience of cancer was a catalyst for building supportive long-lasting friendships with other men. Like Jacob, meeting other men who were willing and receptive to talking about their personal problems and provided Ethan with the opportunity to establish open and supportive social relations. Going to art school provided Ethan with further access to supportive and expressive social relationships with men and women, and he was able to build a strong social support network that was beneficial for his mental health.

These two men’s stories highlight how men can be active agents in establishing open and emotionally supportive relationships with other men. Both Jacob and Ethan experienced significant events as young adults which led them to seek closer and more meaningful friendships with other men. This in turn influenced their future social connections and support networks with other men and women. Their stories suggest that expanding the possibilities in men’s social relationships, such
as allowing emotional disclosure and openness, can open up avenues for greater emotional support among men which has benefits for mental well-being.

### 6.6 Conclusions

This chapter has demonstrated the diversity in men’s social relationships and support networks. These findings show it is not the case that all men have limited social support networks or are unwilling to discuss or share their personal difficulties with others. Furthermore, not all men rely on women for emotional support, some men do have close supportive relationships with other men. Four patterns of men’s social relationships were identified across study men’s lives.

In the first pattern, men differentiated between their social relationships with men and women. While this provided men with alternative avenues for support, this practice has implications. First, the stereotyping of men as problem solvers and doers, i.e. offering instrumental support rather than being listeners and talkers, maintains the façade that men do not talk about their personal issues, and ignores men’s reliance on women for supportive emotional relationships. This could act as a barrier for men who want to seek emotional support from other men (as exemplified by men in the second pattern) and build wider supportive relationships beyond partners or female friends. If unable to forge these supportive relationships, some men can be left with few avenues for social support which is detrimental for mental well-being. (Turner et al., 2014; Umberson & Montez, 2010).

Second, the reliance on and stereotyping of women as being naturally better listeners and talkers creates an expectation on women to be the ones to provide men with emotional support. This has the potential to erode women’s mental well-being if these social relationships are not mutually beneficial, positive, and supportive for those involved. Umberson and Montez (2010) argue there is a “dark side” to social relationships where the provision of support to others can be stressful and demanding (p. S57). Thus, while men’s mental well-being may benefit
from supportive emotional relationships with women, one-sided relationships may lead women’s mental well-being to suffer in turn.

In the second pattern, some men experienced difficulties trying to establish closer social relationships with male friends. Men met with varied responses, often leaving them feeling self-conscious and wondering if perhaps they should have not disclosed their personal problems. These men were pursuing a more ambivalent masculinity, and to some extent had resisted the hegemonic ideals of self-sufficiency and independence by reaching out, or wanting to reach out to a male friend for emotional support. However, these negative experiences deterred men from trying again and reinforced their belief that it was safer to rely on women for emotional support than men. For one man, the fear underlying men’s social relations with other men was so debilitating that it hampered his efforts to build any friendships with other men. This pattern of social practice has clear implications for the mental health and well-being of men who attempt to seek support from other men.

In the third pattern, men had supportive social networks with family and friends but would not use these connections for support if they experienced personal difficulties. Instead, they pursued hegemonic masculinity and maintained their desire to remain independent, self-sufficient and deal with their issues alone. These men were also content with social connections based around shared activities, companionship or practical support that allowed them to maintain their independence. Emotional aspects of social relationships were avoided, and sharing or talking about personal difficulties with others was shunned. While men’s social relationships based around “doing” activities and companionship enhances mental well-being, they are not relationships men will use for emotional support in times of need.

The fourth pattern included men who resisted the confines of hegemonic masculinity and created close supportive social relationships with both men and women. For these men, experiencing significant distressing events in their lives acted as a catalyst for creating more open and supportive social relationships,
particularly with other men. This pattern suggests that men's negotiation of masculinity and active pursuit of open and emotional relationships with others can support and promote mental well-being. Not only does it provide men with support during times of personal difficulty, but provides men with supportive social networks in their everyday lives.
Chapter 7

Work-related practices

7.1 Introduction

In Chapter 2, I discussed how masculinities and men’s health researchers have begun to demonstrate the links between men’s pursuit of hegemonic masculinity through paid work and men’s depression (e.g. Coen et al., 2013; Oliffe et al., 2011; Oliffe et al., 2013). Coen et al. (2013) illustrate how the negotiation of traditional gender divisions of labour within heterosexual couples can support men in managing their depression. Likewise, Oliffe et al. (2011) demonstrate how unemployment can derail men’s pursuit of hegemonic masculinity which can in turn lead to or exacerbate men’s depression.

In this chapter, I explore the work-related practices of the fifteen participants in this study and link these to mental well-being. I will also consider men’s trajectories into paid and unpaid work. Twelve of the fifteen participants in this study had a university degree education and two were currently enrolled in university degree programmes. At the time of interviewing, eleven men were in full time employment in various occupations including engineering, marketing, sport and recreation, finance and government jobs, one man was self-employed and one man had recently become unemployed.

7.2 A sense of disillusionment

Five men in this study described pursuing hegemonic masculinity through paid work but started to feel a sense of disillusionment with their chosen career paths when the secondary emotional gains they had expected did not eventuate. This pattern applied to Dylan, Thomas, Max, Peter and Zac.
Dylan’s middle-class family background had provided him with the financial resources to pursue hegemonic masculinity in terms of his university education and career choices. His father had been a school principal and his mother a theatre nurse. Dylan’s parents had expected him to go to university and get “a good job”. Dylan had originally chosen to study law because he liked the “allure” of being a respectable lawyer. However, after his first year at university, Dylan failed to achieve the grades he needed to continue and was forced to change his studies to a commerce degree. With hindsight, Dylan thought he should have taken a “gap year” and “figured out where he was at” before going to university. It seems Dylan’s doubts about pursuing hegemonic masculinity through work had already started to creep in and he was questioning whether he had made the right career decision.

On finishing his commerce degree, Dylan went straight into his first full-time paid job in the private finance sector. It was a very well paid job and Dylan started to earn more money than he needed, particularly as he continued to live at home with his parents. As Dylan described:

> When you’re earning money, and you don’t have kids, a mortgage, and you don’t have any debt, what do you do? You want to travel, but you’ve got no one to travel with. Money isn’t an object, it really isn’t. I could go out and spend, I don’t know, 500 dollars in a night. I wouldn’t think about it, and that’s a lot of money to some people. But when you’ve got no obligations, you’ve got nothing. It’s just there.

Dylan started to see the power of earning money and what he referred to as its “flow-on effects” in terms of his lifestyle choices and social relationships. Dylan was able to go and out and socialise whenever he wanted to, often buying expensive “drinks and drugs” for all his friends because money was not an issue. Dylan described doing this because he “just wanted to be happy”. As discussed in Chapter 5, Dylan’s home life was upsetting him: his mother was diagnosed with terminal
cancer and his father was having an affair. Although living at home, during and after his university studies had been financially beneficial for Dylan, it was now making him desperately unhappy. Dylan’s socialising and partying as a means of coping with his distressing home life started to lose its appeal:

What’s the point of earning money if you don’t have anything to spend it on? Or you don’t have anyone to spend it on or spend it with? What’s the point, really? I could be working a minimum wage job. I’m not, but I could be. It wouldn’t matter, you know. I see it all the time: people working minimum wage jobs that have awesome families, people that don’t have any jobs and they are fulfilled in other ways. You get taught from a very young age that you need to go to university and get a good job, but what’s the point if you’ve got nothing to do with it? I don’t see the point.

In this quote, it is clear that Dylan was questioning the purpose of pursuing a well-paid career and the power that money could bring when he had no-one to share the rewards with and was so unhappy in his personal life. Despite having a well-paid full-time job Dylan’s lack of success in finding a long-term relationship left him feeling dissatisfied with both his work and his personal life. Dylan had clearly believed that pursuing hegemony through paid work would bring him the fulfilment and secondary gains of a partner and family that he was entitled to. However, this had not eventuated and his pursuit now seemed pointless to him.

Dylan described feeling like he was “being left behind” because he saw his friends with successful jobs and romantic relationships with women. Dylan decided to leave home, thinking he might have more success in his personal life if he moved city and got a new job. Dylan continued to pursue hegemonic masculinity and embarked on a job in commerce that was even better paid and higher status than his previous job. However, Dylan continued to feel a sense of failure in his personal
life and described himself as the “rebound guy” for women. Dylan’s lack of success at dating women was a major source of unhappiness for him. As he said, it had “taken away the gloss” from his successful career. It seems that not only had Dylan been unable to construct traditional gender relations, he had also lost trust in the pursuit of paid work to achieve hegemonic masculinity. As a consequence of this sense of disillusionment, Dylan’s mental well-being was seriously compromised. He described feeling lonely, unhappy and felt that things “haven’t been right” in his life for some time.

Thomas also became disillusioned with his choice of career path when his personal life started to derail his pursuit of hegemonic masculinity. Despite being interested in the arts, religion and history, Thomas had chosen to study law because he associated it with “getting the good jobs and the money”. Thomas did not want to be a teacher like his mother, or a tradesman like his father; he wanted a job with more masculine status and earning potential. Thomas went straight from school to university and enrolled in a law degree. As he said, “that’s where the big paying jobs are now”.

Thomas’ career plans were disrupted when his partying lifestyle and causal sexual encounters caught up with him. As discussed in Chapter 5, Thomas’ distress over an unplanned pregnancy affected his studies, resulting in his decision to put his university degree on hold and seek paid work. Not only had he failed academically, but he now had compulsory financial child support to pay. Thomas stated it took “a long time to accept” what had happened and described how he started to feel like a failure as he saw his university friends finish their law degrees and gain “hot” jobs, earning lots of money, while he continued to work in low-paid hospitality. Thomas’ pursuit of hegemonic masculinity had been seriously derailed as a result of leaving university and hindered his mental well-being.

Thomas felt powerless in his low-paid hospitality work. To bolster his masculine status, Thomas used his position as café manager to seduce and sleep with young women who came into his workplace. He boasted that he had never had a problem seducing women, unlike his friends who may have top paying jobs but were all
“unfortunately single” and hopeless at “interacting with girls”. Thomas on the other had “never struggled with girls” and had always been, as he said, “really good at dealing with girls”. Thomas described how he would flirt and be “frivolous”, offering free food and giving out his phone number to women on the back of a napkin. The masculinities scholar Messerschmidt (1999) has argued that young men who experience challenges to their masculinity, such as Thomas’s failure to complete his university degree, can be motivated to correct their subordinated status by engaging in “appropriate” masculine practices. In Thomas’s case, he used heterosexual practices, seducing and sleeping with women, in order to bolster his sense of failed masculinity.

After a number of years working in hospitality, Thomas started to “hate” it and decided to go back to university to finish his law degree. However, it seems Thomas was now less sure about his reasons for pursuing his degree. As he described:

There’s a certain amount of disillusionment with the real world that happens at some stage, maybe not for everyone but somewhere in the last five years, I’d say. It’s not like it’s a terrible disillusionment; it’s just certain veils get pulled off, pulled away from your eyes, I guess, and you see the world in a different way and that’ll change you I suppose.

Thomas had become disillusioned because he could start to see that pursuing hegemonic masculinity through education and masculine work did not always bring the fulfilment or the secondary gains he had expected. Unlike his peers who had finished their law degrees and now pursued lucrative careers, Thomas had struggled, both financially and emotionally, to complete his degree. At the time of interview, Thomas still had two years to finish. His education had not brought the status, financial rewards, lifestyle or happiness that he had anticipated:
I definitely developed a mentality that university and qualifications and my career objectives, whichever they may be at that time, and all those things, like, I would consider, I guess what, vocational or whatever, I've definitely developed a mentality that they're not everything. Now I've got a real appreciation of enjoying life while you.

In this explanation Thomas had changed his view on his career objectives. Thomas no longer felt the same “passion” for law school that he once had, but he was committed to finishing his law degree. He now had a large student loan to pay off and felt he had to “do something” with his life. Thomas’ education was now just a “means to an ends” rather than a stepping stone to a career that would bring him happiness or a sense of fulfilment. Despite his sense of disillusionment and unhappiness, Thomas still believed that money and occupation was the answer, and was determined to get his masculine status back on track in terms of his education and work. Even though Thomas was unsure if he wanted to be a lawyer, he stated that “if the pay is good then I probably can do a job that I don't really even love”. However, this compromise came at a cost to his mental well-being. Thomas described having “depressing days” where he did not feel good about himself, and regularly used drugs to “distract” himself from thinking about his current circumstances and the three years he had left to complete his degree.

Max also became disillusioned by his pursuit of hegemonic masculinity through paid work when his personal life started to impact seriously on his work life. As discussed in Chapter 5, Max had experienced relationships problems with women and then his father had become very unwell. As with other men in this study, it seems when relations with women were not working, neither did Max’s work relations. The emotional distress that Max experienced in his personal life began to impact on his day-to-day functioning at work:
It's a very intellectual job, so if your mind is distracted it's no good. I mean, I would have been better off labouring, then I could of just thought away whilst I broke some concrete, that would have been great. But instead I'm sitting there trying to get my head around a novel legal argument enough so that I can understand it and research it. You know it's like shit, it's shit if your head's not on it, and if it's wondering and thinking about something else, particularly something else that makes you feel shit, then that's a nasty spiral, to be honest.

This quote demonstrates not only how Max was struggling to cope with the competing issues in his personal life and perform his job well, but also the impact it was having on his mental well-being. Max described feeling as though he “had a monkey on his back” all the time and felt under pressure because he had been given a prestigious job position after finishing his law degree, yet he was so distracted by his personal life, he was struggling to meet the expectations of the position. Max uses interesting masculine imagery of breaking concrete, to suggest that he would have been better off in a manual job, doing physical work, rather than struggling with intellectual work, because he was so distracted. Max was constantly worried what his peers thought of his poor work performance and had resigned himself to the idea that he would not be given an “outstanding” reference when he left.

Max became further disillusioned when he started to question how other people appeared to be able to “deal with stuff” in their personal lives without it affecting their work lives. It upset Max that he was unable to keep his personal and work life separate. As he explained:

It’s fascinating, the guys who have got it and the guys who don’t. The guys who’ve got it are packing everything they can in and you can tell they are enjoying life, working as hard as they can so they can leave at six and go for a mountain bike ride, earning as much money as they
can and saving like crazy so they can spend three months in Whistler snowboarding. And I’m just, you know, fucking around at work, wasting time and not having plans, not properly enjoying the things I’m doing. That’s how it’s been for me for a couple of years.

Max clearly felt he was not living up to the ideal of hegemonic masculinity that he believed other men were. This ideal included financial success through work, relationships and a lifestyle to match. Max started to doubt his pursuit of hegemonic masculinity and did not see himself as successful in either his romantic relationships or his paid work. This is interesting, given he had not only completed a law degree but had gone on to receive a very prestigious job position. For Max, pursuing hegemony through work had not brought the fulfilment and secondary gains he had hoped for. This appeared to have serious consequences for his mental well-being and he described feeling “desperately unhappy” and stated that the “happiness had been sucked out of everything”.

Likewise, Peter felt disillusioned in his pursuit of hegemonic masculinity through paid work. However, it had not always been the case. After leaving school, Peter had completed a philosophy degree and become what he called a “street artist”. However, Peter’s street art led to a number of arrests and fines, and he was eventually convicted and sentenced to intensive supervision. Peter’s masculine project at this stage of his life was an example of what Connell (2005) terms “protest masculinity”, a pattern of masculinity that arises from the experiences of poverty and powerlessness (p. 111). After finishing his university degree Peter had been left him with large student debts and no job prospects. Disempowered by his education Peter had engaged in illegal, risk-taking practices and legitimatised them by positioning himself as a street artist. However, when faced with the threat of prison, Peter reconsidered the direction of his life.

Peter went back to university to study computer science as he was sure this would provide him good job opportunities and “a career”. Peter had renegotiated his
masculine project and was now pursuing hegemonic masculinity through education and paid work. However, despite finding a respectable, well-paid government job, it did not live up to his expectations, as Peter described:

*Three months in they were like, we think you ask too many questions and it's disruptive, and you're disorganised. It was rubbish, it was such bad management. So I should have basically left after that, but I managed to talk myself into staying and, yeah, you could say I've been work-place bullied. The word "bully" had been used.*

Peter became very unhappy, bored and frustrated in his job and felt he was treated unfairly. Peter described being placed on performance review from the start of his job which he stated was “bullshit”. When the salary review he had expected to happen did not eventuate, he became even more disappointed and dissatisfied with his job. Peter started to look for another job, a position that would give him more autonomy and control over his own work, rather than being told what to do by others and being bullied. However, after a number of job applications and interviews, Peter had no success. His unhappiness in his current job started to impact on his mental health and Peter described having a “melt down” and subsequent time off work. He clearly linked his unhappiness at work and lack of success in finding a new job to his deteriorating mental health.

Peter was not surprised when his team leader gave him a warning for not being “engaged in his work”. Peter had lost all interest in his job, took long lunch breaks and spent too much time on the internet. However, he said he would rather stay in his current job and be unhappy than be unemployed, as it would look bad on his curriculum vitae. Furthermore, he had a “huge” student debt to pay off and could not afford to be unemployed. Peter was prepared to stick to the hegemonic project and stay in his job, even though he hated it and it was impacting on his mental health.
Finally, Zac’s case (Case Study 2, Chapter 4) highlights how this sense of disillusionment can be somewhat resolved. After years of unhappiness and dissatisfaction in his pursuit of hegemonic masculinity through paid work, Zac’s project was bolstered when he met his partner, Kate. Through constructing traditional gender relations with Kate, buying a house, moving in together and having their first child, Zac was able to receive the secondary emotional gains he had felt he had been missing out on. Zac described how he began to feel successful in both his work/career and his personal life which supported his mental well-being.

These men’s stories highlight how the pursuit of hegemonic masculinity through education, paid work and career choices is not without its problems. The lack of success and happiness some of these men felt in their personal/private lives led to feelings of disillusionment in their work/public lives, when the gains expected from this pursuit did not eventuate. For many, this disillusionment appeared to have negative implications for their mental well-being.

7.3 When traditional arrangements breakdown

Two men in this study described pursuing hegemonic masculinity through establishing traditional gender arrangements with women. However, the breakdown of these arrangements had consequences for their masculine project and their mental health. This pattern applied to Liam and Ritchie.

For a number of years Liam pursued hegemonic masculinity through his “high-powered job” in corporate management with a large multinational company overseas. Liam also built traditional domestic relations with his wife, Wendy, who stayed at home to care for their children while Liam engaged in paid work outside of the home. Liam and Wendy had been living overseas for many years while Liam pursued his career and moved up corporate ladder. They decided to return to New Zealand so they could settle down with their children and build their “dream home”.

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Liam continued to commute back and forth from New Zealand to London and Australia for work, leaving Wendy to care for their children. This arrangement was part of his long term plan of retiring before the age of forty. However, this was not to be. After six months of being back in New Zealand, Liam was shocked and devastated when his wife asked for a divorce. Liam surmised that she had only ever “wanted the children but not the man that came with them”. But perhaps she did not desire the same plan for the future as Liam.

Liam was reluctant to give up his high-paid international job and plans for early retirement so despite having shared custody of their children, he continued to commute overseas for work on the weeks he did not have his children. However, after a couple of years this arrangement was no longer sustainable and, as Liam stated, he was “forced to make a trade off” between his job and his children. Liam’s hegemonic masculine project started to break down because without the unpaid domestic labour and support of his wife, he was unable to pursue both his international career and care for his children.

Liam was forced to look for jobs closer to home and went to work for a local corporate company. However, he described how he soon became disappointed by the job and started to feel “squashed, constrained and clipped”. As Liam explained:

*I’d been running very serious units with, you know, seven hundred people in them was my largest team, and I’d bought companies and sold companies and merged them and restructured them six ways till Sunday [sic] and, you know, a lot of quite serious stuff. You know, I was quite senior in the UK, and when I moved back here I started to go down.*

Liam, it seems, had been accustomed to positions of power and status in his previous jobs, but in this job he felt “dismayed” and “frustrated”. Liam
resented the organisational structure where “less qualified and experienced” people than him exercised power over his job role and could “tell him what to do”. Liam’s hegemonic status had been subordinated by going down the corporate ladder. He could not live with this and left the job, disgruntled. After a number of failed job applications, Liam stated his “career was in the toilet”. He was now unemployed and divorced with shared custody of their children.

Social research on mental health has established job loss and divorce as key life-changing events than can be stressful, distressing and increase the risk of mental health problems, including suicide (e.g. Paul & Moser, 2009; Strohschein et al., 2005; Wheaton & Montazer, 2010). In Liam’s case, while he had found these events very stressful and distressing he did not think he had experienced any problems with his mental health. Perhaps the supportive social relationships that Liam had access to (see Chapter 6 for discussion of social relationships) had helped to buffer the impact of these stressful life events on his mental health.

Ritchie also pursued hegemonic masculinity through paid work and establishing traditional gender relations. Ritchie married Annabel and they bought their first “family home” together in their early twenties. Ritchie described coming from a middle-class, religious family that had “very traditional values” around marriage and work. His parents, he said had instilled in him a “work hard ethic” in both his professional and personal life. Unlike other men in this study, Ritchie left high school and did not go straight to university. Instead he went into a local government job. After a few years, Ritchie decided to study part time for a degree while continuing to work full time. Over time he moved into more senior positions, eventually moving into a management position responsible for a team of people.

However, Ritchie’s pursuit of traditional gender relations was derailed when Annabel asked for a divorce after three years. She had met someone else. Ritchie was devastated and asked Annabel if they could work things out together, but she refused. For Ritchie, there was a deep sense of failure. It had been important for him that he treat his marriage with the same “values” he had learned from his parents and this meant making a commitment and sticking to it. Ritchie was
embarrassed about being labelled as a divorcee in his early twenties and rarely told people. Ritchie had failed to live up to the hegemonic masculine ideal of the heterosexual married man, and there was a stigma attached to this. His sense of failure meant Ritchie would “think twice” about getting married again. He stated that he would not be the one “initiating that kind of conversation” in his next relationship. It seems Ritchie had been more affected by his failed marriage than he would have liked.

Like Liam, Ritchie did not feel his mental health had been affected by his separation and divorce. However, arguably his sense of failure and embarrassment had hampered his mental well-being. Perhaps the impact of Ritchie’s separation on his mental health had been buffered by access to supportive relationships, namely his female work colleagues and the fact that he could continue his pursuit of hegemonic masculinity through his management job which he really enjoyed.

Liam and Ritchie’s stories suggest the breakdown of traditional gender arrangements may have more of an impact on the masculine project of those men with children in terms of paid work. While Liam had been forced to give up his career path because he could not maintain his career and have shared custody of his children, Ritchie, who had no children, was able to continue his pursuit of hegemonic masculinity through his paid work.

### 7.4 The conflicts of paid work

Some men in this study experienced conflict in their paid work because they wanted to pursue hegemonic masculinity, but also wanted to be in more caring work or to spend more time with their children. This created tension in men’s masculine projects which had implications for mental well-being.

For example, since childhood Steve had always wanted to join the army. However, he did not want to be on the front line as he did not think he could ever shoot someone, rather he want to be a “medic” in the army. Steve explained that his type
of job would allow him to "help people" but also be an officer and wear the uniform. In other words, this was a way of helping or caring for people, but in a masculine occupation and a more socially masculine environment. Steve had been influenced by his mother who was a nurse. As he explained:

*I really enjoy helping people, probably quite influenced by my mother, because she has always sort of worked in that social rehabilitation sort of field, and it is just something I sort of fell into quite naturally.*

While Steve had a lot of respect for his mother, he did not want to be a nurse; he wanted to be an army medic. Steve struggled with the femininity associated with nursing and instead referred to this field of work as “social rehabilitation”. This tension occurred because care work is defined as feminine, therefore jobs that entail caring for others, such as nursing, are viewed as subordinated, or less masculine (Hanlon, 2012). Engaging in care work means relinquishing the power associated with pursuing hegemonic masculinity and Steve was reluctant to do this.

Steve’s career choice did not go to plan. He was diagnosed with colour blindness as a teenager, which precluded him from joining the army. After this disappointment, Steve decided on an alternative pathway for his desired career, or, as he called it, his “Plan B”. Steve went to university and trained to become a teacher, with the hope that he could join the education core of the army through his teacher training as a civilian. Steve explained that he had “always had my life planned out and what I was going to do” and this involved joining the army one way or another.

However, after finishing his teaching degree Steve found out this route was not viable, either. It turned out even the education core of the army was off limits to someone with colour blindness. Steve felt “annoyed” that his career goal of joining the army had been, as he said, “denied” him. Steve did not really want to be a
teacher and now felt he was “forced” to rethink his career options. Steve was at a loss what to do next in terms of paid work. As he explained:

I had my life planned out to that moment so it was sort of like what do I do now, well I guess I had better grow up and get a job and that was it. I sort of just bummed around really. I worked as a relief teacher only because I had no idea of what I wanted to do. I filled in for a few people and I thought this is alright, turn up at 8.30 and leave at 3.30, good money and it was pretty easy but it wasn’t a long term solution. When I was a teacher a lot of people responded well to my relaxed nature. You get people who push you because they thought you were a bit of a soft touch, but I had no problem to stand to my authority when I needed to.

Steve did not want to be just a teacher working with children. Again he rejects the feminine aspects of teaching and states that while children and other teachers responded well to his laid back nature, he was not “a soft touch” and could assert his superiority when he needed to. After a couple of years Steve quit teaching and worked in a number of different jobs. As he described:

I worked as a support person in mental health and people with intellectual disabilities. It was low pay, but I sort of thought, well I have quit this career, I need to start from the bottom somewhere else, and I really enjoyed it, too. I always knew it was going to be a temporary thing, and I was going to work my way up from there.
Despite enjoying this work, Steve clearly viewed care work as being at the “bottom” of the career ladder. Care work is often low pay because economic markets do not reward the “public good” that care work provides (England, 2005). Care work is also associated with feminine work. Steve rationalised being in low-paid work by describing it as a “temporary” state while he worked his way back up the career ladder. Furthermore, he reasoned that he “had bills to pay” therefore paid work was a necessity, even if it was not the type of work he had hoped for. Steve maintained the idea of pursuing hegemonic masculinity through paid work, even though this was not actually what he wanted.

Steve’s masculine project was further knocked when his marriage ended. After his wife asked for a separation, Steve felt like a “failure” and became more determined to rectify his failed masculine project through more masculine paid work. Steve decided to sell their marital home and move to the city to pursue a better paid job. It is interesting that when his relationship ended, he tried to fix his life through paid work and did not attempt to repair his marriage. Steve stated he was “much better off without her quite frankly”.

Steven managed to secure a well-paid civilian job within the New Zealand military. This paid work allowed Steve to help veterans through co-ordinating access to social and health care services. Steve had finally found the compromise he had been looking for: a job that would allow him to help people but without compromising his masculine status. Although Steve described his current job as being less “female dominated” than teaching and “a lot more balanced” in terms of employing men and women, the military remains a patriarchal institution. Through this paid work, Steve was able to resolve the tension he felt between pursuing hegemonic masculinity and wanting to care for and help people. As he explained:

*I like to have a job where people sort of respect what you do because people do judge you by what you do and when I tell people what I do,*
they think a bit more of me. Not that that is really important, but it just makes you feel a bit more ... and the money is pretty good, too.

This quote demonstrates how Steve was clearly aware of the status that paid masculine work could bring. As a result of having the “highest-paying job” he had ever had, and being part of a well-respected masculine organisation, that he had dreamed of joining since he was a child, Steve started to feel like a “success” again. He had found a safe way of doing care work while preserving his masculine status. Steve’s current job bolstered his social standing and helped him to get his masculine project back on track post-divorce. It was also beneficial for his mental well-being:

I feel like you have got to do something that is worthwhile, you know. Like, I enjoy my job because I am really helping people and people who I think deserve that help as well. I have a lot of respect for them.

Steve’s job clearly had positive consequences for his mental well-being because he felt he was doing something “worthwhile”. He indirectly linked a sense of mental well-being with being successful at work and said he not only “loved” his job but stated the future was “looking good”. Steve had managed to resolve the conflict in his masculine project in regards to engaging in paid work that allowed him to pursue hegemonic masculinity but also help and care for others.

Similarly, Cameron felt conflicted between pursuing hegemonic masculinity through paid work and engaging in more feminine caring work. Cameron had begun to see the value of care work after volunteering as an au pair while travelling overseas. As he described:
This one big moment I had actually which is really significant. It’s probably when I started leaning how much I love my mum and how much I appreciate my mum is when I was overseas and I was volunteering. I was living with this English family and so I was helping them. I pretty much became the de facto parent for these five kids and I was cooking and cleaning, and I remember writing this big email to my mum, just being like, “Aw, Mum, I love you so much, thank you for everything you’ve ever done, sorry for being such a shit for the whole time I was a teenager”. Yeah, so that was a massive moment.

Cameron’s experience of looking after someone else’s children was a turning point for him in terms of how he viewed caring work. He had not only enjoyed caring for children; he had also developed a new respect and appreciation for his mother’s years of unpaid care work in their family. Cameron’s mother had not only been the primary caregiver in his family, but had also continued with the on-going care for his now adult sister who had “special needs” and required 24 hour supervision and care. Cameron described how his own experience of care work, made him appreciate the “big impact” that being the sole carer had on his mother’s life, while his father had pursued paid work outside of the home. Cameron stated his mother had “given up quite a lot of her life” to care for his sister. As an adult, Cameron felt he and his mother had “a lot of traits” in common in terms of wanting to help and care for others.

However, although Cameron began to see the value of care work, which society had not taught him to value, he remained ambivalent about this type of work. He did not fully commit to pursuing care work, but, like Steve, found a compromise working and helping people through providing sport and recreational activities within the local community. As Cameron explained:
Just working with people, just working with passionate people really, and just being able to make a difference, I guess, to people's lives. Just being able to make people happy and to better their lives through recreation, because I love recreation and I love sport, and I've played sport all my life and I feel like I can benefit more people.

Cameron clearly enjoyed the community aspect of his paid work and being able to connect with people through sport, which he was passionate about. However, like Steve, Cameron helped people within the safety of a socially masculine institution. Sport is one of the key signifiers of masculinity in many Western societies (Wheaton, 2000). Through paid work in sport and recreation, it seems Cameron was able to resolve the conflict between pursuing hegemonic masculinity and wanting to help people. Furthermore, being in a job which combined his passion for sport with his desire to help others appeared to be beneficial for Cameron’s mental well-being, as demonstrated by the following quote:

I guess I sort of believe if you do good things and be happy, then that will lead to your happiness, and doing good things for other people will generally lead to you having a good life. I really believe in public service, so working for [employer name] and working for the community, that’s probably sort of my highest belief that I would have.

In this explanation, Cameron links helping people and public service with his own happiness and job satisfaction. Research has shown a significant link between job satisfaction and mental health; employees with higher levels of job satisfaction are less likely to experience emotional burnout and lower levels of anxiety and depression (e.g. Faragher, Cass, & Cooper, 2005). It seems reasonable to argue that people who feel unhappy or unfulfilled in their jobs are at increased risk of mental
health problems, particularly if it continues unresolved or spills over into their home or social life. In Cameron’s case, he resolved the tension in his masculine project by finding a job that aligned with his beliefs of “doing good”. This gave him a sense of fulfilment and enjoyment in his paid work which impacted positively on his mental well-being.

As described in Ben’s case (Case Study 1, Chapter 4), he felt conflicted between pursuing his well-paid job and spending more time with his young children. While Ben enjoyed his paid work, he was unhappy about working long hours and the regular travel it entailed as it took him away from spending time with his family. Ben strongly believed in traditional family arrangements and that his place in the family was as the breadwinner but he also wanted to be a good father. As Ben explained:

*I’d like to work less because I travel all the time and it’s not where I want to be, I want to be with my family in the evenings or in the mornings, but I’m working on that. I want to be a family man, I want to prioritise my children and my job fits in around that. It’s a good job, I get well paid and that works for us but if that takes me away from them or affects that then it’s a no brainer really. If I died and someone was to stand up and say something about me I’d want it to be them saying I was a good Dad, not my work colleagues saying I was a good whatever I do. So that’s where my focus lies in the next five to ten years.*

While Ben wanted to resolve the conflict he felt between balancing his paid work and spending time with his family, he was not prepared to give up on the hegemonic project. Ben wanted to spend less time at work and prioritise more time with his children however it seemed that for the next few years, his family life would have to “fit” around his paid work.
At the time of the interview, Ben's mental well-being was already being impacted by the tension created by his work and family life arrangements. He stated that he was “tired and sleep deprived” because he had been awake during the night with his sick daughter. Research has shown that work-related stress due to an unhealthy work-life balance, particularly the balance of working hours, can be damaging to mental health and well-being and can lead to physical health problems, poor relationships and poor home life (e.g. Haar, Russo, Suñe, & Ollier-Malaterre, 2014; Lunau, Bambra, Eikemo, van Der Wel, & Dragano, 2014). For Ben, the cumulative effect of increased working hours and time away from his family was already having consequences for his physical, emotional and social well-being.

These men's stories highlight the conflicts and tension that can exist in men's lives as a result of pursuing hegemonic masculinity through paid work. While Steven and Cameron were able to resolve these tensions which benefited their mental well-being, Ben’s conflict remained unresolved and was hampering his mental well-being.

### 7.5 Resisting the gendered division of work

Ethan’s story (Case Study 4, Chapter 4) illustrates how men’s resistance to traditional gender divisions between paid work and domestic relations can be beneficial for their mental well-being, but also comes at a cost. Ethan was a self-employed artist, an occupation which arguably is not viewed as typically masculine work. He had also chosen a less traditionally gendered arrangement at home in terms of domestic relations. Ethan was heavily involved in the child care of his two young sons, while his wife was in paid work outside of the home. For a number of years Ethan had been a “play centre dad” spending time with his children at nursery and caring for them at home.

Ethan used the term “thriving” to describe his own mental health. He believed that because he had “stayed true to himself” in making these particular choices around
paid work and caring for his children, his mental and physical health had benefited. Yet, his masculine project was not without tension. Ethan felt the pressure that society put on him to be, as he said, “the breadwinner” of their family. He described being very conscious about the fact that being an artist was not a high-paying job and he did not earn as much money as other men he knew. The financial pressure of raising young children meant Ethan eventually had to seek part-time paid work, in addition to his own work as an artist in order to make ends meet.

Ethan’s case demonstrates how men can be active agents in their engagement with hegemony through paid work and resist the traditional gendered division of work. However, it also provides evidence of how societal expectations on men to be breadwinners can still cause stress in men’s everyday lives, even when they choose not to pursue these particular gendered expectations.

### 7.6 Intersection between paid work, social class and ethnicity

Kieran’s story (Case Study 3, Chapter 4) illustrates the implications of the intersection between gender, social class and ethnicity for men’s engagement with paid work. Kieran came from a working-class Māori family who had experienced significant financial hardship and unemployment. On leaving high school, Kieran was given little support or advice from his teachers in regards to further education or paid work opportunities. His parents had been unable to provide him with any advice as they had never finished high school. With a lack of alternatives, Kieran pursued the class project of his father, working in manual labour jobs for many years, including furniture removal and bar work.

However, unlike his parents who had few opportunities to gain educational qualifications, Kieran was able to change his social class project by going to university in his twenties. Gaining a university degree, opened doors Kieran in terms of paid work. Kieran was offered full-time paid work in a government job. After a number of years, Kieran moved into more senior and better paid positions
within government. He also met his partner Hannah. Together they were able to buy their first house. This was something Kieran’s parents had never been able to do due to financial and economic constraints.

Kieran’s university studies and full immersion in Te Reo, Māori language, enabled him to reconnect with his Māori culture. Kieran was not only the first person in his immediate family to go to university but also the first to become fluent in Māori.

Kieran’s story highlights how men’s engagement with paid work can be impacted more by issues of social class than by the pressures of pursuing hegemonic masculinity. Kieran’s change in social class project, through education, had provided him with opportunities which his parents’ generation had not had (see Chapter 4 for discussion of the impacts of colonisation). Kieran had obtained a well-paid skilled job, bought his own house and had a happy and supportive relationship with his partner: all social determinants of good mental health (Allen, Balfour, Bell, & Marmot, 2014).

However, like Ethan, there were also external pressures on Kieran’s mental well-being related to his paid work. The upcoming birth of his first child would present challenges because Kieran was only entitled to two weeks’ unpaid parental leave and beyond this would be required to use his annual leave entitlement. Once Kieran had used all his leave entitlement, he would be forced to take unpaid leave in order to spend more time with his son. This could be financially prohibitive, given Hannah would be on maternity leave and they had a mortgage to pay.

### 7.7 Conclusion

This chapter has demonstrated the diverse work trajectories of the men in this study and the ways in which pursuing paid work can help or hinder men’s mental well-being. Five patterns emerged from the life history data.
In the first pattern, men pursued hegemonic masculinity through paid work, but experienced a sense of disillusionment when this pursuit did not result in the secondary emotional gains they had expected. These missing gains included romantic relationships with women and the construction of traditional gender relations, and feelings of success and achievement in their jobs. This sense of disillusionment hampered men’s mental well-being by contributing to unhappiness, depression and loneliness. One man’s case pointed to how this tension could be resolved, to some extent, through the establishment of traditional gender relations with women. However, it did not appear to fully resolve his mental health difficulties.

In the second pattern, men established traditional gender relations with women, but when these gendered arrangements broke down, through separation and divorce, their hegemonic masculine project was derailed by a sense of shame and failure. Although these men reported that their mental health had been unaffected, they had clearly been distressed and their experiences had hindered their mental well-being.

In the third pattern, men pursued hegemonic masculinity through paid work, but it created tensions in their lives, leaving them with a sense of conflict or ambivalence about their career choices. For two men, tension arose because of the conflict between engaging in typically masculine work and socially feminine care work. However, both these men were able to resolve this tension, to some extent, by finding work which provided a compromise, allowing them to be in jobs where they were able to help others, but in a socially masculine environment. This not only provided them with job satisfaction which was beneficial for their mental well-being, but it also preserved their masculine identity. One man experienced conflict because his paid work took him away from his young family. He wanted to have both the career and be an engaged father, but this was difficult to do with his current work-life balance. This had negative consequences for his mental well-being.

Finally, two cases provided very different patterns of social practice in terms of paid work. One man resisted the traditional gendered division of work and cared for his
children while being self-employed at home. This resistance was beneficial for his mental well-being, in that he felt fulfilled by following both his passion and personal values in terms of paid work and domestic relations. However, this resistance also came at a personal cost. His story highlights how society’s gendered expectations on men can still create pressure even when men choose not to pursue gendered work arrangements.

The second man’s story illustrates how men’s engagement with paid work can be impacted more by issues of social class and ethnicity than by the pressures of pursuing hegemonic masculinity through paid work. His story is closely tied to the history of New Zealand as a colonised country and points to the implications of the intersection between gender, social class and ethnicity for the mental well-being of Māori men.
Chapter 8
Help-seeking and engagement with mental health professionals

8.1 Introduction

This chapter examines the formal help-seeking practices and engagement with mental health professionals among the men in this study. These professionals included psychologists, counsellors, psychotherapists and general practitioners (GPs). As discussed in Chapter 2, the psychological literature has focused on men’s poor help-seeking, frequently attributing it to a singular construct of traditional masculinity which frames men as strong, stoic, reluctant help seekers (e.g. Addis & Mahalik, 2003; Galdas, 2009; Seidler, Dawes, Rice, Oliffe, & Dhillon, 2016). Masculinities and health researchers, on the other hand, have criticised this homogenous view of men’s help-seeking for ignoring the diversity among men’s health-related practices and the influence of health services on men’s help-seeking (e.g. O’Brien et al., 2005; River, 2016; Wenger, 2011). The experiences of men who may be struggling with their mental health, but who do not have a diagnosed or self-reported mental illness, such as depression, has received little attention.

At the time of interviewing, the help-seeking practices and mental health history of the fifteen participants was varied. Five men reported they had never experienced problems with their mental health and rejected the notion of help-seeking. Eight men reported experiencing a mental health-related problem and had sought professional help. These problems included feeling depressed, distressed, unresolved grief and reliance on alcohol. A summary of the help-seeking and mental health history of the study participants is presented in Table 1.
<table>
<thead>
<tr>
<th>Participant</th>
<th>Mental health history</th>
<th>Help-seeking history</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adam</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Liam</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Nathan</td>
<td>Previous suicide attempt, recreational drug use</td>
<td>Sought help from a GP once</td>
</tr>
<tr>
<td>Ben</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Zac</td>
<td>Repeat episodes of feeling depressed</td>
<td>Accessed counselling and psychotherapy</td>
</tr>
<tr>
<td>Thomas</td>
<td>Regular recreational drug use</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Jacob</td>
<td>Depression and anxiety</td>
<td>Accessed counselling and psychotherapy</td>
</tr>
<tr>
<td>Ritchie</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Max</td>
<td>Emotional distress</td>
<td>Accessed psychotherapy</td>
</tr>
<tr>
<td>Cameron</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Dylan</td>
<td>Emotional distress</td>
<td>Accessed counselling</td>
</tr>
<tr>
<td>Kieran</td>
<td>Reported problematic alcohol use</td>
<td>Accessed counselling</td>
</tr>
<tr>
<td>Steve</td>
<td>Reported never experiencing problems</td>
<td>Had never sought help</td>
</tr>
<tr>
<td>Ethan</td>
<td>Reported never experiencing problems</td>
<td>GP visits for physical health issues</td>
</tr>
<tr>
<td>Peter</td>
<td>Depression, recreational drug use, suicidal thoughts</td>
<td>Accessed counselling and visited GP</td>
</tr>
</tbody>
</table>
8.2 Active but problematic help-seeking

Four men in the study described being proactive and open about getting appropriate professional help and support for personal difficulties that were affecting their mental health. While these men did not attempt to hide their help-seeking practices from others, their help-seeking was problematic for a number of reasons. This pattern applied to Peter, Ethan, Nathan and Dylan.

Peter had sought professional help for “various mental health issues” over the years, particularly for what he called “meltdowns”. These were reoccurring periods of poor mental health, which lasted for two to three weeks, where Peter said he would feel depressed, unhappy, unmotivated and engage in “self-destructive behaviour”. Peter described feeling like “a switch flicked” and he would start binge eating, not sleeping well and not taking care of himself.

Peter first accessed fully funded psychological counselling services at university. Peter attributed his poor mental health during this time to being “a full on hippie” who went to “all-night dance parties”, took “psychedelic drugs” and “experimented with sleep deprivation”. Peter knew his mental health was suffering when he stopped his usual daily routines, such as doing yoga, and his physical health started to go downhill. Peter made use of these funded psychological services on a number of occasions, however he felt the “didn’t believe” him and thought he just had a “bad attitude”. It seems that beyond accessing free services, Peter did not find the counselling particularly useful.

After leaving university, Peter undertook professional counselling as part of his community service (unpaid work carried out by offenders) which had been enforced by the judicial courts as a result of being charged by police for graffiti (see Chapter Seven for discussion of Peter’s work history). A number of years later, Peter accessed a clinical psychologist through the Employee Assistance Programme (EAP) at his workplace. As noted in Chapter Four, EAP is a confidential service funded by some employers to provide psychological assistance when personal or work issues arise that may impact on someone’s ability to do their job or affect their
mental well-being (EAP Services Ltd, 2017). Peter explained why he accessed this service:

> I was quite stressed at that time because I was not enjoying my job, and so I started having suicidal thoughts, even though I was perfectly onto it and I was exercising and ra ra ra. So I was, like, “Well, I better go and talk to someone about this”. I started seeing a psychologist through work and, yeah, unfortunately that didn’t prevent me from having a meltdown.

In this explanation Peter links his need to seek professional help to his deteriorating mental health caused by his current work situation and his awareness that he was at risk of having another “meltdown”. Peter reported he had also started having suicidal thoughts. Peter explained how he felt bored and frustrated by his “shitty job” and that his boss did not respect him. Peter was frustrated at being on continual performance reviews for his work and thought it was “bullshit” and “bad management”. Peter stated that he had been “bullied” in his workplace and although he knew he should leave he kept “talking himself into staying”.

While accessing EAP services did not help Peter to establish a satisfying work life, it did stop him from acting on his suicidal thoughts. As Peter explained:

> Well, I’m still alive obviously, but I would probably put that down more to my biology. I was talking to my psychologist and I think she said that 50% of people have suicidal thoughts at some point in their life, so it’s a lot of people, so it’s very normal, right? But the number of people that actually commit suicide is only less than 1%, right, so, your circumstances have to be exceptional. Perhaps your programming,
Peter found the psychologists medical explanation adequate and it helped to reduce his suicidal feelings. Peter believed his biology had prevented him to some extent from acting on his suicidal thoughts. However, his engagement with the psychologist did not resolve his underlying unhappiness about his work situation. Peter started to take more sick days from work and struggled to get out of bed in the morning. Peter also stopped socialising with his friends and smoked “a lot of weed”.

An unsolicited encounter with a work colleague led Peter to continue with his help-seeking. His colleague told him he did not look physically well and suggested he visit his doctor. Peter took this advice and described his encounter with his GP as the “most helpful” GP he had ever met because he felt that his doctor was “genuinely interested” in his issues. The doctor inquired about Peter’s everyday activities including whether he was getting out the house and going to work. Peter appreciated the fact that his GP “asked him” if he would “consider” antidepressants rather than telling him that is what he needed. Peter appeared to see his relationship with his GP as more collaborative, which left him feeling he had more choice about how to treat his mental health issues.

This type of collaborative approach within primary care has been argued to be essential for assisting with recovery from depression as it ensures individual’s needs are listened to and acted upon accordingly (Chambers et al., 2015). For Peter, it certainly seems the communication with his GP enabled him to feel understood, listened to and validated which in turn created a positive help-seeking experience for him. Further, it suggests that it is not always the type of health professional men engage with that matters, rather it is the personal interaction, the experience of decision making as collaborative, and whether the help being offered is perceived as beneficial.
Peter found antidepressant medication beneficial and accepted the medicalisation of his issue. After three months, the medication had helped him to “get out of a pattern”. As Peter explained:

I realise how subject to my own brain chemistry I am, where I’d been having real trouble just getting up, getting out of the house and going for a run. I’d be, like, “I have to go for a run” and then just finding it really, really difficult, and then get on the antidepressants and then, like, ah yip it’s not actually me that’s this motivated person, it’s the drugs that are doing that.

Peter was the only participant in this study to adopt a medical discourse to describe his mental health problems. While it is unclear whether Peter’s GP diagnosed him with depression, Peter referred to himself as depressed and was relieved at being given medication. Peter described going on antidepressants as a significant event in his life. He could now make sense of his repeat meltdowns and was able to get back to maintaining his regular daily activities.

While Peter’s story highlights that for some men a medical framing and treatment through primary care is helpful for addressing mental illness, there are also limitations to this approach. Despite medication helping Peter to reengage with his everyday activities and lift his mood, it did not help him in addressing the underlying work issues that had triggered his meltdown in the first place. Peter continued to feel “disengaged” and “frustrated” in his job because while he had, as he said, “fairly high” career aspirations he felt like his life was “going nowhere”. This ongoing sense of dissatisfaction with paid work has been shown to be detrimental for men’s mental well-being and lead to distress (Lomas et al., 2013).

As described in Ethan’s case (Case Study 4, Chapter 4) he also had a history of being open and active about his health-related help-seeking and engagement with health
professionals. However, his story also demonstrates how a single bad experience can be a deterrent for particular types of help-seeking. For some time after his remission from cancer, Ethan continued to experience what he called “physical sensations”. Ethan went to his GP worried his cancer had returned. Despite these concerns, Ethan’s GP framed his issue as a psychiatric one and prescribed him antidepressants. Ethan trusted his doctor and took the prescribed medication but began to feel “absolutely awful”. Ethan described how he had not realised the implications of taking the medication and felt “angry” that his GP had not explained it well enough to him.

Courtenay (2000) has identified how men often receive briefer explanations and less advice during encounters with health professionals. For Ethan, his encounter resulted in a loss of trust with his GP and he decided he would no longer rely on her. While his prior experience of cancer had led him to experience, as he said “some mental stuff”, in contrast to his GP, Ethan did not view his concerns as mental illness. From then on, Ethan decided he would take “self-responsibility” for his own health and if he had concerns related to his cancer, he would seek specialist help through the hospital and not his GP.

In contrast, Nathan’s help-seeking took a very different turn. Rather than seeking help for a mental health issue, Nathan wanted a medical certificate to apply for a government sickness benefit to help him financially. Nathan described his encounter with a GP:

*One day I just went to a doctor, because I was trying to go on the sickness benefit and I just broke down crying. I told her I’d been emotionally eating a lot. I don’t think I told her I was shoplifting, it was ridiculous. I told her about that and she just kept asking why, and I think maybe I was kind of ready to tell her or something, I don’t know, but I just started crying and saying my parents don’t want me. There were other things I held back, but I just sort of stopped myself. I told*
As this quote demonstrates, Nathan’s account of his engagement with the GP not only appeared desperate but also chaotic. In particular, expressing his emotional distress appeared to be extremely difficult and confusing for him. His distress at the time of visiting a GP was underpinned by having left university due to failing grades, being unemployed, having nowhere to live and a strained relationship with his parents. However, it seems Nathan had been unable to articulate his distress or the reasons for needing a medical certificate. Indeed, during the interview, Nathan became upset and described how he had difficulty in identifying the specific nature of these feelings and that he was “afraid to cry in front of others” (see Chapter 5 for discussion of Nathans emotional relations).

Despite crying in front of his GP and attempting to disclose his emotional distress, it seems Nathan’s GP failed to recognise the extent of his mental distress. There are, as Courtenay (2000) has pointed out, particular problems with health professionals failing to recognise health issues in men, due to dominant ideas about masculinity. While Nathan received the medical certificate he requested, he was not offered any further support or ongoing psychological help for his current distress.

The failure of health services to recognise and act on men’s mental or emotional distress can have serious consequences. Nathan became increasingly distressed and paranoid in the weeks following his encounter with the GP and engaged in suicidal behaviour. After smoking marijuana with a friend and “getting really high” Nathan went to an isolated woodland area and took an overdose of recreational hallucinogenic drugs. Fortunately, for Nathan he did not take enough to kill himself and found his way to a main road where he flagged down a car and got a lift back to the city. Nathan went to his friend’s house, who offered him a couch to sleep on, but Nathan did not disclose what he had just done and his friend never asked. After his non-fatal suicide, Nathan did not seek any further professional help.
Dylan's help-seeking was also problematic. While Dylan had sought professional help through the EAP service offered at his workplace following the death of his mother, he had found these services inadequate to address his grief. Shortly before his mother's death, Dylan had moved to a different city, away from his friends and family, to start a new job. He had only been in this job for one week when his father called to say his mother had died. With no one else to talk to Dylan sought help from a counsellor:

I just need someone to talk to and someone to understand, and someone to work through issues that I'm having. I don't have a partner to do it with, because quite often people just go home and talk to their partner, and bounce ideas off them. I've got friends, but it doesn't always necessarily work, especially when I have my down days. Probably a year ago, over a year ago, probably this time last year, like, when they got to their worst and I'd often sit at work not doing anything cos I had problems and I wanted to fix them straight away and I couldn't fix them and I was trying to work out how I could fix them and it was just this circle of where I get kind of anxious when I've got something that I need to fix and I can't fix it.

Dylan did not frame his need for professional help as a mental health problem; rather he needed someone to talk to and to help him make sense of his personal situation. Dylan linked his need for professional help with a lack of emotional support from his friends, having no female partner to talk to, and his current situation as being beyond his coping abilities. His narrative points to the limits of his friendships in providing this kind of emotional support. Yet, he was not prepared to disclose his unhappiness to his friends and had told few people about his mother's death. Interestingly, Dylan assumed that if he had a female partner he would not need professional help, as she would be able to provide him with the
emotional support he needed. With no romantic partner or close supportive relationships, Dylan saw professional help as his only alternative.

However, Dylan experienced problems with the mental health services he accessed. Only three sessions with a mental health professional were funded through the EAP service and paying for further sessions himself “was not an option” at that time. Dylan stated three sessions was inadequate to discuss and address the issues he had identified. Four other men in this study also discussed how the limited number of sessions funded by EAP was inadequate to address their personal difficulties and the cost of private mental health services made accessing further professional help prohibitive.

Despite the constraints of the EAP service, Dylan pushed on and continued to look for other avenues of professional help and support. However, his efforts were once again hampered. As he explained:

_I went to enrol in a GP around the corner and got told they were full. Pretty much every GP in the city was full, and the only ones were accident and emergency and you’re not going to sit down with an A&E doctor and spill your problems. Where do you go? I mean, apart from ringing up, like, a 24-hour helpline, where do you go? I didn’t need relationship guidance or marriage counselling, I needed someone to talk to. The health system only cares when you need to be locked up or you are going to hurt someone or yourself._

In this instance, the lack of available mental health services limited Dylan’s access to support. Dylan felt frustrated and deterred from future help-seeking and as a result remained isolated and unable to resolve his personal and emotional issues. A lack of access to relevant psychological support was clearly detrimental to Dylan’s mental well-being and he described feeling increasingly depressed.
Contrary to the dominant view in the mental health literature, these men’s stories demonstrate it is not the case that all men are reluctant to seek help. These men actively sought professional help for their personal issues from GP’s and EAP services and did not hide it from others. However, they encountered problems in their help-seeking and engagement with health professionals resulting in a lack of resolution to their problems. While some men pushed on to find alternative sources of professional help, others were deterred and did not pursue further help.

8.3 The shame of help-seeking

Two men in this study described actively seeking professional help for their personal difficulties but kept their help-seeking hidden from friends and family because they felt ashamed.

Zac (Case Study 2, Chapter 4) described how he had sought help from a “number of counsellors” while at university when he felt unable to cope with his mother’s death and his father’s new romantic relationship. Zac found counselling helpful because it was “good to talk to someone” about his personal life as he had no-one else to talk to. However, he found seeking help and expressing his emotional distress particularly difficult because it went against the explicit messages his family had given him as a child: that he had to be emotionally self-sufficient and cope on his own.

Zac felt such as sense of shame about not being able to cope on his own. He was acutely aware that he was going against dominant notions of masculinity regarding men’s help-seeking and it bothered him. He was worried others might see him, as he said, “weak or as a sissy” for not being able to be emotionally self-sufficient and deal with his difficulties on his own. Zac clearly felt that his friends would not view professional help-seeking as acceptable for men and he told old no one apart from his sister about his encounters with mental health professionals.
Beyond talking about his current situation with someone independent, Zac found these services inadequate in addressing his recurring depression and sadness. It seems that Zac felt the pressure to resolve his own emotional issues. However, Zac did not want to be self-sufficient and unemotional, rather he wanted help and support and to be able to talk about his grief. The deep sense of shame Zac felt for wanting to seek help and support bothered him and clearly hindered his mental well-being. Zac also remained at risk of ongoing "bouts of depression" which he had experienced since the death of his mother.

In Kieran’s case (Case Study 3, Chapter 4) he also sought professional help but kept it hidden from his friends and family. He described how he first sought help while at university:

> I went to see a counsellor for a little bit, just because I was having trouble with my drinking and getting a handle on that. I found that he gave me quite a lot of tools for understanding why I was drinking and the underlying things that I might be trying to suppress or not deal with. I think I just saw something on the wall and was, like, “Maybe that will be useful just to talk to someone about what’s happening”, just to get another view. I always found the psychological side of things quite interesting, too, so it was cool to get a perspective on that, too.

It seems that Kieran was aware that men’s health-related help-seeking can be viewed as unmasculine, and framed his help-seeking as both opportunistic e.g. a chance sighting of an advert offering free services, and a rational search for knowledge. Kieran also stated that he was interested in psychology and “learning more” about himself. Despite the hidden nature of Kieran’s help-seeking, he found it extremely helpful in addressing his heavy drinking.
In later years, Kieran accessed EAP services through his workplace. He was able to open up and talk about his personal problems at the encouragement of a counsellor, but again positioned this help-seeking as a rational and responsible decision to seek independent “advice” and “another perspective” on his personal and work situation. This supports Johnson et al. (2012) assertion that men’s discursive reframing of help-seeking, such as talking about help-seeking as responsible and independent action, can be beneficial as it enables some men to resist dominant masculine ideals that men should not seek help. For Kieran, it appears his reframing of help-seeking as opportunistic and rational enabled him to resist the social discourses and sense of shame that can restrain men from seeking professional help for mental health issues.

8.4 Hitting a brick wall

Two men in this study actively sought help from mental health professionals when they felt they were no longer able to cope on their own. This followed a prolonged period of distress and unhappiness. For these men, their decision was not a one-off decision to seek help but involved ongoing engagement with mental health professionals. This pattern applied to Max and Jacob.

Like other men in this study, Max first sought help through the EAP services through his workplace. Max felt increasingly emotionally distressed by difficulties in his private life and their impact on his everyday life and his work. He described how he had “fucked up” his relationship with his girlfriend by having what he called an “emotional affair” with another woman. Max and his girlfriend had spilt up and he now deeply regretted this decision. Max had made a “terrible mistake” and wanted to “salvage” their relationship but did not know how.

Despite feeling like his “world was spinning out of control”, Max tried to maintain an outward appearance that he was fine, hiding his distress from others. However, this became increasingly untenable as his distress started to impact on his paid
work and he struggled to do his job because he was so “distracted”. Max did not want to lose his job and went into what he called “survival mode” focusing solely on maintaining his relationship with his boss. At this point, Max decided to seek help through EAP. He hoped that seeing a mental health professional might be able to “fix” his head and help him work out why he was feeling “so shit about stuff”.

Max’s encounter with a psychotherapist was very beneficial. The male therapist helped Max to understand his “negative thoughts” and make sense of his relationship problems. This successful engagement with a mental health professional encouraged Max to seek help a second time when his father suddenly became unwell. However, like other men, Max’s ongoing access to professional help was limited by cost. Fortunately for Max, he had financial support from his family. Max disclosed to his mother that he had been seeing a therapist and she agreed to cover the costs of further appointments. Max continued to see the psychotherapist for many months. He described his experience as follows:

[It] really helped, I think because, you know, I had a real tendency to get stuck in my own head and try and analyse stuff and ultimately lost connection with reality, really, and would have done the same thing with my dad, for sure. I was well on the way to doing that until [the therapist] kind of said, “Hang on a minute, mate, this is a huge deal for you. This is somebody that you’ve looked up to your whole life and he’s just completely, you know, collapsed mentally, and you’re feeling really lost now.” I actually probably really needed professional assistance, so I was glad he was there.

This quote demonstrates how Max not only found engagement with a psychotherapist helpful, but the reassurance that Max needed professional assistance legitimatised his help-seeking. Max further justified his help-seeking by framing it as a rational choice, taken up as a last resort when he was desperate and
could no longer cope with the enormity of the situation himself. It seems that despite seeking help Max struggled with the notion that is it not what men should do. Max had not given up on the hegemonic masculine ideal of self-sufficiency and continued to maintain his façade of coping around his friends and work colleagues.

Despite framing his help-seeking in this way, Max clearly valued the professional assistance. As he described:

*I felt like I’d fucked my whole life up. You know, I didn’t hold anything back, because I wanted answers about myself, and I didn’t have any pride in that room, because I knew I was never going to see this guy socially.*

It seems a key aspect of Max’s successful engagement with the psychotherapist was allowing himself to be vulnerable and openly express his emotional distress within his private therapy sessions. As he said there were no “social repercussions” from these meetings. Max’s story points to both the benefits and limitations of this type of professional assistance. While help-seeking had clearly been beneficial and helped Max to deal with his personal difficulties, he was left with limited avenues for emotional support beyond a professional fee-for-service relationship.

Similarly, Jacob framed his professional help-seeking as a desperate and necessary action. After leaving home to go to university, Jacob started to get “more and more depressed and anxious”. After the suicide of his mother, Jacob had learned to keep his public and private life separate and concealed his distress and grief (see Chapter Five Emotional Practices). In public, he maintained as he said “a mature and successful” persona while in private he became increasingly distressed and unable to manage his anxiety. Once he got to university and lived in shared accommodation, this divide became impossible to maintain. Jacob described how
his anxiety reached “ridiculous levels” and he felt like he had “hit a brick wall”. Jacob described his experience as follows:

I had finished my exam and felt relief but it lasted for an hour and then I just suddenly went back into high anxiety. I thought “I’m still not good enough”, “I’m still not worthwhile”, “I haven’t done enough in this exam”, “I’m useless”. All these kinds of negative thoughts came back and I was freaking out. I thought, “I’m meant to be relaxed about this.” I always relax after exams. I went for a big run and I came back in an even worse mood than when I left, and I was just, like, there’s something wrong here, there’s something more fundamental if I can’t relax. There is something fundamentally deeper.

This quote demonstrates how Jacob clearly recognised that something was wrong and that he was no longer able to cope on his own. Despite being unable to pin point what exactly he was struggling with, Jacob clearly knew his anxiety was more than just a case of exam stress. Jacob described feeling “anxious all the time” and knew he was “struggling to live”, but it perplexed him that he could not identify what was “upsetting about life”. Jacob decided to access the university counselling services. However, he did not find his first couple of encounters with mental health professionals beneficial. As he described:

They had both just been useless and just said, “You know, people face tough times. We get over it”. They pass you through the door. Or “Your anxiety is just related to time management, you need to manage your time better” and I was, like, “It’s not related to time management. If it was, it would go away as soon as the stress levels go and it doesn’t go”. So I kind of got put off counselling.
Jacob felt his concerns were dismissed by the professionals he encountered, and that his anxiety had not been properly understood. He also objected to the suggestion that he should see a doctor for antidepressants because he believed that medication was “just coping”, not addressing the underlying issues in his life. Jacob did not want to, as he said, “just get by”, he wanted to understand and improve his situation. It seems the counsellors needed to explore Jacob’s problems in more detail. Wenger (2011) argues is it not enough to just examine whether a man has sought help or not, there needs to be a broader consideration of whether men’s needs have been addressed. For Jacob, on this occasion, although he had sought help his needs had not been met and his concerns had been diminished. Despite this unhappy experience of help-seeking, Jacob pushed on and decided to “give it one more shot”. He sought help from a psychotherapist, outside the university, paying to see them privately. Jacob described this encounter:

_The first session was really, really good. Rather than having that attitude of “We’ll just ship you out the door once you’re fixed”, she was kind of, like, “Right, well, there’s some major underlying stuff and we need to start digging a bit deeper into that”._

Jacob’s pursuit of the “right” therapist paid off. Through a number of sessions, he received the help he needed to address his grief and anxiety around the loss of his mother. In the interview, Jacob reflected on the fact that, as a teenager, he was never offered professional support following the death of his mother. With hindsight, Jacob wondered whether receiving this professional help as a teenager would have addressed his anxiety sooner. He also described how it was only years later, as an adult, that he linked his ongoing anxiety and depression to his mother’s suicide. Jacob had obviously been suffering with poor mental health for some time before
first seeking help at university. This narrative of long-term pain, distress and anxiety has been identified in other studies (e.g. Cleary, 2005, 2012; Lomas et al., 2013). Jacob’s story points to the long-term impact that unresolved grief can have in the lives of young men. This is particularly pertinent, given that research has shown individuals who lose loved ones to suicide are at higher risk of developing depression, stress and suicidal behaviours themselves (Young et al., 2012).

These men’s stories highlight how help-seeking can be an ongoing process. While Max found his first encounter with mental health professionals beneficial, which in turn encouraged further help-seeking, Jacob did not find his initial encounters helpful. However, Jacob was not deterred and went in search of the right professional help. For both these men, finding the right help was key to addressing their current high levels of emotional distress but their mental health arguably remained fragile.

8.5 Rejecting help-seeking as a strategy

Five participants reported never experiencing any problems with their mental health or seeking help from mental health professionals. Yet, they had experienced distressing circumstances in their lives, which had impacted negatively on their mental well-being. This pattern applied to Steve, Liam, Adam, Thomas and Ben.

Steve stated that he would never consider seeking professional help or support for a mental health problem because was an “independent man” and could cope on his own. When his wife asked for a divorce, Steve was shocked and devastated, but positioned it as a difficult situation that he could handle alone:

*I don't know, taking that step [seeking help], I just sort of felt I am not that bad, I can sort everything out myself, you know. Don't really need help, because I have always done it myself. The irony is that I*
encourage people all day to go and seek counselling and then I don’t go and do it myself. I just sort of haven’t really felt the need. It is just, like, if you have got a bad situation I always had, you know, instead of thinking “Oh, poor me”, it was like, “What can I do to fix this situation?” – and that is my focus. I don’t really need to talk to anyone about it to get to that conclusion.

Steve dismissed help-seeking as a strategy because he saw himself as self-sufficient and able to “fix” any problems he experienced himself. Interestingly, this quote shows Steve was aware of the contradiction between his own rejection of help-seeking and the fact that through his job he supported others to seek help for issues that were affecting their mental health (see Chapter 7 for discussion of paid work). Steve justified his stance on help-seeking by framing himself as unaffected by the collapse of his marriage and therefore not in need of professional help. As he explained:

I was really angry, because I have done nothing wrong and yet you [his wife] left me for some guy you meet on the internet. But it didn’t take that long to get over it, really. Even now I still just hate that stigma, you know, divorce, although when I actually got the papers in the mail, you know, for making it official, it was, you know, a good feeling.

Steve appeared to cope with his divorce by blaming his ex-wife. He described himself as “not a quitter” and took no responsibility for the end of their marriage. As well as positioning himself as unaffected by his divorce, Steve stated he did not need to talk to anyone about it because he was “not a big person to talk about his feelings”. His rejection of help-seeking was clearly related to his emotional practice of concealing emotions (see Chapter 5) and his desire to maintain his image of self-
sufficiency. Despite describing “close” family, he would never discuss his personal problems or his divorce with them. For Steve, rejecting the notion of help-seeking was a way of demonstrating hegemonic masculinity.

Steve’s dismissal of help-seeking was also influenced by his beliefs around mental illness. He viewed any emotional distress or depression as feminine and therefore weakness. This was demonstrated by the way Steve presented his ex-wife as weak, over-emotional and mentally unwell, while presenting himself as strong and in control of himself. He described his ex-wife as “emotionally unstable and irrational” and blamed their divorce on her anxiety issues and mental health problems. According to Courtenay (2000) the denial of mental illness, such as depression which is viewed as a socially feminine, is one of the ways in which men can demonstrate hegemonic masculinity and deny vulnerability. This was certainly the case for Steve who framed mental illness as something only women suffer from not men, and associated both women and mental illness with problematic emotions and loss of control.

Liam also rejected the notion of help-seeking, describing himself as resilient and able to cope with life’s problems on his own. As he explained:

I look at other people that cope with a quarter of the shit that I do and they're stressed as hell, but for some reason I'm not, and I'm thinking “This is normal” and people think you're off your head. Some things I just don't think about as being particularly stressful. My ability to cope with stress is high and I think a lot of men’s ability to cope is very high. I think people build up layers of resilience. You get used to what you get used to, and you can cope with it in a good way. I've got a quick brain, thinks quickly so that helps as well. I think I've coped with a lot and I don’t think I’m alone. I think there's plenty of men out there who are coping with the same sorts of pressures, who are in the same high-
In this quote Liam frames men as being more resilient and having more coping abilities than women. He did not see the need for seeking help after his marriage ended, because he saw himself as an intelligent and resilient man who had already coped with a lot in his life. While there is no unified definition of resilience in the mental health literature, it is synonymous with the attribute of “bouncing back” when faced with adversity or disruption (Bonanno, 2004). Liam, however, appears to equate resilience with more than just bouncing back, he equates it with being a man, having intelligence, strength and self-sufficiency. In doing so, Liam was able to project an image of strength, dismissing any need for help and side-stepping any recognition of the vulnerability he had felt. Yet, Liam had felt distressed and vulnerable:

The closest I've come to I think just breaking down generally, probably did break down, I probably just didn't realise it was that at the time. But I do remember one afternoon where it all got too much and I just sat in the corner of a room and just cried and didn't get up for three hours, just rocking back and forwards. That's probably not the best mental state to be in.

Liam had clearly been emotionally distressed by his marriage problems, yet he would not consider seeking professional help. Liam stated he was someone who was good at “being able to internalise issues” and “process” them himself. It seems he wanted to remain self-sufficient and hide his vulnerability from others if he could. Like Steve, Liam’s rejection of help-seeking as a strategy was also related to his beliefs around mental illness, particularly depression. As he described:
I'm not a depressed person. I feel fundamentally happy about life most of the time. You know, maybe that’s my own stigmatizing, but I don’t think of myself as depressed, but nor would I want to be diagnosed as depressed or have depression as the only option available to me if I wanted help because it isn’t about that to me. I don’t think I’ve got a mental health problem. I just think it’s normal; what I go through is normal.

Liam was undoubtedly aware of the stigma associated with depression, and more generally mental illness. Like Steve, Liam framed depression as something that women suffer from rather than men. When his ex-wife experienced post-natal depression after the birth of their first child, Liam had viewed this as a “legitimate” reason to receive professional help and support because as he said she had “struggled and could not cope with their children”. Yet, the significant emotional distress that Liam had experienced during his marriage breakdown, and the impact of losing his established career and difficulties with child custody issues he called a “normal” part of life that he could cope with. Like Steve, Liam’s denial of vulnerability and mental illness and positioning himself as mentally stronger and better able to cope than his wife was his way of demonstrating masculinity.

Similarly, Adam would not consider help-seeking as a strategy for addressing difficult personal circumstances because he said he took a lot of “pride” in being an independent and self-sufficient man. He said he “backed himself” to be able to cope with any personal difficulties he may experience in his life. As Adam explained:

*I guess one of my coping mechanisms is to not think about it and I know that’s frowned upon in a lot of ways. Say I was losing a job, it's like, “Well, that sucks and that's stressful”, but at the same time being, I*
guess, mindful and present enough to say, “Well, that’s a thing that you have no control over”. But you do have control about how much time and energy you spend actually worrying about that thing. I guess just acknowledging what you have control over and what you don’t and making the most of the things you do have control over.

For Adam establishing control over how he dealt with stressful events in his life and avoiding overthinking his issues was seen as an important part of being an independent man. Even though Adam was aware that avoiding issues was not a recommended coping strategy, he did not wish to be seen as unable to cope as this would bring his masculine status into question.

Adams rejection of help-seeking, like Steve and Liam, also reflected his hegemonic emotional practice of concealing socially feminine emotions and his reluctance to discuss his personal life with friends or family. Adam also positioned himself as stronger and better able to cope than women. Like Steve and Liam, Adam also compared himself to his ex-girlfriend who he described as “unstable”, someone who “manufactured drama” and was unable to deal with issues the way he could.

Finally, as described in Ben’s case (Case Study 1, Chapter 4) he also rejected the notion of help-seeking. Like Liam, Ben rejected the medicalisation of personal difficulties, which he perceived as a “normal part of life”. When his wife had been diagnosed with depression by her GP, Ben believed she just needed to “change her job” and “exercise more” rather than take antidepressant medication. He stated that people who seek professional help for their personal difficulties were “medicalising their sadness”. As Ben explained:

I think it’s a shame that some people get depressed. I wouldn’t be surprised if my mum was depressed, but your guy’s sort of classification. It sucked for her with my brother, it really did; but it
stops her enjoying the fact that she’s got the rest of us. You know, my wife was in the UK miserable for a period of time, which meant she missed out on the real experiences she should have been getting, and, in her case, for a reason that wasn’t good enough. We’re just so lucky and life is so good that, as I kept telling her [his wife], which annoys the hell out of her, but it’s not like anyone’s died. But, you know, do stuff, get exercise and establish some sort of social network. If you’re depressed, don’t go and see a doctor, our lives are better off than even a king two or three hundred years ago.

Ben appeared to believe that people had a choice whether they became depressed or not. That the causes of depression were socially constructed and people could choose to label their personal difficulties as depression or choose to improve their situation. Ben’s denial of help-seeking was also influenced by his own life experiences. The death of his brother had been the most significant life experience for Ben, but one that he had cope with himself and believed other people should do the same, particularly if their issues were not as serious as the death of a loved one. Consequently, Ben viewed himself as resilient, because he had dealt with this trauma on his own. Indeed, he questioned why others could not be more resilient. In the interview, Ben stated that he volunteered for the study because he hoped his story of resilience might help someone else.

While studies have shown that most bereaved people become resilient and recover from their loss over the long-term, there is evidence that the traumatic or violent death of a loved one can increase the likelihood of grief complications including mental health problems (see Stroebe, Schut, & Stroebe, 2007; Stroebe, Schut, & Stroebe, 2005). In the interview, Ben still appeared to be affected by his brother’s traumatic death and was visibly upset when recalling the event. Further, Ben’s narrative suggests there may be broader consequences for boys who experience bereavement. Dealing with the loss of his brother without help reinforced the
dominant masculine ideal that as a man he did not need to seek help and that he was self-sufficient in dealing with his own emotional difficulties.

These men's stories highlight that for some men the denial of professional help-seeking for distressing or difficult personal circumstances is a necessary part of pursuing hegemonic masculinity and being an independent, self-sufficient and resilient man.

8.6 Point of departure: Seeking help exclusively through informal networks

Two men in this study did not have a particular view of professional help-seeking; rather, they described using informal support networks to seek help and support.

Ritchie did not take a hard stance against help-seeking but neither had he ever sought help from a mental health professional. His preference was to seek help through informal networks. When he and his wife separated, Ritchie approached his female colleagues at work (see Chapter 6 Social relationships and support networks). In particular, a woman who he knew had also been through a marriage separation and divorce. Ritchie recalled a conversation where his colleague told him about her experience of going to a doctor and being prescribed antidepressants. While he said he never felt the need to go to his GP, he welcomed his colleague’s disclosure and advice. It had presented him with an option that he would consider if he ever needed to.

Similarly, Cameron did not have a particular view on professional help-seeking for mental health and had never sought professional help. Cameron said that if he ever needed help he would turn to his two female “best friends”. He described these friendships as the type of friendships where “you would do anything for them”. Despite living some distance from his female friends, Cameron knew he could call them any time and they could “talk about anything”. These informal support
networks provided Cameron with an avenue for disclosure and help when he needed it.

8.7 Conclusion

This chapter demonstrates the range of experiences and diverse help-seeking practices of the men in this study. Contrary to the dominant view in the mental health literature that men do not seek help (e.g. Berger, Addis, Green, Mackowiak, & Goldberg, 2013; Vogel et al., 2014; Wahto & Swift, 2016), there was no single pattern of help-seeking among the participants in this study. Furthermore, not all men's help-seeking was related to depression or mental illness. Men in this study sought professional help for a variety of reasons including relationship and work issues, alcohol abuse, unhappiness, emotional distress, anxiety, grief or a general desire to talk to someone. Five distinct patterns of practice in terms of professional help-seeking and engagement with health professionals were identified from the life history data.

First, some men actively and openly sought professional help for their personal difficulties. These men resisted the dominant masculine discourse that men should not seek help. However, their encounters with mental health professionals were problematic resulting in a lack of resolution to the problems they had identified. This included not addressing underlying social issues, framing men's concerns as mental illness, ignoring significant levels of mental distress and barriers to accessing services due to cost and availability. While some men pushed on to find alternative sources of professional help, others were deterred from seeking further help.

Second, some men actively sought help but kept their help-seeking practices hidden from friends and family. These men were not entirely comfortable going against the dominant notion that men should not need to seek help and felt a sense of shame
for seeking help. These men reframed their help-seeking as necessary and rational in an attempt to overcome this feeling of shame.

Third, some men sought help after a prolonged period of distress and unhappiness. Their help-seeking was not only on-going but kept hidden from fear of being exposed for not being able to cope. Although these men found value in professional assistance they were not entirely comfortable going against the dominant notion that men should not need to seek help. As a result, these men framed their help-seeking as desperate and necessary. For these men, finding the right help was key to addressing their current high levels of emotional distress but their mental health arguably remained fragile.

Fourth, for some men their rejection of help-seeking was linked to their pursuit of hegemonic masculinity and closely linked to their practices of emotional containment and confined social relationships. Help-seeking and mental illness was viewed as unmasculine and a sign of vulnerability. These men positioned themselves as independent and resilient men who were able to cope with their personal difficulties on their own. They also rejected the labelling of difficult life experiences such as divorce, job loss or death of a loved one as a mental health issues. Instead, they positioned their personal difficulties as minor personal problems and part of everyday life that they could handle, rather than an event that could be detrimental to their mental health and require professional help or support. These men were more inclined to talk about their female partner’s mental illness rather than directly discuss their own mental health or the mental health of other men. In doing so, they implicitly positioned themselves (and men) as mentally healthy and resilient whereas mental illness was framed as something only women experience.

Finally, two men had never sought professional help for their mental health but did not have strong views about help-seeking. Their preference was to use their informal support networks, namely female friends and colleagues to seek help if and when they needed it.
Chapter 9
Mental health-promoting practices

9.1 Introduction

This chapter presents the last of the five themes which emerged from the collective analysis across the fifteen life history case studies. The men's mental health literature has largely focused on the strategies men use to manage depression (e.g. Bryant-Bedell & Waite, 2010; Fogarty et al., 2015; Oliffe et al., 2012; Oliffe, Robertson, Kelly, Roy, & Ogrodniczuk, 2010; Proudfoot et al., 2015) with less emphasis on the ways in which men without mental illness actively engage in practices that support mental well-being. This chapter explores the practices that men in this study used to engage with their mental health and support their mental well-being. Five patterns emerged and are presented in descending order of value or benefit for supporting mental well-being.

9.2 Pursuing good mental health as a way of life

One man in this study pursued good mental health as a way of life and embodied diverse everyday social practices, which set him up for what he termed “thriving”. As described in Ethan’s case (Case Study 4, Chapter 4), his mental well-being was supported by his embodiment of an alternative masculinity in which he resisted hegemonic social practices. This included embodying a more open and genuine emotional practice with both men and women, including his friends, family, colleagues and his children. This everyday resistant emotional practice contributed to his own mental well-being and the well-being of his partner and young children. It also enabled him to establish close and supportive friendships with other men which he valued and found rewarding.
Ethan’s involvement in the arts community and his choice of paid work also set him up to thrive. He rejected both traditional men’s work and traditional domestic arrangements. Being a self-employed artist allowed him to pursue his love of art and spend more time caring for his children. While this arrangement created some tension in terms of financially providing for his family, Ethan believed that “staying true” to himself and “making the most of your own potential” was more important to him. For Ethan, aligning his paid and unpaid work with his “underlying belief systems and values” about money was beneficial for supporting his mental health.

It was not only the social practices Ethan used to construct his resistant masculinity, and pursue his way of being a man in the world, that enabled him to enhance and support his own mental health. Ethan also thrived on spontaneity, a sense of spirituality, and living his life to the full which were all part of his “philosophy” about life. This positive outlook on life was a direct consequence of his experience of cancer as a young man.

9.3 Promoting good mental health through sport, physical activity and outdoor pursuits

Six men in this study described engaging with their mental health through the practice of sport, physical activities and outdoor pursuits. These included rugby, cricket, surfing, gym workouts, snowboarding, scuba diving and mountain biking. Activities which gender researchers have argued are constructed as socially masculine (see Anderson, 1999; Espiner, Gidlow, & Cushman, 2011; Robinson, 2010; Wheaton, 2000).

This pattern was exemplified by Cameron who described sport as his passion and key to his mental well-being. Cameron not only pursued socially masculine outdoor recreational activities in his leisure time but also through his paid work. Cameron played numerous team sports, including rugby and football several times a week, and regularly engaged in recreational activities, such as mountain biking, at the
weekends. He had also studied sports science at university and pursued paid work in the field of sport and recreation, managing community sports programmes for young people. As Cameron explained:

*Playing sport, just being active and having stuff to challenge me and concentrate on I think is really good, because you feel like you’re using your brain a lot more and feel like you’re accomplishing things, so it puts you in a more positive state of mind, I guess. I like physical activity and I like pushing myself and challenging myself, which is good and keeps me in quite a positive frame of mind.*

Cameron clearly linked his passion for sport and physical activity to promoting mental well-being. For Cameron, it seems, pushing himself physically through sport and recreational activities, and the sense of success and achievement he got as a result, helped him to feel positive about his life. Cameron described how physical activity was the main way he coped with stress and emphasised that without physical activity his body became “run down” which in turn led to his mind “being run down”. For Cameron, there was clearly a strong link between his physical health and mental well-being. According to Robertson (2007) “physical activity and functionality” is so integral to men’s concept of health and well-being, that the loss of functioning can be equated to the loss of health (p. 41). In Cameron’s case, he equated physical ill-health and the loss of physical functioning to a loss of mental well-being.

Cameron also used sport and physical activity as a means of socialising and maintaining his social networks and friendships. He would regularly attend games or watch sport on television with his father, sister and male friends. As a result, Cameron had a wide and diverse social network based around a common interest in sport, which was beneficial for social well-being aspects of his mental health.
However, while physical activity and sport undoubtedly had both direct and indirect benefits for Cameron’s mental health, there are limitations to this practice for maintaining mental well-being. Robertson (2003) argues, even though sport is classed as a social activity and can be an effective way for men to relieve everyday stress, it does not always involve meaningful or close social relationships with others. In particular, given the gendered link between sport and hegemonic masculinity, it can lead some men’s friendships and social connections to remain “superficial” (2003, p. 709). While Cameron maintained a range of social networks through his sporting connections, these predominantly male friendships were not relationships in which he would share details of his personal life or seek support if he needed it. Nor were they relationships in which he would express his feelings, aside from the competiveness allowed in sport.

Cameron’s preference for masculine-dominated sports and recreational activities also had consequences for his social relations with women. He was not as close to his mother as he was his father, because, as he said, he and his mother did not have a “common shared interest” in sport. Although Cameron felt sad about his, he did not engage in any other interests that might help him build a closer relationship with his mother. Rather, he expected her to, as he said, “put up with” his and his father’s obsession with sport. Cameron’s engagement in sporting activities “every night of the week” also meant he had less time to spend with his new girlfriend who was not interested in playing or watching sport with him. Again, rather than finding social activities he and his girlfriend could do together, Cameron continued to pursue sport.

While Cameron used sport and physical activity as a means to socialise and connect with others, other men in this study engaged in physical activities alone. For instance, while Ritchie believed that physical activity was essential for maintaining positive mental health, it was something he did on his own. Ritchie would regularly go to the gym to “work out” or go for a run and, as he said, “put in the earphones and just do my own thing”. 
One of the reasons for Ritchie’s solo activities was he had few friends with which to share his interests with. Following his marriage separation, Ritchie found that while he had plenty of acquaintances, he actually had few friends with which he could socialise with or participate in sport together. He downplayed his need for friendships and socialising by framing his solo physical pursuits as a “necessity” for him in terms of supporting his mental health. Ritchie stated that he was responsible for looking after his own mental well-being. In other words, Ritchie saw himself as an independent man who did not need others to maintain his mental well-being. As he described:

*Imagine a mug of beer sitting on the table and your sort of energy or life source or whatever is beer in a mug. Things that lower the level of the beer in the mug are things like, you know, dealing with work situations, stress, you know, all the things that sort of drain you, if you like. Things that fill that beer mug back up are things like eating well, exercising, physical activity, you know, the good things, getting a good night’s sleep – they are the things that fill it back up. Certainly, for me, making sure that my mug of beer is at an adequate level is always the top of my list. You know, people do burn out, and if you wake up every day and your mug of beer is getting lower and lower at the start of each day, then you know you have got to change something and do something different.*

In this quote Ritchie frames his mental health-promoting practices as individual behaviours; there is no social aspect to them. This echoes much of the mental health promotion literature which focuses on changing individual lifestyle behaviours (Dale, Brassington, & King, 2014; Stranges, Samaraweera, Taggart, Kandala, & Stewart-Brown, 2014; Velten et al., 2014) rather than addressing the influence of social structures such as gender or social relation in supporting mental health. This
focus on individual responsibility for managing mental well-being arguably reinforces the masculine ideal that men should be self-sufficient and responsible for managing their own mental health.

Indeed, Ritchie’s use of a beer analogy enabled him to impart a more masculine framing of his individualistic mental health-promoting strategies. Beer-drinking is a significant activity through which New Zealand men construct dominant masculinity (Willott & Lyons, 2012). By framing his well-being strategies in this way, it seems Ritchie was able to position himself as responsible for managing his own mental well-being without compromising his masculine status. His emphasis on individual strategies and self-sufficiency also meant his lack of social connections was not challenged.

While Adam emphasised his engagement in masculine activities, such as scuba diving, surfing and mountain biking, as a means of maintaining his mental well-being, he also spoke of an appreciation and connection to nature that such activities allowed:

*I like going diving just by myself off the south coast and getting a catch of paua, and then hauling myself out of the water and looking up and seeing the South Island and the sun setting over that. And there is no-one else around, and just kind of being really appreciative of just being alive.*

This quote suggests that Adam, like Ethan linked his mental well-being to a sense of living in the present and appreciating his life. For Adam his outdoor activities allowed him a connection with the environment which he described as a form of “therapy” that promoted a sense of emotional and spiritual well-being. Mental health studies have demonstrated a relationship between connecting with nature and positive mental health through boosting positive emotional experiences (e.g.
Barton & Pretty, 2010; Howell, Dopko, Passmore, & Buro, 2011; Wolsko & Lindberg, 2013). In Adam's case, physical recreation in the natural environment improved his mood, provided positive emotional experiences and contributed to positive mental health.

Engaging in outdoor pursuits was also a coping strategy for Adam when things were not going so well in his personal life. As he explained:

*Just being out and being active and enjoying as much of your life as you can – and those parts that you have no control over, that aren’t going so well, at least you can sort of get away, and at least not everything is terrible. You know, you still got to keep those good things going.*

Adam used physical activity to distance himself from issues that were troubling him. While this strategy clearly helped him to cope with distressing circumstances in his life, it was limited in helping him to resolve the issues that were impacting on his mental well-being. Like Cameron and Ritchie, Adam’s physical activities and outdoor pursuits were either done alone, or with other men who shared similar interests and hobbies, but with whom Adam did not have the depth of friendship where he would discuss his personal life or feelings. In other words, while these social connections and outdoor pursuits undoubtedly conferred benefits for Adam’s mental health, Adam’s avoidance of the emotional aspects of social relationships meant he would not discuss the issues that were troubling him with these companions. As he said, he relied on these activities to “get away” from talking about his personal difficulties.

However, Adam was aware that this was not always a successful strategy for managing his mental well-being:
You don’t always have a choice about what you’re thinking about. I think part of keeping busy is that you know even if you’re busy doing something, often those thoughts will creep in. But it’s a healthier way of dealing with it, because you’re not just lying in bed and it’s all-consuming. You’re actually actively doing something and kind of dealing with it at the same time, but not a hundred percent focused on it. For me, at least, anyway, I don’t see much value in kind of lying in bed wallowing. I don’t think or spend 24/7 worrying about that thing. I don’t think that’s more helpful or more therapeutic than going out and being active. You still work through it but in, I guess, a less direct manner.

While Adam presented physical activity and outdoor pursuits as a positive alternative to “wallowing” in bed when he was experiencing poor mental well-being, he was also clearly aware that it was not a fool-proof strategy for dealing with his “worrying” issues. As he said, the negative thoughts would still “creep in”. It seems that while this strategy provided Adam with a means for promoting his sense of positive mental health by connecting with nature and the enjoyment of outdoor pursuits, it did not prevent him from experiencing emotional distress. Adam’s story suggests that relying on physical pursuits that have limited interpersonal relationships with friends may have both benefits and limitations in terms of promoting men’s overall mental health.

Similarly, Dylan linked physical activity to managing both his mental and physical health. As he explained:

I had male friends who went to the gym a lot and I could see how happy they were and how physically you just feel stronger and healthier, and it’s like a drug. Once you get into the habit of it, it really is like a drug, you have to go and do it. It makes you feel good about yourself,
knowing that someone wants to be around you, and gradually I worked out, you know, if you do those things, if you eat right and you work out, and you dress right, the other things sort of fall into place.

In this explanation Dylan not only links going to the gym to promoting a sense of happiness but it also helped him to “feel good” about himself in terms of his physical appearance, particularly around women. Dylan described how by maintaining his physical health and appearance, he felt more confident in his romantic relations with women, which in turn boosted his self-esteem and helped his mental health. This, however, was the extent of Dylan’s engagement with his mental well-being. Although he acknowledged that activities such as “meditation” might, as he said, “make more sense than going out drinking”, he stated it was not a “priority” for him. Dylan positioned his mental health-promoting strategies as a way of maintaining his masculine status and physical appearance. Like Ritchie, Dylan’s practices were focused solely around his individual lifestyle behaviours.

9.4 Quality time – alone and together

For two men in this study, prioritising time on their own and with their female partners was a key strategy for supporting their mental health. The demands of their paid work and long work hours took its toll on their physical and mental health and without this quality time – alone and together – these men struggled to maintain a sense of positive mental well-being. This pattern applied to Thomas and Kieran.

For Thomas, his full-time university studies and part-time work in hospitality left him little time for the things he used to enjoy such as “shooting hoops at the local park” with his friends. As Thomas fitted his part-time work around his studies, it meant he worked long, unsociable hours, which left him feeling, as he put it, “buggered after a shift”. While he had little time for exercise or socialising with his
friends, Thomas ensured that he did not miss out spending much-needed time on his own. As he described:

*Exercise is definitely the one I have to get back on. I'm really missing the value of that. Just down time, I think most importantly is chill time. Without that I'm fucked. I can't function without that. I can do three 12-hour days in a row if I have to, as long as I know there's a day, like a Sabbath, at the end, where I can do nothing all day, get up and have breakfast, watch TV and do nothing all day. It's really, really important to me, like the most important. I would put that way above everything else.*

In this explanation, it is clear that time out from his busy, daily routine was a priority for Thomas’ mental well-being. He linked a lack of “down time” with not being able to physically or mentally function. Thomas described using marijuana during his down time to help him relax and as he said “figure things out” in his head. Thomas compared his marijuana use to “meditating” where he could take time out from his busy routine and “process thoughts” which he believed helped his “motivation and mentality”. For Thomas, having quiet time for self-reflection was cathartic and a prerequisite for maintaining his mental well-being.

Thomas’s strategy is similar to that reported by men in Lindsay and Marcell’s (2012) study who described engaging in “introspective” activities, such as relaxation time and using meditation-like activities as a means of taking care of themselves when they were feeling low or depressed (p. 357). However, while Thomas believed this strategy promoted an overall sense of mental well-being, the use of drugs to do this is a questionable strategy. Aside from being an illicit drug in New Zealand, there are a number of associated health risks with marijuana use, including addiction, mood and anxiety symptoms (Luther, Lorber, & Shim, 2016) and impaired short-term memory (Volkow, Baler, Compton, & Weiss, 2014). For
Thomas, his strategy of using marijuana to relax could adversely affect his university studies and educational performance, which in turn could have consequences for his mental health longer term.

Studies have drawn attention to men’s use of drugs to ameliorate distress, depression and emotional issues (e.g. Lomas et al., 2013; Oliffe et al., 2012; Oliffe et al., 2010). Thomas’ case highlights how this strategy is also used to divert attention away from more troubling issues. Thomas stated that he smoked marijuana because it made it easier to “be distracted from things” that were bothering him. Although this strategy might have been beneficial for Thomas in dealing with everyday work or study stress, it had limited effectiveness in resolving more serious, ongoing issues in his private life, such as his relationship with his estranged son. Thomas’s drug use, like his strategy of “emotional fortressing” discussed in Chapter 5, was not an entirely effective strategy for maintaining positive mental health. While Thomas acknowledged that his marijuana use could “take a toll” on his mental and physical health he was not prepared to stop smoking.

Thomas also enjoyed spending time at home with his partner Kate, which he described as being “on a par” with spending time alone, in terms of supporting his mental health. Since moving in together, Thomas had taught himself to cook and enjoyed making elaborate meals for Kate when he had time off from his studies and work. As he described:

*I love to do the cooking. I’ll get in the kitchen for the whole day. Kate loves curries and stuff like that, so that motivated me to get into the habit. I taught myself how to make curries from scratch, like, I’ve nailed that. I’ve been doing it for about a year and a half now. I think I actually started doing that cos I knew she was right into curry and heaps of different foods. But I just like to cook and she loves to eat. She’s said a lot of times that that’s probably the thing I do that she appreciates the most.*
Thomas linked the pleasure he got from cooking with Kate’s appreciation and enjoyment of it. His relationship with Kate had been the motivation for taking up cooking and learning new skills. Thomas stated it felt “rewarding” to do simple everyday things for his partner, such as cooking and doing her laundry. This corresponds to research in the field of positive mental health, which emphasises the importance of hedonic well-being, or feelings of pleasure or happiness (e.g. Barry, 2009; Catalino & Fredrickson, 2011; Huppert, 2005; Ryan & Deci, 2001). For Thomas, connecting with his partner through everyday domestic activities was not only pleasurable and enjoyable but contributed to his sense of mental well-being.

Spending time with Kate also provided Thomas with an avenue for someone to talk to and who would listen. Even though he described talking as “cringey” and something that he tried to “avoid as much as possible”, Thomas was aware of the benefits of meaningful conversations for his relationship with Kate. As he described:

I have to spend time with Kate even if it’s just a little while, just like have some one-on-one time. Even if it’s very small talky chat, I make the time to chat and you’ll both feel better for it. Sex, I guess, as well is in the same category, but that is important too, you gotta keep up that. At least, that’s important to me.

For Thomas, spending time with his girlfriend was important for his relationship, as it brought them together emotionally and physically, but it was also important for supporting his mental well-being. Thoits (2011) argues that everyday demonstrations of love, care and understanding within intimate relationships, such as Thomas described, can support mental well-being by providing a sense of “purpose and meaning in life” (p. 148). Despite the fact that Thomas was not
entirely comfortable with this level of intimate emotional connection, his relationship with Kate appeared to provide a sense of purpose and meaning for him. He described his relationship with Kate as the healthiest relationship he had ever had, and credited her with helping him give up his unhealthy lifestyle of heavy drinking and partying.

Likewise Kieran (Case Study 3, Chapter 4) valued “time alone” or going to the gym to “get rid of a bit of extra energy and get the endorphins going”. For Kieran, spending time on his own, whether engaging in introspective activities or physical activity, was an important strategy for dealing with the pressure and confines of his paid work. For Kieran, self-reflection and time out from his daily routine was an opportunity to “process the clutter” in his head. It allowed him achieve what he termed “clarity of thought” or to understand his current thoughts and feelings. It was also essential for his physical health as Kieran described:

*Just down time I think is good, realizing when you’re stressed or feeling a bit tired and you need to sleep, take some time out – those sort of things. I’ve not really been doing that in the last couple of weeks, and I think that’s probably why I’ve been sick. A lot has been happening at work, it’s been really busy and that’s just sort of my body’s way of telling me to slow down a bit, I think.*

Kieran linked a lack of time out from his everyday responsibilities and obligations to stress and poor physical health. There is increasing empirical evidence that downtime or mentally disengaging from work during non-work time is important for preventing emotional exhaustion and supporting mental well-being (see Sonnentag, 2012; Sonnentag et al., 2010). For Kieran, having time out was not only necessary for his physical health, but essential for helping him to manage his work-related stress and in turn supporting his mental health.
Like Thomas, Kieran also emphasised spending downtime with his partner Hannah as a priority for his mental well-being. They would watch movies or have “nice dinners” together. For Kieran, spending time with his partner, particularly during their first pregnancy, was important to him, as it strengthened their relationship and enabled him to emotionally and practically support her. Both the giving and receiving of support has been shown to be beneficial for mental health (Fiori 2012). Being able to support his partner clearly helped Kieran’s sense of mental well-being. Interestingly, Kieran was also acutely aware that having a baby “might change their relationship” and that he and Hannah would have to “find a balance between a baby and both of us”. In other words, while having a baby would undoubtedly bring them closer together, he and his partner may have less time for their own well-being strategies after the birth of their child.

9.5 Personal development as a means of relieving distress

For three men in this study, developing their own specific health-promoting strategies was a priority after their engagement with mental health professionals had failed to provide ongoing relief or resolution of their personal difficulties. However, while these men framed their strategies as mental health-promoting, they appeared to be more about alleviating emotional distress than promoting mental well-being. This pattern applied to Jacob, Max and Zac.

Jacob first turned to practices such as meditation and mindfulness as a way of managing his high levels of anxiety and distress. Jacob decided he no longer wanted to rely on professional help. As he described:

I had been doing counselling and uncovered a lot of stuff and I was, like, “Cool, I know all the reasons I’m really depressed and anxious just now” but I still kind of felt, like, “But I’m still really depressed and anxious, now I’m just even more hyper-aware of why I’m fucked up”. I
guess I was, like, this was kind of helpful to uncover, but it’s really just kind of burdened me a lot more.

As Jacob’s narrative shows, despite receiving help from mental health professionals, counselling had not given Jacob the skills he needed to manage his feelings of distress, anxiety and depression longer term, nor had it completely resolved the underlying issues in his life that were contributing to these feelings. In particular, counselling had failed to address Jacob’s ambivalence in terms of wanting to be more open with his emotions or his personal “struggle” with his sexual identity. While Jacob had “come out as gay” at university, he was not ready for a relationship with another man, and remained vigilant about who he disclosed his homosexuality to. Furthermore, as discussed in Chapter 5, the death of Jacobs’s mother seemed to push him towards a hegemonic project, but he never quite reconciled his private emotions and sexual orientation. These tensions appeared to contribute to Jacob’s ongoing mental health issues and counselling resulted in him feeling more “burdened” by his awareness of this.

Jacob started going to weekly meditation classes and learnt how to meditate on his own at home. After practising daily, Jacob noticed that he felt considerably less anxious. He eventually created a “habit” of meditating. Jacob became reliant on this practice, stating that when he did not meditate, he noticed how he became “a lot more anxious”. For Jacob, meditation had provided him with a strategy for managing his everyday feelings of distress, which psychological therapy had been unable to do. Meditation and the self-regulation practices it entails, including cognitive and emotional practices, is argued to be beneficial for mental well-being, as it teaches self-awareness and control of one’s own mental processes (Walsh & Shapiro, 2006). In Jacob’s case, meditation gave him a sense of control over his emotional distress and anxiety. As he explained:
Just the frame of mind where I’m not worried about the future because the present’s great! I can sit down and have a coffee with someone and just be totally intrigued and engaged in conversation; or I can be lying on a beach and I can just hear the waves and see the sun and the sand and the beach, or like tramping somewhere and be inspired by these jagged peaks covered in snow.

Meditation provided Jacob with a more constructive means for managing his anxiety and provided him with moments of reprieve from his distress. He seemed to have found a sense of peace, solace and inspiration in nature and was able to experience more “moments of contentedness” and connection in his life. However, meditation, like counselling, had its limitations and it seems no amount of personal development strategies could resolve the distress and conflict Jacob experienced between hegemonic masculinity and being an openly gay man. Jacob’s narrative suggests that much of his anxiety centred around giving up on hegemonic masculinity.

Further, like the well-being practices of other men in this study, Jacob’s meditation was an individual practice. In contrast to Lomas et al.’s (2013) study where the benefits of meditation for men’s mental well-being largely came from men’s collective practice within a community group and social networks with other men, there was no social dimension to Jacob’s meditation. He practised at home, in privacy, away from the view of others and did not talk openly about his meditation. Consequently, it had limited contribution to the social aspects of his mental well-being. There was also a sense that by focusing on his individual practice, Jacob could control his emotional distress in a way that would not compromise his masculine status.

Similarly, while Max’s engagement with a psychotherapist had helped him to understand his negative thinking and make sense of his relationships problems, it had not provided him with the skills he needed longer term to manage his distress.
After months of seeing a psychotherapist, Max went on a weekend retreat where he learned how to meditate. He also described how he “got into yoga in a big way”. For Max, yoga and meditation helped him to manage his distress more effectively. As he described:

*When I started doing meditation, it was hugely positive. It just cut through a lot of those thoughts and gave me a lot more energy, because when you’re thinking dark thoughts all the time and you can’t get rid of them, it’s exhausting and you don’t get anything done and then you feel worried about that, too.*

Max’s narrative, like Jacob’s, suggests that meditation was more about controlling his negative thoughts and alleviating his distress than about promoting aspects of positive mental health. While Max found this strategy helpful because it helped him to break the cycle of rumination and stop the “dark thoughts”, it had limitations. Like Jacob, Max was unable to resolve the tension and conflict caused by the constraints of hegemonic masculinity. In particular, Max struggled to reconcile the hegemonic practice of emotional concealment with his desire to connect to and allow his emotions. Both psychological therapy and Max’s personal development strategies were unable to help him change his emotional practice and as such, they were limited in promoting his overall mental health.

As described in Zac’s case (Case Study 2, Chapter 4), he too continued to experience feelings of depression and emotional distress which had not been addressed by professional help. Zac developed his own strategy of relying on his inner resources when he was experiencing low periods. As he said he was “inquisitive” and felt “interested in the world”. Zac would read books and pursue his curiosity even if it was “about being unhappy”. While Zac’s strategy of relying on his inner resources provided him with the means to alleviate his distress to some extent, like Jacob and
Max, it did not provide longer-term resolution to the personal issues that were troubling him.

Zac continued to aspire to the hegemonic version of masculinity, yet it was also a major source of tension in his life. He continued to question his emotional practices and remained unable to resolve the conflict he experienced between the hegemonic practice of denying particular emotions and his own need for emotional connections with others. Zac also struggled to build friendships that were more meaningful with his male friends and his older brothers. He also continued to struggle with the emotional impact of losing his mother. For Zac, it seems that neither counselling nor his strategy of engaged learning was enough to help him resolve this emotional ambivalence, or his recurring depressive episodes. As such, Zac continued to experience symptoms of mental illness and low levels of mental well-being.

9.6 Constraints on mental well-being practices

Some men in this study described struggling to engage in practices which would be beneficial for their mental well-being due to constraints on their social circumstances. This pattern applied to Ben, Nathan and Peter.

In Ben’s case (Case Study 1, Chapter 4), long hours in paid work, regular work-related travel away from home and two young children left him with little time and energy for engaging in the type of activities that he loved, such as socialising with his friends or outdoor pursuits such as running, climbing and tramping. Long, inflexible or unpredictable work hours, commuting and mandatory overtime has been shown to have negative impacts on mental well-being by creating conflict and imbalance between the demands of work, family and non-work time (e.g. Haar et al., 2014; Jang, Park, & Zippay, 2011; Lunau et al., 2014). This was certainly the case for Ben, as his work commitments affected the amount of time he spent with his wife and young children. Some nights he would get home from work after his
children were in bed and then leave again early morning. Ben was already suffering from the emotional exhaustion which Sonnentag et al. (2010) argue can occur from high job demands and a lack of detachment from work during non-work time.

Work practices were not the only social constraints on men’s mental well-being practices. Peter’s case highlights the difficulties some men can experience in engaging in mental well-being when they are already struggling with current mental health difficulties. As Peter became increasingly mentally unwell, he found engaging in any sort of activity that could be beneficial for his mental well-being difficult. As he explained:

*I was basically eating junk food and playing lots of computer games at home and not going to bed at a reasonable hour, and I was smoking quite a lot of weed. I was really socially withdrawn, so not going out with my friends. There were periods of trying to do exercise and trying to get myself out of it, but it wasn’t enough. I was also destroying my social relationships by not maintaining them, I guess, and you know my work habits – it’s my whole life, really. Your habits, your professional reputation. Although it’s not like you are intentionally destroying your social relationships, you are neglecting them. Same with everything.*

Peter was clearly aware that his deteriorating mental health was having a negative impact on his social connections with others, his job and his physical health, but he felt unable to do much about it. Peter’s description echoes what Oliffe et al. (2010) call a “lethargic discontent”, whereby depression had negative impacts on men’s physical well-being (p. 469). For Peter, as he became increasingly depressed, his loss of physical and regular activities led to a sedentary lifestyle and social isolation. He described these periods of deteriorating mental and physical health as
“meltdowns”. Peter’s usual strategies of socialising with friends and exercising were no longer effective enough coping strategies.

Peter’s case provides an example of what Keyes (2002) would term “languishing” in terms of mental health. He experienced mental illness and low levels of mental well-being. At this point Peter benefited from medical treatment, as his depression was constraining his ability to engage with his mental well-being. He eventually sought help from a doctor and was prescribed antidepressants, which he found helpful. Within weeks, he started to feel better and was able to going running regularly and socialising again with his friends.

Likewise, Nathan’s current social circumstances and mental health difficulties were constraining his ability to engage with practices beneficial for his mental well-being. Nathan had returned to university, following two previous attempts to engage in his studies. He struggled to make new friends and worried that people may think he was “a loser or something” because he had been unable to complete his degree. Nathan stated that he needed “to feel good about himself” before he could socialise with other people and he currently did not feel that way. He would rather “stay away” from people when he was feeling unhappy. Nathan was socially isolated and as he said had no one “to hang out with and do stuff”.

As discussed in Chapter 6, Nathan’s lack of social networks meant he relied increasingly on his girlfriend as his sole avenue for support and connection. However, this was increasingly causing problem in their relationship and it seems she had had enough of being his sole supporter. Combined with these social and relationship problems, Nathan was also struggling financially. During the interview, Nathan was not only distressed but stated he had only volunteered because he had no money. Nathan’s current poor mental health and lack of financial and social resources were seriously hampering his ability to engage in any practices that would contribute to his mental well-being.
9.7 Conclusion

This chapter provides insights into the diverse ways in which the men in this study engaged with their mental well-being. These findings draw attention to both the benefits and limitations of particular mental health-promoting strategies, an area which has been largely overlooked in the men’s mental health literature. Five distinct patterns were identified from the life-history data.

In the first pattern, one man pursued good mental health as a way of life through the embodiment of an alternative masculinity, which resisted hegemonic emotional, social and work practices. In doing so, he enjoyed meaningful emotional and social relations with other men and women; he pursued a non-typical masculine career, which aligned with his passion, values and beliefs; he was heavily involved in the domestic labour in his family and the emotional care of his young children. He also embraced a philosophy in his everyday life where he lived in the present, ensuring that his way of being a man in the world aligned with his belief system. For him this was “thriving” and promoted overall good mental health.

In the second pattern, men’s engagement with their mental health was associated with typically masculine sports, physical activities and outdoor pursuits. For these men, engaging in these practices was not just a contributor to good mental health, but also a signifier of masculinity. While the mental health literature emphasises the benefits of physical activity and exercise for mental well-being, for example by improving mood and decreasing anxiety and stress (e.g. Biddle, 2016; Lubans et al, 2016; Mammen & Faulkner, 2013; Mitchell, 2013), it often overlooks the gendered or social context of mental health-promoting activities. For example, for a number of men in this study, these practices were individualistic pursuits and lifestyle behaviours and not about actively engaging in friendships or social relations with other people. While these undoubtedly confer both direct and indirect benefits for mental health, they are limited in terms of building the social and emotional aspects of mental well-being which are fundamental to overall mental health.
In the third pattern, prioritising time on their own and with their female partners was a key strategy for some men in supporting their mental health. For these men, their strategies were often a way of coping with the demands of modern life, in terms of busy work schedules and long hours, which took their toll on men’s physical and mental health. Time alone helped men to disengage from the stress of work. Time spent with partners built and maintained emotional connections within their relationships and contributed to emotional well-being.

In the fourth pattern, men developed their own health-promoting strategies when their engagement with mental health professional failed to provide resolution for their personal difficulties. Although meditation, yoga and engaged learning helped these men to manage their distress and anxiety and offered temporary relief, these strategies did not address the more fundamental social causes of men’s personal difficulties. In particular, they could not help men to resolve the internal conflict they experienced due to the social constraints of hegemonic masculinity. For example, these strategies were clearly inadequate to address men’s emotional ambivalence, unresolved grief or issues of sexuality.

The final pattern highlighted the difficulties some men have in engaging in mental health-promoting activities due to work constraints, mental health difficulties and a lack of social resources. It would appear that men’s engagement in their mental well-being requires more than individual intent; it also requires aspects of their social environment to be conducive to mental well-being.
10.1 Summary of the study

While a growing body of work has sought to understand the complex relationship between masculinities and men’s experiences of mental illness, namely depression, limited attention has been given to men’s mental well-being. The aim of this study was to explore the everyday social practices of a group of New Zealand men who do not have a diagnosable or self-reported mental illness, but whose state of mental well-being may be hampering their ability to live a happy and fulfilling life (Conrad & White, 2010).

The study specifically used Connell’s framework of gender relations to consider men’s emotional practices, work-related practices, social support and social relationships, help-seeking practices and men’s engagement with their mental well-being. The life-history method combined with gender-relations theory, detailed in Chapter 3, was used to create case studies for each man’s life story. These life-history case studies enabled me to identify multiple patterns of masculinities and to understand how masculinity is constructed and negotiated in different social contexts and through diverse social practices. The four patterns of masculinity that were identified in this study were presented in Chapter 4. These comprised hegemonic, ambivalent, marginalised and resistant masculinity.

This study points to a number of interesting and new ideas in relation to men, masculinities and mental health. The findings in Chapters 5, 6, 7, 8 and 9 illustrate the diversity in men’s social practices and their implications for mental well-being. They also highlight how men are active agents in constructing their masculinity through these social practices. Whether men pursued or resisted a hegemonic pattern of masculinity, their social practices had implications for mental health.
This study makes an original contribution to the current research on men’s mental health in a number of ways. First, it contributes to the small but growing body of research on masculinities and men’s mental health by highlighting the diversity of masculinities among men without mental illness. Second, it provides new insights into the relationship between masculinity, men’s emotional lives, work lives, social support, and how men engage with their mental well-being. Third, the theorised life-history method addresses some of the existing methodological challenges that health researchers experience in applying gender-relations theory in their qualitative health research. Finally, the findings of this study have implications for promoting men’s mental health in the New Zealand context and they suggest that looking further upstream at men’s everyday mental well-being may be one way of contributing to our lack of understanding of what hinders men’s mental health and leaves a man at risk of mental illness or suicide.

This chapter is organised around these contributions. I begin by discussing the different patterns of masculinity that arose in this study and their links to mental well-being. Thereafter, I discuss the findings of this study in the context of existing research and consider how they challenge and enhance our current understanding of men’s mental health. Following this, I provide critical reflections on some of the methodological issues of this research. Finally, I consider the implications of the study findings and offer suggestions for future research in the area of men’s mental health.

10.2 Multiple masculinities and mental health

Life-history case studies were created for each man’s story using the theorised life-history method detailed in Chapter 3. These case studies enabled me to understand how the men in this study constructed masculinity through everyday gendered social practices. Four distinct patterns of masculinities became visible from the life-history data of the fifteen participants. These comprised patterns of hegemonic, ambivalent, marginalised and resistant masculinity. These four patterns, which I
will now discuss, highlight the heterogeneity among the masculine projects of the men in this study, the tensions and contradictions which can arise within each man’s masculine project, and the diverse implications men’s masculine projects have for men’s overall mental health.

The first pattern noted in the data, exemplified by Ben (Case Study 1, Chapter 4), indicates that some men pursue a *hegemonic pattern of masculinity*. The social practices of these men included restricted emotional practices, confined social relationships with men and women, the pursuit of paid work, the rejection of professional help-seeking and varied engagement in mental well-being activities. This pattern tended to have personal costs for men’s mental well-being through a lack of meaningful emotional connections to others, limited social relationships with other men, external pressures from pursuing paid work and the denial of help or support from others during times of need.

The second pattern noted in the data, exemplified by Zac (Case Study 2, Chapter 4), indicates that some men pursue a more *ambivalent pattern of masculinity*. The social practices of these men included the questioning of their emotional practices, difficulties in creating closer social relationships with other men, and emotional conflict between their public work lives and private emotional lives. These men actively went against dominant notions of men’s help-seeking to seek professional support when experiencing personal difficulties. These men actively engaged in mental well-being practices but still faced considerable unresolved tensions in their masculine projects, which led to ongoing symptoms of mental illness i.e. depression and anxiety. This pattern often meant men were vulnerable in terms of both their masculine project and their overall mental health.

The third pattern noted in the data, exemplified by Kieran (Case Study 3, Chapter 4), indicates that some men can pursue an *ambivalent, marginalised pattern of masculinity*. The social practices of this pattern reflect the intersection of masculinity, indigenous ethnicity and the historical process of colonisation in New Zealand. While this pattern included the ambivalent emotional and social practices described above, it also included the work and education practices of a marginalised
masculinity. This pattern included attempts to recoup power and change social class through education and reconnection to Māori culture. This pattern points to aspects of building mental well-being that are particular to Māori men in New Zealand, including the importance of breaking the cycle of inter-generational cultural disconnection and socio-economic disadvantage.

The fourth pattern noted in the data, exemplified by Ethan (Case Study 4, Chapter 4), indicates that some men can pursue a resistant pattern of masculinity. The social practices of this pattern of masculinity included rejecting the concealment of socially feminine emotions, refusing to embody masculine emotions such as anger, creating closer social relationships with men and women, resisting undertaking socially masculine work, actively seeking help and support from others, and taking self-responsibility for managing their mental well-being. This pattern suggests that rejecting the hegemonic pattern of masculinity can provide opportunities for men to pursue social practices that are more beneficial for overall mental health, such as meaningful emotional relationships with others, closer connections with children and family, and engaging in fulfilling paid and unpaid work.

It is important to emphasise that these patterns of masculinity are not fixed categories and participants did not always fit neatly into one pattern. For example, while only one man in this study exemplified the pattern of resistant masculinity, aspects of resistant emotional, social and work practices were identified within the stories of men who were pursuing an ambivalent masculinity. As detailed in Chapter 3, one of the strengths of the theorised life history is it allows for the examination of the complexities and contradictions in the construction of masculinity. Connell (1995) refers to this as the “making and unmaking” of masculinity within each man’s story (p. 92). Thus, the four patterns of masculinity described here were configurations of social practices, which were clearly identifiable in men’s current patterns of practice, but participants at different moments of their lives may have engaged in social practices from different patterns of masculinities.
These findings extend current understanding of men's mental health by demonstrating not only the diversity of masculinities but also men's diverse mental health experiences. In Chapter 2, I discussed Keyes model of complete mental health which underpinned the concept of mental health used in this study. According to this model, it was possible to identify men in this study who (i) experienced high levels of mental well-being and no mental illness; (ii) men who experienced low levels of mental well-being and no mental illness; and (iii) men who experienced minimum mental well-being and symptoms of mental illness (see Figure 2 with blue circles highlighting these groupings).

Figure 2: The diverse mental health experiences of the men in this study based on the complete mental health (adapted from Keyes 2013, p. 17)

This study suggests that whether a man pursues a hegemonic pattern of masculinity, remains ambivalent or embodies a resistant masculinity, there are varying costs and benefits to his overall mental health. It also highlights the social aspects of men's lives which can hinder mental well-being and leave men at risk of mental illness. The findings of this study confirm Conrad and White’s quote which
opened this thesis: that there are men who do not have a diagnosable mental illness and who will never seek help, but whose state of mental well-being is hampering their ability to live a “happy, well-balanced and fulfilled life” (2010, p. x)

10.3 Discussion of findings and relationship with previous research

10.3.1 Emotions and mental health

Emotions emerged as a major theme in the life-history data. The findings in Chapter 5 provide insights into men’s emotional lives and demonstrate the diverse and complex patterns of men’s emotional practices. These findings contradict the psychiatric literature that assumes all men suppress their emotions (e.g. Brownhill et al., 2005; Martin et al., 2013; Rice et al., 2015) and the psychological literature which argues that men are socialised to conform to a single male role that entails the restriction of all emotions (e.g. Syzdek & Addis, 2010; Tsan et al., 2011; Vogel, Wester, & Larson, 2007; Wester et al., 2007). Instead, the findings from this study illustrate that not all men conform to the hegemonic practice of concealing emotions. Rather, the men in this study were active agents in their emotional practice and could conform to or resist the hegemonic masculine ideals of emotionality within different social contexts and within different social relations with others.

The dominant practice of men in this study was to conceal emotions such as sadness, distress and crying in order to be seen by others as emotionally self-sufficient and to ensure their masculine status was not undermined or threatened. This finding furthers previous research examining the links between depression and the concealment of emotions (e.g. O’Brien et al., 2007; Oliffe et al., 2012; Oliffe et al., 2011) by demonstrating how men without any specific diagnosis or self-reported history of depression can embody the practice of emotional concealment. Furthermore, this practice was detrimental for men’s mental well-being.
This research also highlights how this practice can have significant consequences for men who experience emotional trauma as boys and adolescents through the death of a parent or sibling. For men in this study who lost a loved one, without professional or family encouragement to talk about their distress, continued to conceal their grief and distress for many years. The impacts of this sort of unresolved grief on mental health have been shown to include increased risk of depression and suicide (e.g. Bylund-Grenklo et al., 2016; Stroebe et al., 2007). My research suggests that the messages boys receive from family and peers about restricting particular emotions and the ongoing social expectations on men to conceal prohibited socially feminine emotions has long term consequences for men’s mental well-being and puts some men at increased risk of mental illness and even suicide.

This study also raises questions regarding men’s reliance on women for talking about their emotions. A number of men were complicit with hegemonic masculine ideals and concealed socially feminine emotions in particular social contexts, such as in the workplace or with male friends, but in private, away from the view of other men, they would express these emotions within the safety and privacy of their social relations with women. Oliffe et al. (2011) have demonstrated how some men with depression will only talk about their mental illness and allow themselves to be emotionally vulnerable in the privacy and safety of their intimate relationship with women. The findings from my study build on Oliffe’s work in two ways.

First, this study highlights that the pattern of relying on women in private for discussing emotional issues is present in men without mental health problems or depression. The majority of men in this study perceived women as the appropriate avenue for expressing prohibitive socially feminine emotions. As Connell (2005) has argued many men benefit from patriarchal emotional relations that provide them with emotional support from women without the need to reciprocate.

Second, this study points to the problematic nature of men’s reliance on female partners for expressing their emotions. If partners no longer want to be the sole avenue for men’s emotional difficulties, this can lead to tension within
relationships, which in turn has implications for the mental well-being of men and women. For others, there is a risk that in the event they became divorced, single or widowed they are left with no other safe avenues for emotional relations. This practice also reinforces gender stereotypes and the “common sense” belief that women are the listeners, carers and providers of emotional support to men and that men should not express or talk to other men about prohibitive socially feminine emotions. Put another way it maintains unequal power and social relations between men and women and does nothing to benefit emotional relations among men.

My research also provide new insights into men's ambivalence around their emotional practices and suggests that the longer this ambivalence or questioning remains unresolved the more likely it is to impact mental well-being and put men's mental health at risk. Some men in this study experienced tension and contradiction in their masculine projects as they wavered between conforming to the hegemonic practice of concealing emotions and their desire for a more open pattern of emotional expression. This ambivalence was often the result of men's experiences of significant life events such as the death or illness of a family member, or becoming a father for the first time.

This finding builds on the work of Lomas et al. (2013) who have highlighted how men's past experiences of negative and distressing events can be a catalyst for changing their gendered emotional practices. However, unlike men in Lomas' study, who had the support of other men, through what he termed a community of practice which encouraged and support changes in social practice, the men in this study had limited support from others for resisting the hegemonic practice of emotional concealment. While the questioning of emotions by some men in this study had the potential to push them towards an alternative resistant masculinity, where a more open emotional practice could be embodied, for most this ambivalence was accompanied by uncertainty and confusion. Until this tension in their masculine project could be resolved, it hindered their mental well-being and left their overall mental health at risk.
The findings in Chapter 5 also draw attention to the link between anger, a socially masculine emotion, and men’s mental well-being. While the majority of men in this study concealed socially feminine emotions in public, they were less wary of expressing anger and blame, particularly towards women. Thus, anger was a resource for men in constructing hegemonic masculinity with many viewing it as a characteristic that was inherently “natural” to men. My findings extend the work of Oliffe et al. (2012) who show that the expression of anger and aggression in men with depression is partly a means of communicating pain and dissipating the frustration associated with depression, by pointing to the implications of men’s expression of anger for gender relations and mental well-being.

The problem with anger being viewed as natural to men or as an expression of depression is that it overlooks the fact that anger is deeply implicated in the exercise of gendered power relations and an emotion related to a sense of entitlement (Shields, 2002). For many men in this study, openly expressing anger and blame towards women, particularly ex-partners, was often related to the breakdown of heterosexual romantic relationships and, in a number of cases, divorce. For these men, expressing anger had implications for their social relations with women leading to fractured relationships, harboured feelings of resentment and negative views of any future romantic relationships with women.

Dominey and Dominet (2010) argue that being able to manage anger in a healthy way is essential for men’s mental health and for not damaging the mental well-being of those around them. However, if anger is “invisible” as an emotion, or seen as something that is natural to men or simply a consequence of depression, it raises questions about how men can be expected to understand anger as something that needs to be understood and managed in the interest of their and others’ mental health and well-being.

Finally, the findings in Chapter 5 demonstrate that it is not the case that all men conform to this hegemonic pattern of emotionality. One man in this study actively and openly contested hegemonic patterns of emotionality, expressing socially feminine emotions and rejecting socially masculine anger. My findings extend the
work of Lomas et al. (2013) who demonstrate how men’s engagement with their emotions can be facilitated by men’s connection to new communities of practice, by demonstrating the possibilities for mental well-being if men are able to resist the hegemonic patterns of emotionality and embody a resistant masculinity in both their public and private lives. In other words, not just among particular communities of men but as an everyday resistant social practice.

10.3.2 Social support and mental health

The findings in Chapter 6 offer new insights into men’s diverse social support networks and social relations with other men and women. These findings challenge the social science literature which frames men’s social relationships as being purely instrumental (e.g. Balaswamy, Richardson, & Price, 2004; Fiori & Denckla, 2012; Matud et al., 2003) and demonstrates the diverse ways in which men seek and receive support from their social relations. While some men in this study differentiated between the social relations they had with men and women, others experienced difficulties trying to establish supportive relationships with other men. Some men had well-established social relationships with family and friends, but would not use these connections for support in the event they needed it. Finally, not all men relied on women for support; some men created close supportive relationships with both men and women.

The dominant practice of men in this study was to differentiate between their social relations with men and women. While social relations with men were kept mainly instrumental, based around social and physical activities, social relations with women involved confiding, sharing and disclosing personal issues. Both these types of social relationships conferred benefits for men’s mental well-being and provided avenues for social connection with men through shared activities and emotional support through friendships with women. These findings support the work of Robertson (2007) who argues that while instrumental relationships are often framed in the literature as a “poor second to, or polar opposite to emotional depth
and intimacy”, they still provide men with a means of connecting and supporting each other through shared activity (p. 118). My findings also extend Robertson’s work by drawing attention to the limitations of mens’ differentiating of their social relationships for supporting mental health.

That is, the stereotyping of men’s social relations as predominately instrumental or based purely on physical activities can reinforce cultural ideas of men as problem-solvers and doers, rather than as listeners and talkers. This in turn can create barriers for men who want to seek support from their male friends and have supportive relationships with men that involve listening, sharing and discussing men’s concerns. For some men in this study, despite their attempts to confide in and share their difficulties with other men whom they deemed to be close and safe, they did not receive the support they had hoped. Instead, the lack of response left them feeling embarrassed, ashamed and second-guessing whether they should not have crossed the unwritten rules of men’s social relationships. This was detrimental for men’s mental well-being. This finding also extends the work of O’Brien (2007) and Coen et al (2013), who highlight the difficulties some men experience in attempting to talk to other men about their depression, by demonstrating how men without mental illness can experience difficulties talking about personal issues that are unrelated to their mental health.

The findings in Chapter 6 also contribute to the existing masculinities and men’s mental health literature by drawing attention to the mental health risks for men who do not currently have a mental illness and downplay the need for any sort of social support from men or women. In other words, men who expressed an overriding desire to remain independent and self-sufficient at all times. For these men, their social support practices echoed their hegemonic emotional practices and they viewed sharing intimate details about their personal lives with anyone as a socially unacceptable practice for men. In the event these men experienced personal difficulties such as a relationship problems or work problems these men would not only conceal their problems but they would reject any offers of support.
This practice blocked mental and social well-being and put their overall mental health at risk.

Contrary to Seidler's (1992) argument that men do not ask for support in their friendships because they find it hard to be vulnerable and risk rejection, some men in this study actively reached out for support from their male friends. A few men in this study actively sought and built supportive social relations with other men that were more than the activity-based companionship other men in this study described. The key to these closer social relations was meeting men who were willing and receptive to having male friendships based on openness, confiding and the mutual sharing of support. In other words, seeing the embodiment of meaningful social relationships with other men who go against social expectations around men's friendships, enabled some men to create closer social relations with both men and women. Furthermore, not only did these social networks provide men with support during personal difficulties, they also provided men with supportive social networks in their everyday lives, which supported and enhanced their mental and social well-being.

10.3.3 Work and mental health

The findings in Chapter 7 provide interesting insights into men's career choices, domestic relations and the links between the pursuit of masculine paid work and men's mental well-being. For the majority of men in this study, full-time paid work was a resource for actively constructing masculinity. Some men had successful well-paid jobs but became disillusioned when they failed to receive the secondary emotional gains they had expected. Some men established traditional gender relations with women, but their masculine project became derailed when these gendered arrangements broke down. Other men became ambivalent about their paid work and career choices, and pursued work which was more satisfying and enjoyable. For one man, his resistance toward pursuing traditionally masculine work was clearly beneficial for his mental health.
As noted in Chapter 2, the links between men’s education, paid work and depression have been demonstrated by men’s health researchers (e.g. Coen et al., 2013; Oliffe et al., 2012; Oliffe et al., 2011; Oliffe et al., 2010; Oliffe et al., 2013; Oliffe et al., 2010; Valkonen & Hänninen, 2013). The findings in this chapter build and expand on this work by showing that men without mental illness can experience low levels of mental well-being and are at risk of experiencing mental illness as a result of their paid work. For some men in this study their middle-class family backgrounds had given them the resources to pursue a hegemonic pattern of masculinity through university education and particular career choices. Despite this, they experienced a deep sense of disappointment and disillusionment in their lives.

This disillusionment occurred because the feelings of success, accomplishment and happiness that these men had expected to result from this pursuit did not eventuate in their private lives. This led them feeling unhappy, dissatisfied and in some cases depressed with their lives. This finding extends Lomas’ (2013) study who reported that some men tried to use paid work as a means of resolving their emotional problems, yet it failed to bring the fulfilment and satisfaction they had hoped. My research suggests that even for men who do not experience emotional or mental health related problems, the pursuit of hegemonic masculinity through paid work can lead to a lack of fulfilment and enjoyment which in turn constrains men’s mental well-being and puts their overall mental health at risk.

My findings also support and extend the work of Coen et al. (2013) and Oliffe et al (Oliffe et al. 2011) who have illustrated how traditional gendered divisions of labour within men’s heterosexual relationships can both help and hinder men’s ability to manage their depression. For some men in this study, the gendered division of labour had both costs and benefits for their mental well-being. For instance, some men were able to pursue masculine careers outside of the home precisely because their partners stayed at home to care for their children or supported the running of their household. This was often beneficial for men’s mental well-being as they were able to pursue the pattern of hegemonic masculinity and felt successful and accomplished in their careers.
However there were also costs to this pursuit. Some men felt conflicted between being financial providers for their family and spending more time with their children; for others, divorce and separation derailed their masculine project and their pursuit of hegemony through paid work; and for some divorce and separation led to difficulties in continuing this pursuit because they struggled to juggle their careers and being a parent. These costs were detrimental to men’s mental well-being and carried risks for their overall mental health. My research supports Schofeild et al.’s (2000) assertion that both the workplace and families are key settings where men and women’s daily lives are not only intricately interwoven, but consist of particular arrangements of social practice which can both help and hinder the health of men and women.

This study also provide new insights into the links between men’s paid work and mental health, by drawing attention to the impact of work-related institutional policies on men’s lives. For example, a number of men in this study were expected by their employers to work long hours, including overtime, which took them away from spending time with partners and young children, and limited their social connections with friends. Despite the New Zealand government providing guidance around workplace policies to enable employers to adopt flexible working arrangements (Ministry of Business Innovation & Employment, 2016), most men in this study had not experienced this flexibility in their paid work. As Connell (2005) argues while working long hours may be good for job security or promotion prospects, it can lead to a loss of balance between work and family. This loss of balance had consequences for men’s mental and social well-being.

For other men in this study, restrictive government paid parental leave entitlements overshadowed becoming fathers for the first time. Current entitlements in New Zealand mean that men who are not going to be the primary carer of their children and remain in paid work are only entitled to one to two weeks of unpaid partner’s leave (Ministry of Business Innovation & Employment, 2016). This makes it difficult for men who want to be more involved in the care of their children, but also remain in the working economy for financial reasons. The current
parental leave policies could constrain men’s mental well-being in the short term, through financial stress and limited time and connection with their new-born baby. O’Brien (2009) has argued that policies which provide access to extended parental leave and income replacement have the potential to boost fathers’ emotional investment in and connection with their children, because they are able to able to spend more time at home without financial consequences. This clearly has positive implications for men’s mental well-being.

Finally, the findings in Chapter 7 provide new insights into how some men are able to resolve the tensions created by pursuing a hegemonic pattern of masculinity through paid work. Some men in this study renegotiated their work trajectories in order to embody a more caring masculinity but in a socially masculine work environment: for example, social and care work within the military, and community work with young people within sport and recreation. This work brought a sense of fulfilment, enjoyment and satisfaction for these men without having to outright reject traditionally masculine work. This enhanced their mental well-being. In contrast, one man outright resisted traditionally masculine work and became a self-employed artist and took on the domestic labour within his family which was beneficial for his mental well-being.

My research provides a point of difference from the current literature on men’s work practices and depression by highlighting aspects of men’s work lives that can not only leave men without mental illness at risk of mental health problems, but also work practices that can promote the mental well-being of men.

10.3.4 Help-seeking and engagement with mental health professionals

The data presented in Chapter 8 illustrates the diverse help-seeking practices of the men in this study. The findings demonstrate the need to acknowledge that there is no single pattern of help-seeking among men and that we need to consider the help-seeking practices of men without diagnosed or self-reported depression.
Over half the men in this study actively sought professional help and support for a range of diverse needs and personal problems in their lives, including relationship and work issues, alcohol use, unresolved grief, emotional difficulties and a general desire to talk to someone for support. These men engaged with their mental health, even though they did not necessarily frame it within a mental health or illness discourse. They were clearly aware when they were struggling with everyday life and it was affecting their mental well-being and happiness. This is important, because it suggests there is a need to look upstream at how men without mental illness recognise potential problems with their mental health before it escalates to mental illness, rather than focusing solely on men’s recognition of depression (e.g. Brownhill et al., 2005; Chuick et al., 2009; Rochlen et al., 2010).

The findings also draw attention to the openness of some men’s help-seeking practices as they did not attempt to hide it from others. These men openly resisted hegemonic masculinity in terms of their help-seeking behaviour and were not concerned about being seen as weak or unmasculine. However, others hid their help-seeking from family and friends. While these men wanted professional assistance with their personal difficulties, they were not entirely comfortable going against the dominant hegemonic view of help-seeking. These men were aware that seeking help challenged their masculine status and attempted to rationalise their decision to seek help, either framing it as a necessary and desperate action as they could no longer cope, or a sensible way of understanding their situation. These findings support and build on the few studies that have demonstrated the multiple patterns of active help-seeking practices for men with depression or suicidal behaviour (e.g. Johnson et al., 2012; O’Brien et al., 2005; River, 2016) by highlighting the help-seeking practices of men without mental illness.

River (2016) argues that it is not just the decision to seek help that is important for men’s interactions with health professionals, but also whether the help and support men receive actually addresses their issues. The men in this study had varied interactions with mental health professionals. For some, the support they received was helpful in addressing their distress and emotional problems, and they valued
the disclosure and openness allowed and encouraged in the confines of a safe place. For others, help-seeking was problematic and failed to resolve their personal issues. There were a number of reasons for this, including limited access to ongoing services, addressing long-term unresolved grief, lack of help resolving work-related issues and the psychiatric framing of personal concerns. While some men pushed on, finding alternative sources of professional help, finances or a lack of availability of alternative services limited others from seeking further help. My research suggests that it is important for psychological and health services to address the mental health needs of men without diagnosed or self-reported mental illness.

The findings in Chapter 8 also provide new insights into the avenues through which men access psychological services for issues which are impacting on their everyday mental well-being. Many men in this study used fully or partially funded psychological services provided by university or employer assistance programmes. In a number of cases, ongoing engagement with mental health professionals was prohibitive due to the financial cost of ongoing therapeutic sessions beyond the limited number subsided by employers. This finding supports the recent observations of Roy et al. (2014) that seeing a therapist in private practice is a financial investment that can be hard for some men to meet, particularly when financial difficulties are contributing to the mental health issues which men are experiencing.

Finally, the findings also echo the work of O’Brien et al. (2005) and Johnson et al. (2012) who have demonstrated how hegemonic masculine ideals can act as a barrier to men’s help-seeking for depression because it implies a loss of independence, weakness and compromises men’s masculine status. Some men in this study rejected the notion of seeking help from mental health professionals and viewed mental illness as feminine and something only women suffer from, not men. Courtenay (2000) refers to these health-related demonstrations of gender as forms of “micro level power practices” which enable men to reinforce cultural beliefs that men are less vulnerable than women and that their bodies are structurally stronger than women’s (p. 1389). By aligning their mental health beliefs and behaviours
with hegemonic ideals, some men in this study reinforced cultural beliefs that men are mentally stronger than women and that asking for help for one’s mental health is feminine.

Like men in O’Brien et al.’s study who would rather stay “strong and silent” about mental health or emotional problems than seek help (p. 514), some men in this study remained silent despite experiencing poor mental well-being and emotional difficulties. This finding is important because it suggests there is a need to move beyond the focus on barriers to help-seeking for men with diagnosed or reported mental illness, to explore the barriers for men who may be experiencing problems with their mental well-being that could potentially escalate to mental illness.

10.3.5 Mental health-promoting practices

The findings in Chapter 9 provide new insights into the diverse mental health-promoting strategies of men. In her review, Hoy (2012) draws attention to the dominant focus in the men’s mental health literature on what she refers to as “maladaptive” or “avoidant” coping strategies (p. 214). These include practices such as using alcohol, substances, sex and paid work to distract oneself from experiences of distress and depression. In contrast, researchers give is less attention to men’s “adaptive” coping strategies, or the practices men use to manage their distress and depression effectively, such as remaining active or socialising with others (2012, p. 214). This study enhances the current men’s mental health literature by demonstrating how men without mental illness engage in diverse practices to maintain good mental health.

The dominant practice of men in this study was to use physical activities, sport and outdoor pursuits understood as socially masculine, such as rugby, cricket, surfing or going to the gym (see Espiner et al., 2011; Wheaton, 2000) to engage with their mental well-being. While these practices conferred direct and indirect benefits for men's mental health through improving physical health, contributing to a sense of
mental well-being; and providing relief from the stresses of everyday life, this research suggests there are also limitations to these practices.

Many of these activities were engaged in alone or in small groups with other men where social and emotional interactions were limited, and women were largely excluded. In contrast to Robertson’s (2003) study, where some men viewed sport as a means of actively engaging in friendships, only one man in this study described sports and physical activities as a social practice for building and maintaining social relations. For others, their engagement in physical activities and sport lacked the socialising with others that could be beneficial for men’s mental and social well-being and reinforced restricted emotional and social relations between men.

This study supports Robertson’s (2003) assertion that health-promotion activities need to be more critical of the gendered and social context of particular strategies, such as sport, for promoting men’s mental health. It seems that for some men in this study, framing socially masculine activities as mental health-promoting strategies, with less emphasis on practices regarded as socially feminine (see Stalp, 2015), enabled men to maintain their masculine status and present themselves as strong, self-sufficient and independent in regards to managing their mental health and well-being.

In contrast, some men emphasised friendships with other men and women, socialising with friends and colleagues, and spending time with partners and family members. For these men, these strategies involved social and emotional connections with others, which contributed to men’s emotional and social well-being. For example, Ethan had close relationships with other men who shared his passion for art and they would talk at length about their personal lives, feelings, problems and aspirations. Likewise, Kieran would go to the pub and socialise with his male friends, talking about their personal lives and current issues. These findings point to the opportunities for building and maintaining men’s mental well-being through promoting social and emotional connections among men.
The findings in Chapter 9 also support the work of Robertson (2007), who argues that men rarely reflect on “health” as an abstract concept; rather, being “healthy” is understood as an experience which is realised “in and through everyday life” (p. 68). For many men in this study, their understanding of mental well-being or being mentally healthy, as opposed to mental illness, was so integrally linked to everyday life that in describing how they maintained their mental well-being, they described activities which occurred through everyday life. For instance, some men described how if their body felt run down, their mind felt run down. Others described how looking after their mental health was about ensuring they maintained their ability to function in their everyday lives in terms of paid work, romantic relationships and family responsibilities, and included activities such as down time, sleep and rest.

This study also provides new insights into the constraints on men’s engagement with mental health-promoting practices. For some men, existing poor mental health made it difficult to engage in social or physical activities, because they were already struggling with everyday life. For others, paid work and taking on other responsibilities, such as children, left little time for the things they enjoyed. For a few men, pursuing individual personal development strategies, such as meditation and yoga, alone and away from the view of others, while framed as promoting well-being, were more about alleviating distress. My research suggests that recognising aspects of men’s broader social lives that can create barriers to engaging in daily mental well-being practices, and acknowledging the limitations for those men already experiencing symptoms of mental illness, are key considerations in helping men to engage with and support their mental well-being.
10.4 Critical reflections on the thesis

10.4.1 Strengths of the study

This study makes several original contributions to research on men's mental health. First, it demonstrates the value of the life-history method combined with the theoretical framework of gender relations in examining men's lives in relation to mental well-being. The theorised life-history approach makes gender visible within men's stories and everyday social practices. This enabled me to theorise the links between masculinity, social practices and mental well-being within men's individual stories and to explore patterns of social practice across men as a group. In doing so, I was able to identify multiple patterns of masculinities, diverse patterns of emotional, social, work and health practices and men's varying experiences of mental health.

Second, a structural gender-analysis using Connell's four substructures of gender (power, production, emotions and symbolism) gave me the means to explicitly examine aspects of men's everyday lives that have remained largely overlooked in the mental health literature, including men's emotional relations, men's social relations with women and social support practices. Connell (2005) argues that a focus on the gender relations among men is needed to keep the analysis "dynamic" and to ensure the identification of multiple masculinities does not end up as character types (p. 76). This study overcomes some of the challenges health researchers experience in applying gender relations to qualitative studies on men's health and demonstrates the value of an explicit gender-relations analysis for examining men's mental health.

Third, this study demonstrates the value of moving beyond a sole focus on men's depression and exploring men's broader mental health. By recruiting men from the community, using criteria that did not restrict participants to diagnosed or self-reported depression, I was able to collect the life histories from men with diverse experiences of mental health. Further, this study was underpinned by a broader concept of complete mental health that acknowledged that men can experience
varying degrees of mental well-being and symptoms of mental illness (Keyes & Michalec, 2010). Thus, while I did not seek to sample men who had experienced depression and mental illness, I did not exclude men who experienced significant emotional distress and despair in their lives. By doing so, this study provides a point of difference to the current research on men’s mental health. It highlights the social and gendered aspects of men’s lives which promote mental well-being among men who do not have mental illness, as well as what hinders mental well-being and leaves a man at risk of mental illness.

Fourth, the use of life-history narratives in this study provides an extremely powerful and moving way of telling men’s stories. This story telling could lend itself to mental health awareness campaigns which are male friendly. I pick up on this further in section 10.5.1.

10.4.2 Limitations of the study

The limitations of this research in many ways reflect the challenges of exploring the social reality of people’s lives and the subjectivities of health and illness. The theorised life-history method worked better for some participants’ stories than others. One man’s story, Nathan’s, was chaotic and disjointed, making it difficult to organise into a life-history case study. While there were aspects of his story which aligned with that of other participants, his story had many contradictions which were difficult to make sense of. It may be the case that Nathan’s level of emotional distress at the time of being interviewed made his story particularly incoherent.

Alternatively, the gender-analysis might have been constrained by the limitations of Connell’s structural model of gender relations. Connell (2012) notes that her model may have difficulties in analysing gender relations in post-colonial countries which have a particular social history. In New Zealand, for instance, Hokowhitu (2015) has described how British colonial masculinity merged with indigenous Māori culture to create “hybrid post-colonial” cultures (p. 85). Thus, gender relations can change and evolve in different directions in different countries due to difference
social histories. It may be the case therefore that the gender-relations analysis used in this study was limited in capturing the current gender order within contemporary New Zealand. However, it did bring to light the impact of colonisation and the exclusion from economic, cultural and educational opportunities of Māori men and the consequences of this for mental health.

While researchers working in a positivist paradigm might argue that the sample of men who agreed to be interviewed in this study is not representative, life-history research does not target large and representative samples in order to draw generalisations (Cole & Knowles, 2001; Messerschmidt, 2000). The aim of this study was not to generalise the findings to all men in New Zealand, but to integrate an under-theorised area and gain a deeper understanding of the relationship between men’s everyday social practices and mental well-being. Nonetheless, my research does provide an initial understanding of the complex and diverse ways in which the broader gendered social context of the New Zealand setting can influence the mental health of men.

With this in mind, it is important to acknowledge that this study captures the rich life stories of a particular cross-section of New Zealand men (Patton, 2002). The findings are constructed through interviews with fifteen men, recruited through the Wellington community who were willing to participate in the research and talk to me about their personal experiences. The subject of this research was interesting enough to prompt these men to respond to my invitation and make time to meet with me. It may be, therefore, that these men self-selected because the research topic resonated with them, because they had experienced particular life events. A number of men told me they participated because they wanted to help improve the lives of other men.

Finally, all but one participant had a university education, which could reflect changes in the education opportunities for men in this age group in urban contemporary New Zealand. The consequence of this is that the final sample of men were highly educated with a similar social class. The findings therefore may not be
suggestive of the experiences of men from lower socio-economic groups, or who have less formal or no education.

### 10.4.3 Practising reflexivity

In Chapter 3, I reflected on how my role as a female researcher may have influenced the narratives I collected. Reflecting on the research as a whole, this study was a difficult journey for me given I had never formally studied gender or the sociology of health and illness. Despite reading widely on masculinities and the theory of gender relations, I discovered that no amount of reading could really prepare me for the difficult and time-consuming nature of life-history research and a gender-analysis. Indeed, the presentation of patterns of men's social practices in the various chapters of this thesis almost belies the messier aspects of making sense of the gendered aspects of men's stories.

While my analysis was embedded within Connell's structural gender-relations approach, my own experiences of analysing and interpreting men's stories and the learning process for me as a novice gender scholar are less visible. One of the first difficulties I experienced with this framework was analysing the overlaps of the different dimensions of gender (power, production, cathexis and symbolism). They are not discrete categories; rather, they are dynamic and intersect with each other (Connell, 2009). For example, in this study, emotionality emerged as a major theme in the life-history data and it was possible to see where the data crossed over with the power relations among men and between men and women. However, it was more difficult to locate power within men's work practices. This may be because the men in this study had similar education and work trajectories, in terms of gaining university degrees and going onto full-time employment. Perhaps if I had collected the stories of a more diverse group of men in terms of paid and unpaid work I may have been able to examine power relations in more detail. However, the men's stories collected during this study were far from uniform, and the stories
of two of them did point to how a lack of education and work opportunities can lead men to become marginalised.

The second difficulty I experienced during this research was coming to grips with a “critical” analysis of men’s lives in relation to mental health. The appeal of Connell’s theory of masculinities is that it provides a critical pro-feminist analysis of masculinities, whilst also acknowledging the different ways in which individual men reproduce them (Wedgwood, 2009). However, in the early stages of analysing the life-history data, I started to feel uncomfortable and felt I was being too critical and judgemental in my interpretation of men’s everyday practices. Perhaps this was because I embarked on this research without fully understanding feminism. Despite being a well-educated women from a middle class family I had never questioned the political or social inequality between men and women. Yet, as I discussed in the introduction chapter, I had been acutely aware of the health inequalities between men and women.

Through a practice of reflexivity and reading more widely around feminist viewpoints, I started to appreciate that in order to become comfortable with my analysis and interpretation, I had to understand that feminist-informed research not only required doing research differently to how I had done it in the past, but required investigating the power dynamics within my research (Pillow, 2003). I came to understand that masculinities research must include a critical reading of gender if it is to uncover the power relations and hegemonic masculine practices which are detrimental to men’s mental health and prevent men from pursuing alternative masculinities which support mental well-being.

Third, on reflecting on my research methods I realised that the boundaries placed around the original sampling frame in this study were unnecessary, particularly given how under-theorised and under-researched men’s mental health is in New Zealand. Although restricting the sample to men born in New Zealand was based on the views of key informants’ interviews, with hindsight it might have restricted the different patterns of masculinities which could have been noted in a more diverse sample of men. Perhaps a study of men born in New Zealand cannot tell us
any more about the social influences on mental health than, for example, a study of New Zealand-born men who have spent years living overseas, or of immigrants who have lived in New Zealand for a number of years; but a study of the latter two categories would be interesting. While the men’s stories collected during this study were far from uniform (men had different family structures, childhood backgrounds, diverse experiences of life events and different overall life trajectories), I am left curious as to whether a more diverse sample of men might contribute to a better understanding of how men’s social practices influence mental health.

Finally, throughout this research I was conscious of the ethical aspects of taking participant’s stories, using their words and applying a critical lens. I am privileged that these men shared their stories with me and I am mindful of the harm that could be done if the knowledge gained from their accounts was not used in an ethical way. For this reason, as I have unpacked and compared men’s accounts I have ensured confidentiality has been maintained throughout. I have taken great care in ensuring pseudonyms are used and that identifying information has been changed without altering the meaning of the men’s stories. I have endeavoured to be honest in my interpretation and reflection of these men’s stories, using their words to support their accounts.

10.5 Implications and recommendations

In the remainder of this last chapter, I discuss the implications of my research findings for promoting and supporting men’s mental health; men’s access to psychological and mental health services; social policy; and make some recommendations for future research.
10.5.1 Promoting men’s mental health

A critical lens on gender has remained absent from mental health promotion and mental illness prevention population-based strategies in New Zealand (e.g. (Associate Minister of Health, 2006; Mental Health Foundation, 2017; Ministry of Health, 2016; Ministry of Health and Health Promotion Agency, 2014). This study suggests there is a need to critically examine mental health promotion work within a broader discourse relating to gender and gender relations.

Whilst there has been speculation in the New Zealand media that the current National Depression Initiative fronted by John Kirwan, a former All Black rugby player, has “challenged some stereotypes of masculinity” by making it seem okay for men to ask for help (see McKenzie-Minifie, 2006; Yates, 2015), there is little empirical evidence to support or evaluate this. Keppel (2014) in her critical discourse analysis of contemporary mental health campaigns asserts that the current depression campaign has resulted in the emergence of a “new national imagery” around men’s mental health promotion by encouraging men to identify mental illness and their need for help (p. 375). While this may be the case, and the campaign has made it more socially acceptable for some men to seek help for mental illness, this campaign still offers a narrow view of masculinity: the white, heterosexual, middle aged, sporting figure with a successful and financially lucrative career history. As such it has not challenged hegemonic masculinity. In fact, for some men it could reinforce negative behaviours and perpetuate masculine stereotypes by focusing on hegemonic masculine values (Smith, 2007)

Furthermore, while this campaign has undoubtedly raised awareness of depression and anxiety in New Zealand, and provided resources and support for many men and women experiencing mental illness (see Edwards, Gill, Drown, Thapliyal, & Babbage, 2016; Wylie, 2009), it does not necessarily speak to men who do not see themselves as having a mental illness but may be experiencing minimum mental well-being. In other words, those men whose state of mental well-being is blocking their ability to live a happy, well-balanced and fulfilled life, and who will never seek help or support (Conrad & White, 2010).
My research suggests there is value in mental health promotion considering the needs of men with and without mental illness, from a gender perspective that demonstrates the different ways of being a man, and in particular, patterns of masculinity which resist hegemonic masculinity through everyday emotional, social, work and health promoting practices. Put another way, an approach which not only highlights multiple patterns of masculinity, but portrays them not as character types or traits, but as arrangements of social practice that men engage in their everyday lives in different social contexts.

This approach needs to address dominant masculine ideology and social expectations around men’s behaviour which make it so difficult for some men to engage in social practices which could be beneficial for their mental health. For example, being more open with their expression of social prohibited emotions; creating and building closer supportive relationships with other men; pursuing satisfying and enjoyable paid work whilst including unpaid work caring for children; seeking help and support from friends and health professionals; and engaging with their own mental health, both illness and well-being.

Smith (2007) argues that the health-promotion community is well positioned to “strategically free men from the constraints of hegemonic masculinity” (p. 20). To do this, the narrow and uniform view of masculinity, and the ideology of the man who is emotionally self-sufficient, does not talk about his feelings and can deal with his own problems, need to be deconstructed and alternatives presented. My research suggests there could be value in developing social marketing approaches to promoting men’s mental health that demonstrate the different ways of being a man or multiple patterns of masculinities. They could also show how some patterns of masculinity are linked to improved mental health outcomes.

For example, there is value in tackling the stereotypes and cultural ideals around men’s emotional practices. Many men in this study experienced conflict in their emotional lives due to the social expectations around men’s public display of particular emotions. Consequently, most men in this study concealed emotions viewed as socially feminine, which was ultimately detrimental to their mental well-
being. Others believed that talking about socially feminine emotions was “whining” and that men should “harden up”, which as the findings in this study show, can have serious implications for the mental well-being of other men who want to talk more openly about their feelings in public or with other men. These findings suggest it could be beneficial for mental health promotion to address the damaging effects of social expectations on men (from other men and women) to restrict their emotions by demonstrating alternative masculinities where the public expression of emotion is embodied. However, there is little literature to suggest what these alternative masculinities might look like.

The Australian social marketing campaigns Soften The FCK Up (Spur Projects, 2017) and Man Up (Movember Foundation, University of Melbourne, & Australian Broadcasting Corporation, 2017) are current examples of suicide prevention campaigns aimed at raising social awareness of the links between men’s concealment of emotions and high rates of suicide, particularly in men aged under 45 years. These campaigns are to be applauded for their innovation and creativeness in reaching men. However, like the New Zealand National Depression Initiative fronted by John Kirwan, these campaigns still rely on a fairly narrow and uniform view of masculinity rather than demonstrating alternative masculinities.

For instance, the Soften THE FCK Up campaign uses men’s narratives and notions of bravery and strength to encourage men’s expression of emotions, which in turn are positioned as soft and weak. The underlying premise, therefore, is that emotions are feminine but men should express them anyway. It also overlooks emotions such as anger that are socially coded as masculine and equally damaging for the mental well-being of others. This reframing of socially feminine emotions, such as crying, as something that men should be strong and do anyway does not challenge masculine ideology or the social gendering of emotions. That is, by focusing on hegemonic masculine values such as strength, it perpetuates stereotypes of hegemonic masculinity. As such, this campaign continues to present men as a homogenous group who conceal emotions. Similarly, while the Man Up campaign
shows men and boys of all ages crying, it also relies on a narrow view of masculinity, referring to the “average Aussie bloke”.

This study suggests that rather than looking at mental health through a “male lens”, as the Movember Foundation calls it (Movember Foundation, 2017), this work need to engage with a “masculinities lens” that acknowledges the diversity that exists among men. A campaign like *Soften The FCK Up* could be used in New Zealand, but enhanced by acknowledging a critical framework of masculinities that demonstrates not only the different patterns of masculinity, or different ways of being a man, but also highlights how the social gendering of emotions can create significant barriers for men and their mental well-being.

This study also draws attention to how the boundaries around men’s social relations with other men can act as a barrier to mental well-being: in particular, how social expectations of men’s behaviour in relation to their social relations and emotional practices can deter men from seeking support from their male friends. Many men in this study felt the weight of social expectation of appropriate male behaviour, such as not talking to other men about their personal problems or feelings. Others experienced the “policing” of their behaviour by other men who deemed it to be unmasculine (Frosh et al., 2002, p. 74). These social expectations on what is and is not appropriate behaviour for men can make life extremely difficult for those men who want to seek support from their social relations, or have friendships with other men that are more intimate. My research suggests there is value in mental health promotion encouraging and supporting men to openly resist the confines of hegemonic masculinity and to create closer supportive social relationships with other men. However, this is a difficult endeavour for mental health promotion, because it involves challenging socio-cultural ideas about what is socially acceptable behaviour for men.

The recent Scottish campaign *The Power of Okay* (Scottish Association for Mental Health, 2017) is an example of a mental health-promotion campaign directed at encouraging people to start conversations with friends and colleagues within the workplace. It also provides ideas about how people can respond to others who may
be experiencing problems with their mental health. While this campaign is not framed as gender-specific, it uses as examples conversations between men to demonstrate how these conversations might occur. As such, it indirectly addresses the difficulties some men experience in starting conversations with other men.

A comparable social marketing campaign could be employed in New Zealand, but reoriented to be inclusive of multiple masculinities. Indeed, the current Like Minds, Like Mine anti-stigma campaign already demonstrates diverse conversations around mental illness between Maori, Pacific Islanders, men and women. A similar campaign addressing the discussion and promotion of mental, emotional and social well-being among men and women, underpinned by a gender-relations framework, could be of great value in New Zealand.

10.5.2 Implications for mental health services

The findings from this study not only have implications for promoting and supporting the mental health of men but also preventing mental illness and mental health problems. While most men in this study did not report experiencing a mental illness, many had actively sought professional help from counsellors, GPs, psychotherapists and psychologists when they were experiencing personal difficulties. Despite seeking professional help, many of these men remained at risk of developing a mental illness due to unresolved emotional difficulties and personal issues. This study has a number of implications and recommendations for men’s interactions with mental health or psychological services.

First, the finding that financial cost is a barrier to men’s access to professional support indicates the importance of addressing the cost and availability of mental health-related services for men. For a number of men in this study, the cost of accessing support outside of those offered through employers or universities was prohibitive. For those who accessed help through employee assistance programmes (EAP), the limited numbers of sessions (three), combined with the financial cost of further sessions, meant that most men were unable to continue
their engagement with professionals and were often left with unresolved issues. The fact that all the men in this study who sought professional help raised the issue of financial cost suggests this is an issue for psychological service provision in New Zealand.

Second, the fact that the most common way men in this study accessed professional support for personal issues was through workplace EAP services (and mainly through government based jobs) suggests there is value in providing workplace programmes for supporting men’s mental health which are accessible and fully or partially funded. This also raises concerns and questions of unmet need for men in New Zealand who do not have access to employee-based mental health programmes through their workplace, such as those in manual work, those working in small companies of self-employed. There is increasing international evidence of the value of workplace programmes for promoting the mental health and well-being of men, particularly in male-dominated workplaces, such as the building and construction industry (e.g Broadbent & Papadopoulos, 2014; Gullestrup, Lequertier, & Martin, 2011; Lee, Roche, Duraisingam, Fischer, & Cameron, 2014).

Third, this study found that men had diverse mental health-related needs in terms of seeking professional support and help. Most men did not frame their need for professional assistance in terms of mental illness, but rather as a need arising from difficulties in their private lives, such as relationship problems, unresolved grief, feelings of distress or despair, general unhappiness with life and struggling to function day to day. This raises questions about the medicalisation or psychiatric framing of everyday problems by mental health professionals if this is not how some men view them.

The findings from this study suggest there is value in framing psychological or mental health-related services as addressing mental well-being concerns, including emotional difficulties, rather than only help for mental illness. Further, the fact that a number of men in this study were left with unresolved issues after engaging with mental health professionals raises questions about whether psychological services are catering for the diverse mental well-being needs of men or, as River (2016)
suggests, whether mental health professionals overlook men’s emotional issues because they are complicit in maintaining men’s socially masculine pattern of emotional concealment.

Contrary to studies which suggest men are more likely to value psychological therapy which has practical results, rather than emotional support (Emslie, Ridge, Ziebland, & Hunt, 2007; Good & Wood, 1995), men in this study valued both the emotional and psychological support offered by talking therapies. Good, Thomson and Braithwaite (Good, Thomson, & Brathwaite, 2005) suggest one way to increase men’s use of counselling services would be to focus less on emotional expressiveness and more on instrumental changes and control. Yet, my research refutes this and would suggest this view only serves to reinforce the idea that men are a homogenous group who do not talk about their emotions.

Finally, this study suggests there may be unmet need for men who experience trauma and grief as boys and young men. A number of men in this study had experienced traumatic life events including the death of a parent or sibling, and had never been offered access to professional help or support. Furthermore, many of these men hid their grief and never spoke to peers, friends or family about these events at the time. For some of these men, this crisis brought into question their emotional resilience, which had ongoing implications for their mental and emotional well-being as adults. This raises questions about the availability and provision of trauma and grief services for young New Zealand men, through either schools or the community. Bush (2010) argues that mental health promotion should be a key priority in tackling bereavement issues, ensuring young men and boys (and I would add women and girls) have the knowledge, skills and confidence to access support services when they need it. In addition, parents need to know how and where to get help and support for children and teenagers affected by bereavement.
10.5.3 Policy implications

Unlike Ireland, Australia and the UK, New Zealand does not have a men’s health policy, despite calls for the development of one similar to the national male health policy in Australia (Johnson, Field, & Stephensen, 2006; Johnson et al., 2008). However, the Australian policy has been criticised for its reliance on the social determinants of health framework and failure to acknowledge the importance of gender, or masculinities and the diversity among men, in understanding the wider determinants of health (Robertson et al., 2016; Saunders & Anita, 2009). As such, it tends to present men as a homogenous group who are all disadvantaged in terms of health.

While men’s health policy discussions in the UK, Ireland and Australia could provide a useful framework for discussing a similar men’s health policy in New Zealand (e.g. Richardson & Carroll, 2009; Richardson & Smith, 2011; Saunders & Anita, 2009), this study suggests there are other areas of policy in New Zealand which have implications for men’s mental well-being. For many men in this study, paid work was central to their everyday lives, but high stress levels, poor job satisfaction and long or inflexible working hours all had negatives consequences for mental well-being. Greater support for flexible working policies, which allow men to have more control of their scheduled working hours and location, could be beneficial for promoting mental well-being, both in the workplace and in men’s private lives. While a number of employers in New Zealand have already adopted flexible working arrangements (Ministry of Business Innovation & Employment, 2016), many men in this study had not experienced this flexibility in their workplace. This study also draws attention to the impact of current parental leave policies in New Zealand on men’s mental well-being. Supporting paid leave, income replacement and more flexible work arrangements for men could promote men’s mental health by making it easier for men who want to spend more time with their children, but who are not classed as the primary carer. It could also make it easier for women to return to paid employment and have the potential to boost fathers’ emotional investment in and connection with young children, because there is more incentive to take parental leave (O’Brien, 2009).
10.5.4 Future research

Further research could usefully focus on a number of areas. For example, there is value in using life-history methods to study gender relations and mental health in other populations of men and women. Within New Zealand, future studies might consider the gendered social practices of Māori and Pacific men, using both gender-relations theory and indigenous models for health promotion (Durie, 2005). Similarly, there is value in exploring how gendered social practices constrain or promote mental well-being in specific groups of men from lower socio-economic groups, diverse sexual identities and different age groups.

There is also value in further examining men’s emotional relations to better understand how men reject hegemonic practices of emotionality and build emotional resilience. Also how men who are experiencing confusion and ambivalence around their own emotional practice can be supported. This study shows that contrary to assumptions in the literature that men’s emotional lives are difficult for researchers to access, it is possible to examine the heterogeneity and agency in men’s emotional practice and their implications in men’s everyday lives through men’s narratives.

Further research examining the diverse social support networks and friendships in men’s lives in relation to supporting mental well-being would be a fruitful area. My research has challenged the mental health literature, which positions all men’s social support as inferior to that of women, or based only on instrumental, action-orientated activities. Future research could consider a number of aspects of men’s social support, including how men negotiate and resist the gendered boundaries of men’s social relations. While I interviewed only men in this study, further research interviewing men and women, or men’s partners or friends, has the potential to contribute to a gender-relations understanding of men’s social relations and mental health.
Finally, in this study I deviated from the dominant focus on depression in the men’s mental health literature to explore men’s mental well-being using Keyes model of complete mental health. Future research could consider other ways of conceptualising men’s mental health that address not only preventing mental illness but also promoting and supporting men’s mental well-being or good mental health.

10.6 Final thoughts

This study makes a considerable contribution to the current field of masculinities and men’s mental health and captures findings which have not been shared before. Through the life history method, this study demonstrates new insights into the sorts of social practices that can promote and support the mental health and well-being of men who do not have mental illness, as well as those practices that can hinder mental well-being, leaving some men at risk of mental illness or even suicide.

In particular, the findings presented in this thesis highlight the complex relationships between multiple patterns of masculinities and diverse mental health experiences among men. The life history data demonstrates that hegemonic masculinity is not a given, that men are active agents in their own social practices and can indeed question and resist the dominant pattern of masculinity. This study presents a contemporary and fresh understanding of how ambivalence, tensions and contradictions within men’s construction of masculinity can hinder mental well-being, while resisting hegemonic masculinity can provide possibilities for men to flourish and experience a state of mental well-being that supports a happy and fulfilled life.

The study has highlighted the diversity and centrality of emotions to men’s everyday lives and shown it is not simply the case that men are unable, or unwilling, to express their emotions. Similarly, not all men lack supportive social relationships and avenues for support. However, the relationship between masculinities and
men’s mental health is a truly complex and multi-faceted one that requires a great deal of further attention from health researchers. I would encourage all researchers with a passion for men’s mental health to take a critical perspective of the gender relations in men and women’s everyday lives.


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Patterson-Kane, L., & Quirk, F. (2013). Within the boundary fence: an investigation into the perceptions of men's experience of depression in rural and remote areas of Australia. *Australian Journal of Primary Health*. [https://doi.org/10.1071/PY12106](https://doi.org/10.1071/PY12106)


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Appendices
Appendix A: Published literature review

SARAH K. MCKENZIE*, PhD (CAND.), GABRIELLE JENKS*, PhD, and SUNNY COLLINGS*, PhD

Men’s Perspectives of Common Mental Health Problems: A Metasynthesis of Qualitative Research

The majority of qualitative research relating to men’s experiences of mental health problems has been published within the last 15 years. Building on a previously published review, we conducted a qualitative metasynthesis of 26 studies on men’s perspectives of common mental health problems. Findings show the causes of problems cited by most men relate to work, family, relationships and the pressure of dominant notions of masculinity. Many men struggle to recognize when a problem exists despite experiencing significant emotional pain. The complex relationships between masculinity and common mental health problems are evident in men’s accounts of coping and seeking help. This metasynthesis emphasizes that despite increasing research on this topic there still remains a need to broaden the focus from depression, professional help-seeking, and the negative impact of hegemonic masculinity on mental health.

Keywords: men’s mental health, mental illness, lay perspectives, qualitative metasynthesis, masculinities

Historically men’s mental health has not been a topic of major research or clinical interest in its own right (Addis & Cohane, 2005). Much of the early research on men’s mental health came from large-scale quantitative studies focusing on gender differences in mental health. Studies either aimed to uncover the structural determinants of these differences or the methodological reasons for why women’s rates of mental illness were higher (Risik, 2009). It is only in recent years that the influence of gender as a social construct in men’s mental health practices has become a focus in both the men’s health and social science literature. The majority of qualitative empirical studies relating to men’s gendered experiences of common mental health problems are relatively recent, with most published since 2000.

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A number of themes have been established in the qualitative literature so far. Briefly, these include how men’s experience and expression of depression can differ substantially to women’s, emphasizing physical complaints and externalizing behavior (Brownhill, Wilhelm, Barclay, & Schmied, 2005; Danielsson et al., 2009; Danielsson & Johansson, 2005). That the ways in which men cope with their mental health problems is diverse. For example, some use avoidant strategies to cover up their depression (Brownhill et al., 2005; Chuick et al., 2009; Rochlen et al., 2010), whilst others use strategies to frame their depression as an “heroic struggle” (Emslie, Ridge, Ziebland, & Hunt, 2006). That the relationship between gender and help-seeking for mental health is more complex than originally thought (Johnson et al., 2012; Rochlen et al., 2010). Finally, that generalizations about men being silent about their mental health problems are misleading. Studies have recruited men who are willing, and want, to talk about their mental health problems.

A meta-ethnography published in this journal (Hoy, 2012) was the first comprehensive review of the qualitative literature on men’s lay perspectives of mental health and help-seeking, covering published literature up to 2010. This review highlights that the focus of studies has been on men’s experiences of depression and professional help-seeking. Hoy’s review also draws attention to the fact that many researchers suggest the poorer mental health of men can be explained by the negative impact of masculinity which results in men being unwilling or unable to seek help. More specifically, that behaviors and beliefs associated with traditional forms of masculinity such as being stoic, strong and in control are likely to be hazardous to men’s health (Hoy, 2012).

Since this time there has been a substantial number of qualitative studies published investigating men’s experiences of common mental health problems. The present article builds and expands on Hoy’s review by conducting a qualitative metasynthesis of studies on men’s perspectives of common mental health problems published since 2010. We used a qualitative metasynthesis approach developed by Sandelowski and Barroso (2007). Although there are a number of distinct perspectives on metasynthesis methodology within qualitative health research, they all represent rigorous attempts to render what exists within a body of evidence based qualitative studies into a coherent and synthesized product (Thorne et al., 2004). Moreover, metasynthesis has been promoted as a strategy for making isolated qualitative findings more accessible to clinicians, researcher and policy makers (Finfgeld, 2003; Finfgeld-Connett, 2010). It can also play an important role in adding value to systematic reviews of interventions thereby bringing qualitative research into discussions on evidence-based practice (Noyes et al., 2008).

The qualitative metasynthesis is a systematic approach to the identification and analysis of qualitative studies, a focus on the findings from those studies, and the use of quantitative methods to synthesize those findings (Thorne et al., 2004). A metasynthesis is more than the sum of parts because it offers novel interpretations of findings which will not be found in any one research report (Sandelowski & Barroso, 2003, 2007). The purpose of this review was to conduct a qualitative metasynthesis of studies on men’s perspectives of common mental health problems published since 2010.

**METHOD**

The metasynthesis had three stages: (1) systematic search; (2) critical appraisal; and (3) synthesis using techniques of metasynthesis described by Sandelowski and Barroso (2007).
Systematic Search

Formulating the search and scope. In order to identify the parameters of the synthesis we reviewed each of the fifty-one studies included in the previous review. We then refined our research question and search terms through exploring the use of keywords and journal indexing in the previously published studies. We decided not to use terms such as “qualitative” or “interview” or “grounded theory” in our search strategy due to the known problems with the indexing of qualitative research in databases, the descriptive nature of the titles used in some studies and the variable information provided in abstracts (Barroso et al., 2003; Dixon-Woods, Fitzpatrick, & Roberts, 2001; Evans, 2002). The final research question which guided the synthesis was, “What does the qualitative literature published since 2010 say about men’s understanding of common mental health problems?” The final set of terms used in the search strategy are shown in Table 1 and refer to three key components of the review topic: (1) mental health and related terms; (2) health beliefs, attitudes, perspectives, understanding, or experience of people; (3) text words related to research with men.

Databases and search strategy. We conducted a systematic search of seven online databases (Medline, PsychINFO, EMBASE, CINAHL, Scopus, Web of Science, PubMed) in February 2014. An individual search strategy was tailored for each database using the search terms in Table 1 (or their database equivalent) combined using the Boolean logic terms OR and AND. For Scopus, Web of Science and PubMed databases, which have less developed search functions, a simplified search strategy was used based on similar key words as those in Table 1.

Each search occurred in two phases. Phase one consisted of individual searches for each of the three components combined using OR. Phase two consisted of combining the three components of the search using the AND function. The database searches were limited to the time period 1 January 2010 to 31 December 2013. The earlier time limit covered (and overlapped) the end period of the previous meta-ethnography, which was June 2010, and allowed the synthesis to cover three full years. The searches were limited to studies including adult participants and written in English. The reference lists of known key studies were checked and key journals in men’s health and mental health were individually searched using the journals’ online search engine.

Table 1
Key Search Terms Used

<table>
<thead>
<tr>
<th>Mental health and related terms (combined with “or”)</th>
<th>Health beliefs and understanding terms (combined with “or”)</th>
<th>Terms for men in the title (combined with “or”)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health, psychological distress/stress, mental distress, mental well-being, emotional well-being, emotional distress, anxiety disorders, mood disorders, substance use disorders, alcohol use disorders, depression, depressive disorder, mental illness</td>
<td>Attitude to health, attitude to illness, health belief, lay understanding, health knowledge, lay knowledge, narrative, lay view, experience, explain, construct, understand, belief, perception, express</td>
<td>Men, men, male(s), masculinity, gender</td>
</tr>
</tbody>
</table>

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**Inclusion and exclusion criteria.** Initial screening of title and abstracts was undertaken by one reviewer with a subset screened by a second reviewer. Records were excluded if they did not look like a qualitative study or mention qualitative methods; did not include men as participants; focused on the views of health professionals; did not appear to be specifically about men’s views of mental health; focused on severe mental illness; or included institutionalized populations. Full-texts of remaining articles were then downloaded and read in more detail. Studies were excluded if they did not focus specifically on men’s views of a common mental health problem; did not explicitly adopt qualitative methods for both data collection and analyses; did not include as participants working men aged 18–64 years; and if they included both men and women but analysis did not yield gender-specific data.

**Critical Appraisal**

The remaining articles were appraised prior to the synthesis using a version of the Critical Appraisal Skills Programme (CASP) criteria for qualitative studies adapted for use as a precursor to a synthesis (Campbell et al., 2003; Pound et al., 2005). The aim of this appraisal was not to exclude studies based on quality but to help generate an understanding of the basic methodological standard of the qualitative studies included in the synthesis. Using the tool also facilitated a structured and systematic reading of each article and aided the identification of findings, interpretations and concepts prior to the synthesis (Sandelowski, Docherty, & Enden, 1997). An overall rating of each article (1 = excellent, 2 = very good, 3 = good, 4 = not very good, 5 = poor, 6 = very poor) was included to help assess which studies could be given more weight in the synthesis. Two reviewers independently appraised each article. The lead reviewer read and appraised all studies and two other reviewers appraised 50% of the studies each.

**Synthesis of Studies**

The synthesis involved translating *in vivo* concepts which constitute researchers’ (not research participants’) representations of the data they obtained from research participants. These *in vivo* concepts, metaphors, or other such interpretive devices by which researchers synthesize their data lend themselves to metasynthesis by “reciprocal translation” (Sandelowski & Barroso, 2003, 2007). This entails examining the concepts in relation to others in the original study as well as across studies, and is an adaptation of meta-ethnography (Noblit & Hare, 1988).

The full-text of each article which met the inclusion criteria was imported into QSR Nvivo8 (computer software designed for the management of qualitative data). The first stage involved reviewing each article and coding key concepts within the findings. Once the main concepts from each article were identified, studies were read and reread in an iterative process to ensure the concepts were searched for in all the studies to be synthesized. The second stage involved determining how the concepts could be translated within and across all studies by aggregating and recoding the findings from individual studies under broader themes and, through discussion, identifying higher-order theoretical commonalities.
RESULTS

Description of the Synthesis Studies

The database search produced 3,802 records with an additional four records identified from reference lists. A summary of the process for inclusion of studies in the metasynthesis is detailed in Figure 1. Removing duplicates reduced this number reduced to 1971. Following the first screening, 68 articles were identified and the full-text of each was downloaded and read in more detail. After further exclusions, 26 studies remained which met the inclusion criteria for the synthesis. The characteristics of these studies are presented in Table 2. Collectively, these studies represent the views of over 727 men (one study did not report sample size) ranging in age from 17 to 82 years. Twenty studies included men only as participants while the other six included both men and women, but specified their findings by gender. Eight studies focused on men of African-American, Aboriginal, Kurdish, Black, and other ethnic minorities (Brown et al., 2012; Bryant-Bedell & Waite, 2010; Griffith, Ellis, & Allen, 2013; Isaacs, Maybery, & Grinis, 2013; Lindsey & Marcell, 2012; Patterson-Kane & Quirk, 2013; Robinson, Keating, & Robertson, 2011; Ward & Besson, 2013). A number of studies included heterosexual and gay men, but sexuality was a focus in only two studies (Korner et al., 2011; Lomas, Cartwright, Edginton, & Ridge, 2013). The majority of studies (n = 22) recruited participants from community settings using brochures/flyers placed in community/public places to advertise the study. Four studies recruited participants from clinical settings including primary care, hospitals and counselling centres (Cleary, 2012; Danielsson, Bengs, Samuelsson, & Johansson, 2011; Grove, 2012; Korner et al., 2011). The most common method of data collection was face-to-face semi-structured interviews with 18 of the 26 studies using this method, five using focus groups, one using telephone interviews (Fletcher & StGeorge, 2010), and two using a mix of both interviews and focus groups.

Figure 1. Summary of process for inclusion of studies in the systematic review.
(Patterson-Kane & Quirk, 2013; Taloyan, Al-Wind, Johansson, & Saleh-Stattn, 2011). The majority focused on men’s experiences of depression (n = 18) with the remainder focusing on suicidal experiences, emotional distress, stress and well-being and a more general concept of mental health issues. The majority of studies came from Canada, Australia and the USA with one or two coming from Ireland, Sweden, Finland, India and the UK.

**Appraisal of the Synthesis Studies**

Overall the level of agreement between reviewers was good when independently categorizing the studies as either “yes”, “no” or “unclear” for each of the CASP items. Consensus on the critical appraisal of the 26 studies is presented in Table 3. Where questions were reported as unclear this was usually due to a lack of information in the article to make a judgement. The majority of studies adequately reported research design, sampling and recruitment, however many did not justify the size of their sample or report on how and why participants accepted or refused to take part. The reporting of analysis was generally good across studies but very few reported feedback to respondents or triangulation of data. We would argue, however, that these criteria depend on the purpose of the research and are not always appropriate to the study. The interpretation and presentation of data varied across the studies and a number of researchers did not examine their role, potential bias or influence on the study or give consideration to the relationship between researcher and participants. Some of the gaps in reporting research methods in studies may be due to space constraints of journals.

**The Synthesis**

The synthesis comprised five themes: “triggers and causes”, “being aware of emotional pain”, “managing the problem”, “seeking help and support” and “to disclose or not to disclose”. Within each theme a number of subthemes were identified, as reported below.

**Triggers and Causes**

Although men’s understanding of the onset, triggers and causes of their mental health problems varied across studies, throughout all studies it was consistently observed that it was not one particular cause or issue but a number of different issues which accumulated and led to mental health problems. Four subthemes were constructed to represent the most common explanations of these causes and triggers. These include “work-related issues”, “relationship and/or family issues”, “pressure to subscribe to dominant masculine ideals”, and “racism and cultural differences”.

**Work-related issues.** For many men the workplace and work-related issues were a major cause or trigger of stress and depression or exacerbated existing conditions. These issues included increased job responsibilities, working overtime, long commutes, relationships with co-workers, feeling undervalued in their workplace, and pressure to perform and succeed. Job security was a key concern: losing a job, fear of losing a job or being forced to retire unexpectedly, were all triggers for men’s depression (Griffith et al., 2013; Oliffe, Geldas, Han, & Kelly, 2013a; Oliffe et al., 2011). Two studies highlighted how the relationship between work and mental health can go in both directions, with work issues impacting on men’s mental health and, at the same time, depression and/or anxiety hindering men’s abil-
Table 2
Studies Included in the Final Metasynthesis: Characteristics

<table>
<thead>
<tr>
<th>#</th>
<th>Authors, year, country</th>
<th>Focus of study</th>
<th>Methodology</th>
<th>Participants</th>
<th>Setting</th>
<th>Data collection</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brown et al., 2012 (Australia)</td>
<td>The expression, experiences, manifestations and consequences of emotional distress and depression in Aboriginal men</td>
<td>Grounded theory</td>
<td>n = 22 Aboriginal men; 20-55 years</td>
<td>Community</td>
<td>17 semi-structured interviews; 2-3 hours per interview; use of vignette</td>
</tr>
<tr>
<td>2</td>
<td>Bryant-Bade &amp; Weite, 2010 (USA)</td>
<td>To identify how African American men recognize and express symptoms of depression and how depression impacts their lives</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 10 African-American men with or have had depression; 40-59 years</td>
<td>Community</td>
<td>10 semi-structured interviews; 60-90 mins per interview</td>
</tr>
<tr>
<td>3</td>
<td>Cleary, 2012 (Ireland)</td>
<td>To understand the practice and to explore the background circumstances and motivations involved in suicidal behaviour in young men</td>
<td>Modified version of grounded theory</td>
<td>n = 52 men attempted suicide; 18-30 years</td>
<td>Hospitals</td>
<td>52 unstructured in-depth interviews; 1-2 hours per interview</td>
</tr>
<tr>
<td>4</td>
<td>Coen et al. 2013 (Canada)</td>
<td>How men with depression negotiate masculinities in a northern resource-based Canadian community</td>
<td>Reported an interpretive qualitative approach</td>
<td>n = 9 men with depression and 9 women (partners); 26-44 years</td>
<td>Community</td>
<td>18 individual in-depth interviews; 60-90 mins per interview</td>
</tr>
<tr>
<td>5</td>
<td>Danielsson et al., 2011 (Sweden)</td>
<td>To explore the impact of gender on the depression narratives of young men and women</td>
<td>Grounded theory</td>
<td>n = 11 men and 12 women with depression; 17-25 years</td>
<td>Primary care</td>
<td>23 in-depth interviews; 1-2 hours per interview</td>
</tr>
<tr>
<td>6</td>
<td>Fletcher &amp; McGeorge, 2010 (Australia)</td>
<td>To explore how fathers manage their mental and physical well-being in the context of family dissolution and separation from their children</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 26 men; 31-53 years</td>
<td>Community</td>
<td>26 telephone interviews; 10-40 mins per interview</td>
</tr>
<tr>
<td>7</td>
<td>Griffith et al., 2013 (USA)</td>
<td>To examine the main sources of stress faced by African American men</td>
<td>Phenomenology</td>
<td>n = 150 men and 77 women; 32-82 years</td>
<td>Community</td>
<td>18 focus groups with men; 8 focus groups with women</td>
</tr>
<tr>
<td>8</td>
<td>Grove, 2012 (Canada)</td>
<td>Men’s perspectives and experiences of managing mid-life depression and the role of counseling</td>
<td>Hermeneutic inquiry</td>
<td>n = 6 men who had counselling for depression; 55-55 years</td>
<td>Counselling centres</td>
<td>6 semi-structured interviews; 1-2.5 hours per interview</td>
</tr>
<tr>
<td>9</td>
<td>Isaacs et al., 2013 (Australia)</td>
<td>To explore the help-seeking behaviour of Aboriginal men who are mentally unwell in a rural community.</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 15 men and 2 women; 25-65 years</td>
<td>Community</td>
<td>17 interviews; 20-45 mins per interview</td>
</tr>
</tbody>
</table>

Table 2 continued on page 87
<table>
<thead>
<tr>
<th></th>
<th>Authors and Year of Publication</th>
<th>Methodology</th>
<th>Sample Description</th>
<th>Setting</th>
<th>Sample Size</th>
<th>Length of Interview(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Johnson et al., 2012 (Canada)</td>
<td>Discourse analysis</td>
<td>n = 38 men with depression; 24-50 years</td>
<td>Community</td>
<td>38 semi-structured interviews; 60-90 mins per interview</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Kosek et al., 2011 (Australia)</td>
<td>Discourse analysis</td>
<td>n = 40 men with depression and self-identified sexuality, 20-73 years</td>
<td>General practice</td>
<td>40 semi-structured interviews; length not reported</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Liang &amp; George, 2012 (South India)</td>
<td>Phenomenology</td>
<td>n = 9 men with depressive symptoms; 30-45 years</td>
<td>Community</td>
<td>9 semi-structured interviews; length not reported</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Lindsey &amp; Marcell, 2012 (USA)</td>
<td>Reported a qualitative approach</td>
<td>n = 27 African-American men; 15-30 years</td>
<td>Community</td>
<td>4 focus groups; 1.5 hours per focus group</td>
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<tr>
<td>14</td>
<td>Lomas et al., 2013 (UK)</td>
<td>Reported a modified constant comparison approach</td>
<td>n = 30 men (included 9 gay men); 20-60 years</td>
<td>Community</td>
<td>30 semi-structured interviews; average 2 hours per interview</td>
<td></td>
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<tr>
<td>15</td>
<td>Oliffe et al., 2010a (Canada)</td>
<td>Reported a qualitative approach</td>
<td>n = 26 male university students with depression, 19-28 years</td>
<td>Community</td>
<td>26 semi-structured interviews; length not reported</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Oliffe et al., 2010b (Canada)</td>
<td>Reported an interpretive descriptive approach</td>
<td>n = 15 male university students with depression, 19-28 years</td>
<td>Community</td>
<td>15 semi-structured interviews; 1-1.5 hours per interview</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Oliffe et al., 2011 (Canada)</td>
<td>Reported an interpretive descriptive approach</td>
<td>n = 22 men with depression; 55-79 years</td>
<td>Community</td>
<td>22 semi-structured interviews; 60-90 mins per interview</td>
<td></td>
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<tr>
<td>18</td>
<td>Oliffe et al., 2012 (Canada)</td>
<td>Modified grounded theory</td>
<td>n = 38 men with depression; 24-50 years</td>
<td>Community</td>
<td>38 semi-structured interviews; 60-90 mins per interview</td>
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</tr>
<tr>
<td>19</td>
<td>Oliffe et al., 2013a (Canada)</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 25 male university students with depression; 19-28 years</td>
<td>Community</td>
<td>25 semi-structured interviews; length not reported</td>
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Table 2, continued from page 87

<table>
<thead>
<tr>
<th>No.</th>
<th>Reference</th>
<th>Objective</th>
<th>Methodology</th>
<th>Sample Size</th>
<th>Study Design</th>
</tr>
</thead>
<tbody>
<tr>
<td>20</td>
<td>OliFte et al., 2013b (Canada)</td>
<td>To describe the connections between masculinities, work and retirement among older men who experienced depression</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 30 men with depression; 55-82 years</td>
<td>Community; 30 semi-structured interviews; 60-90 mins per interview</td>
</tr>
<tr>
<td>21</td>
<td>Patterson-Kane &amp; Quirk, 2013 (Australia)</td>
<td>To investigate the relationship between rural lifestyles and the experience of depression for men in rural and remote areas</td>
<td>Grounded theory</td>
<td>n = 26 men with depression; 11 women; ages not specified</td>
<td>Community; Semi-structured interviews and focus group (number not specified)</td>
</tr>
<tr>
<td>22</td>
<td>Robinson et al., 2011 (UK)</td>
<td>To explore the beliefs and experiences of mental health services in men from black and minority ethnic groups</td>
<td>Not specified</td>
<td>Number of men not reported; 18-55 years</td>
<td>Community; 12 focus groups stratified by age and ethnicity</td>
</tr>
<tr>
<td>23</td>
<td>Rechlin et al., 2010 (USA)</td>
<td>To explore the interaction between the male role, masculinity, depression and experiences of treatment for depression</td>
<td>Reported a qualitative approach</td>
<td>n = 45 men with personal and/or family history of depression; 24-68 years</td>
<td>Community; 6 focus groups; 75-110 mins per focus group</td>
</tr>
<tr>
<td>24</td>
<td>Talayan et al., 2011 (Sweden)</td>
<td>To describe Kurdish men’s experiences of migration related mental health issues</td>
<td>Grounded Theory</td>
<td>n = 14 Kurdish men; 24-60 years</td>
<td>Community; 1 focus group with 4 men; 10 in-depth interviews; 60-120 mins per interview</td>
</tr>
<tr>
<td>25</td>
<td>Volkomen &amp; Hammen, 2012 (Finland)</td>
<td>To explore the connection between masculinity and depression in Finnish men in their forties</td>
<td>Narrative analysis</td>
<td>n = 24 men self-identified as depressed; 40-49 years</td>
<td>Community; 24 semi-structured interviews; length not reported</td>
</tr>
<tr>
<td>26</td>
<td>Ward &amp; Besson, 2013 (USA)</td>
<td>To explore African-American men’s beliefs about mental illness</td>
<td>Reported a qualitative descriptive approach</td>
<td>n = 17 African American men; 24-75 years</td>
<td>Community; 17 interviews; 60-75 mins per interview</td>
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<td>350</td>
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Table 1: Continued from page 60.

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Table 2: Continued from page 60.

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<tr>
<td>5a. Who collected data</td>
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ity to perform at work. Some men felt depression was the key reason for failing to reach their full potential at work, or to leverage work opportunities to further their careers prospects, or for losing their job security (Oliffe et al., 2012; Oliffe et al., 2013b).

For some older men, depression and suicidal thoughts were seen as a consequence of failing to build a career, wealth and fulfill their roles as breadwinner/provider (Oliffe et al., 2011; Oliffe et al., 2013b). On the other hand, for others, reaching retirement meant the loss of routine and structure of work which had been therapeutic for managing their depression by providing purpose and structure to their days (Oliffe et al., 2013b). For a number of men failing to “measure up” to the success of others, particularly financially, and the inability to accept failure was perceived as a cause of mental health problems (Bryant-Bedell & Waite, 2010; Liang & George, 2012; Oliffe et al., 2013b). Younger men at college/university felt academic underachievement, emergent debt, poor career prospects, fear of failing, and the impending transition into a career, were causes of their depression (Oliffe et al., 2010a; Oliffe et al., 2010b). Maintaining a work-life balance was particularly challenging for some men and seen as a key contributor to stress and depression. The competing demands between job, family, household and community responsibilities were a struggle, particularly for men who felt the pressure or expectations from others or from themselves to balance and fulfill their various roles and responsibilities as breadwinner and provider (Coen, Oliffe, Johnson, & Kelly, 2013; Griffith et al., 2013; Grove, 2012).

**Relationship and/or family issues.** Relationship problems, particularly marital problems, failed relationships, breakups or divorce were reported by many men as a cause or contributing factor to their mental health problems, resulting in loss, grief and isolation (Bryant-Bedell & Waite, 2010; Griffith et al., 2013; Lomas et al., 2013; Oliffe et al., 2012). The association between relationships and mental health was also shown to go in both directions, with relationship problems/issues impacting on men’s mental health and depression and/or anxiety negatively impacting on intimate relationships at the same time (Bryant-Bedell & Waite, 2010; Oliffe et al., 2010a). In one study men reported the experience of negotiating access to their children during a family break up as a significant contributor to distress, depression and suicide attempts (Fletcher & StGeorge, 2010).

The focus was not always solely on the “here and now” stressors, with some believing the onset of mental health problems were a consequence of past life events occurring in childhood or teenage years such as physical or sexual abuse, dysfunctional family, learning difficulties, low self-esteem, household conflict or violence, alcoholism in the family, relationships with parents or growing up with rigid stereotypes about emotional expressivity (Bryant-Bedell & Waite, 2010; Grove, 2012; Liang & George, 2012; Ward & Besson, 2013). Some younger men found events such as family conflicts, painful school events, failures in relationships with friends or shameful sexual experiences contributed to their poor mental health (Danielsson, Bengs, Samuelsson, & Johansson, 2011). There were some men who believed their depression was inherited or had existed from birth while others believed their signs and symptoms had started in childhood or during their teenage years (Oliffe et al., 2012; Oliffe et al., 2010b; Ward & Besson, 2013).

**Pressure to subscribe to dominant masculine ideals.** Men in a number of the studies experienced the pressures of adhering to dominant masculine ideals such as being in control, not showing emotion, and maintaining independence. For many men, their depression or distress was seen as a consequence of the pressure they felt to “be a man”. This was particularly in terms of remaining emotionally tough, for example, suppressing, denying, or dis-
Men’s Perspectives of Common Mental Health Problems

Connecting from their feelings (Lomas et al., 2013; Robinson et al., 2011; Roehlen et al., 2010; Valkonen & Hänninen, 2013).

Young college men felt the pressure to embody masculine performances around heterosexuality and sexual performance, inhibiting them from initiating and/or sustaining intimate relationships, which adversely impacted their mental health (Oliffe et al., 2010a). Others viewed depression as a female illness, where men’s depression was weakness because it went against the dominant constructions of masculinity as rational and robust (Oliffe et al., 2010b). For some men their distress and depression were seen as a consequence of not living up to their own masculine standards, seeing themselves as a “loser” or as a result of challenging traditional ideals of masculinity such as being the primary care giver for their children (Valkonen & Hänninen, 2013). For gay men in particular, their depression was seen partly as the result of their struggle to enact values of traditional masculinity in the workplace while being unable to do the same in their personal lives, leaving them internally conflicted (Korner et al., 2011).

Racism and cultural differences. For those studies including men from ethnic minorities there were some causes or triggers of stress and depression which differed from other studies. These included racism, marginalization within contemporary society and cultural differences. For Aboriginal men the impact of colonization, particularly its influence on their way of life, and racism had significant negative consequences on their emotional well-being and distress (Brown et al., 2012; Isaacs et al., 2013). Some attributed their alcoholism to loss of culture, language and traditional roles as leaders, providers and teachers (Isaacs et al., 2013). For African-American men, experiencing racism and discrimination in their daily interactions such as inequitable access to opportunities, including promotion in the workplace and resources, significantly impacted their mental health (Bryant-Beddell & Waite, 2010; Griffith et al., 2013). For others, acculturation, particularly the combined pressure of having to live up to Western masculine ideals while maintaining their own cultural or social expectations, impacted significantly on their mental health (Oliffe et al., 2010b; Robinson et al., 2011; Taloyan et al., 2011).

Being Aware of Emotional Pain

A second theme described men’s emotional and physical experiences of a mental health problem. These fell into two subthemes: “recognizing a problem exists” and “experiencing emotional pain”.

Recognizing a problem exists. In order to have some understanding of their experience, men in most studies needed to be able to recognize or be aware that something was wrong. Though most men in these studies knew when something was not right, they were not always sure what the problem was and how men recognized or became aware of a potential issue with their mental health varied. Some men could recognize and articulate what they were feeling or what the problem may be, whereas others had difficulty identifying the specific nature of their feelings because they were “non-specific” feelings of emotional distress or they were unfamiliar with the feelings (Bryant-Beddell & Waite, 2010; Cleary, 2012). For example, referring to being in “the funk” when experiencing noticeable changes in their emotions and feelings (Bryant-Beddell & Waite, 2010). Others recognized physical symptoms and more tangible changes such as chest pains or a drop in energy levels and tiredness, neglecting their usual self care, experiencing sleeping problems or changes in their eating


...habits (Brown et al., 2012; Bryant-Bedell & Waite, 2010; Cleary, 2012; Johnson et al., 2012; Liang & George, 2012; Oliffe et al., 2013a; Oliffe et al., 2010a).

Some recognized their suffering as depression but talked about it as “external agent” or condition that they had no influence over (Korner et al., 2011; Liang & George, 2012). Others knew something was not right but flatly refused to accept that what they were experiencing might be depression (Rochlen et al., 2010). Only two studies included men who used classic psychiatric symptoms, such as loss of pleasure and lack of enjoyment in activities, when talking about recognizing their depression (Korner et al., 2011; Ward & Besson, 2013). Depression was not a term used in Aboriginal communities; Aboriginal men rather talked of excessive sadness and worry caused by a misaligned spirit or used traditional indigenous terms (Brown et al., 2012; Isaacs et al., 2013).

**Experiencing emotional pain.** For most men, their experience of a mental health problem, whether it was depression, emotional distress or suicidal thoughts, involved experiencing significant emotional pain, distress, and anger. For some, the pain or distress was described as long-term, extending over their lifetime, whereas for others it was more short-term (Bryant-Bedell & Waite, 2010; Cleary, 2012; Danielsson et al., 2011; Fletcher & StGeorge, 2010; Johnson et al., 2012; Liang & George, 2012; Lomas et al., 2013; Oliffe et al., 2013a; Oliffe et al., 2010a; Oliffe et al., 2012). Many men were able to articulate the negative emotions they were experiencing even if they did not link them directly to their depression or distress. They talked of experiencing isolation and loneliness (Bryant-Bedell & Waite, 2010; Danielsson et al., 2011; Liang & George, 2012; Oliffe et al., 2013a; Oliffe et al., 2010a), desperation (Johnson et al., 2012), vulnerability (Danielsson et al., 2011; Lomas et al., 2013; Oliffe et al., 2013a), frustration (Bryant-Bedell & Waite, 2010), anxiety and panic (Cleary, 2012; Fletcher & StGeorge, 2010; Lomas et al., 2013), hopelessness (Bryant-Bedell & Waite, 2010; Oliffe et al., 2011; Oliffe et al., 2012), anger, aggression, or physical violence (Brown et al., 2012; Bryant-Bedell & Waite, 2010; Danielsson et al., 2011; Lomas et al., 2013; Oliffe et al., 2013a; Patterson-Kane & Quirk, 2013). For most men, these emotions exacerbated their distress or depression and unintentionally impacted on relationships with friends and family.

Separate to, yet associated with, emotional pain was men’s experience of anger as a result of depression or distress. Some men believed they had no control over their depression and it caused them to act in angry and violent ways (Korner et al., 2011; Liang & George, 2012). Some used anger or physical violence as a means of suppressing or covering up their sadness and vulnerability (Brown et al., 2012; Danielsson et al., 2011; Oliffe et al., 2013a). For others, feelings of anger were just one of the many symptoms they experienced alongside despair and sadness (Johnson et al., 2012; Lomas et al., 2013; Rochlen et al., 2010). For college men, anger was an emotional release that gave them a way of communicating their pain, however it often made matters worse by affecting friends and family (Oliffe et al., 2013a). Some older men saw anger as both cause and consequence of their depression, particularly in those men who lost their jobs which further fueled their anger and hostility (Oliffe et al., 2013b).

**Managing the Problem**

A third theme was found to reflect men’s desire to deal with or manage the problems themselves. This included the subthemes “putting on a front”, “doing other stuff”, and “negotiating dominant masculine ideals”.

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Putting on a front. Many men in these studies wanted, or thought they should be able, to manage the problem themselves, a concept Johnson refers to as “manly self-reliance” (Johnson et al., 2012). One way men tried to manage their problems themselves was by hiding or concealing their depression or distress from others in order to appear like nothing was wrong, and to project an image of well-being, or pass as being well, in front of friends, family or work colleagues (Bryant-Bedell & Waite, 2010; Cleary, 2012; Oliffe et al., 2013a; Oliffe et al., 2013b; Patterson-Kane & Quirk, 2013; Rochlen et al., 2010). Some did this through constant monitoring of their own behavior and emotions while they were around others, which they found exhausting, whereas others were not even aware they were doing it. Some chose to isolate themselves in order to hide their problems because of the belief that men should be able to cope on their own, while others felt it was easier to hide or avoid others than to pretend that everything was alright (Bryant-Bedell & Waite, 2010; Danielsson et al., 2011; Fletcher & StGeorge, 2010; Johnson et al., 2012; Liang & George, 2012; Oliffe et al., 2013a; Patterson-Kane & Quirk, 2013). The down side of this self-imposed isolation is that it often led to more loneliness and exacerbated emotional pain. Other men hid their distress out of fear of being judged as weak for disclosing their emotional vulnerability (Cleary, 2012). Often drinking, drugs or being overinvolved at work were used as a means to hide or cover up their distress or depressed feelings (Brown et al., 2012; Cleary, 2012; Rochlen et al., 2010).

Doing other stuff. The various strategies that men used to cope with or manage their mental health problems themselves varied across studies. They were often influenced by the level of men’s self-awareness or recognition of a problem, whether it was the first time they had experienced problems or had prior experience, and whether they had seen a health professional or not. In many studies men talked about doing things for themselves such as hobbies, physical activity and sports, helping others, or doing something they enjoyed such as watching television or “chilling out or mellowing” (Bryant-Bedell & Waite, 2010; Fletcher & StGeorge, 2010; Liang & George, 2012; Lindsey & Marcell, 2012; Lomas et al., 2013; Oliffe et al., 2010b; Patterson-Kane & Quirk, 2013). For some, these activities were seen as a means of problem solving and a way of stopping them from dwelling on their problems, in other words practical ways of alleviating their distress or depression. For others, these activities were clearly used as distractions and ways of distancing themselves from the problem.

Alcohol and substances such as cannabis were used for a variety of reasons, however for most substance use presented a way of easing their emotional pain (Bryant-Bedell & Waite, 2010; Cleary, 2012; Fletcher & StGeorge, 2010; Isaacs et al., 2013; Lindsey & Marcell, 2012; Oliffe et al., 2012). For others, alcohol and/or drugs provided relief from over-thinking and unhealthy introspections (Lomas et al., 2013). Younger suicidal men used alcohol to prepare or to give them courage to act on their suicidal thoughts (Cleary, 2012). Young college men with depression viewed binge drinking and illicit drug taking as a manly strategy which reduced the chances of them being ostracized or marginalized by their peers (Oliffe et al., 2013a). Using alcohol and drugs to self-medicate was not viewed in the same way by all men, however. For example, men in Lomas’s study, who were arguably more experienced in coping with their distress, reported that using work or alcohol and drugs to sort out problems were not strategies sustainable in the long term (Lomas et al., 2013).

Not all men used distraction as a way of coping. Many men did not know about effective coping strategies until they had already experienced a problem or episode, and by trying different strategies, they learnt what did and did not work. For example, some men learned
about their depression triggers and developed strategies that worked from experience, reading self-help materials or (other) online resources rather than from counselling (Grove, 2012). Others found they were better able to manage their distress long-term using strategies such as meditation (Bryant-Bedell & Waite, 2010; Lindsey & Marcell, 2012; Lomas et al., 2013).

**Negotiating dominant masculine ideals.** Underlying many of the decisions to deal with problems themselves were men’s desire to conform to dominant masculine ideals of being in control, being strong and courageous and maintaining their independence. Many men kept their feelings to themselves thinking that they just needed to shake it off or control their emotions, or that they would run their course and they could control the situation (Bryant-Bedell & Waite, 2010; Johnson et al., 2012). However, in a number of studies some men described traditional masculine ways of thinking and acting which actually helped them to cope with mental distress. For example, suicidal men who aligned with more idealised masculine roles of provider and protector, such as being a good partner, family man and father, were stopped from acting on suicidal thoughts because of concerns that they would be abandoning and inflicting pain on their partner and family (Oliffe et al., 2011; Oliffe et al., 2012). Other depressed men felt they had been able to overcome their problems, or at least relieve their distress, by engaging in activities which were typically seen as masculine such as chopping firewood, playing in a band or motor biking (Valkonen & Hänninen, 2013). Alternatively, younger male students with depression framed their struggle in “fighting talk”, enacting masculine public performances of traditional masculinity visible to others which provided them with relief and a way of coping (Oliffe et al., 2010b). Younger men also embraced idealised masculine identity when framing their struggle with depression as “winning the fight” against depression (Oliffe et al., 2010b). In contrast, men in Coen’s study (2013) actively distanced themselves from traditional masculine ideals and embraced alternative ideals to manage their depression. Examples include reassigning work/carer roles at home, ensuring a work-life balance that worked for them and their families, and openly expressing their emotions and feelings (Coen et al., 2013).

**Seeking Help and Support**

A fourth theme was identified which reflected men’s experiences with seeking help and support. Three subthemes were constructed which included how men experience “reaching the tipping point”, “seeking professional help”, and “seeking informal help and support”.

**Reaching the tipping point.** Many men in these studies did not seek help despite experiencing significant distress and problems with their mental health. For men who did eventually seek help and support, whether it was from a professional or informal support from friends/family, it was preceded by a tipping point or threshold. This often occurred when men found that their self-management or coping strategies were no longer working and their problems escalated, or when their distress had become so bad that they were either forced to seek help or decided it was time to seek help (Oliffe et al., 2010a; Oliffe et al., 2012; Oliffe et al., 2010b). Others felt they had no control over what happened to them and only got help after a breakdown or a tipping point pushed them into it (Bryant-Bedell & Waite, 2010; Johnson et al., 2012; Lindsey & Marcell, 2012). Some men recognized when they reached an “appropriate” stage or threshold of suffering or had exhausted their own inner resources and that this justified seeking help (Johnson et al., 2012). For others, the tip-
ping point was seen as a wake-up call, for example, their current work-life balance was not working (Grove, 2012), or their relationship break-up had created an emotional crisis for them (Lomas et al., 2013).

**Seeking professional help.** The dominant discourse on men’s help-seeking that “manly” men do not seek help, was encountered in a number of studies. Many men were reluctant to seek professional help as they viewed needing help as not aligning with masculine ideals of strength, courage and independence. Rather, these men considered seeking help to signify weakness (Johnson et al., 2012; Lomas et al., 2013; Oliffe et al., 2010b; Rochlen et al., 2010). For many men, seeking professional help was seen as a last resort. Depression was positioned as a minor problem that they could deal with themselves. A number of men were frustrated and dissatisfied with being offered medication (Johnson et al., 2012; Rochlen et al., 2010), worried it could “cloud” their ability to self-manage (Oliffe et al., 2010b).

Seeking help from therapeutic interventions, such as talking therapies, was viewed with scepticism by some men (Cleary, 2012; Rochlen et al., 2010) while others had tried them in the past but not found them helpful (Grove, 2012). Others were dismissive of any solutions requiring any self-disclosure or introspection (Johnson et al., 2012) while for some talking about their emotions was too challenging (Rochlen et al., 2010). Some men avoided help-seeking for fear of being judged. For these men, avoiding help-seeking minimized any additional potential stigma (Isaacs et al., 2013; Johnson et al., 2012).

Not all men reported that talking therapies do not work. Men in one study found talking to a therapist valuable as it allowed them to express emotions they had learned to suppress (Lomas, 2013). Others who did find treatment such as involving psychotherapy beneficial, saw it as a strategy complementary to their own self-management strategies (Oliffe et al., 2012), felt understood and listened to which in turn was empowering (Johnson et al., 2012), or found it helpful to have their depression labelled as a medical condition (Rochlen et al., 2010). Some men thought problem-solving therapies were acceptable because they saw them as responsible approaches to self-management (Johnson et al., 2012). Younger men were prepared to get help from a professional when there was no-one in their circle of friends, or no close relatives, to talk to (Danielsson et al., 2011). In contrast, there were a number of reasons why Aboriginal men were reluctant to have contact services, including fear of being ostracized from their communities, poor understanding of services, lack of trust of services, experiences of racism, and lack of family support to access services (Isaacs et al., 2013).

**Seeking informal help and support.** Few studies explored men’s help-seeking from informal sources such as family members and close friends or partners. Men in one study reported wanting to talk to family or friends but having very few or no people in their close networks with whom they trusted to share their feelings or get support from (Liang & George, 2012). For younger men developing friendships with women, speaking to girlfriends or chatting with close friends was supportive (Danielsson et al., 2011; Oliffe et al., 2010b). Others chose not to talk to family or friends because of fear of being judged or had found other men un receptive to talking about emotional issues in the past (Cleary, 2012; Coen et al., 2013). Connecting with others for support could help to counter suicidal thoughts for some (Oliffe et al., 2012), while others wanted to connect but did not know how to express themselves or were embarrassed to do so (Bryant-Bedell & Waite, 2010; Liang & George, 2012). Some men found approaching individuals who would listen to them talk, even if they did not say anything in return, was beneficial as they felt less isolated (Fletcher
MCKENZIE, JENKIN & COLLINGS

& StGeorge, 2010). For a number of men, intimate partners were a significant source of emotional support (Coen et al., 2013; Oliffe et al., 2012).

To Disclose or Not to Disclose

The final theme identified men’s struggle with choosing how and when to tell others about their mental health problem, and was closely related to their decisions around coping and seeking help. For a number of men, their decision not to disclose, or to disclose rather cautiously, was influenced by their perceptions of what men “should” do: conventional constructions of masculinity such as wanting to appear as strong, stoic, unemotional and not needing to confide in others (Cleary, 2012; Danielsson et al., 2011; Isaacs et al., 2013; Johnson et al., 2012; Oliffe et al., 2010b). Many men were fearful of the consequences of disclosing, of being scrutinised by other men or being seen as unmasculine or weak. Some had tried to tell other male friends about their problems but reported being “shut down” (Cleary, 2012; Coen et al., 2013). Ultimately, disclosure of any sort of emotional pain was seen as a weakness by men and they were afraid of being seen as weak or vulnerable. However, the characterization in the literature of men’s lack of disclosure and seeking help as solely reflecting their need to be seen as masculine was not supported in three studies in this review. There were men who wanted to disclose to others but could not always find the right context (Fletcher & StGeorge, 2010). Others wanted to express how they were feeling to others but did not know how to go about it (Bryant-Bedell & Waite, 2010). A reluctance to self-disclose, for international students, was influenced by cultural pressures that their family status back home could be jeopardized through their disclosure of a mental health problem (Oliffe et al., 2010b).

Discussion

Five themes emerged from the metasynthesis: men’s common explanations of the triggers and causes of their mental health problems; men’s experiences of emotional pain; men’s desire to manage the problems themselves; seeking help and support; and disclosure. Overall, these reflect the findings of Hoy’s earlier meta-ethnography (2012). The present systematic review reveals that the literature is still narrowly focused on men with diagnosable or self-reported depression, professional help-seeking and the negative impact that men’s behaviors and beliefs have on their mental health. Both reviews emphasize that qualitative research in men’s mental health to date remains mainly additive rather than transformative.

Few studies in both Hoy’s (2012) review and the present review, specifically explored men’s help-seeking from informal sources such as family members, close friends or partners. Yet there were studies in this review which suggested that for some men, the desired source of help depended on the type of problem they were experiencing, the closeness of the relationship with the person they were asking for help, and whether that source of help could be trusted. For example, some men in Lindsey’s study described testing potential sources of help before sharing personal information about their emotional struggles and often felt more comfortable asking for help from someone they had known for a while (Lindsey, 2012). Furthermore, many studies in the present review positioned help-seeking as the responsibility of men, ignoring the fact that clinical interactions are two-sided and that professionals may also have problems recognizing and helping distressed men.

Few studies in this review focused on how men without diagnosed or self-reported depression might be self-managing their mental health and using their own strategies to cope
with stressful life events. An exception to this was the study by Lomas of men who had taken up meditation as means of self-care (Lomas et al., 2013). Although men in this study described experiencing significant distress and depression in their lives, depression was not an inclusion criterion. The authors identified men who were actively managing their mental well-being which as Lomas argues is in contrast with research that constructs masculinity as a uniform category where men are “damaged and damage-doing” (Lomas et al., 2013). Their findings also emphasize that it is possible for men to find alternative ways to express their masculinity and better manage their emotions.

As in Hoy’s review, many studies in our review focused on the negative aspects of hegemonic masculinity on mental health. There were exceptions to this which revealed how men are able to challenge or reinterpret dominant masculine ideals to manage their mental health problems. For example, some depressed men in Coen’s study (2013) coped by legitimizing alternative masculine ideals, such as being the primary care giver or home-maker, rather than aligning with the dominant and rigid version of masculinity that existed in their rural town. However, as Coen argues, because many of these alternative masculinities were performed in the domestic sphere it also served to keep these diverse masculine expressions “behind closed doors” (Coen et al., 2013). For other men, thinking and acting in a way that is traditionally seen as masculine was beneficial in allowing them to cope with distress. Men in Valkonen and Hanninen’s study (2013), for instance, felt they had been able to overcome their problems or had at least relieved their distress when acting in a masculine way or engaging in typically male activities in an effort to relieve their distress. Similarly, men in Oliffe et al. studies (Oliffe et al., 2011; Oliffe et al., 2012) tended to align themselves to masculine ideals around work and family. As argued by Oliffe, embracing protector and provider roles can bolster resilience and give men a sense of purpose that can counter self-harm and suicidal thoughts (Oliffe et al., 2011). These studies provide examples of the ways men are able to negotiate their masculinity to find more constructive ways of dealing with their distress. They also demonstrate that in order for the men’s mental health literature to evolve from the focus on the negative impacts of hegemonic masculinity, it needs to move from theorizing masculinity in the singular to pluralized “masculinities”. This approach recognizes the multiple ways men live out masculine gender identities (Connell, 2005).

Despite a number of studies in this review including men from diverse ethnicities and sexual preferences, largely absent was any exploration of how these differences between men influenced their perceptions and experience of mental health problems. Furthermore, as Hoy (2012) found, many of our studies focused on middle class, educated men. The construction of health and gender does not occur in isolation from other forms of social action that demonstrate differences among men such as ethnicity, social class, and sexuality (Courtenay, 2000). The benefit of a pluralized masculinities approach is that it may help to emphasize the heterogeneous nature of men’s lives as they are differentiated along class, ethnicity, age, and sexuality lines (Connell, 2005).

Based on our review of the literature, we have two suggestions which could move the men’s mental health literature in new directions. First, consideration should be given to exploring the perspectives of men who are not sampled solely on their experience of having diagnosed or self-reported depression. This would include men who may be experiencing emotional distress, subthreshold symptoms, or who do not label their problem in terms of mental illness. Many of the participants in the studies reviewed believed their mental health problems were caused or exacerbated by social and personal issues relating to work, relationships, family, racism or cultural differences. Therefore, as Hoy rightly argues, we need to go beyond the dominant paradigm of the disease model of depression in our research, pol-
icy and practice, and take a broader view that takes social factors into account (Hoy, 2012). If we consider the World Health Organization definition of mental health—"a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community" (WHO, 2015)—then we need to scrutinize the experiences of men who may not have a mental illness but whose current state of mental well-being is severely hampering their ability to cope with the normal stresses of life. Second, we suggest a shift in focus to study those men who are engaged in practices which support their mental health and emotional well-being and to explore how men negotiate masculinity in this context. The study in this review by Lomas is a strong example of this. Another example, which did not set out to explore men’s mental health and was not included in this review, is Emslie’s study of Scottish men in their thirties (Emslie, Hunt, & Lyons, 2013). When asked about the role alcohol played in forming and maintaining friendships, men constructed drinking with friends as helping men talk to each other, providing social support and improving mood. Mental health issues were raised spontaneously by some men who discussed both the negative and positive effects of alcohol on their mental health during focus groups. Therefore, focusing men’s mental health research on broader areas of men’s lives seems prudent.

LIMITATIONS

The limitations of our review relate in part to the limitations of qualitative metasynthesis in general. Pragmatic decisions have to be made in order for a metasynthesis to be manageable and to provide findings that are useful. We did not include grey literature or non-peer reviewed articles and confined the search to a three-year period. Since this time auto-alerts set up for the databases searches used have yielded a further twelve articles up to the time of submission. Qualitative metasynthesis also involves the interpretation of researchers’ constructions of the data they obtained from research participants, who in turn have provided an interpretation of their own experiences. The findings are, at the very least, three times removed from the lived experiences of the research participants they are meant to represent (Sandelowski, 2006). However, a metasynthesis is not meant to supersede the studies from which it is derived. The goal is rather to produce a new and integrative interpretation of findings that is more substantive than those resulting from individual studies (Finfgeld, 2003).

We compared our approach to Hoy’s by running our search strategy for the time period of Hoy’s review. Our search identified 17 of the 26 key studies in that review. Those that were not included did not use keywords or mesh headings that fell into all three categories of our search terms (that is, terms related to mental health, experiences or understanding, and terms for men). This is partly a consequence of having a broader research question to guide our metasynthesis but also shows that subtle changes in search terms can yield different results.

CONCLUSIONS

Our review, which builds on and extends a previous meta-ethnography, confirms that the current qualitative literature on men’s mental health remains predominately focused on depression, professional help-seeking and negative aspects of hegemonic masculinity. Although the masculinity and men’s mental health research is a relatively new and emergent area, studies to date continue to be additive rather than transformative to our understanding of men’s perspectives of mental health.
Our recommendation for moving past the current focus on depression is to broaden our conception of mental health beyond an illness framework and to investigate the complex and interrelated issues that affect men’s daily lives. Currently, we know little about how men experience or manage issues that impact on their mental health and emotional wellbeing before their problems potentially progress to a mental disorder like depression. Furthermore, although no longer invisible, men’s lives remain undertheorized in the mental health literature. There is a diversity of social and health practices and a diversity of mental health outcomes among men which is not captured in much of the current research. In order to move the research agenda forward we need to embrace a more nuanced and sophisticated way of looking at the patterns of difference among men (and between men and women) and move away from viewing men as a homogenous group. Social constructionist theories of gender offer a useful theoretical basis for explaining the diversity in men’s health beliefs and behaviors and the multiplicity of masculinities. More specifically, adopting a gender-relations approach would allow the examination of men’s mental health concerns in the context of men’s and women’s interactions with each other and their positions in the larger, multidimensional structure of gender relations (Bottorff et al., 2011; Schofield et al., 2000). Findings from research that theorizes men’s everyday lives in the context of gender relations and the practices that impact on their mental health and wellbeing, could help us be more upstream in promoting men’s mental health. It would help us to propose workable solutions to the problems men face in their daily lives. It would also assist health care providers and mental health promoters to understand men’s mental health practices in the wider context of social structures and institutions and the implications of this for service design and interventions.

REFERENCES


Lindsey, M.A., & Marcell, A.V. (2012). “We’re going through a lot of struggles that people don’t even know about”: The need to understand African American males’ help-seeking for mental health on multiple levels. *American Journal of Men’s Health, 6*(5), 354-364.


Appendix B: Ethics approval for key informant interviews

Professor S Collings
Dean’s Office (Wgnt)
Faculty of Medicine
University of Otago, Wellington

12 March 2014

Dear Professor Collings,

I am writing to confirm for you the status of your proposal entitled “Mental health promotion strategies for me: what can we learn from mens’ experiences and perspectives?”, which was originally received on February 27, 2014. The Human Ethics Committee’s reference number for this proposal is D14/076.

The above application was Category B and had therefore been considered within the Department or School. The outcome was subsequently reviewed by the University of Otago Human Ethics Committee. The outcome of that consideration was that the proposal was approved.

Approval is for up to three years from the date of HOD approval. If this project has not been completed within three years of this date, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte
Manager, Academic Committees
Tel: 476 6256
Email: gary.witte@otago.ac.nz
Appendix C: Key informant information sheet

Information Sheet for Key Informants

Thank you for showing an interest in this project. Before you decide whether you want to take part, please read this information sheet carefully. If you decide not to take part, there will be no disadvantage to you and we thank you for considering our request.

What is the aim of the project?

The aim of this project is to investigate how men understand and experience good mental health and to identify the self-management and coping strategies that men use when they are experiencing everyday stress or mild to moderate mental health problems. The research aims to inform innovative and alternative approaches to mental health promotion and suicide prevention strategies from the perspectives of men.

The project is being undertaken as doctoral research and will occur in two stages. This first stage of the project is to identify the current issues in New Zealand (NZ) for men and their mental health through talking to key informants. These findings will then be used to inform the second stage of the research which will involve interviewing a sample of men aged 25-64 years about their understanding and experiences of mental health.

Why have I been chosen?

You are being invited to take part in this project as someone who is in a good position to offer insight into this topic, and express views on what the current issues in NZ are for men and their mental health.

What will participation involve?

Should you agree to take part in this project, you will be asked to meet with the researcher and take part in a semi-structured interview. The interview can be carried out in your workplace or at a mutually agreed venue, whichever would be more convenient for you. The interview will be based around open-ended questions and will take approximately an hour. It is intended as an opportunity for you to express your views on the current issues for men and their mental health and the mental health promotion and suicide prevention strategies that are ongoing in NZ. The results of these initial key informant interviews will be used to inform the second stage of the research and the guide for interviewing men.
What will I be asked?

This research involves an open-questioning technique. The general line of questioning includes your views on what is mental health, day-to-day mental health issues for men, men’s lay views, how men recognise and seek help/support for their mental health, coping strategies and stereotypes that impact on men’s health. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the Deans Department is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s). Please be aware that you may decide not to take part in the project without any disadvantage to yourself. You may also withdraw at any time and without any disadvantage to yourself.

What data or information will be collected and what use will be made of it?

The interview will be recorded and notes taken by the researcher. No personal information will be collected except your job role/title and/or the name of your organisation. Recordings of interviews will be securely stored in such a way that only those mentioned below will be able to gain access to it. As per the University’s research policy, any raw data on which the results of the research depend will be kept in secure storage for ten years, after which it will be destroyed. The results of this study will be written up as part of my PhD thesis but your anonymity will be preserved, and you will not be identified in the final thesis. You would be very welcome to a copy of the final findings of the research.

Please feel free to contact Sarah McKenzie (PhD researcher) or Professor Sunny Collings (Supervisor) if you have any questions about the project.

Sarah McKenzie  
Social Psychiatry and Population Mental Health Research Unit  
Email: sarah.mckenzie@otago.ac.nz  
Phone: 04 806 1499

Sunny Collings  
Social Psychiatry and Population Mental Health Research Unit  
Email: sunny.collings@otago.ac.nz  
Phone: 04 918 5600

This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix D: Key informant consent form

Consent form for Key informants

I have read the Information Sheet concerning this project and understand what it is about. I understand that I am free to request further information at any stage. I know that:

1. I have had the opportunity to discuss the interview and I am satisfied with the answers I have been given.
2. I have had time to consider whether to take part.
3. I understand that taking part in this interview is my choice and that I may withdraw at any time at no disadvantage to myself.
4. I understand that my participation in the study will be confidential and that no material which could identify me will be used in any reports on the study.
5. I understand that any raw data on which the results of the study depend will be kept in secure storage for ten years, after which it will be destroyed.
6. I understand that this research involves an open-questioning technique. The general line of questioning includes your views on men's mental health, coping strategies and barriers to help-seeking. The precise nature of the questions will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

I agree to take part in this project.

..................................................................................................................  ................................................
(Signature of participant)                                          (Date)

..................................................................................................................
(Printed Name)
Appendix E: Key informant interview guide

Interview Guide: Topics for discussion with Key informant interviews

1. The concept of mental health
   a. What is your understanding of the term ‘mental health’?
   b. Thinking about the general population in New Zealand, do you think there is a lay view of mental health? How does it differ from mental illness?
   c. What is your view on the level of mental health literacy in NZ?

2. Men’s lay view of what mental health is
   a. Following on from the general population view, do you think men might have a different view of mental health?
   b. In your experience, what words do men commonly use to describe their mental health or illness?
   c. What do you think are the influences on the mental health of men?

3. Men recognising and coping with problems with their mental health
   a. How do you think men recognise when they are having problems with their mental health?
   b. How do you think others close to men e.g. partners, friends would recognise if a man is having problems with his mental health?
   c. What’s your view on how men cope when they are experiencing everyday stress or problems that could impact on their mental health?

4. Men and help-seeking/accessing support/asking for help
   a. Do you think men have difficulty asking for help and if so why?
   b. What happens to those men who need help but don’t ask for it?
   c. What barriers do you think exist for men who may need to seek help?
   d. How do men that do seek help or consult a GP frame seeking help?

5. Stereotypes that impact on men’s health
   a. What is your view on the male deficit model that prevails in men’s health?
   b. Is there a male culture in NZ or a stereotype of the Kiwi bloke?
   c. How much do you think masculinity or gender play a role in men’s mental health problems?

6. My research study
   a. Do you think it is feasible to ask men how they maintain good mental health?
   b. If I wanted to speak to men who are engaging in and maintaining healthy behaviour that supports good mental health, then who would I speak to in order to get rich information?
   c. Given that I am a female researcher what impact do you think this could have on my research?
   d. What sort of language do you think would work to recruit men into my study and ensure men feel comfortable during an interview?
Appendix F: Ethics approval for life history study

Professor S Collings  
Dean’s Office (Wgnt)  
Faculty of Medicine  
University of Otago, Wellington

Dear Professor Collings,

I am again writing to you concerning your proposal entitled “Putting the ‘mental’ into health: men’s lay perspectives”, Ethics Committee reference number 14/130.

Thank you for your letter of response to the Committee dated 5 September 2014 and for providing your revised documentation. We note that Dr Jenkin and Jo River have been added as co-supervisors. Thank you for further clarifying your method of recruitment, and for providing a copy of your advertisement. Thank you for amending the Information Sheet, and for ensuring a list of support services and resources is included.

We note that you will pilot test the advertisement, information sheet and interviews and will make modifications where necessary. We look forward to hearing from you in due course.

On the basis of this response, I am pleased to confirm that the proposal now has full ethical approval to proceed.

Approval is for up to three years from the date of this letter. If this project has not been completed within three years from the date of this letter, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.

Yours sincerely,

Mr Gary Witte  
Manager, Academic Committees  
Tel: 479 8256  
Email: gary.witte@otago.ac.nz

c.c. Professor C D Collings  Dean of University of Otago, Wellington  Dean’s Office (Wgnt)
Appendix G: Participant information sheet

[University of Otago Logo]

Information Sheet for Participants

Thank you for showing an interest in this study. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the study about?

We know very little about how men perceive mental wellbeing and how they achieve it. This study aims to explore the lay perspectives of ordinary New Zealand men aged between 25 and 34 years about how they get through the stuff that life throws at them and propose ways that men’s mental wellbeing could be better supported in New Zealand.

What type of participants are being sought?

We are seeking New Zealand born men aged between 25 and 34 years living in the Wellington area. This study is specifically about men who have never accessed any secondary mental health services. For this study that means men who have never accessed an inpatient mental health unit or had contact with a community mental health team.

What is involved?

You will be asked to participate in a loosely structured interview with the researcher which will last between 60-90 minutes. The interview will focus on both good and tough experiences you’ve had in your life. You will be asked to talk about events or occurrences in your life that you feel may have had an impact on your mental health and well-being. If you feel uncomfortable at any time you have the right to decline to answer any particular question(s).

Can I change my mind and withdraw from the project?

This is a voluntary study and you may choose to withdraw from participation at any time and there will be no disadvantage to yourself.
What information will be collected and what use will be made of it?

This study involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. The general line of questioning includes experiences you’ve had in your life and strategies you have used to look after your mental health and wellbeing. Consequently, although the University of Otago Human Ethics Committee is aware of the general areas to be explored in the interview, the Committee has not been able to review the precise questions to be used.

In the event that the line of questioning develops in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s) and that you may withdraw from the study at any stage without any disadvantage to yourself of any kind.

Your interview material will be available only to the lead researcher and supervisors. Your interview will be digitally recorded and transcribed by the researcher. The results of the study may be published and will be available in the University of Otago Library (Dunedin/Wellington, New Zealand) but every attempt will be made to preserve your anonymity. You are most welcome to request a copy of the results of the study should you wish.

Data storage and confidentiality

The interview data collected will be securely stored in such a way that only those mentioned below will be able to access it. At the end of the study any personal information will be destroyed immediately except that, as required by the University’s research policy, any raw data on which the results of the study depend will be retained in secure storage for five years, after which it will be destroyed.

What if I have questions?

If you have any questions about our research or want to know more, please feel free to contact by phone or email:

Sarah Mckenzie (PhD student) sarah.mckenzie@otago.ac.nz  ph: 04 806 1499
Sunny Collings (Supervisor) sunny.collings@otago.ac.nz  ph: 04 918 5600
Gabrielle Jenkins (Supervisor) gabrielle.jenkins@otago.ac.nz

This study has been approved by the University of Otago Human Ethics Committee (Ref. 14/130). If you have any concerns about the ethical conduct of the research you may contact the Committee through the Human Ethics Committee Administrator (ph 03 479 8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix H: Participant Consent form

Consent Form for Participants

I have read the Information Sheet concerning this study and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage. I know that:

1. My participation in the study is entirely voluntary.

2. I am free to withdraw from the project at any time without any disadvantage.

3. The audio-recordings will be destroyed at the conclusion of the study but any raw data on which the results of the study depend will be retained in secure storage for five years, after which it will be destroyed.

4. This study involves an open-questioning technique where the precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. In the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the study without any disadvantage of any kind.

5. The results of the study may be published and will be available in the University of Otago Library (Dunedin/Wellington New Zealand) but every attempt will be made to preserve my anonymity.

6. I will receive a $35 voucher for my participation.

I agree to take part in this project.

..................................................................................................................  ........................................
(Signature of participant)  (Date)

..................................................................................................................
(Printed Name)
Appendix I: List of support services

What if I need to talk to someone?
If you need to talk to someone or seek professional help here is a list of resources with helplines and contact numbers of organisations.

Lifeline – Provides 24 hour telephone counselling 0800 543 354
Samaritans – Provides 24 hour telephone counselling 0800 726 666
Depression Helpline 0800 111 757
Suicide Prevention Line (TAUTOKO) 0508 828 865
Provides support, information and resources for those at risk of suicide, and their family, whānau and friends
Outline- GLBT telephone support 0800 6885463
Healthline - General health advice from registered nurses 0800 611 116
Alcohol and Drug Helpline 0800 787 797
Are You Ok- Family Violence Helpline 0800 456 450
Gambling Helpline 0800 654 655

Local DHB Crisis Help
Capital and Coast Mental Health Crisis Team (CATT) – covers Kapiti to Wellington 04 494 9169
Hutt Valley DHB Mental Health Crisis Team- covers Lower and Upper Hutt 04 566 6999
Websites for further information

Depression http://www.depression.org.nz/

Lifeline http://www.lifeline.org.nz/

Men’s Health http://nz.movember.com/mens-health/mental-health/

Suicide prevention http://www.spinz.org.nz/

Mental Health Foundation http://www.mentalhealth.org.nz/

Men’s Health http://www.getthetoools.org.nz/the-toolbox/
Appendix J: Recruitment posters
Men wanted!
How do you get through the stuff that life throws at you?

If you are a New Zealand born man aged between 25 and 34 years old living in the Wellington region then we want to talk to you about how you’ve got through the good stuff and tough stuff that’s happened in your life.

This is a chance for you to contribute to research about what men need to get through.

All participants will receive a $20 fuel or grocery voucher.

If you’d like to know more then email us at: sarah.mcleren@otago.ac.nz or call 02 BLOKESOK (02 256 53765)