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**Masculinity and Psychological Help-Seeking:
A Qualitative Study of Men's Pathways into
Psychological Help in Primary Care**

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Psychological Help in Primary Care**

**Thesis submitted for degree of Doctor of Clinical Psychology (Conversion)
to the Centre of Applied Psychology, University of Leicester.**

By Stephen Melluish

January 2002

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Abstract

The research describes a qualitative investigation of men's pathways to seeking psychological help. A total of seven men were interviewed using a semi-structured interview schedule. Qualitative data was analysed using grounded theory. One core category 'distancing' emerged from the analysis. This theme reflects the way in which men distance themselves from their distress and attempt to preserve a public appearance of coping. This general theme is reflected in five higher order categories that were also identified. These include: preserving a public identity; separating problems from self; crisis as disconnection; use of lay networks and self in psychological help. These themes are discussed in relation to men's pathways into psychological help and the network-episode model of help-seeking is revised to take account of these themes. Findings are discussed in relation to the relevant literature on help-seeking and masculinity. Recommendations for further research are made.

Acknowledgements

I would like to thank my supervisor, Professor Ed Miller, for his helpful advice and encouragement throughout the research process. I am also grateful to Joanna Teuton for her advice regarding research methodology and to my colleagues in the primary care service for their support.

Most of all this study depended on the involvement of the men interviewed and I am immensely grateful to them for their goodwill and for giving up their time to be interviewed for this study.

Finally, my special thanks for the support of Nik, Billie and Theo.

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1.0 INTRODUCTION

It has long been recognised that there is considerable variation in the ways in which people perceive, evaluate and respond to physical and psychological discomfort. Mechanic (1962) coined the term 'illness behaviour' to explain this variation, and he argued that illness and illness experience are shaped by social and cultural processes, irrespective of their biological bases. Consulting a doctor can be viewed as part of a process of illness behaviour and a substantial research literature has been developed around the patterns of help-seeking for medical and mental health care. One of the most firmly established findings in this extensive, albeit contradictory literature, is around sex differences in help-seeking, with women generally having more contact with their GPs than men (McCormack et al. 1995).

In terms of seeking professional help for psychological difficulties, these sex differences are even more marked. Two thirds of all those that seek psychological help are women, and one in three women compared to one in seven men seek services from a mental health professional at some point during their lifetime (Good, Dell and Mintz, 1989). Whereas much research and theoretical writing has focussed on the psychological and sociological reasons for women's use of mental health services there has been very little that has focussed on men's use or reluctance to use psychological services.

There are several possible reasons for the lack of research on men's use of psychological services. Firstly, there seems to be an assumption on the part of researchers that men are less likely to be able or willing to talk about their mental health. An example of such an assumption is found in the work of Brown and Harris (1978) who are quite explicit that their choice of a female only sample stemmed from a gender assumption: '*It also seemed likely that women, who are often more at home during the day, would be more willing to agree to see us for several hours...most of the women we approached were willing to talk to us at length about their lives and appeared to enjoy doing so*' (Brown and Harris 1978: 22). Secondly, the research on sex differences in help-seeking has tended

to have a female focus as researchers have been concerned to understand the over representation of women in mental health statistics. Consequently, this may have had the effect of making men relatively invisible. Thirdly, in terms of research into health service use the principal rationale has been to reduce healthcare costs and consequently high service users have been an understandable focus with non-attendance or low use of services tending to be associated with health.

Much of the recent scrutiny of men's health issues, (Harrison and Dignan, 1999; Kirkby, Kirkby and Farah, 1999; O'Dowd and Jewell, 1998) has tended to have a clinical physical disease focus, for example concern with testicular cancer or prostate problems, and has been less focussed on the psychosocial aspects of health for men or on men's psychological health. There are signs, however, that in terms of mental health policy and practice concepts such as gender and masculinity are beginning to be considered. In 1996, the Royal College of Psychiatry organised a campaign to highlight the problem of depression in men stating that 'the way men see themselves can actually be harmful to their mental health.' More recently, in 1999, the Government published a paper as part of its 'new' public health strategy entitled 'Men's health: a public health review', which states that 'most important... is the question of how men's sense of their own masculinity affects many aspects of public health'. These pronouncements reveal a growing awareness that men's beliefs and attitudes about what it is to be masculine may directly influence their health behaviour. There is, however, little research in this area and a clear need for more detailed investigation into the attitudes and beliefs that men have about their health and how these influence their use of health services.

This study is an attempt to do this through investigating the pathways by which men come to seek psychological help and to understand more about the relationship between their conceptions and experience of psychological distress and their use of health services. The exploratory nature of this research suggested that a qualitative methodology was most suitable. The present study uses a grounded theory approach to analyse qualitative data gained through interviews with men referred for psychological help to the Nottingham primary care clinical psychology service where the author works part-time as a clinical psychologist. The justification for this research derives from a wish to

understand more about the barriers to help-seeking for men and to use this understanding to improve access to psychological services for men.

Before describing the present study, an overview of the background research literature on help-seeking is given and discussed in relation to recent theorising around gender and masculinity. This background literature is organised in the following way. To begin, there is a brief overview of the main models of help-seeking and the concept of 'help-seeking pathways' is introduced. Next, there is a review of the research on the main social correlates of mental health service use followed by a discussion of psychological help-seeking in a primary care context. Then, the research into sex-differences in help-seeking is considered and finally, the concepts of gender and masculinity are introduced and discussed.

1.2 Models of help-seeking and the concept 'Help-seeking pathways'

Various psychological models of health care utilisation have been developed, of which there are three dominant models: the socio-behavioural model, the theory of reasoned action model and the health belief model.

In the late 1960's Ronald Anderson developed the socio-behavioural model (Anderson, 1995). This model described three basic categories: need, predisposing and enabling factors. The model suggests that some need must be defined or individuals are not likely to consider using services. The model also emphasises how the way people perceive need and how they experience symptoms influences the nature of illness. Over time the model has been revised to incorporate more variables such as the effect of service use, how previous experience alters need, and predisposing and enabling characteristics.

Fishbein and Ajzen (1975) developed the theory of reasoned action. In this model, expectancy is key and health behaviour is seen as being determined by the way individuals rate how current and alternative actions can reduce their health problems. The model focuses primarily on motivations,

assessment of risk and avoidance of negative outcomes. Individuals are seen as evaluating whether or not to engage in healthy or risky behaviours and whether to seek preventative as well as curative services.

The most prominent and widely used of these models is the health belief model which was first developed to explain preventative health behaviour (Kasl and Cobb, 1966) but has more recently been adapted to explain illness behaviour and help-seeking. The health belief model uses a cognitive framework that emphasises 'vulnerability' and 'barriers' to help seeking and includes psychological and social variables with which to predict individual behaviour. According to this model, *'seeking medical care is determined by perceived benefits and barriers to seeking care and cues that instigate appropriate behaviour'* (Rosenstock, 1966). This model has been applied in a number of studies of the use of specialist services (Saunders, 1993) and in the utilisation of primary care services (Eagen and Beaten, 1987).

Over the last decade, each of these models of help-seeking has been revised to include other social and systemic influences (e.g. social networks) and become less focussed on solely individual factors. However, the assumptions underlying these models (that individuals decide on the basis of rational choice and that service use equates to help-seeking) do not always accurately reflect the actions of people and tend to ignore the role of meaning and context in the purposeful action of individuals. Often what is missing, or at least underplayed within much of the research using these models, is the potential that lay knowledge has in understanding utilisation behaviour and an awareness that the way people deal with health problems is essentially a social process.

Within the psychological literature there is a small body of literature examining lay attributions of illnesses which are viewed as indirectly linked to help-seeking. Furnham (1994) for example investigated lay beliefs about overcoming common illnesses often seen in primary care services. The most important factors were found to be inner control and understanding the availability of help on offer to deal with the illness. Within medical sociology, there is a well-established tradition of examining lay understandings and experiences of illness. Blaxter (1985) takes the view that while lay views are at times less 'expert' than professional views, because they are grounded in subjective

experience, in other ways they may be better informed. One of the deficiencies of research into the utilisation of mental health services, particularly by men, has been the lack of understanding of the reasons for service use as seen from the patient's perspective.

A further weakness in the psychological models relates to the importance attributed to individual behaviour at the expense of other variables. A growing body of qualitative research exploring different people's perceptions of the cause of their health and the actions they take in relation to their health highlights the significance of social processes. Social process approaches to health care utilisation draw heavily on the notion of illness as a social entity and the concept of illness behaviour. Illness behaviour has been defined by Mechanic (1980) as '*the manner in which persons monitoring their bodies define and interpret their symptoms, take remedial action and utilise the healthcare system*'. From a functionalist perspective Parsons (1951) argued that illness was the inability to fulfil one's role, while Friedson (1960) suggested that the criteria by which lay people judge illness are related to norms about bodily experiences or normal capacity. Parson's work on the sick role included a focus on the obligations and responsibilities that set the parameters for people to seek help and enter the sick role and patient role. Other social scientists have placed greater emphasis on how individuals define and cope with illness as an everyday experience (Fitzpatrick et al. 1986). They have viewed the defining of illness as a selective, interpretative and evaluative process taking place within a specific social context, and have drawn attention to the ability of people to use a combination of health care advisors and means of dealing with illness simultaneously.

The 'illness career' approach, rooted in the symbolic interactionist tradition within sociology, draws attention to the way in which the patient role is negotiated and maintained and how others react and categorise illness. The illness career approach has similarities to the socio-behavioural approach in that it conceptualises a set of phases which people embark on but it differs in that the experience of illness is viewed as a set of logical critical decision points which are flexible and where '*alternative decisions at any stage can lead to further decisions or a reconsideration of earlier ones*' (Twaddle and Hessler, 1977). A number of social models of health service use have been suggested as part of an illness career approach. Mechanic (1980), for example, identified three stages of the help-

seeking process: the illness stage during which the problem exists and is recognised; the illness behaviour stage during which attributions for the problem are made and various coping strategies are tried; and the help-seeking stage during which the individual seeks professional help.

Within this approach to understanding the use of mental health services David Goldberg and Peter Huxley (Goldberg and Huxley, 1980) developed the concept of 'pathways' into care. The pathways concept has more recently been discussed in relation to mental health service use by Roglers and Cortes (1993). Roglers and Cortes define the concept in the following way:

'By "pathways" we mean the sequence of contacts with individuals and organisations prompted by the distressed person's efforts, and those of his or her significant others, to seek help as well as the help that is supplied in response to such efforts'. (p555)

This concept moves beyond just looking at the initial recognition of the distress as a health problem and the decision to seek professional care and instead places the help-seeking in an interpersonal, social and cultural context. The pathways concept offers a more comprehensive way to understand help-seeking which takes account of the individual's cultural interpretations of the evolving distress and the attempted therapeutic and social interventions by lay persons and professionals. For clinical psychologists the concept seems to make intuitive sense, as the story surrounding the distress brought by the client is often revelatory including a biography of the events and pressures surrounding the particular problem. As this is being revealed so is the pathway that brought the individual to the clinician.

Some researchers have suggested stages in the help-seeking pathway for psychological problems that define points or phases that individuals pass through as they cope with mental health problems. Goldsmith, Jackson and Hough (1988) identify four such stages: symptoms appear, the problem is recognised, services are used and particular types of providers are accessed.

The problem with such a stage model is that it suggests that individuals have to pass through every stage in the model. As this clearly does not always happen a revised model (Figure 1.) known as the network –episode model has been proposed by Pescolido and Boyer (1996).

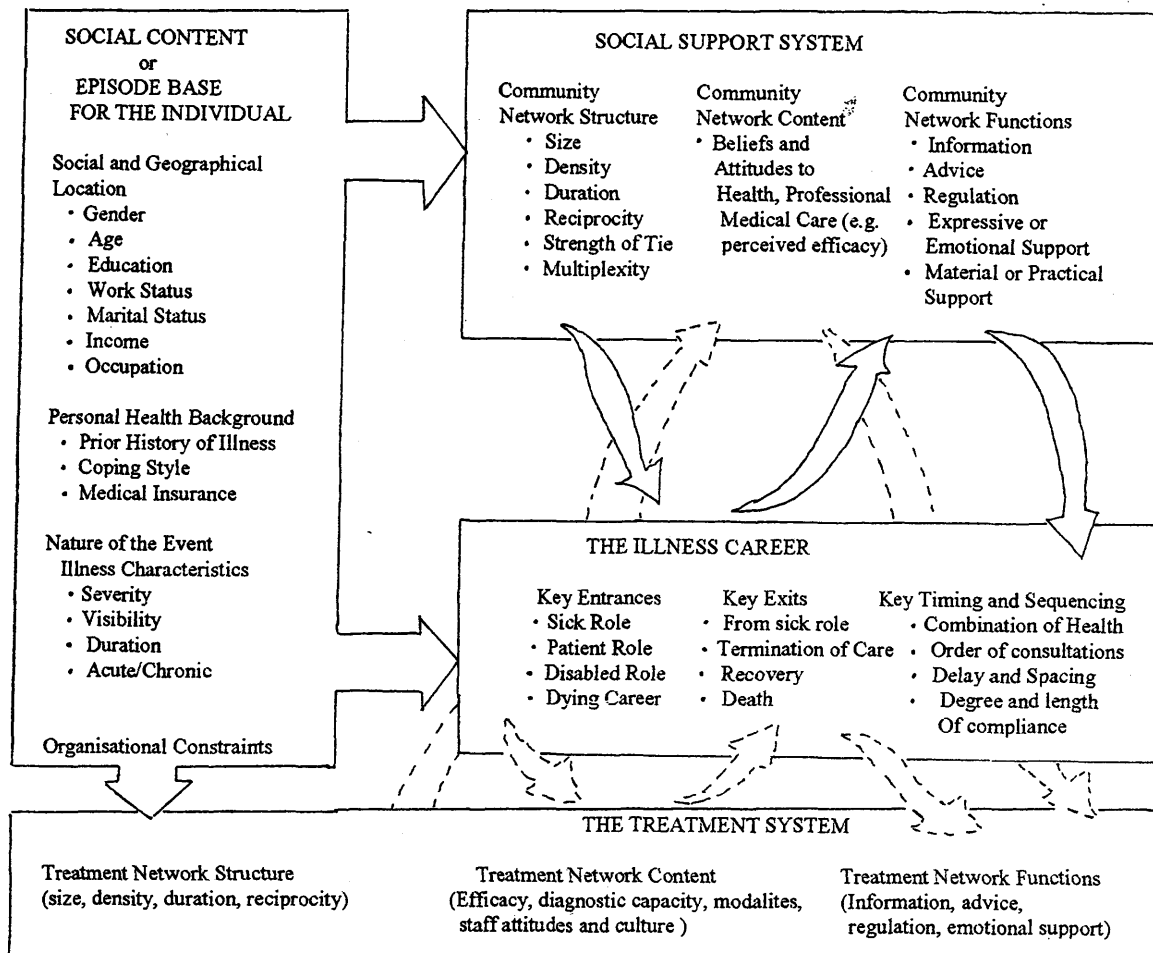


Figure 1. Network-episode model (Pescolido and Boyer, 1996)

Pescolido suggests that individuals are pragmatic and use common sense knowledge and cultural routines as well as seeking out and responding to others when symptoms of psychological distress occur. As Pescolido states *‘ they face illness in their day-to-day lives by interacting with other people who may recognise (or deny) a problem, send them to (or provide) treatment, and support, cajole, or nag them about appointments, medications, or life style’*.

While ‘help-seeking as a social process’ forms a minority trend within the work undertaken in the area of health utilisation behaviour it seems useful as it offers the potential to move beyond a focus

on the individual and to understand a person's illness behaviour or illness career in a wider social context. With regards to men, it allows for their help-seeking to be understood within a social context structured by gender.

1.3 Research into the use of Mental Health services

Epidemiological studies of health care use have consistently shown that those who seek medical care represent the tip of an iceberg, and that a large proportion of morbidity in any community never reaches health care services. Community surveys show that psychological and emotional problems are widespread throughout the population with a one-year prevalence rate of between 26 – 31% and that 23% of consultations in general medical practice can also be attributed to psychological problems (Goldberg and Huxley, 1992). Of these people with psychological problems, only a small percentage (2.3% according to Goldberg and Huxley, 1992) ever use mental health services or receive professional help. This huge gap between need and use of services raises many questions about the process of social selection into treatment.

Research has consistently shown that the best predictor of mental health service use is 'need' for care (Pescolido and Boyer, 1996). This is the case whether 'need' is defined by the level of psychological distress, one or more psychiatric symptoms, limitations in mental health functioning, self-reports of mental health or a psychiatric diagnosis (Pescolido and Boyer, 1996). The research literature, however, illustrates how the wider social context also influences entry into treatment. The factors that have been shown to be the strongest and most consistent predictors of outpatient mental health service use are: gender, social class, race and age. Other factors that have been noted include: a person's lay or social network (Cornford and Cornford, 1999); marital status (Gove and Howell, 1974); the stigma of seeking help (Wells et al., 1994), attitude towards the service (Furnham and Wardley, 1990), and treatment fearfulness (Deane and Chamberlain, 1994).

As stated in the introduction, one of the most firmly established findings in the literature is that there are marked sex differences in the rates of consultation. This will be explored in detail in a later section on sex differences in psychological help-seeking. With regard to the other factors, the

main social correlates are briefly discussed below. In general, the findings repeatedly demonstrate that those at the very bottom of the social stratification system experience mental health problems disproportionately and yet are less likely to receive professional mental health care.

Social Class

In early studies of the links between social class and the use of mental health services, Hollingshead and Redlich (1958) found that individuals in higher social classes were more likely to use outpatient mental health services than those in lower social classes. Similarly, Kashudin (1966) showed that individuals in higher social classes were more likely to support the use of psychotherapy. Holmes and Lindsey (1989) suggest that there are class based filtering processes that influence both referral for psychotherapy and its provision, so that relatively fewer working class patients are offered it by services. Since these early studies research has focussed on education and income as components of social class. The effects of education on service use have been consistent, with studies showing that people with more education have a higher probability of using outpatient mental health services (Greenlay, Mechanic and Cleary, 1987). The effects of income on the use of mental health services are less clear. Several studies have reported that income is not significantly related to the use of mental health services (Leaf et al. 1985; Veroff et al. 1981).

Race and Ethnicity

Ethnicity has also been shown to be an important factor in mental health service use with people from ethnic minorities receiving fewer outpatient mental health services and less psychological therapy (Padgett et al. 1994). Some research has shown the primary reason for not using services amongst people from ethnic minorities, at least in the U.S., is that they fear hospitalisation (Lin et al. 1987). There is also some evidence that the ethnic background of clinicians is an important factor in whether people take up treatment (Sue et al. 1991).

Age

In terms of age, it has been found that younger and older age groups have the lowest rates of use, while the middle-aged (25 – 64 year olds) use the most outpatient mental health services (Horgan, 1984; Shapiro et al. 1984). The opposite occurs for physical ailments, where the very young and the elderly are the highest consumers of services (Rowlands et al. 1997).

Although these social correlates are informative, one cannot understand the patterns and processes of help-seeking by looking at any single factor in isolation. For men, the complex patterns of help-seeking have to be understood as an interplay between gender with other structures of difference (such as social class, ethnicity and age). It must also be recognised that help-seeking behaviour is influenced by men's experience of illness, the way in which services and professionals have responded to men in the past and the levels of social support and alternative health care resources available to them in the community (Rogers et al, 1998).

The rates of psychological distress are further complicated because of the high rate of referral by other people. In a study by Rogers et al. (1993) in nearly two thirds of cases, professional psychological help was sought by others or in conjunction with others. A decision to seek professional help for psychological distress is therefore dependent on both the individual and others' notions of psychological distress and the translation of the experience of these problems into a willingness to contact formal agencies. In 1960, Friedson introduced the idea of a lay referral network and stated that, *'the whole process of seeking help involves a network of potential consultants, from the intimate and informal confines of the nuclear family through successively more select, distant, and authoritative laymen, until the professional is reached... the lay system is built on lay culture and a network of personal contacts along which the client travels on the way to secure services'*. A more contemporary study (Cornford and Cornford, 1999) of the role of lay networks in GP consultation found no evidence of such an extensive network as described by Friedson instead, *'patients talked to people they came into contact with in the context of conversations occurring for other reasons, but were not referred to progressively more remote, expert people. On the contrary, those with greatest influence were partners'*.

Psychological help-seeking is thus a complex process influenced by distal factors such as one's gender, social class, ethnicity and age and the interplay of these with more proximal psychosocial factors such as one's immediate social or lay network..

1.4 Psychological help-seeking in primary care

Primary care is a key point at which to study help-seeking for psychological distress as it is the interface between lay and formal healthcare. Primary care is the point in the system that is influenced by the patient's decision making about when and how to access services. As only a small proportion of healthcare problems are seen in primary care, small changes in the behaviour of the population or the accessibility and organisation of a service could produce large changes in the demand for formal care.

In recent years the organisation and provision of mental health care services and the public's view of mental health has changed significantly. Within the NHS there has been an enormous shift to provide more services in primary care and a growth in mental healthcare being provided in GP practices. This shift in the contours of mental health care inevitably means changes in the way people respond and make contact with health services. The research on mental health service utilisation, therefore, needs periodic re-investigation and earlier findings may not be directly transferable to understand current health behaviour.

1.5 Patterns of GP consultation

The available data on the utilisation of primary care services highlight the substantial use made of general practice services by the general population. Estimates suggest that 78% of those registered with a GP consult at least once a year with the average number of consultations per person per year being five (Rowlands et al., 1997). However, the number of consultations with a GP over one year varies strikingly between people and the distribution is highly skewed with many people seeing their doctor only rarely and a few seeing their doctor many times. The highest consultation rates are found among young children aged 0-4 years and the elderly aged over 75 years. Overall,

women are more likely to consult than men and this is particularly true for the age group 16-44 years. Among this age group the average consultation rate for women is six consultations per year compared with only three for men (Rowlands et al. 1997).

Sex differences in GP consultation patterns are evident throughout the life span (Williams et al. 1986; Rickwood and Braithwaite, 1994). From birth until the age of five, boys attend their general practice more frequently than girls. Between the ages of five and fourteen, there is little difference in attendance rates and from then on, throughout the age groups, men are less frequent consulters and their consultations may also be shorter (Westcott, 1977). Men's lack of contact with GPs is particularly striking in middle age. Cooke et al. (1990) found that in all social classes, 10% of men aged between 46 – 65 did not consult their GP over a three year period and a further 44% consulted on average twice a year or less.

Men's relationships with their GPs also appear to be more remote than women's. It seems that men are more prepared to see a locum GP or partner rather than wait for their individual doctor and are more likely to use casualty services as an alternative to general practice (Cartwright and Anderson, 1981). In terms of the gender of GP seen, men's gender preferences mirror women's with 25% of men reporting that they would like to consult a male doctor compared to 21% of women expressing a preference for a female doctor (Cartwright and Anderson, 1981).

A number of studies have shown that men appear to delay consulting their GP when they are ill, choosing instead to 'tough it out' (Rafuse, 1993; Griffiths, 1992; Jackson, 1991; Eisler and Blalock, 1991; Gijbers van Wijk et al. 1995). For life threatening illness or conditions that interfere with normal activities, men are as likely as women to consult but not so for milder forms of illness or disability or for psychological problems (Verbrugge, 1982). A study by Briscoe (1987) into sex differences in general practice consultation found that men consulted less than women and showed a marked tendency to come when in need of a medical certificate. Women on the other hand consulted more frequently and were more likely to ask about more than one condition during a consultation

In terms of help-seeking outside of primary care, men are also less likely to use other sources of help or advice about health. For example, there is some evidence that men are less likely to seek help from practitioners of alternative medicine with one survey showing two thirds of the users of a range of therapies were female (Thomas et al. 1991).

1.6 Consulting GPs for psychological problems

Consultation rates to GPs for psychological problems also vary according to household composition. Women and men living alone are more likely to consult for psychological problems than those who live with someone else. Among men aged 16-64 years, those living alone have higher consultation rates than those who are not. McCormack et al. (1995) also found that widowed and divorced people living without a partner are more likely to consult than those who are single or married. Unemployment and being permanently sick are also associated with higher consultation rates with unemployed men aged 16-44 years consulting their GP twice as often as employed men for psychological problems.

For the majority of people who experience psychological problems, the GP represents the first port of call on the pathway to psychological care. As such GPs have an important role to play in determining the extent to which their patient's mental health needs are met. Mental health referral rates among GPs are very variable (Ross and Hardy, 1999), and this may reflect in part their attitudes towards the use of psychological approaches in the management of mental health problems; those interested in psychotherapy refer relatively infrequently to psychiatrists and show a preference for referral to psychologists (Robertson, 1979). This pattern is supported by the finding that GPs who write detailed referral letters refer more often to psychologists and less often to psychiatrists compared with those who write briefer referral letters (Creed et al. 1990). Furthermore, GPs who are interested in psychological treatments refer relatively infrequently and treat more patients themselves (Verhaak, 1993). As these GPs may detect more psychological problems this suggests that the relationship between the ability to detect psychological problems and the tendency to make a referral is not a straightforward one (Kincey & Creed, 1991; Verhaak, 1993).

GPs referral decisions are also influenced by their perceptions regarding the extent to which available mental health services will meet the needs of their patients. For example, referral practice may be affected by GPs concerns about long waiting times for psychological services (Ramsden & Burton, 1994) or by their beliefs pertaining to the adequacy of local resources (Hendryx et al. 1994). These perceptions are likely to be shaped by feedback from clinicians and patients regarding client outcomes and experiences of psychological help.

1.7 Sex differences in psychological help-seeking

Most studies of sex differences in relation to mental health care show that men are less likely than women to report symptoms of psychological distress (Kessler et al. 1981) and tend to consult GPs less frequently for psychological and emotional problems (Briscoe, 1987). O'Brien suggests three reasons for men 's absence from seeking help with regards to emotional or personal difficulties. Firstly, men seem less likely to perceive such problems. Secondly, where such problems are recognised men may be reluctant to articulate and disclose them and thirdly, there are institutional barriers which inhibit men from seeking psychological help.

Perception of problems

There is some evidence that individuals perceive and conceptualise their problems in a sex-specific way. Hibbard and Pope (1983) state that '*females may be more sensitive to bodily cues and more willing to interpret them as symptoms than males*'. Men seem less able to perceive emotional or psychological difficulties and appear to differ from women in their experience, expression, understanding and response to pain (Bendelow, 1993). Men also seem less likely to accept an emotional influence on pain or to acknowledge emotional pain as valid (Wilson, 1995). Miller and Bell (1996) explain men's stoicism by reference to what they term 'men's restricted entitlement to emotionality' which leads them 'to remain silent and strong' and thus less willing or less able to identify their own emotional distress. There also is some evidence of differences in what men and

women identify as distressing. Rogers et al. (1993) found that men were less likely to identify marital stress as the source of their difficulties and Lewis and O'Brien (1987) found that men are less likely than women to report marital unhappiness or institute divorce proceedings. Men did, however, report work stress to be of relevance to their psychological difficulties three times more often than did women. This seems to suggest that the relationships in the domestic arena seem to take on a lesser meaning for men than women. It also seems that men may be less willing to recognise and label psychological distress than women or to put it the other way, men may be less likely to view their problems as psychological.

Disclosing problem

In terms of help-seeking for emotional or personal difficulties men are notably absent and are less likely to act on their psychological symptoms than women by seeking professional help. It has been estimated that women are approximately twice as likely as men to refer themselves for psychological help (Leaf and Bruce, 1987). Further, one in three women compared with one in seven men seek services from a mental health professional at some point during their life time (Collier, 1982).

As has been outlined earlier, the help-seeking pathway involves not only the perception and interpretation of symptoms by an individual but also their willingness to discuss this in a consultation. This entails the individual making sense of their difficulties in psychological terms and then seeking help once a problem has been defined. Dohrenwend and Dohrenwend (1977) suggest that these processes for men and women may differ and be influenced by attitudes, norms, values and expectations. They state, '*Sex differences in the seeking of help correspond to attitudinal differences: women are more likely to admit distress.. to define their problems in mental health terms .. and to have more favourable attitudes towards psychiatric treatment*'.

Briscoe (1987) argues that men are less psychologically predisposed to make use of GP services than women due to their greater 'inexpressiveness' (Doherty et al., 1986). This has been documented by Helgeson (1995) who contends that men's difficulty in disclosing emotional difficulties stems

from their concern with maintaining objectivity and proving themselves. According to Naifeh and Smith (1984) the more a man becomes confused about his emotions the more he will retreat into the safer realm of rationality and objectivity. Avoiding feelings may also result in the inability to feel. Rubin (1983) has said that some men do not know how to respond to the question, 'How do you feel?', and that feelings consciously available to women are not always available to men who have learned to repress them.

An explanation for women being more able to acknowledge distress and being less fearful about self-revelation and receiving help from others, is that women's lives are spent more intensely in close interpersonal relationships. Horowitz (1992) states that '*the collective knowledge of women's networks may be used to resolve (psychological) problems. Men isolate themselves from receiving information about the existence of professionals*'. There is some research showing that men are less ready to share their difficulties with others and are less likely to choose their lay networks of friends and neighbours as their first attempt to seek help (Rogers et al., 1993). This may be due to earlier influences as Skelton (1988) found that boys developed wider circles of friends than girls, but fewer close relationships or confidantes. This explanation suggests that cultural forces and stereotypes define vulnerability as inappropriate for men and make men less able to share intimate concerns with others. This interpretation is echoed by Kessler et al. (1981) who make the observation from a female perspective: '*it has been speculated that women are more willing than men to admit to themselves that outside help is needed to deal with problems of living. There are several reasons why this might be so, beginning with socialisation experiences that teach women to think of themselves as helpless...Women may be more willing to accept the view that they need outside help because their characteristic roles are more consistent with the sick role than men*'.

Institutional Barriers

A number of system barriers to men seeking help have been suggested. These include the limited hours of operation of GP surgeries; long waiting periods before an appointment with a GP is given;

and having to disclose the reason of the visit to a receptionist ((Tudiver and Talbot, 1999). These institutional barriers, however, are not specific to men only.

One explanation for the differences in GP consultation patterns between men and women is that women are seen as having greater familiarity with health services. This idea has, however, been questioned. Rogers (1999) argues that it seems unlikely that this higher propensity for women to seek help is due to them having more time to visit their GPs as women often have to combine maternal, domestic and employment roles and therefore have less time than employed men. However, Verbrugge and Wingard (1987) argue that women's roles as part-time workers or house wives, may allow them greater flexibility (not time per se) to consult their GP. There has also been some suggestion that women with young children may have more contact with GPs when taking their children to be seen and therefore are more familiar with the service. This interpretation is not clear as there is also some evidence that women with young children may put their children's needs before their own and this inhibits them from entering the sick role (Roger et al, 1999). Further more it may be that higher rates of consultation are not due only, or mainly, to the active help-seeking of women. Women's accounts of stress, anxiety and depression seem to suggest that women normalise the mental health problems they report (Walters 1993) which is not commensurate with problem recognition from formal services.

The experience of using GP services, including negative experiences and learning the limits of what can be provided may also deter an individual from seeking help. A study by Cape and McCulloch (1999) looked at patient's reasons for not consulting for emotional problems and found that the main reasons were to do with perceptions that GPs did not have enough time or that GPs could not do anything as their business was medical. 25% of those interviewed were also deterred by the feeling that the 'doctor was not interested' and 13% by what the doctor had said or done previously.

1.8 Concepts of gender and masculinity in relation to men's health and illness

Efforts to understand and explain the patterns of men's health behaviour have tended to focus on the differences in social roles between men and women. The concept of social role was developed in anthropology in the 1930s and a socio-psychological version of role theory was applied to gender

producing the idea of sex roles. Sex roles were understood as patterns of social expectation, norms for the behaviour of men and women that were transmitted to young people through a process of socialisation. The male role was thus explained by boys learning to conform to the norms of what it means to be a man. Lewis and Lewis (1977) suggest that such patterns of socialisation along the lines of gender may explain why men are discouraged from admitting vulnerabilities and from seeking help. They argue that health beliefs and ways of coping are developed in childhood where boys learn to be self-reliant and tolerant of pain whereas girls learn that it is acceptable to be expressive about their discomfort and to be dependent on others. Rubin, (1983) argues it is even possible that socialisation has taught men not to experience feelings and symptoms they perceive as signs of weakness.

In the 1970's, the sex role idea was radicalised by feminism. The idea of 'gender as conformity' was questioned and feminist analysis focussed on how women's sex role oppressed women. This led to a few writers to argue that the male sex role may also be oppressive to men and be detrimental to men's health. Robert Brannon (1976), for example, identified the following major components of the male role:

- '1. No sissy stuff: the need to be different from women*
- 2. The Big Wheel: the need to be superior to others*
- 3. The Sturdy Oak: the need to be independent and self-reliant*
- 4. Give 'em hell: the need to be more powerful than others through violence if necessary.'*

Brannon argued that the extent to which boys or men adopt masculine behaviours can impact on their health and increase their susceptibility to illness or accidental deaths. For example, he argued that a 'Give 'em hell' approach to life can lead to greater risk taking (driving fast, drinking heavily) which may explain the higher mortality rates for male adolescents. This approach while offering an understanding of how men's roles put them at risk for illness, led to little new research and a vague concept of the male role or men's role persisted which meant little more than stereotypes or norms.

In the 1980's a third approach to the study of gender appeared called social constructionism. This approach contended that gender identity and behaviour are not simply imposed on individuals

through socialisation, but that individuals actively participate in the construction of their gender identity and behaviour (West and Zimmerman, 1987). Gender identity is thus actively worked out and maintained by individuals who are immersed in socially and historically constructed webs of power relations. Thus, from a constructionist perspective there is no one pattern of male behaviour or male role but a diversity. As Connell (2000) states, '*there is no such thing as masculinity; there are only masculinities*'. Connell goes on to argue that '*all men are not alike, nor do all male groups share the same stakes in the gender order. At any given historical moment, there are competing masculinities – some hegemonic, some marginalised, and some stigmatised – each with their respective structural, psychosocial and cultural moorings*'.

Connell's argument is that there are not only different masculinities which co-exist but that there are definite social relations between them and that some masculinities are dominant while others are sub-ordinated or marginalised. Miller and Bell (1996) argue that many men live in a state of tension with or distance from the dominant or hegemonic masculinity in their community or culture. This dominant or hegemonic masculinity imposes expectations about masculinity on men and it is their relationship to it that may have a seriously detrimental effect on their health. Miller and Bell (1996) argue that '*one of the consequences for men of masculinity is the injunction placed on emotional entitlement*'. Men are required to be silent and strong, leaving individuals little scope to acknowledge and deal constructively with feelings of vulnerability or powerlessness. Instead men are offered safety through dominance and control of the external world. As Miller and Bell (1996) put it: '*the end product of male socialisation is alienation from meaningful intimacy and objectification of all those who are not me*'.

This constructionist approach to understanding sex differences and the roles men adopt is congruent with contemporary constructionist approaches to health and illness, where illness is seen as socially and culturally constructed. In understanding the way men conceive of their health and their health behaviour it seems important to draw on the constructionist ideas about both masculinities and health.

1.9 Rationale for a present study into men and help-seeking

As has been shown in the literature, men's health has only recently become an area of interest to researchers but within this emergent literature there is very little that is concerned with men's help-seeking (Tudiver and Talbot, 1999; Julian, 1992; Leeflang, 1992; Nahon and Lander, 1993) and even less in relation to men's help-seeking for psychological problems (Good, Dell and Mintz, 1989).

Studies that have looked at help-seeking in men have often approached this from the professional perspective. An example is a study by Tudiver and Talbot (1999) that looked at why men do not consult their GP but focussed on the physician's perspective and not on the men themselves. They concluded their discussion by stating that 'future research needs to examine attitudes directly from male patients themselves'. Similarly, in terms of psychological help-seeking, Thoreson, Shaughnessy, Cook and Moore (1993) studied the attitudes of male counsellors towards men. The reasons that researchers may have decided to study men indirectly may be based on an assumption that men are less willing to talk about their health or mental health and also that men are more difficult to practically engage in research.

One study that has looked at psychological help-seeking from a male perspective is that by Good, Dell and Mintz, (1989). This study, however, used a relatively accessible student sample and did not interview men directly but instead used questionnaires. It was conducted with 401 undergraduates who were asked to complete measures of attitudes towards seeking psychological help and attitudes toward the stereotypic male role. While this study did seek the attitudes of men directly, it is limited in how useful it is for understanding how men with psychological distress seek out help as it is based on a student sample; did not study men at the point of seeking help and through using standardised questionnaires, did not try to uncover the meanings men may have about help-seeking for psychological difficulties.

This study by Good, Dell and Mintz (1989) did, however, look at men's attitudes to psychological help-seeking in the context of ideas about masculinity and male roles. It found that 'traditional'

attitudes towards male gender roles have been related to negative attitudes towards seeking psychological help and to a history of not having sought help for personal or vocational problems.

There have been a few studies that have specifically looked at how differences in help-seeking may be a product of male and female role expectations (Nathanson, 1975; Verbrugge, 1985). These studies have tended to talk in terms of a 'traditional male role' and have shown that men who adhere to the traditional male role may fail to respond to symptoms because they believe help is not warranted or it is inappropriate to seek help. For such men, seeking help may be seen as inconsistent with self-reliance and may be seen as signifying weakness.

There have also been a few studies that have looked at how the help given to men may be influenced by the extent to which other people adhere to or endorse the traditional male gender role. For example, the study of male counsellors by Thoreson, Shaughnessy, Cook and Moore (1993) showed that counsellors who held traditional attitudes towards men emphasised vocational concerns rather than emotional or psychological. This idea that men's lack of desire to seek help for problems may be due in part to others responses to men with problems has also been shown by Hammen and Peters (1977) who found that other people view depressed men more negatively than depressed women and by Goldberg (1976) who found that others may encourage men to solve their own problems or to overcome their symptoms of illness.

The present study aimed to take account of these limitations in previous studies by looking at the attitudes of men directly and at the point in which they were engaged in seeking psychological help. As such the study interviewed men just after they had been referred for psychological help by their GP but before a clinical psychologist saw them. The study approached the issue of help-seeking as a social process and drew on the idea of the 'pathway' (Roglers and Cortes, 1993) as the basis for the interview. Thus, the researcher was interested to understand the pathways by which men had come to seek help from their GP and to understand the influence of the man's social network on this process. The researcher was also interested to understand how men's help-seeking could be understood in terms of concepts of masculinity and to know what part such concepts as masculinity and the male role may play influencing men's decisions to seek psychological help.

A qualitative methodology was felt to be the most appropriate means of investigating this area. There are several reasons why this is the case. The first involves the lack of research conducted in the area of interest. As Henwood and Pigeon (1995) point out qualitative methodologies may successfully be employed where theories about the phenomena are non-existent or outdated.

Secondly, a qualitative approach can more effectively access the meaning of experiences from the participants' perspective than a quantitative approach. As Elliott et al. (1999) state 'qualitative research aims to understand and represent the experiences and actions of people as they encounter, engage, and live through situations'. A qualitative approach may also seem to capture representations of meaning concerning a phenomenon and to explore and elaborate upon its significance (Parker, 1994). Given that men's view of mental health and men's attitudes to psychological help-seeking have been relatively ignored by researchers it was considered important to deploy a methodology which asked open ended questions and which allowed them to articulate and expand their views.

Grounded theory was chosen to analyse men's accounts for the following reasons. Firstly, the grounded theory approach places an emphasis on the building of theory and involves an iterative process where there is continual sampling and analysis of qualitative data (Pidgeon, 1996). This enables the researcher to make conceptual sense of large amounts of data and provides vigorous procedures for researchers to develop ideas and build theory (Charmaz, 1995).

Building a theory was seen as an important aspect of the research process because as the literature review showed, while there is a large body of research into help-seeking and a number of theories of help-seeking, there has not been any theorising that has specifically focussed on men's psychological help-seeking. It seemed important to try and understand this and to relate it to recent theorising around masculinity.

Secondly, Strauss and Corbin (1990) have detailed how to practically apply the techniques and method of grounded theory and this approach has been widely used in social and health research

(Solomon et al., 2001; Helgeson, 1995). In terms of psychological research, several authors have described grounded theory as a useful means of investigating psychological phenomena (Burt and Oaksford, 1999; Hayes, 1997; Charmaz, 1995; Henwood and Pidgeon, 1995).

1.10 A Statement of the Aims of the Study

The present study aims to achieve the following:

- To investigate the subjective decision making pathways by which men come to seek help for psychological distress in a primary care context.
- To investigate how ideas about masculinity may influence men's help seeking.

The interest in exploring these questions lies in the need to identify:

- What inhibits or makes it difficult for men to access psychological help, especially within primary care
- What would improve the uptake of psychological services by men

2.0 METHOD

The method section is divided into three parts. The first part provides an overview of the qualitative research paradigm. This includes a discussion of the qualitative – quantitative debate and what is seen as good practice in qualitative research. The second part outlines grounded theory as a particular form of qualitative inquiry. It also provides a review of grounded theory and how this has been used in psychological research and a discussion of the literature about the use of interviewing as a research tool. The third part of this method section details the procedures for the present study.

2.1 The Qualitative research paradigm

The aim of qualitative research is the development of concepts which help us to understand social phenomena in natural rather than experimental settings and which give emphasis to the meanings, experiences and views of all the participants. Data gathered in qualitative research tends to be non-numeric and may include interview transcripts, written texts and less usually visual material. As Denzin and Lincoln, 1998 state, '*Qualitative research is multi-method in focus, involving an interpretive, naturalistic approach to it's subject matter*'. Qualitative researchers emphasise that in order to get behind respondents' formal public statements and behaviour and to uncover their personal perceptions and actual day to day actions, it is important not to impose a *priori* categories and concepts from the researcher's own professional knowledge on to the process of data collection. The researcher is thus central to the sense that is made of the issue or phenomenon under investigation and with the emphasis on the development of concepts from the data, the researcher is freed to explore multiple interpretations and meanings of the information.

Qualitative research methods have always been part of psychological research but up until recently they have tended to be treated as a relatively minor methodology to be used at early or exploratory stages of a study and sub-ordinate to quantitative data gathering. The reason for this is that psychology in the 1950s and 1960s strived to emulate the model of research in the natural sciences known as the scientific method. This paradigm within psychology was termed 'positivism' and it's goal was to identify cause and effect relations among isolated variables that the experimenter could

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control. Often experiments were carried out in laboratory settings and were set up to test *a priori* hypotheses. Due to the emphasis within this approach on quantifying data and using statistical analyses it is known as the quantitative paradigm.

In the past two decades, the quantitative paradigm has been criticised for failing to take account of meaning and language in the research setting and qualitative methods have increasingly been incorporated into psychology from sociology, anthropology and feminist research. In clinical psychology and health services research there is an increasing recognition of the importance of qualitative methods (Richardson, 1996, Walsh 1996, Jarman et al. 1997) and few clinical psychologists today would espouse a strict positivism. Instead, in practice, a range of post-positivist epistemologies are being used which recognise an element of interpretation in the production of social scientific theory.

2.2 Quality vs. quantity

In the broader discipline of psychology, however, there is ongoing debate about methods in research with qualitative and quantitative methodologies often presented as adversaries in a methodological battle (Burt and Oaksford, 1999). This polarisation of views can be traced to arguments about the nature of human knowledge and psychological explanation. On the one hand, some (Morgan, 1996; 1998) advocate an objective view where science is seen as providing the one true picture of the world. On the other hand, the post-modernist view is that an objective reality is unknowable (Potter and Wetherell, 1987).

Despite the distinctions between the qualitative and quantitative paradigms, they are in practice not necessarily mutually exclusive or one better than the other. Woolgar (1996) suggests that traditional scientific practice, which generally espouses the quantitative paradigm, is in fact less objective and is often more creative and contingent than the idealised version of itself. Similarly, qualitative researchers need to be aware that qualitative methods are not necessarily a more reliable way of 'unearthing the facts' than quantitative approaches.

The idea of mixing qualitative and quantitative approaches has been proposed by a number of writers (Silverman, 1999; Pope and Mays, 1995; Todd, 1998). Silverman contends that the use of numbers and counting can provide the reader with a quick sense of the data, which acts as a useful adjunct to the main qualitative analysis. In thinking about this methodological debate, it is important to remember that all research is selective. There is no way that the researcher can, in any sense, capture the literal truth of events. All research depends on collecting particular sorts of evidence through the prism of particular methods, each of which has its strengths and weaknesses. As Dingwall (1992) states: *“One of the greatest methodological fallacies of the last half century in social research is the belief that science is a particular set of techniques; it is, rather, a state of mind, or attitude, and the organisational conditions which allow that attitude to be expressed”*

2.3 Sampling in qualitative research

In qualitative research, the purpose of sampling is to identify specific groups of people who either possess certain characteristics or live in circumstances relevant to the phenomenon being studied and not to establish a random or representative sample. Participants are identified because they will enable exploration of a particular aspect of behaviour relevant to the research.

Theoretical sampling is a specific type of non-probability sampling in which the objective of developing theory or explanation guides the process of sampling or data collection. Thus, the researcher makes an initial selection of participants; collects, codes and analyses the data; and produces a preliminary theoretical explanation before deciding which further data to collect and from whom. Once these data are analysed, refinements are made to the theory, which may in turn guide further sampling and data collection. The relation between sampling and explanation is iterative and theoretically led.

In the present study, some of the theoretically relevant characteristics that may effect men's attitudes to seeking psychological help were age, social class and ethnicity. These had been identified from the general literature on psychological help-seeking. Though not statistically representative of all men

seeking help, such a sample is theoretically informed and relevant to the research question. It also minimises the disadvantages of selecting the sample on the basis of convenience.

2.4 Strategies to ensure rigour in qualitative research

As in quantitative research, the basic strategies to ensure rigour in qualitative research are systematic and self-conscious research design, data collection, interpretation and communication. Beyond this the qualitative researcher aims to create an account of method and data which can stand independently so that another trained researcher could analyse the same data in the same way and come to essentially the same conclusions; and to produce a plausible and coherent explanation of the phenomenon under scrutiny. Thus, for example, it should be possible for any specific themes identified in a qualitative study to be traced back through the analytic process to their occurrence within the data or text.

In the literature on qualitative research there has been an ongoing debate about how to determine the quality of qualitative research (Burt and Oaksford, 1999; Morgan, 1998; Cooper and Stevenson, 1998). It is generally felt that the quality standards used to assess quantitative research (internal and external reliability and validity and objectivity) cannot be used as qualitative research has different 'epistemological priorities and commitments' (Henwood and Pigeon, 1992). As yet no firm criteria have been agreed although a number of ideas have been suggested (Elliot et al. 1999; Turpin et al.,1997) for how qualitative researchers can attend to issues of reliability, validity and generalisability..

Reliability

In quantitative research the concept of reliability refers to replicability. In qualitative research, however, there has been debate about whether this is a useful concept or whether it can be achieved. Lincoln and Guba (1995) suggest that what is important is consistency and they have coined the term 'dependability'. They argue that for an inquiry to be dependable it must provide its audience with evidence that if it were replicated with similar participants, in similar contexts, the findings would be repeated. Silverman (1999) argues that for reliability to be assessed in qualitative research, the

researcher must document his or her procedure. This means for qualitative researchers to ensure the reliability of their analyses they must maintain meticulous notes and records of any interviews or observations and must document the research process in detail. The reliability of the analysis of qualitative data can also be enhanced by organising an independent assessment of transcripts and comparing agreement between raters. The use of audiotapes also allows the opportunity for subsequent analysis by independent observers.

Validity

Validity relates to whether interpretations are 'internally consistent, useful, robust, generalisable or fruitful' (Stiles, 1993). It also refers to the degree to which what has been measured corresponds with other independent measures using other research tools. This process is called triangulation and data may be sought from different, independent sources and by different means.

One approach to validation that is sometimes used in qualitative research is known as 'respondent validation'. This involves feeding the findings back to the participants to see if they regard the findings as a reasonable account of their experience (Smith, 1996). Feminist researchers see this commitment to reciprocity as a means of redressing the power relationship that exists between the participant and the researcher (Burman, 1994). A number of possible difficulties with this have been raised. Stiles (1993) suggests that a participant may not understand aspects of him or herself and so may be unable to comment on the interpretations made by the researcher. Participants may also be reluctant to disagree with the researcher (Smith, 1996). While respondent validation is an important aspiration for any study, these potential limitations suggest that it needs to be used cautiously and may be best used alongside other techniques.

'Internal coherence' has been proposed as another measure of validity. Coherence is assessed by the reader of the research and refers to the quality of the interpretation made by the researcher. Stiles (1993) suggests that coherence might include 'internal consistency, providing an understandable explanation of the phenomenon under study, an awareness of rival interpretations and an ability to deal with loose ends'. Consulting readers external to the research project on the level of fit between the

data and theory and allowing others to comment on interpretations can help to add internal coherence to a research study (Erlandson et al. 1993). Participants' responses to preliminary interpretations may also be a means by which ideas can be grounded in participants' reality, although the limitations discussed earlier would need to be considered. With regards to grounded theory, Strauss and Corbin argue that 'the findings must be rendered through a systematic account of a setting that would be clearly recognisable to the people in the setting (by for example recording their words, ideas and actions) whilst at the same time being more structured and self-consciously explanatory than anything the participants themselves would produce'.

A further method to enhance validity is for the researcher to thoroughly examine 'negative cases' or 'deviant cases'. These are cases that in the researcher's explanatory scheme appear weak or are contradicted by the evidence. The researcher should give an account of these occasions and try to explain why the data vary. Exploring cases that do not fit the emerging theory allows the researcher to widen or modify the theories they are developing. Cycling back between the data and developing theory is key to qualitative research and as Reason and Rowan (1994) suggest that 'the validity of research is enhanced by a systematic use of feedback loops and going around the research cycle several times'.

Lastly, validity relates to the researchers position in the research. Stiles (1993) states that it is recommended in a qualitative study for there to be '*disclosure by the researcher of his or her expectations for the study, preconceptions and theoretical orientation*'. This is to allow the reader to gauge the stance and assumptions the researcher may hold.

Generalisability

In quantitative research it is usually assumed that the findings from research can be generalised to the wider population. In qualitative research, instead of generalisability researchers talk in terms of transferability (Lincoln and Guba, 1995) which refers to applying the findings of a study to similar contexts from where they were first derived. Thus, instead of the researcher having to ensure their findings can be generalised to wider populations, it is for other researchers to apply the findings to

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cues and to ask questions in such a way that encourages the interviewee to answer and to elaborate on their experience.

Lastly, the relevance of the research topic to the interviewee is significant in determining how much information they reveal. Maruyama (1981) describes how prison inmates feel exploited by researchers and develop sophisticated phoney answers to minimise the intrusion. In conducting in-depth interviews, it is important to consider how the interviewee may feel about the interview. While some people may feel rewarded by being listened to and by knowing that the interview is important to the researcher, others may not and may be reluctant to reveal things. Jones (1988) advises on conducting more than one interview as this allows a deeper exploration of the topic and '*builds a higher level of trust and the opportunity for negotiating relevance*'. Where this is not possible, it is still important for the researcher to be attuned to how engaged interviewees are and to what extent this may influence the analysis and interpretation of the interview.

3.0 The Present Study

3.1 The Research Procedure

The present study employed a qualitative methodology, namely a grounded theory approach. Interview transcripts provided the raw data for the study, and were analysed using the grounded theory approach based on Strass and Corbin's (1990) version. As outlined earlier this version of grounded theory has been criticised. The approach outlined demonstrates how some of these criticisms were taken into account.

This section provides a detailed account of how the study was conducted. It begins by describing the characteristics of the researcher and the ethical considerations for conducting the study. The location of the study in the primary care clinical psychology service is then described. This is followed by the characteristics of the participants, the process of participant selection, the development of the interview guide, the interview procedure, and the procedure of data analysis.

3.2 The researcher

The researcher is a 37 year old white, middle class male and at the time of writing, the researcher was working part-time as a clinical psychologist in a primary care mental health service and part-time as a senior clinical tutor with a clinical psychology training course. Since qualifying as a clinical psychologist he has worked for eight years providing a psychological service in primary care settings. In the last five years he has developed an interest in the area of men's health and has been involved in setting up a grass-roots men's health project and more recently has become involved in the European Institute of Men's Health. In terms of theoretical orientation the author is interested in community psychology and draws on theoretical perspectives that focus on the person in context and in particular have a concern with issues of power. The author is relatively inexperienced in qualitative research and prior to this study had no previous experience of using a grounded theory approach.

3.3 Researcher's epistemological position

The researcher's position is what has been termed critical realist (Collier, 1994; Bhaskar, 1989). This refers to the view that there is a reality but that people's constructions of it will vary according to their experience. The author believes that people are not organisms simply responding to external stimuli nor inexorably driven by internal needs and instincts but are active agents who construct the meaning and significance of their realities. They do so through bringing to bear upon events a personal framework of beliefs and values which they have developed through their lives to categorise, explain and predict events in the world. This framework is part of a social world and will be shared in some parts by others. As the social world is structured by gender then the accounts that men have about their experience will inevitably be influenced by the ways in which they have engaged with the forms of masculinity available to them. These points of commonality cannot be assumed as self-evident or given as there will be great variation in the ways in which individuals make sense of their reality.

3.4 Ethical Considerations

Ethical approval for the study was sought from the Queens Medical Centre Ethics Committee and approval was granted on 11th December 2000. (See appendix 7.1). The anonymity of the participants, and any others to whom they refer, has been protected by changing their names and any identifying details contained within the interview transcripts.

3.5 The study location – the primary care service

The study was conducted within a primary care clinical psychology service in Nottingham between January 2001 and June 2001. The background to this service is that it was established in its current form in 1998 although within Nottingham there has been a long history, dating back over 20 years or more, of clinical psychologists working in primary care and offering a direct referral service for GPs. At the time of the study the service comprised of three clinical psychologists and the service was organised so that each clinical psychologist covered a defined geographical area of the city and took referrals directly from GP practices within that locality. The clinical psychologists delivered the service through offering clinics at health centres and GP surgeries in the locality in which they worked.

The study did not cover the whole service but instead was restricted to GP practices in two localities and excluded those from GP practices in the locality where the researcher worked as a clinical psychologist. One of these areas, covered by the South and East Primary Care Group, is an inner city area of Nottingham and has high levels of social deprivation. The other area is a more suburban area, covered by the Gedling Primary Care Group, and in terms of its socio-economic profile it is significantly more affluent. By including both areas it was hoped men from different socio-economic groups could be interviewed.

At the time of the study, the clinical psychology service operated an 'opt in' system for referrals. As soon as the referral was received by the service a letter was sent to the referred client informing them of the referral and asking them to 'opt in'. This simply meant they are asked to return a slip stating their wish to have an appointment. This system was based on an approach developed by Martin Seager (1994) and aims to reduce non-attendance and to give the client some say over the referral.

On average the clinical psychology part of the primary care service receives on average eight referrals a week. These referrals are wide ranging and cover a broad spectrum of psychological problems. During the six-month period of the present study there were 196 referrals to the clinical psychologists of whom 73 (37%) were men and 123 (63%) women. This pattern of referral (ratio 1: 1.7) is consistent with the national picture showing a 1:2 ratio of men to women referred.

A breakdown of these referrals is shown in Tables 1 & 2 below.

Table 1 : Breakdown of referrals to Primary Care service from the two study localities over a six month period

	Gedling	South and East
Women	29	24
Men	26	20

Interestingly, over the study period, the ratio of men to women referred was in fact lower in these two localities than for the service as a whole. It is unclear as to why this was so as the general pattern of referrals from these areas is not consistently different from other areas of the city.

Table 2 : Breakdown by age and sex of referrals to the Primary Care service from the two study localities over six month period

	Gedling P.C.G.					South and East P.C.G.				
	20-29	30-39	40-49	50-59	60+	20-29	30-39	40-49	50-59	60+
Women	6	10	5	5	2	13	4	4	1	1
Men	8	6	3	5	2	8	4	3	4	1

3.6 Selection of Participants

Participants were selected from these two areas on the basis of whether the GP referral letter indicated that the men met the criteria set out in Figure 1. below. Men were excluded if there was evidence within the referral letter that the man had sought previous psychological help e.g. past referral to a community mental health team, counselling or psychotherapy. It was felt that as this study was concerned with understanding the help-seeking pathway it may be most useful to investigate those that had not had previous service contact.

Figure 1 : Criteria for selection of participants

Potential responders were identified using the following criteria:

Male

Aged between 20 and 65 years

Referred by their GP to a clinical psychologist in primary care mental health service

Currently on 'opt in' or waiting list for the service (i.e. not currently being seen)

no previous contact with mental health services both NHS and non-statutory.

Exclusion criteria

GP or clinical psychologist felt should not be interviewed (with reason).

previous contact with mental health services

In qualitative research the approach to sampling is not about trying to gain statistical representativeness or in taking a random sample but instead to select participants purposively on the basis that they offer in-depth illumination of the phenomena under study. Participants are included as long as they provide new insights. In grounded theory the approach to sampling is termed theoretical sampling that involves sampling on the basis of concepts that have proven theoretical relevance to the evolving theory (Corbin and Strauss, 1990). In theoretical sampling the researcher makes an initial selection of participants; collects, codes and analyses the data and produces a preliminary theoretical explanation before deciding which further data to collect and from whom. As Mays and Pope (1995: p110) explain, '*the relation between sampling and explanation is iterative and theoretically led*'. In this study the initial selection of participants was limited to the information available on referral. This information allowed selection to take account of age, socio-economic status (based on postcode) and some notion of living circumstances. As the literature on help-seeking has shown these factors have been shown to be correlated with psychological seeking help.

3.7 Gaining access to participants

Once a referral had been identified as meeting the study requirements, a letter was sent asking if the referred man would be interested in participating in the study (See appendix 7.2). A stamped addressed envelope was enclosed and the man was asked to post back a return slip stating whether he wished to take part in the study and his preference as to the date and time. All the men were also

offered the option of being interviewed at home or at the researcher's office. The researcher then made phone contact to arrange a time for the interview and to discuss the study in more detail and answer any queries. All interviews were arranged to take place as soon as possible after referral and prior to the appointment with the clinical psychologist.

3.8 Participants

Participants in the study were seven men, all referred by their GPs over a six-month period (January 2001 to June 2001) to the primary care clinical psychology service. During this six-month period, forty-six men were referred to the service but only twenty-nine of these were identified as meeting the research criteria and invited by letter to participate in the study. Fourteen men responded to the letter but only eight agreed to be interviewed. Unfortunately, one of these interviews was later discounted at the transcription stage as the interview did not record properly and was not recoverable. The final interview sample was, therefore, only seven men.

The socio-demographic characteristics of the participants are summarised in Table 3.

Table 3 – Socio-demographic characteristics of participants

Participant	Age	Relationship	Children	House -hold	Work status	Last job
1	53	Married	3 children	Wife & youngest daughter	Employed but on sick leave	Primary School Head master
2	60	Living together	3 sons	Partner only	Incapacity - not worked for 10 years	Own business
3	33	Divorced	None	Alone	Incapacity	Sales
4	38	Living together	Son from 1 st marriage	Partner only	On Sick	Lorry Driver
5	41	Divorced	None	Alone	Incapacity since 1990	Self- employed
6	61	Married	2 children	Wife and son (22 years)	Incapacity	Loader / checker For lorries
7	27	Fiance	1 daughter (second child due in 2 months)	Lives with fiance's mother	Employed as a baker	Baker

The mean age of the seven participants was 44 years, with the youngest being 27 years and the oldest 61 years. Two of the participants were married, three were co-habiting and two were divorced. The two divorced men were living alone while the rest were living with their spouses/ partners. At the time of the study, four of the participants were claiming incapacity benefit, two were on sick leave from their work and one was in full time employment.

3.9 Interview guide

A semi-structured interview guide was developed (See appendix 7.3) . The guide aimed to be flexible, to facilitate participants' expression of their own thoughts and experiences, rather than to restrain them by adhering to a specific schedule. The interview guide was based on the stages of the pathways to care model described by Roglers and Cortes (1993) and included the following areas:

1. How the participant recognised the problem and the onset of distress

(Reasons for consulting / name of problem / perceived cause, consequences, severity / effect on body, social network, home life, work, finances)

2. The process of deciding to seek help

(Influence of lay network on help-seeking, perceived barriers to help-seeking, alternative sources of help)

3. The experience of being referred for psychological help

(Interaction with GP, expectation of help, others knowledge of help-seeking)

A set of basic demographic questions were also asked of each participant that included the following:

Age

Ethnic origin

Employment status

Living circumstances

Frequency of illness and health conditions

Frequency of GP consultation

3.10 Interview procedure

Six interviews were conducted at the participants' homes and two at the researcher's office. Before starting the interview the aims of the study were explained to participants and participants were given information on the estimated length of the interview and the confidentiality of the data collected. This information also gave a contact telephone number for the researcher. The researcher sought agreement from the participant to tape-record the interview, and a consent form was signed (See appendix 7.4) .

The researcher began the interview by asking about the basic demographic information as this was thought to help put the participants at ease. This was followed by one of the main questions above. The researcher aimed to take a flexible approach to the interview and questions were not necessarily asked in a pre-set order. The general format was however to try and trace the stages in the help seeking process from the point of symptom perception, through problem recognition to the point at which the problem is reported. Any ambiguities in the participants account were followed up and attempts were made not to constrain the participant in their answers.

The interviews lasted between 45 minutes to an hour. After the interviews were completed, there was a brief discussion about the interview and the participant was asked to feedback their views. These were noted in the researcher's field notes.

3.11 Transcribing

The tape-recorded interviews were transcribed verbatim either by the researcher or by a professional audio-typist and then checked against the recording by the researcher. Pauses were indicated in the transcript, but were not timed. This is in contrast to the discourse analysis method, which would require very high levels of precise transcription. Brackets were used to denote parts of the interview that were inaudible and therefore missing from the transcript. As a means of anonymising the participants, any identifying material in the transcript was changed and each participant was given an initial. This enabled the transcript to be ready for the process of grounded theory analysis.

The transcripts are not included in the appendix of this thesis, but are part of a separate appendix.

3.12 Grounded theory analysis

Seven interview transcripts were analysed using grounded theory as described by Strauss and Corbin (1992). The procedure was as follows:

3.12a Open coding

The first transcript was read several times in order that the researcher could become familiar with the participant's account. Listening to the taped interview helped to clarify the meanings attributed to this account by the participant.

Each line of the transcript was then coded. Such line-by-line coding means naming each line of the data in as specific terms as possible. The right hand margin of the text was used to make a note of the codes. Memo notes were also made at this stage and recorded at the foot of the page. These included summaries or interpretations of the material or more general speculations that attempted to draw links between related aspects of the participants account. Everything said by the participant was subjected to this initial stage of analysis, no attempts being made to emphasise particular aspects of the text or to produce conclusive themes. Charmaz (1995) argues that line-by-line coding allows the researcher to keep close to the data and to begin to build an analysis from the ground up without '*taking off on theoretical flights of fancy*'. Such close coding also forces the researcher to think about the material in new ways and to refrain from imputing their own motives to the data.

An example of line-by-line coding from the interview with MS is given below. A fuller example of a completed transcript coded at this level is also given in separate addendum.

"Well she said you need to see the doctor and I haven't thought of that. I thought it was my fault, I wasn't coping, I was doing something wrong. I didn't see, I didn't believe that I was sort of ill, or needing medical help. I thought I was just running out of resources really and that somehow I needed rest and, you know, I needed to rest and you know to have a rethink about, or to re-plan things, you know, to try and organise things better. ... When it manifested itself like that, um, you know, she said, you've got to see the doctor. Shall I make an appointment for you? And that, I don't know whether I would have made an appointment that day, but she did it for me, I think she was looking after me. I was quite happy for her to look after me. (19, 416 – 430)

**not seeing need for help
self-blame
diff. in seeing 'self' as ill
sense of depletion (int.)
exhaustion
action on world not self
seeking ext. control
other (f) suggesting GP
other (f) initiating help
delay in help-seeking
being cared for
giving up control**

[f – female]

Once the first transcript had been coded then the second transcript was coded. This time however, when the codes were derived for the second interview, the codes from the first interview were borne in mind. All seven transcripts were coded in this way. This process is known as the '*constant comparative* method' and involves comparing participants' accounts or categories systematically for differences between them. In this way each transcript is compared to the emerging theory and also compared with each other data set. This process of coding was continued until a point of 'saturation' was reached. This is when no new codes were being created.

3.12b Categorising

On completion of this first stage, a list of all the line-by-line codes relating to the transcripts was drawn up. The researcher then grouped together similar codes and assessed which codes made most sense to the phenomena of men's psychological help-seeking. This process is known as categorizing (Strauss and Corbin, 1992). These categories were then named but at a more abstract level than the names given to the codes as the category goes beyond being a purely descriptive tool to being something that helps to synthesise the data. As categories were produced and named they were also developed in terms of their properties. This involves building the category by examining all the data it covers and by identifying the variations within it and between other categories.

3.12c Axial Coding

Once initial categories had been identified, a further process known as axial coding was carried out. This involves refining categories and making connections between categories. This process creates a hierarchical structure in which certain key categories subsume lower-order categories. These categories were intended to capture everything said by the participant that was relevant to the research question. Strauss and Corbin (1990) refer to this process as the 'Paradigm Model' and suggest that a category is specified in terms of the phenomena itself. Each category could be traced back through the analytic process to their occurrence in the text.

3.12d Selective Coding and Theory Development (Core Category)

Through the process of axial coding a small number of super-ordinate categories emerged with high frequency and of these one was identified as being most densely connected to all the other emerging categories. This was adopted as the core category. This core category captured the themes that seemed evident within the other categories. Categories were then grouped in relation to this core category and according to patterns developed during the analysis. Strauss and Corbin (1992) recommend the formulation of a story line to assist with the integration of categories around the central phenomena. This account or story line was developed and validated against the data.

3.13 Validity

Various methods for assessing the validity of qualitative research have been proposed as discussed earlier. In the present study the following procedures for ensuring appropriate standards of validity were adopted.

First, to enhance reliability and generalisability the research process has been described in detail. It is accepted that the study could only be replicated in terms of the practical procedure. Both the researcher and the participants will be different in any future study and this will have an impact on the analysis and conclusions reached.

Secondly, to enhance validity the researcher has provided sufficient raw data for the reader to assess the validity of the conclusions drawn and so that theories derived, can be traced back to the raw data in the interview transcripts.

Thirdly, as a form of respondent or 'testimonial' validity (Pidgeon, 1996; Stiles, 1993) throughout the research interviews, the researcher reflected back and summarised participants' responses in order to check that their understanding was compatible with the meaning intended by the participant. Each participant was also offered a copy of the written transcript of his interview. This allowed participants to check for errors that may have occurred in the transcription process and to verify the authenticity of the account contained within the transcript.

Fourthly, as a means of achieving greater internal coherence in the present study the researcher attended a qualitative research group. Members of this group included two experienced qualitative researchers and the meetings allowed for a number of exemplar transcripts produced at different stages in the analysis to be discussed and commented upon. The researcher also asked another clinical psychologist working in the primary care service to provide feedback at different stages in the analysis. A summary of the results of the analysis were also sent to the participants and they were asked to return their comments so that these could be considered as part of the analysis.

Lastly, to increase what is described as 'reflexive validity' (Stiles, 1999), the researcher has specified his own theoretical and personal orientation towards the topic under investigation, and provided descriptions of how this altered over the course of the study. By making the researcher's position explicit it helps the reader to understand the interpretations made and allows for consideration of alternative interpretations.

4.0 RESULTS

In the first stage of the grounded theory analysis distinct categories or 'meaning units' were identified in the transcripts of the seven men. These data were then used to generate second level categories through the method of constant comparison, where the meanings of all the items contained within each category could readily be seen as similar. A total of eleven second level categories were identified. These were then grouped into five higher order categories through axial coding, from which a single core category emerged. The five higher order categories developed by the analysis were identified in the interview texts of all the participants. Second level categories were identified in the texts of at least four participants and first level categories were identified in the interview texts of at least two participants. Negative case examples are also presented as an illustration of where an account deviates from the main analysis.

The results to be presented are structured around the five higher order categories: preserving public identity, separation of problems from self, crisis as disconnection, use of lay networks and self in psychological help. Firstly, the core category 'distancing' is described, followed by a description of the higher order level categories encompassed by this core category. Diagrams of the relationships between categories are provided as a guide. Figure 3 shows the relationship of all the categories derived from the analysis and Figure 5 shows the core and five main categories. Within each section, the main categories are denoted in bold capitals, second level categories are in capitals and sub-categories in italics. Quotations of participants' own words are provided in order to illustrate specific features of each theme and these appear in italics. A series of denote repetitive, or irrelevant text which has been omitted for the purposes of clarity. Round brackets denote a pause in speech.

A process model is shown in Figure 4, which shows how the core and main categories map onto the network-episode model of Pescolido and Boyer (1996). This shows how the help-seeking pathways for men are influenced by the concept of masculinity. In each section of the results the accounts of the participants are understood in relation to ideas about masculinity.

DISTANCING

PRESERVING PUBLIC IDENTITY

Isolated Sufficiency Preserving Past Self Preserving Work Identity

Delay In Seeking Help *Treatment Fearfulness* *Fear of Dependence*

Over valuing Work Identity *Work Taking* *Breadwinner* *Working Too Hard*

SEPARATION OF PROBLEMS FROM SELF

Lack of a Language Medicalisation

CRISIS AS DISCONNECTION

Loss of Past Self Loss of Work Identity Shift in Self

Influence of Partner/ Male Friends Limited Extended Network Lay referral

GP as part of Network

USE OF LAY NETWORKS

SELF IN PSYCHOLOGICAL HELP

Influence of Past Help Psych. Help Reconnection Psych. Help as Not Involving Self

Lack of Knowledge of Where to go *Psych. Help as a Relationship* *Just Talk*

Conditional *Help as Intervention* *Release*

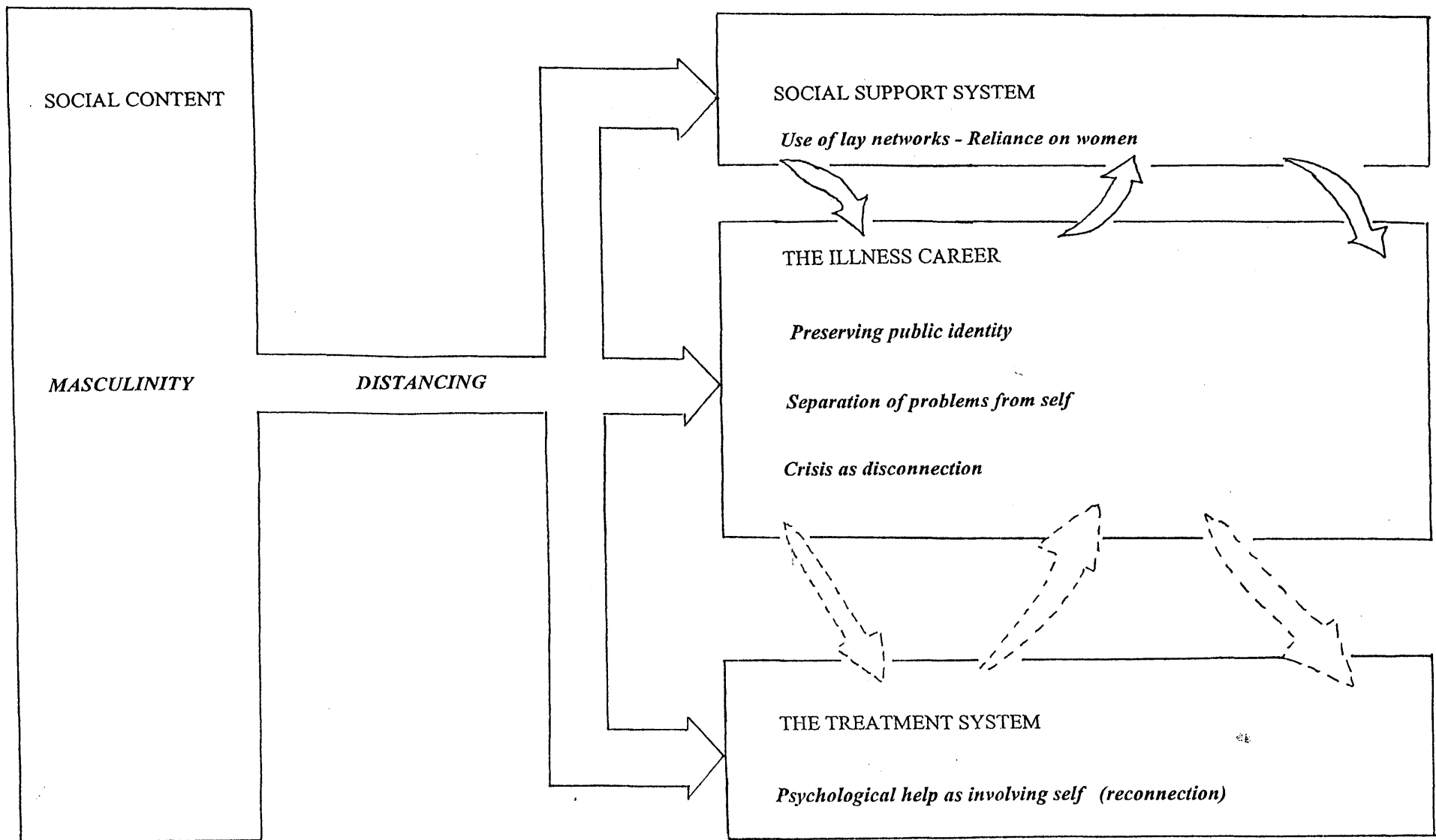


Figure 4: Process model – Adaptation of Network Episode model (Pescolido and Boyer, 1996) to take account of influence of masculinity

DISTANCING

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graph TD; A[DISTANCING] --- B[PRESERVING PUBLIC IDENTITY]; A --- C[SEPARATION OF PROBLEMS FROM SELF]; A --- D[CRISIS AS DISCONNECTION]; A --- E[USE OF LAY NETWORKS]; A --- F[SELF IN PSYCHOLOGICAL HELP];
```

**PRESERVING
PUBLIC
IDENTITY**

**SEPARATION OF
PROBLEMS FROM
SELF**

**CRISIS AS
DISCONNECTION**

**USE OF LAY
NETWORKS**

**SELF IN
PSYCHOLOGICAL
HELP**

4.1 The Core Category: DISTANCING

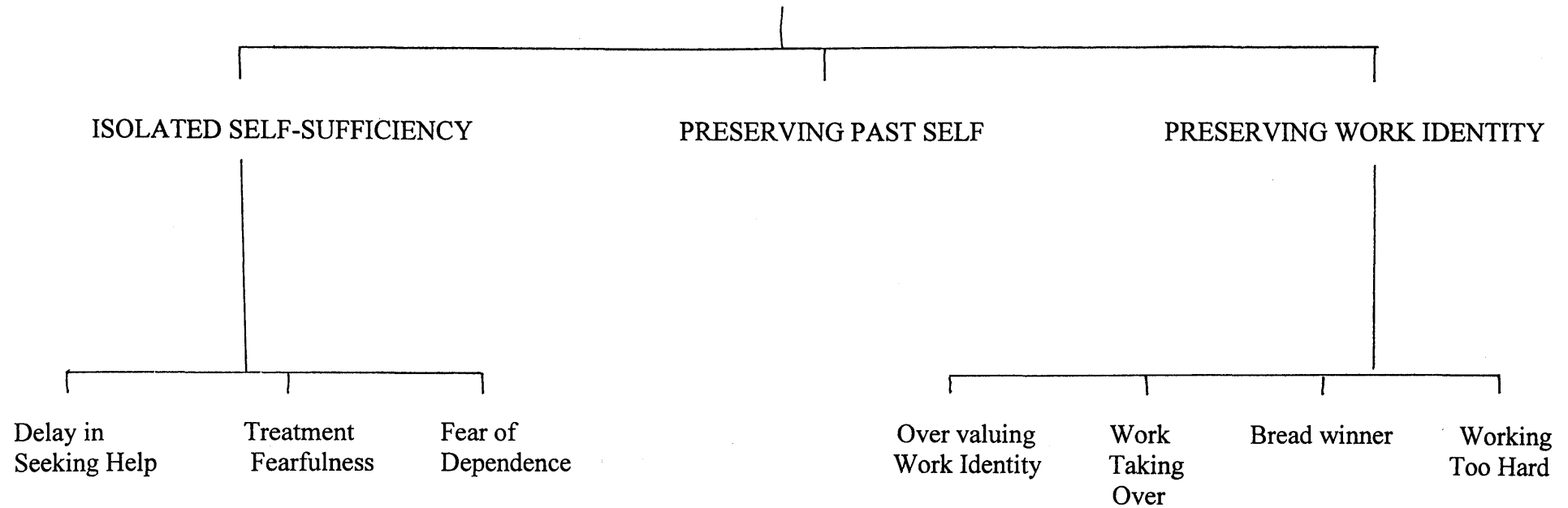
The core category identified in the analysis was termed '*Distancing*'. This describes how for the men interviewed there was a sense of remoteness from their problems and a wish to objectify or externalise their distress and to keep it at a distance. This separation of their public and private identities was shown through men trying to preserve their public identity often at a clear cost to their health and well-being. Men seemed concerned to keep a distance between themselves and others in relation to them seeking help. For all the men there was a strong desire to be seen as self-reliant and to work problems out for themselves. To involve others was associated with weakness or fear. In terms of the help-seeking pathway for men '*distancing*' suggests how at different points in the pathway men struggle to maintain a coping identity through trying to keep at a distance any signs of vulnerability. Psychological help itself can perhaps be seen as a process of reconnection through which men come to acknowledge their vulnerability. Interestingly for the men interviewed who were in the process of being referred for psychological help, there was great variation in their views of such help and they were clearly at different points in terms of their ability to reconnect or to reduce this distance.

4.2 Higher order category : PRESERVING PUBLIC IDENTITY

From the analysis a higher order category '*Preserving Public Identity*' was identified. A diagram of this category is presented in figure 6. As can be seen this category consists of three second order categories. These are: isolated self-sufficiency; preserving past identity; preserving work identity. This category is linked to the core category through what seemed to be a distancing between the participants' private and public selves.

'My wife would say that it was only her and the children that ever saw the real me for a couple of weeks in the year and they were the two weeks in the middle of the summer holidays .. when I had a chance to wind up and finish things off that I needed to do and then before I needed to get back into gear'. 1: 206-210.

**PRESERVING
PUBLIC IDENTITY**



For the participants it seemed as if illness or psychological difficulties threatened their taken for granted identities that support and sustain them as men. Within the narrative accounts of the participants there seemed to be a significant thread, which related to fears about how their problems had reduced their status in the masculine hierarchies, shifted power relations with women and raised doubts about their masculinity. It seemed as if their problems had relegated them to a position of '*marginalised masculinity*' (Connell, 2000).

'I sort of do all the house keeping. I wash the pots, I cook the food, I do a bit of ironing. I'm like a housewife now. Exactly like a housewife. ' 4: 364-369.

'I felt very much on my own.() I felt grossly embarrassed and I felt that people looked down on me because of my situation'. 1:527-529.

Efforts to preserve their identities as men seemed to be part of what men struggled to do even when this meant costs to themselves or others close to them.

Second level category: ISOLATED SELF-SUFFICIENCY

This second level category was termed 'Isolated self-sufficiency' and is split into three sub-categories: *delay in help-seeking; treatment fearfulness; fear of dependence*. The category is defined by the participants' desire to be seen as self-sufficient and on top of things. As men, participants saw themselves as needing to be able to sort out problems on their own, without having to ask others to help. Inability to solve these problems was seen as eroding their personal identity and their identities as men.

'If you've got a problem you sort it. That's how it's always been, that's how I've ever known it'. 4: 293-294..

'I've always been taught to stand up on my own two feet. You don't go whinging to the doctors you don't do this, you don't do that, you don't cry on somebody else's shoulder. You take it and sort it out yourself'. 5: 299-301.

Participants spoke of their attempts to cope and to gain control of their feelings of vulnerability. This often took the form of active coping and trying to master their problems.

'I have adopted many strategies to try and cope, relaxation techniques and you know, past time hobbies, something to do that's different when you come home but I've never been able to master it'. 1:105-107.

Participants referred to the expectations they felt on them as men to not admit problems or to show that they felt vulnerable or fragile. Instead they spoke of a need to *'tough it out'* and not to complain.

'As men we're supposed to show a stiff upper lip, and stand there and be able to take it and not complain about nothing'. 6: 268-269.

'the male mind doesn't seem to work that way does it. It's just sort of.. pull yourself together and get on with it kind of thing'. 2: 44-45.

To either be seen to be in need of help or to be seen to be looking after yourself could be perceived as being feminine or unmanly. For some of the participants it was difficult to acknowledge inner experiences to themselves or others and they were caught in a kind of self-imposed emotional isolation that made it difficult to trust others. This strong emphasis on having to cope alone and the resulting isolation may affect men's ability to assess whether how they are feeling is similar or different to others and to know whether it would be appropriate to seek help.

'People expect a man to know it and go and do it and not sort of like turn around and ask for help....I was brought up and everything I was expected to do was, you know, go ahead and do the job and try and get on with it without actually turning round and asking people or asking for help'. 7:201- 203.

'Being a man you are put in the situation or it's put in front of you and you have to sort it out without actually asking for help, you have to sit there and figure it out yourself and try and get through as best you can'. 7: 214-216.

'I never usually, I never go out for help, I usually keep myself to myself'. 7: 74-75.

Participants saw their inability to solve their difficulties and to meet the expectations on them to be a 'proper' man as evidence of a personal failing or internal inadequacy.

'I felt that I should be able to sort this out myself. I should have inner resources'. 1: 469 – 470.

This fear of not being seen to cope and to do so on your own was for some participants clearly linked to events in their pasts and what can be seen as early socialisation experiences into the 'masculine role'. For men who do not fit into or conform to ideas of 'hegemonic masculinity', (Connell, 2000) then one way of coping is to keep quiet so as to give the outward appearance of isolated self-sufficiency.

'It's like all the way through school, you know, I was forever bullied and, you know, the only time teachers became involved was if it ever got really heavy, but then again if it ever happened it was in break time and things like that. I used to go in part of the school where there wasn't many people ... I think it has had an impact on me. I think it's just basically shut me up and kept me well I don't know. I think it destroyed my trust in other people'. 7:420 – 430.

Sub-category: Delay in seeking help

This sub-category was identified as a specific consequence of the way men attempted to be self-sufficient. Putting off as long as possible from going to their GP and from seeking help allowed them to maintain a distance from their problems and to attempt to preserve an outward (or public) appearance of

normality. It seemed as if through delaying the visit to the GP the men could deny their difficulties and the real effect they were having on their lives.

'I delayed on and off. I think I said to you earlier that it was about January time that I really bottomed out and I think it was march or April that I got to see the doctor first o f all'. 2: 244-245.

Delaying seeking help often meant having to bear symptoms. For one participant who had injured his back and suffered constant pain, he not only delayed seeking help but also struggled to carry on working as a lorry driver even though this caused him immense difficulty.

'I carried it for months and I used to wake up with pains, they used to run, shoot down my leg. It was unbelievable when I was away in the wagon but I just carried on and on and on'. 4:152-154.

Sub-category: *Treatment fearfulness*

This sub-category related to possible reasons for some men delaying seeking help. Some participants spoke of feeling fearful of what the doctor might do in terms of treatment and the need to build up courage to go and ask for help.

'It took me about two week to build up the courage to go there but I knew I had to go there'. 3: 262

'I'm scared of what they're going to do ..I'm terrified of hospitals'. 7:349-352

'I suppose it frightened me ,the idea of seeing a psychologist'. 2:323.

For others, the fear was less to do with the anticipated treatment and more to do with how they might be perceived. Concern about whether their problems were serious enough to seek help or whether they would be seen as wasting the doctor's time. This may also relate to a fear of being seen to not cope. As

outlined in the main category of self-sufficiency (above), this is another key aspect of the masculine role.

'I've seen other men they just don't bother about it, they just carry on as they would normally. I mean unless, was it, as far as I'm aware, it's probably for men to actually go and seek psychological help is, well they've got to be in a real bad way'. 7: 333-336.

Sub-category: Fear of dependence

For three of the participants who had suffered injuries at work and were now disabled, their narrative accounts were characterised by what seemed to be a fear of dependence and a fear of being seen in the role of passive patient. For these men it seemed as if they were facing an identity dilemma of being the traditional breadwinner versus becoming dependent. It seemed important for them to show that their injuries had not affected their masculine identities as the provider.

'It seems to have worked itself out, I've got, I'm not so depressed you know with this sort of job. It's sort of ..it's nice because I'm getting back to work, but I'm doing it in a different way'. 4:83-85.*

(* This man after losing his job as a lorry driver had just started to make picture frames in his shed.)

'I've had a metal pin, a metal bar with pins put into the ankle to support it. That hasn't worked so now I've got to wear this calliper...I suggested to them well how about amputating my leg ..it's preventing me from getting back to work'. 5:136-143.

Second level category: PRESERVING PAST SELF

For some participants it was important to reaffirm their pasts and demonstrate continuity with that past. Some of the men attempted to recapture the past, to reclaim their past identities as if their real self was their past self. In the narratives they offer of their lives there is at times an attempt to distance themselves from their current difficulties and to see their psychological problems as playing only a minor role in their identity. These efforts may be seen as founded on assumptions of preserving masculinity or demonstrating that they had an earlier position that was closer to the 'hegemonic masculinity' in terms of the gender order (Connell, 2000).

'I can honestly say that up to about, well up to about two years ago I'd never ever taken a day off sick because of stress or anxiety reasons. My attendance record is absolutely exemplary. I think I'd only had about half a dozen days off in the first 27 or 28 years of my working life'. 1:35-37.

'I was the character that ran the business and people use to gain strength from me, you know. They'd come to me and not just for work and that but also for personal problems..... I was a very much more positive person. There was no such thing as 'no', it was a question of how do we do it'. 2: 206-208.

'I was a very, very confident sort of person, I was confident in my job'. 3: 211

For some men it was important to emphasise their earlier health and this tended to be through emphasising physical fitness and exercise.

'I was very rarely ill like operations, hernia things like that. I was a very fit person. I was an active person'. 4:212-214.

'I didn't see the point in registering as I only used to get colds and things like that. I didn't ever have anything serious wrong with me or anything like that'. 3: 23-24.

'Physically I'm fit as a flea. A bit overweight, but I'm very physically fit. You know I do a five mile walk without getting out of breath and, you know, physically I'm fine'. 1: 1:27-29.

Second level category: PRESERVING WORK IDENTITY

This second level category was split into four sub-categories. These are: *over-valuing of work identity; work taking over; working too hard; breadwinner*. Preserving a work identity seemed a key aspect of the participants' public identities. For men, work often has a central significance in shaping their masculine identities, and for those who are out of work, disabled or in a position of being forced into early retirement the distance they experience from a working identity can lead them to feel 'non-men'. It is thus understandable how many of the participants strived to keep going in to work even when they were experiencing inner distress.

'I was determined after I got back after that spell, I was determined to persevere and crack it and to keep myself under control, and I did for several months. I obviously had, you know, negative spells but I kind of, you know, I got into the practice of sort of managing those to try to almost damage limitation exercise, and I knew that I had to be careful because of the negative effect I could have on other people because of my key role'. 1: 178- 183.

'I managed to do a whole year without taking time off with stress without even a day off. But I went off work in the middle of October because it got too much for me. I was struggling by then'. 1: 6-8.

'At that particular time I felt that I was strong enough to keep going and you know to take whatever came along'. 1:446-447.

'I felt a pull and I stood up and I had to stop for about fifteen minutes to get my breath back, and I carried on working and as I carried on over the months, I started to get cramp in at the back of my thigh'. 4:4-6.

Even when the psychological distress becomes unbearable it seems that for some men it is still important to maintain their work identity and to conceal how they are feeling inside. For participant 1, a head master in a primary school, he describes vividly how he tried to cope with his distress and still remain at work.

'I just broke down and screamed one day and you know I just broke down over and over again repeatedly during the day, but I stayed there at work, and tried to hide myself away'. 1:52-53.

For participant 4 returning to his job as a lorry driver was important for restoring his sense of his own identity but when his physical injuries prevented him from being able to continue working he experienced a real sense of loss.

'I felt marvellous and then I went back to work after all the course had finished and everything and I just couldn't do it, I couldn't, I'd lift the ramp and I felt a twinge and I dropped the ramp straight away'. 4:201-203.

'It just made me feel down and so depressed, you know, I couldn't do anything, I couldn't physically doit was all in my heart and my mind'. 4:112-114.

Sub category: Over valuing work identity – putting work first

This sub-category is closely linked to the second order category of preserving a work identity. It stood out as a separate category as it specifically captures the 'distancing' from the domestic world that occurs through men over valuing work or putting work first. This over valuing can put strain both on the man himself and on others in the family as is shown in the account of participant 1:

'I was working myself into an early grave and I hadn't got a life at all'. 1: 44.

*'The situation at home was tense a lot of the time and, you know, I was very distant with her (wife).
...my daughter , I think she saw me as a bit distant'. 1:195- 198.*

Even when the man is out of work the difficulty of not having a work identity can also cause tensions as with participant 4.

'I was getting stressed over not being able to go back to work and do my job and I found myself arguing with my partner quite a lot'. 4: 25-26.

Sub-category: Working too hard

Pressure and demands of work were reported by a few participants. In the context of masculinity, not being able to cope with work pressures may be perceived as a personal failing and a weakness, rather than as the fault of work overload.

'I feel as though the expectations, you know, you're paid to do this job, you think you're fit to do the job, just come in and do the job, work hard, you know, in at half seven in the morning, come home, perhaps six, till work to do, I mean it's a familiar story to anybody who's in a professional field. And then, maybe twice a week , you have to go back into school in the evening for meetings and so on and it's almost as if you've got to be constantly on top of things ..and there is no opportunity for any release'. 1: 97-104.

Heavy demands of work were not always spoken about in totally negative terms but also seemed to be a way of acknowledging a past identity that managed to cope and as a testimony of an ability to live up to expectations of the male role to compete and succeed.

'I mean I was getting home in the morning at three o'clock and by seven they were calling me out of bed again and with things going wrong and that I could do nothing about anyway'. 2: 48-51

'I spent from 1962 to 1990 building that business up. I mean ..you know.. just working, working, working...'. 2: 132-135.

For men in manual jobs such as participant 7, the physical effects of working hard also diminish one's ability to develop other identities or to look after one's own health..

'I think I left it about a month and a half due to my work situation and things like that. Its sort of like my job is very tiring so when I come home from work some days I sort of like , I don't know, I don't feel bothered and like I go straight to bed and have a few hours'. 7: 64-67.

Sub-category: Work identity taking over

The work identity can at times appear to take over and leave no or little space for any other identity. Some participants spoke of a desire for a release from their work identity to be able to be more like their 'real' self.

'a constant need to be on top of things has deprived me of any release ...I've never been able to shake it off. I've never been able to switch off. You know, I've been off since October and I just can't get work and associated difficulties out of my mind, even while I'm doing something else....I kind of wait for phone calls all the time....so I'm kind of almost on pins....I'm not free of it'. 1: 103- 118.

'My thumb here I caught that in a machine once and chopped the end section off through here. It just went straight through it and they sewed it back in the hospital and four hours later I was back. It was

that type of business, you know and eventually you get to the point where you sort of burn out you've had enough and you just don't want anymore'. 2: 136-141.

'I felt a pull and I stood up and I had to stop for about fifteen minutes to get my breath back, and I carried on working '. 4:4-5

Sub-category: Bread winner

For some of the participants the traditional model of the male breadwinner, bringing home a 'family wage' was important in conferring a sense of status, pride and security. This seemed to be more so for those who had worked in more manual jobs and had suffered injuries, which prevented them from working.

'We are the bread winners of the family aren't we? So we have to get out there and earn the money'. 4:334-335.

'A man is supposed to be at work, a man is the provider you know.. when you get in a situation where you can't do that, you know, you have to think of ways of trying to resolve that problem, of getting back to that level of providing'. 5:306-310.

'In society that's how it was always, always been like that so it's ingrained into you, but to get on in life ...you've got to earn money to get the things you want in life and to pay your way in society'. 5: 535-538.

It can be argued that this model of traditional masculinity is really about models of masculinity that are from another era. Beck (1992) for example argues that societies today are increasingly becoming 'risk societies', characterised by decline in traditional ties and forms of solidarity and support, including the family. This together with changing job structures and employment patterns have served to undermine the foundations of traditional masculinity making it much harder for men to occupy the role of

'breadwinner'. An awareness of this and yet a sense that this is still an expectation on men was shown in the accounts of several participants.

'I'm very old fashioned in my way of thinking. I . . . the man is the provider and I felt like I couldn't, I felt I couldn't fulfil my obligation to myself and to them'. 3: 233-235.

'It's just the way I've been brought up. Society as I was growing up in the 50's and 60's and the 70's and when I was working in the 70's the man provided, you know. My mum, my mum's friends they never worked. The husband always provided. My granddad always provided, my uncles always provided, the women stayed at home'. 5:530-534.

4.3 Higher order category: SEPARATION OF PROBLEMS FROM SELF

The next higher order category identified was termed 'Separation of problems from self'. This was seen as comprising of two second level categories: medicalisation and lack of a language for distress (See figure 7). This higher order category clearly linked to the core category of 'distancing' as participants described a separation of their problems from themselves.

Distancing was evident in the way that men were reluctant to recognise illness or psychological distress in themselves and this led to a kind of bottling up of emotional distress that in itself was self-destructive. In many ways it seems as if men often accommodate to uncertainty in their emotional lives and in their bodies by ignoring, minimising or glossing over it. For participants there was a strong need to remain in control of emotions and to preserve an appearance of coping. Husserl (1970) uses the term 'bracketing' which means setting an event apart by putting a frame around it and treating it as something separate from the flow of life. It seemed as if, for some participants, there was an attempt to 'bracket' their distress so as to lessen its impact on their social and personal identities.

'I thought I was strong enough to kind of just get on with it and not let it bother me. But I think in so doing what I was kind of doing was, I was kind of putting it away and not dealing with it myself, within my own personality'. 1: 86-89.

'I tend to (pause) control the urges to do that, and .. I'm not sure of my emotions or anything like that, the way that I feel, I just get on with life and do the best I can'. 3: 121-123.

For some this separation of their problems from themselves was necessary to maintain their jobs.

'I didn't want to lose my job or anything like that, I didn't want to come in, I just tried to sweep everything under the carpet'. 3: 159-160.

**SEPARATION OF
PROBLEMS FROM
SELF**

**LACK OF A LANGUAGE
FOR DISTRESS**

For others the process of separating the inner from the outer relied on resorting to practical strategies that prevented or deterred the outside world impinging.

'I tend to shut the outside off, even though I'm very aware, I wear headphones all the time when I go out, so I don't, so no one can approach me easily'. 3:220-221.

Separating oneself from the problems is not always a conscious process and may occur through denial. It is then others who are more likely to be aware and recognise the problems or the problems may become manifest in physical symptoms.

'I didn't think in myself that I had a problem, but my wife, my partner did so ... we did use to argue a hell of a lot'. 4: 81-82

'Because I was losing weight, because I was still eating, you see, and I was losing weight. Couldn't understand it, couldn't explain it and I kept saying I was all right and she said it must be my nerves, something like that and that's why I went and told my doctor'. 4:415-417.

Second level category: MEDICALISATION

Many of the participants spoke about how their psychological difficulties tended to be treated with medication or given a medical diagnosis of depression by their GPs. In some ways this process of medicalisation reinforces the idea that the emotional problem is separate from ones self and due to an illness. For many men medical explanations were seen as positive as the problems became objectified and as something to be 'sorted out'. In terms of concepts of masculinity men are often seen as activity focussed rather than emotion focussed – 'doing' instead of 'being'. Treating emotional distress through taking medication allows men to be active and to maintain an image of control whereas psychological help through 'talking' would require self-disclosure or revealing weaknesses or vulnerabilities.

'He described me as suffering from, you know, clinical depression which obviously can be sorted out'. 1: 54-55.

'I really felt that I should be able to sort this out myself. I should have the inner resources. The fact that I wasn't coping too well I rationalised that as not being a problem with me, myself needing counselling type of support. I saw it more as, well, the doctor explained it's a kind of chemical imbalance'. 1:470-473.

Medication was seen as a way of keeping going and maintaining a public identity. There was an awareness that the medication was not addressing the underlying problems but was a means to cope and as a strategy this seemed to work for a period. Viewing one's problems as an illness, separate from the self, may also be more acceptable to others as not being able to cope with emotion may be viewed negatively or construed as a sign of weakness or as being feminine.

'The doctor asked me if I wanted time off or not and I said I didn't I wanted to get through and he put me on drugs'. 1: 141-142.

'I would have periods of depression. The doctor could give me some tablets which would rectify the chemical imbalances and that would do the trick, you know, then I'd be all right, I'd be able to cope with what was coming and facing me. It was a case of getting the chemical imbalance right'. 1: 454-458.

'I got the imipramine and then, you know, I just got on with it really, I thought I was cured, but then a couple of years later I had to go back again. I thought, I felt as though oh well my chemical imbalance must be back again, it needs sorting out again, so the doctor advised me to take something else'. 1: 476- 480.

Not all the men found disclosure of their distress difficult. A negative case example is shown in the account of participant 3 which describes how he went to his GP and explained his sense of loneliness and 'hurt' and how through the consultation this experience was given a medical label of depression. This process of medicalisation has been well documented in the sociological literature (Tuckett, 1976) where a key aspect of the GP's role in the medical consultation is to define and legitimise what is and

what is not illness. Labelling the problems as illness may absolve the patient from some responsibilities and legitimise the person's behaviour and demands for health care. For men, however, this medicalising process may serve to reinforce traditional masculinity which in itself also denies men expression of emotionality.

'I just said that I'd been through a lot in the last year and I told him exactly what I've been through and how I felt very hurt and I felt very, sort of, nervous around people now and very (pause) I felt very, very lonely inside me and that's the way I said it to him and he turned round and said how long have you had this depression'. 3: 265-269.

Second level category: LACK OF A LANGUAGE FOR DISTRESS

The second aspect of the higher order category, 'Separating problems from the self' was termed 'lack of a language for distress'. This referred to participants finding it difficult to express how they felt or to find words to describe their experience. This difficulty in emotional expressiveness has been termed 'restricted emotionality' (Miller and Bell, 1996). This can be the result of men learning to repress emotions as part of their socialisation into being men. Avoiding feelings may eventually result in the inability to feel and the experience of emotional distress becomes something that is difficult to comprehend as with participant 2.

'In this state ..you don't believe It ..you don't understand it ..you just don't understand these types of things .. you know you get a cut leg .. you get a broken leg .. something like that, you can see it. Something physical you can understand. Or you get a virus, or something, you can understand that but when it's in your brain – what is there to see? You know, it's like a deaf person. They look perfectly normal, everything would appear to be all right but they're deaf. There is nothing you can see. Nothing. I still don't think I understand it', 2:60-67.

'How do you explain it? It's just something that .. you can't seem to grasp. I mean I've been through it but I'm still not really ant nearer understanding what has happened. Gill tells me it is a chemical imbalance in the brain that has caused it but I don't know'. 2: 186-190.

'It's difficult to talk about something you don't understand'. 2: 256.

The lack of a language for distress makes self-disclosure more difficult for men even when they are talking to those in close relationships. Self-disclosure may suggest weakness, which is inconsistent with a masculine identity and revealing vulnerabilities may provide the recipient with a source of power over the discloser.

'I'm shaking and she could see me shaking and she says what's the shaking for? I says I don't know, you know'. 3:87-88.

'I never used to really talk to her, explain you know, explain what, how I really felt and things like that. I just sort of kept everything bottled up inside myself and I never sort of like talked to anybody about anything'. 7:186-189.

4.4 Higher order category: CRISIS AS DISCONNECTION

The next higher order category was termed 'Crisis as disconnection'. This relates to how participants described the actual point of crisis when they no longer felt able to preserve a public identity and the ability to separate their problems from themselves became impossible to sustain. Participants described this point in numerous ways as: 'breaking down', 'falling apart', 'burn out', 'worn out', and 'release'. In the analysis three second level categories were identified which attempted to capture what can be seen as a process of disconnection. These three second level categories are: loss of past self, shift in self and loss of work identity (See figure 8). Loss was a particular feature of the accounts of men whose psychological distress had been precipitated by physical injuries that had left them disabled and unable to work. For all the participants there was a specific event or crisis that marked the beginning of their problems.

Distancing as described above has related to ways that participants struggled to cope with their emotional distress. At the point of crisis this distance is no longer possible to sustain and it is as if the men participants experience a sense of disconnection from their former identities.

In this extract from the interview transcript of participant 1 he describes the point of crisis.

' We have what we call link inspectors, they're members of the local Education Authority Advisory Inspection Service., and our link inspector at the time, he just happened to call in one morning and, I don't know why, it just sort of opened the flood gates and it just came, and he said 'how's it going?'. I didn't know he was coming into the school and I took him into my office and I just fell apart. It was almost as if nobody had asked me, nobody had triggered any kind of release from inside and I, it all had to come out'. 1:90-96.

**CRISIS AS
DISCONNECTION**

LOSS OF PAST SELF

LOSS OF WORK IDENTITY

For participant 2 the crisis point was more a point of emotional breakdown and a loss of control over his emotions.

**P: 'I think things had got to the point where your mouth was twitching all the time and you weren't yourself.. and that was it'*

M. 'I was all emotional and er uncontrolled'. 2:74-76

*[*P: partner, M: participant 2]*

'I look back now and see that I was in a heck of a bleedin' state. I couldn't you know, men don't go round crying their eyes out like that.. which is.. er. well silly things would happen like you'd feel a bit weepy and you couldn't control it'. 2:82-84.

He traces this to him becoming 'burnt out'

'..eventually you get to the point where you sort of burn out. You've done enough and you just don't want anymore'. 2: 140-141.

Participant 4 recounts how his difficulties began following an accident at work in which he injured his back. The fact that accident was 'simple' makes acceptance of the resulting disability and disconnection from his former identity much harder to bear.

'Just a simple accident that is all it was, but it put me from what I was to where I am now and er it's ..I still can't get over it. I still think I can get up , just go for a run and what have you, but I can't do it. I can't physically do it. I want to do it but I can't do it, I know I can't'. 4:132-136.

Second level category: LOSS OF PAST SELF

Loss of past self was often a key precipitant or consequence of the crisis for participants. For some the emotional crisis seemed to be partly about an awareness of having become disconnected from a past

identity and this past self was referred to as somehow more the 'real' self or a reminder of how much had been lost.

'It's what it has done. It is what has happened to me. You know the character I am now to the character I was a couple of years ago. I'm just not the same character'. 2: 194-196.

'It's like when I wanted to do something I just did it but afterwards I felt , I was so sore.. I can't really explain the feelings, it's just everything just felt wrong, you know, my whole life is finished. My career is finished. I can't play football. I can't play golf no more. I can't go back driving no more'. 4:30-34.

'My actual depression started going through the divorce because I lost my house, my children, my car, my job, everything'. 5: 177-178.

Men are prone to what Jourard (1971) calls 'dispiritisation'; that is, the loss of meaning in life. Instead of investing in intimate relationships men depend on their jobs, status and sexual potency for their identities none of which are immutable. When these things are lost such as through becoming ill or even retirement, then much of life's meaning is lost. This sense of 'dispiritisation' is evident in the account of participant 3.

'I've never gone back on anything in my life. I don't think you ever should, I've always been going forward. Like now I don't even see, I just feel like I'm existing, I'm not living. I'm existing'. 3: 242-245.

Second level category: SHIFT IN SELF

A part of the point of crisis participants described a shift in themselves, in their identities. Although this shift in self was closely linked to loss and loss of a past self it seemed to be describing the absence of something in the present.

'I just noticed my sort of energy levels and ability to stick at it, you know, it was rapidly diminishing and therefore, you know, by about midday I felt absolutely worn out and ineffective'. 1: 39-42.

'You could look at something in the business and sort of weigh it up and er like I said you didn't need the figures, you didn't need anything you knew where it was going. But er I can't get that feeling anymore. I feel as if I've lost a lot'. 2:231-232.

For some participants the difficulty in accepting this shift in themselves was an aspect of being a man and may relate back to men's lack of a language for distress.

'Men don't seem able to accept it .. you know.. much the way I feel about it. I still feel.. although I've been down like this, I still can't understand.. I can't really accept it'. 2: 182-184.

Second level category: LOSS OF WORK IDENTITY

Loss of work identity was seen as a separate category from loss of past self. This clearly links again to the primacy of work in men's identity formation and the consequent impact of job loss on men. Participants spoke about the importance of work and for those who particularly saw their role as being the provider, the impact of losing a work identity seemed central to their distress. This was highlighted by the following quotation from the interview with participant 4.

'I've never been out of a job. I've always worked and to all of a sudden just stop, find out you can't be the same as you used to be, which I've done for 35 to 36 years, and now it's just freaked me out. I couldn't believe it'. 4:107-110.

4.5 Higher order category: USE OF LAY NETWORK

The next higher order category is concerned with participant's use of their lay networks for both support and in initiating help-seeking. This higher order category is further sub-divided into four second order categories. These are: influence of a partner/women, male friends, limited network and lay referral to other sources of help (See figure 9).

In the process of seeking psychological help participants described various conversations with others in their lay networks, which acted as a source of advice, support, reassurance, active persuasion and material help. Although Friedson in coining the term 'lay referral network' argued that a person experiencing symptoms would receive advice from a close relative before being referred to progressively more remote and expert people, participants gave no evidence of such an extensive network. This may be part of the process of 'distancing' that seems to characterise participants relationships to their problems, themselves and to sources of help. For those in relationships the greatest influence on their decision to seek help was their partner. For all the men, women seemed to play a central role in the process of lay consultation and as sources of emotional support.

Second order category: THE INFLUENCE OF A PARTNER/ WOMEN

Partnered men

For participants in relationships, their partners provided the essence of 'being there' for them. Their partners were vigilant, attentive, helpful advocates and companions. These women provided the men with a continuity link to both past and future identity through their involvement in the present.

'She's been helping me through a lot of the problem with myself. She's been a tower of strength....She's always just there for me, she always helps me, she always gives me good advice. She always makes sure that, you know, she always looks out for me'. 7:95-104.

**USE OF LAY
NETWORKS**

INFLUENCE OF PARTNER

MALE FRIENDS

LIMITED EXTENDED

GP as part of Network

'...things got very strained and even the wife adopted a very stoical attitude, a very dignified attitude, you know, that, well, she knew it was really difficult for me and the last thing she wanted to do was to make things worse...she did everything she could to support me and encourage me and help me to relax'. 1:201-205

'She seems very understanding and she's got time for me. She'll sit down and she'll talk to me about how I was brought up and help me feel my problems. She sort of like, in a sense, she sort of like acts as a second mother to me'. 7:302-304.

Partners were central to the decision to seek help with often the partner being the one who suggested that the participant needed to see their GP.

'Well, basically, my fiancée, she said, 'you know the best place perhaps for you to go is my GP.. she might recommend some place for you to go to where I can get some help'. 7: 22-24.

'My partner says go and see the doctor and talk to someone'. 4: 27.

For some participants their partner was the one who actually took the step of contacting the GP and of accompanying the participant to the consultation.

'When it manifested itself like that, you know, she said you've got to see the doctor. Shall I make an appointment for you? And that, I don't know whether I would have made an appointment that day, but she did it for me, you know, I think she was looking after me. I was quite happy for her to look after me'. 1:428-431.

'When I broke down it was my wife that took me along to the doctor. She rang and made an appointment. I rang her up and told her I was in a bad way and she made an appointment and she took me along to the doctor's that evening'. 1:124-126.

Participants often reported that it was their partners who noticed they were not well and encouraged, instructed, 'nagged, or 'pushed' them to see the doctor.. Without this encouragement it seems several of the participants may not have taken the step of going to their doctor.

'Gill was getting very concerned about the condition I was getting in and it was her that basically kept pushing to go to see the doctor'. 2: 240-242.

'I don't know if I would or not. I don't think I would, no. Not on my own. But then again somebody pushing me, that's what my partner did, yeah, but on my own I wouldn't have'. 4:90-91.

Men's lack of a language for distress may make them more uncomfortable asking for help particularly if it concerns emotions. This can lead to men relying on women to actually decipher and articulate their distress. For participant 2, his partner acted in this role of 'interpreter' and attended all consultations with the doctor. Even in the research interview this man called to his partner to come in and answer questions he found difficult to answer even though these were about his own experience.

'Gill's been with me all the time. She's .. this is what gets me I wish I could have a proper vocabulary. All the time, all the way along Gill has spoken for me all the time. It's just been support from Gill all along'. 2:266-268

'Interviewer: 'What actually led up to you going to the doctor?'

Participant: 'My wife' (calls wife from other room. Partner enters)

He was asking what led up to me going to the doctor in the first place?

Partner: 'It was me, wasn't it.. pushing you..' 2: 33-37.

Not all partnered men experienced support from their partner. A negative case example is found in the account of Participant 6. His main difficulties centred on marital problems with his wife. He was disabled following a work injury and relied on his wife for practical and physical support. He felt that

there was an absence of emotional support and this had led him to seek help. For him, it was important that his partner did not know that he was in the process of seeking psychological help.

'No apart from the fact of telling her I'm seeking help which is what I'm doing. I've told her as much as I'm going to tell her. If I told her I'm seeking psychological help she'll say I'm going crackers'. 6: 308-310.

Unpartnered men

For men without a partner, there is often few people to confide in about health concerns or to use as support for coping with emotional distress. The absence of such support leaves men often to neglect or ignore health symptoms and make them vulnerable to psychological difficulties.

Only one of the participants (Participant 3) was not in a relationship. He lived alone, renting a room in a shared house and had no contact with his ex-partner. This man's narrative described more about his sense of loneliness and the consequence of not having a partner seemed to have significant influence on his emotional state. In a limited lay network, it was another woman (his step-mother) that acted as a source of support and as the catalyst to him seeking help.

'I rang my step mother up and said could she possibly see me.. she's married to my father, and she came across and sat down and just got everything out of me and .. she said well I'll have to go and see the doctor and so I went and registered with the doctors'. 3: 16-19.

'She said 'don't give it a go, go and do it'. She gave me a kick up the backside and I went and did it. I went to the doctor and I explained everything to him'. 3:103-105.

Second level category: MALE FRIENDS

A noticeable aspect of the participant's descriptions of their lay networks was the absence of men in confiding roles or in positions to offer advice or support. Participants seemed to rely solely on women to discuss health concerns and to be providers of emotional support. Men's relationships with other men are often circumscribed by what may seem appropriate to say. Traditional masculine discourse tends to exclude personal issues such as health as both physical illness and psychological problems may be signs of weakness and not to be advertised. Sabo and Gordon (1995) suggest that competitiveness and homophobia often restrict friendships amongst men. In this context, the limits on male-male friendship may cause the heavy reliance on women for intimacy and emotional support.

'Men don't talk about these sort of things. You know, when men get together they talk about football matches or the weather or boat engines or something of that sort. It was never discussed anything about the human body or people having problems with it in any shape or form. It's just not something that tends to crop up in male conversation ..it never really crops up with men'. 2:346-351.

'Women seem to have a more sympathetic or understanding nature towards anything like this ..I haven't felt there is any man who understands it. I don't blame them because I wouldn't have understood...somehow or other it's always in the male mind to 'pull yourself together, you'll be all right'. 2:177-180.

Even when some men attempted to talk to their male friends they encountered a lack of understanding and did not feel as if the other man was able to listen to their concerns. This is found in the account of Participant 2 who explains how it seemed as if his words simply bounced back

'There's a pal of mine. He's .. you know.. you get this feeling that it's just hit him and just bounced right back like water off a window pane. It just hits and bounces off. He will listen as such but you don't feel that he's taking things on board or understanding anything'. 2: 285-288.

Empathy is clearly a useful skill to maintain a social network and yet it seems almost inversely related to traditional masculinity. In the following extract from the interview with Participant 5, it reveals how some men compartmentalise friendship so that certain problematic aspects of life are not shared. This highlights a further aspect of 'distancing' where men attempt to keep at a distance from other's personal troubles.

'My bestest mate, Michael, he lives on .. road. He's the only person that's actually in Nottingham. But he's got matrimonial problems at the moment, so I've not seen him for about two years because he's going through a real bad patch and I thought well I'm not going to get into that because it's going to make me worse'. 5: 287-291.

Not all male friendships conform to models of traditional masculinity. Participant 7 offers a negative case example in that he described a confiding relationship with a male friend where he could discuss his difficulties and receive advice and support.

'The only person I have talked to is like one friend.. he knows all the situation round me and he's always sitting there advising me...but other things I'll probably not talk to him about, I don't talk to him about everything'. 7:321-333

Second level category: LIMITED EXTENDED NETWORK

Participants did not describe an extensive lay network of people with whom they discussed health matters or from whom they received advice as detailed by Friedson (1960). Instead many described a very limited network of support.

'It's like I can't go to my mother because she's got stepchildren ..she's very much involved with my younger sister and her children. I can't go to my father because, you know, he sticks his hands up in the air and shakes his head and all that. My step mother she works very hard.. she hasn't got a lot of spare time. My sisters have all got families of their own. I suppose .. I feel very alone'. 3: 315-323.

'I've never asked my father's advice or anything like that. He's not the best person to talk to basically. So basically I didn't want to turn to my father'. 3:28-30.

As described earlier for most of the participants the most important lay conversations in terms of deciding whether to seek help were with their partners or with other significant female figures in the men's lives. Where men did try to discuss their concerns with more remote people the response was often not supportive as shown by Participant 2.

'My old secretary, basically her attitude was pretty much the same as mine would have been for anybody coming in which is pull yourself together'. 2:277-279.

Sub-category: GP as part of network

The notion of the GP as a 'family doctor' who has knowledge of a whole family's health and is aware of the context to problems was described by two participants. For them the GP was not a remote figure but was viewed as part of their social network and someone who had a privileged understanding of their difficulties or at least knowledge of the context in which they occurred.

'The GP knows the situation, she's fully informed. She knows quite a lot about my fiancée's family and things like that....she knows a lot about me'. 7:112-118.

For this man (Participant 7), although he had very little contact with his GP, when he eventually went to her to seek help he went in the knowledge that she already knew something of his situation. He therefore did not have to face the embarrassment of disclosing the details of how he had injured his daughter.

'As it was she knew the whole situation. She basically asked me what, you know, I thought of the situation'. 7:128-129.

Another participant (Participant 6) visited his GP for regular health checks due to his chronic physical health and through this contact had established a confiding relationship with his doctor where he could discuss his marital difficulties. Again, the GP understood the context as he also was the family's GP and had contact with the man's wife.

'I see my doctor as my only.. shall we say open door to discuss the problem I had and I told him what the problem was.. and he said I'll put you in touch with someone'. 6: 23-25.

Sub-category: LAY REFERRAL

The 'lay network' is not there just to provide support but also serves as a source of information on self-care and knowledge about alternative care to that provided by the GP. Participant 1 had used a number of different types of help before his GP had decided to refer him to a clinical psychologist. Often this type of care is utilised following a personal recommendation as described in the following interview extract.

'A friend of mine, you know, .. who I went for a drink with , his wife had a fear of flying and she went to see a hypnotherapist....so I made an appointment to go and see him... I went about six times and paid privately'. 1: 496-503.

Knowledge of others having used a particular type of help also serves to reduce any associated stigma. For psychological help, while it is becoming more acceptable, there remains a degree of stigma and for men the idea of talking may be perceived as 'cissyish' (See).

'.. a good friend of mine , who I grew up with and had a very similar background to myself...he's having on-going counselling'. 1:582-584.

For one participant lay referral did not involve seeing an alternative therapist but was for him to discuss his concerns with his vicar.

'I did speak to a friend and he said, he said, go to the church. He said, 'how about the vicar?'''. 6: 69-70.

4.6 Higher order category: SELF IN PSYCHOLOGICAL HELP

This higher order category is termed 'Self in psychological help' and refers to how psychological help can be viewed as a process of engaging one's 'self' in a therapeutic relationship and taking one's 'self' rather than one's problems for help. In terms of the help-seeking pathway for men this means that men have to reduce the distance between themselves and their problems in order to seek help. This involves men being able to emphasise the subjectivity of their difficulties and to recognise their problems as not separate from them; to find a way of expressing and disclosing their distress; and take steps to seek out help. This goes against the traditional assumptions of masculinity which involve 'distancing' and which encourage men to objectify and externalise their problems. For some of the participants this personal identification with their problems had not happened and for some men psychological help was viewed as another treatment that involved having something done to them and in which they were passive participants. For others psychological help was not something they had chosen out of their own volition but something which they felt they had been coerced into doing and they saw it as a means to an end and not something with which they were personally engaged. These different aspects of the way men viewed psychological help are represented within this higher order category by three second order categories: engagement of self in help-seeking; disengagement of self self; and influence of past help (See figure 10). The higher order category was termed 'self in psychological help' as this was seen as encompassing both engagement and disengagement within the help-seeking pathway which for men is part of the broader process of 'distancing' as described in the core category.

Second level category: INFLUENCE OF PAST HELP

This category was defined by how participant's experience of using services in the past had shaped their attitudes to seeking psychological help. Views of psychological help may be derived directly from a person's own past experience or they may be transmitted via their social networks. Positive and negative experiences have a ripple effect to others by means of the stories that are told about services and advice people give each other. A complex interaction of expectation, prior service experience and contact with services emerged from men's narratives. Negative and positive past experiences were

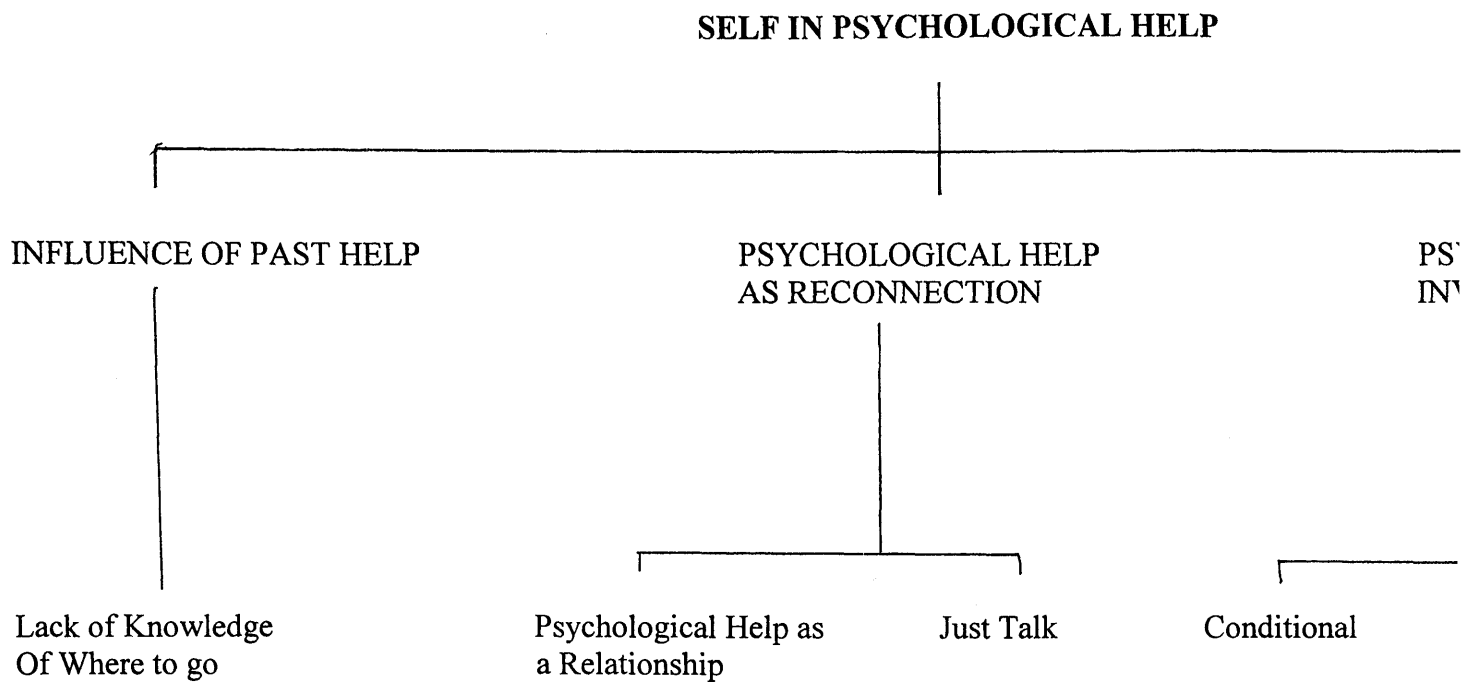


Figure 8: Higher order category – Self in psychological help

described some of which involved previous experiences of actually having seen a clinical psychologist and others referred to experience of seeing a Community Psychiatric Nurse, a counsellor and a hypno-therapist.

Positive

Several participants described earlier positive experiences of having 'talking treatments' and these disposed the men to feel positive about the idea of being referred to a clinical psychologist which was often seen as being the same as counselling or 'talking'.

'Having experienced some kind of benefits from psychotherapy, hypnotherapy I'd been to, I felt a bit more positive about being referred for on-going counselling'. 1: 520-522.

'When I was there I used to talk to people, like we'd go round in a group and, you know, talk about our problems and things like that. And everyone was quite open, and that was helpful'. 4: 56-58.

'He had my records, he said well I still have a note from the last time and it says you saw someone back then didn't you? .. He said the best thing you can do . he says go back to see them and see if they can help you..... I did I thought it was helpful last time'. 6: 151-158.

Negative

One participant (Participant 7) had actually been seen by a clinical psychologist in the past. He described a negative experience of seeing a male clinical psychologist.

'It felt really difficult to sit down and talk to him, because the way that he was coming across to me and things like that, I just couldn't open myself up and I just couldn't talk to him'. 7:248-250.

'Sometimes I say something but I mean to say something else, and of course I wanted it to tell something else, but he picked up on the way that I said it and he made me feel uneasy and then I just didn't want to talk to him. So then I basically switched off...I basically answered his questions as he wanted to hear them'. 7: 253-259.

He viewed the reason that this was not helpful as more to do with the person than the role of the clinical psychologist and so he managed to maintain a sense of optimism about future help. Previous experience of having being seen by a clinical psychologist had allowed him to think about way he might approach future help

'I couldn't get on with the chap that was interviewing...he made me feel uneasy'. 7: 46-49.

'This time I'll probably talk to them in a different sense...they'll probably be able to help me a lot better'. 263-267.

Sub-category: Lack of knowledge about where to go

Knowledge of where to seek help is often transmitted through a person's social network. As described earlier for men in relationships this knowledge seemed to mainly come via their partners who made suggestions of where to seek help. For men access to a wider lay network seemed limited and it may therefore be difficult to know where to go for help. This was the case for participant 3 who on realising he needed help didn't know where to go. He did not immediately think of going to his GP as he did not consider his problems to be 'medical'.

'When I needed help I couldn't think of where to go and that was one of the obstacles. It wasn't, I didn't see it as a degrading thing about being a man to seek help or anything like that'. 3: 254-256.

Second level category: : PSYCHOLOGICAL HELP AS RECONNECTION

This second level category describes how men came to the point of realising that their difficulties were personal, involving the 'self', and that psychological help entailed actually taking themselves along for help rather than a collection of problems. This process can take some time and for some participants there was still the nagging sense that they did not have 'real' problems - problems that were external to themselves and visible..

'I think looking back at the last two or three years, I've taken the initiative in going to the doctor. Not particularly for drugs, but because I wanted the doctor to know that I was finding it really difficult'. 1:149-152.

'I kept going back to the doctor and kept saying I can't face going back and so on, and then when I went back in January I actually wanted to be referred'. 1: 540-542.

'You feel almost a bit of a charlatan when you see people in the surgery...I wander in without any trouble at all now. I feel a bit guilty taking her time but she has been marvellous, she really has. She is very understanding'. 2: 296-300.

Sub-category: Psychological help as a relationship

Taking one's self for help also meant that the help being received was personal and that central to this was the forming of a relationship with the helper. Participant 1 described this in terms of an affinity with the person in the role of helper.

'I was quite pleased that it was a man because in some ways ...I suppose if I look back and see that woman that I was seeing, I didn't really enjoy talking to her. I didn't strike up a very good affinity with her. I think that was part of the reason why it wasn't doing me any good'. 1:647-649.

'I look forward to, actually looking forward to setting up a new affinity with somebody who I don't know at the moment, somebody who will help me to grow and develop, even at this stage in my life'. 1:669-671.

The significance of the relationship in psychological help is revealed when the help comes to an end or when the person returns to seek further help.

'I felt that the person who knew me best he wasn't really available any more, so then I went back to the doctor'. 1:165-166.

Other participants spoke of specific aspects of the helping relationship that they hoped to be present. These included having someone who could help them to understand the reasons for their distress and having someone to listen to them.

'I just hope that I can get some result from it, so that I can get it in my mind to understand it. To understand it I'm sure is going to go a long way towards curing it'. 2: 360-363.

'I want someone to sit down and listen to me (pause). I needed to turn round and say look how I'm feeling inside, I'm feeling very lonely and very disturbed, and I don't know why'. 3: 305-307.

'They're not here to resolve my problems or anything like that, I know that, but just to sit there and talk to someone and know that they're listening'. 3: 313-314.

One participant (Participant 7) describes how he was aware of the expectation to personally engage but that he was wary of doing this unless the relationship felt right.

'I won't sort of like talk about myself, I'll just basically give them what they want to hear and that's it. Just to shut them up, because you know that's 'cos I can't talk. If somebody sits down and talks calmly and plainly and things like that I can basically open myself up and talk about things'. 7: 228-232.

Sub-category: 'just talk'

In terms of the process of reconnecting one participant described how he had initially been dismissive of psychological help, seeing it as being something feminine or as 'just talk'. Fear of femininity is often a key aspect of masculinity and in coming to seek psychological help men may have to overcome this barrier that 'talking' is incompatible with being a 'real' man. Although this was only mentioned by one participant it was felt that this view may have been more widely held and that this may contribute to the 'distancing' of some men from seeking psychological help.

'I felt that it was a kind, almost sort of cissyish or a bit namby pamby really the counselling, just having a chat'. 1: 468-469.

'You know all I'm doing is, I'm just talking about it, just talking about it, but I talk about it at home, but I talk about it to the one friend I go for a drink with'. 1:492-494.

Second order category: PSYCHOLOGICAL HELP AS NOT INVOLVING SELF

Participants interviewed for this study, while all at the same stage in terms of having been referred by their GPs to a clinical psychologist, were at very different points in terms of how personally engaged they were in the process. For some men there still remained a clear separation of themselves from their problems and their discourses invoked images of trying to beat their problems as if it were an enemy.

Sub-category: Conditional – not own choice

As explained in the description of the higher order category, 'Self in psychological help', not all participants chose to seek out psychological help but felt coerced into it by their circumstances. Participant 5 had been referred for help via his GP by the disabled employment services as he was felt to have significant interpersonal problems. He saw no personal need for help and viewed the help as a means for him to return to employment and was approaching it like a test.

'I just need to go back to work, but before I can go back to work I've gotta go through this scenario of having my head tested, sort of thing'. 5:607-609.

'In my mind it's pointless because I know exactly what I want to do, but they're saying, I mean at the job centre, because I have a problem of getting on with people, they're stating, well you know, it's a psychological problem there. There isn't. How can there be a psychological problem there if I know exactly what I want and I can go out and do it'. 5:508-512.

Another participant (Participant 7) had been referred via his GP by social services following an incident in which he had harmed his young daughter.

'It was at the request of Social Services. I'm in trouble with them at the moment with my daughter when she was younger. I marked her when she was a young child'. 7: 3-5.

He saw the consultation with a clinical psychologist as a one way process where he was being scrutinised and not as something that he was to actively participate in. It would not have been his choice to seek help and he did not accept that he had a problem.

'They said that they wanted me to go seek help to sort of like, they basically wanted to see that I'm not going to flip my lid and harm my child again or anything like that'. 7:9-11.

'If we wasn't in this mess I wouldn't have gone out for help'. 7: 298.

Sub-category: *Help as intervention*

This sub-category describes how for several of the men they saw themselves in the role of passive patient awaiting the intervention of an expert who would have the answer to their problems and be able to sort them out. They did not see the process as involving them on a personal basis and thus maintained a distance between their public and private selves.

'I'm concerned whether the psychiatrist can get into it, you know, and maybe sort it out'. 2:328-330.

'Someone who like knows all about psychology and knows the workings of the mind and why people do this and why people do that, and it's easier to talk to someone here who knows all about and they can give you some good answers'. 4:472-475.

'.... And (pause) and hopefully, even I mean if somebody can intervene'. 6: 280-281.

'I didn't know what type of help I was expecting... I know it's got to be something like anger management and keeping tempers under control and things like that and sort of keeping myself under control when situations get tight'. 7:138-141.

Sub-category: *Release from work/public identity*

An aspect of help-seeking that was in the accounts of two participants also related to seeing the help as a means to an end. For one participant this meant a release from their work identity and a legitimisation of them in the sick role.

'I'm fearful of work. I'm fearful of the work situation...I can't face it and I'm in a kind of limbo at the moment, so I need counselling to help me through this. But I also, I may be more selfish about this I suppose, I also need an independent, as it were, an independent professional opinion regarding my

suitability to work in the kind of environment I'm working in...because if I'm to apply for retirement on health grounds I will need the backing of someone'. 1: 548-555.

For others it was about a restoration of something that had been lost and a return to a past identity before the difficulties had begun.

'I would like to think that I'm on the break through point where I can start working again. I hope that is the case.. I'm coming out of it, you know, I'm clambering back. I'm hoping to be able to start making money again'. 2: 154-158

'...I can get some help, you know, to help me back, you know, to get our family back together basically'. 7: 24-25.

5.0 DISCUSSION

This study aimed to discover more about the process of psychological help-seeking for men and to understand what factors influence men's pathways into psychological help in a primary care context. It extends previous work on psychological help-seeking through focussing on the male perspective and by looking at the process of help-seeking as a form of gendered social practice.

From the analysed accounts of the seven participants in this study, a process model of men's help seeking is presented which is characterised by an overarching theme of 'distancing'. This theme of 'distancing' is understood within the context of assumptions about traditional masculinity and is seen as describing a process through which men attempt to cope with feelings of vulnerability and strive to preserve a public (masculine) identity. 'Distancing' is seen as central to the men's accounts of their help-seeking and characterises the various stages in their pathways into psychological help.

The process model (p. 51) proposed in this study can be seen as an elaboration of other models within the illness career approach, notably the pathways model described by Roglers and Cortes (1993) and the Network Episode model (Pescolido and Boyer, 1996). The model proposed introduces the concept of masculinity and provides a framework to understand how masculinity influences men's help-seeking behaviour. In this study, help-seeking is seen as socially and culturally constructed. Men's pathways into psychological help are mediated by men's own relationship to broader ideas about masculinity or the 'hegemonic masculinity' (Connell, 2000) in their community and by interactions with significant women in their lives (predominantly partners for partnered men).

There are several key issues arising from this study that are of importance in terms of understanding men's health behaviour in relation to seeking psychological help.

1. Men appear to invest a lot in maintaining a public identity and efforts to maintain this often lead to men distancing themselves from their distress and their problems. Traditional assumptions about male identity and masculinity encourage men to be active and find solutions when facing problems. While this can prompt men to recover from their distress, these assumptions can narrow the range

of credible male behaviours and lead men to struggle to preserve their male public identity or to hold onto a past identity and this can set the conditions for slipping into psychological crisis. The men in this study primarily founded their preferred identities in work and in being the breadwinner. Subsequently if they could no longer work due to physical injury or if they could no longer preserve a valued self in their work, then the likelihood increased of them reaching a crisis point.

2. Men may try to accommodate to psychological problems by bracketing their distress and through separating themselves from their problem. Men struggled to talk about their emotional problems and often took recourse in medical language, which reinforced the notion of their problems as separate from themselves and as something to be treated. Conceptualising their distress in medical terms was congruent with traditional masculinity but made it more difficult for them to contemplate the idea of psychological help which involved self-disclosure or revealing vulnerability to others.
3. Men appear to take a more individualistic stance towards illness and psychological distress and place a strong emphasis on self-sufficiency and being able to sort out their problems on their own. Men often have limited social networks and rely on women, particularly partners, as sources of emotional support. Women also seem to play a central role in the process of lay consultation and in initiating help-seeking. Men were noticeably absent from men's lay networks and where men were present the relationships seemed circumscribed to exclude personal issues or health concerns.
4. Seeking psychological help can be viewed, as about reducing the distance between the self and one's problems and taking one's self rather than one's problems for help. This process can perhaps be seen as a process of reconnection and involves men emphasising the subjectivity of their difficulties. This is counter to the traditional assumptions of masculinity, which emphasise objectivity and encourage men to externalise their problems. Men in this study were at different stages in relation to their ability to recognise the subjectivity of their problems and for some it had taken several attempts at seeking help for them to reach this point.

5. The research suggests that the concept of 'masculinity' or 'masculinities' can be useful in thinking about men's health behaviour and for understanding the meaning behind men's accounts of their distress. The concept of masculinity provides a way to talk about men's involvement in the '*gender domain*' (Connell, 2000) and some way of naming that behaviour as distinct from conduct related to other patterns of social life. Masculinity is thus not a description of groups of people but describes patterns of gender practice. It is clear from social research (Cornwall, A. and Lidisfarne, 1994) that there is no one pattern of masculinity and that different cultures, classes and different periods of history construct gender differently. In this study, men's psychological help-seeking can be viewed as a form of gendered social practice. The way in which men 'distance' themselves from their distress, attempt to preserve a public identity, rely on women for their health and avoid professional help can all be seen as part of this complex pattern of social practice.

5.2 Implications of study

For clinical psychologists

The research highlights the need for clinical psychologists and other mental health professionals who deal with men to be aware of the influence of gender on men's health behaviour and actions and in particular to be aware of how men 'distance' themselves from their problems. This 'distancing' may, at a consultation, lead men to emphasise their coping and play down their distress. Men may find it difficult to reveal their vulnerabilities or to articulate how they feel. As little psychological research has focussed on men or masculinity, psychological models and practice are not necessarily attuned to take account of men. There may be a tendency to dismiss men's lack of emotional openness or an apparent reluctance to talk about how they feel as either as signs of coping or as a lack of *psychological mindedness* rather than as aspects of masculinity.

Focussing on men's pathways into help in a clinical interview may be useful in determining where a man is in relation to his difficulties. As shown in the study, seeking psychological help can be seen as a process of reconnection where men come to recognise their need to bring themselves for help rather

than their problems. Although all the men in the study had been referred for psychological help, men varied in terms of the degree to which they construed their problems subjectively. By making the help-seeking pathway an explicit focus of assessment it allows an understanding of the man's difficulties to be placed in a much broader context that takes account of the influence of social and cultural factors on the man's decision to seek help so allowing the clinician to gain a fuller understanding of the help he is seeking.

At a broader level, this study reveals the need for mental health services to take much greater account of gender and for there to be a greater gender or masculinity awareness amongst mental health practitioners. Currently, in most mental health services, gender is seen as simply a demographic variable and not as a complex domain of social practice. Thinking about gender and masculinity in this way will have implications for the way services are structured and delivered.

For primary care

For GPs the study has a number of implications. The research revealed the key role that women play in men's help seeking. Men's seeming reliance on women as responsible for initiating help and as the main supports for men suggests that it may be useful for GPs to direct attention to the partners of partnered men in terms of outlining options for psychological help.

It also seems important for GPs to be sensitised to and aware of men's absence from the surgery. Currently, few services in GP practices are specifically tailored to men's needs and this may lead to men being overlooked. Allocating responsibility for men's health to one individual in the practice might encourage a more co-ordinated response and for men's health to be made more visible. For many men in the study, employment issues, stress at work or loss of employment were key to men's difficulties. It may be that more targeting of these issues in practices may be useful for example having specific clinics on 'work stress' or 'coping with job loss'.

In the long term there is a much bigger issue about the way the concepts of masculinity and the male role, and the part they play in constituting a masculine identity, may negatively affect men's health and

lead men to ignore their health needs and to make less use of health services. It is not just the impact of lifestyles and biology but society's expectations have created an environment in which men are less able than women to recognise physical and emotional distress and to seek help. For the NHS at district, regional and national levels there is a need for further investigation into the health related behaviour of men so as to allow the development of a greater understanding of how to improve men's psychological and physical health.

5.3 Future research

As outlined in the introduction there has been little in the way of research on men's psychological help-seeking or on the psycho-social aspects of men's health. This study has outlined how by focussing on men it is possible to begin to develop some insight into the wider contextual factors that influence men's health behaviour. There is a need for further research and this study suggests a number of possible avenues for future research.

1. The study highlighted the importance of female partners in the help-seeking process and it would be useful to study their role in relation to men's help-seeking. It would seem that the degree of sex role segregation within a relationship or family may be associated with women's role in relation to attending to matters of illness or emotional issues. One hypothesis is that where sex-roles are highly segregated it may be that women are more likely to take on the role of looking after their partner's and the family's health but where sex-role segregation is less then this may be more equally shared.
2. The present study focussed on men who were in the process of seeking professional help after having been referred by their GP to a clinical psychologist. It would be interesting and useful to look at men experiencing psychological distress who do not get referred for professional help and to understand how their pathways differ. This is often seen as the area of unmet need by health services and little is known about this group. It may be that for some men who do not seek help it is because they have closely knit social / lay networks with strong interconnectedness between

individuals and that this provides the necessary support. Alternatively, it may also be that men utilise other systems of support outside of formal services. Understanding more about the pathways for this group is important for planning psychological services and for developing a greater understanding of the nature of psychological distress for men.

3. The present study focussed on men only and suggested how men's pathways may be influenced by masculinity. It would be useful to conduct future research that investigated men and women comparatively in relation to psychological help-seeking so as to allow the psychological interpretations of men's help-seeking to be refined and for the influence of gender as a form of social practice to be elaborated in relation to pathways into psychological help.

5.4 Limitations of study

A number of limitations were apparent in the present study. These are discussed as limitations of the grounded theory method and limitations in the research design and procedure.

5.4a Limitations of Grounded theory

Grounded theory methods aim to discover and define processes of action and interaction by identifying patterns and as a result are mainly concerned with fracturing data sets in order to define their total analytic properties rather than focussing on individual narratives. Participants' stories are thus used to illustrate points rather than provide complete portrayals of their lives. Charmaz (1995) has criticised grounded theory on this count as she says it detracts from '*the totality of the individual's story*'. While this is true, grounded theory methods in themselves do not exclude the possibility of working with individual narratives and it depends on what is the focus of the study. In this study, it seemed important to not reveal individual's stories as many of the men would not have wanted this and to have had such an aim may have made it even harder to recruit participants. It must be acknowledged that choosing to

not look at individual narratives, however, may mean that some meaning is lost and perhaps some of the nuances of individual men's accounts are not emphasised.

In grounded theory in order to enhance theoretical sensitivity the constant comparison method is used and variations in the data are investigated through examining negative case examples. While in the present study these methods were deployed the focus was always on psychological help-seeking and it may have been possible for fuller substantive comparisons to have been made. Henwood and Pidgeon (1995) refer to 'focussed conceptual development' which refers to full exploration of the properties of a defined set of categories. Their selection is determined by their particular relevance to the problem under investigation and are said to generate depth of vision as opposed to breadth of coverage.

As pointed out in the method section, grounded theory has been criticised by Charmaz (1995) as not leading to theory development but instead to rich conceptual analyses of people's experiences and social worlds. This criticism is to some extent supported by the present study which is perhaps best seen as providing an initial study of key conceptual and contextual elements of psychological help-seeking in relation to men and does not represent a formal theory. A further criticism might be around the structure proposed for the relationship between categories. The model suggested places categories in a hierarchical relationship to each other based on the number of participants' accounts that endorsed a particular category. Grounded theory tends to imply such a hierarchy by talking about higher order categories and by seeking a single core category. In other approaches to qualitative analysis such as Interpretative Phenomenological Analysis (Smith, Jarman and Osborn, 1999) while there is a structured analytic framework it does not require a hierarchy of themes.

5.4b Limitations in research design and procedure

Recruitment of participants.

Participants were recruited over a six-month period from referrals to the Nottingham Clinical psychology primary care service. As noted earlier in the method section (participants) of the twenty-nine men who were referred to the service and met the research criteria during this period, only eight

agreed to participate in the study. Questions may therefore be raised about the factors that led men to take part. It is well recognised that people who volunteer to be involved in research studies may not be representative of 'normal' populations (Parker, 1994). This notion is also relevant for qualitative studies. In the present study, the men were recruited at the point of referral to a primary care clinical psychology service. Asking men to be involved in the research study at this point meant that the men had to be willing to talk and to reflect on a process in which they were currently involved. For some men this may have been threatening and this may explain the reluctance of men to participate in the study. Of those who agreed to participate it is also possible that they viewed the research as some how connected to the referral and that by taking part they were influencing when they would be seen or how the service would respond to them.

Participants

Rennie et al. (1988) suggest that saturation of categories generally occurs after the analysis of five to ten transcripts. In the current study the analysis was based on seven interview texts. Although this is viewed as an adequate number of participants for this type of study (Turpin et al., 1997) it is clear from the analysis that saturation of some of the sub-categories was not complete and may have benefited from further interview data.

Although some attempt was made to construct a theoretical sample that took account of age, marital status and socio-economic background (based on postcode) the small numbers of men agreeing to participate in the research limited the scope of the sample. Pragmatic and time considerations also meant that participants were not re-interviewed during the process of data analysis. Although negative cases were analysed in light of the emerging theory, the limitations on the sample may have had implications on the emerging theory. As theoretical sampling helps to fill out categories and to discover variation within and between them (Charmaz, 1995), the developed theory may therefore not be as rich, dense or conceptually grounded.

With more time it would have been useful to develop certain parts of the theory and perhaps to extend the focus of the study which was on men and to interview others in their lay networks. In particular, as the interviews revealed the importance of women and specifically partners in the process of help-seeking and it may have been interesting to have interviewed partners as well as the men themselves.

Interviews

Inevitably there are limits on the kind of data that can be collected in a one off interview that lasted between 45 – 90 minutes. Research interviews are based on a relationship and clearly for each participant this relationship will vary and there will be different degrees of engagement. For men it would seem that inevitably masculinity issues influence the research interview and for some men it was difficult to talk about their difficulties in this context. It was important for this to be considered by the researcher and for the data not to be treated simply at face value when it came to the analysis. Transcribing some of the interviews and checking the others against the recordings enabled the researcher to gain some insight into how questions were phrased and his role in the interaction. It also aided the coding process as listening to the tapes allowed non-linguistic data such as mood and intonation to be used to elaborate meaning. The degree of engagement of participants, however, may have had an effect on the richness of the data provided for the study. Jones (1988) suggests that one way to approach this issue of participant engagement is to conduct more than one interview as this ‘*allows a deeper exploration of a complex topic but also provides some evidence of commitment by the researcher to the person and the topic*’.

Another possible limitation of the interviews were that they asked men to describe a process rather than a singular experience or event. Although this tended to revolve around the events leading up to them being referred by their GPs for some participants this was only part of what had been a long and convoluted journey in which they had utilised various other forms of help. Asking men to provide retrospective accounts of their help-seeking may also be a weakness in the study.

5.5 Reflexivity

Reflexivity emphasises an awareness of the researcher's own presence in the research project (Pels, 2000). In terms of the present study, the researcher worked in the primary care clinical psychology service that was used in the study. Although the men recruited in the study came from a different part of the service in terms of referral pathways, it is possible that the fact that the researcher was a clinical psychologist in the service may have had an influence both on some of the men's decisions to participate and how open they could be in the interviews about the process of help-seeking. It is also possible that the researchers own feelings about the service may have influenced the analysis and interpretation of the results.

Another influence on the study is clearly the researcher's own interest in the topic of concern. The researcher had been involved in helping to set up a grass roots men's health project and had more recently become involved in the European Institute for Men's Health. This later project had raised the researcher's awareness of the debates around men's health and masculinity and this will have had an influence on the interpretation of the data. It is hoped that this did not influence the interviews unduly and that the researcher maintained a stance of 'empathic neutrality' (Patton, 1990) when interviewing the participants. As the researcher transcribed some of the interviews and checked the other transcripts against the recordings this enabled the researcher to gain some insight into how questions were phrased and his role in the interaction. These observations were recorded in a field diary and discussed with other researchers in the qualitative research group.

Respondent validation

Although respondent validation has been criticised in terms of its usefulness within the research process (Smith, 1996) it seemed important to attempt this within the present study. As outlined in the method section, copies of the transcribed interviews were sent to all participants for them to confirm as accurate

records and the analysis section of the research was sent for critical feedback and to allow for re-evaluation of the researcher's interpretation of the analysis. Only two replies were received from the participants and these were as simple phone messages, which simply agreed the transcripts as accurate and concurred with the researcher's analysis. It is perhaps a lot to ask of participants to read through research material in the form presented here and on reflection greater care could have been taken to revisit the participants to discuss the analysis in person. As discussed above in relation to interviews there is an argument for conducting more than one interview with each participant and if this had been part of the research design it may have not only allowed for more respondent validation but perhaps also contributed to a greater richness in the data.

6.0 CONCLUSION

This study suggests that men's help-seeking and pathways into psychological help are a form of gendered social practice and therefore influenced by concepts of masculinity and the male role and the part they play in constituting a masculine identity. It shows that men tend to distance themselves from any signs of emotional vulnerability and this 'distancing' can be seen to characterise the way they try to cope and also the way they approach professional psychological help. This study indicates the need for mental health and primary care services to be more *masculinity and gender aware* and to adapt their practice and systems to take greater account of the meaning behind the absence of men from health services.

7.0 References

- Anderson, R. (1995). Revisiting the behavioural model and access to care: does it matter? *Journal of health and Social Behaviour*, 36, 1-10.
- Beck, U. (1992). *Risk Society – Towards a New Modernity*, London, Sage.
- Bendelow, G. (1993). Pain perceptions, emotions and gender. *Sociology of Health and Illness*. 15 (3), 273-94.
- Bhaskar, R. (1989). *Reclaiming Reality: A Critical Introduction to Contemporary Philosophy*. London, Verso.
- Blaxter, M. (1985). Self-definition of health status and consulting rates in primary care. *Quarterly Journal of Social Affairs*, 1(2), 131 - 71.
- Brannon, R. (1976). The male sex role: our culture's blueprint for manhood, and what's it done for us lately. In D. David and R. Brannon (Eds.), *The forty five percent majority* (pp 1-45). Reading MA: Addison-Wesley.
- Briscoe, M. (1987). Why do people go to the doctor? Sex differences in the correlates of GP consultation. *Social Science and Medicine*, 25(5), 507-513.
- Brown, G. W. and Harris, T. (1978). *The Social Origins of Depression: A Study of Psychiatric Disorder in Women*. London: Tavistock.
- Burman, E. (1994). *Deconstructing Developmental Psychology*. London, Routledge.
- Burt, k. and Oaksford, M. (1999). Qualitative methods: beyond beliefs and values. *The Psychologist*, 12, 7, 332-335.
- Burton, M. V. and Ramsden, R. (1994). A survey of GP referrals to outpatient psychiatry, clinical psychology, community psychiatric nurses and counsellors. *Clinical Psychology Forum*, 74, 13-17.
- Calnan, M. (1987). *Health and Illness: the Lay Perspective*. Tavistock, London.
- Cape, J. and McCulloch, . (1999). Patients' reasons for not presenting emotional problems in general practice consultations. *British Journal of General Practice*, 49, 875-879.
- Cartwright, A. and Anderson, R. (1981). *General Practice Revisited*. Tavistock: London.
- Charmaz, K. (1995). Grounded Theory. In: J. Smith, R., Harre and L. Langenhove, (1995) *Rethinking Methods in Psychology*, Sage: London.
- Clegg, J.A., Standen, P.J. and Jones, G. (1996). Striking the balance: a grounded theory analysis of staff attitudes. *British Journal of Clinical Psychology*, 35, 249-264.
- Collier, H. V. (1982). *Counselling women: a guide for therapists*. New York: MacMillan.
- Connell, R. W. (2000). *The Men and the Boys*. Los Angeles: University of California Press.
- Cooke, D. G., Morris, J.K. Walker, M. and Shaper, A.G. (1990). Consultations amongst middle aged men in general practice over three years. *British Medical Journal*, 301, 647-50.
- Cornford, C.S. and Cornford, H.M. (1999). 'I'm only here because of my family.' A study of lay referral networks. *British Journal of general Practice*, 49, 617 – 620.
- Cornwall, A. and Lindisfarne, N. (1994). *Dislocating masculinity: Comparative Ethnographies*, Routledge, London.

- Creed, F., Gowrisunker, J., Russell, E., and Kinsey, J. (1990). General practitioner referral rates to district psychiatry and psychology services. *British Journal of General Practice*, 40, 450-454.
- Deane, F.P. and Chamberlain, K. (1994). Treatment fearfulness and distress as predictors of professional help-seeking. *British Journal of Guidance and Counselling*, 22, 2, 207-17.
- Denizen, N.K. and Lincoln, Y.S. (eds) (1994). *Handbook of Qualitative Research*. London: Sage.
- Dingwall, R. (1992). Don't mind him – he's from Barcelona: qualitative methods in health studies. In: Daly, J. MacDonald, I. Willis, F. (eds). *Researching Healthcare: Designs, Dilemmas, Disciplines*. London: Tavistock.
- Dohrenwend, B. and Dohrenwend, B.S. (1977). Sex differences in mental illness: reply to Gove and Tudor. *American Journal of Sociology*, 82, 1336-41.
- Dosser, D.A., Balwick, J.O. and Halverson, C.F. (1986). Male impressiveness and relationships. *Journal of Soc. Pers. Relationships*, 3, 241-258.
- Eagen, K. and Beaten, R. (1980). Response to symptoms in healthy, low utilizers of the health care system. *Journal of Psychosomatic Research*, 31, 11 - 21.
- Edwards, D. and Potter, J. (1992). *Discursive Psychology*. London, sage.
- Eisler, R.M. and Blacock, J.A. (1991) Masculine gender role stress: implications for the assessment of men. *Clinical Psychology Review*, 11, 45 – 60.
- Elliott, R., Fischer, C. and Rennie, D. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology*, 38: 215-29.
- Erlandson, D.A., Harris, E.L., Skipper, B.L. and Allen, S.D. (1993). *Doing Naturalistic Inquiry: A guide to Methods*. Newbury Park, California, Sage.
- Fishbein, M. and Ajzen, I., (1975). *Belief, Attitude, Intention and Behaviour: An Introduction to Theory and Research*. Boston, Mass.: Addison-Wesley.
- Fitzpatrick, R., Hinton, J., Newman, S., Scrambler, G. And Thompson, J. (1986). *The Experience of Illness*. London, Tavistock.
- Friedson, E. (1960). Client control and medical practice. *American Journal of Sociology*, 65, 374 – 382.
- Furnham, A. (1994). Explaining health and illness: lay perceptions on current and future health, the causes of illness, and the nature of recovery. *Social Science and Medicine*, 39(5), 715-25.
- Furnham, A. and Wardley, Z. (1990). Lay theories of psychotherapy: attitudes and beliefs towards and about, psychotherapy and therapists. *Journal of Clinical Psychology*, 46, 878-890.
- Gijbers van Weijket, Kolk, A.M., Van den Bosch, W. and Van den Hoogen (1995). Male and female health problems in general practice: the differential impact of social position and social roles. *Social Science and Medicine*, 40, 5, 597 - 611.
- Goldberg, D. and Huxley, P. (1980). *Mental Illness in the Community: The Pathway to Psychiatric Care*. London: Tavistock.
- Goldberg, D. and Huxley, P. (1992). *Common Mental Disorders. A biosocial model*. London: Routledge.
- Good, G, Dell, D. and Mintz, L. (1989) Male role and gender conflict: relations to help-seeking in men. *Journal of Counselling Psychology*, 36(3) 295 - 300.

- Gove, W.R., and Howell, J. (1974). Adult sex roles and mental illness. *American Journal of Sociology*, 78, 812-835.
- Glaser, B.G. (1992). *Basics of Grounded Theory: Emergence vs. Forcing*. Mill Valley: Sociology Press.
- Glaser, B.G. and Stauss, A.L. (1967). *The Discovery of Grounded Theory: Strategies for Qualitative Research*. Chicago, Aldine.
- Greenlay, J.R. , Mechanic, D. and Cleary, S. (1987). Social selection in help-seeking for psychological problems. *Journal of Health and Social Behaviour*, 17, 249-62.
- Griffiths, S. (1992) The neglected male. *British Journal of Hospital Medicine*, 48, 627 – 9.
- Hammen, C. and Peters, S. (1977) Differential responses to male and female depressive reactions. *Journal of Consulting and clinical psychology*, 45, 994 - 1001.
- Harrison, T. and Dignan, K. (1999). *Men's Health: An Introduction for Nurses and Health Professionals*. Churchill Livingstone, London.
- Helgeson, V. (1995). In: D. Sabo and D. Gordon. (1995). *Men's Health and Illness: Gender, Power and the Body*. Sage:London.
- Hendryx, M.S., Doebbeling, B. and Kearns, D. (1994). Mental health treatment in primary care: physician choices and psychiatric admission rates, *Family Practice Research Journal*, 14, 127 – 137.
- Henwood, K.I. and Pigeon, N.F. (1992). Qualitative research and psychological theorising. *British Journal of Psychology*, 83, 97-111.
- Hibbard, J.H. and pope, C.R. (1983). Gender roles, illness orientation and use of medical services. *Social Science Medicine*, 17, 129-137.
- Hollingshead, A. and Redlich, F. (1958). *Social Class and Mental Illness*. Wiley: London.
- Holmes and Lindsey (1989). Quoted in B. Richards (1995). Psychotherapy and the Injuries of Class. Paper presented at BPS Psychotherapy Section Conference.
- Horgan, C.M. (1984). Specialty and ambulatory mental health services. *Archives of General Psychiatry*, 42, 565-572.
- Husserl, E. (1970). *The crisis of the European sciences and transcendental phenomenology*. Evanston, IL: Northwestern University Press.
- Jackson, C. (1991). Men's health: opening the floodgates. *Health visitor*, 64, 265 – 6.
- Jarman, M., Smith, J.A. and Walsh, S. (1997). The psychological battle for control: a qualitative study of healthcare professionals' understandings of the treatment of anorexia nervosa. *Journal of Community and Applied Psychology*, 7, 137-52.
- Jones, S. (1988). Depth Interviewing. In: Pawson, R. and Tilley, N. *Realistic Evaluation*. London: sage.
- Jourard, S. M. (1971). *The transparent self* (Rev. ed.). New York: Van Nostrand Reinhold.
- Julian, T. (1992). Components of men's well-being at mid-life crisis. *Issues in mental Health Nursing*, 13, 285 - 99.
- Kadushin, C. (1966). The friends and supporters of psychotherapy: on social circles in urban life. *American Sociological Review*, 31, 786-802.
- Kasl, S. & Cobb, S. (1996). Health behaviour, illness behaviour and sick role behaviour. *Archives of Environmental Research*, 12(2), 246-7.

- Kessell, N. and Shepherd, M. (1965) The health and attitudes of people who seldom consult a doctor. *Medical Care*, 3, 6-10.
- Kessler, R.C., Brown, R.L. and Broman, C.L. (1981). Sex differences in psychiatric help-seeking: evidence from four large scale surveys. *Journal of Health and Social behaviour*, 22, 49-64.
- Kincey, J. and Creed, F. (1991). Referrals to clinical psychology and psychiatry from general practice: a controlled trial evaluation. *Journal of the Royal College of General Practitioners*, 36, 307-309.
- Kirkby, R.S., Kirkby, M.G. and Farah, R.N. (Eds.) (1999). *Men's Health*. Isis Medical Media: Oxford.
- Leaf, P.J. and Bruce, M.L. (1987). Gender differences in the use of mental health related services: a re-examination. *Journal of Health and Social Behaviour*, 28, 171-183.
- Leeftang, R. (1992) Health effects of unemployment: long-term unemployed men in urban and rural areas. *Social science and Medicine*, 34, 341 - 50.
- Lewis, C.E. and Lewis, M.A. (1977). The potential impact of sexual inequality on health. *N. England Journal of Medicine*, 297, 863-869.
- Lewis, C. and O'Brien, M. (1987). Constraints on fathers: research, theory and clinical practice. In C.Lewis and O'Brien, M.(1987) *Reassessing fatherhood*. Sage: London.
- Lin, K.M., Inui, T.S., Kleinman, A.M. and Womack, W.M., (1989). Ethnicity and patterns of help-seeking. *Culture, Medicine Psychiatry*, 2, 3-14.
- Lincoln, Y.S. and Guba, E.G. (1985). *Naturalistic Inquiry*. Beverley Hills: Sage.
- Maruyami, D. (1988). Quoted in Walker, R. (1988). *Applied Qualitative Research*. Aldershot: Gower.
- Mays, N. and Pope, C. (1995). Rigour and Qualitative Research. *British Medical Journal*, 311, 109-112.
- Mc Cormack, A, Fleming, D. and Charlton, J. (1995) *Morbidity Statistics from Great Britain: Fourth National Study*. London, HMSO.
- Mechanic, D (1962). The concept of illness behaviour. *Journal of Chronic Disease*, 15, 189.
- Mechanic, D. (1980). The experience and reporting of common physical complaints. *Journal of Health and Social Behaviour*, 20, 146.
- Mechanic, D. (1995) Sociological dimensions of illness behaviour. *Social Science and medicine*, 41(9), 1207 - 16.
- Miller, J. and Bell, C. (1996). Mapping men's mental health. *Journal of Community and Applied Social Psychology*, 6, 317-327.
- Morgan, M. (1996). Qualitative research: A package deal? *The Psychologist*, 9, 31-32.
- Morgan, M. (1998). Qualitative research: science or pseudo-science? *The Psychologist*, 11, 481-483.
- Nathansan, C. (1985) Illness and the female role; a theoretical review. *Social Science and Medicine*, 9, 57 - 62.
- Nahon, d. and Lander, B. (1993) A clinic for men: challenging individual and social myths. *Journal of Mental Health*, 14, 405 -16.
- Naifeh, S. and Smith, G. (1984). *Why can't men open up? Overcoming men's fear of intimacy*. New york: Clarkson-Potter.

- O'Dowd, T. and Jewell, D. (eds.) (1998). *Men's Health. Oxford General Practice Series 41*. Open University Press: Oxford).
- Padgett, D.K., Patrick, C., Burns, B.J. and Schlesinger, H.J. (1994). Women and out-patient mental health services: use by black, Hispanic and white women in a nationally insured population. *Journal of Mental Health Administration*, 21(4): 347-60.
- Parker, I. (1992). *Discourse Dynamics: Critical Analysis for Social and Individual Psychology*. London: Routledge.
- Parker, I. (1994). Qualitative research. In: P. Bannister, E. Burman, I. Parker, M. Taylor and C. Tindall (Eds) *Qualitative Methods in Psychology: A Research Guide*. Buckingham: Open University Press.
- Patton, M. Q. (1990). *Qualitative Evaluation and Research Methods*. London, Sage.
- Parsons, T. (1951). Illness and the role of the physician. *American Journal of Orthopsychiatry*, 21, 452-60.
- Pescolido, B. and Boyer, C. (1996). From community into the treatment system – how people use health services. In A. Horowitz and T. Schield (eds) *The Sociology of Mental Illness*. New York; Oxford University Press.
- Pope, C. and Mays, N. (1995). Reaching the parts others cannot reach: a introduction to qualitative methods in health and health services research. *British Medical Journal*, 1195; 331:42-5.
- Potter, J. and Wetherell, M. (1987). *Discourse and Social Psychology*. London: Sage.
- Radley, A. (1994) *Making Sense of Illness: The Social Psychology of Health and Disease*. London, Sage.
- Rafuse, J. (1993). Men's attitudes about seeking health care may put them at risk. *Canadian Medical Association Journal*, 149, 329 –30.
- Reason, P. and Rowan, J. (eds) (1981). *Human Inquiry: A Sourcebook of New Paradigm Research*. Chichester: Wiley.
- Rennie, D.L., Phillips, J.R. & Quartaro, G.K. (1988). Grounded theory: a promising approach to conceptualisation in psychology. *Canadian Psychology*, 29, 139-150.
- Rennie, D. (1998). Grounded theory methodology: the pressing need for a coherent logic of justification. *Theory and Psychology*, 8(1), 101-119.
- Richardson, J. (Ed.) (1996). *Handbook of Qualitative Research Methods for Psychology and the Social Sciences*. Leicester: BPS.
- Rickwood, D. and Braithwaite, V. (1994). Social-psychological factors affecting help seeking for emotional problems. *Social Science and medicine*, 39(4), 563 - 72.
- Robertson, N.C. (1979). Variations in referral patterns to the psychiatric services by general practitioners. *Psychological Medicine*, 9, 355-364.
- Rogers, A., Chapple, C. and Halliwell, S. (1998). The influence of paid and unpaid work on help-seeking in primary care. *Social Sciences and Health*, 4(3), 188-99.
- Rogers, A., Pilgrim, D. and Lacey, R. (1993). *Experiencing Psychiatry*. Basingstoke: MacMillan.
- Rogers, A. and Pilgrim, D. (1995). The risk of resistance: perspectives on the mass childhood immunisation programme. In J. Gabe (ed.) *Medicine, Health and Risk, Sociology of Health and Illness Monograph*. Oxford: Blackwell.

- Roglers, L.H. & Cortes, D.E. (1993). Help-seeking pathways: a unifying concept in mental health care. *American Journal of Psychiatry*, 150, 554-61.
- Rosenstock, I. (1966). Why people use health services. *Millbank Memorial Fund Quaterly*, 44, 94-127.
- Ross, H. and Hardy, G. (1999). GP referrals to adult psychological services: a research agenda for promoting needs led practice through the involvement of mental health clinicians. *British Journal of Medical Psychology*, 72, 75-91.
- Rowlands, O., Singleton, N., Maher, J. and Higgins, V. (1997). *Living in Britain: Results from the 1995 Household Survey*. London: HMSO.
- Rubin, L.B. (1983). *Intimate strangers*. New York: Harper & Row.
- Saunders, S. (1993). Applicants' experience of the process of seeking therapy. *Psychotherapy*, 30(4), 554-63.
- Shapiro, S., Skinner, E., Kessler, L., Von Korff, M., German, P., Tischler, G., Leaf, P., Benham, L., Cottler, L., and Reiger, D. (1984). Utilisation of health services: three catchment area studies. *Archives of General Psychiatry*, 41, 971-82.
- Sharma, U. (1990). Using alternative therapies: marginal medicine and central concerns. In P. Abbott and G. Payne (eds) *New Directions in the Sociology of Health*. London: Farmer Press
- Silverman, D. (1999). *Interpreting Qualitative Data: Methods for Analysing Talk, Text and Interaction*. London, Sage.
- Skelton, R. (1988). Man's role in society and its effect on health. *Nursing*, 3(26), 953-6.
- Smith, J.A. (1996). Qualitative methodology: analysing participants' perspectives. *Current Opinion in Psychiatry*, 9, 417-21.
- Solomon, N., Pistrang, N. and Barker, C. (2001). The benefits of mutual support groups for parents of children with disabilities. *American Journal of Community Psychology*, 29, 1, 113-132.
- Stern, P.N. (1994). Eroding grounded theory. In J.M. Moore (Ed). *Critical Issues in Qualitative Research Methods*. Thousand Oaks, California, Sage.
- Stiles, T. (1999). Evaluating qualitative research. *Evidence-Based Mental Health*. 2:99-101.
- Strauss, A. and Corbin, J. (1990). *Basics of Qualitative Research: Grounded Theory Procedures and Techniques*. Newbury Park, Sage.
- Strauss, A. and Corbin, J. (1994). Grounded theory methodology: an overview. In: N.K. Denzin and Y.S. Lincoln (eds): *Handbook of Qualitative Research*. Thousand Oaks, California: Sage.
- Sue, S. and Zane, N. (1991). The role of culture and cultural techniques in psychotherapy: a critique and reformulation. *American Psychologist*, 42, 37-45.
- Thomas, K.J., Carr, J. Westlake, L., Williams, B.t. (1991). Use of non-orthodox and conventional healthcare in Britain. *British Medical Journal*, 302, 207-10.
- Thoreson, R., Shaughnessy, P., Cook, S., and Moore, D. (1993). Behavioural and attitudinal correlates of masculinity: a national survey of male counsellors. *Journal of Counselling and Development*, 71, 337 - 342.
- Todd, Z. (1998). Symposium report; mixing methods. *Clinical Psychology Forum*, 114, 32-34.

- Tudiver, F. and Talbot, Y. (1999). Why men don't seek help? Family physicians' perspectives on help-seeking behaviour in men. *The Journal of Family Practice*, 48, 1, 47 - 52.
- Turpin, G., Barley, V., Beail, N., Scaife, J., Slade, P., Smith, J. and Walsh, S. (1997). Standards for research projects and theses involving qualitative methods: suggested guidelines for trainees and courses. *Clinical Psychology Forum*, 108, 3-7.
- Twaddle, A. and Hessler, R. (1977). *A Sociology of Health*. St Louis, MO: Misby.
- Van Dalen, H. et al. (1994). Lay people's evaluations of health: are there variations between different subgroups? *Journal of Epidemiology and Community Health*, 48, 248 - 253.
- Vebrugge, L. (1985). Gender and health: an update on hypotheses and evidence. *Journal of Health and Social Behaviour*, 26, 156 - 182.
- Verbrugge, L. and Wingard, D.L. (1987). Sex differentials in health and mortality. *Women and Health*, 12, 103-145.
- Verhaak, P.F. M. (1993). Analysis of referrals to mental health problems by general practitioners. *British Journal of General Practice*, 43, 203-208.
- Veroff, J.B. (1981). The dynamics of help seeking in men and women: a national survey study. *Psychiatry*, 44, 189-200.
- Walsh, S. (1996). Adapting Cognitive Analytic therapy to make sense of psychologically harmful work environments. *British Journal of Medical Psychology*, 69, 3-20.
- Walters, V. (1993). Stress, anxiety and depression - women's accounts of their health problems. *Social Science Medicine*, 36(4): 392-402.
- Wells, J.E., Robins, L.N., Bushnell, J.A., Jarosz, D. and Oakley-Browne, M.A. (1994). Perceived barriers to care in St. Louis (USA) and Christchurch (NZ): reasons for not seeking professional help for psychological distress. *Social Psychiatry and Psychiatric Epidemiology*, 29, 155-164.
- West, C. and Zimmerman, D. (1987). Doing gender. *Gender and Society*, 1, 125-151.
- Westcott, R. (1977). The length of consultations in general practice. *Journal of the Royal College of General Practitioners*, 27, 552-5.
- Williams, P., Wilkinson, G. and Arreghini, E. (1990). The determinants of help-seeking for psychological disorders in primary health care settings. In N. Sartorius, D. Goldberg, G. de Girolamo, J. A. Costa e Silva, Y. Lecrubier and H. U. Wittchen (Eds), *Psychological disorders in general medical settings*, pp21-33. Bern: Huber-Hogrefe.
- Williams, P., Tarnopolosky, A., Hand, D. and Sheperd, M. (1986). Minor psychiatric morbidity and general practice consultations: the West London survey. *Psychological Medicine Monograph*, Supplement, 9.
- Wilson, A. (1995). Getting help. In T. O'Dowd and Jewell, D. (1998) *Men's Health*. Oxford: Open University Press.
- Woloshynowych, M., Valori, R. and Salmon, P. (1998) General practice patients' beliefs about their symptoms. *British Journal of General Practice*, 48, 885 - 889.
- Woolgar, S. (1988). *Science: The Very Idea*. London: Tavistock.
- Zola, I. (1973). Pathways to the doctor - from person to patient. *Social Science and Medicine*, Vol.7, 677 - 689.

7.1 Appendix 1 – Ethical approval

Please reply to:

Mr. Steve Melliush,
Clinical Tutor,
Astley Clarke Building.
Tel: 0116 252 2492
Fax: 0116 252 2503

Our ref: SM/MSL
30 October 2000

Dear Dr. Holland,

re: Under-utilization of primary health care services by men: a Q-methodological investigation of men's attitudes to help-seeking for psycho-social problems

I am writing to seek the Committee's approval for a number of modifications to my original research proposal. The reason for these changes is that I have encountered difficulties in recruiting men for the study as it was originally designed. The modifications I would like to make are as follows:

1. To conduct a qualitative study instead of using Q methodology. This would involve ten in-depth interviews which would be transcribed and analysed using a grounded theory approach.
2. To approach men who have been referred for psychological help instead of trying to contact men who are low consulters of GP services. This would mean writing to ten men who had been referred to the primary care mental health service asking if they would be willing to be interviewed about their help seeking (see consent letter attached).
3. To amend the title to: Under-utilization of primary care cover by men: a qualitative study of men's attitudes to help-seeking for psychosocial problems.

I hope that these changes will meet with the approval of the Ethics Committee. I look forward to hearing your decision.

Yours sincerely,

Steve Melliush

Dr. I.M. Holland,
Honorary Secretary,
Ethics Committee,
University Hospital,
NOTTINGHAM,
NG7 2UH.

SPECIAL NOTE

THE FOLLOWING
IMAGE IS OF POOR
QUALITY DUE TO THE
ORIGINAL DOCUMENT.

THE BEST AVAILABLE
IMAGE HAS BEEN
ACHIEVED.



Queen's Medical Centre
Nottingham

Research and Development Directorate

Please ask for: Janet Boothroyd, Business Manager, Ext. 44307
Ruth Doyle, Data Manager, Ext. 44771
Linda Ellis, Administrative Assistant, Ext. 41049
Debbie Cocks, Secretary/Administrator Ext. 35117

Our Reference: EX010001

14th February 2001

Mr S J Melliush
Nottingham Healthcare Trust
Duncan Macmillian House
Porchester Road
Nottingham
NG7 2UH

Dear Mr Melliush

Re: Amendment: Modifications for recruiting men
Under-Utilization of primary health care services by men:- a Q-methodological investigation of mens
attitudes to help-seeking for psycho - social problems

The Ethics Committee met on 11th December 2000 and approved the amendment subject to your providing of some information, or clarification. We are now in receipt of this, and the amendment is now fully approved.

Kind regards

Yours sincerely

Dr I M Holland
Honorary Secretary
Ethics Committee

University Hospital
Nottingham NG7 2UH
Telephone (0115) 9249924
Direct Line (0115) 9709049
Fax External (0115 8493295) Internal 35295
Dr Ian Holland, Honorary Secretary, Ethics Committee
Queens Medical Centre, Nottingham, University Hospital NHS Trust

7.2 Appendix 2 – Participant research letter

Duncan MacMillan House
Porchester Road
Nottingham
NG3 6AA

Dear Mr,

I am writing to you as I understand that you have recently been referred by your GP to the Primary Care Psychology Service. I am conducting a research project concerned with men's psychological health and am specifically interested in how men access health services. I would be grateful if you would agree to be interviewed as part of this study. The interview will last approximately 45 to 60 minutes and can be arranged to take place either at your home or here at Duncan MacMillan House if you prefer. All the information you give in the interview will only be for the purposes of this study and will not be identifiable and not placed on any medical records.

If you would be interested in taking part in this study, please complete the slip at the bottom of this letter and return it to me in the stamped addressed envelope provided. I will then contact you to arrange a convenient time for the interview.

If you wish to have any more information about the study or wish to discuss the research in more detail before deciding to take part, then please do not hesitate to contact me on (0115) 955 5399.

Many thanks for your help,

Yours sincerely

Steve Melliush
Researcher

Name: Tel. No.
.....

Address:
.....
.....

I am interested in being interviewed for the study: YES [] NO []

I would like to be interviewed at: HOME / Duncan MacMillan House

The best days and times for me are:
.....

7.3 Appendix 3 – Interview schedule

Interview Guide

1. Personal and cultural background

(Demographic data / living situation / employment status / health conditions / frequency of consultations to GP)

Age

Ethnic origin

Employment status

Living circumstances

How often are you ill?

How often do you visit your GP?

2. Recognising the problem – the onset of distress

(Reasons for consulting / name of problem / perceived cause, consequences, severity / effect on body, social network, home life, work, finances)

Probes

What did you go to the doctor for?

What did you call these problems? (If you had given them a name what would they be?)

How long ago did you first notice these problems?

Why did you think these problems started when they did?

What do you think is the cause of these problems?

What do you fear most about your problems?

What are the main difficulties your problems have caused you?

In what ways do you think men's beliefs about health differ from women?

3. Deciding to seek help

(Influence of lay network on help-seeking, perceived barriers to help-seeking, alternative sources of help)

Probes

How did the awareness about your problem lead you to seek help?

Did you delay seeking help? What made it difficult for you to seek help?

Has there been a time when you have decided not to seek help? What influenced your decision?
Did you discuss your problems with others?

How important were others (your peers, partner, family) in your decision to consult your GP?

Did you consider or seek out alternative sources of help prior to seeing your GP?

If so, what were these?

Were you clear about what type of help you wanted and what was available via your GP?

As a man have there been any particular obstacles to you seeking help?

4. Referral to mental health services

(Interaction with GP, expectation of help, others knowledge of help-seeking)

Probes

How did you describe / explain your problems to your GP?

How well did you feel your GP understood your problem?

How did you feel when your GP suggested seeing a clinical psychologist?

What expectations do you have for the appointments?

Are others aware that you have been referred?

Do you know other people who have been to a clinical psychologist or other mental health practitioner? What influence did this have on your decision to go ahead with the referral?

As a man, how do you feel about talking about your problems to a clinical psychologist?

Is there anything about being a man that might make this difficult?

7.4 Appendix 4 – Interview consent form

Research project : Under-utilisation of primary health care services by men : a qualitative study of men's attitudes to help-seeking for psychosocial problems.

Introduction to the interview

Thank you for agreeing to participate in this research study about your experience of seeking psychological help.

The interview will be very informal, rather like an open ended discussion about how you see things from your point of view. I will need to record the conversation because I have to write it out in order to make sense of what we've talked about. The tape will be erased afterwards and the transcription kept in a secure place. No one except myself will have access to it thereby ensuring strict confidentiality.

Although your signature has been requested for consent purposes this cannot be traced to particular interview transcripts which will be coded numerically, so assuring your anonymity.

As explained in the letter the interview will last about one hour. If you wish to withdraw at any time you are free to do so. Also, if after our conversation, you wish to follow up any thing that has been raised for you I will be happy to discuss this with you. This will have no bearing on the research.

I intend to complete my research by the end of 2001. If you would like some feedback on the overall research findings I will be happy to talk to you again about the research at this time.

Do you have any questions before we start?

Consent for interview

I agree to take part in this research project and agree to the interview being tape recorded. I understand that the interview will not be identifiable and that the tape will be erased after it has been transcribed.

I agree to extracts of the interview transcript being quoted as part of the research study.

Interviewee signature Date

Interviewer signature Date

7.5 Appendix 5 – Example of data analysis

