It's how you look in your mate's eyes: A systematic review and thematic analysis exploring UK men's experiences of mental health and help seeking

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Portfolio Abstract

Background: Men are the highest risk group of suicide worldwide, but little is known about the mental health experiences of individual groups of men. This thesis portfolio therefore focuses exclusively on the mental health experiences of men in the United Kingdom (UK).

Method: The thesis portfolio consists of two studies: a systematic review which aimed to explore the experiences of men seeking support for mental health difficulties in the UK and an empirical paper which aimed to explore the mental health experiences of men living in former mining communities, a group theoretically at higher risk of mental health difficulties and less likely to access support.

Results: The systematic review presented four main themes. These are 'service barriers', 'facilitators of help-seeking', 'lack of mental health literacy', and 'societal expectations.' Results highlighted that different groups of men in the UK have unique experiences regarding mental health support seeking influenced by societal, familial, occupational, and individual factors. The empirical paper also presented four themes. These were 'the old hard life was better than the new hard life', 'stoicism as an intergenerational survival strategy', 'mental health is good for others, but not men like us', and 'peer pressure maintains the status quo'. Results provided a rich understanding of the origins of masculine norms in the community and the mechanisms which maintain them.

Conclusions:

The findings from both studies highlight the importance of further research into the unique mental health experiences of specific groups of men.

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Chapter 2: Systematic Review

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Thank you to my parents and partner for supporting me every step of the way. I will return to being a functioning adult again soon.

Finally, to my late grandma June. Whilst you sadly did not see me finish this, I know you would have been proud. I will always remember your love and kindness.

CHAPTER ONE: General Introduction

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Statistics suggest that across the world men are at a greater risk of suicide than women (Värnik, 2012). In England and Wales specifically, men account for approximately three quarters of all suicides, with men aged 45-64 being a particularly high-risk group (Office for National Statistics, 2024). It is important to note that the higher suicide completion rate of men compared to women is likely linked to men's usage of more lethal suicide methods, and is one factor contributing to the gender inequality in suicide statistics (Office for National Statistics, 2024). Despite this, depression statistics suggest that women are more likely to have a diagnosis of depression than men across much of the world (Seedat et al., 2009). To add to this, a recent meta-analysis found that across representative national samples, gender inequality in diagnosis of depression began at age 12, peaked between the ages of 13 and 15, and then slightly declined and plateaued during adulthood (Salk et al., 2017). The study highlighted that across nations women were consistently diagnosed with depression at higher rates than men, and that this was particularly pronounced in nations with greater gender equity. Men, on the other hand, are two to three times more likely than women to abuse alcohol in Western societies and generally display more maladaptive coping strategies to manage their mental health (Bilsker et al., 2018). There may also be gender differences in how depression presents. Depression in men can present as anger and aggression, both of which are not commonly identified as being symptoms of depression (Genuchi & Valdez, 2015). It may therefore be then, that the gender inequality in depression diagnoses is complex, and cannot be reduced to simple biological sex differences (Parker & Botchie, 2010). Research suggests, for example, that men often feel unable to disclose or seek help for distress in the first instance as this deviates from sociocultural constructions of masculine behaviour (Seidler et al.,

2018). Another barrier is encountered if men do decide to seek help from a mental health professional. Research suggests that male distress is often inadequately assessed or overlooked by clinicians (Smith et al., 2018). Some of the reasons for this include measurement and clinician biases, whereby clinicians also enacted societally constructed masculine norms in a way which disadvantages male patients. Taken together, it is evident that the differences in how mental health is experienced and expressed by men and women are not yet well understood. It is possible that rates of male depression are underestimated and underreported because of this lack of understanding. This is a problem in the context of the high rates of suicide amongst men, which clearly indicates an unmet need.

Help-seeking is defined as a coping mechanism which occurs when task demands exceed an individual's coping ability or resources (Chan, 2013). It is well established that men are less likely to seek help for mental health difficulties than women across the world (Andrade et al., 2014; McManus et al., 2016; Oliver et al., 2005; Seedat et al., 2009). Instead of help-seeking, men are more likely than women to engage in riskier coping strategies such as alcohol and drug abuse, and acts of anger and aggression (Lynch et al., 2018; Singh et al., 2025). These strategies are disadvantageous to men's health and more research to try and understand and modify these behaviours is needed (Courtenay, 2002; Courtenay, 2003). Men themselves are not the only ones to be affected by their reduced likelihood to seek help. The impact of men's psychological wellbeing and riskier management strategies has also been found to deeply impact women and children within a man's family, which further demonstrates the need to understand men's mental health and help seeking (Furman, 2010).

Men's reluctance to seek help is discussed in the literature as mainly being a result of attitudinal, rather than structural barriers (Andrade et al., 2014). These attitudinal barriers are thought to concern societal constructions of masculinity, and how men operate within these (Gough & Novikova, 2020; Murphy, 1998; Seidler et al., 2018; Sheikh et al., 2024; Struszczyk et al., 2019). Different societies are thought to construct their own masculine ideals, but these tend to socialise men into values of self-reliance and stoicism, the act of suppressing emotions and presenting as unaffected (Gough & Novikova, 2020; Jones et al., 2019). This socialisation often results in men feeling ill-equipped in recognising, managing, and seeking help for emotional distress (Gough & Novikova, 2020). Further, Courtenay (2000) suggests that men's health related beliefs and behaviours are a way of consciously demonstrating their masculinity and that not getting help is rewarded by society. An example given is that men view other men who neglect their health and safety as being highly masculine, and therefore respected. Further, research suggests that a primary reason for men not seeking mental health support is the fear of rejection or criticism from their male peers (Gough & Novikova, 2020). Masculine norms, and how these operate on an individual, familial, and societal level are evidently important factors in men's attitudes towards mental health support seeking. Despite this, little is known regarding the experiences of masculinity and help-seeking of specific communities of men (Courtenay, 2002).

The need to further understand men's mental health and help-seeking is evident. Barriers to male mental health support seeking are largely modifiable and understanding the experiences and needs of specific groups of men in the UK will allow services and organisations to effectively counter these barriers (Courtenay, 2002). This thesis portfolio presents two studies which explore the topic of male mental health

from two different perspectives. First, a systematic review and narrative synthesis of qualitative literature surrounding men's experiences of mental health support seeking in the UK, which takes an aggregated, top-down approach to exploring the topic. Second, a qualitative empirical paper and thematic analysis of men's experiences of mental health within a former mining community that takes a focussed, bottom-up approach to provide a rich understanding of a specific community of men. Together, these two studies add to the existing literature surrounding men's experiences of mental health and support seeking. Clinical recommendations and areas for further enquiry are presented within the studies.

CHAPTER TWO: Systematic Review

Prepared for submission to Psychology of Men & Masculinities

(see Appendix A for author guidelines)

Word count: 7497

Men's experiences and perceptions of mental health support seeking in the UK: A qualitative systematic review

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Abstract

Aims: This systematic review aimed to explore the experiences and perceptions of men seeking support for mental health difficulties in the United Kingdom (UK).

Method: Using the Preferred Reporting Items for Systematic reviews and Meta-analyses (PRISMA) guidelines, 19 qualitative studies with data concerning UK men's experiences and perceptions of mental health help-seeking were systematically gathered. Narrative synthesis was used to synthesise the results due to a high degree of heterogeneity across study populations and methodology.

Results: The four resultant themes were 1) Service barriers, which included two subthemes: i) Distrust of professionals and ii) Structural barriers, 2) Facilitators of help seeking, 3) Lack of mental health literacy, and 4) Societal expectations, which contained the subthemes i) Conformity and ii) Perceived impact of deviation.

Conclusion: Men in the UK have a wide array of experiences and perceptions concerning mental health support seeking. These experiences were contextualised by the men's age, ethnic background, occupation, and many other characteristics. The synthesised findings provide several recommendations to UK providers of mental health support. It is recommended that future research focuses on understanding the mental health support seeking experiences and perceptions of specific groups of men, as this will allow more targeted recommendations to be made.

Public Significance Statements

The current understanding of men's experiences and perceptions of mental health support seeking is based on cross-cultural literature reviews. This review provides a synthesised understanding of the mental health support seeking experiences and

perceptions of a wide and diverse range of men specifically from the UK. Whilst this review provided a useful overview of UK men's experiences, future research is needed to understand the unique experiences and perceptions of specific groups of men within the UK. This should focus specifically on the experiences and perceptions of hard-to-reach groups of men who are known to be at increased risk of mental health difficulties, or less likely to seek support.

Keywords: men, masculinity, mental health, support seeking, United Kingdom, systematic review, narrative synthesis

Men's experiences and perceptions of mental health support seeking in the UK: A qualitative systematic review

Men are the highest risk group of suicide in England and Wales compared to women (Office for National Statistics, 2024) and every other country worldwide (Värnik, 2012). Despite this, men in England report lower rates of common mental health difficulties than women, and lower rates of accessing mental health treatments (McManus et al., 2016; Oliver et al., 2005). This trend is replicated globally across countries (Andrade et al., 2014; Seedat et al., 2009).

Help-seeking is a coping mechanism which becomes useful when task demands exceed coping ability or resources (Chan, 2013). Current literature suggests that men's reluctance to seek help is largely a result of attitudinal, rather than structural barriers (Andrade et al., 2014). Individual societies and communities develop their own values and norms, which men are socialised into from an early age (Gough & Novikova, 2020). These include constructions of masculinity, and what it means to be a man. Current literature suggests that, across cultures, these masculine norms often include stoicism, the endurance of suffering without complaint, self-reliance, and other traits which then form men's attitudinal barriers to seeking help (Gough & Novikova, 2020; Jones et al., 2019; Murphy, 1998; Seidler et al., 2018; Sheikh et al., 2024; Struszczyk et al., 2019). Socialisation into these norms leaves men unskilled in recognising, managing, and seeking help for emotional distress (Gough & Novikova, 2020). Men may even be rewarded by society for not seeking help. Courtenay (2000) describes how men perceive other men to be highly masculine when they are seen to neglect their health and safety. Further, Gough and Novikova (2020) found in their literature review that a primary reason for men not seeking help is the fear of criticism or rejection by other men. Even

when men do seek support, they encounter further barriers. Smith et al. (2018) suggest that clinicians can either overlook, or inadequately assess male distress, which may be a further enactment of societally held expectations of men and their self-reliance. If clinicians do overlook male distress, this may lead to the lower prevalence of common mental health diagnoses in men which is particularly concerning in the context of high male suicide rates (McManus et al., 2016; Oliver et al., 2005; Värnik, 2012). There is evidently a need to develop the understanding of how help-seeking and masculinity operate within society, as this presents an unmet health need.

Literature suggests that men employ alternative strategies to help-seeking when in distress. Riskier strategies, such as alcohol and drug abuse, and externalised displays of emotion such as anger and aggression are more common in men than women (Lynch et al., 2018; Singh et al., 2025). In Western societies, men are up to three times more likely to abuse alcohol than women (Bilsker et al., 2018). Evidently these strategies are disadvantageous to men's health and wellbeing, and so research efforts to understand and attempt to modify these behaviours are warranted (Courtenay, 2002; Courtenay, 2003). Further, women and children are also likely to be impacted by men's distress, its expression, and the unhelpful strategies men often use to manage their emotions (Furman, 2010).

The role of masculine norms and other social factors are evidently important in men's mental health help-seeking, but little is currently known about how these factors are experienced by individual groups and communities of men (Courtenay, 2002). Men are a heterogeneous group, whose experiences vary greatly dependant on their unique individual characteristics and environment. Even within a single nation, the male experience will be affected by geographic and cultural contexts (Courtenay, 2002). It is

therefore important to develop contextually bound understandings of male experiences of mental health, so that recommendations can be made to services trying to meet their needs.

The United Kingdom (UK) consists of four constituent countries: England, Northern Ireland, Scotland, and Wales, each with their own cultural identity and respective histories (Bechofer, 2013; Mackenzie, 2008). The UK is also a multicultural nation with a rich immigration history (Metz et al., 2016). The National Health Service (NHS) is a free at the point of access healthcare system across the UK which is predominantly funded by taxation. How NHS services are organised and paid for is in control of the UK's individual constituent countries, who must take into consideration their respective needs, as health inequalities and the gap between the most and least deprived in the UK continue to widen (Cylus et al., 2015). Mental health services are often seen as being amongst the first services to be neglected in times of austerity (Docherty & Thornicroft, 2015). Waiting times for NHS mental health services presently vary by service type and location, with a recent study stating that the average wait for secondary care mental health services was 2.2 years (Iqbal et al., 2021). It is therefore important for the UK to be able to draw upon research relevant to its own unique demographics, and which is relevant within the context of its own healthcare system.

This research aims to systematically review primary qualitative research related to UK men's experiences and perceptions of seeking support for mental health difficulties. This will develop the existing literature with an understanding of men's mental health support seeking within the context of a single nation and its healthcare system. The research question is therefore: What are the experiences and perceptions of men seeking support for mental health difficulties in the UK?

Method

Design

The systematic review was conducted in alignment with both the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) guidelines (Tong at al., 2012; Appendix B) and the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist (Moher et al., 2009; Appendix C).

A critical realist perspective underpinned this research, and the design reflected this (Archer et al., 2013). The assumption is that a better, although still imperfect, understanding of the phenomenon of men's help-seeking in the UK can be achieved by synthesising the existing literature on the topic.

A systematic review protocol was registered on the International Prospective Register of Systematic Reviews (PROSPERO) database (reference number: CRD42024607175).

Ethical Considerations

As no recruitment or primary data collection was undertaken for this systematic review, no specific ethical approval was required. Each included study reported having received ethical approval.

Eligibility Criteria

The review searched for studies which used qualitative methodologies, were conducted in the UK, and explored men's experiences and perceptions of mental health support-seeking. The SPIDER tool was used to inform both the inclusion criteria, and the search strategy (Cooke et al., 2012). This tool has greater specificity for qualitative research than the commonly used PICO, whose domains are more suited for quantitative research (Methley et al., 2014). Inclusion criteria are detailed in Table 1.

Search Strategy

Four databases were searched, using a combination of databases with a wide array of accessible research, and specialised databases more likely to contain unique references relevant to the research question (Bramer et al., 2017). The databases used were CINAHL Ultimate, MEDLINE Ultimate, PsycINFO, and Scopus.

Search terms were discussed with the research team, with resultant combinations trialled with scoping searches on the selected databases. The SPIDER tool was used to increase specificity for qualitative papers (Methley et al., 2014). For the 'Sample' field, search terms included "male" OR "men" OR "man" OR "males" AND "United Kingdom" OR "UK" OR "Britain" OR "Scotland" OR "England" OR "Wales" OR "Northern Ireland". The 'Phenomenon of Interest' field included "help seeking" OR "support seeking" OR "treatment seeking". The 'Evaluation' field included "experiences" OR "Perceptions" OR "attitudes" OR "views" OR "feelings" OR "qualitative" OR "perspective". The 'Design' and 'Research Type' fields were incorporated into the search terms and also used to filter results to include only published work. Search terms and modifiers were adapted to each individual database to produce optimal results. Results were filtered to include only research published from the year 2000 onwards as this coincides with academic focus on male-specific mental health needs (Courtenay, 2002). See Appendix D for search strategy.

Table 1.

Inclusion and exclusion criteria using the SPIDER framework

	Sample	**Phenomenon of Interest**	**Design**	**Evaluation**	**Research Type**
Inclusion Criteria	Study participants must be men aged 18 and over. Study participants must be in United Kingdom.	Study must include men's experiences or perspectives of seeking support for mental health difficulties.	Study must be published from 2000 onwards. Studies must be in English language.	Study must include qualitative methods which explore experiences, attitudes, or perspectives of mental health support seeking.	Study must be primary research.
Exclusion Criteria	Studies with a mixed gender sample Studies which include participants under the age of 18. Studies including participants outside of the United Kingdom.	Studies with no findings related to men's attitudes towards seeking mental health support.	Studies published prior to 2000. Studies not available in English due to constraints in time and cost needed to translate.	Studies that only contain quantitative data.	Studies that contained no primary research.

The final electronic search was conducted on 14th January 2025. A total of 985 citations were retrieved. The number of results from each database were: CINAHL Ultimate (163), MEDLINE Ultimate (437), PsycINFO (362), Scopus (23). A further 5 articles were

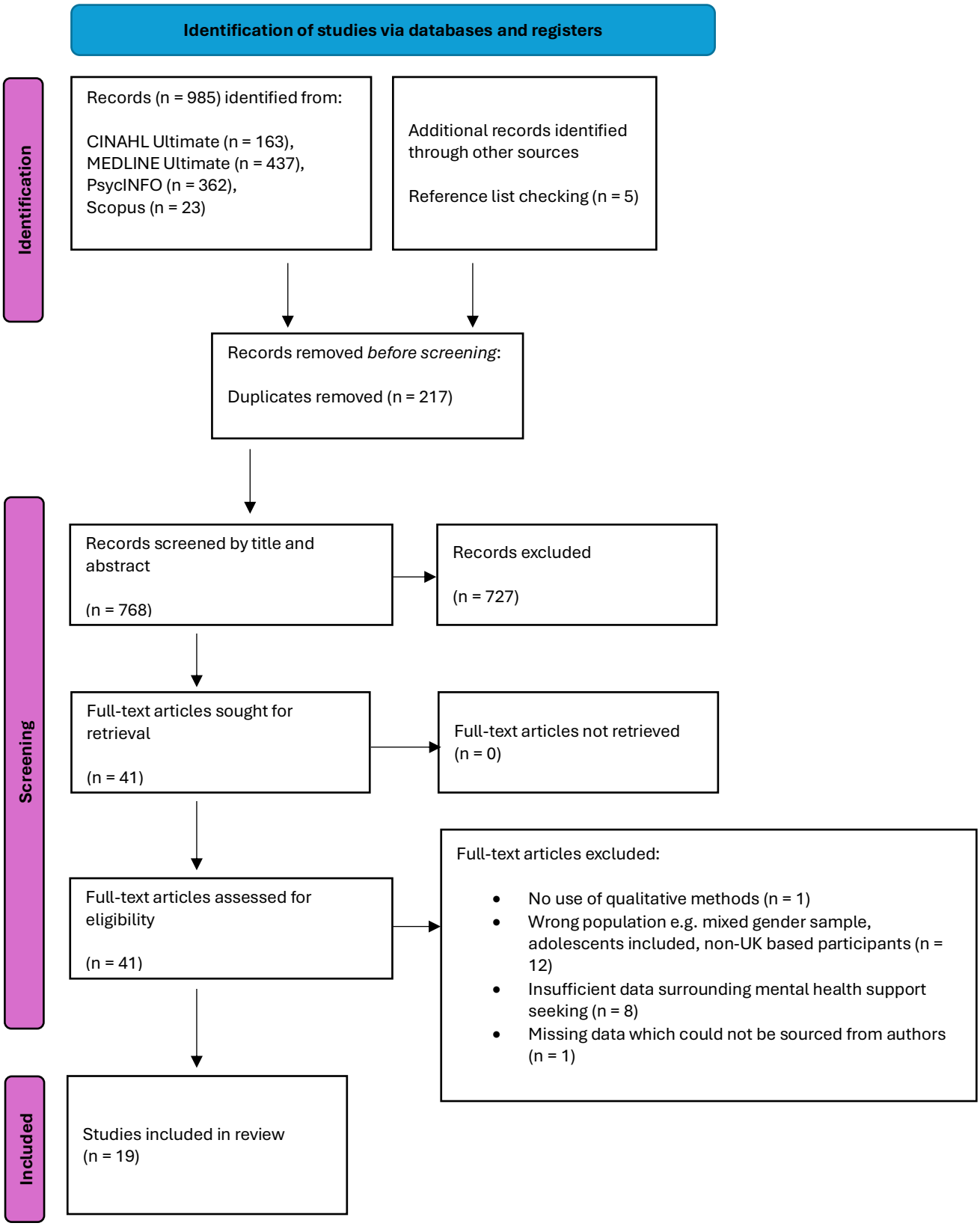
iteratively added by reference searching the final studies included in the review, but of these only two met the inclusion criteria.

Screening

Search results were uploaded to Rayyan, a free online systematic review management system (Ouzzani et al., 2016). Rayyan identified 217 duplicated articles, which were manually removed by the lead author. The lead author screened the remaining 768 citations by title and abstract against the pre-defined inclusion and exclusion criteria. After this process, a total of 41 citations remained. Full-text papers were retrieved. Each of the 41 papers were full text screened by the first, third, and fourth authors. At least two authors discussed each paper, and any discrepancies in opinion were resolved through team discussion. Reasons for exclusion were clearly documented. Twelve papers were excluded for containing the wrong population, for example including participants from outside the UK. Eight papers were excluded for containing insufficient data concerning mental health support seeking. One paper was excluded for not using qualitative methods, and one paper was excluded due to missing demographics which could not be sourced from the paper's authors. This process identified a total of 19 papers which met the inclusion criteria of the review. The PRISMA flowchart of this process can be seen in Figure 1.

Figure 1.

PRISMA Flowchart Diagram



Data Extraction

Two sets of data were extracted from the 19 papers included in the review and imported into Microsoft Excel. The first set of data included key characteristics of the studies which are presented in Table 3. This included study details such as author(s), location of study, population group, recruitment strategy, number of participants, research aims, data collection method, research design, and analytic framework. The second set of data included information relevant for synthesis. This included all relevant data, such as themes, author interpretations, participant quotes, and other information found in the study's results section which was relevant to the review question. Any information relevant to the original study but not this review was not extracted. Both sets of data were organised into simple matrices on Microsoft Excel.

Synthesis

Narrative synthesis was chosen to analyse the findings of the papers due to its suitability for heterogeneous data (Popay et al., 2006). The first step of narrative synthesis, creating a theoretical model, was omitted in favour of a data-driven inductive approach to synthesis (Popay et al., 2006). This allowed the findings to emerge from the data without preconceptions (Thomas, 2006), besides those that exist within the research team which were discussed and challenged during supervision.

The data of each paper was presented in a simple matrix on Microsoft Excel. The lead author made notes regarding any potential patterns within and between the data, until all data had been reviewed. Then, all data was organised into clusters of information and reviewed. This process was repeated several times until it was clear that the meaning of the data was represented in several distinct clusters. These clusters were then organised into overarching themes which captured the narrative of

the data. Relevant quotes were included for credibility and to illustrate the theme. This process was discussed in research supervision to increase credibility and ensure a coherent narrative of the data was captured. See Table 2 for an example of this process.

Table 2.

Worked Example of Data Synthesis

Theme	Relevant Clusters	Associated Studies (P=Paper)	Example Quote
Facilitators of Help Seeking	Wanting support outside of family and friends	P1, P4, P5, P6, P10, P16	"It started off with friends, then parents, then the GP and then who they referred me to. Whereas I don't think I could have gone straight to the GP or the services. I think I needed to make that admission to somebody else I was comfortable with first and then that would have given me time to sort of process that and say yeah, I do need help." (Vickery, 2021, p.7)
	Redefining help seeking as being masculine	P1, P4, P5, P6, P7, P10, P11, P12, P18	
	Social support promotes help seeking	P2, P3, P4, P5, P10, P12, P13, P14, P15, P16	
	Positive experiences of help seeking	P1, P4, P17, P18, P19	

Note. Corresponding paper titles can be found in Table 3.

Results

Study Characteristics

Of the total 19 papers, 15 were conducted in England, two in Wales, one in Northern Ireland, and one across the UK. Participant samples were diverse across studies. Populations included men from the general public, men attending groups for mental health difficulties, men who had sought mental health support from their GP, students, fathers, men who had consciously decided against ending their own lives, soldiers and veterans, prisoners, professional footballers and cricketers, disadvantaged groups of men, refugees, ethnic minority groups in the UK, and men with prior mental health education. Most studies used purposive sampling to recruit specific groups of men of interest, although some used opportunity sampling in specific circumstances such as in male only prison wards (see Table 3 for full details). Sample sizes ranged from 6 to 38 per study. All study designs were qualitative. Twelve of the included studies used thematic analysis , two used interpretative phenomenological analysis, two used grounded theory, one used template analysis, one used Foucauldian discourse analysis, and one study was not clear about their specific analytic method besides stating that the data was analysed thematically.

Table 3.

Study Characteristics

Study	Reference	Location of study	Population	Recruitment Strategy	Number of Participants	Aims	Data Collection Method	Design	Analysis Method
1	Cramer et al. (2014)	Bristol, England	Men attending groups for anxiety and/or depression Men not attending groups but who had spoken to GP about anxiety and/or depression Men who had not attended groups or	Opportunity and purposive sampling	N=17	To establish if men do attend therapeutic/ support groups for depression, the types of groups they attend, the reasons why they attend them and the advantages and disadvantages of groups	Semi-structured interviews conducted in person	Qualitative	Thematic Analysis

			spoken to their GP						
2	Sagar-Ouriaghli et al. (2020)	London, England	Male students at a London university	Purposive sampling	N=24	To highlight key features that might be incorporated into mental health initiatives to help encourage male students to seek help for mental health difficulties	Focus groups	Qualitative	Thematic Analysis
3	Gheyoh Ndzi and Holmes (2022)	York, England	Fathers	Purposive, opportunity, and snowball sampling	N=20	To explore how, in the York area, the breakdown in informal support networks may have contributed to some fathers'	Semi-structured interviews conducted online	Qualitative	Thematic Analysis

						existing mental health concerns during the COVID-19 pandemic To explore the role of hegemonic, masculine cultural norms in shaping these fathers' experiences of and access to informal support networks			
4	Ridge et al. (2021)	London, England	Men who had consciously decided against ending their own lives	Purposive sampling	N=11	To explore male accounts of stepping back from, or conscious	Semi-structured interviews conducted in person	Qualitative	Thematic Analysis

						avoidance of death			
5	Vickery (2022)	South Wales	Men attending charity sector organisations and support groups for depression, anxiety, loneliness, or isolation	Purposive sampling	N=19	To explore men's experiences of using support groups for mental distress and the perceived effectiveness of groups for men	Semi-structured interviews conducted in person	Qualitative	Thematic Analysis
6	Hitch et al. (2024)	Northern Ireland	Military veterans residing in Northern Ireland	Purposive and snowball sampling	N=6	To explore the experiences of any veterans residing in Northern Ireland in relation to lifetime trauma, mental well-being, alcohol and help-seeking	Semi-structured interviews conducted by phone	Qualitative	IPA

7	Cobb and Farrants (2014)	England	Male prisoners	Systematic sampling	N=10	To understand the experiences of male prisoners and their constructions of help-seeking	Semi-structured interviews conducted in person	Qualitative	Foucauldian Discourse Analysis
8	Wood et al. (2017)	England	Professional footballers	Unclear – information not provided	N=7	To expand upon the knowledge and understanding of male professional footballers' experiences of mental health and help-seeking	Semi-structured interviews conducted in person	Qualitative	IPA
9	Wolstenholme (2024)	Sheffield, England	Second-year undergraduate students	Opportunity sampling	N=16	To explore the perceptions of male	Semi-structured interviews	Qualitative	Template Analysis

						students about mental ill-health, including potential causes of, and support seeking for male students specifically	conducted online		
10	Vickery (2021)	South Wales	Men from the general public, and men who attended support groups for mental distress	Purposive sampling	N=38	To examine how a diverse sample of men navigate help-seeking for broad mental health difficulties in everyday life and considers how masculinities can be practiced	Semi-structured interviews conducted in person	Qualitative	Thematic Analysis

						both negatively and positively to both restrict and facilitate mental health help-seeking			
11	Crawford et al. (2009)	Across United Kingdom	Soldiers who had been treated by Departments of Community Mental Health (DCMH) after intentional self-harm	Purposive sampling	N=10	To examine factors that may be important in the aetiology of suicidal behaviour among soldiers and to try to identify steps that might be taken to prevent suicidal behaviour among soldiers	Semi-structured interviews conducted in person by DCMH link workers who received a day of training regarding the study, recruitment, and qualitative data collection	Qualitative	Unclear. Study states that data was analysed thematically by hand. A reference for Grounded Theory is cited in analysis section, although not explicitly named in text.

						To explore the extent and type of help seeking behaviour prior to and following an episode of self-harm and consider factors that promote and inhibit contact with support services during this period			
12	Simpson and Richards (2019)	East Manchester, Merseyside, and West Lancashire, England	Men facing disadvantage	Purposive sampling	N=14	To generate accounts of what men facing disadvantage actually know and do about achieving and maintaining	Focus groups	Qualitative	Thematic Analysis

						health/wellbeing			
13	Rae (2014)	London, England	Somali first-generation refugees	Purposive sampling	N=12	To explore how Somali male refugees in the UK understand and perceive the Western concept of depression, alongside their views on coping and professional help in the UK	Focus groups and individual interviews	Qualitative	Grounded Theory
14	Awan et al. (2024)	England	Men of South Asian origin living with diabetes or coronary heart disease	Purposive and snowball sampling	N=17	To explore how men of SA origin with LTCs understand and experience emotional distress as well as the experiences	Semi-structured interviews conducted online	Qualitative	Thematic Analysis

						of GPs supporting them.			
15	Elliott and Owens (2023)	North England	Men with mental health literacy education i.e. university students studying psychology, and men without mental health literacy education	Purposive and convenience sampling	N=8	To explore the perceptions and awareness of symptoms of anxiety and depression in male participants with varying levels of mental health literacy to examine potential barriers and facilitators of help-seeking behaviours	Focus groups	Qualitative	Thematic Analysis
16	Robinson et al. (2011)	London and West	Men from black and minority	Purposive sampling	Twelve focus groups. Six focus	To provide a better understandi	Focus groups	Qualitative	Thematic Analysis

		Midlands, England	ethnic groups in the UK		groups for men aged 18-25 of African-Caribbean, African, Indian, Pakistani, Bangladeshi, and Chinese ethnic backgrounds. Six more focus groups for men aged 26-55 of the same ethnic groups Unclear how many participants per focus group	ng of BME men's beliefs and experiences regarding mental health, and their experiences of mental health services			
17	Wainwright et al. (2017)	Five prisons across England	Ex armed forces personnel in prison	Purposive sampling	N=10	To understand what ex armed	Semi-structured interviews	Qualitative study which is part of	Thematic Analysis

						forces personnel in prison, consider their needs to be and the factors they perceive to influence their help-seeking behaviour and engagement with services	conducted in person	larger mixed-methods study	
18	Ogden et al. (2023)	Across United Kingdom	Current and former professional cricketers	Purposive sampling	N=15	To explore UK male professional cricketers' mental health experiences and their experiences of mental health support	Semi-structured interviews conducted via phone or online	Qualitative	Thematic Analysis

19	Howerton et al. (2007)	Southern England	Male prisoners	Purposive sampling	N=35	To learn more about the factors that influence help seeking behaviour among men leaving custody	Semi-structured interviews conducted in person	Qualitative	Grounded Theory

Quality Appraisal

The Critical Appraisal Skills Programme (CASP) was selected to appraise the quality of the final 19 studies (CASP, 2024). The CASP was chosen over other appraisal tools due to its focus on methodological strengths and limitations which allowed assessment of the overall rigour of the included studies (Noyes et al., 2019). The CASP checklist consists of 10 questions which are concerned with the design of the study and its appropriateness, the findings and considerations of methodological factors that may have influenced them, and the value of the study to the existing literature (CASP, 2024). A decision was made to not exclude studies based on perceived rigour, as there are no standard guidelines for the appraisal of qualitative research (Thomas & Magilvy, 2011). The lead author completed the CASP for each of the 19 studies. Authors three and four also completed the CASP checklists. Any discrepancies in ratings were resolved through a group discussion. Table 4 details the outcome, and how all studies were deemed to be of good quality. Overall, most of the criteria were present and well detailed within each study. The only noticeably lacking criterion amongst the 19 studies was due consideration of reflexivity, and how the researchers' characteristics and experiences may have influenced the research. This may be due to the differences in analytic approaches across studies, which vary in their emphasis on the importance of reflexivity (Dodgson, 2019). This was not, however, considered to be sufficiently detrimental to the overall synthesis of findings. An example of a completed, fully detailed, CASP can be seen in Appendix E.

Table 4.

CASP Checklist Scores Across Studies

Quality Criteria	Study Number																		
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19
Clear statement of aims	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriate methodology	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriate research design	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Appropriate recruitment strategy	✓	✓	✓	✓	✓	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Data collection	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Relationship between researcher and participant		✓				✓	✓	✓	✓	✓	✓		✓	✓				✓	
Ethical issues considered	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Rigorous data analysis	✓	✓		✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	✓		✓	✓	✓
Clear statement of findings	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Value of research	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

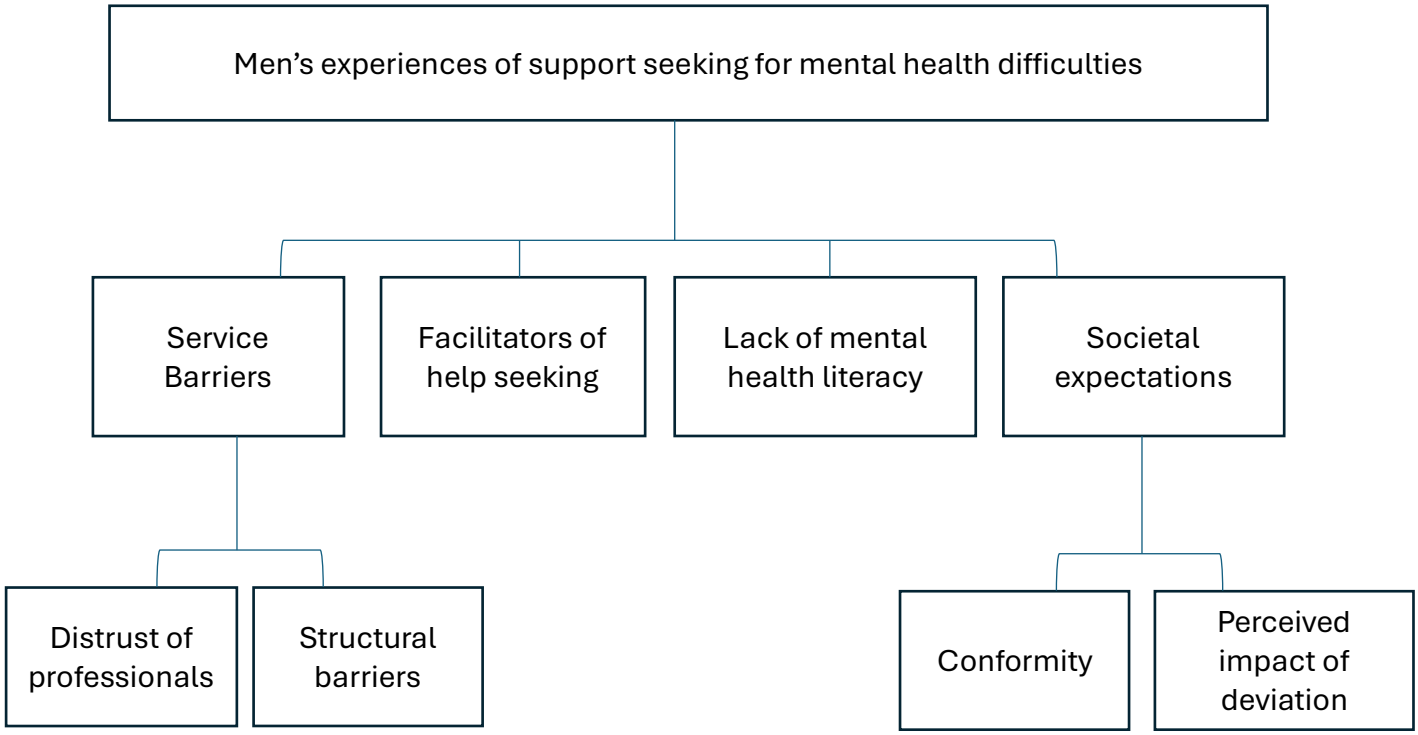
Note. Corresponding paper titles can be found in Table 3.

Narrative Synthesis

Data analysis revealed four primary themes across the 19 studies related to men's perceptions of mental health support seeking. These were: (1) Service barriers (2) Facilitators of help-seeking, (3) Lack of mental health literacy, and (4) Societal expectations (see Figure 2). Participant quotes from individual studies will be included to illustrate the themes.

Figure 2.

Visual Display of Themes Across Studies



Theme 1: Service barriers

Men in the UK reported many barriers to accessing mental health services. This theme has two distinct subthemes related to service barriers: i) distrust of professionals, and ii) structural barriers.

i) Distrust of professionals

Many groups of men in the UK distrusted healthcare professionals, which adversely affected their likelihood to seek mental health support. Male prisoners, for example, felt that healthcare professionals "just don't care", "just want to medicate", and "treat patients superficially" (Howerton et al., 2007, p.3).

Negative views of healthcare professionals were not exclusive to prisoners. Other men also distrusted clinicians, some due to prior negative experiences. A veteran in Northern Ireland recalled seeing a colleague seek support for mental health

difficulties and described the experience as “walking down an alleyway towards a clown with an axe and severed head” (Hitch et al., 2024). Viewing others’ experiences this way proved detrimental to personal help-seeking, even when the problem drastically worsened. In one study of men who had consciously decided against ending their own life, a man talked about building up the courage to disclose his distress to the GP, only to be shut down. “I said to him, oh there’s actually another thing. He actually huffed and said ‘you know we only get fifteen minutes per patient’, so I never told him” (Ridge et al., 2021, p.244).

Even when willing to disclose mental health difficulties, men expected to be treated less favourably by clinicians due to their gender. One man reported that his clinician will check on his wife’s mental wellbeing, but not his.

> If I want to take two minutes, he doesn’t sit and see how you feel, or how is your mood. But when my wife goes in, he asks how she's feeling, in terms of her mood, as opposed to just other stuff. (Elliott & Owens, 2023, p.122)

The distrust of professionals was particularly prevalent in studies focussing on the help-seeking of men from global majority ethnic backgrounds. In a study of Somali refugees in the UK, the community relied on each other for support and feared healthcare services in the UK. One man said “people will tell you like ‘Oh, don’t go to the hospital, because they will give you medication that will make you a zombie. Yeah, so don’t go to the doctor, never go to the doctor” (Rae, 2014, p.54).

ii) Structural barriers

Several structural barriers to seeking support were reported across the included studies. A common finding was that lengthy waits for support was a detriment. One

man described how he gave up his search for support after finding out his first choice was at capacity.

> It's quite ironic that I'm doing this because about 3 months ago I just woke up and I had, I wouldn't call it a panic attack, but a bit like an anxiety attack. So, I tried to go to a psychiatrist, a psychologist. She wasn't able to fit me in, so I haven't gone. Yeah, I rung this woman up and typical man, sort of you know, can you fit me in, and she was like "no I can't take anybody on." Oh, forget it! (Vickery, 2021, p.6)

Some men talked about how the prospect of waiting multiple months for support which does not meet their needs is a deterrent to help-seeking. One man suggests that it might be too late after going through multiple referrals and a lengthy wait for support.

> It's referral after referral… then you wait maybe another six months before seeing them again…when I have reached out, you're waiting that long thinking, what's the support? Is it just a tick box or is it really support? We have that long to wait to get support, maybe it's then too late? (Elliott & Owens, 2023, p.128)

Men also reported that having limited time and resources due to their work hours conflicting with the operating hours of mental health services was a barrier. One man said that "It's got to be accessible to like coming back to your point around impacting work and time, it's got to be accessible for you to be able to continue it" (Elliott & Owens, 2023, p.128).

Specific groups of men found themselves more disadvantaged when it came to help-seeking options. The findings from a study of army personnel who had recently self-harmed highlighted the lack of confidential support for this group of men. When asked about what changes could be made to reduce suicidal behaviour amongst

soldiers, one solider required “Having someone I could sit down with and talk all the problems through” whilst another wanted “Access to confidential support 24 hours a day.” (Crawford et al., 2009, p.205).

Men from global majority ethnic groups in the UK shared structural barriers of feeling unrepresented by mental health services in the UK. Rae (2014) reported how Somali refugees in the UK were fearful of being medicated and required spiritual and religious approaches to mental health support. An African-Caribbean man described how cultural differences, despite being born in the UK, meant that he could not access mainstream support due to structural racism.

> My parents were foreign to this country and had foreign ways and attitudes and it fed down to me. As an English-born person I have to go into the mainstream with foreign attitudes and teaching, and the stress of going into the mainstream and trying to do everything normal that my other white kindred do, it didn’t work. I was getting racism, negativity, pushed to one side and it brought a lot of stress. (Robinson et al., 2011, p.8)

Theme 2: Facilitators of help-seeking

This theme outlines the factors that increase UK men’s likelihood of seeking psychological support. Having close relationships with family and friends was a commonly cited reason for men seeking support, but for two very different reasons. Some men wanted to avoid disclosing distress to loved ones for fear of negatively impacting them. This motivated them to seek support elsewhere. One man discusses how comfortable his sister was going to their mother for support, but that he himself was the opposite.

> Oh, her and mum talk about it (depression) all the time. My sister was actually receiving medication for… I think it was a good year before I was. She spoke to my mother about it, she spoke to her GP, her friends. I'm completely the polar opposite of my sister. I didn't want to burden them (friends or family). I didn't want… cos you know, I don't wanna drag everyone down with my problems so… I don't wanna sit there and be the miserable one. (Cramer et al., 2014, p.295)

Other men highlighted that loved ones were an essential first step in reaching out to professionals. One man reported that he needed someone he trusted to talk to first, before he had the confidence to seek professional support.

> It started off with friends, then parents, then the GP and then who they referred me to. Whereas I don't think I could have gone straight to the GP or the services. I think I needed to make that admission to somebody else I was comfortable with first and then that would have given me time to sort of process that and say yeah, I do need help. (Vickery, 2021, p.7).

Seeking support from family was perceived to be very important for some groups of men from ethnic minority backgrounds in the UK. One Somali refugee felt that the individualist culture of the UK was detrimental to mental health.

> People from other cultures where it was more kind of, er, family orientated, people staying together, that kind of illness was very rare. It was there, but it was very rare… and then here, people are very individualistic, very isolated, and that illness is starting. (Rae, 2016, p.51)

Other commonly reported factors that would make men more likely to seek help included having professionals that understood the men's unique perspective. This meant for some men having therapists from similar ethnic or cultural backgrounds

(Awan, 2024, p. 184). For others it meant men that had shared lived experiences. One ex-armed forces prisoner described how it was easier to seek support from a guard who also had a military background.

> It would've been harder to talk to someone… he's been there himself sort of thing so it's a friendly face… I'd always approach him rather than another officer on the wing because he'd be more approachable and take that time. (Wainwright et al., 2017, p.764)

A simple factor was knowing that you were going to be treated with respect. When asked who he would contact if in mental distress, one man said his doctor because he knew he would be treated "like a normal person".

> My family doctor. He knows I've been in prison, and he knows I've been arrested, but he still treats me as a normal person. He doesn't try and talk down to you and he doesn't say, oh, you're alright, you go and do what you want to do. He tries to resolve the problem. (Howerton et al., 2007, p.5)

Finally, reframing help-seeking as masculine seems to increase the likelihood of the behaviour. Some men saw receiving support as enabling them to take back control of their lives, such as one man who described the process as "the fight back starts" (Ridge et al., 2021, p.246). Others framed their own help-seeking as an opportunity to help other men in distress. One prisoner described the advantages of having knowledge that can help others in prison. He said, "the more information I get, the more I can pass onto other people because there's no information given to anyone in this prison" (Cobb & Farrants, 2014, p.51).

Theme 3: Lack of mental health literacy

This theme captures how UK men felt unskilled managing their mental health. This included difficulty recognising they were experiencing mental health symptoms, defining common mental health difficulties, knowing where to seek professional support, and choosing unhelpful methods of self-management. Men talked about relying on loved ones to identify their suffering. One man said, “I didn’t realise it (I needed help)… she (my wife) suggested I get some counselling, and I was always like ‘what for’?” (Hitch et al., 2024, p.6).

Men felt that they had not been socialised to understand mental health due to dominant societal narratives surrounding men being an inherently privileged group. One student discusses how this had led to a lack of mental health support options for men. He described how “there’s so much available for literally everything else. Men are like, they’re pushed to one side, you don’t need the help as much as women, young children, older people, disabled people, but men, we have nothing for ourselves” (Sagar-Ouriaghli et al., p.5).

Not having a basic understanding of mental health has consequences when men experience a mental health difficulty themselves. A professional footballer describes how he thought he was ‘abnormal’ when he was experiencing mental health difficulties because he didn’t know what was happening to him. Instead of recognising the problem and seeking appropriate support, he isolated himself in case others were to notice something was unusual about him.

> I wasn’t aware enough or I suppose I didn’t wanna accept where I was you know? I wanted to be isolated, not wanting people to find out how I was feeling cos at that point I didn’t want to talk about it, cos I didn’t understand it. I thought I

> was… for want of a better word abnormal. I suppose I took it as part of the game, and I had to find a way round it and toughen up. (Wood et al., 2017, p.123)

Men attempted to self-manage their mental health in numerous ways. One of the most common methods was alcohol. Men who had actively decided against ending their own lives described trying to "look good and fit in" by using alcohol as a coping strategy and that it "felt normal" when drunk, although this made the men feel inauthentic and dishonest, and led to further shame (Ridge et al., 2021, p.244).

When men do seek support, men feel unable to communicate their needs. A commonly reported perspective was that men are bad at talking, particularly when the topic is feelings. A father who joined an informal support group during the COVID-19 pandemic described how men who all wanted support were not able to provide it to each other. He described how "within two days, the mums… one of the other mums had set up a mum only group for the NCT group, which then meant the main group just died, because dads are crap at talking, me included" (Gheyoh Ndzi & Holmes, 2022, p.6).

Theme 4: Societal expectations

Studies commonly reported findings concerning masculinity, gender norms, and stigma. Although men were unequivocally aware of societally constructed gender norms, there was variation in how men interacted with these. This is discussed in the subthemes i) conformity and ii) perceived impact of deviation.

i) Conformity

Across papers there was a shared understanding of the societal expectations of men. A male student described how society will attempt to stigmatise men into conformity.

> There's always been the stigma that boys don't cry, that if they're struggling, they have to, excuse the expression, "grow a pair", and "man up" and "deal with it". Those are the expressions that I absolutely hate to be honest, because it's not manly to be strong. (Wolstenholme, 2022, p.60)

Different groups of men reported varying levels of conformity to masculine norms. This highlights the importance of understanding the perspective of different groups of men of varying intersecting characteristics. One former soldier grappled with their understanding of what it means to be a man and striving to meet these unclear criteria.

> What does it mean to be a man, and a dad and a masculine figure, what am I supposed to be like, what am I supposed to do? I've always had very, very masculine jobs. I've been military, I've worked in warehousing… so very masculine… What's that all about you know? (Ridge et al., 2021, p.243)

Some men seemed to reject masculine norms entirely. One man compared seeing a therapist regularly to having "a golf lesson once a month just to tidy up my golf swing, it's exactly the same as probably going to see somebody" (Vickery, 2021, p.7). Men tended to prefer the idea of talking therapies over medication also, which is another example contrary to gender norm expectations. One man said that he preferred "talking (treatment) for me, that's basically my personal experience. That's my preference all day long" (Elliott & Owens, 2023, p.123).

The heterogeneous nature of masculinity and maleness is evident across studies. Attempts to make services more appealing to men by promoting male stereotypes were seen as alienating to some men.

> But there was something about the image of just a lot of men on the front and a lot of, I don't know I'm probably just being prejudiced. But a lot of them had shaved heads and were wearing football shirts and I kind of thought I'm not sure I would fit in there. (Gheyoh Ndzi & Holmes, 2022, p.6)

Knowing that other men had sought mental health support was reported to increase the likelihood of support seeking. This could be interpreted as conformity to new constructs of masculinity.

> He (friend) said he went to the GP and started just the talking therapies, and he took medication, and he described it as the wall started to come down and he started to see a way over it, and how to move on and that's exactly how it felt to me. I went to the GP, and I was really surprised, I just burst into tears and just sort of off-loaded everything which came as a… I didn't expect to do that. (Vickery, 2021, p.8)

ii) Perceived impact of deviation

Men shared a felt sense that they would be stigmatised by others if they were to deviate from masculine norms, which would lead to isolation. One prisoner described how being known to suffer from a mental health difficulty would result in social ostracization.

> Say a criminal going out there and doing crime and stuff and all your friends are there for you, and then you are diagnosed with a mental illness then they all seem to turn their back like… I mean no-one… it seems people are scared of mental illness. That's one of their worst fears, actually being diagnosed as mentally ill you know. (Howerton et al., 2007, p.4)

Some groups of men reported that it would be actively dangerous to seek mental health support. An ex-armed forces prisoner described how rigid adherence to masculine norms would prevent him from being victimised in prison.

> I wanted to keep my head above water… get used to it (prison) and not draw any unwanted attention to myself. If someone knows you've got a weakness, they're going to work on that, and its survival of the fittest in prison the same as when you're out there fighting. (Wainwright et al., p.763)

Other groups of men believed that being known to suffer from a mental health difficulty would adversely impact their career and earning potential. A professional footballer said that "what they want is this robust, you know, performance machine. Performance machines don't have erm… issues and insecurities, and problems, they get on with it" (Wood et al., 2017, p.123).

The men saw themselves as having a role to play, even amongst those closest to them. Whilst some men felt able to confide in loved ones, others expected ridicule or ostracization. One man described how an interaction with his father led to him conforming to masculine norms. He reported "Dad said last year stop being a girl, stop crying. So, I haven't cried. I just get on with it, and I still get on with it." (Robinson et al., 2011, p.88).

Discussion

The systematic review aimed to synthesise men's experiences surrounding mental health support seeking in the UK. This will develop the understanding of men's unique experiences and perceptions of help-seeking within a single nation. The implications for UK mental health services and organisations will be discussed.

The first theme concerned how men experienced barriers to accessing UK mental health support. The first barrier was men's distrust of healthcare professionals. Some men felt that professionals would not understand, or neglected, men's distress. Men sometimes associated this with their gender, reporting experiences of female relatives receiving more attention from clinicians concerning their mental health. This aligns with research suggesting that men's distress can be inadequately assessed or overlooked by clinicians (Jones et al., 2019; Smith et al., 2018). Some men assumed that clinicians would simply prescribe medication if they were to disclose distress. This particularly concerned some global majority groups in the UK, who distrusted the Western medicalisation of distress and instead reported faith in religious and community support.

Men also reported structural barriers which either have, or would, impact their ability to seek support. Men in the UK reported experiences of long waiting lists and inappropriate referrals which significantly impacted their motivation to seek help. This aligns with recent findings concerning lengthy waits for mental health support in the UK, with secondary care support taking on average 2.2 years (Iqbal et al., 2021). Some men cited general barriers, such as mental health services only opening during standard work hours and therefore being inaccessible for individuals with the same work pattern. Limited healthcare provision, or provisions which do not meet the needs of specific groups, have been found to adversely impact the likelihood of men seeking mental health support (Gough & Novikova, 2020). Whilst these structural barriers will apply to many men in the UK, smaller groups of men cited unique barriers. British army personnel reported not having access to confidential mental health support. This adds to research which suggests that there is a culture of mental health stigmatisation in the

British military (Jones et al., 2015; 2018). Structural racism was also reported by global majority groups of men living in the UK, for example the scarcity of clinicians of global majority ethnic backgrounds, and the lack of consideration of spirituality in mental health treatment.

Together, these findings suggest that UK men experience multiple barriers to accessing mental health services. Some barriers, such as inadequate time in appointments to adequately assess male distress are linked to overarching political and systemic issues related to healthcare funding. Other barriers might be more easily modifiable. Clinician training surrounding men's mental health, self-stigma, and masculinity may lead to increased recognition of male distress, for example. Providing services outside of standard work hours might also be beneficial.

The second theme presented men's experiences of what motivated them to seek mental health support. Some men were motivated to seek help because they feared they were burdening others. Many studies also included narratives of men seeking help to develop skills to support others who were also struggling. These findings align with literature suggesting that reframing help-seeking as masculine promotes the behaviour (Johnson et al., 2012). Other men were motivated to seek help because they had first confided in family or friends, and this led to accessing professional support. This aligns with findings from Gough and Novikova (2020), who found that men were more likely to seek mental health support from trusted others and within trusted communities. Further, men often discussed being motivated to seek help from others with similar characteristics or backgrounds to themselves. Whilst this may also be due to trust, it may also represent an attempt to remain within shared masculine norms (Gough &

Novikova, 2020). Finally, past experiences of being treated with respect by healthcare professionals resulted in increased willingness to seek future support.

These findings may have implications for UK mental health services and organisations. Group interventions designed for specific groups of men may promote a normative and trusted space for men to discuss mental health and support each other. It is also clear that UK men interpret masculinity in different ways which should be accounted for in the promotion, and design, of mental health resources and interventions targeting men.

Theme three highlighted that men in the UK lacked mental health literacy. This had several implications for mental health support seeking. Men reported difficulties recognising and defining symptoms of mental health and knowing where to seek support. Research suggests that cultural and familial masculine norms may be enacted on boys from an early age, leading to men not developing basic mental health skills (Gough & Novikova, 2020). Men also reported a preference for surface-level conversation and found discussing feelings challenging. These men often relied on female partners or relatives to identify their distress, and either seek support on their behalf or encourage them to do so. Not knowing where to seek support may also mean that mental health campaigns are not reaching some groups of men (Sheikh et al., 2024).

When men were able to recognise that they were struggling with a mental health difficulty, they often reported unhelpful coping strategies. Some men reported self-isolation as a response to struggling, as they feared the unknown, and hoped to hide this from others. This may also reflect low social support and community cohesion associated with individualist countries such as the UK (Scott et al., 2004). Some men

also used harmful coping strategies such as alcohol to numb distress, which aligns with research suggesting that men's use of alcohol as a coping mechanism has a huge toll on mental and physical health (Bilsker et al., 2018).

These findings suggest that efforts to improve mental health literacy in UK men are likely to be beneficial to future help-seeking behaviours. Any campaign to provide 'male friendly' resources and interventions should be designed with specific groups of men in mind, to account for the wide array of values and experiences men possess (Courtenay, 2002; Sheikh et al., 2024).

The fourth theme outlines men's experiences and perceptions of societal gender norms related to help-seeking. Men conformed to masculine ideals due to societal stigma surrounding men's help-seeking, which became self-stigma when internalised. These findings align with research citing conformity to masculine norms as a primary reason for men's reluctance to seek support (Gough & Novikova, 2020; Jones et al., 2019; Sheikh et al., 2024; Yousaf et al., 2015). Men experienced distress if they did not understand societal expectations, or that they did and were deviating from these. Other men rejected societal norms entirely or reframed them to aid help-seeking which aligns with research suggesting that this promotes men's help-seeking (Johnson et al., 2012). Further, some men sought support when they knew that their peers had previously accessed services, thus making it acceptable for them. This suggests that conformity can be beneficial to men's mental health support seeking when help-seeking is normative (Gough & Novikova, 2020). Men feared rejection, isolation, or distrust from other men should they deviate from masculine norms, which aligns with research emphasising the importance men place on peer evaluation (Gough & Novikova, 2020). Further, some groups of men, such as prisoners, reported fears of being bullied or

exploited by other men should they deviate from masculine norms. Professional sportsmen also reported that perceived deviation may negatively impact their careers. This aligns with findings from Souter et al., (2018) who found that men participating in elite level sports reported unique mental health challenges and vulnerabilities throughout their career and lives. Together, these findings suggest that efforts to normalise male help-seeking would be beneficial. This may include involving respected members of specific communities in mental health initiatives or sharing male success stories of help-seeking.

Strengths and Limitations

A strength of the review is that it utilised the ENTREQ guidelines and PRISMA statement. This meant that the review was conducted in a standardised, transparent, and replicable manner. The review was also pre-registered on PROSPERO, which meant that the methodological process of the review was pre-defined, which further adds credibility. The application of the SPIDER tool for the inclusion criteria and search strategy increased the likelihood of retrieving qualitative papers relevant to the review question. The SPIDER tool has been criticised for being too specific and potentially limiting results, although was successful in retrieving a wide range of qualitative papers in the present study (Methley et al., 2014).

A limitation of the present review is that the focus on men's experiences across the UK limits the ability to understand contextual factors for any particular group of men. This means that whilst the review provided a useful summary of UK men's experiences, it has less useful clinical implications for specific groups of men with clear clinical need (Courtenay, 2002). For example, immigrant and refugee experiences surrounding barriers to help-seeking were specific to their individual culture and

identities (Metz et al., 2016). Further, men in the army or prison reported experiences of mental health support seeking specific to that context which was therefore not generalisable to the rest of the UK.

The selection of the Critical Appraisal Skills Programme (CASP) for quality appraisal of the included studies also raised potential limitations. Checklist tools such as the CASP have been argued to align more with positivist paradigms and may therefore be less useful in qualitative research (Williams et al., 2020). Further, the consideration of ethics in the CASP checklist has been critiqued for being arbitrary, focussing more on the presence of statements of ethical approval than how ethics was considered and to what extent (Majid & Vanstone, 2018). Other quality appraisal tools, such as the Qualitative Assessment and Review Instrument (Hannes et al., 2020) are suggested to provide a more robust assessment of study validity than the CASP, as well as a useful consideration of the congruity between philosophy, methodology, and method in a studies design (Majid & Vanstone, 2018).

Constraints on Generality

Generalisability of the findings has been considered in line with recommendations from Simons et al. (2017). The findings of this systematic review are intended to generalise to men living in the UK. Whilst the findings may be of interest to other countries, they are bound within the geographical and cultural context of the UK and its healthcare system. The methodological process enables other researchers who wish to replicate this review to be able to do so.

Areas of Future Research

The review calls for more primary research surrounding the mental health support seeking experiences and perceptions of specific groups of men within the UK.

This might focus on hard-to-reach groups of men, those who are known to be at increased risk of mental health difficulties, or men who are particularly resistant towards help-seeking. Focussing solely on the experiences and perceptions of these groups will develop a rich understanding and allow mental health service providers and organisations to develop contextually bound campaigns and interventions.

The present review focussed on the experiences and perceptions of men themselves. Several papers were retrieved which also included experiences of health care providers, providing further insight into UK men's help-seeking. These findings were not included for two reasons. First, the pre-defined methodology specified that the review would focus solely on the experiences and perceptions of men in the UK. Second, papers that may have focussed solely on healthcare providers and other professionals' experiences of men's help-seeking were not the focus of the search strategy and would therefore have been excluded during screening. It may therefore be useful to conduct a future review on professionals' experiences of male help-seeking in the UK to add to our understanding of the research question.

Conclusion

The findings of this systematic review of men's experiences and perceptions of mental health support seeking in the UK outlined how men's experiences and perceptions of help-seeking differed by individual, familial, occupational, and cultural characteristics. Several considerations for UK mental health services and organisations were suggested. These included providing services outside of standard working hours in the UK to broaden availability of access. Clinician training was supported on topics including masculinity, self-stigma, and the role of spirituality in mental health care. Promotion of mental health initiatives which take an overtly masculine and stereotyped

approach were discouraged. Psychoeducation surrounding mental health for boys and men was supported, as well as ‘male-friendly’ interventions tailored to the needs of specific groups of men. Finally, normalising male mental health support seeking was supported. This might include providing support groups solely for men or including respected men in efforts to promote mental health campaigns or interventions. Future research should focus on the experiences and perceptions of specific groups of men to provide more specific clinical recommendations.

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CHAPTER THREE: Bridging Chapter

Word count: 435

The systematic review presented in Chapter Two aimed to develop an understanding of men's experiences of mental health support seeking in the United Kingdom (UK). Existing reviews on the topic have synthesised studies conducted across a wide range of countries and cultures (Gough & Novikova, 2020; Jones et al., 2019; Sheikh et al., 2024; Yousaf et al., 2015). Whilst this provides a broad understanding of male help seeking, men are not a homogeneous group who all share the same experiences (Courtenay, 2002). This means that relevant individual, familial, and societal information might be neglected in the pursuit of generalisability (Gough & Novikova, 2020). The present review therefore focussed specifically on studies conducted within the UK to isolate any important cultural context relevant to help-seeking. This included the benefit of having all included studies within the single healthcare context of the National Health Service (NHS). The included studies captured the experiences of diverse groups of men, including men from the different nations of the UK, men in prisons, soldiers, refugees, fathers, and men from disadvantaged backgrounds to name but a few. This resulted in an aggregated, top-down overview of men's experiences which was broadly in line with findings from cross-cultural reviews (Gough & Novikova, 2020). This approach, however, risks neglecting the experiences of specific groups of men. Focussing on the experiences of specific groups of men develops our understanding of that group, which then allows contextually bound recommendations for local mental health services and organisations.

The next chapter presents the empirical project, which qualitatively explores the mental health experiences of a specific group of men. Men aged 45-64 who live in former mining communities were the population of interest due to research suggesting that they are theoretically at increased risk of mental health difficulties, but also less

likely to access mental health services than other men. The lead researcher is also a member of this community, a phenomenon often described as “insider researcher” (Aburn et al., 2021). Being a member of the target community has advantages, such as the quick development of rapport and trust from participants, but also has challenges to be mindful of, such as the risk of assumed understanding, which need to be carefully managed (Aburn et al., 2021). The empirical project complements the systematic review by taking a bottom-up approach to research, examining the mental health experiences of a specific community of men. This complementary approach was underpinned by the author’s critical realist epistemological stance, which assumes that we can only ever achieve a ‘best guess’ understanding of a phenomenon by studying it from a variety of perspectives (Archer et al., 2013).

CHAPTER FOUR: Empirical Paper

Prepared for submission to Psychology of Men & Masculinities

(see Appendix A for author guidelines)

Word count: 7058

"It's how you look in your mate's eyes": A thematic analysis exploring men's perceptions of mental health in former mining communities

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Abstract

Men are more at risk of suicide but less likely to access mental health services than women. Men aged 45-64 are the highest risk group of suicide in England and Wales. Recent gender-specific research has attempted to explore the reasons for this health inequality, although much more enquiry is needed into smaller groups of men with unique characteristics. Former mining communities have many risk factors associated with mental health difficulties. These include lower than national average levels of education and household income, and higher levels of underemployment and unemployment. The present research therefore focuses on the mental health perspectives of these men. The underpinning research question is: How do men from former mining communities who have never accessed mental health support perceive mental health? The study utilised a cross-sectional qualitative design. Semi-structured interviews were conducted with 15 men aged 45-64 who had never accessed mental health services and lived in former mining communities. Reflexive thematic analysis was used to analyse the data, and 4 main themes are described. The men described how life had always been hard, but increasing isolation since the mines closed had adversely affected mental health in the community. Stoicism was seen as a male strategy to survive hardships, passed down through generations of men. Mental health support was perceived as positive for others, but was something that men of the community could not access for fear of judgement and rejection by their peers. Recommendations for next steps and further areas of enquiry are discussed.

Keywords: men, masculinity, mental health, former mining communities, qualitative, thematic analysis,

Public Significance Statement

Research has often overlooked the importance of male-specific constructions of mental health, despite the known suicide risk and suspected underreporting of mental health difficulties in men. This study explored the constructions of mental health in a theoretically at-risk group of men living in former mining communities who had never sought professional support. Key findings discussed include: the adverse impact of the closure of the mines, the intergenerational benefits of stoicism, the promotion of mental health support for others but rejection of it for themselves, and the fear of criticism and rejection from within the community which maintains these attitudes.

“It’s how you look in your mate’s eyes”: A thematic analysis exploring men’s perceptions of mental health in former mining communities

Men account for approximately three quarters of all suicides in England and Wales, with men in the 45-64 age range being the group at the highest risk of suicide since 2010 (Office for National Statistics, 2024). Despite this, in England, women report higher rates of common mental disorders than men, as well as higher rates of accessing mental health treatment (McManus et al., 2016; Oliver et al., 2005). One potential explanation for this gender inequality is that sociocultural constructions of masculinity prevent men feeling able to disclose, and seek help for, their distress (Seidler et al., 2018). Further, these same constructed expectations of masculinity may lead to practitioners overlooking or inadequately assessing male distress (Smith et al., 2018).

Gender-specific approaches to researching health needs have become more prevalent in recent years. In the United States, Courtenay (2003) identified thirty key determinants of the physical and mental health of men and boys and concluded that the greatest health risks are the result of modifiable factors. Focussing specifically on mental health, the current research seems to indicate that attitudinal, rather than structural, barriers prevent men from accessing mental health support (Andrade et al., 2014). These attitudinal barriers seem to revolve around conformity to masculine norms which result in men attempting to self-manage mental health difficulties and fearing rejection from others, particularly male peers (Herron et al., 2020; Lynch et al., 2018; Rice et al., 2020; Sagar-Ouriaghli et al., 2020; Seidler et al., 2018). In contrast, some men reconstruct ideas of masculinity in a way that aids support-seeking, for example seeing it as a way of managing their problems and regaining self-reliance (Johnson et al., 2012). Other men may elect to disregard gender norms entirely (Courtenay, 2002). It

is evident, therefore, that men interpret masculinity in numerous different ways and that understanding the dominant narratives surrounding mental health, masculinity, and support-seeking in specific groups of men is likely to be beneficial to mental health service providers who serve these communities.

Contemporary Research

Reviews of contemporary research have synthesised what is presently known about the factors influencing men's mental health support seeking. Sheikh et al. (2024) examined the perceived barriers and facilitators of mental health support seeking in young men. The key themes of this systematic review suggest that young men felt governed by social norms, particularly the pressure to conform to cultural norms of masculinity and the self-stigma that arose from this. A meta-analysis found that conformity to masculine norms was moderately and unfavourably related to both mental health and psychological support seeking (Wong et al., 2017). Other research finds that whilst men themselves may be ambivalent towards mental health support seeking, they generally promote this for others (Wolstenholme, 2024). Sheikh et al. (2024) also found that young men felt they had limited access to information about mental health, and that they wanted 'male-friendly' mental health literacy campaigns.

Gough and Novikova (2020) conducted a scoping review exploring how sociocultural constructions of masculinities related to mental health support seeking in men of all ages across Europe. The findings of this review emphasised that stigma regarding mental health support seeking arose from traditional gender norms, but that these norms varied and operated differently across individual, community, and societal contexts. On an individual level, men with a greater adherence to masculine norms were more likely to have higher levels of self-stigma, more difficulty expressing

emotions and self-control, and be less likely to seek help. Boys and men were found to be particularly concerned about criticism and rejection from male peers if they were to deviate from masculine norms and seek support. Further, men with poor mental health literacy were less likely to seek support due to having a poorer understanding of mental health difficulties, leading to misinterpretation or minimisation of psychological symptoms. It is argued that poor mental health literacy in men may arise from cultural, familial, and occupational norms which discourage mental health discourse in males. It was also found that the specific community to which men belong also present unique barriers. Certain communities may have specific masculine ideals and practices which make it particularly difficult for men to express distress and seek support (Vickery, 2021). Marginalised groups of men reported that economic insecurity, inequality, and limited health and social care provision within their communities were key barriers. Communities with a high proportion of men working in traditionally male-dominated professions may also be less likely to seek support due to greater exposure to masculine norms. On the other hand, men were more likely to seek support from trusted people and within trusted communities. Communities and cultures where help-seeking is normative, and with readily available support were also conducive to male help seeking. If help-seeking was endorsed by role models or trusted members of the community, this was also more likely to promote help seeking. Finally, the availability of masculinity-framed interventions encouraged men to access support, and this was most effective when designed for specific groups of men. These findings led to the review recommending that policy makers consider the prevailing cultural norms of masculinity in diverse groups of men from a diverse range of communities in order to provide effective intervention. This finding is supported by Courtenay (2002), who

argues that men are a heterogeneous group who have varying experiences dependent on age, ethnic identity, sexual orientation, social class, and many other unique characteristics. Research should therefore focus on the experiences of smaller subsets of the male experience to better understand the health needs of individual communities.

Mining Communities

Former mining communities comprise of large and distinct settlements located in close proximity to natural sources of coal across England, Scotland, and Wales. They are historically white working-class communities, whose long history of coal mining has shaped their economy, culture, and landscape (Abreu & Jones, 2021; Beatty et al., 2019). Many mining communities were left economically devastated by the closure of the mines from the mid-20th century right up until the final UK mine closed in 2015. The communities have remained economically peripheral ever since, their primary economic source removed, and the communities themselves are often situated far from large cities due to their proximity to coal sources (Abreu & Jones, 2021). Abreu and Jones (2021) describe the cultural building blocks of these communities as “solidarity, social justice, communitarianism, and resistance”, but notes that it is unclear what implications this cultural identity has on current attitudes and behaviours.

Former mining communities in the United Kingdom very rarely appear in academic literature. Despite this, research suggests that mental health is significantly poorer in former mining communities than other areas, which indicates a need for research (Abreu & Jones, 2021). Abreu and Jones (2021) highlighted several characteristics of former mining communities which are associated with poor mental health and lower levels of help-seeking. First, mining communities were found to have

lower than average levels of education. Lower levels of education are often associated with higher levels of common mental disorders (Araya et al., 2003; Niemeyer et al., 2019). One potential reason for the lower levels of education in these areas is presented by Bright (2011), who suggests the presence of 'resistant aspiration' in mining communities. This is defined as young people rejecting an education system which is geared towards participating in an economy which has historically been disadvantageous for their families and community.

Mining communities were also found to have a significantly lower average household income. Lower levels of household income have been found to be associated with a higher risk of mental health difficulties and suicide attempts (Gresenz et al., 2001; Sareen et al., 2011). Likely related, former mining communities were also found to have higher levels of underemployment and unemployment (Strangleman, 2001). Uncertainty surrounding employment and the ability to produce income is suggested to have a greater impact on men's mental health specifically (Backhans & Hemmingsson, 2012; Paul & Moser, 2009).

Evidence suggests that former mining communities may also be less likely to seek support for mental health difficulties, despite being theoretically more at risk of these. Hammer et al. (2013) examined the relationship between various demographics of Western men, and their likelihood of seeking support for mental health difficulties. It was found that men who live in rural areas and who have lower levels of education have poorer attitudes towards psychological support seeking. Further, the relationship between masculine norms and self-stigma was twice as strong for rural men than other men. Mining communities are often rurally located due to the need to be in close proximity to sources of coal, and as previously discussed have lower levels of

education. This has the implication that men in mining communities may be much more likely to conform to masculine gender norms, self-stigmatise, and are therefore much less likely to seek psychological support than other groups of men.

Clearly this is a group whose experiences warrant a more in-depth understanding. The research question, therefore, is: How do men from former mining communities who have never accessed mental health support perceive mental health?

Method

Design

The research was conducted through a critical realist lens (Archer et al., 2013), aiming to provide a deeper understanding of how a small community of men understood and interacted with the concept of mental health. The hope is that this will progress our overall understanding of men's mental health by adding supplementary, focussed findings concerning specific groups of men.

The research used a cross-sectional, qualitative design to address the research question. Individual interviews were conducted with 15 men using a semi-structured interview schedule, with a focus on understanding the participant's construction of mental health, and what it means to them. Reflexive thematic analysis was the analytic framework used (Braun et al., 2022). This allowed the patterns and shared meaning across the data to emerge whilst also reflecting upon how the lead researcher's membership of the target community influenced the research process.

Sample

Purposive sampling was used to recruit 15 participants from former mining communities across Nottinghamshire and Derbyshire, UK. The ward-based map depicted in Beatty et al. (2019) was used to define what constitutes a former mining

community. This map captures labour market data from before the mass closure of the mines and resultant job losses of the 1980s and 1990s (see Appendix F).

Recruitment posters were displayed in local businesses within close proximity of miner's welfare halls, social hubs formerly built for, and used by, miners (Appendix G). Inclusion criteria for the study included being male, aged between 45-64 due to the known suicide risks, living in a former mining community, and never having accessed mental health services. Most participants were eventually recruited through recommendations from other participants i.e. snowball sampling. Participant demographic data is presented in Table 5.

Table 5.

Sample Demographics

	n	%
Age		
45-49	-	-
50-54	4	26.6
55-59	4	26.6
60-64	7	46.6
Prefer not to say	-	-
Ethnic group		
White (English, Welsh, Scottish, Northern Irish or British)	14	93
Mixed or Multiple Ethnic Groups (White and Asian)	1	7
Highest level of attainment		
Foundation Qualifications (fewer than 5 GCSEs (grade A*–C), NVQ level 1 etc.)	6	40
Intermediate Qualifications (5 or more GCSEs (grade A*-C), NVQ level 2 etc.)	3	20
Advanced Qualifications (2 or more A levels, NVQ level 3 etc.)	2	13.3
Higher Qualifications (degrees or above, NVQ level 4 and above etc.)	3	20
Prefer not to say	1	6.6
Approximate household income before tax		
Below £20,000	1	6.6
£20,000-£40,000	3	20
£40,001-£60,000	10	66.6
£60,001-£80,000	-	-

Above £80,000	1	6.6
Prefer not to say	-	-
Years lived in former mining community		
Less than a year	-	-
1-10	-	-
11-20	1	6.6
21-30	1	6.6
31-40	1	6.6
41-50	2	13.3
51-60	3	20
Over 60 years	7	46.6
Prefer not to say	-	-
Employment status		
Full-time employment	8	53.3
Part-time employment	2	13.3
Unemployed	-	-
Self-employed	3	20
Homemaker	-	-
Student	1	6.6
Retired	1	6.6
Prefer not to say	-	-
Hours worked per week		
1-10	-	-
11-20	2	13.3
21-30	-	-
31-40	10	66.6
41-50	2	13.3
51-60	-	-
Over 60 hours	-	-
Prefer not to say	-	-
Not applicable	1	6.6

Note. Ethnic groups not applicable to the participants were omitted for brevity.

Procedure

The research received ethical approval from the Faculty of Medicine and Health Sciences Research Ethics Committee at the University of East Anglia (see Appendix H).

A semi-structured interview schedule was co-created using the lived experience of the lead researcher and a Patient and Public Involvement (PPI) panel of three men from within the community. Once participants had expressed interest in the research, they were screened for inclusion criteria via telephone call. This also provided the

opportunity for participants to ask any questions concerning the research. Participants that met the inclusion criteria were then provided with interview location options; participants were free to choose from local public venues with a private function room, their own home, or online via Microsoft Teams. Relevant researcher safety policies were adhered to if interviews took place in private accommodation. The lead researcher conducted all interviews. Prior to interview, participants were given information sheets to read (Appendix I), and the opportunity to ask any questions. Informed consent forms (Appendix J) were completed if the participant wished to proceed. Interviews lasted on average approximately 40 minutes. Interviews were audio-recorded, with each recording containing verbal consent from the participant to do so. A full debrief (Appendix K) was provided following interview, and participants were given a £10 grocery voucher to compensate them for their time. Information regarding mental health support was given to the men in the event of the interview being particularly distressing to them, although none of the men indicated this had been the case. Recruitment stopped once it became clear that no new data was being generated. Throughout the study, all information was shared between authors using University of East Anglia's (UEA) Microsoft Outlook and OneDrive accounts. This in line with UEA's Information Classification and Data Management Policy (2018). The UK's General Data Protection Regulation (2018) requirements were adhered to when collecting, storing, processing, and deleting personal information. All data for this research will be securely stored in the UEA data repository and deleted 10 years after the study's conclusion in line with UEA's Research Data Management Policy (2022).

Analysis

Each interview was transcribed verbatim by hand to facilitate immersion of the data (Braun & Clarke, 2023). Identifiable information was removed during transcription.

Anonymised transcripts were uploaded to NVivo (V.15) for coding and generation of themes. The 6-phase approach of Braun et al.'s (2022) reflexive thematic analysis was followed in an iterative manner (see Table 6).

Table 6.

Six Phases of Reflexive Thematic Analysis

Phase	Steps
Familiarisation	Transcription by hand. Reading and re-reading the transcripts. Listening to the audio-recordings. Making notes of interest.
Coding	Creating codes for relevant clusters of data. Checking to ensure codes address research question.
Initial Theme Generation	Grouping codes together to form core concepts.
Reviewing and Developing Themes	Reviewing and developing themes to ensure that they capture meaningful patterns within the data which addresses the research question. Considering the narrative of each theme, as well as how they fit together to tell the narrative of the men's experiences.
Refining, Defining, and Naming Themes	Brief definitions of each theme are written which capture the core concept. Names are assigned to themes.
Producing the Report	Narrative is told by presenting analytic commentary and supporting quotes from the transcripts. Narrative cohesion with the existing literature is described. Methodological processes are reflexively described.

Note. Sourced from Braun et al. (2022).

Coding was undertaken by the lead researcher. A data-driven inductive approach to coding was taken, to allow themes to arise from the participants' experiences (Boyatzis, 1998). Themes and the overall narrative of the data were scrutinised by all members of the research team. This was done in a reflective manner which challenged existing assumptions and enhanced the credibility of the findings (Noble & Smith, 2015). Each step of the analysis was discussed by the research team and revisited several times until it was clear that the resultant themes were refined, and the meaning of the data had been captured.

Reflexivity

The unique experiences of researchers have important bearings on how their research is designed, conducted, and interpreted (Guillemin & Heggen, 2009; Staller, 2013). As a member of the community of interest, the lead researcher ensured the strategies outlined in Noble and Smith (2015) were utilised in the present study to enhance credibility. To maximise the credibility of the research, the lead researcher maintained a reflexive journal throughout, and carefully documented all research decisions (Darawsheh, 2014). This allowed the lead researcher to document and reflect upon their assumptions leading up to the research, and how these may have influenced the data analysis. Another useful strategy for enhancing truth value was to frequently revisit the audio-recorded interviews to check emerging themes.

In terms of neutrality, the coding process and emerging themes were discussed during research supervision with experienced researchers who were not members of the target community. This allowed the lead researcher's assumptions to be challenged, and the meaning of the data could be re-examined with alternative

perspectives. This resulted in an iterative process whereby codes and themes were revisited multiple times.

Finally, in terms of applicability the lead researcher ensured that rich detail was provided regarding the characteristics of the participants and setting. Substantial quotes from the participants were also included in the results section so that readers can see how the meaning was extracted from the data.

Results

Four themes were developed from the data. These were: (1) The old hard life was better than the new hard life; (2) Stoicism as an intergenerational survival strategy; (3) Mental health is good for others, but not men like us; and (4) Peer pressure maintains the status quo. Each theme is illustrated with relevant data extracts.

Theme 1: The old hard life was better than the new hard life

The men normalised adversity, as this was something that they had experienced throughout their lifetimes. The difference lies in how the men experienced adversity in the past compared to the present. One of the most commented on life changes for the men was the closure of the mines. Interestingly, the men simultaneously held the position that the working conditions of the mines were difficult and dangerous, but also that life was better when the mines were operating. Participant 15 reflects on how the camaraderie that the miners enjoyed outweighed the hardships of the job.

> I've never been down pit so I can only talk... I mean I've got loads of friends who had but most of them when they worked down pit, they all watched each other's backs. Honestly, their bond... when you talked to them, they got the worst job in the world, but they all are back in a flash. Every one of them would go back and

> do the same job and they loved the thing of clocking on and all going down and watching… it was one of the most dangerous jobs anybody could do but they were all there to watch each other's backs. (Participant 15)

The men suggested that the community is no longer as close as it was when the pits were open. The increased cost of living is cited as one reason for this.

> I think people need to be together more as a community. Most people don't do that now and are struggling with finances and stuff. They can't afford… the bills are so dear and that. What do we do? Go out with friends or put food on table for another week? (Participant 15)

A major shift in the men's lives was the introduction of computers and social media. The men viewed this as a poor substitute to the community cohesion they enjoyed growing up. Again, there is a felt sense by the men that the hardship they experienced bestowed upon them certain advantages. One man describes how he and his friends were "dragged up" (Participant 5). This shared experience led to close interpersonal relationships which were protective against mental health difficulties.

> We were dragged up. Get out on street, go play football, come back when streetlights come on… The pros for us were that we made proper friends. We were always out with us friends. There weren't any computers or anything like that, so we had to go out and entertain ourselves. I think nowadays they will sit on a computer, and I don't think they get the life experience of going out and enjoying yourself with your mates. It's all talking on a thing. Yeah, I probably would have said that helped with our mental health, 'cus we weren't sat alone indoors all day long. (Participant 5)

Whereas the community once came together to overcome hardship, the men now feel increasingly isolated from those around them. At the same time, the development of digital media means that there is easy access to the lives of people around the world. One man describes how it can feel like “browbeating” (Participant 6) to be exposed to the apparently idyllic lives of others.

> It’s hard to look at news because its full of shit. It’s all ‘oh this multimillionaire is doing this, or this footballer isn’t playing football but has brought this fancy car and all this… The general person thinks fucking hell. I don’t know if it’s just browbeating everyone, and some people are gonna pick up and think why can’t I be like that? (Participant 6)

Theme 2: Stoicism as an intergenerational survival strategy

This theme describes how stoicism, the endurance of hardships without complaint, has been a useful strategy for generations in the community. The men recalled how their grandfathers had fought in world wars, and how their fathers’ best chance at a good life was to risk the dangers of working in the local mines. The men were reverent of their forebears and viewed their attitudes and values as examples of what it means to be a man.

> My father worked down the mine, and my grandfather did. In days that were really, really tough. I mean, my grandad fought in the first world war. He was dragged out of the mines to go out and fight in the first world war. They were, in the end, used as almost cannon fodder almost, to be chucked out. So, you learn from that and what they went through, and you’ve got to be tough. (Participant 8)

The men described how stoicism was explicitly taught to them as a male strategy for surviving hardship.

> It was sort of shut up and put up with it type of thing because that's the way they were brought up and it stems from, perhaps, a hard life for your parents and grandparents and what they had to go through. (Participant 1)

Not displaying emotions was felt to have benefitted the previous generations of men in the community.

> I think it's partly because these men who worked down pits didn't get paid if they didn't work. So, if they weren't right, they'd hide it. Whether it was a mental injury or a physical injury. I know a relative, and my friends have relatives, who have worked down the pit with broken hands and stuff like that because if they didn't, they didn't get paid. (Participant 9)

The men offered suggestions as to why values of stoicism persist in more peaceful times, without war and after the closure of the local mines. The men, broadly, revered the past and strived to be like those that came before them.

> It was really only the last couple of generations that have seen an easier, as such, life… but of my age we come from an era when men were men, and I sort of strived to take after my Dad. (Participant 10)

Theme 3: Mental health is good for others, but not men like us

This theme describes how the men were simultaneously pleased that mental health support had become increasingly common for others, but that it was still not for men like them. This created a sense that these men were on the outside looking in. Participant 7 describes a generational difference in perspectives. He felt that younger generations of men hold more accepting views towards mental health than his generation. He describes how "it already has changed for people of a different generation, but I don't think you'll change… my opinions have changed, obviously, but it

wouldn't mean that I'm going to access a service." (Participant 7). When asked why men do not access mental health services despite believing that they are useful and positive for others, one man says, "I suppose men are big proud chaps, aren't we?" (Participant 2).

Pride was just one facet of why the participants felt mental health was not for men like them. There was also an entrenched need to continue upholding hegemonic masculine ideals held by the community. One man used the word "dogma" (Participant 8) to describe the way in which men in the community unquestioningly adhered to the established masculine norms. He also used the word "unable" rather than unwilling to describe men's ability to share their feelings. This suggests that ability, as well as choice, may distance the men from mental health support.

> They've been the main breadwinner, and they'll seem to have to continue that, and that sort of dogma, and that sort of... way they live their life... unable to share things... and I think they are, by far, the worst for doing it. (Participant 8)

The men spoke with hope about a future where everybody felt able to access mental health support if they were struggling. The consensus was that the generation of men interviewed would be slower in changing their attitudes towards mental health than perhaps younger generations who have been more exposed to mental health discourse.

> I think it is good that there is a growing... a better onward growing attitude towards receiving care, mental health care. I think it is good that it is more socially acceptable now than it probably ever has been. I think it is gonna be slow moving, I think, but we are going in the right direction. (Participant 1)

Despite the men feeling that mental health support is not for men like them at present, there was a broad sense that the men would want their family and friends to access mental health support if they needed it. Many of the men reported selfless attempts to support others with their mental health. Participant 4 describes how his wife "went absolutely loop-de-loop. We couldn't get any help. Me and our (family member's name), we went to numerous hospitals… we went to Derby, we went to the mental health place at Derby where she was finally interviewed." (Participant 4).

When asked what could be done to make mental health support more appealing to men, suggestions included education which "has got to start young" (Participant 1). For the age range of the men interviewed, participants suggested that seeing "successful dynamic people" (Participant 8) and other relatable individuals discussing mental health is helpful. The men also believed that having mental health promoted by sports clubs and other areas of interest for men of similar ages would be useful.

> Um, things like football clubs promoting it. A lot of men… football is a men's game and if the clubs promote it, they might think hold on a minute, that might be alright for me if the club are promoting that sort of thing. (Participant 11)

Theme 4: Peer pressure maintains the status quo

Theme 4 describes why this cohort of men feel that they cannot break out of the intergenerational cycle despite their acknowledgement that modern attitudes towards mental health are broadly positive. The men feel pressure from their peers to conform to their shared belief of what it means to be a man. One man stated that this was exacerbated because former mining communities are "just smaller, close-knit community and people seem to listen to other people's attitudes and are scared to say something different to what the other people are saying." (Participant 11).

The men feared that if anybody discovered their deviation from the idealised male role held by their peers, everybody would know. The men particularly feared judgment from other men their age. One man aptly summarised the sentiment with “It’s how you look in your mates’ eyes. Showing weakness again.” (Participant 5).

> Well, I just think the mining communities, they’re villages, aren’t they? Everybody knows everybody. I think that would be another reason why somebody wouldn’t be openly talking about it front of other people, because if you told one person the whole village would know. (Participant 2)

The men did not even trust healthcare institutions within the community to adhere to basic confidentiality standards. One man reported his distrust of people working in the community who also live in the community: “Say you go t’local medical centre… I know they shouldn’t, but people living in village work in the local medical centre as well… so everybody is supposed to be confidential but, oh no!” (Participant 7).

The pressure to conform comes from other men within the community specifically. Many of the men described feeling comfortable talking to female relatives, and even strangers, about their emotions. Participant 2 describes how female relatives would treat a disclosure of distress with concern, whilst male relatives would be dismissive.

> I think my daughters would be kind of worried. My brothers would probably say get a pint down ya and shut up. That’s what I’d expect from them. (Female partner’s name) would say, well, you need to go see the doctor. (Participant 2)

When asked whether the men would support their peers if they were to disclose a mental health difficulty, the consensus was that they would. In one example, Participant 5 said that he would help his peer with no hesitation. Then, he backtracks

and seems to return to the peer pressure role, wanting to test how his friend would respond: “I would not be the one who takes piss. Actually, I probably would take piss to start off with and see how he reacts.” (Participant 5).

Discussion

The purpose of this study was to develop an understanding of how men in former mining communities who have never accessed mental health support perceive mental health. Findings from primary research into the mental health experiences of individual groups of men supplement the existing literature with rich, context-specific information. Interventions and services can then be tailored to meet the needs of hard-to-reach groups, such as the men who participated in the current study (Barbour & Barbour, 2003).

The first theme outlined the men’s experience of adversity, and how this links to mental health. Adversity is normalised by the men, who have all experienced deindustrialisation, and the resultant economic peripherality of their community compared to other areas of the UK (Abreu & Jones, 2021). Interestingly, the men reported that it was positive for mental health when the mines were open, despite the acknowledgement that it was a dangerous job. This is in line with findings suggesting that unemployment has a greater impact on men’s mental health, possibly due to gender norms linking men’s value to their ability to generate resources (Backhans & Hemmingson, 2012; Paul & Moser, 2009). The men viewed the camaraderie of the miners as being protective against mental health difficulties, even in the face of dangerous work. The loss of this camaraderie when the mines closed, and the increased sense of isolation due to rising living costs were viewed by the men as having

an adverse impact on mental health. This is both in line with findings from Abreu and Jones (2021), who found that community cohesion in former mining communities was relative to other communities in modern times, and research suggesting that disadvantaged groups of men were more likely to experience mental health difficulties (Gough & Novikova, 2020; Gresenz et al., 2001; Sareen et al., 2011). The men described how the introduction of computers and social media was negative for mental health also. This was because the men saw it as denying young people the opportunity to make close friendships, which was seen as being protective against the adversity they experienced growing up. The findings of this study, therefore, emphasises how important male closeness, friendship, and camaraderie has been in surviving adversity for this group of men. It suggests that efforts to restore or promote male bonding in the community may be beneficial for mental health.

Stoicism, the suppression of suffering, was presented as an intergenerational male strategy for navigating adversity in the community. Men from wartime eras were presented as tough and admirable for enduring hardship without complaint. Participants also gave accounts of how miner relatives had endured severe injuries such as broken hands but continued to work down the pit in order to get paid. These consecutive generations of men were revered by the participants and formed an idealised standard of masculinity within the community. This masculine standard is particularly important and entrenched within the community, as it is seen as being upheld by generations of men encompassing all living memory of the participants. This is in line with findings from Vickery (2021), who reported how individual communities of men develop their own masculine norms which can either be a barrier to, or promote, individual help-seeking for distress. For this community of men, the prevalent

masculine norms seem to be barriers to disclosing distress. This aligns with Gough and Novikova's (2020) cross-cultural literature review which found that men living in communities with greater proportions of traditionally male professions may be less likely to seek support. This was seen as being due to the men having greater exposure to dominant masculine norms. As former mining communities are defined by the male-dominated mining industry, men are likely to have experienced a particularly high exposure to the dominant masculine narratives of the time.

The implication of having a strong masculine standard within a community is that men who feel they are not adhering to the standard can experience self-stigma. The men in the present study felt compelled to replicate the attitudes of men who had lived through adversity, despite the relative peace of modern times. This suggests a strong need to conform, which in turn suggests an increased likelihood of self-stigma (Gough & Novikova, 2020). These findings are in line with Hammer et al. (2013), who found that the relationship between masculine norms and self-stigma in rural areas was twice as strong than for other areas. These findings develop the existing literature by providing an understanding of the unique constructs of masculinity which have developed in mining communities. Men from these communities may therefore be particularly resistant to talking therapies for mental health difficulties. The availability of alternative psychological support which aligns with the dominant constructs of masculinity may prove beneficial.

The third theme describes how men in former mining communities promote mental health support for others but would not access it themselves. The men were broadly positive about increasing mental health awareness, and many reported helping others with their mental health. This finding is in line with Wolstenholme (2024) who

found that young men were ambivalent towards accessing support but promoted this for others. Men not being willing to access support that they acknowledge is beneficial likely points towards conformity to masculine norms of stoicism (Gough & Novikova, 2020; Sheikh et al., 2024). Further, men in the current study describing how they took great lengths to support others with their mental health could be seen as another enactment of hegemonic male norms of leadership and problem solving (Gough & Novikova, 2020). Taken together, these findings suggest that attitudinal barriers are more important than structural barriers, in line with findings from Andrade et al. (2014). This is also evidence that the mental health risks associated with being a man living in a former mining community are modifiable (Courtenay, 2003).

The men reported that they believed societal attitudes towards mental health were becoming more accepting, and the men were positive about this. Younger generations were seen by the participants as more likely to seek mental health support than them due to a greater exposure to mental health discourse growing up. Contemporary research suggests that young men generally still report a strong need to conform to traditional masculine gender norms (Sheikh et al., 2024). It may be, however, that young men in former mining communities do not feel such pressure, but this was not the remit of the present study and young men were not interviewed. This may present an opportunity for further research.

Men in the community were presented as unable to express their feelings, which goes beyond choosing not to. This may mean that cultural and familial norms in the community are enacted from an early age, and men grow up without developing basic skills such as being able to recognise or communicate distress (Gough & Novikova, 2020). Indeed, the men did suggest that strategies to promote mental health support in

their demographic should target traditional male interests. This is in line with the existing literature which suggests that men have limited access to information about mental health and request 'male friendly' mental health literacy campaigns (Sheikh et al., 2024). The findings of the present study suggest that such strategies may be beneficial to men in former mining communities. Alternatively, some men reframe support seeking as adhering to masculine norms. Support seeking may be seen by these men as a method of regaining independence or solving a problem (Johnson et al., 2012). Masculinity-framed interventions aimed at specific groups of men have been found to facilitate support seeking in hard-to-reach groups of men (Gough & Novikova, 2020) and therefore may be beneficial to men in former mining communities.

The final theme described how peer pressure from other men in the community ensured that the community's masculine ideals were adhered to. The men reported that they were more concerned about the opinion of other men their age than any other group. This is in line with research suggesting that fear of criticism or rejection by other men is a key barrier in men's decisions to seek support (Gough & Novikova, 2020; Sagar-Ouriaghli et al., 2020). The men reported that they are more likely, although still reluctant, to disclose distress to female relatives or even strangers. This is in line with findings suggesting that men are more likely to seek support from trusted individuals and within trusted communities (Gough & Novikova, 2020).

The close-knit nature of a mining community was seen by the men as detrimental to mental health support seeking. This was due to fear of others within the community discovering that they had sought support for their mental health, thus deviating from the community's idealised masculine standard. This is in line with Vickery's (2021) findings, which suggested that certain communities have specific

cultural norms and practices which make it more difficult for men to seek support. The men also reported that they were reluctant to seek help from services situated within the community. This was because healthcare workers often lived within the community, and the men were distrustful of confidentiality policies being upheld. These findings provide a deeper understanding of some of the unique barriers preventing men in former mining communities from accessing mental health support. One potential recommendation based on these findings might be to involve respected members of the community in mental health initiatives, as this has been found to promote help seeking in men (Gough & Novikova, 2020). The availability of remote options of accessing treatment also seems beneficial, as this would allow the men to access support confidentially. A final consideration may be to provide a normative space for men in the community to discuss mental health, such as a male-only group. Spaces where it is clear that mental health is an acceptable topic for men have been found to facilitate male help-seeking (Gough & Novikova, 2020).

Limitations

One limitation of the study was that coding was undertaken solely by the lead researcher. This is relatively common in qualitative research (Creswell & Poth, 2018) but had specific implications for this study. As the lead researcher is a member of the target community, their unique experiences of the community had the potential to shape the coding of the data. One consideration that the lead author was mindful of was the assumption of understanding due to their lived experience (Aburn et al., 2021). This was managed by having reflected upon their position in a reflexive diary prior to data collection and critically discussing the coding process in research supervision with two experienced researchers outside of the target group (Noble & Smith, 2015). The data

was revisited frequently following supervision to minimise bias in coding and theme generation.

The lead author's membership of the target community also presented unique advantages and limitations for the recruitment process. Existing literature suggests that men are particularly concerned about judgment from other men if they were to deviate from perceived masculine gender roles (Gough & Novikova, 2020). As a male researcher, this may have been a barrier to recruitment, as men may have been apprehensive about discussing mental health with another man. This potential barrier was overcome with snowball sampling. Once a man had experienced the interview and had not been negatively evaluated, but instead had their experiences listened to without judgment, this led to recommendations to other men to participate. This suggests that talking about mental health, in a research setting at least, became normative when men were seen to engage with the process and were not negatively evaluated for doing so. The lead researcher's own 'insider' characteristics likely aided this process, as shared experiences and characteristics meant that rapport and trust were quickly built (Aburn et al., 2021). Whilst snowball sampling had potential to lead to an unrepresentative sample of men from mining communities, the demographic data collected does suggest a representative sample except for household income (Abreu & Jones, 2021). Household income was in line with the national average, whereby data from Abreu and Jones (2021) would suggest that this might be lower in former mining communities. The lead researcher's identity as a male may also have impacted the participant's responses during interview. As the findings of the study suggest that men are wary of judgment from other men within the community, this may have meant that the participants were more likely to uphold masculine norms during interview. Having said

this, the lead researcher is a member of a younger generation. The men reported in this study that they believed younger generations were more accepting of mental health than their generation, which may have led to more openness and therefore credible findings.

Areas of Future Research

The findings of the present study provide a rich account of the mental health experiences of a specific community of men. This contextual information will allow local services to better understand the needs of their target population and then design services and interventions with this in mind. In terms of former mining communities specifically, it may be valuable to understand the perspectives of younger men within the community. The participants in the present study believed that younger men in the community were accepting of mental health, and more willing to seek support than they were. Qualitative enquiry to explore this may further our understanding of how young men position themselves in relation to deep-rooted masculine norms within the community. It may also be beneficial to research men in the community who have previously sought mental health support. This would develop our understanding of what experiences lead to men seeking support, and how they then resume life in a community where men feel stigmatised for seeking help.

Future research into the experiences of other hard to reach groups of men will further develop our understanding of male mental health and hopefully make progress in facilitating men's help-seeking (Courtenay, 2002).

Conclusion

This study provides a rich understanding of the mental health experiences of a group of men from a community who are at risk of mental health difficulties and also resistant towards accessing support. The findings provide a unique narrative of how masculine ideals, such as stoicism, have developed over many generations of adversity in mining communities, and how this group of men feel both societal and individual pressure to conform to them. Male relationships were found to be very important factors for this group of men's mental health. The perceived loss of social cohesion and male camaraderie with the closure of the mines suggests that efforts to restore male-only spaces, such as support groups, where mental health discourse is normative may be beneficial. Another important finding was how the context of living within a tight-knit mining community can make men feel unable to disclose distress. Men felt that they could not deviate from the community values for fear of criticism or rejection, particularly from male peers. This was exacerbated by a perception that everybody knew each other, and any deviation would quickly become public knowledge. Efforts to promote confidential support and remote treatment options may therefore be beneficial to this community. Future research is recommended to explore similarly hard to reach groups of men's perceptions of mental health. It is hoped that mental health services and organisations covering former mining communities make efforts to meet the needs of men in these areas.

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CHAPTER FIVE: Portfolio Discussion and Critical Evaluation

Word count: 4810

Gender-specific research into mental health is a relatively new area of academic interest (Courtenay, 2002). Due to this, there are many gaps in the literature surrounding men's mental health. The most recent literature reviews concerning men's experiences of mental health and mental health support seeking have synthesised the limited pool of research conducted across multiple countries (Gough & Novikova, 2020; Sheikh et al., 2024). These reviews conclude that men's experiences of mental health vary dramatically based on their individual, familial, societal, occupational, and cultural characteristics and contexts. Further research focussed on the experiences of specific groups and communities of men is therefore required (Courtenay, 2002; Gough & Novikova, 2020).

This thesis portfolio sought to advance the understanding of the mental health experiences of specific groups of men. The two included studies focussed exclusively on the mental health experiences of men in the UK. The systematic review explored UK men's experiences of mental health support seeking. This ensured that all included studies would have been conducted within the context of the National Health Service (NHS), the UK's free at the point of access healthcare system. The empirical paper focussed on the mental health experiences of an under researched community of men who are theoretically at higher risk of mental health difficulties and suicide than men from outside of the community. Findings highlighted that men in the UK have varying experiences concerning mental health and support seeking, which broadly related to men's individual characteristics and cultural context. Overall, results highlighted the important role of masculinity, conformity, and stigma. Both studies demonstrated how important it is to understand how masculinity is defined and interacted with by specific groups of men, as this varied between groups. The empirical paper presented one

example of how a community of men constructed their own masculine ideals, and how this was maintained and reinforced within the community. Specific research such as this is likely to be useful for addressing health inequalities within the NHS on a local level by providing contextually bound recommendations.

This chapter discusses the results of both pieces of research, provides a critical evaluation of methodological strengths and weaknesses, overall clinical implications, and personal reflections concerning the research. Areas of future research will also be suggested.

Overview of findings

The systematic review synthesises primary qualitative research conducted in the UK of men's experiences of mental health support seeking. A total of 19 studies utilising various qualitative methods met the criteria, were included in the review, and were critically appraised.

The review highlighted that men's experiences of mental health support seeking varies greatly between different groups of men within the same nation. This aligns with research suggesting that even in individual communities, men's experiences of mental health and support differs (Gough & Novikova, 2020). Common challenges for men in the UK included a distrust of healthcare professionals. This was due to beliefs and experiences of having their emotional distress overlooked compared to others. This aligned with research suggesting that men's distress is often inadequately assessed by clinicians (Smith et al., 2018). Whilst not uniquely a male experience, long waiting lists, multiple referrals for support, and unsuitable service opening hours were commonly reported structural barriers to men seeking support. Existing research suggests that

attitudinal barriers are a more important factor than structural barriers in men's decisions to not seek help as an overall group (Andrade et al., 2014; Rice et al., 2020). Having said this, smaller groups of men(e.g. Spengler et al., 2023) may experience greater structural barriers which further highlights the need to understand the experiences and needs of specific groups of men. The perception that healthcare professionals in the UK overly medicalised mental health also prevented men seeking support, and this was especially true for global majority groups. Different countries and cultures construct and treat mental health in a variety of ways (Chakravarty, 2011). More primary research exploring the experiences of immigrants and refugees living in the UK, and how they interact with the UK construct and treatment of mental health, would therefore be useful.

Commonly reported facilitators of mental health support seeking in men included having loved ones. Men were either encouraged to seek professional support by trusted loved ones, or chose to do this themselves out of concern that loved ones would be troubled by their distress. These findings add to the existing literature suggesting that men are less likely to disclose emotional distress if they perceive they lack social contacts (Cleary, 2005; Willems et al., 2020). Being able to reframe help seeking as a masculine endeavour was a common facilitator of help seeking across men. This included narratives such as taking back control and improving skills to help others in similar positions which aligns with the findings of a recent systematic review suggesting that reframing a more fluid masculinity may boost help-seeking in men (Seidler et al., 2016).

Global majority groups living in the UK experienced more motivation to seek help from within their communities and from religious leaders than UK professional services. This aligns with a recent literature review which found that global majority groups in the UK did not understand their cultural and religious views surrounding mental health (Jacobs & Pentaris, 2021). More research is evidently needed to explore the experiences of individual global majority groups in the UK, from a wide range of different backgrounds, to understand their experiences of accessing UK services. Men generally also reported being more likely to seek help from men with similar characteristics or backgrounds. This was reported as being because they would feel understood but could also be a way of staying within perceived masculine norms. This finding was consistent with research suggesting that men are more likely to seek mental health support from trusted others or within trusted communities (Gough & Novikova, 2020).

Men felt unskilled regarding managing their mental health across groups which was discussed as primarily being due to differences in socialisation for men. Men were not able to recognise mental health symptoms, and when they did, they struggled to correctly define these or know where to go for appropriate support. This aligns with findings that men do not have the same opportunity to develop key skills due to the enactment of cultural masculine norms on boys from an early age (Gough & Novikova, 2020). Men were often reliant on female partners or family members to recognise they were struggling and either seek support for them or encourage them to do so. Existing research does suggest that women can be adversely impacted by men's poor coping strategies for their mental health (Furman, 2010). Men also struggled to talk about emotions and distress generally, preferring surface level conversations. When men tried to self-manage their mental health, this was often in unhelpful or risky ways such as

self-isolating or abusing alcohol. The current literature consistently outlines how men are more likely than women to choose coping methods for their mental health which are harmful to their health (Bilsker et al., 2018; Courtenay, 2003;Lynch et al., 2018; Singh et al., 2025).

Societal expectations regarding masculinity were commonly reported across groups of men. Whether men conformed to these constructs of masculinity varied greatly. Some men reported that help seeking for mental health difficulties would be stigmatised within their community, and others reported that self-stigma prevented them from seeking support. These findings align with recent reviews which suggest that gender norms and how men interact with these vary dramatically across cultures, communities, and individuals (Gough & Novikova; Sheikh et al., 2024). Some groups of men knew what the dominant masculine norms were, but did not feel pressure to adhere to these or rejected them outright. Further, if other men were seen as able to seek mental health support, this made help-seeking normative in some men's eyes regardless of wider societal beliefs. Research does suggest that if help-seeking is seen as normative within a community, this increase men's likelihood of seeking support (Gough & Novikova, 2020). Despite this, it was common for men to fear rejection, isolation, distrust, bullying, and other negative responses from other men if they were to deviate from the dominant masculine norms. The role of peer judgment was important in maintaining adherence to masculine norms in both the empirical paper and systematic review of this portfolio, as well as in the current literature (Gough & Novikova, 2020). Some men even reported adverse impacts on their careers should they seek help for their mental health, especially professional sportsmen. Further investigation into the mental health and help seeking experiences of sportsmen may be

warranted due to existing literature identifying a unique and adverse mental health culture in elite sports (Souter et al., 2018).

The empirical paper qualitatively explored the mental health experiences of a group of 45–64-year-old men living in former mining communities. This group of men were theoretically amongst the highest risk of mental health difficulties and suicide in the UK, and the least likely to seek support. Fifteen men who had never sought mental health support participated in semi-structured interviews to better understand the experiences of this group.

Thematic analysis resulted in four themes. These were 'the old hard life was better than the new hard life', 'stoicism as an intergenerational survival strategy', 'mental health is good for others, but not men like us', and 'peer pressure maintains the status quo'. The narrative of the men surrounding mental health was that life had always been hard within the community, but male camaraderie and social cohesion had been protective against mental health difficulties whilst the mines were open. Now men were increasingly isolated, and social media was seen as one factor highlighting the men's own adversity, which was detrimental for mental health (Sadagheyani & Tatari, 2021). Stoicism, the endurance of suffering without complaint, was presented as a male strategy passed down through generations which has helped men survive wars and the hardships of the mines. Masculine norms such as these are often suggested in the literature to be key factors in men's decisions to not seek help for their mental health (Seidler et al., 2016). The findings suggest that stoicism as a masculine norm was particularly deep-rooted in former mining communities, and that this may be why the men simultaneously held positive views surrounding mental health support for others but felt unable to access it themselves. This aligns with literature suggesting that

community values can directly and indirectly influence men's decisions to seek help or not (Gough & Novikova, 2020). Men were very willing to help others but were highly reluctant to deviant from masculine norms themselves. The masculine norms of the community seemed to be maintained through peer pressure. Men were highly worried about their peers rejecting them should they deviate from the norms. This aligns with recent research which suggests that self-stigma arises out of the stigmatising views of men's peer group and wider community (McKenzie et al., 2022). The study therefore provided a rich understanding of how the community constructed masculinity, how the men interacted with this, and what was maintaining the transmission of these values despite the societal changes that had occurred since the values were formed.

The thesis portfolio findings overall call for more research into the specific mental health experiences of individual groups of men (Courtenay, 2002). The systematic review highlighted that many groups of men in the UK have their own unique experiences and context surrounding mental health support seeking which warrant further exploration. These groups of men included, but were not limited to, global majority ethnic groups living in the UK, ex-army personnel, professional sportsmen, and prisoners. Men who had already accessed mental health support in the UK also had unique experiences which would benefit from further exploration, particularly within groups of men who are known to be resistant to help seeking. The empirical project provided a rich understanding of how mental health has been constructed over generations in former mining communities, and the challenges that mental health services now face in encouraging men from within the community to access support when needed. Taken together, the thesis portfolio presents evidence that gender specific exploration into mental health is worthwhile and important. Mental health

services and organisations will benefit from further primary research into the needs of the specific groups of men that they serve.

Critical Evaluation

The systematic review was conducted in a transparent and rigorous manner. It was pre-registered on PROSPERO which meant that the intent to conduct the review and proposed methodological process were available for other authors to view. The conduct of the systematic review also followed the ENTREQ guidelines (Tong et al., 2012) and PRISMA statement (Moher et al., 2009). Following these standardised guidelines helped ensure that the methodology was rigorous and replicable by other researchers.

The SPIDER tool was selected to develop the inclusion criteria and search strategy for the review. This was because the review was focussed specifically on qualitative research, and the SPIDER tool was designed in response to the quantitative focus of other tools (Methley et al., 2014). This is therefore a strength of the systematic review.

The use of the Critical Appraisal Skills Programme (CASP) to assess the quality of studies included in the systematic review had some strengths and limitations to consider. There are numerous quality appraisal tools available, and yet no standardised protocol for assessing the quality of qualitative research (Majid & Vanstone, 2018). Furthermore, the process of quality appraising research with a checklist tool, such as the CASP, aligns more with a positivist paradigm and is therefore arguably less meaningful in qualitative research (Williams et al., 2020). Nevertheless, quality

appraisal was an important step of the narrative synthesis procedure to ensure the findings of the synthesis were adequately robust (Popay et al., 2006).

The CASP has some advantages. It is the most widely used appraisal tool, is easy to interpret and apply, and it assesses the presence of important methodological processes in qualitative studies (Majid & Vanstone, 2018). During the quality appraisal process, however, some issues became clear. The CASP relies solely on the ability of the authors to accurately report their methodological processes (Long et al., 2020). As word limits of journals vary significantly, it is possible that studies which were otherwise conducted rigorously cannot fully describe their processes within the word count. This would lead to a less favourable CASP appraisal. The CASP has also been suggested to be less useful for assessing study validity than other tools, such as the Qualitative Assessment and Review Instrument (QARI) (Hannes et al., 2020). The QARI also has more of a focus on the congruity of a studies underpinning philosophy, methodology, and method, which the CASP seems to neglect the importance of (Majid & Vanstone, 2018). Finally, it was noticed that the consideration of a studies ethics was somewhat arbitrary from the CASP perspective. The CASP is more focussed on the presence of statements concerning whether a study has received ethical approval instead of how and to what extent ethics was considered in a study (Majid & Vanstone, 2018). Should the systematic review be conducted again, other appraisal tools such as the QARI would be considered, or the CASP would be modified to more appropriately consider study details such as ethics (Long et al., 2020).

The empirical paper was the first of its kind to explore the mental health experiences of men in former mining communities. Narrowly focussed studies such as this acknowledge the heterogenous nature of the male experience and provide rich

information about hard-to-reach clinical groups with identified risks (Courtenay, 2002; Courtenay, 2003). The empirical paper adds contextual information to the existing gender specific research and calls for more studies into the mental health experiences of specific groups of men.

The use of reflexive thematic analysis was a strength of the data collection and analysis process (Braun et al., 2022; Braun & Clarke, 2023). It allowed the lead researcher to reflect upon their own membership of the target community, to openly discuss preconceived assumptions in research supervision, and generate credible results as a collective effort. This led to the rich and detailed account of the men's experiences presented in the paper. An important consideration for the lead researcher was to ensure that the raw data was revisited following research supervision, as the perspectives of the two experienced supervisors were from outside of the target community and therefore provided alternative viewpoints from which to consider the data. This led to an iterative process of revisiting the coding and theme generation multiple times throughout the analysis stage, working towards an increasingly more objective, although still imperfect, presentation of the data's meaning. One aspect of the methodology which might be seen as a limitation is that the lead researcher conducted all interviews alone. The reason why this might be a limitation is that the lead researcher is male. Research, including the present portfolio, has established that men are particularly fearful of the judgment of other men in matters concerning masculinity (Sheikh et al., 2024; Gough & Novikova, 2020). It is therefore possible that the participants were more likely to present views and experiences which aligned with masculine norms, than if they were interviewed by a female researcher (Herron et al., 2020). It may even be that the empirical studies reliance on snowball sampling was due

to men being unwilling to discuss mental health with a male lead researcher, as the researcher's name was present on the recruitment posters. The lead author attempted to mitigate this likelihood by developing rapport with each participant prior to interview and ensuring that each participant understood that the research was confidential, and their quotes would not be identifiable in the final paper. The men were also aware of the research topic through the recruitment poster, and informed consent sheet. This ensured that the men felt able, and explicitly had permission, to talk about their experiences of mental health and anything related to this. Furthermore, the shared characteristics of the participants and lead researcher likely had a positive impact on developing rapport and trust (Abreu & Jones, 2021).

Implications and Further Research

The thesis portfolio has implications and recommendations for researchers, clinicians, and mental health services and organisations. For researchers, there is an evident need for more primary research into the mental health experiences of specific groups of men. This should start with groups of men who are identified as being most at risk of mental health difficulties, or least likely to access mental health services. Some research areas of interest which arose from the systematic review include primary research concerning the mental health experiences of male refugees in the UK (Byrow et al., 2019; Rae, 2014), men from global majority groups living in the UK (Robinson et al., 2011; Yalcin, 2020), and male prisoners in the UK (Cobb & Farrants, 2014; Howerton et al., 2007). Once primary research is available concerning the mental health experiences of specific groups of men in the UK, systematic reviews should be conducted to synthesis the knowledge base. In terms of research recommendations arising from the empirical paper, two such areas warrant further attention. First, men

living in former mining communities believed that young men within their community did not share their own ambivalence towards discussing mental health and accessing mental health support. First, research is needed to ascertain whether this is accurate. If so, it would be useful to understand how and why young men in former mining communities moved away from deep-rooted masculine norms as this deviates from recent evidence concerning young people (Sheikh et al., 2024). Further, it would also be useful to explore the experiences of men who have sought professional mental health experiences within former mining communities. This would also develop an understanding of what led to the decision to seek help amidst the context of strong community masculine norms, and how this affected, if at all, the man's membership of the community. This would add to the current empirical paper's findings and help local efforts to promote male help seeking.

The systematic review findings highlight the need for more primary research into the mental health experiences of specific groups of men in the UK. This could lead to contextually bound recommendations for mental health services who serve the communities where these men live. Some general suggestions that arose from the systematic review included being mindful that men's distress may present differently to women's distress. Clinicians in the UK may benefit from training surrounding men's mental health, self-stigma, and masculinity. Training surrounding the role of spirituality in mental health care may also benefit men from global majority groups and begin addressing structural racism within the NHS (Hatala, 2013). Other suggestions for mental health services might include exploring whether extended opening hours increase the access rate of men and other hard to reach groups. For men specifically, it may be worth considering the value of normative spaces for men to discuss emotions

when designing interventions. One suggestion might be to explore the benefit of support groups specifically for men (Cramer et al., 2014; Vickery, 2022). Such interventions should be designed with specific groups of men in mind to account for the variety of experiences men have as a group (Courtenay, 2002). Psychoeducation may also be generally beneficial to men in the UK, who reported feeling unskilled and lacking knowledge surrounding mental health. Further, campaigns to advertise mental health services which feature respected men, or men of a wide variety of backgrounds may be beneficial in promoting a normative culture surrounding male mental health.

The empirical paper provided recommendations specific to the context of former mining communities. Like the systemic review, the empirical paper provided a rationale for normative spaces within former mining communities for men to discuss mental health related issues. This was due to the empirical paper concluding that men in former mining communities valued male bonding and peer support, and that seeking help was seen as deviating from community held masculine values. Such groups would therefore provide an opportunity for men to feel that their distress was accepted by other men from within the community and would present an opportunity for social cohesion which was particularly important for these men (Abreu & Jones, 2020; Gough & Novikova, 2020). Any effort to promote male bonding seem likely to be welcomed by men from within the community. Interventions aligned with masculine values such as helping others or developing skills rather than talking may particularly benefit this community due to the strongly held masculine norms (Seidler et al., 2018). Alternatively, finding ways to align mental health awareness with male interests may be beneficial (Seidler et al., 2018). Participants spoke of how effective local football clubs had been in promoting spaces for men to talk about their mental health, for example. A

specific suggestion based on the close-knit nature of former mining communities was to consider providing remote options of accessing and receiving mental health treatment within these communities. The innovative use of technology, for example video conferencing, can be useful for enhancing service delivery in rural and remote areas (Dew et al., 2013). This would ensure that men felt safe seeking help without the social threat that a breach of confidentiality would cause.

The thesis portfolio presents implications for how Clinical Psychologists consider the role of masculinity and community identity within their work. Both aspects of identity are evidently important to men and greatly influence their decisions to talk about mental health and seek support. Clinical Psychologists would likely benefit from curiosity surrounding men's perspectives of gender norms, and how these fit or deviate from the norms of the wider community surrounding them. If a man is attending therapy, open and curious questions could be asked to gain insight into the client's perspective on these issues and then added into the formulation accordingly. As the findings of the portfolio conclude that men's perspectives vary broadly across and within groups, assumptions should not be made regarding an individual's beliefs based on physical or assumed characteristics. If a Clinical Psychologist is attempting to address health inequalities by designing services that appeal to men, a similar approach can be taken. Attempts to design services or produce promotional materials which are stereotypically 'masculine' should be avoided as this will alienate a significant proportion of any community. Instead, measures to understand the local demographics and their needs should be undertaken. It is likely that different methods will be needed for different groups of men even within the same community. Focus groups of specific groups of

men may help Clinical Psychologist understand the needs of these groups and to tailor provisions accordingly.

Intersectionality, and the importance of viewing different groups of men as having nuanced experiences is an important consideration for researchers and clinicians alike. The thesis portfolio demonstrates that many characteristics besides gender may influence a man's decision to seek mental health support. In the case of the empirical project, socioeconomic status and occupation are important influences on men's help-seeking decisions. The systematic review provides further evidence that age, ethnicity, religion, employment status, and many other characteristics interact with gender in men's help-seeking decisions. Gender should now therefore be researched in the context of specific additional characteristics which may impact men's decisions to seek, or not seek, mental health support. Some examples of intersectionality from the systematic review which seem to have important context include the help seeking experiences of south Asian men, refugee men, male prisoners, and army personnel to highlight but a few areas of potential further qualitative exploration.

Researchers should therefore consider investigating the experiences of men of different specific groups, to identify any unique experiences related to mental health support seeking that is not currently explored in the literature.

Personal Reflection

Using the 'social graces' framework to reflect upon personal characteristics and how they influence our professional roles can be a useful endeavour (Burnham & Nolte, 2019). Considering power and difference in relation to these characteristics, and how they operate, is also important (Birdsey & Kustner, 2021). My motivation to research

men's mental health, particularly in former mining communities, is rooted in my identity of being a white male from a working-class background. I have been aware for some time of the relative position of power that men hold within society. I grew up in a former mining community and was socialised into the masculine norms that many young boys are. It was not until much later that I began to realise that men are not infallible and invulnerable to life's struggles. The incongruency between the idealised version of men who never show signs of 'weaknesses', and the men I knew who had ended their own lives, or who were regularly abusing alcohol, became all too apparent. Maleness is one of the characteristics typically associated with relative power within society. Why then are men the highest risk group for suicide worldwide? Was it that masculinity, and adherence to masculine norms, was more important than biological sex in terms of power? Is it that the characteristic of 'class' is an important moderator, and that socioeconomically disadvantaged men have relatively less power? There is a convincing argument that the patriarchy oppresses vast groups of men as well as women, which might support the idea that 'class' is an important moderating characteristic (Grasmick et al., 1996). These are, however, questions well beyond the scope of this thesis portfolio. What we do know is that the association between maleness, or masculinity, and power is disadvantaging large numbers of men. Men are three to four times more likely than women to end their own lives worldwide (Varnik, 2012). Male distress is often overlooked or inadequately assessed by clinicians (Smith et al., 2018). Gender specific research surrounding mental health is also a recent area of interest and very little is still known about the mental health experiences of different groups of men (Courtenay, 2002). This may be due to incorrect assumptions that male mental health is less of a priority due to societally held beliefs of male resilience and

stoicism. My reasons for completing this portfolio are, therefore, to reject blanket categorisations of maleness and to explore the topic of male mental health with nuance from a place of compassion and curiosity.

I would also like to offer reflections on how my identity influenced the conduct of the empirical paper. I found myself thoroughly engaged with the research process, from conducting the interviews to analysing the data. I believe that my motivation came from not only an academic interest, but a personal interest. I had bracketed my preconceptions concerning the research findings in my reflexive diary prior to data collection. This was to reduce the likelihood of my own experiences of the community interfering with the research process (Tufford & Newman, 2012). As it transpired, my preconceptions were mostly unfounded. For one, I had not expected men to hold such positive views of mental health generally. I only had my own experience of not hearing men discuss emotions growing up and never hearing about men accessing support for their mental health. I hope I can be forgiven for assuming that the men would report disdain for mental health as a concept based on my experience. The nuance and conflict within the men's experiences increases my compassion for them, further highlighting why I believe it is important that we take the time to explore men's experiences on a very small scale, rather than making sweeping generalisations about the male experience. For example, understanding that men in the community recognised the benefit of mental health awareness and support but felt unable to access it due to deep-rooted community norms and peer pressure elicits compassion and a desire to support, rather than overlook, this group. As I was interviewing men and uncovering these surprising (to me at least) views, I felt that my genuine curiosity led to excellent semi-structured interviews, and many follow-up questions (Adams, 2015). On

a personal note, it was also nice to hear that what I do for a career as a mental health professional is valued by men in communities like where I grew up. Perhaps I, too, had been concerned about deviating from the norms of my community.

The rigour in which I conducted the research was borne out of a desire to accurately represent the experiences of the men. There were lengthy discussions in research supervision, for example, surrounding the order in which the themes were presented, leading to numerous amendments. Even the title of the empirical project was scrutinised. One title was particularly controversial and was considered from multiple angles by the research team. A participant had described how his brothers would dismiss any attempts to disclose his feelings with 'get a pint down ya and shut up'. This was considered as part of the title, as it captured one of the key themes surrounding peer pressure to adhere to community masculine norms. Ultimately it was decided to omit this title, as there was a small possibility that it could be construed as advocating the suppression of male distress. This was very unlikely, but my compassion towards the target group meant that accurate representation was more important than an attention-grabbing title.

Conclusion

This thesis portfolio sought to develop the gender-specific literature surrounding men's experiences of mental health and mental health support seeking in the UK. The systematic review provided the experience of men seeking mental health support in the UK. Various barriers and motivators to help seeking were highlighted across different groups of UK men, as well as their experiences of poor mental health literacy and the role of societally held masculine norms and how they interacted with these. Some

groups of men reported unique help seeking experiences to their group, which suggests that more primary research into specific groups of UK men is needed. The empirical paper presented a qualitative exploration into the mental health experiences of a specific group of men living in former mining communities. This provided a rich narrative surrounding how masculine norms were formed with the community, how men in the community feel unable to express distress due to these norms, and how peer pressure from men within the community keeps these attitudes going. It is therefore evident that much more research is needed concerning the mental health experiences of specific groups of men in the UK.

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Appendices

Appendix A: Author Submission Guidelines for Psychology of Men & Masculinities

Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). **Please include your submission's word count on the title page.**

If Microsoft Word Track Changes was used in preparing the manuscript, please execute the "accept all changes" procedure, and remove all comments prior to submission.

Psychology of Men & Masculinities is now using a software system to screen submitted content for similarity with other published content. The system compares the initial version of each submitted manuscript against a database of 40+ million scholarly documents, as well as content appearing on the open web. This allows APA to check submissions for potential overlap with material previously published in scholarly journals (e.g., lifted or republished material).

If you are submitting a literature review, please read the Literature Review Guidelines.

Manuscripts for *Psychology of Men & Masculinities* may be regular-length submissions (7,500 words, not including references, tables, or figures) or brief reports (2,500 words, not including references, tables, or figures). Please include your submission's word count on the title page.

Psychology of Men & Masculinities requires all manuscripts to comply with guidelines on equity, diversity, and inclusion (EDI). Read our EDI guidelines before submitting your manuscript.

Masked Review Policy

Psychology of Men & Masculinities uses a masked review process.

Each copy of a manuscript should include a separate title page with author names and affiliations, and these should not appear anywhere else on the manuscript. The first page of the manuscript should include only the title of the manuscript and the date it is submitted. Footnotes containing information pertaining to the authors' identity or affiliations should be removed.

Every effort should be made to see that the manuscript itself contains no clues to the authors' identity.

Please ensure that the final version for production includes a byline and full author note for typesetting.

Manuscript Preparation

Prepare manuscripts according to the *Publication Manual of the American Psychological Association*using the 7th edition. Manuscripts may be copyedited for bias-free language (see Chapter 5 of the *Publication Manual*).

Review APA's Journal Manuscript Preparation Guidelines before submitting your article.

Double-space all copy. Other formatting instructions, as well as instructions on preparing tables, figures, references, metrics, and abstracts, appear in the *Manual*.

Additional guidance on APA Style is available on the APA Style website.

Below are additional instructions regarding the preparation of display equations, computer code, and tables.

Display Equations

We strongly encourage you to use MathType (third-party software) or Equation Editor 3.0 (built into pre-2007 versions of Word) to construct your equations, rather than the equation support that is built into Word 2007 and Word 2010. Equations composed with the built-in Word 2007/Word 2010 equation support are converted to low-resolution graphics when they enter the production process and must be rekeyed by the typesetter, which may introduce errors.

To construct your equations with MathType or Equation Editor 3.0:

Go to the Text section of the Insert tab and select Object.

Select MathType or Equation Editor 3.0 in the drop-down menu.

If you have an equation that has already been produced using Microsoft Word 2007 or 2010 and you have access to the full version of MathType 6.5 or later, you can convert this equation to MathType by clicking on MathType Insert Equation. Copy the equation from Microsoft Word and paste it into the MathType box. Verify that your equation is correct, click File, and then click Update. Your equation has now been inserted into your Word file as a MathType Equation.

Use Equation Editor 3.0 or MathType only for equations or for formulas that cannot be produced as Word text using the Times or Symbol font.

Computer Code

Because altering computer code in any way (e.g., indents, line spacing, line breaks, page breaks) during the typesetting process could alter its meaning, we treat computer code differently from the rest of your article in our production process. To that end, we request separate files for computer code.

In Online Supplemental Material

We request that runnable source code be included as supplemental material to the article. For more information, visit Supplementing Your Article With Online Material.

In the Text of the Article

If you would like to include code in the text of your published manuscript, please submit a separate file with your code exactly as you want it to appear, using Courier New font with a type size of 8 points. We will make an image of each segment of code in your article that exceeds 40 characters in length. (Shorter snippets of code that appear in text will be typeset in Courier New and run in with the rest of the text.) If an appendix contains a mix of code and explanatory text, please submit a file that contains the entire appendix, with the code keyed in 8-point Courier New.

Tables

Use Word's Insert Table function when you create tables. Using spaces or tabs in your table will create problems when the table is typeset and may result in errors.

Equity, Diversity, and Inclusion

Psychology of Men & Masculinities requires all manuscripts to comply with equity, diversity, and inclusion guidelines.

Participant description

Authors are encouraged to include a description of the study participants in the Method section of each empirical report, including (but not limited to) the following:

Sex/Gender

Race/Ethnicity

Age

Nativity or immigration history

Socioeconomic status

Any other relevant demographics (e.g., disability status; sexual orientation)

In the discussion section of the manuscript, authors are encouraged to discuss the diversity of their study samples and the generalizability of their findings.

Academic Writing and English Language Editing Services

Authors who feel that their manuscript may benefit from additional academic writing or language editing support prior to submission are encouraged to seek out such services at their host institutions, engage with colleagues and subject matter experts, and/or consider several vendors that offer discounts to APA authors.

Please note that APA does not endorse or take responsibility for the service providers listed. It is strictly a referral service.

Use of such service is not mandatory for publication in an APA journal. Use of one or more of these services does not guarantee selection for peer review, manuscript acceptance, or preference for publication in any APA journal.

Submitting Supplemental Materials

APA can place supplemental materials online, available via the published article in the APA PsycArticles® database. Please see Supplementing Your Article With Online Material for more details.

Abstract and Keywords

All manuscripts must include an abstract containing a maximum of 250 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

Public Significance Statements

Authors submitting manuscripts to *Psychology of Men & Masculinities* are required to provide 2–3 brief sentences regarding the public significance of the study or meta-analysis described in their paper. This description should be included within the manuscript on the abstract/keywords page, but in a separate paragraph from the abstract and keywords. It should be written in language that is easily understood by both professionals and members of the lay public.

When an accepted paper is published, these sentences will be boxed beneath the abstract for easy accessibility. All such descriptions will also be published as part of the Table of Contents, as well as on the journal's web page. This new policy is in keeping with efforts to increase dissemination and usage by larger and diverse audiences.

Examples of these 2–3 sentences include the following:

"A brief cognitive–behavioral intervention for caregivers of children undergoing hematopoietic stem cell transplant reduced caregiver distress during the transplant hospitalization. Long-term effects on caregiver distress were found for more anxious caregivers as well as caregivers of children who developed graft-versus-host disease after the transplant."

"Inhibitory processes, particularly related to temporal attention, may play a critical role in response to exposure therapy for posttraumatic stress disorder (PTSD). The main finding that individuals with PTSD who made more clinical improvement showed faster improvement in inhibition over the course of exposure therapy supports the utility of novel therapeutic interventions that specifically target attentional inhibition and better patient-treatment matching."

"When children participated in the enriched preschool program Head Start REDI, they were more likely to follow optimal developmental trajectories of social–emotional functioning through third grade. Ensuring that all children living in poverty have access to high-quality preschool may be one of the more effective means of reducing disparities in school readiness and increasing the likelihood of lifelong success."

To be maximally useful, these statements of public health significance should not simply be sentences lifted directly from the manuscript.

They are meant to be informative and useful to any reader. They should provide a bottom-line, take-home message that is accurate and easily understood. In addition, they should be able to be translated into media-appropriate statements for use in press releases and on social media.

Prior to final acceptance and publication, all public health significance statements will be carefully reviewed to make sure they meet these standards. Authors will be expected to revise statements as necessary.

Constraints on Generality

In a subsection of the discussion titled "Constraints on Generality," authors are encouraged to include a detailed discussion of the limits on generality (see Simons, Shoda, & Lindsay, 2017). In this section, authors should detail grounds for concluding that results are specific to characteristics of the participants and address limits on generality not only for participants but for materials, procedures, and context. They should also specify which methods the authors think could be varied without affecting the result and which should remain constant.

References

List references in alphabetical order. Each listed reference should be cited in text, and each text citation should be listed in the References section.

Examples of basic reference formats:

Journal Article

McCauley, S. M., & Christiansen, M. H. (2019). Language learning as language use: A cross-linguistic model of child language development. *Psychological Review*, *126*(1), 1–51. https://doi.org/10.1037/rev0000126

Authored Book

Brown, L. S. (2018). *Feminist therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/0000092-000

Chapter in an Edited Book

Balsam, K. F., Martell, C. R., Jones. K. P., & Safren, S. A. (2019). Affirmative cognitive behavior therapy with sexual and gender minority people. In G. Y. Iwamasa & P. A. Hays (Eds.), *Culturally responsive cognitive behavior therapy: Practice and supervision* (2nd ed., pp. 287–314). American Psychological Association. https://doi.org/10.1037/0000119-012

Figures

Preferred formats for graphics files are TIFF and JPG, and preferred format for vector-based files is EPS. Graphics downloaded or saved from web pages are not acceptable for publication. Multipanel figures (i.e., figures with parts labeled a, b, c, d, etc.) should be assembled into one file. When possible, please place symbol legends below the figure instead of to the side.

Resolution

All color line art and halftones: 300 DPI

Black and white line tone and gray halftone images: 600 DPI

Line weights

Adobe Photoshop images

Color (RGB, CMYK) images: 2 pixels

Grayscale images: 4 pixels

Adobe Illustrator Images

Stroke weight: 0.5 points

APA offers authors the option to publish their figures online in color without the costs associated with print publication of color figures.

The same caption will appear on both the online (color) and print (black and white) versions. To ensure that the figure can be understood in both formats, authors should add alternative wording (e.g., “the red (dark gray) bars represent”) as needed.

For authors who prefer their figures to be published in color both in print and online, original color figures can be printed in color at the editor's and publisher's discretion provided the author agrees to pay:

$900 for one figure

An additional $600 for the second figure

An additional $450 for each subsequent figure

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Starting in August 2017, articles are eligible for open science badges recognizing publicly available data, materials, and/or preregistration plans and analyses. These badges are awarded on a self-disclosure basis.

At submission, authors must confirm that criteria have been fulfilled in a signed badge disclosure form (PDF, 33KB) that must be submitted as supplemental material. If all criteria are met as confirmed by the editor, the form will then be published with the article as supplemental material.

Authors should also note their eligibility for the badge(s) in the cover letter.

For all badges, items must be made available on an open-access repository with a persistent identifier in a format that is time-stamped, immutable, and permanent. For the preregistered badge, this is an institutional registration system.

Data and materials must be made available under an open license allowing others to copy, share, and use the data, with attribution and copyright as applicable.

Available badges are:

Open Data:

All data necessary to reproduce the reported results that are digitally shareable are made publicly available. Information necessary for replication (e.g., codebooks or metadata) must be included.

Open Materials:

All materials necessary to reproduce the reported results that are digitally shareable, along with descriptions of non-digital materials necessary for replication, are made publicly available.

Preregistered:

At least one study's design has been preregistered with descriptions of (a) the

research design and study materials, including the planned sample size; (b) the motivating research question or hypothesis; (c) the outcome variable(s); and (d) the predictor variables, including controls, covariates, and independent variables. Results must be fully disclosed. As long as they are distinguished from other results in the article, results from analyses that were not preregistered may be reported in the article.

Preregistered+Analysis Plan:

At least one study's design has been preregistered along with an analysis plan for the research — and results are recorded according to that plan.

Note that it may not be possible to preregister a study or to share data and materials. Applying for open science badges is optional.

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It is a violation of APA Ethical Principles to publish "as original data, data that have been previously published" (Standard 8.13).

In addition, APA Ethical Principles specify that "after research results are published, psychologists do not withhold the data on which their conclusions are based from other competent professionals who seek to verify the substantive claims through reanalysis and who intend to use such data only for that purpose, provided that the confidentiality of the participants can be protected and unless legal rights concerning proprietary data preclude their release" (Standard 8.14).

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Authors are required to state in writing that they have complied with APA ethical standards in the treatment of their sample, human or animal, or to describe the details of treatment.

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The APA Ethics Office provides the full Ethical Principles of Psychologists and Code of Conduct electronically on its website in HTML, PDF, and Word format. You may

also request a copy by emailing or calling the APA Ethics Office (202-336-5930). You may also read "Ethical Principles," December 1992, *American Psychologist*, Vol. 47, pp. 1597–1611.

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Appendix B: Enhancing Transparency in Reporting the Synthesis of Qualitative Research: the ENTREQ statement

No	Item	Guide and description
1	Aim	State the research question the synthesis addresses.
2	Synthesis methodology	Identify the synthesis methodology or theoretical framework which underpins the synthesis, and describe the rationale for choice of methodology *(e.g. meta-ethnography, thematic synthesis, critical interpretive synthesis, grounded theory synthesis, realist synthesis, meta-aggregation, meta-study, framework synthesis).*
3	Approach to searching	Indicate whether the search was pre-planned (*comprehensive search strategies to seek all available studies)* or iterative (*to seek all available concepts until they theoretical saturation is achieved).*
4	Inclusion criteria	Specify the inclusion/exclusion criteria *(e.g. in terms of population, language, year limits, type of publication, study type).*
5	Data sources	Describe the information sources used (e.g. *electronic databases (MEDLINE, EMBASE, CINAHL, psycINFO, Econlit), grey literature databases (digital thesis, policy reports), relevant organisational websites, experts, information specialists, generic web searches (Google Scholar) hand searching, reference lists)* and when the searches conducted; provide the rationale for using the data sources.
6	Electronic Search strategy	Describe the literature search *(e.g. provide electronic search strategies with population terms, clinical or health topic terms, experiential or social phenomena related terms, filters for qualitative research, and search limits).*
7	Study screening methods	Describe the process of study screening and sifting *(e.g. title, abstract and full text review, number of independent reviewers who screened studies).*
8	Study characteristics	Present the characteristics of the included studies *(e.g. year of publication, country, population, number of participants, data collection, methodology, analysis, research questions).*

No	Item	Guide and description
9	Study selection results	Identify the number of studies screened and provide reasons for study exclusion *(e,g, for comprehensive searching, provide numbers of studies screened and reasons for exclusion indicated in a figure/flowchart; for iterative searching describe reasons for study exclusion and inclusion based on modifications t the research question and/or contribution to theory development).*
10	Rationale for appraisal	Describe the rationale and approach used to appraise the included studies or selected findings *(e.g. assessment of conduct (validity and robustness), assessment of reporting (transparency), assessment of content and utility of the findings).*
11	Appraisal items	State the tools, frameworks and criteria used to appraise the studies or selected findings *(e.g. Existing tools: CASP, QARI, COREQ, Mays and Pope* [25]*; reviewer developed tools; describe the domains assessed: research team, study design, data analysis and interpretations, reporting).*
12	Appraisal process	Indicate whether the appraisal was conducted independently by more than one reviewer and if consensus was required.
13	Appraisal results	Present results of the quality assessment and indicate which articles, if any, were weighted/excluded based on the assessment and give the rationale.
14	Data extraction	Indicate which sections of the primary studies were analysed and how were the data extracted from the primary studies? *(e.g. all text under the headings "results /conclusions" were extracted electronically and entered into a computer software).*
15	Software	State the computer software used, if any.
16	Number of reviewers	Identify who was involved in coding and analysis.
17	Coding	Describe the process for coding of data *(e.g. line by line coding to search for concepts).*
18	Study comparison	Describe how were comparisons made within and across studies *(e.g. subsequent studies were coded into pre-existing concepts, and new concepts were created when deemed necessary).*
19	Derivation of themes	Explain whether the process of deriving the themes or constructs was inductive or deductive.

No	Item	Guide and description
20	Quotations	Provide quotations from the primary studies to illustrate themes/constructs, and identify whether the quotations were participant quotations of the author's interpretation.
21	Synthesis output	Present rich, compelling and useful results that go beyond a summary of the primary studies (e.g. *new interpretation, models of evidence, conceptual models, analytical framework, development of a new theory or construct)*.

Appendix C: Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist

Section and Topic	Item #	Checklist item	Location where item is reported
TITLE			
Title	1	Identify the report as a systematic review.	p.14
ABSTRACT			
Abstract	2	See the PRISMA 2020 for Abstracts checklist.	p.15
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of existing knowledge.	p.17-19
Objectives	4	Provide an explicit statement of the objective(s) or question(s) the review addresses.	p.19
METHODS			
Eligibility criteria	5	Specify the inclusion and exclusion criteria for the review and how studies were grouped for the syntheses.	p.22
Information sources	6	Specify all databases, registers, websites, organisations, reference lists and other sources searched or consulted to identify studies. Specify the date when each source was last searched or consulted.	p.21-22
Search strategy	7	Present the full search strategies for all databases, registers and websites, including any filters and limits used.	p.21
Selection process	8	Specify the methods used to decide whether a study met the inclusion criteria of the review, including how many reviewers screened each record and each report retrieved, whether they worked independently, and if applicable, details of automation tools used in the process.	p.23
Data collection process	9	Specify the methods used to collect data from reports, including how many reviewers collected data from each report, whether they worked independently, any processes for obtaining or confirming data from study investigators, and if applicable, details of automation tools used in the process.	p.23-25
Data items	10a	List and define all outcomes for which data were sought. Specify whether all results that were compatible with each outcome domain in each study were sought (e.g. for all measures, time points, analyses), and if not, the methods used to decide which results to collect.	p.25-26
	10b	List and define all other variables for which data were sought (e.g. participant and intervention characteristics, funding sources). Describe any assumptions made about any missing or unclear information.	p.25-26
Study risk of bias assessment	11	Specify the methods used to assess risk of bias in the included studies, including details of the tool(s) used, how many reviewers assessed each study and whether they worked independently, and if applicable, details of automation tools used in the process.	p.37-38
Effect measures	12	Specify for each outcome the effect measure(s) (e.g. risk ratio, mean difference) used in the synthesis or presentation of results.	N/A for qualitative narrative synthesis
Synthesis methods	13a	Describe the processes used to decide which studies were eligible for each synthesis (e.g. tabulating the study intervention characteristics and comparing against the planned groups for each synthesis (item #5)).	p.25
	13b	Describe any methods required to prepare the data for presentation or synthesis, such as handling of missing summary statistics, or data conversions.	N/A for qualitative

Section and Topic	Item #	Checklist item	Location where item is reported
			narrative synthesis
	13c	Describe any methods used to tabulate or visually display results of individual studies and syntheses.	p.28-36
	13d	Describe any methods used to synthesize results and provide a rationale for the choice(s). If meta-analysis was performed, describe the model(s), method(s) to identify the presence and extent of statistical heterogeneity, and software package(s) used.	p.25-27
	13e	Describe any methods used to explore possible causes of heterogeneity among study results (e.g. subgroup analysis, meta-regression).	N/A for qualitative narrative synthesis
	13f	Describe any sensitivity analyses conducted to assess robustness of the synthesized results.	N/A for qualitative narrative synthesis
Reporting bias assessment	14	Describe any methods used to assess risk of bias due to missing results in a synthesis (arising from reporting biases).	N/A for qualitative narrative synthesis
Certainty assessment	15	Describe any methods used to assess certainty (or confidence) in the body of evidence for an outcome.	N/A for qualitative narrative synthesis
RESULTS			
Study selection	16a	Describe the results of the search and selection process, from the number of records identified in the search to the number of studies included in the review, ideally using a flow diagram.	p.24
	16b	Cite studies that might appear to meet the inclusion criteria, but which were excluded, and explain why they were excluded.	p.24
Study characteristics	17	Cite each included study and present its characteristics.	p.29-36
Risk of bias in studies	18	Present assessments of risk of bias for each included study.	N/A
Results of individual studies	19	For all outcomes, present, for each study: (a) summary statistics for each group (where appropriate) and (b) an effect estimate and its precision (e.g. confidence/credible interval), ideally using structured tables or plots.	N/A
Results of syntheses	20a	For each synthesis, briefly summarise the characteristics and risk of bias among contributing studies.	p.37-38 and p.55
	20b	Present results of all statistical syntheses conducted. If meta-analysis was done, present for each the summary estimate and its precision (e.g.	p.39-49

Section and Topic	Item #	Checklist item	Location where item is reported
		confidence/credible interval) and measures of statistical heterogeneity. If comparing groups, describe the direction of the effect.	
	20c	Present results of all investigations of possible causes of heterogeneity among study results.	N/A for qualitative narrative synthesis
	20d	Present results of all sensitivity analyses conducted to assess the robustness of the synthesized results.	N/A for qualitative narrative synthesis
Reporting biases	21	Present assessments of risk of bias due to missing results (arising from reporting biases) for each synthesis assessed.	N/A for qualitative narrative synthesis
Certainty of evidence	22	Present assessments of certainty (or confidence) in the body of evidence for each outcome assessed.	N/A for qualitative narrative synthesis
DISCUSSION			
Discussion	23a	Provide a general interpretation of the results in the context of other evidence.	p.49-55
	23b	Discuss any limitations of the evidence included in the review.	p.37-38 and p.55
	23c	Discuss any limitations of the review processes used.	p.54-55
	23d	Discuss implications of the results for practice, policy, and future research.	p.49-57
OTHER INFORMATION			
Registration and protocol	24a	Provide registration information for the review, including register name and registration number, or state that the review was not registered.	p.20
	24b	Indicate where the review protocol can be accessed, or state that a protocol was not prepared.	p.20
	24c	Describe and explain any amendments to information provided at registration or in the protocol.	N/A
Support	25	Describe sources of financial or non-financial support for the review, and the role of the funders or sponsors in the review.	N/A
Competing interests	26	Declare any competing interests of review authors.	N/A
Availability of data, code and other materials	27	Report which of the following are publicly available and where they can be found: template data collection forms; data extracted from included studies; data used for all analyses; analytic code; any other materials used in the review.	N/A

Appendix D: Search strategy

S (Sample) – UK Men
P of I (Phenomenon of Interest) – Support seeking
D (Design) – Qualitative or Mixed Methods
E (Evaluation) – Experiences or attitudes
R (Research Type) – Thematic Analyses, IPA

(experiences or perceptions or attitudes or views or feelings or qualitative or perspective) AND (male or men or man or males) AND ("united kingdom" or uk or britain or scotland or england or wales or northern ireland) AND ("mental health" or "mental illness" or "mental disorder" or "psychiatric illness") AND ("help seeking" or "support seeking" or "treatment seeking")

Appendix E: Example of a completed CASP

CASP Checklist:
For Qualitative Research

Reviewer Name:	Aaron Howard, Alistair Page, and Sophie Gennery
Paper Title:	Do depressed and anxious men do groups? What works and what are the barriers to help seeking?
Author:	Helen Cramer, Jeremy Horwood, Sarah Payne, Ricardo Araya, Helen Lester and Chris Salisbury.
Web Link:	
Appraisal Date:	20/12/2024

During critical appraisal, never make assumptions about what the researchers have done. If it is not possible to tell, use the "Can't tell" response box. If you can't tell, at best it means the researchers

have not been explicit or transparent, but at worst it could mean the researchers have not undertaken a particular task or process. Once you've finished the critical appraisal, if there are a large number of "Can't tell" responses, consider whether the findings of the study are trustworthy and interpret the results with caution.

Section A Are the results valid?	
1. Was there a clear statement of the aims of the research?	☐Yes There was a clear statement of the aims of the research. The goal of the study was to explore the experiences of men with depression and anxiety in relation to group interventions, including their acceptability, perceived benefits, and barriers to participation. The study emphasised the importance of addressing men's underrepresentation in mental health services and highlighted the stigma and cultural barriers men face in seeking support. This addressed a gap in research concerning how group-based interventions can be tailored to better meet the needs of men, potentially informing policy and practice improvements in mental health services. In summary, the study's aims were clearly stated, justified, and relevant to addressing a significant issue in mental health care.
CONSIDER: • *what was the goal of the research?* • *why was it thought important?* • *its relevance*	
2. Is a qualitative methodology appropriate?	☐Yes The research aimed to interpret and explore the subjective experiences of men with depression and anxiety in relation to group interventions. This focus on understanding participants' perspectives, feelings, and actions lends well to the strengths of qualitative methods. The methodology allowed for in-depth exploration of the acceptability, benefits, and barriers of group participation, which could not have been captured as effectively through quantitative research methodology.

	Therefore, qualitative research was well-suited to achieving the research goal.
CONSIDER: • *If the research seeks to interpret or illuminate the actions and/or subjective experiences of research participants* • *Is qualitative research the right methodology for addressing the research goal?*	
3. Was the research design appropriate to address the aims of the research?	Yes Both men attending groups and the professionals who worked with depressed men were interviewed. The research design has elements that suggest appropriateness, such as using interviews, observations, and a mapping exercise to explore men's experiences with groups for depression and anxiety. However, there is a lack of evidence in the paper to determine whether the researchers fully justified their design choices. The rationale behind selecting these specific methods or addressing potential limitations in their design is not thoroughly discussed. The authors acknowledge some strengths and weaknesses, such as exploring an under-researched topic with a combined methodology and the limitations of the PHQ-9 tool.
CONSIDER: • *if the researcher has justified the research design (e.g., have they discussed how they decided which method to use)*	
4. Was the recruitment strategy appropriate to the aims of the research?	☐Yes The researchers explained how participants were selected using diverse methods, including inviting group attendees, searching medical records, and advertising in local media. This captured a wide range of perspectives and aligned with the study's aims. They justified why these participants were suitable for understanding barriers and benefits of group participation. However, the study provided limited discussion on why some declined to take part, though this did not significantly detract from the overall recruitment approach.
CONSIDER: • *If the researcher has explained how the participants were selected* • *If they explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study* • *If there are any discussions around recruitment (e.g. why some people chose not to take part)*	
5. Was the data collected in a way that addressed the research issue?	☐Yes

	The settings, including interviews, group observations, and a mapping exercise, were justified and suitable for exploring men's experiences with mental health groups. However, these groups were limited to a single city (Bristol). The methods were clearly described: semi-structured interviews used a topic guide, and group observations were recorded through notetaking and audio recordings. These methods were well-justified, with the combination allowing for sound examination of the topic. While the researchers did not explicitly discuss whether methods were modified during the study, the forms of data collected (audio recordings and notes) were clearly outlined. Data saturation was not explicitly mentioned, but the mapping exercise ended when no new themes emerged, implying acknowledgment of saturation. Considering the above, the chosen methods and settings were appropriate and clearly detailed.
CONSIDER: • *If the setting for the data collection was justified* • *If it is clear how data were collected (e.g. focus group, semi-structured interview etc.)* • *If the researcher has justified the methods chosen* • *If the researcher has made the methods explicit (e.g. for interview method, is there an indication of how interviews are conducted, or did they use a topic guide)* • *If methods were modified during the study. If so, has the researcher explained how and why* • *If the form of data is clear (e.g. tape recordings, video material, notes etc.)* • *If the researcher has discussed saturation of data*	
6. Has the relationship between researcher and participants been adequately considered?	No The study states that all data collection was conducted by a single female researcher (H.C.) and ethical approval was obtained. However, there is no critical examination of the researcher's role, potential bias, or influence during the formulation of research questions or data collection. While recruitment strategies and choice of location are described, the study does not discuss how the researcher's role or identity might have impacted participants' responses.

	Although semi-structured interviews and observations suggest the researcher's responsiveness to events, there is no discussion of how the researcher managed potential bias or managed unanticipated circumstances. The study does not address whether the researcher considered the implications of any changes to the research design. This lack of information makes it difficult to assess how well the researcher addressed their relationship with participants.
CONSIDER: • *If the researcher critically examined their own role, potential bias and influence during (a) formulation of the research questions (b) data collection, including sample recruitment and choice of location* • *How the researcher responded to events during the study and whether they considered the implications of any changes in the research design*	
Section B: What are the results?	
7. Have ethical issues been taken into consideration?	☐ Yes Ethical issues were addressed appropriately. The study explains that participants were given written and verbal information about the research before providing informed consent, ensuring they understood their involvement. Ethical approval was obtained from the 'South West 4' committee (10/H0102/47), and group consent was also required for observations, with participants having the option to decline. However, the study provides limited details about how confidentiality was maintained or how potential distress or effects on participants during or after the study were managed.
CONSIDER: • *If there are sufficient details of how the research was explained to participants for the reader to assess whether ethical standards were maintained* • *If the researcher has discussed issues raised by the study (e.g. issues around informed consent or confidentiality or how they have handled the effects of the study on the participants during and after the study)* • *If approval has been sought from the ethics committee*	

8. Was the data analysis sufficiently rigorous?	☐Yes The data analysis is sound, with a clear description of the process, using thematic analysis and constant comparison. The coding framework was developed from transcripts, refined iteratively, and verified by another researcher to strengthen the analysis. Thematic derivation is well-supported by quotes, ensuring transparency. Sufficient data, including interview and observation excerpts, are provided to support the identified themes. However, the analysis lacks any discussion of contradictory data and how it was handled, which limits the depth of the critique. Additionally, while steps for reliability were taken, there is no detailed reflection on the researcher's potential bias or influence. Generally, the analysis is well-supported, but greater critical reflection on bias and contradictory data could have been beneficial.
CONSIDER: • *If there is an in-depth description of the analysis process* • *If thematic analysis is used. If so, is it clear how the categories/themes were derived from the data* • *Whether the researcher explains how the data presented were selected from the original sample to demonstrate the analysis process* • *If sufficient data are presented to support the findings* • *To what extent contradictory data are taken into account* • *Whether the researcher critically examined their own role, potential bias and influence during analysis and selection of data for presentation*	
9. Is there a clear statement of findings?	☐Yes The study provides a clear statement of findings with themes such as isolation, social benefits of groups, and barriers to help-seeking being clearly articulated and supported by evidence, including quotes from participants and detailed observations. There is good discussion of evidence supporting the researchers' perspectives. However, although some opposing perspectives are briefly mentioned (e.g., preferences for mixed-gender versus men-only groups), there is limited discussion of any evidence that might challenge their conclusions. Credibility of findings are moderately well addressed. The use of multiple data sources (interviews, observations, and mapping exercises) suggests triangulation. The coding framework was reviewed by another team

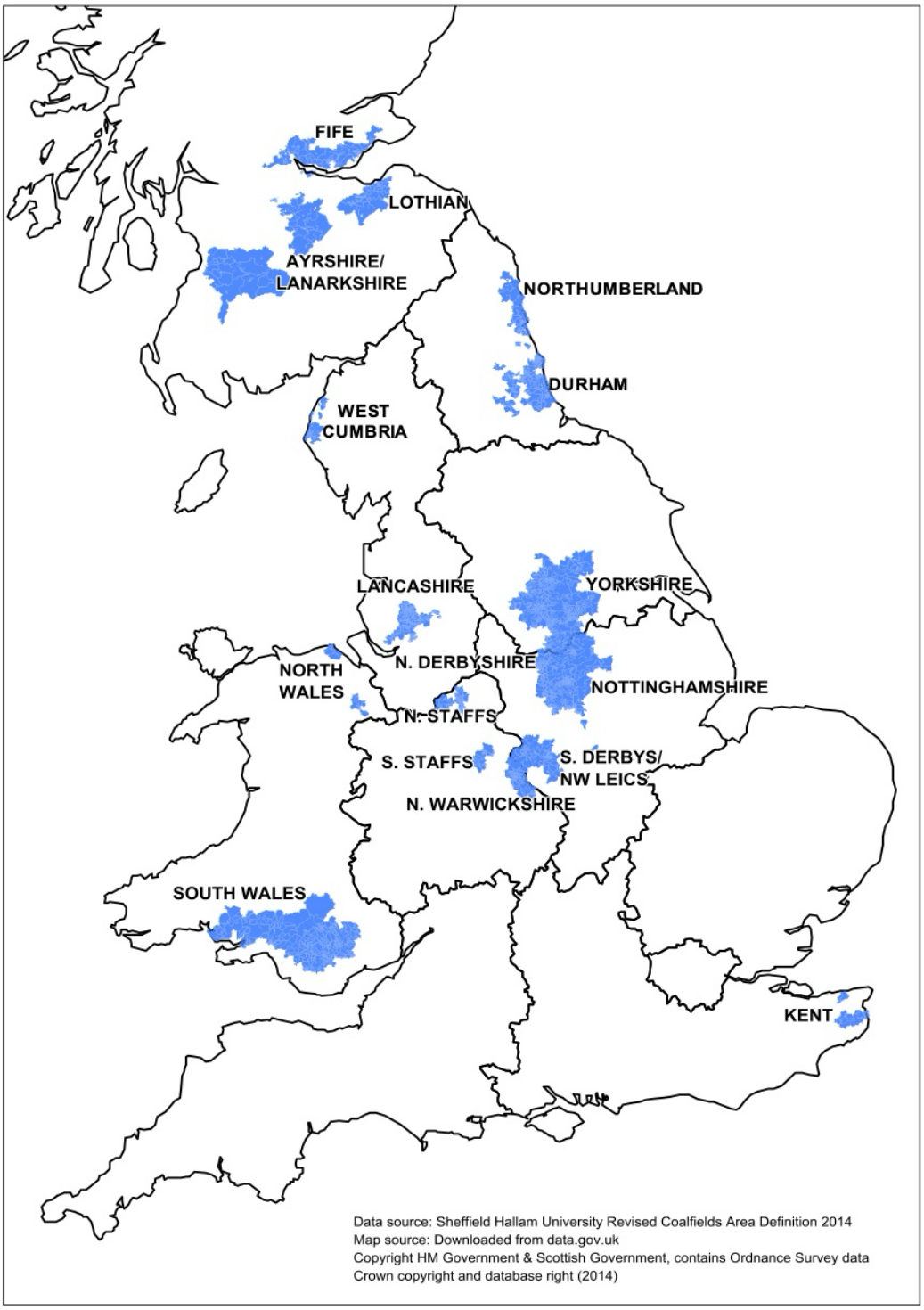
	member, enhancing reliability, although there is no mention of respondent validation/member checking. The findings are discussed directly in relation to the research question, focusing on the acceptability of group interventions for men with depression and anxiety, their experiences, and barriers to participation. Although the findings are clear and align well with the research question, deeper discussion of contradictory evidence and credibility measures like respondent validation would strengthen the study further.
CONSIDER: • *If the findings are explicit* • *If there is adequate discussion of the evidence both for and against the researcher's arguments* • *If the researcher has discussed the credibility of their findings (e.g. triangulation, respondent validation, more than one analyst)* • *If the findings are discussed in relation to the original research question*	
Section C: Will the results help locally?	
10. How valuable is the research?	☐ Yes The researchers discuss the study's contribution to existing knowledge by highlighting how group interventions can address men's mental health challenges and barriers to help-seeking, which they suggest are underexplored in the literature. They link findings to current practice and policy, such as the role of GPs and peer-led community groups, while emphasising the need to de-stigmatise and de-medicalise mental health support for men. New areas for research are identified, such as exploring younger men's experiences, ethnic minority groups, and the role of men's mental health workers. The researchers briefly discuss the wider implications of findings, noting how different group styles and facilitation methods might suit various subgroups of men, although this part of the discussion limited.
CONSIDER: • *If the researcher discusses the contribution the study makes to existing knowledge or understanding (e.g., do they consider the findings in relation to current practice or policy, or relevant research-based literature*	

- *If they identify new areas where research is necessary*
- *If the researchers have discussed whether or how the findings can be transferred to other populations or considered other ways the research may be used*

APPRAISAL SUMMARY: *List key points from your critical appraisal that need to be considered when assessing the validity of the results and their usefulness in decision-making.*		
Positive/Methodologically sound	**Negative/Relatively poor methodology**	**Unknowns**
Appropriate Research Design: The qualitative design, using interviews, observations, and a mapping exercise, is well-suited to explore the experiences of men with depression and anxiety in group settings. Methods are well described, including semi-structured interviews and thematic analysis, and their suitability for addressing the research aim appears justified. **Clear Data Collection and Analysis:** Thematic analysis was well-described, with iterative coding which was verified by another researcher to increase reliability. Data collection methods (e.g., note-taking and audio recordings) and participant recruitment methods are clearly described, supporting a comprehensive exploration of the research topic.	**Limited Consideration of Bias:** They do not critically assess their own role, potential bias, or influence during the formulation of research questions, data collection, or analysis. **Management of Contradictory Data:** Limited discussion of contradictory data, which hinders the critical depth of the analysis. **Limited Discussion of Distress Management:** Despite informed consent being obtained, there is little detail about how participant distress or confidentiality was managed during and after the study. **Missing Context for Saturation:** Although the mapping exercise stopped when no new themes emerged, there is no specific discussion of data saturation for interviews and observations, which weakens all claims of	**The Impact of Researcher Identity:** The potential influence of the researcher's identity and presence (e.g., as a female researcher interviewing men) on participants' responses is not addressed, leaving an unknown impact on the findings. **Transferability:** Although the study touches on transferability by discussing group formats for subgroups of men, it does not comprehensively explore how findings might apply to other populations, limiting broader applicability. **Modification of Methods:** There is no mention of whether methods were modified during the study, leaving it unclear whether the researcher adapted to unforeseen challenges or opportunities. **Ensuring Credibility:** Although triangulation through multiple data sources is implied, other credibility measures like

Ethical Considerations: Ethical approval was obtained, and participants were informed through verbal and written consent. Group consent was also considered for observational data. **Findings and Contribution to Knowledge:** The findings are clearly stated and aligned with the research question, offering practical insights into group therapy acceptability and barriers to men's help-seeking. Contributions to existing knowledge are discussed, with implications for policy and practice. The study highlights the need to de-stigmatise group therapy and explores how different group formats and settings might appeal to various subgroups of men.	comprehensive data coverage.	respondent validation or detailed peer review processes are not really discussed.
Summary: The research paper is methodologically sound overall and makes a valuable contribution to understanding men's mental health and group therapy. It is limited by insufficient exploration of researcher bias, contradictory data, and transferability, with some unknowns related to methodological flexibility and participant management. However, these limitations do not appear to significantly detract from the paper's overall quality and relevance.		

Appendix F: Location of former coalfields as depicted in Beatty et al. (2019)



Appendix G: Recruitment Poster

PARTICIPANTS NEEDED!

OVERVIEW:

We are recruiting **men aged between 45-64** who live in former mining communities and have not previously accessed mental health services, such as therapy or counselling. We are researching local views about mental health and mental health services.

WHAT IS INVOLVED?

An interview lasting no longer than 1 hour 30 minutes about your views on mental health and mental health services. We will not be asking about your own experiences of mental health. Interviews can take place online or at your home, whatever works best for you.

BENEFITS OF TAKING PART?

Each participant will receive a £10 Aldi gift card for their time.

Your voice, and the voice of your community, will be heard in research. This may influence how mental health services operate, locally and nationwide.

-

I AM INTERESTED, WHAT NEXT?

Please contact the lead researcher, Aaron Howard, to express your interest.

CONTACT DETAILS

EMAIL (preferred):
Aaron.howard@uea.ac.uk.

TEXT OR PHONE:
07713 892484.

University of East Anglia

This project is supervised by Dr Amy Carroll of University of East Anglia.
Email: Amy.carroll@uea.ac.uk

Appendix H: UEA Ethics Approval Email

University of East Anglia

Study title: A Thematic Analysis of Men's Perceptions of Mental Health and Mental Health Services in Former Mining Communities.

Application ID: ETH2324-0216

Dear Aaron,

Your application was considered on 2nd December 2023 by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee).

The decision is: **approved**.

You are therefore able to start your project subject to any other necessary approvals being given.

If your study involves NHS staff and facilities, you will require Health Research Authority (HRA) governance approval before you can start this project (even though you did not require NHS-REC ethics approval). Please consult the HRA webpage about the application required, which is submitted through the IRAS system.

This approval will expire on **2nd September 2024**.

Please note that your project is granted ethics approval only for the length of time identified above. Any extension to a project must obtain ethics approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) before continuing.

It is a requirement of this ethics approval that you should report any adverse events which occur during your project to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) as soon as possible. An adverse event is one which was not anticipated in the research design, and which could potentially cause risk or harm to the participants or the researcher, or which reveals potential risks in the treatment under evaluation. For research involving animals, it may be the unintended death of an animal after trapping or carrying out a procedure.

Any amendments to your submitted project in terms of design, sample, data collection, focus etc. should be notified to the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) in advance to ensure ethical compliance. If the amendments are substantial a new application may be required.

Approval by the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee) should not be taken as evidence that your study is compliant with the UK General Data Protection Regulation (UK GDPR) and the Data Protection Act 2018. If you need guidance on how to make your study UK GDPR compliant, please contact the UEA Data Protection Officer (dataprotection@uea.ac.uk).

Please can you send your report once your project is completed to the FMH S-REC (fmh.ethics@uea.ac.uk).

I would like to wish you every success with your project.

On behalf of the FMH S-REC (Faculty of Medicine and Health Sciences Research Ethics Subcommittee)

Yours sincerely,

Dr Paul Linsley

Ethics ETH2324-0216 : Mr Aaron Howard

Appendix I: Participant Information Sheet

University of East Anglia

Participant Information Sheet V.2 (12/11/2023)

Study title: A Thematic Analysis of Men's Perceptions of Mental Health and Mental Health Services in Former Mining Communities.

Invite: You are invited to participate in this study exploring how men living in former mining communities perceive mental health services. We are interested in your views and experiences if you are: male, aged between 45 and 64 years old, have never accessed a mental health service before, and live in a former mining community. You will be compensated for your time with a £10 shopping voucher.

Confidentiality: Your identity will remain entirely confidential throughout the research process. Your data will be accessed only by the research team, which consists of the lead researcher and their two supervisors (details at bottom of this document). When we write up the research, we will use a false name instead of your own and remove any identifiable information, such as street names or rare medical conditions you may disclose. Once your data is anonymised, a panel of three members of the community will have access to the anonymous data to help interpret the data in a fair and representative way. All of your data will be stored on a password locked computer and accessed only by the researcher.

What's involved: If you would like to participate, we can arrange a time slot for the researcher to interview you. This should last approximately 1 hour, but no longer than 1 hour and 30 minutes. The interview can take place on Microsoft Teams, or at your home if you prefer. There is an option to consent to either method of interview on the consent form, which includes consent to provide the lead researcher with your email address or home address for the purpose of interview. There are no right and wrong answers, we are interested in your honest views and opinions only. The researcher will read out a series of questions, and you will answer them however you see fit. If you wish to add information which you think is important to your experience, we welcome this too. The interview may raise some difficult feelings for you, and we will provide contact details of services you can contact if you wish to talk to somebody afterwards.

Why are we doing this research: We know that men aged between 45 and 64 are the most likely group to end their own life by suicide. We also know that men are less likely to speak about their mental health than women and much

less likely to access mental health services. We are interested in former mining communities because your voice is very rarely heard in research, but you will have unique experiences which may shape your views of mental health and mental health services. We know that when the mines were closed your area and possibly your families suffered a great deal. The loss of a large employer, the lack of alternative careers available, the impact on your community's culture and identity, and the distrust of political and wider systems that followed. All these things make your experiences valuable, and we want to know how this has shaped men's views on mental health services. We are interviewing between 12 and 15 men and hope that you would be interested enough to lend us your time.

Advantages of taking part:

- Have your voice and the voice of your community heard in research which is aiming to be published in a scientific journal.
- Receive a £10 grocery voucher for your time.

Disadvantages of taking part:

- The topic has potential to be emotionally challenging to some individuals. You will be supported throughout the interview by the researcher, and you will be given contact details for further support following interview should you require this.

What will happen if I do not want to carry on with the study: No worries! We will end the interview and not use your data. Please be aware that payment of the voucher will be made only after completion of the full interview, as we only have so many of these to give out.

How have members of the public been involved in this study: We are involving a small number of men from former mining villages to help prepare what questions they think should be asked and to make sure that the researcher is drawing conclusions that they agree with. Fairness is paramount in this study, and we want to represent the views of the community as honestly as possible.

Contact details of the research team:

Lead researcher: Aaron Howard – aaron.howard@uea.ac.uk

Supervisor: Dr Amy Carroll – amy.carroll@uea.ac.uk

Supervisor: Dr Paul Fisher – paul.fisher@uea.ac.uk

Course director: Sian Coker - s.coker@uea.ac.uk

Please refer any complaints to Sian Coker, the course director.

Appendix J: Consent Form

CONSENT FORM V.2 (12/11/2023)

Title of Project: A Thematic Analysis of Men's Perceptions of Mental Health and Mental Health Services in Former Mining Communities.

Name of Lead Researcher: Aaron Howard

Please initial box

1. I confirm that I have read the information sheet dated 18/06/2023 (V.1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw my consent up until two weeks after interview without giving any reason. Even though I can withdraw my data from being used in the study, I am aware that what I say in the interview cannot be completely destroyed, as the researcher will have heard it. ☐

3. I agree to take part in the above study and consent for my words to be used in the write up. Any names or identifiable information will be anonymised or removed prior to the write up. I accept that the supervisory team will have access to the recordings and transcripts for the purposes of this present piece of research only. I also consent to a panel of three members of the community having access to my transcript once it has been anonymised to ensure the research is accurately and fairly representing the views of the community. ☐

   AND EITHER

4. I consent to be interviewed via Microsoft Teams, and to provide my email address for the purpose of interview and to receive my grocery gift voucher. ☐
   My email address is : _____

   OR

5. I consent to be interviewed at my home, and to provide my home address for the purpose of being interviewed and to receive my grocery gift voucher. ☐
   My home address is: _____
   _____

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

When completed: 1 for participant; 1 for researcher site file

Appendix K: Debrief Form

University of East Anglia

Research Debrief Information V.2 (28/11/2023)

A Thematic Analysis of Men's Perceptions of Mental Health and Mental Health Services in Former Mining Communities.

This research was conducted to examine how men from former mining communities who have never accessed mental health services perceive those services and mental health generally. Previous research has suggested that men aged between 45 and 64 are the highest risk group for suicide, and that men generally are less positive towards mental health support seeking than women. We were particularly interested in former mining villages as the closure of the mines left the communities economically disadvantaged, which is another risk factor for mental health difficulties. It has been suggested in research that, because of the closure of the mines, the communities have felt disenfranchised with systems, including political, educational, and health systems. Research also suggests that former mining communities hold strong traditional views on topics such as gender roles which may impact men's abilities to express their emotions and seek help. This unique combination of characteristics would theoretically place men from former mining communities both at the highest risk of mental health difficulties, but also the least likely group to access support for mental health difficulties. By researching this perspective, we can gain a deeper understanding of what it means to be male in this community, and how mental health services can make men feel like they can approach them if they would like or need to.

We will be interviewing between 12 and 15 men within the same age range, and from the same community as you. We will protect your identity by removing any names or identifiable information you may mention during the interview. We will identify themes and patterns across all these interviews and interpret your unique perspectives. The researcher is from a former mining community, and members of the community will help interpreting the information, so you can rest assured that everything is being done to reach a honest reflection of your experiences.

If you would like to receive the findings of the study please provide the researcher with your email address, or home address, so that the findings can be sent to you when the data has been analysed.

If you would like to withdraw permission to participate in the study, please contact the researcher using the contact details below. You will have two weeks from interview date to do so, during which you can review your transcript if you wish. Any complaints can be addressed to the course director whose details are below.

If the content of the interview has left you feeling distressed, please contact the following organisations for support:
Your local GP for any physical or mental health concerns you may have.
Samaritans: call 116 123 for this free service who can listen and talk to you no matter what you are going through.
SHOUT (text-based service): Text 'SHOUT' to 85258 for text-based mental health crisis support.

Thank you very much for your time.

Contact Details:
Aaron.howard@uea.ac.uk - Lead Researcher
Amy.carroll@uea.ac.uk - Primary Supervisor
Paul.fisher@uea.ac.uk - Secondary Supervisor
s.coker@uea.ac.uk – Course Director (please direct any complaints here).
fmh.ethics@uea.ac.uk – UEA research ethics subcommittee.