The Experience of Psychological Distress and Mental Health Help-Seeking in the Context of Masculinity

Zuleika Irvanipour

DClinPsy

Thesis submitted in partial fulfilment of the degree of Doctor of Clinical Psychology Faculty of Medicine and Health Sciences

University of East Anglia

Submission Date: 31 January 2022

Thesis Portfolio Word Count: 22,222

Thesis Portfolio Abstract

Background: Research suggests that men experience psychological distress as reflected in high levels of male suicide globally, however, there are low levels of help-seeking, and the construct of masculinity has been cited as a possible explanation for this barrier to help-seek.
Aim: This research portfolio aimed to further the understanding of men's experience of psychological distress, specifically depression and stress, and explore if there is a role masculinity has on help-seeking.
Design: Two main research papers are provided in this portfolio, a systematic review which thematically synthesises the most recent findings on male experiences of depression and help-seeking, and a qualitative photo-elicitation empirical study that tries to understand the experiences of stress and help-seeking among young men in the UK, and explores the role of hegemonic masculinity, using discourse analysis to synthesise the dataset. These two main studies are presented alongside an introduction, bridging section, extended methodology and overall discussion.
Findings: The systematic review identified five themes; 'recognising, understanding and communicating depression', 'masculinity and help-seeking', 'male views of treatment', 'masculinity and meaning making from depression', and 'impact of masculinity on coping'. The empirical study identified five interpretive repertoires; 'stress as unchangeable and unmanageable', 'stress reflected in and out of self', 'powerful and powerless against stress', 'survivor of stress' and 'self-reliance'.
Conclusions: The findings suggest that the construct of masculinity does have a role in help-seeking among some men experiencing depression, as shown in the review, and stress, as indicated in the empirical paper. Masculinity can enforce the idea of needing to be self-reliant and this can be a barrier for help-seeking. The construct of masculinity exemplifies many nuances and a possible key implication is for health services to work with this construct and what it can mean for some men to increase help-seeking in a way that does not challenge masculinity. Recommendations for clinical practice and future research are provided.

Table of Contents

List of Tables for Systematic Review

List of Tables for Empirical Study

List of Figures

List of Photo-elicitation Material

List of Appendices

List of Abbreviations

BPS ..... British Psychology Society
CBT ..... Cognitive Behavioural Therapy
COVID-19 ..... Corona Virus Disease 2019
CPFT.....Cambridge Peterborough Foundation Trust
CQR ..... Consensual Qualitative Research
CRD ..... Centre for Reviews and Dissemination
GDPR ..... General Data Protection Regulation
GP ..... General Practitioner
HCPC ..... Health and Care Professions Council
IAPT..... Improving Access to Psychological Therapies
IPA ..... Interpretive Phenomenological Analysis
NHS ..... National Health Service
ONS ..... Office for National Statistics
PPD..... Postpartum depression
PRISMA .....Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROSPERO .....The International Prospective Register for Systematic Reviews
UEA ..... University of East Anglia
UK ..... United Kingdom
USA ..... United States of America
WHO ..... World Health Organisation

Acknowledgements

I would firstly like to thank my primary supervisor Dr Caitlin Notley for all her support and guidance on this project. I would also like to thank Professor Paul Fisher for his invaluable support.

I would like to give thanks to all the young men who shared their experiences with me, and helped the empirical study materialise. Without the participants there would be no thesis, and I am very thankful that the seven individuals engaged in this study.

I would lastly like to thank my family and friends who have supported me in the follow up to this research and during the write-up of this thesis. I am very grateful.

Chapter 1
Introduction

The broad aims of this portfolio are to help further the evidence base on the experience of psychological distress among men and if there is a role masculinity as a social construct has on help-seeking. This is an important area of research as the existing literature suggests that men do experience psychological difficulties as indicated in the high rates of suicide (White & Holmes, 2006) among male populations. Although psychological distress is indicated, there is evidence of low uptake of mental health service utilisation among men (Eggenberger et al., 2021), which has been partially explained by the socially constructed masculine norms prevalent in society often cited as contributing to the help-seeking barriers felt by some men (Call & Shafer, 2018).

Hegemonic masculinity as a social construct describes a cluster of norms whereby men are expected to be powerful, tough and emotionally unobtrusive (Courtenay, 2000). Although this portfolio recognises that masculinity as a construct evolves across cultures, the life course and has nuanced meaning for each man (Beasley 2008; Robertson, Williams & Oliffe, 2016), the term hegemonic masculinity is included and referred to in this portfolio as it accurately describes the dominant view western society has built-in it's the construction of gendered norms and appears to have a role in low levels of help-seeking among some men (Brydges, Rennick-Egglestone, & Anderson, 2020). In this portfolio, help-seeking for mental health distress is defined generally as a process of recognising a problem, communicating this, identifying sources of support and disclosing the need for support (Mitchell, 2017; Rickwood et al., 2005). This portfolio explores both depression (Rhimer, 2001) and stress (Van Heeringen, 2012; Liu & Miller, 2014) are precursors to the development of coping strategies breaking down leading to suicide among men, so stress and depression are key areas of psychological distress explored in this portfolio.

This thesis portfolio aims to explore male experiences of psychological distress, with a focus on depression and anxiety, and any role hegemonic masculinity may have on help-seeking. As part of this portfolio, a systematic review aiming to provide a synthesis of the most recent data is given, with a focus on what role masculinity has on men's help-seeking for depression. This is followed by a bridging section that outlines how we move from the findings of the review to the empirical paper. In the empirical paper, we move on to explore

the experiences of stress and help-seeking among young men in the UK and explore if there is a role hegemonic masculinity has on help-seeking in this sample. The empirical paper, therefore, provides views and the lived reality of a specific group of young men from their perspective, to contribute to the growing literature and provide the latest evidence from a qualitative empirical study to inform further what we know about masculinity and help-seeking.

The paper is followed by an extended methodological chapter, which highlights the detailed discourse analysis and general methodological factors that were considered in the empirical study. Lastly, an overall discussion and critical evaluation is given at the end of the portfolio that spans both empirical and systematic review papers, interpreting what the findings of both studies mean, outlining the implications in this portfolio.

Chapter 2

The Role of Masculinity in Men's Help-Seeking for Depression: A Review of Recent Evidence

Zuleika Irvanipour

Wordcount: 8,902

Prepared for submission to Clinical Psychology Review (Author guidelines in Appendix A)

Doctoral Programme in Clinical Psychology

University of East Anglia

REVIEW ARTICLE

The Role of Masculinity in Men's Help-Seeking for Depression: A Review of Recent Evidence

Zuleika Irvanipour [a*], Caitlin Notley [b], Paul Fisher [c], Fjolla Kukaj [d]

[a] *Norwich Medical School, University of East Anglia, Norwich, UK*

[b] *Norwich Medical School, University of East Anglia, Norwich, UK*

[c] *Norwich Medical School, University of East Anglia, Norwich, UK*

[d] *Royal Holloway, University of London, Egham, UK*

*Author for correspondence: Zuleika Irvanipour, Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, University of East Anglia, Norwich Research Park, Norwich, NR4 7TJ. Email: z.irvanipour@uea.ac.uk

Abstract

Aim: The current literature indicates that conformity to masculine norms has an unhelpful influence on the experience of depression and help-seeking intentions among men. A systematic review conducted by Seidler et al., 2016 explored the impact of masculinity on help-seeking for depression. This review aims to provide an update.
Method: Systematic review of studies from 2015-2021. MEDLINE, PsycINFO, SCOPUS, CINAHL, Web of Science and ProQuest Central were searched using terms related to masculinity, depression and help-seeking. Titles and abstracts were screened, then full texts for inclusion. Data quality was assessed using a bespoke quality rating form devised by Seidler et al., 2016.
Results: Of 1218 citations identified, 23 met inclusion criteria. Thirteen (56.5%) were qualitative studies, ten (43.5%) were quantitative and one study employed mixed-method design. Five themes were identified; 'recognising, understanding and communicating depression', 'masculinity and help-seeking', 'male views of treatment', 'masculinity and meaning making from depression', and 'impact of masculinity on coping'.
Conclusion: Novel findings suggest a cluster of positive masculine characteristics, favourably influencing the intention to seek help for depression not reported so far in the literature. Clinical interventions and campaigns need to enhance helpful masculine ideas pertaining to help-seeking as this may increase help-seeking behaviour among men. The use of standardised screening tools for depression, help-seeking and depressive symptoms for future research are discussed.

Highlights:

- Depression seen as caused by life stressors, physical health and interpersonal difficulties
- Men report finding meaning from depression
- Masculine norms may reinforce maladaptive coping styles.

Article Info:

Keywords Depression, Help-seeking, Masculinity, Healthcare, Systematic review

Introduction

Women are twice as likely to be diagnosed with depression compared to men (Kilmartin, 2005), and as depression is one of the major precursors to suicide (Rhimer, 2001), to make sense of the current literature it is suggested that many men could be left undiagnosed, as the incidence of suicide by men is higher than for women. In an analysis of mortality patterns spanning 44 countries, suicide among men (aged 15-44 years) was one of the top three causes of death in 57% of all included countries (White & Holmes, 2006). In the UK, the male suicide rate is 17.2 deaths per 10,000 in comparison to 5.4 deaths per 100,00 for women (ONS, 2018), which cannot provide insight into distress felt by individuals but can provide insights into gender differences derived from a breakdown of coping strategies culminating in fatality.

The Swedish Committee for the Prevention and Treatment of Depression (PTD) implemented an education programme for general practitioners in Gotland, Sweden focusing on the diagnosis and treatment of depression, and found that early recognition and appropriate treatment for depression is the most important preventative strategy for suicide (Ruts et al., 1989). Another seminal finding from the Gotland study was that people who did commit suicide were predominately male (Rihmer, Rutz & Pihlgren, 1995), and due to this over-representation of the male gender, masculinity has been an area of interest when trying to support male mental health.

Dominant masculine norms of embodying strength, and avoiding being perceived as weak or vulnerable (Brownhill et al., 2005), suggests that the expression and coping strategies for dealing with depression are perhaps different among men than for women (Johnson et al., 2012). Stigma associated with depression for men (Johansson et al. 2009) is likely to have an impact on help-seeking practices, as men may come up against barriers due to stigma derived from social constructions of ideal masculine norms. The literature does indicate this, as many men with depression remain resistant to seeking help (Johnson et al., 2012; Rice et al., 2017).

The research literature has provided insights to the social construction of traditional masculine norms and the negative impact on psychological problems such as depression (Oliffe et al., 2019), and coping strategies (Courtenay., 2000; Ramaeker & Petrie, 2019). Men who adhere to traditional masculine norms are often characterised as self-reliant, have

restrictive emotionality (Mahalik & Di Bianca., 2021; Rochlen et al., 2010), and are less likely to engage in help-seeking behaviour for depression (Addis & Mahalik., 2003; Lane & Addis, 2005).

There is an unmet psychological need for some depressed men, and reticence to mental health help-seeking can endorse other forms of coping and risky self-care. Externalising psychological distress is a prevalent feature of how some men experience depression (Kendler & Gardner, 2014) as unhelpful coping strategies such as substance abuse and physical violence are common (Harrison et al., 2004).
An up to date synthesis of the evidence, is needed to enhance our understanding of the interrelated nature of masculinity and help-seeking for depression. The aim of this review is to examine the most recent evidence pertaining to the role masculinity has on help-seeking for depression among men following from Seidler et al., 2016 review.

Methods

This review was registered with PROSPERO on 16/02/2021 registration number CRD42021182441.

Data sources and search strategy

A systematic search was conducted following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher et al., 2009; Appendix B)). As this current review is following the review conducted by Seidler et al. 2016, the search terms and strategy are an exact duplicate of the original study, updated (Appendix C).

Both qualitative, quantitative, and mixed-method studies were identified through six electronic databases searched in July 2020 and again in October 2021 (MEDLINE, PsycINFO, SCOPUS, CINAHL, Web of Science and ProQuest Central). Further manual searching of reference lists from identified studies were undertaken.

Screening

At initial title and abstract screening, each paper published in 2015 with no timestamp was manually searched so that papers published prior or during August 2015 were excluded. Papers were excluded based on the eligibility criteria stipulated (Appendix D). For studies

not published in English, the first author was contacted and an English language version requested. Where there was no reply, the study was excluded at initial screening.
The lead author assessed title and abstracts of all the studies generated from the initial search. Initial search results from the database search and hand searched studies were merged, and duplicates removed following Cochrane Collaboration guidelines (Deeks, Higgins & Altman, 2008). The reference manager 'Mendeley' was used to organise references.
Following Seidler et al. 2016, we utilised a search strategy with time limits from '1950-August 2015'.

Two peer reviewers independently assessed a random selection of studies 8% (n=80) of the title and abstracts, 5% of studies screened by each researcher (n=40) (Appendix E). Inter-rater reliability between peer reviewer 1 and 2, assessed across 5% of included studies was (k=0.62, 'substantial agreement') and (k=0.68 'substantial agreement) respectively (Vogt, 2005). Where there was disagreement, A consensus agreement was sought. Studies (n=4) that were not able to reach agreement between lead author and peer reviewers were assessed by second author (CN), and after titles and abstracts were reviewed a decision was made. The lead author assessed full text articles against eligibility criteria. (see Fig 1.).

Data abstraction and synthesis

Data were extracted by the lead author to a standardised data extraction form (Appendix F).

Quality assessment

Each included study was assessed for methodological quality (including risk of bias in sampling and measurement) using the original preformulated rating criteria developed by Seidler et al., 2016 for qualitative or quantitative research methods (Appendix G).

Data synthesis

Prior to data synthesis, the screening process was designed so that the content of findings from both qualitative and quantitative papers addressed the same aspects of masculinity in the context of help-seeking for depression among men. Thus, qualitative and quantitative findings were combined with an interpretive approach (Sandelowski et al. 2012), as study aims and methodology were purposefully not brought into focus during the aggregation of studies in this mixed-method synthesis.

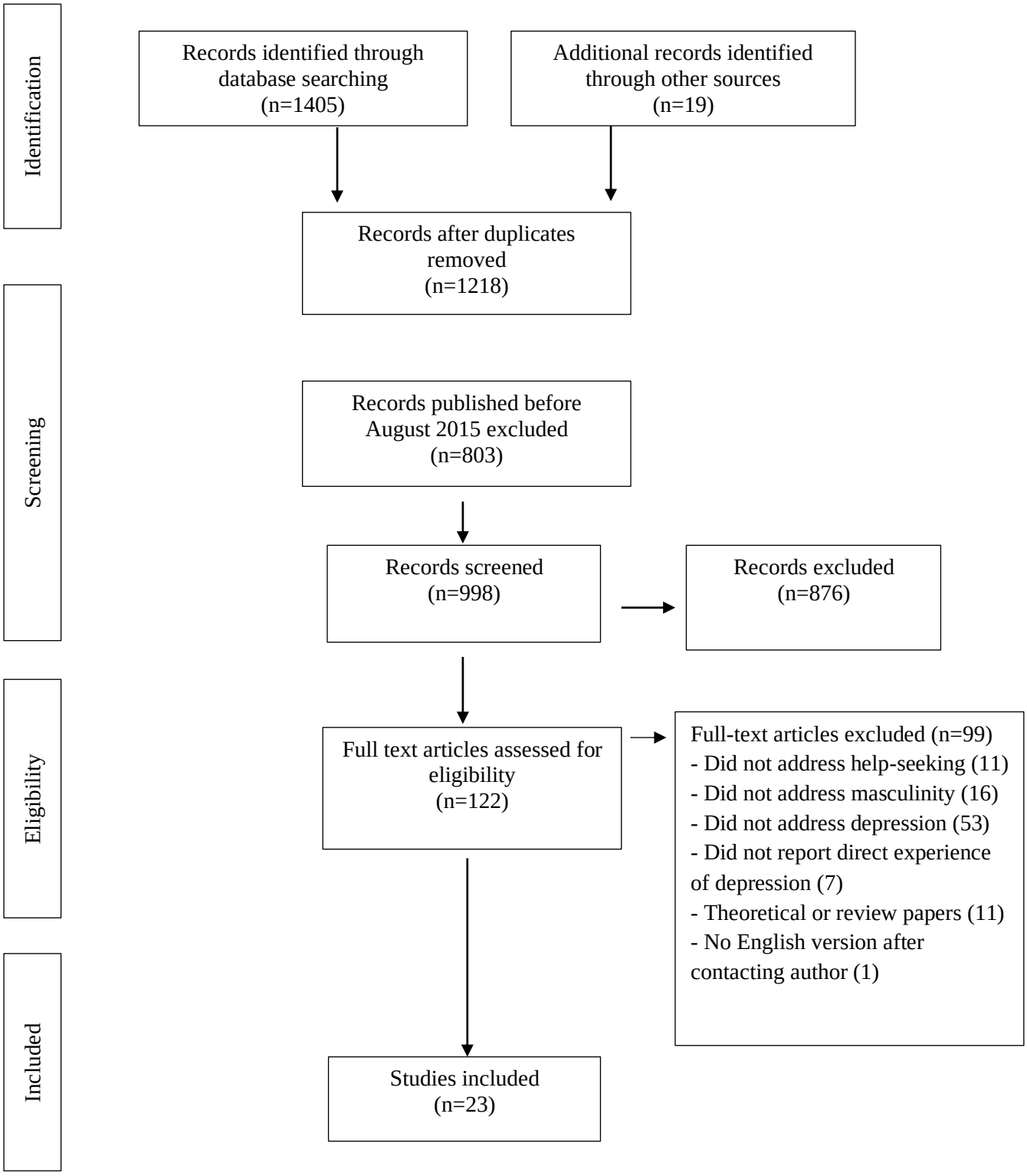
This mixed-methods review adopted an interpretive approach to the synthesis of data grounded in the qualitative and quantitative data (Dixon-Wood et al., 2005), utilising thematic analysis and narrative synthesis. Thematic analysis has been used previously in systematic reviews managing diverse areas of evidence. As in previous systematic review research this review provides a tabulation of both papers both qualitative and quantitative and the counts of papers contributing to prominent themes (Garcia et al., 2002).

Quantitative findings were not homogenous in measures used across findings and therefore, no formal quantitative analysis was conducted in this review, however a detailed narrative synthesis is provided in line with a mixed approach to evidence synthesis (Pope et al. 2007).

Qualitative data were analysed thematically, as per CRD guidance (CRD, 2019) culminating in a qualitative thematic synthesis of review findings. Thematic analysis involved familiarisation and initial coding of the data, then early provisional analytical themes were generated, followed by a stage of theme development where themes were constructed from the data. The last stage of analysis involved reviewing and defining themes (Terry et al., 2017).

From the thematic analysis five 'analytical themes' were created which provided overarching interpretive constructs spanning across findings from all twenty three studies. The number of studies that addressed each theme is reported in Fig 1.

Fig 1: PRISMA flow diagram



From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). *P*referred *R*eporting *I*tems for *S*ystematic Reviews and *M*eta-*A*nalyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Study and Sample Characteristics

The search process, quality assessment and method of synthesis followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance (Appendix B). Refer to Table 1 for study and sample characteristics.

Year and location of studies

Included studies were published between 2015 and 2021. Ten studies (42%) were conducted in North America (USA and Canada)[15,17,19, 22, 2, 6, 9, 21, 23, 4]. Eight studies (33%) were conducted in Europe[16,,1,7,18,13,10,14]. Four studies (17%) were conducted in Oceania[20,11,12,5]. One study (4%) was conducted in Myanmar/Burma[8]. One study (4%)was conducted across continents[3].

Study type and sample characteristics

13 out of 23 studies employed qualitative methods and ten out of 23 studies employed quantitative methods. One study[7] reported both qualitative and quantitative data and data was included in the data synthesis across both qualitative and quantitative data tables. Thematic analysis was predominately used for synthesising qualitative data.

In total, data were reported on 4,760 participants. Sample sizes ranged from 21 to 88 for qualitative studies and 18 to 88 for quantitative studies. The majority of included studies were male-only samples. More than a third of studies did not report age range, or mean age of participants. Of included studies which provided a mean age, the overall mean age of participants in this review sample was 38.13 years.

Participants were recruited from general community[1, 5, 9, 11, 12, 13, 15, 16, 17, 20,21,22], general community specifically fathers[2,4,10], primary care[6,7,14], tertiary students[19,23], elite athletes[3], secondary care[18] and political prisoners[8].

Mental health status of participants

In six studies, mental health status was self-reported as depression [2,3,4,9,8,13]. Four studies included participants clinically diagnosed with depression[1,5,14,18], and the remaining studies used screening tools to measure depression. All participants were recruited at a point where they exhibited significant depressive symptoms.

Quality assessment

Overall, the majority of all included studies were judged to be of moderate or high quality. The empirical standard of qualitative and quantitative findings were similar, as qualitative findings in four out of 23 studies[5,8,10,11] and quantitative findings in five out of 23 studies [7,15,17,19,23] were assessed as low quality. Refer to Table 1.

Measures

Included studies used a wide range of different screening tools. Studies predominately reported the use of PHQ-9, CESD, MDRS-22, BDI and MSS. The variability among help-seeking measures was extensive. To measure masculinity, quantitative studies used a variety of measures; Bem Sex-Role Inventory (BSRI), Male Role Norms Scale (MRNS), Conformity to Masculine Norms Inventory (CMNI-46), and the 37-item Gender Role Conflict Scale (GRCS). All three constructs (depression, help-seeking and masculinity) were measured heterogeneously across studies.

Table 1. Descriptive characteristics of included studies

Author, year,	Country	Design, setting	Total Sample (n)	Measures used	Population type	Age range in years	Mean age in years	Quality rating*
Brydges, Egglestone & Anderson[1] 2020	UK	Qualitative, thematic analysis, individual semi-structured interviews	14	Clinical diagnosis of depression with and without anxiety	Male, general community	26-61	NR	2
Caperton et al.[2] 2020	USA	Qualitative, CQR, individual semi-structured interviews	12	SRD	Male, general community (fathers)	30-51	31.75	2
Doherty, Hannigan & Campbell[3] 2016	North America, Australia/Oceania, UK	Qualitative, interpretive descriptive analysis, individual semi-structured interviews	8	SRD	Male, elite athletes	22-65	NR	2
Dye[4] 2019	USA & Canada	Qualitative, thematic analysis, individual semi-structured interviews	21	SRD	Male, general community (fathers)	NR	34.86	2
Gibson, Cartwright & Read[5] 2018	New Zealand	Qualitative, thematic analysis, individual semi-structured interviews	20	Clinical diagnosis of depression	Male, general community	29-81	NR	1
Hinton et al.[6] 2017	USA	Qualitative, thematic analysis, individual semi-structured interviews	15	Depression assessed using rating scale cut-off (PHQ-9)	Male, primary care	NR	63.5	2
House et al.[7] 2018	UK	Mixed method, Q methodology, individual semi-structured interviews	29	Depression assessed using rating scale cut-off (self-report PHQ-9) - HS and masculinity assessed using statements on 'Q set'	Male, primary care	30-80	NR	1 (quantitative) 3 (qualitative)

Lakin[8] 2019	Burma/Myanmar	Qualitative, thematic analysis, individual semi-structured interviews	30	Depression assessed using locally- validated screen	Male, general community (political prisoners)	24-72	NR	1
Mahalik & Dagirmanjian[9] 2019	USA	Qualitative, CQR, individual semi-structured interviews	12	SRD	Male, general community (fathers)	NR	40.42	2
Pedersen, Maindal & Ryom[10] 2021	Denmark	Qualitative, IPA, individual semi-structured interviews	8	SRD, lived experience of postpartum depression(PPD)	Male, general community (fathers)	29-38	NR	1
Scholz, Crabb & Wittert[11] 2017	Australia	Qualitative, thematic analysis, individual semi-structured interviews	10	Depression assessed using rating scale cut-off (BDI)	Male, general community	45-88	NR	1
Siedler et al.[12] 2018	Australia	Qualitative, interpretive descriptive analysis, individual semi-structured interviews	20	Depression assessed using rating scale cut-off (PHQ-9);	Male, general community	23-66	39	3
Staiger et al.[13] 2020	Germany	Qualitative, content analysis, narrative - biographical and semi-structured interview	12	SRD	Male, general community	30-62	52	2
Wirback et al.[14] 2018	Sweden	Qualitative, interpretive content analysis, individual semi-structured interviews	13	Clinical diagnosis of mild-moderate depression	Male, primary care	21-32	27.5	2
Call & Shafer[15] 2018	USA	Quantitative, cross sectional study, online questionnaire	2,382	- Depression assessed using Male-typical symptoms of depression and Masculine Symptoms Scale (MSS)	Male, general community	NR	NR	1

				- HS assessed asking "Did you ever in your life talk to a professional about your sadness/discouragement/lack of interest?" - Masculinity not measured				
Eggenberger et al.[16] 2021	Europe (Switzerland, Germany, Austria, Liechtenstein and Luxembourg)	Quantitative, cross sectional study, online questionnaire	716	- Depression assessed using Patient Health Questionnaire -9 (PHQ-9), Male Depression Risk Scale -22 (MDRS-22) - HS not measured - Masculinity assessed using Bem Sex-Role Inventory (BSRI), Male Role Norms Scale (MRNS)	Male, general community	NR	32.7	2
Hayward & Honegger[17] 2018	USA	Quantitative, cross sectional study, online questionnaire	238	- Depression assessed using rating scale cut-off (self-report of depression using the Center for Epidemiologic Studies Depression Scale Revised (CESD-R-10). - HS assessed using the Barriers to Access to Care Evaluation, version 3 (BACEv3). - Masculinity not measured	Male, general community	NR	NR	1
Killian et al.[18] 2020	Germany	Quantitative, cross sectional study, online questionnaire	250	- Depression assessed using a clinical diagnosis for depression - HS assessed using Depression Stigma Scale (DSS) - Masculinity assessed using Male Role Norms Scale (MRNS)	Male, secondary care	NR	46.6	3
Ramaeker & Petrie[19] 2019	USA	Quantitative, cross sectional study, online questionnaire	425	- Depression assessed using the 20-item Center for Epidemiological Studies Depression Scale–Revised (CESD-R) - HS assessed using the 10-item Attitudes Toward Seeking Professional Psychological Help Scale– Short Form (ATSPPHS) and the 17-item Intentions to Seek Counselling Inventory (ISCI) - Masculinity assessed using the 46-item Conformity to Masculine Norms Inventory (CMNI-46) and the 37-item Gender Role Conflict Scale (GRCS)	Male, tertiary students (male athletes)	NR	NR	1

Rice et al.[20] 2015	Australia	Quantitative, longitudinal study, online questionnaire	125	- Depression assessed using rating scale cut off (self-report PHQ-9) - Help-seeking (HS) assessed using Barriers to Help-Seeking Scale (BHSS) - Masculinity not measured	Male, general community	18-67	39.02	2
Rice et al.[21] 2020	Canada	Quantitative, cross sectional study, online questionnaire	117	- Depression assessed using rating scale cut off (self-report PHQ-9) - HS assessed using a modified version of the Barriers to Mental Health Services Scale–Revised (BMHSS-R) - Masculinity not measured	Male, general community	19-88	47.91	3
Sileo & Kershaw[22] 2020	USA	Quantitative, cross sectional study, online questionnaire	117	- Depression assessed using a rating scale cut-off (Center of Epidemiological Studies-Depression Scale (CES-D) - HS not measured - Masculinity assessed using Masculine Role Norm Scale (MRNS)	Male, general community	18-25	21	3
Wasylkiw & Cairo[23] 2018	Canada	Quantitative, cross sectional study, online questionnaire	166	- Depression assessed using the Center for Epidemiological Studies Depression Scale (CESD-R) - HS assessed using the Self-Stigma of Seeking Help Scale (SSOSH) and Inventory of Attitudes toward Seeking Mental Health Services (IASMHS) - Masculinity assessed using the short form (of the Conformity to Masculine Norms Inventory (CMNI)	Male, tertiary students	NR	19.46	1

*Note: Quality Ratings 1(low) 2(medium), 3(high)

Findings

Key findings from both qualitative and quantitative outcomes are detailed in table 2 and 3.

Thematic analysis revealed five distinct themes and sixteen related subthemes. (see Fig 2.).

Fig 2. Themes and related content

Theme	Subthemes (recurrence)
Recognising, understanding and communicating depression	• Mental Health Literacy and difficulty recognising depression (4) • Understanding depression as caused by life stressors (10) • Understanding depression as caused by physical health problems (5) • Understanding depression as caused by interpersonal difficulties (3) • Communicating depression (2)
Masculinity and Help-Seeking	• Masculinity and attitude towards help-seeking (6) • Restrictive emotionality and extreme distress before help-seeking (6) • Conflict with masculine norms: not wanting to appear weak, vulnerable or inadequate (9) • Masculine norms and stigma (10) • Impact of others on help-seeking (5) • Help-seeking barriers unrelated to masculinity (5)
Male Views of Treatment	• Helpful features of therapy (9) • Anti-depressants, a challenge to masculinity (4) • Psychotherapy outcomes (3)
Masculinity and Meaning Making from Depression	• Depression as an important life experience (3) • Self-compassion (2)
Impact of Masculinity on Coping	• Impact of masculinity on maladaptive coping (11) • Impact of masculinity on helpful coping (2)

Recognising, Understanding and Communicating Depression

Mental health literacy and difficulty recognising depression

Three of 23 included studies found that the men in the included papers had difficulty recognising symptoms of depression, due to low levels of mental health literacy. Not feeling able to justify depressed emotion until formally diagnosed[7,10] was found to be a barrier to seeking help, thus meeting formal criteria for depression [22] was part of help-seeking for depression.

One participant reflects the uncertainty in identifying depression:

'You know that something is wrong, but you don't know what it is'
(Study 10)

Men included in this review sample presented as vulnerable to experiencing worsening depression with limited access to support as some find it difficult to label what their distress is, which seems to be a help-seeking barrier. This may contribute to 'outcome beliefs', as help-seeking for mental health could be viewed as an ineffective strategy if depressive mood is not initially validated. This affect contributes to ones 'personal attitude' toward help-seeking intention.

Understanding depression as caused by life stressors

Four of the included studies reflected the theme of depression being understood as caused by external stress factors, such as occupational stress[8], struggling with everyday life[14], post incarceration issues[8], and failure leading to social isolation[2,3].

Understanding depression as caused by physical health problems

Findings from five of the included studies cited physical health problems as a key factor in the development of depressive symptoms[4,, 8,11,15], including sexual dysfunction[5]. One study referenced a loss of self-care routine as a perceived cause of depressive symptoms[3].
An extract reflects the recurring theme of physical health leading to depression:
Interviewer (I): *Has [emotion] had a big impact upon your health?*
Participant (P): *Ah yeah when a thing happens like that, you know, the stroke, the heart attack, this thing here (indicating his lungs), and they tell you "by gee you are lucky to be here still" ah you still break down. You can't help it.*
(Study 11)

Some male participants in the included studies[4,8,11,15] were able to identify how their physical health can impact their mental health, however, it does not seem that the reverse relationship is easily identifiable, suggesting marked low mental health literacy among this sample of included men.

Understanding depression as caused by interpersonal difficulties

Three studies cited interpersonal difficulties as a perceived cause of depression[11,19,2]. Conflict between work and family relationships and general relational difficulties at home were among interpersonal stressors reported.

Communicating depression

Two of the included studies found that men were hesitant with speaking to a professional pharmacist[1], or physician[21] about their experience of depression.

The dilemma here is that the sample from these two studies seem to find it helpful to understand their symptoms of depression once a diagnosis is made, however also find it difficult reaching out to those who may be able to provide this diagnosis.

Masculinity and Help-Seeking

Masculinity and attitude towards help-seeking

Six of the included studies discussed male participants attitudes towards help-seeking. The majority of these reported men adopting a positive attitude towards help-seeking for depression. Findings suggest seeking help being synonymous to being wise[11], taking charge [7,5] being courageous[7] and a form of self-compassion[23]. One study reflected the view that help is available if depression is disclosed[7].

I: *So are there any issues . . . that you have wanted to talk to your doctor about but haven't been able to?*

P: *Many years ago, you wouldn't. The man, most men, males don't wanna bring anything up to their doctor. As you get a bit older, you get a bit wiser, you've been around for a while, you start to think hey you're stupid if you don't. Ask. (Study 11)*

Help-seeking here is perceived as an empowering act, and a path to self-development.

Restrictive emotionality and extreme distress before help-seeking

Restrictive emotionality and minimising symptoms of depression was a recurring theme in six studies[19,20,14,22,17,4]. Lack of mental health literacy and believing that the difficulty will 'alleviate by itself' creates an obstacle in help-seeking for some men[17]. Experiencing extreme distress before seeking help for depression was another theme found across five of the included studies[5,15,17,16,20]. One study found increased duration of depression associated with less help-

seeking behaviours[5], perhaps related to learned helplessness. This is reflected in findings from paper 5, where male participants describe their distress just before seeking help for depression.
"Pretty much all the classic things . . . highly emotionally unstable I guess in the sense of bursting into tears at a moment's notice" (Study 5)

"Well I'm quite a rational, stable sort of person but that would get me at times, in areas that were completely beyond my control. So I was worried that I might be in the middle of a business presentation and suddenly crack up for no reason." (Study 5)

This theme is a reactive approach to mental health care, and not conducive to recovery or the health systems that are in place, as for many there are processes to access mental health care which often require time. By minimising symptoms of depression, men may be left feeling depressed for longer, thus leading to extreme distress at the point of help-seeking. Although not a prevalent finding, the duration of distress can mediate the relationship to help-seeking in an unhelpful way, and this is possibly where men do not access help but instead turn to unhelpful coping strategies.

Conflict with masculine norms
Not wanting to appear weak, vulnerable or inadequate was a recurring theme found among nine studies[7,17,13,9,14,20,21,1,2]. Findings suggests distress is derived from a conflict with masculine ideals of capability and power[7]. Two quotes from the included studies reflect this conflict between help-seeking and masculine ideals.
'I should have been man enough to deal with it' (Study 7)

"Yeah, I think it goes back to before, a sign of weakness. I think that's basically, it's a sign of weakness. You know, you're supposed to be, men are supposed to be strong and up front, ready to go type of people and I guess when you're, I guess that's why men tend to not to go, not to go to see somebody for help." (Study 9)

Self-reliance specifically was found to be a masculine ideal that is challenged when seeking help, a recurring theme among some studies [7,17,14,20,21,1,2]. Being dependent on others challenges ones masculinity and accepting help can be seen as not having coped with depression independently, pertaining both to psychotherapy and antidepressant use.

Paper 1 reflects this help-seeking barrier with regards to adhering to anti-depressant use:
'You feel you need something just to get by, I think it feels like a failure.' (*Study 1)*

Masculine norms and stigma

Stigma associated with help-seeking for depression was reported in ten studies [23,19,9,4,14,8,7,17,10,15]. Both self-stigma and stigma from others were found among these included studies.

Fear of judgement from others for not being able to cope alone[7,8], and help-seeking perceived as shameful, embarrassing and a failure[7,17,10] was an experience reported by a third of all participants.

"I want to stand on my own two feet. I feel guilty relying on the support of others." (Study 10)

Two studies[2,18] reported a negative self-view and self-stigma associated with having depression. The stigma felt by men experiencing low mood from others and themselves may enhance feelings of inadequacy and is a significant barrier to seek help.

Impact of others on help-seeking

Five studies[5,20,22,4,10] discussed men being impacted both positively and negatively by interactions with others. Findings reported distrust and hostility towards others (e.g., caregivers and significant others) in the context of help-seeking[5]. In contrast, some studies reflected that significant others and close family members play an important role in prompting help-seeking behaviour. Study 4 refers to this theme.

'My wife would say, from time to time, "Make sure you're doing what you need to do to stay happy and healthy." (Study 4)

This theme reflects that support systems can be helpful in prompting men to seek help for depression, but support systems can also be an unsafe place, where men do not feel able to access support and can hinder help-seeking intention. Motivation to comply to messages related to help-seeking are impacted by others and men experience this in the context of family support. Thus, members within close social networks have a key role in supporting men seek help or not.

Help-seeking barriers unrelated to masculinity

Practical barriers to help-seeking was cited among five of the twenty three included studies[3,4,7,14,17,20]. Uncertainty about treatment options, long waiting lists, unsure about how to access support and financial costs were among help-seeking barriers.

Pragmatic considerations are important for some men when seeking treatment for depression, and as the findings suggest that men experience a high level of distress before seeking help, it is possible that combined with practical barriers it would be a challenge for some men to commence treatment.

Male Views of Treatment

Helpful features of therapy

Nine studies discussed preferred elements of psychotherapy. A structured, validating, confidential and collaborative approach to therapy that enables a sense of agency among men was discussed in six of the included studies[4 3,11,12,, 21,6]. Some men reported a preference to be able to disclose weakness in therapy[4], with other findings emphasised the need for a structured 'roadmap of therapy' to avoid 'basically a talkfest'[12, 21]. Male only groups[13], and a preference to disclose difficulties to a female therapist were reported[9].

A key feature of psychotherapy was cited as including family members and significant others within the therapeutic intervention[6,3]. This is reflected in the following extract:

"Maybe the family is angry at the person who is suffering and so there's issues there that need to be addressed, education-wise. And there is some tender and loving care that needs to be done there, from that perspective." (Study 6)

Men in this sample have reported a preference for a structured therapeutic approach, and a dislike for therapy with no clear agenda.

Anti-depressants for depression, a challenge to masculinity

Three studies reported male views on adhering to medication for depression. A recurring theme in two of the studies was the impact of masculine norms on the meaning of adhering to medication for depression[5,1]. For some men adhering to prescribed antidepressants meant giving up control, a challenge to their autonomy and their masculinity. One study reported participant concern regarding side effects of medication[17].

'Maybe that's also wrapped up in this idea about, you know, I should be able to cope with it without medication as well. It's maybe it's some sort of failing, maybe it's some sort of sense of failure about having, you know, I'm not doing what I could do, I'm not achieving what I could achieve because I need medication, I should be able to manage these sorts of things.' (Study 17)

Psychotherapy outcomes

Three studies outlined positive outcomes of engaging in a psychotherapeutic intervention for depression, reporting a sense of relief from disclosing depression[9] and an improvement in wellbeing[1,5]. However, one study reported an ambivalence towards psychotherapy[2].

The predominant view of psychotherapeutic treatment is positive, suggesting that men are more likely to form positive beliefs regarding psychotherapy treatment as opposed to psychiatric medication treatment.

Masculinity and Meaning Making from Depression

Depression as an important life experience

Two studies out of the included twenty-three reported male participants perceiving depression as 'an important life experience'[13], with recovery from depression being a form of 'self-discovery'[3]. Male participants discussed the 'will to win' as a key support during their recovery from depression, and determination integral to recovery.

This theme is reflected in the following quote[3].

"I came to a point in my life where I was able to realize that there is a lot of things that I could control, but there were things I couldn't control in my life, other people's reactions" (Study 3)

This perspective is salient to the masculine ideal of self-reliance and independence, as 'self-discovery' is an empowering view of depression.

Self-compassion

Two studies cited 'self-compassion' [23] and 'self-acceptance' [3] as areas of growth from depression. As male participants in the wider sample of this review have reported fear of judgement from others as being incapable, the theme of improving oneself and coming out of depression improved is congruent with the masculine ideal of 'taking charge'.

Impact of Masculinity on Coping

Impact of masculinity on maladaptive coping

Eleven out of the twenty three studies discussed a recurring theme of men engaging in unhelpful coping behaviours, primarily social isolation or a 'pulling inward' in an attempt to cope alone, thus adhering to masculine norms of self-reliance [2,3,7,8,9,10,13,19,].

Substance abuse was prevalent in five studies [3,4,8,15,22]. A quote from one study[4] reflects one man engaging in substance abuse to try and cope with his experience of depression:
'I was drinking to try to numb myself and self-medicate. I was trying to self- medicate, so I wouldn't be bothered as much by all my problems.' (Study 4)

Impact of masculinity on helpful coping

Two studies discussed healthy, adaptive coping strategies used among male participants[8,3]. Engaging in a self-care routine[8] and pursuing hobbies such as sport [3] and politics [8]. Exercising self-compassion through self-care and engaging in activities with a social element such as sport or politics is a helpful coping approach as it may reduce opportunity for social isolation.

Table 2: Characteristics, key findings and quality rating of qualitative and mixed-method studies

Study, design, setting	Key findings	Quality ratings*
Brydges, Egglestone & Anderson[1] 2020; UK; individual semi-structured interviews; general community	- The theme 'Antidepressant's attributions to benefits' highlighted all men in the sample noticed improvements in functioning when taking antidepressants. - The themes 'Views of pharmacist's role influences engagement', and 'Influence of cognitive state upon healthcare interactions' outlined that some men did not want to discuss mental health concerns with their community pharmacist. - 'Hegemonic Masculinity and taking antidepressants', reflected that for some taking antidepressants could challenge ones masculinity, and for some, an assertion that they had not solved depression themselves, symbolising weakness, failure, or dependency.	2
Caperton et al.[2] 2020; USA; individual semi-structured interviews; general community (fathers)	- Depression experienced as 'pulling inward' and increased negative emotionality. - Feeling of being a burden to others exacerbated participants depressive symptoms. - Feelings of interpersonal isolation perceived as contributing to severity of depression. - Cause of depression described in relational terms (parenting difficulties, spousal isolation), rather than structural terms (poverty, unemployment). - Development of depression understood as failure to achieve masculine success (high powered job, independence, self-sufficiency) leading to isolation and stigma, reinforcing negative self-view. - Ambivalence towards progress in therapy	2
Doherty, Hannigan & Campbell[3] 2016; North America, Australia/Oceania, UK; individual semi-structured interviews; elite athletes	- Athletic identity, sporting pressures, external locus of evaluation considered predisposing factors. - Life stress, adjusting to off-season, loss in competition and not able to practice self-care related to development of depression. - Self-recognition of initial manifestations of depression both in and out of training, competition and sport. - Maladaptive coping strategies including; social isolation, alcohol use and overtraining interpreted as self-harm. - Perceived barriers to recovery from depression including; lack of psychological support, lack of collaboration in treatment and public expectations from elite sport athletes. - Adaptive processes and turning points in recovery including; self-discovery outside of sport, utilising will to win toward commitment to recovery, expressing self in therapy and support from significant other. - Developing internal locus of evaluation, falling in love with sport again and gaining self-acceptance as central to recovery.	2

Dye[4] 2019; USA & Canada; individual semi-structured interviews; general community (fathers)	- Physical exhaustion connected to depression as a trigger for a depressive episode. - Partners having impact on men's HS behaviours - Perceptions of masculinity as a barrier to HS, stigmatisation and minimisation of depression as a key barrier. - Men needing a balance between validation, active support and space to cope with depression. - Maladaptive coping with the use of alcohol.	2
Gibson, Cartwright & Read[5] 2018; New Zealand; individual semi-structured interviews; general community	- 17/20 men stopped taking antidepressants at one point or another. - Taking antidepressants seen as 'taking charge or giving up control' - 19/20 men expressed concern about change in sexual functioning due to depression. - Experience of extreme emotional distress before HS for depression. - Men struggled to weigh up autonomy around decision to use antidepressants, or trust evaluations of others (doctors, partners) - Therapy as a way of relieving distress	1
Hinton et al.[6] 2017; USA; individual semi-structured interviews; primary care;	- Family involvement preferred after individual understands own difficulties with depression. -Person-centred approach important to participants - Participants want to manage privacy concerns within therapy and decide level of disclosure within the family. - Therapy helpful when discussions with family members are facilitated.	2
House et al.[7] 2018; UK; mixed method, individual semi-structured interviews; general community, primary care**	- Help-seeking (HS) for depression seen as shameful. - Men made attempts to cope with depression alone prior to making contact with services. - Optimistic view of the availability and accessibility of health care for depression - Men expressed wanting to cope with depression alone, as this was the 'masculine' thing to do. - Men fearing judgement from other men for not being able to cope alone (loss of personal and professional status). - Waiting lists perceived as problematic	3
Lakin[8] 2019; Burma/Myanmar; individual semi-structured interviews; general community (political prisoners)	- Endorsed ideas around masculinity; 'Honesty & Morality', 'Breadwinning', 'Leadership' and Self-Reliance'. - Areas of difficulty elicited, related to occupation stress, isolation, physical health, feelings of distress and post-incarceration issues. - Coping strategies adopted by men involved alcohol use, establishing healthy routines and political involvement. - The fear of appearing weak or vulnerable instead of self-reliant was enough to keep men from seeking help.	1
Mahalik & Dagirmanjian[9] 2019; USA; individual semi-structured interviews; general community	- Concerns about threat and stigma - 10/12 endorsed the perception that being a man means not seeking help. - Experiences of safety and relief when talking to others and ‘holding it in’ not working.	2

	- Conditions that reduce threat and stigma; death in the family, preference to disclose to women, less stigma in society generally and increased HS with age. - Seeking help is weak	
Pedersen, Maindal & Ryom[10] 2021; Denmark; individual semi-structured interviews; general community (fathers)	- 'Recognition and Perception of Depressive Symptoms' theme, outlining how fathers noticed changes in mood and behaviour but did not perceive these as symptomatic of depression until formally diagnosed. - 50% of fathers spoke about different normative masculine expectations. Describing men as 'proud', 'cynical', 'protective', 'strong' and provider. - Feelings of powerlessness and inadequacy challenged expectations of masculinity. 3/8 fathers cited normative masculine expectations as a barrier in seeking help for PPD. - Close family members e.g., partner plays an important role in prompting fathers to seek help.- 'Taboo, stigma and conforming to masculine norms' theme, outlining 'taboo', stigma and shame associated with seeking help and talking to others about PPD.	1
Scholz, Crabb & Wittert[11] 2017; Australia; individual semi-structured interviews; general community	- Medical understandings underpin discourses around the development and treatment of depression, particularly the relationship between physical and mental health. - Depression reported as it's experienced within a social context. - External factors associated with depressive symptoms (social and occupation - Positive aspects of depression, enabling men to speak about depression with a sense of agency. - Seeking help is wise, as it's best not to engage in masculine norms of not seeking help	1
Siedler et al.[12] 2018; Australia; individual semi-structured interviews; general community	- Men expressed need for better engagement strategies to enhance HS (establish trust, share control of treatment decisions, provide structured and practical therapy style). - Men who sought therapy endorsed a focus on a person-centred, collaborative therapeutic style. - All men experienced limited aim or direction during their treatment pathway 'basically a talkfest', which had negative implications for some. - All men endorsed the importance of honesty and transparency 'roadmap of therapy'.	3
Staiger et al.[13] 2020; Germany; Narrative -biographical and semi-structured interview; general community	- Before seeking treatment, help-seeking behaviour was negatively affected by internalized masculine norms, e.g., 'stigma of being unmanly' and hiding depression due to masculine norms. - Men with depression emphasized meaning toward mental health distress ('depression as an important life experience')and critically reflected on masculine norms. - Men-only groups were described as key for successful service use, a place 'for men to facilitate disclosure of weakness' and 'familiarity'	2
Wirback et al.[14] 2018; Sweden; individual semi-structured interviews; primary care	- Depression reported as interfering with everyday life (struggling with 'business as usual' and feelings from daily life). - Depression reported as interfering with self-identity and gendered ideas, participants negotiating ideal masculinity to accept and express depressive symptoms and ideal masculinity to feel accepted by others.	2

	- Men reported struggling with mental health services, exacerbated by lack of mental health literacy, not enabling them to identify depressive symptoms and seek psychological support. - Negotiation within self between treatment (e.g. medication) and managing on your own.	

* Note: Quality Ratings 1(low) 2(medium), 3(high)

Table 3: Characteristics, key findings and quality rating of quantitative studies

Study, design, setting	**Key findings**	**Quality ratings***
Call & Shafer[15] 2018; USA; cross sectional study; online questionnaire; general community	- HS associated with the endorsement of traditional depressive symptoms ($p<0.001$), the odds of seeking help for depression increased 60% with each additional symptom. - Male-typical symptoms of depression (described as aggression, irritability, violence, substance abuse, risky behaviour, and somatic complaints) decreased the likelihood of seeking help exclusively for depression ($p<0.001$), with each additional male-typical symptom associated with a 23% decrease in the odds of HS.	1
Eggenberger et al.[16] 2021; Europe (Switzerland, Germany, Austria, Liechtenstein and Luxembourg); cross sectional study; online questionnaire; general community	- Although experiencing similar levels of depression, men compared to women showed a reduction in psychotherapy use by 29%. - Masculine role identity was directly associated with reduced psychotherapy use in men ($\beta = -0.41$, $p = 0.029$). - Interactions revealed that men, but not women, with high adherence to traditional male role norms (AtTMRN) use psychotherapy only when exhibiting elevated symptom levels.	2
Hayward & Honegger[17] 2018; USA; cross sectional study; online questionnaire; general community	- Males who reported one or more mental health concern scored low on stigma - Depressed males reported structural and attitudinal barriers to HS; self-reliance (77%); thinking the problem will alleviate by itself (70%); concern around financial costs (67%); not wanting to appear weak (66%); feeling embarrassed and ashamed (66%); concern about available treatments including side effects of medication (64%); and being unsure how to access support (64%).	1
House et al.[7] 2018; UK; mixed-method; cross sectional study; questionnaire; general community, primary care	- Factor 1: 'Help is available if you can get to the point of asking for it' explained 34% of the variance ($p<0.01$) - Factor 2: 'Depression should be dealt with in private'; help-seeking makes you vulnerable explained 11% of the variance. 'I felt that I should have been man enough to deal with it'. - Participants who were significantly associated with both factors 1 and 2 described a sense of shame, relating to their own or others' views that being depressed and help-seeking conflict with 'masculine' values, such as strength and self-sufficiency.	1

	- Showing distress conflicts with hegemonic masculine ideals such as capability and power. - Views that help-seeking endorsed by participants as a courageous act, taking control of one's life and providing for one's family. - Uncertainty about nature of depression and difficulty justifying depressed feelings, thus impacting on help-seeking.	
Killian et al.[18] 2020; Germany; cross sectional study; online questionnaire; secondary care	- Adherence to traditional masculinity concepts directly associated with increased psychological distress and more stigmatizing attitudes towards depression. - Less adherence to traditional masculinity associated with better mental health and less stigmatizing attitudes if it coincides with ambition, recognition and coping strategies at work.	3
Ramaeker & Petrie[19] 2019; USA; cross sectional study; online questionnaire; tertiary students (male athletes)	- The male athletes endorsed greater overall 'conformity to masculine norms' ($p<0.001$) and 'gender role conflict' scores ($p<-.001$) than their non-athlete counterparts. - Among both non-athlete and athletes 'conflict between work and family relationships' significantly predicted higher depressive symptoms ($B=0.37$, $p<0.001$). - Among non-athletes, 'self-reliance' significantly predicted depression severity ($B= 0.25$, $p<0.001$). This was not significant among athletes ($B=0.07$, $p=0.326$). - 'Restrictive emotionality' associated with 'conflict between work and family relations' and 'self-reliance' for both athletes and non-athletes ($p=0.01$). - For both groups of men, higher 'conformity to masculine norms' scores was associated with higher levels of self-stigma and less favourable attitudes toward help-seeking.	1
Rice et al.[20] 2015; Australia; longitudinal study; online questionnaire; general community	- Duration of depression had adverse effects on help-seeking (HS). - Higher mean scores for HS barriers among long standing depression group compared to non-depressed group; 'Need for Control and Self Reliance ($p=0.001$), Concrete Barriers and Distrust of Caregivers ($p=0.001$), 'Emotional Control' ($p=0.001$), Minimising Problems and Resignation' ($p \leqslant .05$) and 'Privacy' ($p=0.01$) - Long standing depression group presented higher HS barriers that those who were not depressed at Time 1, but were depressed 15 weeks later (Time 2), Minimising Problems and Concrete Barriers were significant $p \leqslant .05$.	2
Rice et al.[21] 2020; Canada; cross sectional study; online questionnaire; general community	- Men's attitudinal barriers to mental health HS (minimising, distrust, self-reliance) had a greater predictive effect than structural barriers(e.g. finance, access to treatment) (33% vs 0% of items, respectively). - Lower likelihood of HS associated with men's reluctance to disclose mood-related symptoms to their physician (adjusted odds ratio [AOR] = 0.37), a tendency for self-reliance (AOR = 0.34), and uncertainty about the process of psychotherapy (AOR = 0.29).	3
Sileo & Kershaw[22] 2020; USA; cross sectional study; online questionnaire; general community	- Men endorsing status norms were more likely to see a mental health professional in the prior year ($\beta = 0.07$, $SE = 0.01$, $p < 0.001$).	3

	- Younger age (($\beta = -0.99$, SE = 0.08, $p < .001$), having medical insurance ($\beta = 2.43$, SE = 0.46, $p < .001$), meeting criteria for depression ($\beta = 2.43$, SE = 1.12, $p = .01$) and less hostility ($\beta = -0.21$, SE = 0.03, $p < .001$) associated with higher HS behaviours. - Men endorsing anti-femininity norms and toughness norms utilized mental health services less ($\beta = -0.06$, SE = 0.01, $p < 0.001$). - Men who reported using substances in the prior 30 days were less likely to have reported mental health service utilization in the prior year ($\beta = -1.37$, SE = 0.19, $p < .001$).	
Wasylkiw & Cairo[23] 2018; Canada; cross sectional study; online questionnaire; tertiary students	- Conformity to traditional masculinity norms predicted less favourable attitudes toward help-seeking mediated by self-stigma ($p<0.001$) - Intercollegiate athletes more likely to endorse masculine norms compared to non-athletes ($p<0.05$) - Higher self-compassion scores with favourable attitudes towards HS for athletes but not non-athletes.	1

*Note: Quality Ratings 1(low) 2(medium), 3(high)

Discussion

This review highlights five key themes, related to recognition and communication of depression, masculinity and help-seeking, views of treatment, meaning making from depression and the impact of the construct of masculinity has on coping strategies. Thus, this review reflects that the construct of masculinity has both positive and negative assertions, framing masculine ideals as both helpful and unhelpful for men with depression.

Unhelpful aspects of traditional masculine norms reported in papers included in this review are consistent with the assumption that some men with depression find it difficult to recognise, understand and communicate depression (Seidler et al., 2016); minimising depressive symptoms to avoid conflict with masculine norms (Cleary, 2012; Seidler et al., 2016) and wait until symptoms are severe before considering to seek help for depression (Oliffe & Phillips, 2008). Some men are significantly influenced by masculinity derived stigma which can lead to resistance to seeking help, and instead utilise unhelpful coping strategies characterised by avoidance and isolation (Seidler et al., 2016). Helpful aspects of masculinity reported in this review, rarely cited in the literature, (Englar-Carlson&Kiselica, 2013; Valkonen & Hänninen, 2013) capture the positive influence of self-reliance and courage, self-compassion in the context of seeking help and a skill learnt through recovery from depression, positive meaning making of depression and helpful coping strategies characterised by self-care and social involvement. Goal focused, collaborative, structured features of therapy are reported here as preferred among men with depression and have also been cited elsewhere in the literature as a preference (Seidler, et al., 2018).

This review builds on the Seidler et al., 2016 review as it corroborates and extends some key findings. Both Seidler et al., 2016 and this current review found that participants from included studies expressed difficulty recognising and communicating depression. The current review found that men understood physical health difficulties as potential contributing factors to depression, whereas Seidler et al., 2016 reflected that depressive symptoms were interpreted as indicators of potential physical illness.

Both this current review, and findings from Seidler et al., 2016 have shown that included participants do not want to appear weak and feel societal stigma from others, as according to the stigma felt by participants, depression is seen as indicative of not meeting masculine ideal.

The current review extends the findings from the Seidler et al., 2016 review, as it highlights that there are help-seeking barriers unrelated to masculinity reported in the studies, related to pragmatic factors such as cost and access to therapy. Both this review and the Seidler et al., 2016 review have shown that participants expressed extreme distress and severe symptoms of depression before seeking help, an indication that their resources to cope have depleted at the point of accessing care.

Like the Seidler et al., 2016 review, this current review also found that the use of anti-depressants was perceived by participants as a challenge to their masculinity as it meant not coping independently. Furthermore, this review found that some participants framed depression as an important life experience, a path to self-discovery, perhaps representing a spiritual aspect to the experience of depression not found in the Seiler et al., 2016 review.

Limitations

This review has several limitations. This review follows on from a previous review (Seidler et al., 2016). The search strategy used was replicated, which although helpful in terms of presenting new temporal findings, limited the choice of databases. However, hand searching of reference lists aimed to increase this scope.

Quality assessment was thorough although was not guided by a validated quality assessment tool as this review followed the quality assessment tool used by Seidler et al., 2016 to ensure parity in ratings, useful for comparing this current review to the previous review. The empirical standard for the included qualitative papers in Seidler et al., 2016 review was moderate and a higher standard than the quantitative studies. For this current review, peer review and secondary author review of quality ratings aimed to ensure valid and reliable quality assessments of all included studies.

Demographic findings of the included studies show that all included studies in this review highlight the vast range of help-seeking measures, reflecting inconsistency in screening tools utilised in clinical research. This limits the ability to compare, combine and synthesise results from a heterogenous dataset. Thus, this review is limited in being able to synthesis the available literature, which is not standardised in areas.

Inconsistency in measures for depression, masculinity and help-seeking prevented quantitative synthesis or meta-analysis and reflects the varying quality of included studies. However, the majority of studies were assessed to be of medium to high quality, indicating that the findings from this review are based on good quality primary findings.

It should also be recognised that the sample of men included in all studies were defined, rated or diagnosed as depressed. This means that the findings drawn from this review can provide some insight into the experience of some men with depressive symptomology but is not able to examine mental health help-seeking in otherwise non-clinical populations. However, many of the included participants in this review self-reported symptoms of depression, which allowed this review to include a range of men with depression understood as a continuum of experience and not only clinically defined.

Clinical Implications and Future Research

Implications for clinical practice in mental health can be guided by the review findings in the following key ways:

To improve attitude towards help-seeking and evaluating the worthiness of this process, some men may need support in recognising, understanding and communicating depressive symptoms, as this current review has found that some depressed men minimise symptoms of depression and restrict emotionality.

Some depressed men in this sample found it difficult to communicate their emotional needs to others, which can be a barrier to seek help. Masculine norms such as courage to seek help, taking ownership of recovery and feelings of empowerment could be amplified in clinical settings, for example considering treatment options could be presented as a self-reliant way to manage.

Masculine norms of self-reliance and strength could be utilised to break down self and societal stigma where depression and help-seeking conflicts with traditional masculine norms. In addition, perhaps empowering men by supporting them with skills to recognise and communicate depressed emotion could improve confidence in grappling with this mental health condition. Improving self-efficacy among men could support intentions to seek help.

The systematic review utilised a quality assessment tool for the included studies that was bespoke designed by Seidler et al., 2016 in a previous systematic review. The quality ratings were numerical from one to three. This was a useful comparative method to assess quality for both qualitative, quantitative and mixed-method studies, and the approach was consistent for the review which followed the previous work of Seidler et al., 2016. However, perhaps future research could adopt a recognised, validated quality appraisal tool that may facilitate better comparison to other reviews.

Depression is a serious mental health condition and this review highlights the way in which the construct of masculinity can make this journey harder or more compassionate for men experiencing depression. This review systematically presents findings that promote diverse and healthy masculinities.

Contributors

Primary author designed the study and wrote the protocol. Primary author conducted literature searches and provided summaries of previous research studies, and completed synthesis of findings. All authors contributed to the final manuscript.

Acknowledgments

The authors would like to thank University of East Anglia (UEA) supervisory team and librarians for their support.

Declaration of interest

This research was supported by the UEA as part fulfilment of the first author's Doctorate in Clinical Psychology. This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors. The authors declare no conflict of interest.

Data availability

The search history and list of derived papers are available on request.

Disclaimer

The views expressed in this research article are of the authors and are not an official position of the University of East Anglia

References

Brownhill, S., Wilhelm, K., Barclay, L. & Schmied, V. (2005) 'Big build': hidden depression in men. *Australian and New Zealand Journal of Psychiatry*, 39(10), 921–31. https://doi.org/10.1080%2Fj.1440-1614.2005.01665.x

Brydges, S., Rennick-Egglestone, S., & Anderson, C. (2020). Men's views of antidepressant treatment for depression, and their implications for community pharmacy practice. *Research in Social and Administrative Pharmacy*, *16*(8), 1041-1049. https://doi.org/10.1016/j.sapharm.2019.10.016

Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. *American journal of men's health*, *12*(1), 41-51. https://doi.org/10.1177%2F1557988315623993

Caperton, W., Butler, M., Kaiser, D., Connelly, J., & Knox, S. (2020). Stay-at-home fathers, depression, and help-seeking: A consensual qualitative research study. *Psychology of Men & Masculinities*, *21*(2), 235. https://psycnet.apa.org/doi/10.1037/men0000223

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*, 50, 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1

CRD (2009) Systematic reviews: CRDs guidance for undertaking reviews in healthcare. Centre for Reviews and Dissemination: University of York. https://www.york.ac.uk/media/crd/Systematic_Reviews.pdf

Dixon-Woods, M., Agarwal, S., Jones, D., Young, B., & Sutton, A. (2005). Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of health services research & policy*, *10*(1), 45–53. https://doi.org/10.1177/135581960501000110

Doherty, S., Hannigan, B., & Campbell, M. J. (2016). The experience of depression during the careers of elite male athletes. *Frontiers in psychology*, *7*, 1069. https://doi.org/10.3389/fpsyg.2016.01069

Dye, A. R. (2020). *" It's a real thing": fathers' experiences with perinatal depression* (Doctoral dissertation).

Eggenberger, L., Fordschmid, C., Ludwig, C., Weber, S., Grub, J., Komlenac, N., & Walther, A. (2021). Men's Psychotherapy Use, Male Role Norms, and Male-Typical Depression Symptoms: Examining 716 Men and Women Experiencing Psychological Distress. *Behavioral Sciences*, *11*(6), 83. https://doi.org/10.3390/bs11060083

Garcia, J., Bricker, L., Henderson, J., Martin, M. A., Mugford, M., Nielson, J., & Roberts, T. (2002). Women's views of pregnancy ultrasound: a systematic review. *Birth (Berkeley, Calif.)*, *29*(4), 225–250. https://doi.org/10.1046/j.1523-536x.2002.00198.x

Gibson, K., Cartwright, C., & Read, J. (2018). Conflict in men's experiences with antidepressants. *American journal of men's health*, *12*(1), 104-116. https://doi.org/10.1177%2F1557988316637645

Harrison, C. M., Britt, H., Harrison, C. M., & Britt, H. (2004). The rates and management of psychological problems in Australian general practice. *Australian and New Zealand Journal of Psychiatry*, 38(10), 781–788. https://doi.org/10.1080%2Fj.1440-1614.2004.01462.x

Hayward, R. A., & Honegger, L. N. (2018). Perceived barriers to mental health treatment among men enrolled in a responsible fatherhood program. *Social Work in Mental Health*, *16*(6), 696-712. https://doi.org/10.1080/15332985.2018.1483464

Hinton, L., Sciolla, A. F., Unützer, J., Elizarraras, E., Kravitz, R. L., & Apesoa-Varano, E. C. (2017). Family-centered depression treatment for older men in primary care: a qualitative study of stakeholder perspectives. *BMC family practice*, *18*(1), 1-9. https://doi.org/10.1186/s12875-017-0659-4

House, J., Marasli, P., Lister, M., & Brown, J. S. (2018). Male views on help-seeking for depression: AQ methodology study. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(1), 117-140. https://doi.org/10.1111/papt.12144

Johansson, E.F., Bengs, C., Danielsson, U., Lehti, A., & Hammerstrom, A. (2009) Gaps between patients, media, and academic medicine in discourses on gender and depression. *Qualitative Health Research*, 19(5), 633–44. https://doi.org/10.1177%2F1049732309333920

Johnson, J. L., Oliffe, J. L., Kelly, M. T., Galdas, P. & Ogrodniczuk, J. S. (2012), Men's discourses of help-seeking in the context of depression. *Sociology of Health & Illness*, 34, 345-361. https://doi.org/10.1111/j.1467-9566.2011.01372.x

Kendler, K.S., & Gardner, C.O. (2014) Sex differences in the pathways to major depression: A study of opposite-sex twin pairs. *American Journal of Psychiatry* 171(4), 426–435. https://doi.org/10.1176/appi.ajp.2013.13101375

Kilian, R., Müller-Stierlin, A., Söhner, F., Beschoner, P., Gündel, H., Staiger, T., ... & Krumm, S. (2020). Masculinity norms and occupational role orientations in men treated for depression. *PloS one*, *15*(5) https://doi.org/10.1371/journal.pone.0233764

Kilmartin, C. (2005). Depression in men: Communication, diagnosis and therapy. *Journal of Men's Health and Gender*, *2*(1), 95-99. https://doi.org/10.1016/j.jmhg.2004.10.010

Kiselica, M. S., & Englar-Carlson, M. (2010). Identifying, affirming, and building upon male strengths: The positive psychology/positive masculinity model of psychotherapy with boys and men. *Psychotherapy: Theory, Research, Practice, Training*, 47, 276–287. https://psycnet.apa.org/doi/10.1037/a0021159

Lakin, D. P. (2019). *Men's Engagement with Mental Health Treatment: Towards Inclusive Interventions in Low-income Contexts* (Doctoral dissertation, The Johns Hopkins University)

Mahalik, J. R., & Dagirmanjian, F. R. (2019). Working-class men's constructions of help-seeking when feeling depressed or sad. *American journal of men's health*, *13*(3). https://doi.org/10.1177%2F1557988319850052

Mahalik, J. R., & Di Bianca, M. (2021). Help-seeking for depression as a stigmatized threat to masculinity. *Professional Psychology: Research and Practice*, *52*(2), 146–155. https://psycnet.apa.org/doi/10.1037/pro0000365

Oliffe, J. L., Rossnagel, E., Seidler, Z. E., Kealy, D., Ogrodniczuk, J. S., & Rice, S. M. (2019). Men's depression and suicide. *Current psychiatry reports*, *21*(10), 1-6. https://doi.org/10.1007/s11920-019-1088-y

ONS (2018) *Suicides in the UK 2018 registrations.* https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/suicidesintheunitedkingdom/2018registrations

Pedersen, S. C., Maindal, H. T., & Ryom, K. (2021). "I Wanted to Be There as a Father, but I Couldn't": A Qualitative Study of Fathers' Experiences of Postpartum Depression and Their Help-Seeking Behavior. *American Journal of Men's Health*, *15*(3), https://doi.org/10.1177%2F15579883211024375

Pitman, A., Krysinska, K., Osborn, D., & King, M. (2012). Suicide in young men. *Lancet*, 379 (9834), 2383–2392. https://doi.org/10.1016/S0140-6736(12)60731-4

Pope, C., Mays, N., & Popay, J. (2007). *Synthesising qualitative and quantitative health evidence: A guide to methods: A guide to methods*. McGraw-Hill Education (UK). https://doi.org/10.1111/j.1467-9566.2007.1077_5.x

Ramaeker, J., & Petrie, T. A. (2019). "Man up!": Exploring intersections of sport participation, masculinity, psychological distress, and help-seeking attitudes and intentions. *Psychology of Men & Masculinities*, *20*(4), 515. https://psycnet.apa.org/doi/10.1037/men0000198

Rice, S. M., Aucote, H. M., Parker, A. G., Alvarez-Jimenez, M., Filia, K. M., & Amminger, G. P. (2017). Men's perceived barriers to help seeking for depression: Longitudinal findings relative to symptom onset and duration. *Journal of health psychology*, *22*(5), 529-536. https://doi.org/10.1177%2F1359105315605655

Rihmer, Z. (2001). Can better recognition and treatment of depression reduce suicide rates? A brief review. *European Psychiatry*, *16*(7), 406-409. https://doi.org/10.1016/S0924-9338(01)00598-3

Rihmer, Z., Rutz, W., & Pihlgren, H. (1995). Depression and suicide on Gotland an intensive study of all suicides before and after a depression-training programme for general practitioners. *Journal of Affective Disorders*, *35*(4), 147-152. https://doi.org/10.1016/0165-0327(95)00055-0

Rochlen, A. B., Paterniti, D. A., Epstein, R. M., Duberstein, P., Willeford, L., & Kravitz, R. L. (2010). Barriers in diagnosing and treating men with depression: A focus group report. *American Journal of Men's Health,* 4(2), 167–175. https://doi.org/10.1177%2F1557988309335823

Rutz, W., Wålinder, J., Eberhard, G., Holmberg, G., von Knorring, A. L., von Knorring, L., Wistedt, B., & Aberg-Wistedt, A. (1989). An educational program on depressive disorders for general practitioners on Gotland: background and evaluation. *Acta psychiatrica Scandinavica*, *79*(1), 19–26. https://doi.org/10.1111/j.1600-0447.1989.tb09229.x

Sandelowski, M., Voils, C. I., Leeman, J., & Crandell, J. L. (2012). Mapping the mixed methods–mixed research synthesis terrain. *Journal of Mixed Methods Research, 6*(4), 317–331. https://doi.org/10.1177/1558689811427913

Scholz, B., Crabb, S., & Wittert, G. A. (2017). "Males don't wanna bring anything up to their doctor" Men's discourses of depression. *Qualitative Health Research*, *27*(5), 727-737. https://doi.org/10.1177%2F1049732316640294

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: a systematic review. *Clinical psychology review*, *49*, 106-118. https://doi.org/10.1016/j.cpr.2016.09.002

Seidler, Z. E., Rice, S. M., Ogrodniczuk, J. S., Oliffe, J. L., & Dhillon, H. M. (2018). Engaging men in psychological treatment: A scoping review. *American journal of men's health*, *12*(6), 1882-1900. https://doi.org/10.1177%2F1557988318792157

Seidler, Z. E., Rice, S. M., Oliffe, J. L., Fogarty, A. S., & Dhillon, H. M. (2018). Men in and out of treatment for depression: Strategies for improved engagement. *Australian Psychologist*, *53*(5), 405-415. https://doi.org/10.1111/ap.12331

Seidler, Z. E., Rice, S. M., River, J., Oliffe, J. L., & Dhillon, H. M. (2018). Men's mental health services: The case for a masculinities model. *The Journal of Men's Studies*, *26*(1), 92-104. https://doi.org/10.1177%2F1060826517729406

Sileo, K. M., & Kershaw, T. S. (2020). Dimensions of masculine norms, depression, and mental health service utilization: Results from a Prospective Cohort Study among emerging adult men in the United States. *American journal of men's health*, *14*(1), https://doi.org/10.1177%2F1557988320906980

Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gündel, H., ... & Krumm, S. (2020). Masculinity and help-seeking among men with depression: a qualitative study. *Frontiers in Psychiatry*, *11*, 1317. https://doi.org/10.3389/fpsyt.2020.599039

Stroud, I., & Gutman, L. M. (2021). Longitudinal changes in the mental health of UK young male and female adults during the COVID-19 pandemic. *Psychiatry Research*, *303*, 114074. https://doi.org/10.1016/j.psychres.2021.114074

Valkonen, J., & Hänninen, V. (2013). Narratives of masculinity and depression. *Men and Masculinities*, *16*(2), 160-180. https://doi.org/10.1177%2F1097184X12464377

Van Antwerpen, N., Turnbull, D., & Searston, R. A. (2021). The role of anxiety in mediating the relationship between information consumption and COVID-19 protective behaviours: Psychology, Health & Medicine. *Psychology, Health & Medicine*, 1-14. https://doi.org/10.1080/13548506.2021.2008994

Vogt, W.P. (2005). Dictionary of Statistics & Methodology: A Nontechnical Guide for the Social Sciences. SAGE

Wasylkiw, L., & Clairo, J. (2018). Help seeking in men: When masculinity and self-compassion collide. *Psychology of Men & Masculinity*, *19*(2), 234. https://psycnet.apa.org/doi/10.1037/men0000086

White, A., & Holmes, M. (2006). Patterns of mortality across 44 countries among men and women aged 15–44 years. *Journal of Men's Health,*3,139–5. https://doi.org/10.1016/j.jmhg.2006.04.002

Wirback, T., Forsell, Y., Larsson, J. O., Engström, K., & Edhborg, M. (2018). Experiences of depression and help-seeking described by young Swedish men. *Psychology of Men & Masculinity*, *19*(3), 407. https://psycnet.apa.org/doi/10.1037/men0000110

Chapter 3
Bridging Section

The review provides the latest state of the evidence on the role of masculinity and help-seeking for depression. In the synthesis of findings of included studies, thematic analysis was the dominant approach to synthesising the qualitative evidence. No discursive analysis of data was found, nor was photo-elicitation as a method of data collection. Society is a key driver men experience, influencing how masculinity and help-seeking is constructed, therefore, a focus on the language used in society was an integral part of the empirical study design.

The review also focused on male depression, as depression has been cited as one of the precursors to suicide among men (Rhimer, 2001). As stress has also been regarded as a precursor for male suicide in the literature (Van Heeringen, 2012), a focus on the experience of stress was a natural step in the design of the current empirical study.

With the aim to try and further the research in this area of mental health, the empirical study was designed to explore the experiences of younger men between the ages of 16-25 years old and what role if any hegemonic masculinity has on mental health help-seeking, utilising a qualitative design and discourse analysis.

Chapter 4

Discourses of Stress and Anxiety, Exploring the Construct of Masculinity in Relation to Help-Seeking Behaviour

Zuleika Irvanipour

Wordcount: 7,092

Prepared for submission the Social Science and Medicine
(Author guidelines in Appendix H)

Doctoral Programme in Clinical Psychology

University of East Anglia

SOCIAL SCIENCE AND MEDICINE

Discourses of Stress and Anxiety, Exploring the Construct of Masculinity in Relation to Help-Seeking Behaviour

Zuleika Irvanipour [a*], Caitlin Notley [b], Paul Fisher [c]

[a] *Norwich Medical School, University of East Anglia, Norwich, UK*
[b] *Norwich Medical School, University of East Anglia, Norwich, UK*
[c] *Norwich Medical School, University of East Anglia, Norwich, UK*

*Corresponding author: Department of Clinical Psychology and Psychological Therapies, Norwich Medical School, University of East Anglia, Norwich Research Park, Norwich, NR4 7TJ.

Email address: z.irvanipour@uea.ac.uk

Abstract

Aim: Young men's mental health is at crisis point globally, perhaps significantly seen in the statistics on male suicide. There is growing evidence that suggests men experiencing psychological distress are unlikely to reach out for support even when it is perhaps needed. The literature suggests that socially constructed hegemonic masculine norms may be part of a barrier to mental health help-seeking among some men. This empirical study aims to understand the experience of stress among young men in particular, and explore the potential role hegemonic masculinity has on help-seeking.
Method: A qualitative design collecting semi-structured individual interviews alongside photo-elicitation data with seven young men from the UK. Discourse analysis was utilised to draw out interpretive repertoires, subject positions and discursive strategies from individual accounts. *Results:* Young men (20.4 years) were interviewed. Five key interpretive repertoires were drawn from the data; 'stress as unchangeable and unmanageable', 'stress reflected in and out of self', 'powerful and powerless against stress', 'survivor of stress' and 'self-reliance'. Metaphor and alternating positions were identified as key discursive devices among this sample of young men.
Conclusion: The young men from this study indicated that stress and anxiety is recognised as pervasive in nature, and within that they hold subject positions of both being able to and not being able to cope, which closely adhere to hegemonic masculine norms of self-reliance, power and strength. Discursive strategies are employed to portray feeling and also protect the self from perceived weakness. Implications suggest that the operationalisation of self-reliance within health care by working with hegemonic masculine norms in a nuanced way could be a way forward in supporting young men to seek help when they need to.

Highlights:

- Men are able to recognise stress and the impact on the self
- Photo-elicitation and discourse analysis combined provide insights into male mental health
- Young men ask support from select few, and both engage and resist support from services
- Self-reliance is characteristic of hegemonic masculinity and part of help-seeking barrier

Article info

Keywords: Hegemonic Masculinity, Young Men, Stress, Help-Seeking, Photo-elicitation, Qualitative, Discourse Analysis

Introduction

Globally among men life expectancy is five years less than women, and the life expectancy gap is expected to widen over the next decade (Baker & Shand, 2017). This disparity is apparent when considering mental health among men globally too, as men are 1.8 times more likely to end their own lives compared to women (World Health Organization, 2017), with stress and anxiety playing an integral role in the development of distress leading to suicide for some (Van Heeringen, 2012; Liu & Miller, 2014)

Compared to women, men are less likely to seek help for mental health distress (Sagar-Ouriaghli et al., 2019), and this is not due to a lack of need. Intersecting factors relating to men's psychological distress have been cited to include undiagnosed mental health issues among men (Esposito, 2002), challenges in educational settings (Adcock, Bolton & Abreu, 2016), increased workplace stress (Padkapayeva, 2018), prevalent forensic issues (Prison Reform Trust 2005), increased suicide (Pitman, 2012), high levels of potentially traumatic events (Tolin and Fao, 2006) and increased likelihood of homelessness (Susser et al.,1997). In addition to this cognitive factors such as difficulty to recognise and communicate depressive symptoms (Seidler et al., 2016), minimising depressive symptoms (Cleary, 2012) and engage in unhelpful behavioural strategies including avoidance and isolation (Irvanipour et al., 2022).

The navigation of mental health distress characterised by low help-seeking behaviours has been partially explained by hegemonic masculinity (Brydges, Rennick-Egglestone, & Anderson, 2020). The concept of hegemonic masculinity has been hypothesised as impacting male self-perceptions that may limit help-seeking behaviours. Hegemonic masculinity (Connell, 1987) describes the dominant view of masculinity as a social construct representing men needing to be powerful, tough, competitive and emotionally unobtrusive (Courtenay, 2000). Although in western societies the hegemonic masculine norm is described in this way, men are not a homogenous group and masculinity covers nuanced meanings across individuals, cultures and context (Beasley 2008; Robertson, Williams & Oliffe, 2016). Hegemonic masculinity, in this current study and other research in this area is discussed within the context of a problem, however, many contexts allow for more positive interactions with this construct.

Seeking help for mental health distress is an internal, sequential process that occurs within an individual, going through stages of recognising a problem, expressing this, identifying sources of help and ability and willingness to disclose need (Mitchell, 2017; Rickwood et al., 2005). Where hegemonic masculinity encourages certain traits and behaviours, it perhaps discourages others. As seeking help for mental health distress contrasts with the hegemonic masculine norm associated with courage and self-reliance (Cleary, 2017; Courtenay, 2000), it has been suggested that men are unwilling to ask for help to manage their mental health when needed (Addis & Mahalik, 2003).

The literature on suicidality, for example, highlights that the hegemonic masculine ideal works both for and against men. In a study on men experiencing depression, family connectedness and involvement in fathering was a protective factor to acting on suicidal thoughts (Emslie et al., 2006; Oliffe et al., 2012). Similarly, provider-protector characteristics found among a sample of Canadian men were linked to mental health help-seeking (Oliffe et al., 2012). However, research also indicates adherence to masculine norms among men have endorsed high levels of psychological concerns, such as depression (Shepard, 2002). This reflects the complex nature of how masculinity is constructed in the context of help-seeking and matches qualitative methodology which allows for explorative investigation of such constructs.

Although research on the views of young men is scarce, a study on the views of male children spanning 10-15 years old in North America found that children and teenagers alike disclosed that sharing feelings would feel ‘weird’ and pointless (Rose et al., 2012). This belief and consequent behaviour are potentially placing some young men at risk, as some problems can escalate and may ultimately lead to suicide attempts. In the UK, young men aged 25–34, are four times more likely to kill themselves than women in this age group (National Suicide Prevention Strategy for England, 2004). Concealing distress and the tendency to not seek help, and maintaining hegemonic ideals of masculinity, may partially explain this outcome (Cleary, 2012). Thus research into the views of young adult men is integral in the design of future research, including this present study which incorporates this need.

The inclusion of images in qualitative research, combined with more ‘traditional’ oral data has been incorporated in the discourse analysis literature, although the approach is novel

(Norris, 2002). As all discourse is indexical, attention is placed on how data is produced, and by broadening the available channels of discourse, interpreting discourse in a wider sense as both oral and visual data, this study makes space for beliefs, opinions, versions of events to be actively constructed, accomplishing social actions positioned in context, using both linguistics and imagery.

Photo elicitation provides an additional way for participants to develop emotional connections to memories discussed during the interview, thus creating more meaningful accounts (Harper 2002; Kunimoto 2004), and broadening the corpus for discourse analysis. Integrating photo-elicitation with semi-structured individual interviews has been considered by leaders in the field of male mental health as a way to capture men's perspectives adequately (Oliffe and Bottorff, 2007), and current research has generated rich discursive analysis (Oliffe et al., 2020).

The literature on suicidality for example, highlights that masculine ideals can work both for and against men. In a secondary analysis of a UK sample of men experiencing depression, family connectedness and involvement in fathering was a protective factor to acting on suicidal thoughts (Emslie et al., 2006; Oliffe et al., 2012). Similarly, provider-protector characteristics found among a sample of Canadian men were linked to mental health help-seeking (Oliffe et al., 2012). This reflects the complex nature of how masculinity is constructed in the context of help-seeking among men, and thus a qualitative rather than a quantitative approach is required, whereby the parameters of what is being investigated has room to evolve and develop.

Discourse analysis, which focuses on the purposefulness of dialogue, has been utilised within qualitative research to make sense of complex constructs including hegemonic masculinity (Martin, 2016), although thus far discourse analysis has not yet been combined with photo-elicitation to explore the constructs of help-seeking and masculinity as it relates to the experience of stress among young men.

This study aims to explore the views of young men in the UK, asking the question: *What is the experience of stress and anxiety among young men and does the construct of masculinity play a role in their experience of distress and mental health help-seeking?*

Participants and Procedure

In-depth semi-structured interviews were conducted between August 2020 and November 2020 with seven male participants. See Table 1 for participant demographics.

The primary researcher conducted purposive sampling with a criterion sampling approach between July- November 2020. COREQ guidance is used to report qualitative design and findings (Tong, Sainsbury and Craig, 2007). Please refer to 'Extended Methodology Chapter' for more detail.

Recruitment

The primary researcher developed a professional relationship with management and support staff at a community centre from September 2020 to November 2020. Online recruitment was advertised on online forums (Appendix I) and social media platforms (Appendix J). Participants were also recruited in-person opportunistically in public spaces.

Photo-elicitation

Participants were asked to provide one to five photos they felt best represented their experience of stress, and/or help-seeking. This was intended to allow participants to bring to the interview what felt important to them and broaden the available forms of presenting discourse in the interview. Participants were given a secure NHS.NET email to send photos to, and these were then uploaded to a secure encrypted USB.

Data collection

Audiotaped semi-structured interviews were conducted by phone (n=5) and face-to-face (n=2). Participants were offered video calls but all participants declined. For face-to-face interviews, in line with Covid-19 infection guidance at the time, a large outdoor space was used, where both researcher and participant were able to be at a 2-metre distance (Department of Health and Social Care, 2020). Interviews ranged from 50 to 86 minutes.

Interview

As the interview format itself is an unnatural social construction, efforts were made to reduce the impact this context would have on the semi-structured interviews. To enhance naturally occurring speech, the researcher contacted participants before the interview to introduce herself and organise the time and place of the interview. The interview schedule (Appendix

K) was used as a set of prompts for the researcher to ensure that key areas of interest were being covered, however, the order of questions was not forced, to allow for fluid discourse. All participants gave informed written consent before the interview. Participant accounts were anonymised and pseudonyms were given. Ethical approval was sought and granted from the Research Ethics Committee of the Faculty of Medicine and Health Sciences at the University of East Anglia, reference number: 2019/20-086.

Reflexivity

During the course of planning and completing the study, the primary author and research supervisor held regular meetings where reflexivity was discussed. The primary author additionally kept a journal to log reflections (Appendix L). See 'Extended Methodology Chapter' for more detail.

Data Analysis

A social constructionist epistemology was felt to be aligned with the research question, as the construct of key ideas such as 'stress' and 'masculinity' was understood to be formed and made relevant through interactions with others (Edwards & Potter, 1992) and located in a historical-cultural context (Burr, 2015; McMullen, 2021).

Discourse analysis was adopted to understand the social practices and performative characteristics of discourse derived from interviews and photo-elicitation (Locke & Budds, 2020). Discourse analysis was completed in six parts and closely adhered to the discourse analysis approach as outlined by Locke and Budd (2020). The analysis involved data immersion, drawing out discursive constructions, interpretive repertoires, subject positions and discursive devices incorporating wider societal discourses in the final stages of analysis (Appendix M). Accounts were transcribed verbatim and scripts were anonymised. This analysis revealed five key interpretive repertoires (see Table 2). Short direct quotes embedded in tables and text will be in quotation marks. These are chosen to illustrate interpretive repertoires drawn out for analysis.

Findings

Eligible participants were required to a) be between the ages of 16-25 years old, b) identify as male, c) self-identify as having experience with stress and anxiety impacting daily functioning d) living in the UK and the community and e) be fluent in English.

The mean average age of participants was 20.4 years ranging between 17 and 26 years old. One participant, Iman, was 25 years old at recruitment and 26 years old at the time of the interview, so it was decided to include this participant (see Table 1). There were a range of ethnicities reflected in this sample; British ethnicities (Pakistani British, White British, Black British. British Asian, British Bengali) as well as Black African and Black Caribbean. Most young men in this sample were enrolled in a higher education course at the time of interview.

Table 1: Participant Demographics

Participant	Age (yrs)	Ethnicity (verbatim)	Current Location	Education status	Work status	Additional health concerns	Interview Location
Iman	26	Pakistani British	Scotland	University	N/A	None	Phone
Harry	20	White British	London	N/A	Part-time	None	Phone
Steve	17	Black African	London	College	Part-time	Brain Tumour	Phone
Trevor	20	Black British	London	University	Part-time	None	Community Centre
Luke	17	Black Caribbean	London	Sixth Form	None	None	Community Centre
Ayaz	24	British Asian	Cambridge	University	N/A	None	Phone
Azam	19	British Bengali	London	University	N/A	None	Phone

The accounts of these young men combined with photo-elicitation materials generated five core interpretive repertoires and accompanying subject positions relaying specific discursive social functions. See Table 2.

Table 2: Discursive strategies used by participants

Interpretive repertoire	Subject Position	Discursive accomplishment
Stress as unchangeable and unmanageable	• Positions stress as coming from an unknown source • Minimising own mental health distress • Self-fulfilling prophesies • Stress needing to be controlled	- Constructs stress as an intangible emotion - Aligns with invalidating own stress - Positions self as emotionally unaffected by stress - Undermines own influence on stressor - Protects self from feelings of failure - Invokes attacking nature of stress
Stress reflected in and out of self	• Stress is severe when experienced • Stress reflected back to self in environment • Attributes stress as a reason for negative behaviour • Linking stress to other emotions • Linking stress to physiological symptoms	- Positions self as overwhelmed by stress - Positions stress as influencing interactions with others and environment - Positions stress as being reflected outside oneself
Powerful and powerless against stress	• Attributing stress to external factors • Invoking contradictory messages on the cause of stress (goals) • Invoking contradictory messages on managing stress	-Positions stress originating from outside oneself - Constructs future where self is a failure and removes self from the present -Positions self as coping with stress yet also not coping
Survivor of Stress	• Invokes self-attributable coping strategies • Invoking sense of relief from having managed stress • Discusses stress as a shared emotional experience	- Presents self as protective of own wellbeing - Positions self as self-reliant, capable of managing stress - Presents to audience coping strategies that are efficacious - Invokes personal growth from managing stress - Positions self among others who have been affected by stress
Self-reliance	• Attributes belief of "strong on your own" as a course of stress • Expressing preference to socially withdraw as a coping strategy • Positions self as not needing support from health care professionals • Positions self as seeking and receiving help from health care professionals and non-health care professionals • Invokes features of support that have been helpful and unhelpful	- Positions self-adhering to masculine ideals of strength and self-reliance - Separates self from others when in distress - Resists support from services - Positions self as needing support from other people and services - Positions other systems and services as having more information than the self - Constructs both helpful and unhelpful features of support

1. Stress as Unchangeable and Unmanageable

This interpretive repertoire is underpinned by participant discourses that stress originates from an unknown source felt to be "not tangible", which often makes it difficult to ascertain whether feelings of stress are valid or not, making the discursive construct of 'experiencing stress' unchangeable and unmanageable.

Young men's assertions that stress can be dismissed is reflected in the collective discourse which placed stress as felt only for the short-term and temporally in the past, thus taking on the subject position of negating any current impact of stress on themself, therefore stress is talked about as a fixed construct.

"Researcher: ...how do you mange stress?

Steve: I don't really know it's just like it's I don't it's just a quick thing it's like cos I don't really sort it out it's just kind of disappears"

Steve, 17. Line 187-189

Steve's omission of a verb to denote process and action towards the construct of 'experiencing stress' establishes a resistant and perhaps dismissive subject position to the interpretive repertoire 'stress presents as unchangeable and unmanageable', and conveys the notion that stress does not need to be managed or changed. Although this resistant subject position was revealed in other participant accounts, some participants expressed an alternative position where stress needs to be controlled, characterising stress as impeding ones wellbeing and taking on the subject position that conveys purposive action on the experience of stress.

Some participants took on the subject position that stress is unmanageable, reflected in the discursive construction of 'self-fulfilling prophesies'. Accounts revealed occupational and academic stressors as causing anxiety which leads to a loss of focus, fatigue and depression, making a negative outcome in achievement more likely. Participants go on to discuss external factors that are involved in contributing to stress in these areas, invoking the idea that one cannot ultimately do anything to change an outcome.

Iman, 26, shares his view on how stressful applying for jobs have been for him, and factors that have contributed to him feeling that there is little reason to apply in the first place, speaking to the subject position of self-fulfilling prophesies:

"um I suppose like it's maybe because yes I think maybe I lose focus because I um I'm intimidated by the application I feel like it's hard maybe I won't be able to meet the expectations or won't be able to demonstrate my skills properly or maybe like um I don't actually maybe they'll think I'm not suitable for the position so it's a waste of time things like that come into my head mind"
Line 259-263

Maintenance of this subject position has the social function of possibly protecting himself from difficult feelings of failure and inadequacy, thus maintaining the social attributes of competency and agency when presented with a face-threatening act (Goffman, 1967). Thus discursive devices are used as a way of 'saving face' within this interpretive repertoire.

2. Stress Reflected In and Out of Self

Participants reflected that stress is severe when experienced "when it rains it pours", and that the experience of being anxious is reflected back to them in their environment:

"felt quite frustrated then just yes frustrated and just agitated and I thought this image displayed that because it's obviously all black well the sky is dark let's say dark and um darkness is usually obviously associated with um kind of negative feelings you know"
Iman, 26. Lines 748-750

Fig 1. Darkness is usually obviously associated with um kind of negative feelings.

Harry, 20, also depicts his external environment being a manifestation of his affect:

"Harry: It all seemed useless and so for me that unmade bed is kind of like the manifestation of feeling like it's useless

Researcher: yes, feeling that's what's useless in particular is it how you feel about yourself or the world or

Harry: the kind of concept of myself do you know what I mean we kind of

Researcher: yes"

Lines 858-863

Fig 2. It all seemed useless.

The use of ‘metaphor’ is a discursive device utilised within this interpretive repertoire. Metaphorically ‘light and dark’ is situated in the socio-cultural context where this metaphor is synonymous to ‘good and evil’, ‘right and wrong’, an example of intertextually (Hodges, 2015). The social function of this strategy is to situate the construction of ‘stress’ in a negative, all-encompassing framework, where the participant is seen to be not coping in that moment.

Additionally, participants attributed stress as a reason for negative behaviour, including violent behaviour towards self, others and objects. Associations with stress were made within the discourse using words linking stress and; anger, depression, unworthiness, irrationality and self-criticism. This device indicates to the audience/listener that stress has a pervasive effect on the self. Contributing elements to the construction of ‘stress’ was highlighted by most participants as a physiological influence. Ayaz, 24, expresses this assertion:

“Ayaz: ...I was like a missing child and got kidnapped and all this stuff

Researcher: oh

Ayaz: and even after this I had shingles

Researcher: wow

Ayaz: which was like they say the doctors were saying well like it was stress related"

Lines 160-165

Ayaz goes on to discuss agreement with this notion, and adheres to the interpretive repertoire that stress impacts many facets of life. This subject position is widely adhered to among participants and posits that the management of stress is difficult as its impact is vast.

3. Powerful and Powerless Against Stress

Within this interpretative repertoire, stress as a construct is almost personified, and positioned as a source to be battled against. Within this repertoire participants take up opposing subject positions, as either powerful or powerless and in many accounts take up each of these subject positions of both powerful and powerless against stress, consequently simultaneously portraying coping and not coping with stress.

Participants attributed internal feelings of stress to external factors, and adopting the subject position of powerless against stress, highlighting the negative impact of Covid-19, describing; health concerns, uncertainty, missed opportunities, and digital dependency in the context of studying. Harry, 20, illustrated the way in which life had revolved around the Covid-19 outbreak, taken in September 2020:

Fig 3. Incessantly going all around this central covid idea.

"Harry: one of the pictures I took actually

Researcher: yes

Harry: was um so it's the one of the sign saying

Researcher: oh yes

Harry: stuff about covid and uh that was the only one I got to be arty with because it was a pretty abstract thing I wanted to portray and it was just the so I did like a long exposure you can see the people kind of like there they're almost smeared across the screen

Researcher: yes yes

Harry: so I did that because it's just that kind of constant bustle I wanted to capture the movement and how everything was kind of incessantly going all around this central covid idea"

Lines 569-575

Stress was also constructed by many of the young men as being underpinned by academic workload, where unfamiliar tasks, and the requirement to work independently had become a source of anxiety.

Participants cited being influenced by distractions (other people and electronic devices) and a lack of resources, namely time, luck and money as contributing to their experience of stress. The consequence of taking on a 'powerless' position is perhaps similar to the facework seen in 'stress as unchangeable and unmanageable' as a way of shifting source of stress externally to ensure that stress is not presented as something derived from internally. Being powerless against stress also makes it possibly easier to dismiss and invalidate.

The expectation put on oneself to socialise with others was an additional stressor described by many, where meeting new people was often met with anxiety. Many of the participants anticipated social judgement, described in general terms as not being liked and also in specific terms as racism and violence from others. Participants described social judgement being introduced through in-person and online interactions. Luke, 17, described his experience of negative social judgement from others:

"Luke: I didn't really realise it like I knew what like racism was and I knew that I will be treated differently
Researcher: uh huh
Luke: But I never understood how how deep it would go"
Lines 245-248

Ayaz, 24, chose an image illustrating social conflict and described the stress as chaotic.

Fig 4. So much chaos, so much destruction.

"Ayaz: Well first of all you know I thought it was very powerful and moving I think it's really is you know thing the quote that say's pictures can portray a thousand words

Researcher: yes

Ayaz: there was very much resemblance in this you know there's so much going on so much chaos so much destruction

Researcher: yes

Ayaz: and people look very similar"
Lines 551-557

The discursive device of metaphor is used here to represent chaos, uncertainty and stress, as images were purposively chosen that looked busy, crowded and blurry. Perhaps this was to visually enact the confining, stuck and overwhelming nature of stress.

Participants positioned relationships and family issues as causing stress. Being relied upon by others, balancing the needs of others and themselves, and familial expectations of success were cited as key stressors in this area. Men's assertions that past and future worries impact

their experience of stress were cited. Reconstruction of traumatic past events and construction of failed future selves described subject positions of powerlessness. These subject positions have the possible purpose of removing oneself from the present, contributing to a disempowered position where there is little control over one's own wellbeing. The predominately external factors constructed as stressors puts participants in a position of being enacted upon by the world, and perhaps the implication that blame is removed from the individual as one is helpless when positioned as enacted upon. This removal of blame may be a way to protect self-esteem, as stress is seen out of control.

Alternate positions of feeling both powerful and powerless against stress were presented in the discourse, where stressors were and weren't stressors, for example, lack of resources for studying and high familial expectations were both regarded as source of stress and not a source of stress in the same interview. Participants also alternated positions describing striving for goals as both a source of worry and fulfilment. Perhaps alternating positions is a reflection of not knowing which position to inhabit, feeling undecided, or possibly a way for self-esteem to inhabit a protected position as participants are able simultaneously identify and be ambivalent towards the external stress.

Alternating positions were described by Steve,17, who described both knowing what environment can reduce stress for himself, and not knowing what environment would help him:

"Steve: yes cos I'm coaching and teaching them and obviously kids are quite funny sometimes

Researcher: yes

Steve: so

Researcher: yes yes so that doesn't' cause you much stress um why is it do you think that it doesn't cause you much stress

Steve: mainly because it's like I find I'm not so stressed in that environment and sort of relaxed"

Lines 331-339

"R: are there places that you go to feel better about things or to feel like you know a bit less stressed

Pt: no"

Lines 534-536

Thus, different positions towards 'powerful and powerless against stress' are striking here as this one context of managing stress, where the position of knowing how to reduce stress and the position of not knowing are conveyed in the same interview. Perhaps the function of this discursive device may be to disclose what one can do to precipitate stress while simultaneously showing what one cannot do in the face of stress.

4. Survivor of Stress

This repertoire reflects participant discourses that invoked self-attributable coping strategies where one has internal locus of control and can manage, a dominant position to occupy and a consciously chosen narrative to meet perceived masculine ideals of how to cope with stress.

Cognitive based strategies of invoking the "power to be positive" and self-belief were used in essence to keep stress at bay. During these interviews, a strong sense of self was presented and noticed by the researcher, and Trevor, 20, was one young man who both presented in this way and attests to this approach of coping:

"Trevor: no I feel like I'm fine I feel like it's just a thing where I can get a little bit stressed but I feel like I can overcome it
Researcher: yes
Trevor: yes
Researcher: and what is it is it the kind of strategies that we spoke about earlier like how you can overcome things
Trevor: yes I wouldn't let it get to my head like there's an awful lot I always think like I'm superior like I always think nothing can defeat me so that's why I always like yes"
Lines 1020-1027

Participants spoke of the need to both physically and cognitively enforce boundaries to protects ones wellbeing, again portraying confidence in practice. Participants describe not attending to stress, reducing exposure to stress and maintaining boundaries with others to help prevent stress (e.g. financially supporting friends). Physical boundaries were also implied by participants as a way to protect ones physical body.

"Luke: she's more overprotective when she's seen the news and someone's been stabbed
Researcher: ok and how is that for you
Luke: like I mean I don't do anything to anyone so if you try if anyone tries to do something to me that's on them"
Luke, 17
Lines 485- 489

Participants have also regarded themselves as coping with stress by perceiving the presence of a stressor as an opportunity for growth, a prompt to achieve goals and help others in the pursuit of helping oneself. Ayaz, 20, describes helping his sister and being focused on bright horizons:

"It's a really cool place so it's called White Sands and it's just miles and miles of like ?? and pure white sand and then there's like sunset and then you know my sister is in the background like for me this is like my sister kind of like following in my footsteps me being the role model but like we also like the thing of like um you know the worlds your oyster kind of thing being like on the horizon there's so many opportunities ahead and like just you know guided by the light kind of thing"
Lines 590-595

Fig 5. My sister kind of like following in my footsteps.

Ayaz holds a powerful subject position here as presenting himself as a responsible role model, utilising strong use of metaphor in both the text and picture.

Engaging in hobbies were also highlighted as effective coping strategies, with listening to music, engaging in sports and playing video games common activities. Mindfulness based strategies were indicated among all participants where cooking, engaging in nature, mindful breathing, and use of lighting were encapsulated as part of this theme. Iman, 26, captures this strategy, focusing on the supportive characteristics of nature:

"Iman: the first photo was like um I think of um like a green field
Researcher: yes
Iman: Kind of yes a field and because me and my this area is near my house and I sometimes go there just walk sometimes go there just walk through there like on my walk and um
Researcher: yes so it was the green field I'm looking at the same thing as well it looks quite peaceful
Iman: yes yes it is quite peaceful very quiet um not many cars even pass through like travel through there
Researcher: it's a lovely photo I was wondering Pt what made you want to take that photo on that day
Iman: um so actually I took the photo before actually it was taken well back actually but I felt this photo would capture what I was feeling
Researcher: ok lovely

Iman: um yes I mean I yes I was sending you this photo because um I was feeling quite calm on that day
Researcher: yes
Iman: and content and I thought that this photo kind of displays, shows that because it's and you can see it's quite um a natural place it's"

Lines 126-142

Fig 6. I was feeling quite calm on that day.

Participants invoked a sense of relief "like a weight off my shoulders" from having managed stress, positioning the self as powerful and able to cope. The felt subject position of stress as a shared experience where they are firmly not alone was revealed in participant accounts, and pertains to this interpretive repertoire.

5. Self-reliance

Self-reliance is symbolic of independent young adulthood with clear subject positions. The position of striving towards complete independence and be "strong on your own" was described in third person by Harry, 20:

"uh well to help younger men there's a long way to go not just in the NHS there's a whole I mean again toxic masculinity that's in every part of our everyday culture kind of the whole you know the toughness, the perfect man thing..."
Lines 826 – 828

Needing to be self-reliant was described in participants accounts, where the subject position of being or striving towards being responsible for themselves, their own finances and the wellbeing of family and friends were articulated. Participants constructed the hegemonic masculine ideal of self-reliance as being characterised "like the Cure song Boys Don't Cry" and the expectation to "man up" and "pull yourself up" - discourses that potentially forge a significant help-seeking barrier. The accounts indicate that self-reliance is constructed as a daunting prospect and source of stress, whilst also a hegemonic masculine ideal.

Participants invoked hegemonic masculine expectations of strength characterised as both physical and emotional. Iman, 26, described this expectation with the background that he feels that he falls short of this ideal:

"and I suppose men are supposed to be like we're meant to be more stoic and more like strong physically"

Lines 695-696

Within this overarching repertoire of managing in isolation, young men described socially withdrawing from others as a coping strategy and positioned themselves as not needing support from external health care services. Luke, 17, comments on this view and explains his resistance to seeking and receiving help for his mental health from his GP:

"R: and how do you feel about I guess GP's and mental health support that they could signpost to so for example if you had a difficulty how would you feel about going to a GP or anything like that
Pt: I'd probably be hesitant probably
R: yes why do you think that is
Pt: because my mental health is something that has to be taken care of by someone that I know who actually cares

R: uh huh
Pt: and that I can know I can trust"
Lines 748-756

Participants cited a number of reasons for not wanting to seek help from health care services, namely that; seeking help is losing one's independence and that seeking help from the GP is for physical not psychological problems.

Azam, 19, presents an account of how the hegemonic masculine norm of self-reliance developed for him, and his position now:

"Azam: and like again you're just being stupid um the whole concept of man up I think as a kid probably
Research: Yes
Azam: because like when we'd cry it would be like oh stop being a girl or what not
Researcher: Ok
Azam: which is pretty stupid and sexist"
Lines 838-843

An alternative position is seeking and receiving support from people and systems, which could be interpreted as relying on one's resourcefulness, and/or rejecting the hegemonic masculine ideal of being "strong on your own".

Some participants described seeking help from health care professionals, being open to both GP and psychological services, young men in this sample shared that they have received support from a university counsellor, GPs and CAMHS.

Participants discussed effective features of treatment for mental health distress, citing confidentiality, space to disclose feelings, validation and promotion of self-sufficiency as important. Azam, 19 received support from CAMHS after an overdose:

"Azam: I was really privileged I that sense so
Researcher: how was that experience for you going through all of that

Azam: uh surprisingly it was really nice I really liked my therapists and stuff because they were extremely supportive and understanding I didn't feel like once I was being judged and um
Researcher: yes
Azam: even then like and maybe they were also honest as well which I really respected so like if I was to say something illogical, they'd be like they'd obviously like say something complimentary to it like if I said something illogical they'd stop me and lead me through the process so
Researcher: yes
Azam: so I guess they acted as like um a role model or mentor in a way or a teacher I guess
Researcher: yes
Azam: but on a more like intimate deep level for mental health"
Lines: 531-545

Unhelpful features of support were described as; treatment not pragmatically flexible (e.g. time of appointments and long waiting lists), and support unmatched to psychological needs, invalidating treatment, and lack of resources. Participants sought support from a select few as sources of support; friends, girlfriend, parents, other family members and youth workers. The subject position of taking on specific support is a way of enhancing agency as the discourse throughout all accounts described the individual going towards help and not being approached or acted upon by others. This position of relying on oneself is presented as going towards the support of one's own volition.

Discussion

The linguistic and visual discursive strategies presented in these interviews provide insights into the experience of stress among young men being shaped by socially constructed hegemonic masculine norms.

Where this sample invokes the idea that *'stress presents as unchangeable and unmanageable* and indicates through discourse that '*stress reflected in and out of self'* a sense of the intense and pervasive nature of stress and anxiety can be recognised. The interpretive repertoires of '*powerful and powerless against stress'* and *'self-reliance'* narratives are closely adhering to hegemonic masculine ideals of self-reliance, power and strength, as does the repertoire *'survivor of stress'*.

Hegemonic masculine expectations of being tough, powerful and not pulling in attention from outside of oneself are prevalent in the views of the young men in this study as discourses emphasise the need to be "strong on your own", and a preference to withdraw from others when in distress is demonstrated. These subject positions confirm previous findings where preference for displaying strength and control over mental health distress is a barrier to help-seeking among men (Hoy, 2012).

Driven by hegemonic masculine ideals of self-reliance decreases wellbeing and increases mental health difficulties (Coleman, 2015; Oliffe et al., 2017). The findings in this current study are aligned with existing literature describing interiority as a key strategy that men adopt when in crisis (King et al., 2019).

The most prevalent stressors cited among young men were academic, relationships with others (friends, family, partners) and work, which are commonly presented as sources of anxiety. The literature suggests that proximal factors, characterised by an acute onset such as sudden job loss, breakdown of a relationship or a home can precipitate a mental health crisis for men (Allen, Cross, & Swanner, 2005, Hufford, 2001).

The findings from this study indicate that hegemonic masculinity does impact the experience of stress and help-seeking among young men. Discourses revealed here show young men reaching out but predominately to trusted people in their existing network (friends, family, youth workers, girlfriends) even though these close people can also be a source of stress.

Participants in this study seem to want to convey to others and possibly to themselves that they are coping, however, tend to alternate between positions of minimising the impact of stress on themselves, and undermining their impact on changing stress, so they are protected from feelings of failure.

Clinical implications

As self-reliance, striving to achieve and appearing capable are features of socially constructed ideas of stress and coping among men, it may be useful to work with these constructs so that they are synonymous to help-seeking, so that young men do not experience severe stress and anxiety in isolation which ultimately could maintain and exacerbate mental health distress.

A possible route to improving the mental health of young men is utilising the help-seeking paths they are most comfortable with, through selected trusted few in their network. Perhaps providing effective strategies to manage stress and anxiety to those in a young man's network may be beneficial, and would equip loved ones to help a young man who seeks support.

Another way of operationalising the findings would be to work in line with the self-confidence and self-belief that young men demonstrated. This could be done by promoting the use of self-referrals to psychological services where they exist in the context the individual lives. This would speak to and not contrast the repertoire of 'self-reliance' and 'survivor of stress' revealed in this study.

Strengths and Limitations

A possible weakness of this study would be the lack of inclusivity at recruitment as only young men who had a smartphone or digital camera were eligible to take part. This was to ensure that participants had a way of engaging in photo elicitation if they chose, however, it may have inadvertently excluded groups of people, for example, those with limited resources. This study did not exclude any interested participants and although all participants had a way to take photos, not all chose to do so.

Three out of the seven participants utilised the option to provide accompanying images for their interview, which can be seen as a limitation of the dataset. However, all participants were able to provide rich discourse, and it would be a detriment to the research if participants were excluded based on not providing photo material.

In conclusion, the discursive strategies highlighted here both fit in with the existing literature and also provide new insights into the experience of stress among young men and how hegemonic masculinity intersects with the construct of help-seeking. The experience of distress and the impact of masculinity on help-seeking is not considered binary and this study exemplifies the many nuances that exist, as reflected in previous literature (Oliffe et al., 2019). This study shows how this sample of young men talk about their experience of stress as reflected within and outside of themselves, reflected in affect but also their environment, strikingly revealed by the metaphor as a discursive device. Stress has been constructed as difficult to manage and a fixed construct not malleable to change, and young men have

discussed their battles against stress where they have simultaneously at times taken on the position of being both powerful and powerless, reliant on themselves but also choosing close others for support.

Acknowledgments
The authors would like to thank London Youth Community Centre, and all research participants for their participation and active support.

Declaration of interest
This research was supported by the University of East Anglia as part fulfilment of the first author's Doctorate in Clinical Psychology. This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors. The authors declare no conflict of interest.

Data availability
The research data can be made available on request; please contact the corresponding author.

Disclaimer
The views expressed in this research article are of the authors and are not an official position of the University of East Anglia.

References

Beasley, C. (2008). Rethinking hegemonic masculinity in a globalizing world. *Men and masculinities*, *11*(1), 86-103. https://doi.org/10.1177%2F1097184X08315102

Brydges, S., Rennick-Egglestone, S., & Anderson, C. (2020). Men's views of antidepressant treatment for depression, and their implications for community pharmacy practice. *Research in Social and Administrative Pharmacy*, *16*(8), 1041-1049. https://doi.org/10.1016/j.sapharm.2019.10.016

Burr, V. (2015). *Social constructionism* (3rd ed.). Routledge. https://doi.org/10.4324/9781315715421

Cleary, A. (2012). Suicidal action, emotional expression, and the performance of masculinities. *Social Science and Medicine*, 74, 498–505. https://doi.org/10.1016/ j.socscimed.2011.08.002

Department of Health and Social Care (2020). *Press Release:* Local COVID-19 alert level update: 15 October 2020. https://www.gov.uk/government/news/local-covid-19-alert-level-update-15-october-2020

Edwards, D., & Potter, J. (1992). *Discursive psychology* (Vol. 8). Sage.

Esposito, C. L. (2002). Psychiatric symptoms and their relation- ship to suicidal ideation in a high-risk adolescent community sample. *Journal of the America Academy of Child and Adolescent Psychiatry*, *41*, 44–51. https://doi.org/10.1097/00004583-200201000-00010

Goffman, E. (1967). Interaction ritual: essays on face-to-face interaction. Aldine.

Hodges, A. (2015). *The handbook of discourse analysis* (2nd ed.). Wiley.

Hoy, S. (2012). Beyond men behaving badly: a meta-ethnography of men's perspectives on psychological distress and help seeking. *International Journal of Men's Health*, 11(3). https://psycnet.apa.org/doi/10.3149/jmh.1103.202

Irvanipour, Z., Notley, C., & Fisher, P. (2022) The role of masculinity in men’s help-seeking for depression: A review of recent evidence. [Unpublished manuscript].

Liu, R.T., & Miller, I. (2014) Life events and suicidal ideation and behavior: a systematic review. *Clinical Psychology Review*, 34(3),181–92. https://doi.org/10.1016/j.cpr.2014.01.006

Locke, A., & Budds, K. (2020). Applying critical discursive psychology to health psychology research: a practical guide. *Health Psychology and Behavioral Medicine*, *8*(1), 234-247. https://doi.org/10.1080/21642850.2020.1792307

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder'. *European Eating Disorders Review*, *19*(1), 25-36. https://doi.org/10.1002/erv.1011

Martin, S. (2016). 'How can you be strong all the time?' Discourses of stoicism in the first counselling session of young male clients. *Counselling and Psychotherapy Research*, *16*(2), 100-108. https://doi.org/10.1002/capr.12062

McMullen, L. M. (2021). Essentials of discursive psychology. American Psychological Association. https://psycnet.apa.org/doi/10.1037/0000220-000

National Suicide Prevention Strategy for England (2004). National Suicide Prevention Strategy for England: Annual Report on Progress 2004. Leeds: NIMHE.

Oliffe, J. L., Broom, A., Rossnagel, E., Kelly, M. T., Affleck, W., & Rice, S. M. (2020). Help-seeking prior to male suicide: Bereaved men perspectives. *Social Science & Medicine*, *261*, 113173. https://doi.org/10.1016/j.socscimed.2020.113173

Oliffe, J.L., Bottorff, J.L. (2007). Further than the eye can see? Photo elicitation and research with men. *Qualitative Health Research*, 12, 850–858. https://doi.org/10.1177/ 1049732306298756.

Oliffe, J.L., Rossnagel, E, Seidler, Z.E., Kealy, D., Ogrodniczuk, J.S., & Rice, S.M. (2019) Men's depression and suicide. *Curr. Psychiatry Rep*. 21 (10), 103. https://doi.org/10. 1007/s11920-019-1088-y.

Pitman, A., Krysinska, K., Osborn, D., King, M. (2012). Suicide in young men. *Lancet*, 379 (9834), 2383–2392. https://doi.org/10.1016/S0140-6736(12)60731-4

Robertson. S., Williams, B., & Oliffe, J. (2016) The case for retaining a focus on “masculinities” in men's health research. *International Journal of Men's Health,*15,52–*67.*

Sagar-Ouriaghli, I., Godfrey, E., Bridge, L., Meade, L., & Brown, J. S. (2019). Improving mental health service utilization among men: a systematic review and synthesis of behavior change techniques within interventions targeting help-seeking. *American Journal of Men's Health*, *13*(3). https://doi.org/10.1177%2F1557988319857009

Seidler, Z. E., Dawes, A. J., Rice, S. M., Oliffe, J. L., & Dhillon, H. M. (2016). The role of masculinity in men's help-seeking for depression: a systematic review. *Clinical psychology review*, *49*, 106-118. https://doi.org/10.1016/j.cpr.2016.09.002

Shepard, D. S. (2002). A negative state of mind: Patterns of depressive symptoms among men with high gender role conflict. *Psychology of Men & Masculinity*, *3*(1), 3. https://psycnet.apa.org/doi/10.1037/1524-9220.3.1.3

Tolin, D. F., & Foa, E. B. (2006). Sex differences in trauma and posttraumatic stress disorder: A quantitative review of 25 years of research. *Psychological Bulletin*, 132(6), 959–992. https://doi.org/10.1037/0033-2909.132.6.959

Van Heeringen, K. (2012). Stress-diathesis model of suicidal behavior. *The neurobiological basis of suicide*, *51*, 113.

World Health Organization. (2017). *Global Health Observatory (GHO) data*. World Health Organization. https://www.who.int/gho/mental_health/suicide_rates_ male_female/en/

Chapter 5
Extended Methodology

This chapter aims to expand upon the methodological aspect of the empirical paper.

The aim of the empirical study was to attempt to answer the question: 'What is the experience of stress and anxiety among young men, and does the construct of masculinity play a role in their experience of distress and mental health help-seeking?'. This question in itself recognises a continuum of experience among men, and so an explorative approach was taken, as it is well recognised in the literature that mental health help-seeking among men is complex and diverse (Oliffe et al., 2019), therefore a qualitative approach seemed helpful in this instance.

If we were to undertake a quantitative study, the research would likely use predetermined parameters of masculinity. The systematic review identified a variety of commonly used measures exploring masculinity and men's mental health help-seeking, including; Bem Sex-Role Inventory(BSRI) (Bem,1981), Male Role Norms Scale (MRNS) (Thompson & Pleck, 1986), Conformity to Masculine Norms Inventory (CMNI-46) (Mahalik et al., 2003), and the 37-item Gender Role Conflict Scale (GRCS) (O'Neil, 1986).

The disadvantages of a quantitative methodology would be that the research would not be suited to the research question as parameters would be predetermined by design and specific aspects of masculinity would be investigated based on previously held constructions of masculinity and help-seeking. Quantitative analysis would have allowed a much larger number of participants to be involved in the study, and reflect a larger cohort of participants views, but it would not be suitable for the purpose of this research question which was looking for in depth, personal and rich accounts of data.

Furthermore, the review found that no qualitative studies included measures of help-seeking or masculinity in their design, which places this current empirical paper among previous qualitative research in the same field of men's mental health.

Discourse Analysis as applied to the empirical study

Part one involved the initial coding of transcribed interviews, identifying significant data points in both a descriptive and interpretive way. Photos were included alongside the transcriptions and each audio file was replayed during initial coding to allow for the familiarity of the data corpus. This first stage aimed to allow immersion in the data and to check for discrepancies in the transcription.

In stage two, the analysis involved drawing out keywords and discursive constructions, collating them in a way that represents what the visual and verbal language is 'doing'. At this stage, for example, it was considered the different ways in which the discursive object of 'experiencing stress' is constructed within the text and photo-elicitation material.

Stage three analyses the available interpretive repertories embedded within the language of each participant and establishes these interpretive repertoires when considering the identified discursive constructions from stage two (Wetherell & Edley, 2014). Interpretive repertoires drawn out from this stage are ways in which participants present through language and imagery what is being talked about (Potter and Wetherell, 1987).

In the fourth stage, analysis was concerned with how discourse orients a participant within the interpretive repertoires, thus identifying 'subject positions' or 'ways of being' (Davies & Harré, 1990), that discourse allows. It was particularly noted how subject positions were adopted or resisted within the language of participants.

The fifth stage examines the ways accounts are put together by participants, identifying discursive devices at this micro-level of analysis, aiming to understand the communicative purpose with how both photo-elicitation and verbal discourse are conveyed within the interview interaction. How subject positions were communicated to the interviewer were also noted, paying close attention to the tone of voice and discourse markers. It is at this stage that discursive accomplishments are being drawn out whether known or perhaps unknown to the participant.

The sixth and final stage of analysis involved combining the various aspects of analysis; interpretive repertoires, subject positions, discursive devices, discursive accomplishments, and considering what this means in relation to the research question: What is the experience

of stress and anxiety among young men and does the construct of masculinity play a role in their experience of distress and mental health help-seeking?

This macro-level of analysis positions the researcher in between the discourses presented in the interviews and the wider societal discourses, providing the researcher with the opportunity to link both interview data and broader societal and cultural discourses embedding the research data in the zeitgeist.

Reflexivity

Research Team Background

The primary researcher's credentials at the time of the current study were as follows; BSc(Hons), MSc and PGdip, currently on Doctoral Clinical Psychology training at the University of East Anglia. The primary researcher had previously conducted qualitative and quantitative and mixed-method design studies both in the NHS and as part of academic research.

The primary researcher has four years' experience working in IAPT services where it was noticed anecdotally that female patients would often present to services soon after noticing a decline in their mental health, whereas male patients seemed to present to services after having tried to manage on their own for a significant amount of time, reaching out to psychological services when symptoms were severe. This project was felt to be an important area of research for the primary researcher and the entire research team.

The primary researcher, female, conducted all interviews and was the sole coder for the data analysis, gaining research supervision from one social scientist and one clinical psychologist, one female and one male, both with expertise in qualitative analysis.

Reflexivity and Rigour

Linguistic representations of personal experience shared by participants were processed through the epistemological perspective searching for 'meaning', a parallel perspective which does not search for 'truth' or 'facts' (Sparkes, 2001). Through an iterative reflective process, appropriate for discourse analysis, authenticity, trustworthiness, coherency and integrity (Nixon & Power, 2007) were concepts integrated to assess rigour and generate interpretive claims.

Recruitment

Youth centre recruitment

6-weekday visits to the community centre to talk to members of staff about the project, provide information packs which included study poster, and summary of the study for participants and a separate file for gatekeepers (Appendix N).

Time was spent during these visits interacting with young children and young adults at the centre, building rapport and making general conversation as well as discussing the opportunity to take part in the research study. The primary researcher asked community centre gatekeepers to provide a research poster and a participation information sheet to anyone they thought was eligible and interested in participating and to take note of their email address so that they could be contacted by the primary researcher.

Online and Public recruitment

The primary researcher approached distributed the research poster to individuals and spaces including; public houses, cafés, bus stops, high street shops, outdoor gyms and parks.

Online recruitment involved posting adverts to online forums (ClinPsy forum, Gumtree, Reddit) (see the supplementary file 'Online recruitment') and social media platforms through others (friends, family, 'Male Psychology Network', and psychologists in the field) (see supplementary file; Social media recruitment). Public recruitment was approached opportunistically in London and Cambridge.

All potential participants were aware of the main aim of the research. All included participants were encouraged to take photos and/or provide images of what stress meant to them and how they manage stress (example email to participant attached with participation info sheet and research study PDF). No participants that expressed interest in taking part were removed or dropped out of the study.

Data Collection

Although face-to-face interactions are regarded as an important element of interactions within the field of discourse analysis (Goffman, 1981), Covid-19 restrictions, geographical location and participant preference for anonymity led to the majority of interviews being conducted by phone.

Setting up of the interview

It was during pre-arranged 10 minute calls a few days before the interview that participants were given the opportunity to ask the primary researcher any questions. For all participants the primary researcher asked what times they would be available, offering evenings and weekends to help generate naturally occurring speech located in a participant-driven context of time and place.

To foster naturally occurring speech it was important for the participants to be comfortable in the interview setting, and consequently, they chose if they wanted a phone or in-person interview. The two participants interviewed in person were in a familiar setting (community youth centre).

At the start of each interview, the initial 5 minutes were dedicated to completing the patient demographic sheet (Appendix O), allowing brief 'yes' or 'no' answers to start building rapport. Also, it was made clear that participants could say what they would like to and don't have to disclose anything they are uncomfortable with and that they have 7 days after the interview to withdraw participation. Anonymity was outlined in the consent form and participation information sheet, but also at the start of the semi-structured interview.

Three participants were recruited through the youth community centre, two through public recruitment and one person through online channels (gumtree advert). All participants gave informed written consent before the interview either in paper format or electronically via email to a secure nhs.net account.

Encouraging talk around photos

All participants were asked to reflect on their experience of stress, coping and the construct of masculinity and whether this had any effect on their experience of stress. Participants who provided photographic illustrations of their experience were asked to reflect on the meaning of these photos during the interview.

Data preparation for analysis

Interviews were recorded and transcribed professionally verbatim, which is a suitable method of transcription for discourse analysis (Malson et al., 2011). Transcripts and findings were

not returned to participants for comment and/or correction, however the primary researchers direct email was provided to participants if they had any queries after the interview. Interviews were anonymised and pseudonyms were given, except when participants provided a preferred pseudonym.

Choosing Photos

Three participants submitted supplementary photos and/or images. Images were chosen that best fit the interpretive repertoire discussed and a judgement was made by the research team to enable equal representation of participant discourses.

Ethical Approval

Ethical, governance and legal approval will be sought from Faculty of Medical and Health Sciences Research Ethics Committee of the University of East Anglia. This study will adhere to the Health and Care Professions Council (HCPC), the British Psychology Society (BPS) and the UEA codes of conduct (BPS, 2018; HCPC, 2016; UEA, 2016).

Ethical approval was gained on 22/06/2020. Reference: 2019/20-086.

Confidentiality

Photographic data was sent to the researcher's university email and was stored on an encrypted memory stick, with the original attachment in the email deleted. Audio recordings were collected using a CPFT provided Dictaphone that stayed locked in a cabinet and only taken to and from interviews, solely being used for the purpose of this research. Recordings were then be stored on an encrypted memory stick and the original audio clip deleted on the Dictaphone. After the interview, audio recordings and photos were assigned a pseudonym. This study adhered to the *General Data Protection Regulation* (GDPR) Data Protection Act (2018). Collected data was only accessible by the researcher (Zuleika Irvanipour, Trainee Clinical Psychologist), research supervisors (Dr Caitlin Notley, Clinical Psychologist and Dr Paul Fisher, Clinical Psychologist) and professional transcribers who handle audio recordings. There is a potential for auditors and other monitors of UEA Medical School to access the data, however there will be clear guidance given to the research team regarding this. Data will be stored on UEA servers for 10 years.

Risk

As outlined from thesis proposal:

The researcher will at the outset of the interview explain to the participant that 'some questions will ask about some emotive topics and it is completely ok to take breaks for a bit of a breather'. This explanation aims to emphasise to the participant that they are active participants and are encouraged to guide the interview process and how they pace their narrative. The researcher will try and create a non-judgemental atmosphere for participant from the beginning of the interview using core clinical skills; validating, normalising, reflecting and grounding. If the participant demonstrates distress the interview will be offered to end and to be rescheduled. The participant will be given a call from the researcher the next day of the interview to essentially check in with the participant but also offer another appointment. If necessary, participants will be signposted to their GP

Confidentiality will be verbally explained and embedded within the 'Participant Information Sheet'. If suicidality is disclosed, the participants GP will be contacted on the day of the interview and prompted to set up an appointment with the participant. If necessary, the participant will be signposted to services offering further support for wellbeing (e.g. local IAPT service).

Insurance and indemnity arrangements

The research study presented in this paper was covered by the University of East Anglia's indemnity arrangements.

Chapter 6
Overall Discussion and Critical Evaluation

This chapter summarises the findings of the systematic review and research study, examining them in combination to one another, and provides an extended discussion reflecting on strengths and limitations, clinical implications and future research.

The systematic review explored the role of masculinity in the context of help-seeking behaviours for depression. The review found that masculine norms have a complex role in help-seeking among a sample of 4,760 men across twenty-three studies. Restrictive emotionality and engaging in treatment challenged the masculine norm of self-reliance, having a negative impact on help-seeking. Furthermore, the combination of masculine norms of needing to be seen as strong and adequate, the belief of not wanting to appear weak, and the stigma surrounding depression had negative influences on help-seeking. Positive aspects of masculinity generated self-compassion, and a survivorship narrative to depression, leading to helpful influences on normative beliefs around help-seeking.

The empirical paper explored the experience of stress among young men and the construct of masculinity in relation to help-seeking behaviour drawing upon photo-elicitation in the qualitative design of the study and discourse analysis to examine the data. The key repertoires that were revealed by participants through analysis was that *'stress presents as unchangeable and unmanageable'* and '*stress reflected in and out of self'.* The discourse reflected that the construct of stress was for some, described in fixed terms perhaps derived from a low locus of control. Stress was also presented as something that occurred within themselves (e.g., emotion) and externally (e.g. environment), thus purposefully using language to reflect the global effect of stress. Furthermore, the interpretive repertoires of '*powerful and powerless against stress'* and *'self-reliance'* narratives closely adhered to hegemonic masculine ideals of self-reliance, power and strength, as does the '*survivor of stress'* repertoire.
Interpreting the findings from both papers in parallel, hegemonic masculinity as a construct has been used to partially explain how this construct is associated with mental health help-seeking, and has shown the complex nature of this interplay.

In the systematic review masculine norms associated with self-reliance conflicted with help-seeking, similarly in the empirical findings, as the repertoire 'powerful and powerless against stress' a position of battling stress on your own and the resistance of accessing treatment for depression in fear of being seen as weak or inadequate for not having managed alone are similar themes that span both papers. Self-reliance is seen to be constructed within the expectation for men to be strong on their own, and has been found in previous literature where the need to be strong and self-reliant is dominant perhaps to avoid feeling vulnerable (Martin, 2016).

Presenting oneself as being able to withstand stress was revealed in the review as relating to finding meaning in depression, and is in line with the 'survivor of stress' repertoire found in the empirical paper. In addition, the review indicates that men perceive stress external to the self, which is similar to the empirical finding of 'stress presents as unchangeable and unmanageable' where stress was presented as a fixed construct, not malleable to change, and the repertoire 'powerful and powerless against stress' where some men positioned stress originating outside oneself (e.g., academia, occupation, and family worries).

Both the empirical and review papers recognise the harmful effects of hegemonic masculinity whilst also equally acknowledging the helpful elements and areas of amplification that is clinically needed to support men, who are surrounded by the socially constructed hegemonic masculine ideal, to seek help when needed.

Methodological Strengths and Limitations

In the empirical study, two specific questions were asked regarding the construct of masculinity in the interview; 'Does being a young man affect the things that cause you stress?', and 'Does being a young man affect the way you manage stress?'

After asking these two questions the discourse was facilitated to flow as naturally as possible, and the researcher did not have any other set questions relating to masculinity that was within the interview guide. However, it is not possible to ascertain the degree to which masculinity was central to the young men's experience, and as there was no comparison group of young female participants it is difficult to know which responses were pertinent to masculinity unless explicitly associated by the young men themselves. It is therefore a challenge for discourse analysis to be applied to the data corpus as it is a tool reliant on the interpretation of the researcher to translate the function of the discourse, and therefore the data analysis is

limited to being framed by the research question which was primed to explore 'masculinity' as a construct and its impact.

The aim of the empirical paper was to explore the views of young men in relation to stress and help-seeking, and to examine the ways (if any) that the construct of masculinity plays a role. One of the strengths of the empirical paper is that the construct of masculinity was explored, even if no comparison group was part of the study design. This study did not aim to compare or contrast views of men and women in relation to stress and constructs of masculinity and femininity, so the aims of the study were met.

The sample of young men were aged between 17-26 years old, therefore it is important to consider that the discourse around stress, help-seeking and masculinity are specific to this demographic, and not necessarily universally applicable to all men. It is worth acknowledging that there are many different versions and periods of masculinity e.g., fatherhood, retirement, declining physical health, and this study does not touch upon the evolving nature of masculinity across the life course, as the sample size provides a snapshot of what masculinity means for a few young men at a similar time in a life cycle marked by issues such as finding a job, completing exams, managing early relationships, and carving out independence.

Clinical Implications

One of the key discursive devices found in the empirical paper was the use of metaphor to present ideas and beliefs. This was particularly dominant in the photo-elicitation and accompanying text. It is this discursive device that mirrors the devices used in Cognitive Behavioural Therapy (CBT) (Scott et al., 2010). For example the use of metaphor is characteristic of aspects of psycho-education in CBT, such as conceptual metaphors related to emotions (e.g., affection is warmth) and expressions such as 'I'm fuming' (Lakoff & Johnson, 2003), or more complex metaphors such as the 'Passengers on the Bus' metaphor Ciarrochi & Robb, 2005), which externalises thoughts and feelings to foster validation, often used in Acceptance and Commitment Therapy considered to be third wave CBT. As client generated metaphors is part of the therapeutic approach (Kopp, 2013), this approach to psycho-education in particular may be relevant to young male populations, as it is a dominant discursive device found in their accounts.

Future Research

Future reviews aiming to understand help-seeking among men with mental health challenges could expand the search terms to include help-seeking from friends and family, as the empirical paper indicates that opening up and seeking help from a 'select few' is a key route to help-seeking. The search terms in this review included 'help seek', 'patient acceptance of health care' and 'treatment pathway', however future research could expand the idea of what it is to seek help and include terms such as 'friends' and 'family'.

When considering the empirical paper, discourse analysis was considered the best fit for the design of this study, to further research in this area the examination of more naturally occurring speech e.g., in non-interview settings is recommended. As language is performative, the interviewer is part of the social interaction, and is likely to influence the data in some ways. Although this current study took steps to build rapport and support the young men to feel comfortable, it may only have alleviated a fraction of this influence. Perhaps group settings, where men are talking to other men, may be implemented in future research.

The empirical study and review paper presented within this portfolio reinforce previous findings and provide novel insights in the field of men's mental health. The findings suggest that masculine norms support men toward help-seeking by framing help-seeking as a presentation of strength, where stress and depression are survived and overcome. Equally, masculine norms create a shame based view of help-seeking for some men, whereby the stigma and conflict with self-reliance marks a tendency to not seek help when needed. Overall, there appears to be a clinical need to work towards operationalising the helpful features of hegemonic masculinity and utilise the core tenets of masculinity; 'self-reliance' and 'strength', in a nuanced way to help men walk through barriers that society has created for them when seeking help.

Rigour and Future Research

There are various checklists and more structured approaches to assessing the rigour, reliability and trustworthiness of qualitative research, that would be more appropriate to other methods along the realist/constructionist epistemological continuum. For example, the Critical Appraisal Skills Programme (CASP) checklist could be referred to (Critical Appraisal Skills Programme, 2018), in addition to Consolidated Criteria for Reporting

Qualitative research guidelines (COREQ), for reporting qualitative research (Tong, Sainsbury, & Craig, 2007).

Furthermore, Mays and Pope, 1995, outline strategies to ensure rigour in qualitative research, touching on sampling methods, transcript analysis and triangulation in data analysis. If this study was repeated efforts would be made to enhance rigour by ensuring the transcript and findings were fed back to participants to ascertain whether both transcript and discursive strategies were a reasonable depiction of their experience. Member checking is a tool to safeguard validity in qualitative research (Birt et al., 2016; Mays & Pope 1995), and although not conducted in this empirical study, it is an area of improvement for future research.

Societal Discourse and Future Research

Future researchers in this field of mental health may find it useful to understand aspects of societal discourse that the primary researcher interacted with during recruitment. During the recruitment process of the empirical study, a few organisations were approached to recruit participants for the study. 'Men's Shed' in London were emailed and there was a conversation over the phone where the primary author and a team leader at a men's shed in central London expressed interest in the study, however, explained that recruiting from the service would not be appropriate as although they may have contact with young people in the area, the idea of mental health-related projects would be possibly off-putting for clients. A local running group founded by young men in central London 'Run With Purpose', were also contacted after the author had seen a BBC news article on a running group aimed at improving the mental health of young men. In email correspondence, the idea of the project was put forward by the primary author and an email response from the running group expressed that they were not interested and no reason was given.

The primary author also asked a few cafés and pubs in the Islington and Cambridge area and the majority declined to have the recruitment poster up for the view of clients but were more open to having the poster in the 'back office' where the staff congregated, possibly it was a subject matter that the organisation did not want to promote for some reason. The author also noticed that a recruitment poster for the project advertised on the messaging board of a community centre in London was defaced with the words " or a ****" written next to the 'Are you a man' portion of the title. This offensive word was derogatory and reflective of the societal negative discourse around men who are 'stressed or anxious', as included in the title to of the poster.

Overall, there was a sense of resistance among recruitment platforms regarding the project from various recruitment pathways felt by the primary author during the recruitment process. It was difficult to gain access to male-specific platforms but also public platforms, and where access was given, it was often shrouded with an element of secrecy and resistance. This is pertinent to the study, as although not a specific finding driven by the interview data, it does indicate public discourses related to male mental health, as interactions the primary author had with the public were often fraught with difficulty and hesitancy. This has wider implications for this research area in general, as there is the issue of 'voiced and unvoiced' stories due to difficulties with recruitment perhaps driven by harsh societal discourses surrounding male mental health distress.

Portfolio References

Beasley, C. (2008). Rethinking hegemonic masculinity in a globalizing world. *Men and masculinities*, *11*(1), 86-103. https://doi.org/10.1177%2F1097184X08315102

Bem, S. L. (1981). Bem sex role inventory. *Journal of personality and social psychology*. https://psycnet.apa.org/doi/10.1037/t00748-000

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation?. Qualitative health research, 26(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Brydges, S., Rennick-Egglestone, S., & Anderson, C. (2020). Men's views of antidepressant treatment for depression, and their implications for community pharmacy practice. *Research in Social and Administrative Pharmacy*, *16*(8), 1041-1049. https://doi.org/10.1016/j.sapharm.2019.10.016

Call, J. B., & Shafer, K. (2018). Gendered manifestations of depression and help seeking among men. *American journal of men's health*, *12*(1), 41-51. https://doi.org/10.1177%2F1557988315623993

Ciarrochi, J., & Robb, H. (2005). Letting a little nonverbal air into the room: Insights from acceptance and commitment therapy Part 2: Applications. *Journal of Rational-Emotive and Cognitive- Behavior Therapy*, *23*(2), 107–130. https://doi.org/10.1007/s1094 2-005-0006-x

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine,* 50, 1385–1401. https://doi.org/10.1016/S0277-9536(99)00390-1

Critical Appraisal Skills Programme (2018). CASP Qualitative Studies Checklist. [online] Available at: https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018_fillable_form.pdf

Data Protection Act 2018 . https://www.legislation.gov.uk/ukpga/2018/12/contents/enacted

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the theory of social behaviour*, *20*(1), 43-63. https://doi.org/10.1111/j.1468-5914.1990.tb00174.x

Eggenberger, L., Fordschmid, C., Ludwig, C., Weber, S., Grub, J., Komlenac, N., & Walther, A. (2021). Men's Psychotherapy Use, Male Role Norms, and Male-Typical Depression Symptoms: Examining 716 Men and Women Experiencing Psychological Distress. *Behavioral Sciences*, *11*(6), 83. https://doi.org/10.3390/bs11060083

Fishbein, M., & Ajzen, I. (1975) Belief, attitude, intention and behaviour. Reading, MA: Addison Wesley.

Goffman, E.(1981) *Forms of Talk.* Philadelphia: University of Pennsylvania Press

Kopp, R. R. (2013). *Metaphor therapy: Using client generated metaphors in psychotherapy*. Routledge.

Lakoff, G., & Johnson, M. (2003). *Metaphors We Live By*. Chicago: University of Chicago Press.

Liu, R.T., & Miller, I. (2014) Life events and suicidal ideation and behavior: a systematic review. *Clinical Psychology Review,* 34(3),181–92. https://doi.org/10.1016/j.cpr.2014.01.006

Mahalik, J. R., Locke, B. D., Ludlow, L. H., Diemer, M. A., Scott, R. P., Gottfried, M., & Freitas, G. (2003). Development of the Conformity to Masculine Norms Inventory. *Psychology of Men & Masculinity*, *4*, 3–25. doi:10.1037/1524 –9220.4.1.3

Malson, H., Bailey, L., Clarke, S., Treasure, J., Anderson, G., & Kohn, M. (2011). Un/imaginable future selves: A discourse analysis of in-patients' talk about recovery from an 'eating disorder'. *European Eating Disorders Review*, *19*(1), 25-36. https://doi.org/10.1002/erv.1011

Martin, S. (2016). 'How can you be strong all the time?' Discourses of stoicism in the first counselling session of young male clients. *Counselling and Psychotherapy Research*, *16*(2), 100-108. https://doi.org/10.1002/capr.12062

Mays, N., & Pope, C. (1995). Qualitative research: rigour and qualitative research. *BMJ*, 311(6997), 109-112. https://doi.org/10.1136/bmj.311.6997.109

Mitchell, C., McMillan, B., & Hagan, T. (2017). Mental health help-seeking behaviours in young adults. *British Journal of General Practice*, *67*(654), 8-9. https://doi.org/10.3399/bjgp17X688453

Nixon, A., & Power, C. (2007). Towards a framework for establishing rigour in a discourse analysis of midwifery professionalisation. *Nursing Inquiry, 14*(1), 71-79. https://doi.org/10.1111/j.1440-1800.2007.00352.x

O'Neil, J. M., Helms, B. J., Gable, R. K., David, L., & Wrightsman, L. S. (1986). Gender Role Conflict Scale: College men's fear of femininity. *Sex Roles, 14*, 335-350. https://doi.org/10.1007/BF00287583

Oliffe, J.L., Rossnagel, E, Seidler, Z.E., Kealy, D., Ogrodniczuk, J.S., & Rice, S.M. (2019) Men's depression and suicide. *Current Psychiatry Reports*, 21(10), 103. https://doi.org/10. 1007/s11920-019-1088-y.

Potter, J., & Wetherell, M. (1987). *Discourse and social psychology: Beyond attitudes and behaviour*. Sage.

Rickwood, D., Deane, F. P., Wilson, C. J., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Australian e-journal for the Advancement of Mental health*, *4*(3), 218-251. https://doi.org/10.5172/jamh.4.3.218

Rihmer, Z. (2001). Can better recognition and treatment of depression reduce suicide rates? A brief review. *European Psychiatry*, *16*(7), 406-409. https://doi.org/10.1016/S0924-9338(01)00598-3

Robertson. S., Williams, B., & Oliffe, J. (2016) The case for retaining a focus on "masculinities" in men's health research. *International Journal of Men's Health*,15,52–*67*.

Smith, J. P., Tran, G. Q., & Thompson, R. D. (2008). Can the theory of planned behavior help explain men's psychological help-seeking? Evidence for a mediation effect and clinical implications. *Psychology of Men & Masculinity*, *9*(3), 179. https://psycnet.apa.org/doi/10.1037/a0012158

Sparkes AC. 2001. Myth 94: Qualitative health researchers will agree about validity. *Qualitative Health Research* 11, 538 – 52. https://doi.org/10.1177%2F104973230101100409

Stott, R., Mansell, W., Salkovskis, P., Lavender, A., & Cartwright-Hatton, S. (2010). *Oxford guide to metaphors in CBT: Building cognitive bridges*. OUP Oxford.

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. *The SAGE handbook of qualitative research in psychology*, *2*, 17-37.

Thompson, E. H., & Pleck, J. H. (1986).The structure of male role norms. *American Behavioural Scientist*, 29, 531-543. https://doi.org/10.1177%2F000276486029005003

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. International journal for quality in health care, 19(6), 349-357.

Van Heeringen, K. (2012) Stress-Diathesis Model of Suicidal Behavior. In: The Neurobiological Basis of Suicide. Taylor & Francis Group.

Wetherell, M., & Edley, N. (2014). A discursive psychological framework for analyzing men and masculinities. *Psychology of Men & Masculinity, 15*(4), 355–364. doi: 10.1037/a0037148

White, A., & Holmes, M. (2006). Patterns of mortality across 44 countries among men and women aged 15–44 years. *Journal of Men's Health,*3,139–5. https://doi.org/10.1016/j.jmhg.2006.04.002

Appendix A
Journal Guidelines for Clinical Psychology Review

AUTHOR INFORMATION PACK

ISSN: 0272-7358

Clinical Psychology Review publishes substantive reviews of topics germane to **clinical psychology**. Papers cover diverse issues including: psychopathology, psychotherapy, behavior therapy, cognition and cognitive therapies, behavioral medicine, community mental health, assessment, and child development. Papers should be cutting edge and advance the science and/or practice of clinical psychology.

Reviews on other topics, such as psychophysiology, learning therapy, experimental psychopathology, and social psychology often appear if they have a clear relationship to research or practice in **clinical psychology**. Integrative literature reviews and summary reports of innovative ongoing clinical research programs are also sometimes published. Reports on individual research studies and theoretical treatises or clinical guides without an empirical base are not appropriate.

Benefits to authors

We also provide many author benefits, such as free PDFs, a liberal copyright policy, special discounts on Elsevier publications and much more. Please click here for more information on our author services.

Please see our Guide for Authors for information on article submission. If you require any further information or help, please visit our Support Center

AUDIENCE

Psychologists and Clinicians in Psychopathy

IMPACT FACTOR

2020: 12.792 © Clarivate Analytics Journal Citation Reports 2021

GUIDE FOR AUTHORS

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details: • E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided • Indicate clearly if color should be used for any figures in print *Graphical Abstracts / Highlights files* (where applicable)

Supplemental files (where applicable)

Critical Issues Ensure manuscript is a comprehensive review article (empirical papers fall outside the scope of the journal) Ensure that literature searches and reviews are as up to date as possible and at least to 3 months within date of submission Manuscript has been 'spell checked' and 'grammar checked' All references mentioned in the Reference List are cited in the text, and vice versa Permission has been obtained for use of copyrighted material from other sources (including the Internet) A competing interests statement is provided, even if the authors have no competing interests to declare • Journal policies detailed in this guide have been reviewed Referee suggestions and contact details provided, based on journal requirements Ensure manuscripts do not exceed 50 pages, including references and tabular material, unless you have obtained prior approval of the Editor in Chief for an exception Ensure Highlights do not exceed 3 to 5 bullet points with a maximum of 85 characters, including spaces, per bullet point Failure to follow these guidelines may result in your manuscript being returned for reformatting prior to further consideration by the journal.

For further information, visit our Support Center. **BEFORE YOU BEGIN**

Ethics in publishing

Please see our information on Ethics in publishing.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double anonymized) or the manuscript file (if single anonymized). If there are no interests to declare then please state this:

'Declarations of interest: none'. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service Crossref Similarity Check.

Preprints

Please note that preprints can be shared anywhere at any time, in line with Elsevier's sharing policy. Sharing your preprints e.g. on a preprint server will not count as prior publication (see 'Multiple, redundant or concurrent publication' for more information).

Language (usage and editing services)

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Author Disclosure Policy

Authors must provide three mandatory and one optional author disclosure statements. These statements should be submitted as one separate document and not included as part of the manuscript. Author disclosures will be automatically incorporated into the PDF builder of the online submission system. They will appear in the journal article if the manuscript is accepted.

The four statements of the author disclosure document are described below. Statements should not be numbered. Headings (i.e., Role of Funding Sources, Contributors, Conflict of Interest, Acknowledgements) should be in bold with no white space between the heading and the text. Font size should be the same as that used for references.

Statement 1: Role of Funding Sources

Authors must identify who provided financial support for the conduct of the research and/or preparation of the manuscript and to briefly describe the role (if any) of the funding sponsor in study design, collection, analysis, or interpretation of data, writing the manuscript, and the decision to submit the manuscript for publication. If the funding source had no such involvement, the authors should so state.

Example: Funding for this study was provided by NIAAA Grant R01-AA123456. NIAAA had no role in the study design, collection, analysis or interpretation of the data, writing the manuscript, or the decision to submit the paper for publication.

Statement 2: Contributors

Authors must declare their individual contributions to the manuscript. All authors must have materially participated in the research and/or the manuscript preparation. Roles for

each author should be described. The disclosure must also clearly state and verify that all authors have approved the final manuscript.

Example: Authors A and B designed the study and wrote the protocol. Author C conducted literature searches and provided summaries of previous research studies. Author D conducted the statistical analysis. Author B wrote the first draft of the manuscript and all authors contributed to and have approved the final manuscript.

Statement 3: Conflict of Interest

All authors must disclose any actual or potential conflict of interest. Conflict of interest is defined as any financial or personal relationships with individuals or organizations, occurring within three (3) years of beginning the submitted work, which could inappropriately influence, or be perceived to have influenced the submitted research manuscript. Potential conflict of interest would include employment, consultancies, stock ownership (except personal investments equal to the lesser of one percent (1%) of total personal investments or USD$5000), honoraria, paid expert testimony, patent applications, registrations, and grants. If there are no conflicts of interest by any author, it should state that there are none.

Example: Author B is a paid consultant for XYZ pharmaceutical company. All other authors declare that they have no conflicts of interest.

Statement 4: Acknowledgements (optional)

Authors may provide Acknowledgments which will be published in a separate section along with the manuscript. If there are no Acknowledgements, there should be no heading or acknowledgement statement.

Example: The authors wish to thank Ms. A who assisted in the proof-reading of the manuscript.

Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete a 'License Agreement' (more information). Permitted third party reuse of gold open access articles is determined by the author's choice of user license.

Author rights

As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing

Find out how you can share your research published in Elsevier journals.

Role of the funding source

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the report; and in the decision to submit the article for publication. If the funding source(s) had no such involvement then this should be stated.

Open access

Please visit our Open Access page for more information.

Elsevier Researcher Academy

Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Submission

Our online submission system guides you stepwise through the process of entering your article details and uploading your files. The system converts your article files to a single PDF file used in the peer-review process. Editable files (e.g., Word, LaTeX) are required to typeset your article for final publication. All correspondence, including notification of the Editor's decision and requests for revision, is sent by e-mail.

PREPARATION

Queries

For questions about the editorial process (including the status of manuscripts under review) or for technical support on submissions, please visit our Support Center.

Peer review

This journal operates a single anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Use of word processing software

It is important that the file be saved in the native format of the word processor used. The text should be in single-column format. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. In particular, do not use the word processor's options to justify text or to hyphenate words. However, do use bold face, italics, subscripts, superscripts etc. When preparing tables, if you are using a table grid, use only one grid for each individual table and not a grid for each row. If no grid is used, use tabs, not spaces, to align columns. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). Note that source files of figures, tables and text graphics will be required whether or not you embed your figures in the text. See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Article structure

Manuscripts should be prepared according to the guidelines set forth in the most recent publication manual of the American Psychological Association. Of note, section headings should not be numbered.

Manuscripts should ordinarily not exceed 50 pages, *including* references and tabular material. Exceptions may be made with prior approval of the Editor in Chief. Manuscript length can often be managed through the judicious use of appendices. In general the References section should be limited to citations actually discussed in the text. References to articles solely included in meta-analyses should be included in an appendix, which will appear in the on line version of the paper but not in the print copy. Similarly, extensive Tables describing study characteristics, containing material published elsewhere, or presenting formulas and other technical material should also be included in an appendix. Authors can direct readers to the appendices in appropriate places in the text.

It is authors' responsibility to ensure their reviews are comprehensive and as up to date as possible (at least to 3 months within date of submission) so the data are still current at the time of publication. Authors are referred to the PRISMA Guidelines (http://www.prisma-statement.org/) for guidance in conducting reviews and preparing manuscripts. Adherence to the Guidelines is not required, but is recommended to enhance quality of submissions and impact of published papers on the field.

Appendices

If there is more than one appendix, they should be identified as A, B, etc. Formulae and equations in appendices should be given separate numbering: Eq. (A.1), Eq. (A.2), etc.; in a subsequent appendix, Eq. (B.1) and so on. Similarly for tables and figures: Table A.1; Fig. A.1, etc.

Essential title page information

Title. Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible. **Note: The title page should be the first page of the manuscript document indicating the author's names and affiliations and the corresponding author's complete contact information.**

Author names and affiliations. Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the

actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name, and, if available, the e-mail address of each author within the cover letter.

Corresponding author. Clearly indicate who is willing to handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address.**

Present/permanent address. If an author has moved since the work described in the article was done, or was visiting at the time, a "Present address"' (or "Permanent address") may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Highlights

Highlights are mandatory for this journal as they help increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract

A concise and factual abstract is required (not exceeding 200 words). This should be typed on a separate page following the title page. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separate from the article, so it must be able to stand alone. References should therefore be avoided, but if essential, they must be cited in full, without reference to the reference list.

Graphical abstract

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum of 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. You can view Example Graphical Abstracts on our information site.

Authors can make use of Elsevier's Illustration Services to ensure the best presentation of their images and in accordance with all technical requirements.

Keywords

Immediately after the abstract, provide a maximum of 6 keywords, using American spelling and avoiding general and plural terms and multiple concepts (avoid, for

example, 'and', 'of'). Be sparing with abbreviations: only abbreviations firmly established in the field may be eligible. These keywords will be used for indexing purposes.

Abbreviations

Define abbreviations that are not standard in this field in a footnote to be placed on the first page of the article. Such abbreviations that are unavoidable in the abstract must be defined at their first mention there, as well as in the footnote. Ensure consistency of abbreviations throughout the article.

Acknowledgements

Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Formatting of funding sources

List funding sources in this standard way to facilitate compliance to funder's requirements:

Funding: This work was supported by the National Institutes of Health [grant numbers xxxx, yyyy]; the Bill & Melinda Gates Foundation, Seattle, WA [grant number zzzz]; and the United States Institutes of Peace [grant number aaaa].

It is not necessary to include detailed descriptions on the program or type of grants and awards. When funding is from a block grant or other resources available to a university, college, or other research institution, submit the name of the institute or organization that provided the funding.

If no funding has been provided for the research, please include the following sentence:

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Footnotes

Footnotes should be used sparingly. Number them consecutively throughout the article. Many word processors can build footnotes into the text, and this feature may be used. Otherwise, please indicate the position of footnotes in the text and list the footnotes themselves separately at the end of the article. Do not include footnotes in the Reference list.

Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Embed the used fonts if the application provides that option.
• Aim to use the following fonts in your illustrations: Arial, Courier, Times New Roman, Symbol, or use fonts that look similar.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Provide captions to illustrations separately.
• Size the illustrations close to the desired dimensions of the published version.
• Submit each illustration as a separate file.

• Ensure that color images are accessible to all, including those with impaired color vision.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here. *Formats*
If your electronic artwork is created in a Microsoft Office application (Word, PowerPoint, Excel) then please supply 'as is' in the native document format.
Regardless of the application used other than Microsoft Office, when your electronic artwork is finalized, please 'Save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings, embed all used fonts.
TIFF (or JPEG): Color or grayscale photographs (halftones), keep to a minimum of 300 dpi.
TIFF (or JPEG): Bitmapped (pure black & white pixels) line drawings, keep to a minimum of 1000 dpi. TIFF (or JPEG): Combinations bitmapped line/half-tone (color or grayscale), keep to a minimum of 500 dpi.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); these typically have a low number of pixels and limited set of colors;
• Supply files that are too low in resolution;
• Submit graphics that are disproportionately large for the content.

Color artwork

Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article**. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions

Ensure that each illustration has a caption. Supply captions separately, not attached to the figure. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citations in the text should follow the referencing style used by the American Psychological Association. You are referred to the most recent publication manual of the American Psychological Association. Information can be found at https://apastyle.apa.org/

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal and should include a substitution of the publication date with either 'Unpublished results' or 'Personal communication'. Citation of a reference as 'in press' implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in a special issue

Please ensure that the words 'this issue' are added to any references in the list (and any citations in the text) to other articles in the same Special Issue.

Reference management software

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley. Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. More information on how to remove field codes from different reference management software.

Reference style

References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the

same year must be identified by the letters "a", "b", "c", etc., placed after the year of publication. **References should be formatted with a hanging indent (i.e., the first line of each reference is flush left while the subsequent lines are indented).**

Examples: Reference to a journal publication: Van der Geer, J., Hanraads, J. A. J., & Lupton R. A. (2000). The art of writing a scientific article. *Journal of Scientific Communications,* 163, 51-59.

Reference to a book: Strunk, W., Jr., &White, E. B. (1979). *The elements of style.* (3rd ed.). New York: Macmillan, (Chapter 4).

Reference to a chapter in an edited book: Mettam, G. R., & Adams, L. B. (1994). How to prepare an electronic version of your article. In B.S. Jones, & R. Z. Smith (Eds.), *Introduction to the electronic age* (pp. 281-304). New York: E-Publishing Inc.

[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T. (2015). *Mortality data for Japanese oak wilt disease and surrounding forest compositions.* Mendeley Data, v1. http://dx.doi.org/10.17632/ xwj98nb39r.1

Video

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article are strongly encouraged to include links to these within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the file in one of our recommended file formats with a preferred maximum size of 150 MB per file, 1 GB in total. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect. Please supply 'stills' with your files: you can choose any frame from the video or animation or make a separate image. These will be used instead of standard icons and will personalize the link to your video data. For more detailed instructions please visit our video instruction pages. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

AUTHOR INFORMATION PACK 23 Jan 2022 www.elsevier.com/locate/clinpsychrev 11

Supplementary material

Supplementary material such as applications, images and sound clips, can be published with your article to enhance it. Submitted supplementary items are published exactly as they are received (Excel or PowerPoint files will appear as such online). Please submit your material together with the article and supply a concise, descriptive caption for each supplementary file. If you wish to make changes to supplementary material during any stage of the process, please make sure to provide an updated file. Do not annotate any corrections on a previous version. Please switch off the 'Track Changes' option in Microsoft Office files as these will appear in the published version.

Research data

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data

This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online.

For more information, visit the Mendeley Data for journals page.

Data statement

To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

AFTER ACCEPTANCE

Online proof correction

To ensure a fast publication process of the article, we kindly ask authors to provide us with their proof corrections within two days. Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to

MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.
If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.

We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will, at no cost, receive a customized Share Link providing 50 days free access to the final published version of the article on ScienceDirect. The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's Author Services. Corresponding authors who have published their article gold open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

AUTHOR INQUIRIES

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.

Appendix B
PRISMA Guidance Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	13
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	14
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	15
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	16
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	16
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	20
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	16
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	119
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	16
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	17,18
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	N/A
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	17
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	23-25
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	17,18

Note: N/A= Not applicable.

Section/topic	#	Checklist item	Reported on page #
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	80
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	19
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	20
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	22-25
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	22-25
Synthesis of results	21	Present the main results of the review. If meta-analyses are done, include for each, confidence intervals and measures of consistency.	26,27
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	80, 131,132
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	43
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	44
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	45
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	46

From: Moher D, Liberati A, Tetzlaff J, Altman DG, The PRISMA Group (2009). Preferred Reporting Items for Systematic Reviews and Meta-Analyses: The PRISMA Statement. PLoS Med 6(6): e1000097. doi:10.1371/journal.pmed1000097

Appendix C
Correspondence with Dr Seidler and Search Terms for Systematic Review

From: Zac Seidler <zac.seidler@orygen.org.au>
Sent:11 February 2020 21:54
To: Zuleika Irvanipour (MED - Postgraduate Researcher) <Z.Irvanipour@uea.ac.uk>
Subject: Re: Systematic Review Query?

Hi Zuleika,

That sounds like a good starting point. Be exhaustive with your keywords re anxiety, stress etc. then add help-seeking, help, therapy, psychotherapy etc and then men/boys/young men/masculinity/masculine. Go for pubmed, medline, psycinfo and maybe CINAHL as I did. Also I would lower the age to 12-25, that is more universally recognised as young men.

Good luck and keep me posted. There are some reviews in young men out there so make sure you check those out.

Zac

From: "Zuleika Irvanipour (MED - Postgraduate Researcher)" <Z.Irvanipour@uea.ac.uk>
Date: Tuesday, 11 February 2020 at 9:55 pm
To: Zac Seidler <zac.seidler@orygen.org.au>
Subject: Re: Systematic Review Query?

Hi Zac,

Thank you for the search terms, they will be really helpful moving forward. I might take you up on your offer to help out, as it's a pretty new area for me but I think it's such an important and often overlooked area of research.

My initial thoughts are to undertake a similar review but looking at stress and anxiety instead or depression in younger men.

If you have a hunch on other possible review ideas I'm all ears!

All the best,
Zuleika

From: Zac Seidler <zac.seidler@orygen.org.au>
Sent:10 February 2020 21:58
To: Zuleika Irvanipour (MED - Postgraduate Researcher) <Z.Irvanipour@uea.ac.uk>
Subject: Re: Systematic Review Query?

Hi Zuleika,

I've attached the search terms here.
Great to hear you're looking into younger men, it's a much needed review.
Should you need any help let me know as I'd be happy to work with you on a manuscript, I've got plenty of thoughts on this area.

Regards,

Zac

From: "Zuleika Irvanipour (MED - Postgraduate Researcher)" <Z.Irvanipour@uea.ac.uk>
Date: Monday, 10 February 2020 at 6:18 am
To: Zac Seidler <zac.seidler@orygen.org.au>
Subject: RE: Systematic Review Query?

Dear Dr Seidler,

I am currently working on a systematic review for my clinical psychology doctorate at UEA and came across your 2016 paper 'The role of masculinity in men's help-seeking for depression: A systematic review'. I was thinking of doing a similar review as my thesis is on the role of masculinity on the experience of stress and help-seeking among young men between 16-25 years old.

It would be great to see the supplementary files (in particular file 2 with search terms?), as I can't seem to find it online.

Also - I think it's great that there's a scholarship at your university for young mens health! Sounds brilliant.

All the best,
Zuleika

Zuleika Irvanipour
Trainee Clinical Psychologist
Norwich Medical School
University of East Anglia
Norwich NR4 7TJ

OVID Medline search strategy for current systematic review <Sept 2015 – June 2020>

1. exp Gender Identity/ or exp Masculinity/ or masculin*.mp. (28418)
2. traditional masculin*.mp. (156)
3. exp Gender Identity/ or exp Masculinity/ or masculine gender norm.mp. (19542)
4. Gender Identity/ or gender role conflict.mp. (18382)
5. exp Gender Identity/ or gender role strain.mp. (19546)
6. exp Gender Identity/ or gender norm.mp. or Sex Factors/ (280237)
7. gender social norm.mp. or exp Gender Identity/ (19541)
8. 1 – 7 (288480)
9. exp "Patient Acceptance of Health Care"/ or help seek*.mp. (154716)
10. seek* help.mp. or exp "Patient Acceptance of Health Care"/ (153833)
11. seek* treatment.mp. or exp "Patient Acceptance of Health Care"/ (155393)
12. exp "Patient Acceptance of Health Care"/ or help seek* behaviour.mp. (150965)
13. exp "Patient Acceptance of Health Care"/ or help seek* behavior.mp. (151624)
14. "pathway* to treatment".mp. (1925)
15. "pathway* to help seek*".mp. (15)
16. exp "Patient Acceptance of Health Care"/ or help seek* pathway*.mp. (150639)
17. treatment pathway*.mp. (1353)
18. 9 – 17 (165073)
19. exp Depression/ or depression.mp. (399471)
20. exp Depression/ or exp Mood Disorders/ or low mood.mp. or exp Depressive Disorder/ (226570)
21. exp Depression/ or exp Stress, Psychological/ or psychological distress.mp. (245792)
22. exp Depression/ or exp Stress, Psychological/ or mental distress.mp. (236650)
23. mood disorder.mp. or exp Mood Disorders/ (124222)
24. exp Depressive Disorder/ or exp Depressive Disorder, Major/ or emotional problem.mp. (108607)
25. exp Mood Disorders/ or exp Stress, Psychological/ or emotional distress.mp. or exp Depression/ (343090)
26. 19 – 25 (559,392)
27. 8 and 18 and 26 (669)
28. Limit 27 to yr=”2015-Current” (202)

OVID Medline search strategy for Seidler et al., 2016 Systematic Review <1950 to August 2015>

1 exp Gender Identity/ or exp Masculinity/ or masculin*.mp. (22343)

2 traditional masculin*.mp. (81)

3 exp Gender Identity/ or exp Masculinity/ or masculine gender norm.mp. (16349)

4 exp Gender Identity/ or gender role conflict.mp. (16361)

5 exp Gender Identity/ or gender role strain.mp. (16351)

6 exp Gender Identity/ or gender norm.mp. or Sex Factors/ (242293)

7 gender social norm.mp. or exp Gender Identity/ (16349)

8 1 – 7 (247798)

9 exp "Patient Acceptance of Health Care"/ or help seek*.mp. (185453)

10 seek* help.mp. or exp "Patient Acceptance of Health Care"/ (185640)

11 seek* treatment.mp. or exp "Patient Acceptance of Health Care"/ (186908)

12 exp "Patient Acceptance of Health Care"/ or help seek* behaviour.mp. (184096)

13 exp "Patient Acceptance of Health Care"/ or help seek* behavior.mp. (184177)

14 "pathway* to treatment".mp. (1118)

15 "pathway* to help seek*".mp. (8)

16 exp "Patient Acceptance of Health Care"/ or help seek* pathway*.mp. (183983)

17 treatment pathway*.mp. (483)

18 9 – 17 (191384)

19 exp Depression/ or depression.mp. (284806)

20 exp Depression/ or exp Mood Disorders/ or low mood.mp. or exp Depressive Disorder/ (204207)

21 exp Depression/ or exp Stress, Psychological/ or psychological distress.mp. (185460)

22 exp Depression/ or exp Stress, Psychological/ or mental distress.mp. (181136)

23 mood disorder.mp. or exp Mood Disorders/ (126397)

24 exp Depressive Disorder/ or exp Depressive Disorder, Major/ or emotional problem.mp. (87961)

25 exp Mood Disorders/ or exp Stress, Psychological/ or emotional distress.mp. or exp Depression/ (296113)

26 19 – 25 (433247)

27 8 and 18 and 26 (563)

Appendix D
Screening Eligibility Criteria

USE FOR SCREENING: Inclusion & Exclusion Criteria

Participants

Include

- Both purely male and mixed gender samples.

Exclude

- Persons help-seeking on behalf of another individual (e.g. family members, informal carers).

Outcomes

Depression

Include

- Any form of depressive disorder including Major Depressive Disorder, Dysthymia, Sub-clinical depressive symptoms or 'psychological distress'
- Depression as measured by diagnostic cut-off scale, clinician report, structured diagnostic interview or self-report.
- Papers measuring depression as part of a wider mental health analysis or treatment of comorbid disorders.
- Depression as secondary diagnosis.
- Personal Experience of depression and its derivatives. If a mixed sample of participants with direct and indirect experience, it should be clear the findings from men with direct experience of depression.

Exclude

- Papers purely addressing bipolar disorder, anxiety disorders, substance abuse.
- Papers referring to symptoms of low mood, without a focus on depression and its derivatives (mentioned in inclusion above).

Help-Seeking

Include

- Help-seeking
- Measures of help-seeking related attitudes, intentions and behaviours.
- Help-seeking from a health practitioner or service (including primary, secondary or tertiary care) or talking therapy (psychotherapy/psychology/counselling services or practitioner).
- Informal help-seeking from friends, family, religious or community services.
- Measures relating to any stage of help-seeking from seeking initial formal help to service use.

Exclude

- N/A

Masculinity

Include

- Measures of masculine norms, masculine behaviour, masculine ideology, masculinity conformity.
- Measures of gender-role conflict or gender-role strain.
- Measures of 'masculine depression'
- Qualitative discussion of role of masculinity in participants' depression and/or help-seeking intention/behaviour.

Exclude

- Papers that address role of masculinity in discussion (future studies) but do not assess its role specifically.

Study Type

Include

- Reported original data
- Articles published in any language and any date
- Mixed gender or pure male samples
- English
- Non-published theses and dissertations

Exclude

- Editorials, systematic reviews or meta-analyses and purely theoretical paper

Appendix E
Peer-review Tables

Title and abstract screen by peer reviewer 1.		
Study (shorthand reference)	Concordance, notes from peer reviewer	Resolution
Dutton, C. E., Rojas, S. M., Badour, C. L., Wanklyn, S. G., & Feldner, M. T. (2016). Posttraumatic Stress Disorder and Suicidal Behavior: Indirect Effects of Impaired Social Functioning. Archives of Suicide Research, 20(4), 567. https://search.ebscohost.com/login.aspx?direct=true&db=edb&AN=118118924&authtype=sso&custid=s8993828&site=eds-live&scope=site	Agreement, exclude	
Malmberg, M., Lunner, T., Kähäri, K., & Andersson, G. (2017). Evaluating the short-term and long-term effects of an internet-based aural rehabilitation programme for hearing aid users in general clinical practice: a randomised controlled trial. BMJ Open, 7(5 CC-ENT), e013047. https://doi.org/10.1136/bmjopen-2016-013047	Agreement, exclude	
Vanneman, M. E., Phibbs, C. S., Dally, S. K., Trivedi, A. N., & Yoon, J. (2018). The Impact of Medicaid Enrollment on	Agreement, exclude	
Green, J. D., Kearns, J. C., Ledoux, A. M., Addis, M. E., & Marx, B. P. (2015). The Association Between Masculinity and Nonsuicidal Self-Injury. In AMERICAN JOURNAL OF MENS HEALTH (Vol. 12, Issue 1, pp. 30–40). https://doi.org/10.1177/1557988315624508	Disagreement. Lead author: include Peer reviewer: Exclude. 'paper does not specifically talk about depression, but focuses on suicide. Will exclude from screening'. Ask CN	Changed. Excluded from full text screening
Athanasiadis, C., Gough, B., & Robertson, S. (2018). What do counsellors need to know about male depression? British Journal of Guidance & Counselling, 46(5), 596–604. https://doi.org/10.1080/03069885.2017.1346232	Disagreement. Lead author: exclude. Peer reviewer: include.	No change. Keep as excluded as it is a review study.
Dolan, A., Lomas, T., Ghobara, T., & Hartshorne, G. (2017). `It's like taking a bit of masculinity away from you': towards a theoretical understanding of men's experiences of infertility. SOCIOLOGY OF HEALTH & ILLNESS, 39(6), 878–892. https://doi.org/10.1111/1467-9566.12548	Agree- Exclude	
MCCORMICK, R., MORETTI, D., MCKAY, A., LAARAKKERS, C., VANSWELM, R., TRINDER, D., COX, G., ZIMMERMAN, M., SIM, M., GOODMAN, C., & al., et. (2019). The Impact of Morning versus Afternoon Exercise on Iron Absorption in Athletes. Medicine and Science in Sports and Exercise, 51(10), 2147-2155. https://doi.org/10.1249/MSS.0000000000002026	Agree- Exclude	
Tyuse, S. W., Cooper-Sadlo, S., & Underwood, S. E. (2017). Descriptive study of older adults encountered by crisis intervention team (CIT) law enforcement officers. Journal of Women & Aging, 29(4), 281–293. https://doi.org/10.1080/08952841.2016.1174513	Agree- Exclude	
Lin, S.-L., Wu, S.-L., Ko, S.-Y., Lu, C.-H., Wang, D.-W., Ben, R.-J., Horng, C.-T., & Yang, J.-W. (2016). Dysthymia increases the risk of temporomandibular disorder: A population-based cohort study (A STROBE-Compliant Article). Medicine, 95(29), e4271. https://doi.org/https://dx.doi.org/10.1097/MD.0000000000004271	Agree- Exclude	
Bitter, N., Roeg, D., Van Nieuwenhuizen, C., & Van Weeghel, J. (2019). Training professionals in a recovery-oriented methodology: a mixed method evaluation. Scandinavian Journal of Caring Sciences, 33(2), 457-466. https://doi.org/10.1111/scs.12644	Agree- Exclude	
Brown, L., Burns, Y. R., Watter, P., Gray, P. H., & Gibbons, K. S. (2018). Behaviour of 4- to 5-year-old nondisabled ELBW children: outcomes following group-based physiotherapy intervention. Child, 44(2), 227-233. https://doi.org/10.1111/cch.12495	Agree- Exclude	

NCT03304015. (2017). HERrespect Evaluation. Https://Clinicaltrials.Gov/Show/NCT03304015. https://www.cochranelibrary.com/central/doi/10.1002/central/CN-02048200/full	Agree- Exclude	
Dantas, L. O., Breda, C. C., da Silva Serrao, P. R. M., Aburquerque-Sendín, F., Serafim Jorge, A. E., Cunha, J. E., Barbosa, G. M., Durigan, J. L. Q., & Salvini, T. D. F. (2019). Short-term cryotherapy did not substantially reduce pain and had unclear effects on physical function and quality of life in people with knee osteoarthritis: a randomised trial. Journal of Physiotherapy (Elsevier), 65(4), 215-221. https://doi.org/10.1016/j.jphys.2019.08.004	Agree- Exclude	
ISRCTN77449378. (2018). Promoting adolescent engagement, knowledge and health evaluation of PAnKH: an adolescent girl intervention in Rajasthan, India. Http://Www.Who.Int/Trialsearch/Trial2.Aspx?TrialID=ISRCTN77449378. https://www.cochranelibrary.com/central/doi/10.1002/central/CN-01896259/full	Agree- Exclude	
Taani, M. H., Siglinsky, E., Kovach, C. R., & Buehring, B. (2018). Psychosocial Factors Associated With Reduced Muscle Mass, Strength, and Function in Residential Care Apartment Complex Residents. Research in Gerontological Nursing, 11(5), 238-248. https://doi.org/10.3928/19404921-20180810-02	Agree- Exclude	
Fitz, N., Kushlev, K., Jagannathan, R., Lewis, T., Paliwal, D., & Ariely, D. (2019). Batching smartphone notifications can improve well-being. Computers in Human Behavior, 101, 84-94. https://doi.org/10.1016/j.chb.2019.07.016	Agree- Exclude	
Strong, C. E., Schoepfer, K. J., Dossat, A. M., Saland, S. K., Wright, K. N., & Kabbaj, M. (2017). Locomotor sensitization to intermittent ketamine administration is associated with nucleus accumbens plasticity in male and female rats. NEUROPHARMACOLOGY, 121, 195–203. https://doi.org/10.1016/j.neuropharm.2017.05.003	Agree- Exclude	
Jun, T., Wei, H., Xuhui, C., Qian, L., Tingwei, W., Hao, J., Ping, W., & Zhaoming, H. (2019). Liuzijue Qigong: a Voice Training Method For Unilateral Vocal Fold Paralysis Patients. Annals of Otology, Rhinology, and Laryngology, 128(7), 654-661. https://doi.org/10.1177/0003489419837265	Agree- Exclude	
Barbato, A., D'Avanzo, B., & Parabiaghi, A. (2018). Couple therapy for depression. The Cochrane Database of Systematic Reviews, 6, CD004188. https://doi.org/https://dx.doi.org/10.1002/14651858.CD004188.pub3	Agree- Exclude	
Esposito, M., Gimigliano, F., Barillari, M. R., Precenzano, F., Ruberto, M., Sepe, J., Barillari, U., Gimigliano, R., Militerni, R., Messina, G., & al., et. (2017). Pediatric selective mutism therapy: a randomized controlled trial. European Journal of Physical and Rehabilitation Medicine, 53(5), 643-650. https://doi.org/10.23736/S1973-9087.16.04037-5	Agree- Exclude	
Jbilou, J., Grenier, J., Chomienne, M.-H., Talbot, F., Tulloch, H., D'Antono, B., Greenman, P., & Team, M. P. (2019). Understanding men's psychological reactions and experience following a cardiac event: a qualitative study from the MindTheHeart project. In BMJ OPEN (Vol. 9, Issue 9). https://doi.org/10.1136/bmjopen-2019-029560	Agree- Exclude	
Nickerson, A., Schick, M., Schnyder, U., Bryant, R. A., & Morina, N. (2017). Comorbidity of Posttraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees. Journal of Traumatic Stress, 30(4), 409–415. https://doi.org/https://dx.doi.org/10.1002/jts.22205	Agree- Exclude	
Rimes, K. A., Goodship, N., Ussher, G., Baker, D., & West, E. (2019). Non-binary and binary transgender youth: Comparison of mental health, self-harm, suicidality, substance use and victimization experiences. International Journal of Transgenderism, 20(2/3), 230–240. https://doi.org/10.1080/15532739.2017.1370627	Agree- Exclude	
Koehler, A., Richter-Appelt, H., Cerwenka, S., Kreukels, B. P. C., Watzlawik, M., Cohen-Kettenis, P. T., De Cuypere, G., Haraldsen, I. R. H., & Nieder, T. O. (2017). Recalled gender-related play behavior and peer-group preferences in childhood and adolescence among adults applying for gender-affirming	Agree- Exclude	

treatment. Sexual and Relationship Therapy, 32(2), 210–226. https://doi.org/10.1080/14681994.2016.1195908		
Bitter, N., Roeg, D., Van Nieuwenhuizen, C., & Van Weeghel, J. (2019). Training professionals in a recovery-oriented methodology: a mixed method evaluation. Scandinavian Journal of Caring Sciences, 33(2), 457-466. https://doi.org/10.1111/scs.12644	Agree- Exclude	
Rice, S. M., Telford, N. R., Rickwood, D. J., & Parker, A. G. (2018). Young men's access to community-based mental health care: qualitative analysis of barriers and facilitators. *Journal of Mental Health*, *27*(1), 59–65. https://doi.org/10.1080/09638237.2016.1276528	DISAGREEMENT Lead author: Include Peer reviewer: exclude 'Need more detail about whether they looked at depression as part of the MH screening. Can't find the full paper.	No change. Included for full text screen.
Horwitz, A. G., McGuire, T., Busby, D. R., Eisenberg, D., Zheng, K., Pistorello, J., Albucher, R., Coryell, W., & King, C. A. (2020). Sociodemographic differences in barriers to mental health care among college students at elevated suicide risk. *JOURNAL OF AFFECTIVE DISORDERS*, *271*, 123–130. https://doi.org/10.1016/j.jad.2020.03.115	Disagreement. Lead author: include. Peer reviewer: exclude ' Again, they say MH and suicide, but not specified whether they measured depression, which they might have. Can't find the full paper. Ask CN	Changed. Exclude as haven't discussed depression as a focus in abstract.
The Psychology of Men and Masculinities. (2017). In R. F. Levant & Y. J. Wong (Eds.), The Psychology of Men and Masculinities. American Psychological Association. https://search.proquest.com/docview/2134131903?accountid=10637	Agree- Exclude	
Oliffe, J. L., Broom, A., Kelly, M. T., Bottorff, J. L., Creighton, G. M., & Ferlatte, O. (2018). Men on Losing a Male to Suicide: A Gender Analysis. QUALITATIVE HEALTH RESEARCH, 28(9), 1383–1394. https://doi.org/10.1177/1049732318769600	Agree- Exclude	
Aguilar, J. M., Shultz, E. L., Wade, S. L., Cassedy, A. E., Kirkwood, M. W., Stancin, T., Taylor, H. G., & Yeates, K. O. (2019). A Comparison of 2 Online Parent Skills Training Interventions for Early Childhood Brain Injury: improvements in Internalizing and Executive Function Behaviors. Journal of Head Trauma Rehabilitation, 34(2), 65-76. https://doi.org/10.1097/HTR.0000000000000443	Agree- Exclude	
Voegeli, G., Ramoz, N., Shekhtman, T., Courtet, P., Gorwood, P., & Kelsoe, J. R. (2016). Neurotrophin genes and antidepressant-worsening suicidal ideation: A prospective case-control study. International Journal of Neuropsychopharmacology, 19(11), 1–5. https://doi.org/10.1093/ijnp/pyw059	Agree- Exclude	
Seabrook, R. C., & Ward, L. M. (2019). Bros Will Be Bros? The Effect of Fraternity Membership on Perceived Culpability for Sexual Assault. Violence against Women, 25(12), 1471-1490. https://doi.org/10.1177/1077801218820196	Agree- Exclude	
Staiger, T., Stiawa, M., Mueller-Stierlin, A. S., Kilian, R., Beschoner, P., Gundel, H., Becker, T., Frasch, K., Panzirsch, M., Schmaus, M., & Krumm, S. (2020). [Men and Depression: Illness Theories and Coping - A Biographical Narrative Study]. Depression Und Mannlichkeit: Krankheitstheorien Und Bewaltigung - Eine Biografisch-Narrative Studie., 47(2), 65–70. https://doi.org/https://dx.doi.org/10.1055/a-1043-8126	Agree – Include	
Pachankis, J. E., Williams, S. L., Behari, K., Job, S., McConocha, E. M., & Chaudoir, S. R. (2020). Brief online interventions for LGBTQ young adult mental and behavioral health: a randomized controlled trial in a high-stigma, low-resource context. Journal of Consulting and Clinical Psychology, 88(5), 429-444. https://doi.org/10.1037/ccp0000497	Agree- Exclude	
Rice, S. M., Oliffe, J. L., Kealy, D., Seidler, Z. E., & Ogrodniczuk, J. S. (2020). Men's Help-Seeking for Depression: Attitudinal and Structural Barriers in Symptomatic Men. JOURNAL OF PRIMARY CARE AND COMMUNITY HEALTH, 11. https://doi.org/10.1177/2150132720921686	Agree – Include	

Cannella, L. A. (2019). Characterization of the Role and Underlying Mechanisms of Traumatic Brain Injury on Reward Seeking Behavior Using Preclinical Animal Models [Temple University]. In ProQuest Dissertations and Theses. https://search.proquest.com/docview/2238778889?accountid=10637	Agree- Exclude	
Okunrinboye, H. I., Otakpor, A. N., & Ilesanmi, O. S. (2019). Depression and medication-adherence in patients with hypertension attending a tertiary health facility in South-West Nigeria. The Pan African Medical Journal, 33, 27. https://doi.org/https://dx.doi.org/10.11604/pamj.2019.33.27.12941	Agree- Exclude	
Galligan, P. K. (2016). Male Chinese international students' utilization of and barriers to mental health resources [The University of Iowa]. In ProQuest Dissertations and Theses. https://search.proquest.com/docview/1834310376?accountid=10637	Disagreement. Lead author: include. Peer reviewer: Exclude.	No change. Include so I can fully assess at full screen text.
McDermott, R. C., Currier, J. M., Naylor, P. D., & Kuhlman, S. T. W. (2017). Student veterans' self-stigma of seeking help: Contributions of painful self-conscious emotions, traditional masculine norms, and war-zone service. Psychology of Men & Masculinity, 18(3), 226–237. https://doi.org/10.1037/men0000117	Agree- Include	
Isacco, A., Hofscher, R., & Molloy, S. (2016). An examination of fathers' mental health help seeking: A brief report. American Journal of Men's Health, 10(6), N33–N38. https://doi.org/10.1177/1557988315581395	Disagreement. Lead author: include. Peer reviewer: Exclude.	No change. Include so I can fully assess at full screen text.
Total concordance rate :	K=0.62	

Title and abstract screen by peer reviewer 2.		
Study (shorthand reference)	**Concordance**	**Resolution**
Calear, A. L., Banfield, M., Batterham, P. J., Morse, A. R., Forbes, O., Carron-Arthur, B., & Fisk, M. (2017). Silence is deadly: a cluster-randomised controlled trial of a mental health help-seeking intervention for young men. BMC Public Health, 17. https://doi.org/http://dx.doi.org/10.1186/s12889-017-4845-z	Disagreement. Lead author: Include Peer reviewer: 'I would say exclude due to no Depression inventory, there is a distress inventory but this is not depression as such rather anxiety. It does in my opinion meet all the other criteria."	Change. Exclude
Gerlach, L. B., Kavanagh, J., Watkins, D., Chiang, C., Kim, H. M., & Kales, H. C. (2017). With a little help from my friends?: racial and gender differences in the role of social support in later-life depression medication adherence. International Psychogeriatrics, 29(9), 1485–1493. https://doi.org/https://dx.doi.org/10.1017/S104161021700076X	Disagreement. Lead author: Exclude Peer reviewer: ' I would say include as it measures depression it talks about gender conflict (although mainly female part) and you can argue that the social support measure is a way of help-seeking.'	No change. Exclude
Brownlie, E., Beitchman, J. H., Chaim, G., Wolfe, D. A., Rush, B., & Henderson, J. (2019). Early Adolescent Substance Use and Mental Health Problems and Service Utilisation in a School-based Sample. Canadian Journal of Psychiatry. Revue Canadienne de Psychiatrie, 64(2), 116–125. https://doi.org/https://dx.doi.org/10.1177/0706743718784935	Agreement – exclude	
Xiao, H., Huang, W., Qin, X., Zuo, C., Yang, Q., Li, R., & Lin, M. (2019). Day Ward Glaucoma Patients Have Lower Depression Levels and Higher Glaucoma Knowledge Levels than Inpatients. Journal of Ophthalmology, 1-7. https://doi.org/10.1155/2019/4182030	Agreement – exclude	
Gracia-Rubio, I., Moscoso-Castro, M., Pozo, O. J., Marcos, J., Nadal, R., & Valverde, O. (2016). Maternal separation induces neuroinflammation and long-lasting emotional alterations in mice. PROGRESS IN NEURO-PSYCHOPHARMACOLOGY & BIOLOGICAL PSYCHIATRY, 65, 104–117. https://doi.org/10.1016/j.pnpbp.2015.09.003	Agreement – exclude	
Frankfurt, S. B., DeBeer, B. B., Morissette, S. B., Kimbrel, N. A., La Bash, H., & Meyer, E. C. (2018). Mechanisms of moral injury following military sexual trauma and combat in post-9/11 US war veterans. Frontiers in Psychiatry, 9. https://doi.org/10.3389/fpsyt.2018.00520	Agreement – exclude	
Stahlman, S., & Oetting, A. A. (2018). Mental health disorders and mental health problems, active component,U.S. Armed Forces, 2007-2016. MSMR, 25(3), 2–11.	Agreement – exclude	
Kautzky-Willer, A. (2016). Brennpunkt Adipositas: what gender has to do with ...! WIENER MEDIZINISCHE WOCHENSCHRIFT, 166(3–4), 75–78. https://doi.org/10.1007/s10354-016-0440-7	Agreement – exclude	
Hobden, B., Carey, M., Bryant, J., Sanson-Fisher, R., & Oldmeadow, C. (2020). Prevalence and Predictors of Symptoms of Depression Among Individuals Seeking Treatment from Australian Drug and Alcohol Outpatient Clinics. Community Mental Health Journal, 56(1), 107–115. https://doi.org/10.1007/s10597-019-00451-3	Agreement – exclude	
Hobden, B., Carey, M., Bryant, J., Sanson-Fisher, R., & Oldmeadow, C. (2020). Prevalence and Predictors of Symptoms of Depression Among Individuals Seeking Treatment from Australian Drug and Alcohol Outpatient Clinics. Community Mental Health Journal, 56(1), 107–115. https://doi.org/10.1007/s10597-019-00451-3	Agreement – exclude	
Wekerle, C., & Black, T. (2017). Gendered violence: Advancing evidence-informed research, practice and policy in addressing sex, gender, and child	Agreement – exclude	

sexual abuse. Child Abuse and Neglect, 66, 166–170. https://doi.org/10.1016/j.chiabu.2017.03.010		
Rominov, H., Giallo, R., Pilkington, P. D., & Whelan, T. A. (2018). "Getting help for yourself is a way of helping your baby:" Fathers' experiences of support for mental health and parenting in the perinatal period. Psychology of Men & Masculinity, 19(3), 457–468. https://doi.org/10.1037/men0000103	Disagreement: Lead author: Include Peer: 'exclude does not contain masculinity'. Ask CN	No change. Include, in masculinity journal, needs full text screen.
Deshabhotla, S., Vallala, V., Tandur, B., & Subramaniam, S. (2019). Comparison of Dunn and Shukla method of calculating umbilical vein catheter insertion length: a randomized controlled trial. Journal of Neonatal Nursing, 25(5), 249-253. https://doi.org/10.1016/j.jnn.2019.03.00	Agreement – exclude	
Lykkegaard, J., Rosendal, M., Brask, K., Brandt, L., & Prior, A. (2018). Prevalence of persons contacting general practice for psychological stress in Denmark. Scandinavian Journal of Primary Health Care, 36(3), 272–280. https://doi.org/https://dx.doi.org/10.1080/02813432.2018.1499494	Agreement – exclude	
Ketterer, M. W., Chawa, M., & Paone, G. (2017). Prospective correlates of early (30 day) readmissions on a Cardiothoracic Surgery Service. Psychology, Health & Medicine, 22(8), 947–954. https://doi.org/https://dx.doi.org/10.1080/13548506.2017.1287408	Agreement – exclude	
Kilian, R., Muller-Stierlin, A., Sohner, F., Beschoner, P., Gundel, H., Staiger, T., Stiawa, M., Becker, T., Frasch, K., Panzirsch, M., Schmaus, M., & Krumm, S. (2020). Masculinity norms and occupational role orientations in men treated for depression. PloS One, 15(5), e0233764. https://doi.org/https://dx.doi.org/10.1371/journal.pone.0233764	Disagreement: Primary: exclude Peer: 'potentially include as it has gender conflict/ masculinity and depression in it. You could argue the Stigma of mental illness is attitude towards help-seeking'	Change. Include
Spendelow, J. S. (2015). Men's Self-Reported Coping Strategies for Depression: A Systematic Review of Qualitative Studies. In PSYCHOLOGY OF MEN & MASCULINITY (Vol. 16, Issue 4, pp. 439–447). https://doi.org/10.1037/a0038626	Agreement – exclude	
Roy, P., Duplessis-Brochu, É., & Tremblay, G. (2019). RESPONSES TO ADVERSITY FACED BY FARMING MEN: A GENDER-TRANSFORMATIVE ANALYSIS. International Journal of Child, Youth & Family Studies, 10(1), 49.	Agreement – exclude	
Onyechi, K. C., Eseadi, C., Okere, A. U., Onuigbo, L. N., Umoke, P. C., Anyaegbunam, N. J., Otu, M. S., & Ugorji, N. J. (2016). Effects of cognitive behavioral coaching on depressive symptoms in a sample of type 2 diabetic inpatients in Nigeria. Medicine, 95(31), e4444. https://doi.org/10.1097/MD.0000000000004444	Agreement – exclude	
Martin, S. (2016). "How can you be strong all the time?" Discourses of stoicism in the first counselling session of young male clients. Counselling & Psychotherapy Research, 16(2), 100–108. https://doi.org/10.1002/capr.12062	Disagreement. Primary: Include Peer: 'exclude does not address depression/ gender conflict'. Ask CN.	No change. Include at full text screen.
Alangea, D. O., Addo-Lartey, A. A., Sikweyiya, Y., Chirwa, E. D., Coker-Appiah, D., Jewkes, R., & Adanu, R. M. K. (2018). Prevalence and risk factors of intimate partner violence among women in four districts of the central region of Ghana: baseline findings from a cluster randomised controlled trial. Plos One, 13(7) (no pagination). https://doi.org/10.1371/journal.pone.0200874	Agreement – exclude	
SHAW, D., MERIEN, F., BRAAKHUIS, A., MAUNDER, E. D., & DULSON, D. (2019). Effect of a Ketogenic Diet on Submaximal Exercise Capacity and Efficiency in Runners. Medicine and Science in Sports and Exercise, 51(10), 2135-2146. https://doi.org/10.1249/MSS.0000000000002008	Agreement – exclude	
Dunne, E. M., Norris, A. L., Romer, D., DiClemente, R. J., Vanable, P. A., Valois, R. F., Brown, L. K., & Carey, M. P. (2019). Problem Solving Reduces Sexual Risk Associated with Sensation Seeking, Substance Use, and Depressive Symptoms Among African-American Adolescents. Journal	Agreement – exclude	

of Child & Adolescent Substance Abuse, 28(2), 113–118. https://doi.org/10.1080/1067828X.2019.1610679		
Doblyte, S., & Jiménez-Mejías, E. (2017). Understanding help-seeking behavior in depression: A qualitative synthesis of patients' experiences. Qualitative Health Research, 27(1), 100–113. https://doi.org/10.1177/1049732316681282	Disagreement Primary: Exclude 'I initially excluded as looks like a review - after checking again it is a review so will keep as excluded' Peer: 'I would say include as it discusses masculinity, help-seeking and depression albeit all qualitative.'	No change. Exclude
ISRCTN84502355. (2018). Community interventions to prevent violence against women and girls in informal settlements in Mumbai: the SNEHA-TARA trial. Http://Www.Who.Int/Trialsearch/Trial2.Aspx?TrialID=ISRCTN84502355. https://www.cochranelibrary.com/central/doi/10.1002/central/CN-01895523/full	Agreement – exclude	
Lawson, L. M., Glennon, C., Fiscus, V., Harrell, V. S., Krause, K. A., Moore, A. B., & Smith, K. (2016). Effects of Making Art and Listening to Music on Symptoms Related to Blood and Marrow Transplantation. Oncology Nursing Forum, 43, E56. https://doi.org/10.1188/16.ONF.E56-E63	Agreement – exclude	
Reinders, I., Volkert, D., de Groot, L., Beck, A. M., Feldblum, I., Jobse, I., Neelemaat, F., de van der Schueren, M. A. E., Shahar, D. R., Smeets, E., & al., et. (2019). Effectiveness of nutritional interventions in older adults at risk of malnutrition across different health care settings: pooled analyses of individual participant data from nine randomized controlled trials. Clinical Nutrition (Edinburgh, Scotland), 38(4), 1797-1806. https://doi.org/10.1016/j.clnu.2018.07.023	Agreement – exclude	
Hansen, A. H., & Kristoffersen, A. E. (2016). The use of CAM providers and psychiatric outpatient services in people with anxiety/depression: a cross-sectional survey. BMC Complementary & Alternative Medicine, 16, 1–8. https://doi.org/10.1186/s12906-016-1446-9	Disagreement Lead author: exclude, no focus on masculinity Peer: ' You could argue to include as it discusses help-seeking, depression and masculine behaviour (not just in discussion, but very briefly).'	No change. Exclude.
Mueller, S. C., De Cuypere, G., & T'Sjoen, G. (2017). Transgender research in the 21st century: A selective critical review from a neurocognitive perspective. The American Journal of Psychiatry, 174(12), 1155–1162. https://doi.org/10.1176/appi.ajp.2017.17060626	Agreement – exclude	
Mericle, A. A., Hemberg, J., Stall, R., & Carrico, A. W. (2019). Pathways to recovery: recovery housing models for men who have sex with men (MSM). Addiction Research & Theory, 27(5), 373–382. https://doi.org/10.1080/16066359.2018.1538409	Disagreement. Primary: Exclude Peer: ' Tricky one, I feel it discusses help-seeking, depression but not gender conflict explicitly although it does refer to it implicitly. So I would be lenient and say include'.	Change. Include.
Nickerson, A., Schick, M., Schnyder, U., Bryant, R. A., & Morina, N. (2017). Comorbidity of Posttraumatic Stress Disorder and Depression in Tortured, Treatment-Seeking Refugees. Journal of Traumatic Stress, 30(4), 409–415. https://doi.org/https://dx.doi.org/10.1002/jts.22205	Agreement – exclude	
Liang, S., Wang, T., Hu, X., Luo, J., Li, W., Wu, X., Duan, Y., & Jin, F. (2015). ADMINISTRATION OF LACTOBACILLUS HELVETICUS NS8 IMPROVES BEHAVIORAL, COGNITIVE, AND BIOCHEMICAL ABERRATIONS CAUSED BY CHRONIC RESTRAINT STRESS. NEUROSCIENCE, 310, 561–577. https://doi.org/10.1016/j.neuroscience.2015.09.033	Agreement – exclude	

McArthur, M. L., Matthew, S. M., Brand, C. P. B., Andrews, J., Fawcett, A., & Hazel, S. (2019). Cross-sectional analysis of veterinary student coping strategies and stigma in seeking psychological help. VETERINARY RECORD, 184(23). https://doi.org/10.1136/vr.105042	Agreement – exclude	
Buckley, R. F., Hanseeuw, B., Schultz, A. P., Vannini, P., Aghjayan, S. L., Properzi, M. J., Jackson, J. D., Mormino, E. C., Rentz, D. M., Sperling, R. A., Johnson, K. A., & Amariglio, R. E. (2017). Region-specific association of subjective cognitive decline with tauopathy independent of global β-amyloid burden. JAMA Neurology, 74(12), 1455–1463. https://doi.org/10.1001/jamaneurol.2017.2216	Agreement – exclude	
Mitchell, A. E. P. (2018). Psychological distress in student nurses undertaking an educational programme with professional registration as a nurse: Their perceived barriers and facilitators in seeking psychological support. Journal of Psychiatric & Mental Health Nursing (John Wiley & Sons, Inc.), 25(4), 258–269. http://10.0.4.87/jpm.12459	Disagreement Primary: Exclude Peer: 'include, discusses help-seeking, depression and masculinity effects'	No change. Exclude.
O'Brien, H. L., & Cohen, J. M. (2015). Young Adults With Headaches: The Transition From Adolescents to Adults. Headache: The Journal of Head & Face Pain, 55(10), 1404–1409. https://doi.org/10.1111/head.12706	Agreement – exclude	
Olfson, M., Wang, S., Wall, M., Marcus, S. C., & Blanco, C. (2019). Trends in Serious Psychological Distress and Outpatient Mental Health Care of US Adults. JAMA Psychiatry, 76(2), 152–161. https://doi.org/https://dx.doi.org/10.1001/jamapsychiatry.2018.3550	Agreement – exclude	
Rimes, K. A., Goodship, N., Ussher, G., Baker, D., & West, E. (2019). Non-binary and binary transgender youth: Comparison of mental health, self-harm, suicidality, substance use and victimization experiences. International Journal of Transgenderism, 20(2/3), 230–240. https://doi.org/10.1080/15532739.2017.1370627	Disagreement Primary: Exclude Peer: include, discusses help-seeking, depression and masculinity effects	Changed. Include
O'Farrell, T. J., Schreiner, A., Schumm, J., & Murphy, M. (2016). Do outcomes after behavioral couples therapy differ based on the gender of the alcohol use disorder patient?. Addictive Behaviors, 54, 46–51. https://doi.org/https://dx.doi.org/10.1016/j.addbeh.2015.12.005	Agreement: exclude, looks at distress but not depression explicitly	
Harris, M. G., Baxter, A. J., Reavley, N., Diminic, S., Pirkis, J., & Whiteford, H. A. (2016). Gender-related patterns and determinants of recent help-seeking for past-year affective, anxiety and substance use disorders: Findings from a national epidemiological survey. Epidemiology and Psychiatric Sciences, 25(6), 548–561. https://doi.org/10.1017/S2045796015000876	Disagreement Primary: Exclude Peer: 'include, discusses help-seeking, depression and masculinity effects	Changed. Include
		Total concordance rate: k=0.68

Appendix F
Example Data Extraction Form

Quantitative data extraction form

QR	Study	Author	Year	Title	Country	Study Design	Sample Type	Setting	How depression measured	How help-seeking measured?	How masculinity measured?	Total(n)	Pop type	Age range (years)	Mean Age (years)	KF

Qualitative data extraction form

Q.R	Study	Author	Year	Title	Country	Study Design	Sample Type	Setting	How depression measured	Total(n)	Pop type	Age range	Mean (M=?)	KF

QR= quality rating
KF= key findings

Appendix G
Methodological Quality Assessment of Included Studies

Methodological Assessment of **Quantitative** Studies

Study	**Study participants well defined (time, place, personal characteristics)?**	**Selection random or consecutive?**	**Participant rate >80% OR if participant rate is low, comparison respondents/non-respondents described?**	**Standardised, validated questionnaire OR clear description of what outcomes were measured?**	**Methods of data analysis clearly described?**	**Number of criteria present (out of 5)** **(Rating)**
Rice et al (2015)	1	1	0	1	1	**4 (2)**
Ramaeker & Petrie (2019)	1	0	0	1	1	**3 (1)**
Hayward & Honegger (2018)	0	1	0	1	1	**3 (1)**
Wasylkiw & Cairo (2018)	0	1	0	1	1	**3 (1)**
House et al (2018)	1	1	1	1	1	**5 (3)**
Kilian et al (20200	1	1	1	1	1	**5 (3)**
Sileo & Kershaw (2020)	1	1	1	1	1	**5 (3)**
Call & Shafer (2018)	0	1	0	1	1	**3 (1)**
Rice et al (2020)	1	1	1	1	1	**5 (3)**
Eggenberger et al. (2021)	0	1	1	1	1	**4(2)**
Total						

Note: 0 =no, 1= yes
Quantitative Ratings: 1-3 = Low (1), 4= Medium (2), 5= High (3)

Methodological Quality Assessment of **Qualitative** Studies

Study	**Was member-checking employed?**	**Were quotes presented in the report?**	**Were interview questions predefined**	**Were there multiple reviews of data?**	**Were findings analysed by more than one assessor?**	**Was a systematic coding procedure described?**	**Were interviews transcribed verbatim?**	**Was saturation reported?**	**Was researcher bias articulated/ acknowledged**	**Number of criteria met (out of 9)**
Doherty, Hannigan & Campbell (2016)	0	1	1	1	1	1	1	0	0	**6 (2)**
Hinton et al (2017)	0	1	0	1	1	1	1	0	0	**5 (2)**
Caperton et al (2020)	0	1	1	1	1	1	1	0	1	**7 (2)**
Scholz, Crabb & Wittert (2017)	0	1	0	0	0	1	1	0	0	**3 (1)**
Wirback et al (2018)	0	1	0	1	1	1	1	0	0	**5 (2)**
House et al (2018)	0	1	0	0	0	0	0	0	0	**1 (1)**
Gibson, Cartwright & Read (2018)	0	1	0	1	1	1	0	0	0	**4 (1)**
Seidler et al (2018)	1	1	1	1	1	1	1	1	0	**8 (3)**
Dye (2019)	0	1	1	1	1	1	0	1	1	**7 (2)**
Lakin (2019)	0	1	1	1	0	0	0	0	0	**3 (1)**
Mahalik & Dagirmanjian (2019)	0	1	1	1	1	1	1	0	0	**6 (2)**
Pedersen, Maindal & Ryom (2021)	0	1	1	0	0	1	0	0	0	**3 (1)**
Staiger et al (202)	0	1	1	1	1	1	0	0	1	**6 (2)**
Brydges, Egglestone & Anderson (2020)	0	1	1	0	1	1	1	1	0	**6 (2)**
Total										

Note: 0=no, 1=yes, Qualitative Ratings: 1-4 = Low (1), 5-7= Medium (2), 8-9= High (3)

Appendix H
Author Guidelines for Social Science and Medicine

AUTHOR INFORMATION PACK

ISSN: 0277-9536

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of **social science** research on **health**. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, **clinical practice**, and **health policy** and organization. We encourage material which is of general interest to an international readership.
The journal publishes the following types of contribution:
1) Peer-reviewed original research articles and critical analytical reviews in any area of social science research relevant to health and healthcare. These papers may be up to 9000 words including abstract, tables, figures, references and (printed) appendices as well as the main text. Papers below this limit are preferred.
2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.
3) Peer-reviewed short communications of findings on topical issues or published articles of between 2000 and 4000 words.
4) Submitted or invited commentaries and responses debating, and published alongside, selected articles.
5) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.
Please see our Guide for Authors for information on article submission.
The journal has also launched three specialist titles that authors are welcome to submit to: SSM -

AUDIENCE

Social scientists (e.g. medical anthropologists, health economists, social epidemiologists, medical geographers, health policy analysts, health psychologists, medical sociologists) interested in health, illness, and health care; and health-related policy makers and health care professionals (e.g. dentists, epidemiologists, health educators, lawyers, managers, nurses, midwives, pharmacists, physicians, public health practitioners, psychiatrists, surgeons) interested in the contribution of the social sciences.

GUIDE FOR AUTHORS

Important information for prospective authors

Due to logistical constraints, as well as to ensure fairness to all submissions, the Social Science & Medicine Editorial Offices cannot consider any queries related to the appropriateness of a manuscript that is submitted via email outside of the formal submission system. We endeavor to make timely assessments on all manuscripts that we receive through the online submission system (usually within 48 hours).

Your Paper Your Way

We now differentiate between the requirements for new and revised submissions. You may choose to submit your manuscript as a single Word or PDF file to be used in the refereeing process. Only when your paper is at the revision stage, will you be requested to put your paper in to a 'correct format' for acceptance and provide the items required for the publication of your article.

To find out more, please visit the Preparation section below. INTRODUCTION

Click here for guidelines on Special Issues.

Click here for guidelines on Qualitative methods. (please see Appendix B)

Social Science & Medicine provides an international and interdisciplinary forum for the dissemination of social science research on health. We publish original research articles (both empirical and theoretical), reviews, position papers and commentaries on health issues, to inform current research, policy and practice in all areas of common interest to social scientists, health practitioners, and policy makers. The journal publishes material relevant to any aspect of health and healthcare from a wide range of social science disciplines (anthropology, economics, epidemiology, geography, policy, psychology, and sociology), and material relevant to the social sciences from any of the professions concerned with physical and mental health, health care, clinical practice, and health policy and the organization of healthcare. We encourage material which is of general interest to an international readership.

Journal Policies

The journal publishes the following types of contribution:

1) Peer-reviewed original research articles and critical analytical reviews in any area of social science research relevant to health and healthcare. These papers may be up to 9000 words including abstract, tables, figures, references and (printed) appendices as well as the main text. Papers below this limit are preferred.

2) Systematic reviews and literature reviews of up to 15000 words including abstract, tables, figures, references and (printed) appendices as well as the main text.

3) Peer-reviewed short communications of findings on topical issues or published articles of between 2000 and 4000 words.

4) Submitted or invited commentaries and responses debating, and published alongside, selected articles.

5) Special Issues bringing together collections of papers on a particular theme, and usually guest edited.

Due to the high number of submissions received by Social Science & Medicine, Editorial Offices are not able to respond to questions regarding the appropriateness of new papers for the journal. If you are unsure whether or not your paper is within scope, please take some time to review previous issues of the journal and the Aims and Scope at https://www.journals.elsevier.com/social-science-and-medicine/.

Submission checklist

You can use this list to carry out a final check of your submission before you send it to the journal for review. Please check the relevant section in this Guide for Authors for more details.

Ensure that the following items are present:

One author has been designated as the corresponding author with contact details: • E-mail address
• Full postal address

All necessary files have been uploaded:
Manuscript:
• Include keywords
• All figures (include relevant captions)
• All tables (including titles, description, footnotes)
• Ensure all figure and table citations in the text match the files provided • Indicate clearly if color should be used for any figures in print *Graphical Abstracts / Highlights files* (where applicable)

Supplemental files (where applicable)

Further considerations
• Manuscript has been 'spell checked' and 'grammar checked'
• All references mentioned in the Reference List are cited in the text, and vice versa
• Manuscript does not exceed the word limit
• All identifying information has been removed from the manuscript, including the file name itself
• Permission has been obtained for use of copyrighted material from other sources (including the Internet)
• Relevant declarations of interest have been made
• Journal policies detailed in this guide have been reviewed
• Referee suggestions and contact details provided, based on journal requirements

For further information, visit our Support Center. **BEFORE YOU BEGIN**

Ethics in Publishing

For information on Ethics in publishing and Ethical guidelines for journal publication see https://www.elsevier.com/publishingethics and https://www.elsevier.com/ethicalguidelines.

Please note that any submission that has data collected from human subjects requires ethics approval. If your manuscript does not include ethics approval, your paper will not be sent out for review.

Declaration of interest

All authors must disclose any financial and personal relationships with other people or organizations that could inappropriately influence (bias) their work. Examples of potential competing interests include employment, consultancies, stock ownership, honoraria, paid expert testimony, patent applications/registrations, and grants or other funding. Authors must disclose any interests in two places: 1. A summary declaration of interest statement in the title page file (if double anonymized) or the manuscript file (if single anonymized). If there are no interests to declare then please state this: 'Declarations of interest: none'. 2. Detailed disclosures as part of a separate Declaration of Interest form, which forms part of the journal's official records. It is important for potential interests to be declared in both places and that the information matches. More information.

Submission declaration and verification

Submission of an article implies that the work described has not been published previously (except in the form of an abstract, a published lecture or academic thesis, see 'Multiple, redundant or concurrent publication' for more information), that it is not under consideration for publication elsewhere, that its publication is approved by all authors and tacitly or explicitly by the responsible authorities where the work was carried out, and that, if accepted, it will not be published elsewhere in the same form, in English or in any other language, including electronically without the written consent of the copyright-holder. To verify originality, your article may be checked by the originality detection service Crossref Similarity Check.

Use of inclusive language

Inclusive language acknowledges diversity, conveys respect to all people, is sensitive to differences, and promotes equal opportunities. Content should make no assumptions about the beliefs or commitments of any reader; contain nothing which might imply that one individual is superior to another on the grounds of age, gender, race, ethnicity, culture, sexual orientation, disability or health condition; and use inclusive language throughout. Authors should ensure that writing is free from bias, stereotypes, slang, reference to dominant culture and/or cultural assumptions. We advise to seek gender neutrality by using plural nouns ("clinicians, patients/clients") as default/wherever possible to avoid using "he, she," or "he/she." We recommend avoiding the use of descriptors that refer to personal attributes such as age, gender, race, ethnicity, culture, sexual orientation, disability or health condition unless they are relevant and valid. When coding terminology is used, we recommend to avoid offensive or exclusionary terms such as "master", "slave", "blacklist" and "whitelist". We suggest using alternatives that are more appropriate and (self-) explanatory such as "primary", "secondary", "blocklist" and "allowlist". These guidelines are meant as a point of reference to help identify appropriate language but are by no means exhaustive or definitive.

Author contributions

For transparency, we encourage authors to submit an author statement file outlining their individual contributions to the paper using the relevant CRediT roles: Conceptualization; Data curation; Formal analysis; Funding acquisition; Investigation; Methodology; Project administration; Resources; Software; Supervision; Validation; Visualization; Roles/Writing - original draft; Writing - review & editing. Authorship statements should be formatted with the names of authors first and CRediT role(s) following. More details and an example.

Changes to authorship

Authors are expected to consider carefully the list and order of authors **before** submitting their manuscript and provide the definitive list of authors at the time of the original submission. Any addition, deletion or rearrangement of author names in the authorship list should be made only **before** the manuscript has been accepted and only if approved by the journal Editor. To request such a change, the Editor must receive the following from the **corresponding author**: (a) the reason for the change in author list and (b) written confirmation (e-mail, letter) from all authors that they agree with the addition, removal or rearrangement. In the case of addition or removal of authors, this includes confirmation from the author being added or removed.

Only in exceptional circumstances will the Editor consider the addition, deletion or rearrangement of authors **after** the manuscript has been accepted. While the Editor considers the request, publication of the manuscript will be suspended. If the manuscript has already been published in an online issue, any requests approved by the Editor will result in a corrigendum.

Article transfer service

This journal is part of our Article Transfer Service. This means that if the Editor feels your article is more suitable in one of our other participating journals, then you may be asked to consider transferring the article to one of those. If you agree, your article will be transferred automatically on your behalf with no need to reformat. Please note that your article will be reviewed again by the new journal. More information.

Copyright

Upon acceptance of an article, authors will be asked to complete a 'Journal Publishing Agreement' (see more information on this). An e-mail will be sent to the corresponding author confirming receipt of the manuscript together with a 'Journal Publishing Agreement' form or a link to the online version of this agreement.

Subscribers may reproduce tables of contents or prepare lists of articles including abstracts for internal circulation within their institutions. Permission of the Publisher is required for resale or distribution outside the institution and for all other derivative works, including compilations and translations. If excerpts from other copyrighted works are included, the author(s) must obtain written permission from the copyright owners and credit the source(s) in the article. Elsevier has preprinted forms for use by authors in these cases.

For gold open access articles: Upon acceptance of an article, authors will be asked to complete a 'License Agreement' (more information). Permitted third party reuse of gold open access articles is determined by the author's choice of user license.

Author rights

As an author you (or your employer or institution) have certain rights to reuse your work. More information.

Elsevier supports responsible sharing

Find out how you can share your research published in Elsevier journals.

Role of the funding source

You are requested to identify who provided financial support for the conduct of the research and/or preparation of the article and to briefly describe the role of the sponsor(s), if any, in study design; in the collection, analysis and interpretation of data; in the writing of the articles; and in the decision to submit it for publication. If the funding source(s) had no such involvement then this should be stated. Please see https://www.elsevier.com/funding.

Open access

Please visit our Open Access page for more information.

Elsevier Researcher Academy

Researcher Academy is a free e-learning platform designed to support early and mid-career researchers throughout their research journey. The "Learn" environment at Researcher Academy offers several interactive modules, webinars, downloadable guides and resources to guide you through the process of writing for research and going through peer review. Feel free to use these free resources to improve your submission and navigate the publication process with ease.

Language (usage and editing services)

Please write your text in good English (American or British usage is accepted, but not a mixture of these). Authors who feel their English language manuscript may require editing to eliminate possible grammatical or spelling errors and to conform to correct scientific English may wish to use the English Language Editing service available from Elsevier's Author Services.

Submission

Submission to this journal occurs online and you will be guided step by step through the creation and uploading of your files. Please submit your article via https://www.editorialmanager.com/ssm/default.aspx. The system automatically converts source files to a single PDF file of the article, which is used in the peer-review process. Please note that even though manuscript source files are converted to PDF files at submission for the review process, these source files are needed for further processing after acceptance. All correspondence, including notification of the Editor's decision and requests for revision, takes place by e-mail.

Reviewers

Please provide the names and email addresses of 3 potential reviewers and state the reason for each suggestion. Colleagues within the same institution and co-authors within the last 5 years should not be included in the suggestions. Note that the editor retains the sole right to decide whether or not the suggested reviewers are used.

Additional information

Please note author information is entered into the online editorial system (EM) during submission and must *not* be included in the manuscript itself.

Social Science & Medicine does not normally list more than six authors to a paper, and special justification must be provided for doing so. Further information on criteria for authorship can be found in Social Science & Medicine, 2007, 64(1), 1-4.

Authors should approach the Editors in Chief if they wish to submit companion articles. Information about our peer-review policy can be found here .

Please note that we may suggest accepted papers for legal review if it is deemed necessary.

PREPARATION

Queries

For questions about the editorial process (including the status of manuscripts under review) or for technical support on submissions, please visit our Support Center.

NEW SUBMISSIONS

Submission to this journal proceeds totally online and you will be guided stepwise through the creation and uploading of your files. The system automatically converts your files to a single PDF file, which is used in the peer-review process.
As part of the Your Paper Your Way service, you may choose to submit your manuscript as a single file to be used in the refereeing process. This can be a PDF file or a Word document, in any format or lay- out that can be used by referees to evaluate your manuscript. It should contain high enough quality figures for refereeing. If you prefer to do so, you may still provide all or some of the source files at the initial submission. Please note that individual figure files larger than 10 MB must be uploaded separately.

References

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/ book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct.

Formatting Requirements

The journal operates a double blind peer review policy. For guidelines on how to prepare your paper to meet these criteria please see the attached guidelines. The journal requires that your manuscript is submitted with double spacing applied. There are no other strict formatting requirements but all manuscripts must contain the essential elements needed to convey your manuscript, for example Abstract, Keywords, Introduction, Materials and Methods, Results, Conclusions, Artwork and Tables with Captions.

If your article includes any Videos and/or other Supplementary material, this should be included in your initial submission for peer review purposes.
Divide the article into clearly defined sections.

Peer review

This journal operates a double anonymized review process. All contributions will be initially assessed by the editor for suitability for the journal. Papers deemed suitable are then typically sent to a minimum of two independent expert reviewers to assess the scientific quality of the paper. The Editor is responsible for the final decision regarding

acceptance or rejection of articles. The Editor's decision is final. Editors are not involved in decisions about papers which they have written themselves or have been written by family members or colleagues or which relate to products or services in which the editor has an interest. Any such submission is subject to all of the journal's usual procedures, with peer review handled independently of the relevant editor and their research groups. More information on types of peer review.

Double anonymized review

This journal uses double anonymized review, which means the identities of the authors are concealed from the reviewers, and vice versa. More information is available on our website. To facilitate this, please include the following separately:
Title page (with author details): This should include the title, authors' names, affiliations, acknowledgements and any Declaration of Interest statement, and a complete address for the corresponding author including an e-mail address.

Anonymized manuscript (no author details): The main body of the paper (including the references, figures, tables and any acknowledgements) should not include any identifying information, such as the authors' names or affiliations.

REVISED SUBMISSIONS

Use of word processing software

Regardless of the file format of the original submission, at revision you must provide us with an editable file of the entire article. Keep the layout of the text as simple as possible. Most formatting codes will be removed and replaced on processing the article. The electronic text should be prepared in a way very similar to that of conventional manuscripts (see also the Guide to Publishing with Elsevier). See also the section on Electronic artwork.

To avoid unnecessary errors you are strongly advised to use the 'spell-check' and 'grammar-check' functions of your word processor.

Essential cover page information

The Cover Page should **only** include the following information:

● ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible and make clear the article's aim and health relevance.
● ***Author names and affiliations in the correct order.*** Where the family name may be ambiguous (e.g., a double name), please indicate this clearly. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lower-case superscript letter immediately after the author's name and in front of the appropriate address. Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.

● ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that telephone and fax numbers (with country and area code) are provided in addition to the e-mail address and the complete postal address. Contact details must be kept up to date by the corresponding author.**

● ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Text

In the main body of the submitted manuscript this order should be followed: abstract, main text, references, appendix, figure captions, tables and figures. Author details, keywords and acknowledgements are entered separately during the online submission process, as is the abstract, though this is to be included in the manuscript as well. During submission authors are asked to provide a word count; this is to include ALL text, including that in tables, figures, references etc.

Title

Please consider the title very carefully, as these are often used in information-retrieval systems. Please use a concise and informative title (avoiding abbreviations where possible). Make sure that the health or healthcare focus is clear.

Highlights

Highlights are optional yet highly encouraged for this journal, as they increase the discoverability of your article via search engines. They consist of a short collection of bullet points that capture the novel results of your research as well as new methods that were used during the study (if any). Please have a look at the examples here: example Highlights.

Highlights should be submitted in a separate editable file in the online submission system. Please use 'Highlights' in the file name and include 3 to 5 bullet points (maximum 85 characters, including spaces, per bullet point).

Abstract

An abstract of up to 300 words must be included in the submitted manuscript. An abstract is often presented separately from the article, so it must be able to stand alone. It should state briefly and clearly the purpose and setting of the research, the principal findings and major conclusions, and the paper's contribution to knowledge. For empirical papers the country/countries/locations of the study should be clearly stated, as should the methods and nature of the sample, the dates, and a summary of the findings/conclusion. Please note that excessive statistical details should be avoided, abbreviations/acronyms used only if essential or firmly established, and that the abstract should not be structured into subsections. Any references cited in the abstract must be given in full at the end of the abstract.

Keywords

Up to 8 keywords are entered separately into the online editorial system during submission, and should accurately reflect the content of the article. Again abbreviations/acronyms should be used only if essential or firmly established. For empirical papers the country/countries/locations of the research should be included. The keywords will be used for indexing purposes.

Methods

Authors of empirical papers are expected to provide full details of the research methods used, including study location(s), sampling procedures, the date(s) when data were collected, research instruments, and techniques of data analysis. Specific guidance on the reporting of qualitative studies are provided here.

Systematic reviews and meta-analyses must be reported according to PRISMA guidelines. *Footnotes*

There should be no footnotes or endnotes in the manuscript.

Artwork

Electronic artwork
General points
• Make sure you use uniform lettering and sizing of your original artwork.
• Preferred fonts: Arial (or Helvetica), Times New Roman (or Times), Symbol, Courier.
• Number the illustrations according to their sequence in the text.
• Use a logical naming convention for your artwork files.
• Indicate per figure if it is a single, 1.5 or 2-column fitting image.
• For Word submissions only, you may still provide figures and their captions, and tables within a single file at the revision stage.
• Please note that individual figure files larger than 10 MB must be provided in separate source files.

A detailed guide on electronic artwork is available.
You are urged to visit this site; some excerpts from the detailed information are given here. *Formats*
Regardless of the application used, when your electronic artwork is finalized, please 'save as' or convert the images to one of the following formats (note the resolution requirements for line drawings, halftones, and line/halftone combinations given below):
EPS (or PDF): Vector drawings. Embed the font or save the text as 'graphics'.
TIFF (or JPG): Color or grayscale photographs (halftones): always use a minimum of 300 dpi.
TIFF (or JPG): Bitmapped line drawings: use a minimum of 1000 dpi.
TIFF (or JPG): Combinations bitmapped line/half-tone (color or grayscale): a minimum of 500 dpi is required.
Please do not:
• Supply files that are optimized for screen use (e.g., GIF, BMP, PICT, WPG); the resolution is too low. • Supply files that are too low in resolution.
• Submit graphics that are disproportionately large for the content.

Color artwork

Please make sure that artwork files are in an acceptable format (TIFF (or JPEG), EPS (or PDF), or MS Office files) and with the correct resolution. If, together with your accepted article, you submit usable color figures then Elsevier will ensure, at no additional charge, that these figures will appear in color online (e.g., ScienceDirect and other sites) regardless of whether or not these illustrations are reproduced in color in the printed version. **For color reproduction in print, you will receive information regarding the costs from Elsevier after receipt of your accepted article**. Please indicate your preference for color: in print or online only. Further information on the preparation of electronic artwork.

Figure captions

Ensure that each illustration has a caption. A caption should comprise a brief title (**not** on the figure itself) and a description of the illustration. Keep text in the illustrations themselves to a minimum but explain all symbols and abbreviations used.

Tables

Please submit tables as editable text and not as images. Tables can be placed either next to the relevant text in the article, or on separate page(s) at the end. Number tables consecutively in accordance with their appearance in the text and place any table notes below the table body. Be sparing in the use of tables and ensure that the data presented in them do not duplicate results described elsewhere in the article. Please avoid using vertical rules and shading in table cells.

References

Citation in text

Please ensure that every reference cited in the text is also present in the reference list (and vice versa). Any references cited in the abstract must be given in full at the end of the abstract. Unpublished results and personal communications are not recommended in the reference list, but may be mentioned in the text. If these references are included in the reference list they should follow the standard reference style of the journal (see below) and should include a substitution of the publication date with either "Unpublished results" or "Personal communication" Citation of a reference as "in press" implies that the item has been accepted for publication.

Web references

As a minimum, the full URL should be given and the date when the reference was last accessed. Any further information, if known (DOI, author names, dates, reference to a source publication, etc.), should also be given. Web references can be listed separately (e.g., after the reference list) under a different heading if desired, or can be included in the reference list.

Data references

This journal encourages you to cite underlying or relevant datasets in your manuscript by citing them in your text and including a data reference in your Reference List. Data references should include the following elements: author name(s), dataset title, data repository, version (where available), year, and global persistent identifier. Add [dataset] immediately before the reference so we can properly identify it as a data reference. The [dataset] identifier will not appear in your published article.

References in special issue articles, commentaries and responses to commentaries

Please ensure that the words 'this issue' are added to any references in the reference list (and any citations in the text) to other articles which are referred to in the same issue.

Reference management software

Most Elsevier journals have their reference template available in many of the most popular reference management software products. These include all products that support Citation Style Language styles, such as Mendeley. Using citation plug-ins from these products, authors only need to select the appropriate journal template when preparing their article, after which citations and bibliographies will be automatically

formatted in the journal's style. If no template is yet available for this journal, please follow the format of the sample references and citations as shown in this Guide. If you use reference management software, please ensure that you remove all field codes before submitting the electronic manuscript. More information on how to remove field codes from different reference management software.

The current *Social Science & Medicine* EndNote file can be directly accessed by clicking here.

Reference formatting

There are no strict requirements on reference formatting at submission. References can be in any style or format as long as the style is consistent. Where applicable, author(s) name(s), journal title/ book title, chapter title/article title, year of publication, volume number/book chapter and the article number or pagination must be present. Use of DOI is highly encouraged. The reference style used by the journal will be applied to the accepted article by Elsevier at the proof stage. Note that missing data will be highlighted at proof stage for the author to correct. If you do wish to format the references yourself they should be arranged according to the following examples:

Reference style
Text: All citations in the text should refer to:
1. *Single author:* the author's name (without initials, unless there is ambiguity) and the year of publication;
2. *Two authors:* both authors' names and the year of publication;
3. *Three or more authors:* first author's name followed by 'et al.' and the year of publication. Citations may be made directly (or parenthetically). Groups of references can be listed either first alphabetically, then chronologically, or vice versa.

Examples: 'as demonstrated (Allan, 2000a, 2000b, 1999; Allan and Jones, 1999).... Or, as demonstrated (Jones, 1999; Allan, 2000)... Kramer et al. (2010) have recently shown ...'
List: References should be arranged first alphabetically and then further sorted chronologically if necessary. More than one reference from the same author(s) in the same year must be identified by the letters 'a', 'b', 'c', etc., placed after the year of publication.

Examples:

Reference to a journal publication:
Van der Geer, J., Hanraads, J.A.J., Lupton, R.A., 2010. The art of writing a scientific article. J. Sci. Commun. 163, 51–59. https://doi.org/10.1016/j.Sc.2010.00372.
Reference to a journal publication with an article number:
Van der Geer, J., Hanraads, J.A.J., Lupton, R.A., 2018. The art of writing a scientific article. Heliyon. 19, e00205. https://doi.org/10.1016/j.heliyon.2018.e00205.
Reference to a book:
Strunk Jr., W., White, E.B., 2000. The Elements of Style, fourth ed. Longman, New York.
Reference to a chapter in an edited book:
Mettam, G.R., Adams, L.B., 2009. How to prepare an electronic version of your article, in: Jones, B.S., Smith , R.Z. (Eds.), Introduction to the Electronic Age. E-Publishing Inc., New York, pp. 281–304. Reference to a website:
Cancer Research UK, 1975. Cancer statistics reports for the UK.
http://www.cancerresearchuk.org/ aboutcancer/statistics/cancerstatsreport/ (accessed 13 March 2003).
Reference to a dataset:
[dataset] Oguro, M., Imahiro, S., Saito, S., Nakashizuka, T., 2015. Mortality data for

Japanese oak wilt disease and surrounding forest compositions. Mendeley Data, v1. https://doi.org/10.17632/ xwj98nb39r.1.
Reference to software:
Coon, E., Berndt, M., Jan, A., Svyatsky, D., Atchley, A., Kikinzon, E., Harp, D., Manzini, G., Shelef, E., Lipnikov, K., Garimella, R., Xu, C., Moulton, D., Karra, S., Painter, S., Jafarov, E., & Molins, S., 2020. Advanced Terrestrial Simulator (ATS) v0.88 (Version 0.88). Zenodo. https://doi.org/10.5281/ zenodo.3727209.

Preprints

It is journal policy not to consider submissions which have been made available via a preprint server or as working papers prior to submission. Once a final decision has been made on a submission, authors are free to share their preprints as they wish. For more information on sharing your article, please see Elsevier?s sharing policy.

Video data

Elsevier accepts video material and animation sequences to support and enhance your scientific research. Authors who have video or animation files that they wish to submit with their article may do so during online submission. Where relevant, authors are strongly encouraged to include a video still within the body of the article. This can be done in the same way as a figure or table by referring to the video or animation content and noting in the body text where it should be placed. These will be used instead of standard icons and will personalize the link to your video data. All submitted files should be properly labeled so that they directly relate to the video file's content. In order to ensure that your video or animation material is directly usable, please provide the files in one of our recommended file formats with a maximum size of 10 MB. Video and animation files supplied will be published online in the electronic version of your article in Elsevier Web products, including ScienceDirect: http://www.sciencedirect.com. For more detailed instructions please visit our video instruction pages at https://www.elsevier.com/artworkinstructions. Note: since video and animation cannot be embedded in the print version of the journal, please provide text for both the electronic and the print version for the portions of the article that refer to this content.

Data visualization

Include interactive data visualizations in your publication and let your readers interact and engage more closely with your research. Follow the instructions here to find out about available data visualization options and how to include them with your article.

Supplementary data

Elsevier accepts electronic supplementary material to support and enhance your research. Supplementary files offer the author additional possibilities to publish supporting applications, accompanying videos describing the research, more detailed tables, background datasets, sound clips and more. Supplementary files supplied will be published online alongside the electronic version of your article in Elsevier Web products, including ScienceDirect: http://www.sciencedirect.com. In order to ensure that your submitted material is directly usable, please provide the data in one of our recommended file formats. Authors should submit the material in electronic format together with the article and supply a concise and descriptive caption for each file. For more detailed instructions please visit our artwork instruction pages at https://www.elsevier.com/artworkinstructions.

Research data

This journal encourages and enables you to share data that supports your research publication where appropriate, and enables you to interlink the data with your published articles. Research data refers to the results of observations or experimentation that validate research findings. To facilitate reproducibility and data reuse, this journal also encourages you to share your software, code, models, algorithms, protocols, methods and other useful materials related to the project.

Below are a number of ways in which you can associate data with your article or make a statement about the availability of your data when submitting your manuscript. If you are sharing data in one of these ways, you are encouraged to cite the data in your manuscript and reference list. Please refer to the "References" section for more information about data citation. For more information on depositing, sharing and using research data and other relevant research materials, visit the research data page.

Data linking

If you have made your research data available in a data repository, you can link your article directly to the dataset. Elsevier collaborates with a number of repositories to link articles on ScienceDirect with relevant repositories, giving readers access to underlying data that gives them a better understanding of the research described.

There are different ways to link your datasets to your article. When available, you can directly link your dataset to your article by providing the relevant information in the submission system. For more information, visit the database linking page.

For supported data repositories a repository banner will automatically appear next to your published article on ScienceDirect.

In addition, you can link to relevant data or entities through identifiers within the text of your manuscript, using the following format: Database: xxxx (e.g., TAIR: AT1G01020; CCDC: 734053; PDB: 1XFN).

Mendeley Data

This journal supports Mendeley Data, enabling you to deposit any research data (including raw and processed data, video, code, software, algorithms, protocols, and methods) associated with your manuscript in a free-to-use, open access repository. During the submission process, after uploading your manuscript, you will have the opportunity to upload your relevant datasets directly to *Mendeley Data*. The datasets will be listed and directly accessible to readers next to your published article online. For more information, visit the Mendeley Data for journals page.

Data statement

To foster transparency, we encourage you to state the availability of your data in your submission. This may be a requirement of your funding body or institution. If your data is unavailable to access or unsuitable to post, you will have the opportunity to indicate why during the submission process, for example by stating that the research data is confidential. The statement will appear with your published article on ScienceDirect. For more information, visit the Data Statement page.

AFTER ACCEPTANCE

Online proof correction

To ensure a fast publication process of the article, we kindly ask authors to provide us with their proof corrections within two days. Corresponding authors will receive an e-mail with a link to our online proofing system, allowing annotation and correction of proofs online. The environment is similar to MS Word: in addition to editing text, you can also comment on figures/tables and answer questions from the Copy Editor. Web-based proofing provides a faster and less error-prone process by allowing you to directly type your corrections, eliminating the potential introduction of errors.

If preferred, you can still choose to annotate and upload your edits on the PDF version. All instructions for proofing will be given in the e-mail we send to authors, including alternative methods to the online version and PDF.
We will do everything possible to get your article published quickly and accurately. Please use this proof only for checking the typesetting, editing, completeness and correctness of the text, tables and figures. Significant changes to the article as accepted for publication will only be considered at this stage with permission from the Editor. It is important to ensure that all corrections are sent back to us in one communication. Please check carefully before replying, as inclusion of any subsequent corrections cannot be guaranteed. Proofreading is solely your responsibility.

Offprints

The corresponding author will, at no cost, receive a customized Share Link providing 50 days free access to the final published version of the article on ScienceDirect. The Share Link can be used for sharing the article via any communication channel, including email and social media. For an extra charge, paper offprints can be ordered via the offprint order form which is sent once the article is accepted for publication. Both corresponding and co-authors may order offprints at any time via Elsevier's Author Services. Corresponding authors who have published their article gold open access do not receive a Share Link as their final published version of the article is available open access on ScienceDirect and can be shared through the article DOI link.

AUTHOR INQUIRIES

Visit the Elsevier Support Center to find the answers you need. Here you will find everything from Frequently Asked Questions to ways to get in touch.
You can also check the status of your submitted article or find out when your accepted article will be published.

AUTHOR INFORMATION PACK 11 Jan 2022 www.elsevier.com/locate/socscimed 16

Guidelines for Qualitative Papers

There is no one qualitative method, but rather a number of research approaches which fall under the umbrella of ‘qualitative methods’. The various social science disciplines tend to have different conventions on best practice in qualitative research. However SS&M has prepared the following general guidance for the writing and assessment of papers which present qualitative data (either alone or in combination with quantitative methods). General principles of good practice for all research will also apply.

Fitness for purpose

Are the methods of the research appropriate to the nature of the question(s) being asked, i.e.

- Does the research seek to understand social processes or social structures &/or to illuminate subjective experiences or meanings?
- Are the settings, groups or individuals being examined of a type which cannot be pre-selected, or the possible outcomes not specified (or hypothesised) in advance?

Methodology and methods

- All papers must include a dedicated methods section which specifies, as appropriate, the sample recruitment strategy, sample size, and analytical strategy.

Principles of selection
Qualitative research is often based on or includes non-probability sampling. The unit(s) of research may include one or a combination of people, events, institutions, samples of natural behaviour, conversations, written and visual material, etc.

- The selection of these should be theoretically justified e.g. it should be made clear how respondents were selected
- There should be a rationale for the sources of the data (e.g respondents/participants, settings, documents)
- Consideration should be given to whether the sources of data (e.g people, organisations, documents) were unusual in some important way
- Any limitations of the data should be discussed (such as non response, refusal to take part)

The research process
In most papers there should be consideration of

- The access process
- How data were collected and recorded
- Who collected the data
- When the data were collected
- How the research was explained to respondents/participants

Research ethics

- Details of formal ethical approval (i.e. IRB, Research Ethics Committee) should be stated in the main body of the paper. If authors were not required to obtain ethical approval (as is the case in some countries) or unable to obtain attain ethical approval (as sometimes occurs in resource-poor settings) they should explain this. Please anonymise this information as appropriate in the manuscript, and give the information when asked during submission.
- Procedures for securing informed consent should be provided

Any ethical concerns that arose during the research should be discussed.

Analysis

The process of analysis should be made as transparent as possible (notwithstanding the conceptual and theoretical creativity that typically characterises qualitative research). For example

- How was the analysis conducted
  - How were themes, concepts and categories generated from the data
  - Whether analysis was computer assisted (and, if so, how)
  - Who was involved in the analysis and in what manner
- Assurance of analytic rigour. For example
  - Steps taken to guard against selectivity in the use of data
  - Triangulation
  - Inter-rater reliability
  - Member and expert checking
  - The researcher's own position should clearly be stated. For example, have they examined their own role, possible bias, and influence on the research (reflexivity)?

Presentation of findings

Consideration of context

The research should be clearly contextualised. For example

- Relevant information about the settings and respondents/participants should be supplied
- The phenomena under study should be integrated into their social context (rather than being abstracted or de-contextualised)
- Any particular/unique influences should be identified and discussed

Presentation of data:

- Quotations, field notes, and other data where appropriate should be identified in a way which enables the reader to judge the range of evidence being used
- Distinctions between the data and their interpretation should be clear
- The iteration between data and explanations of the data (theory generation) should be clear
- Sufficient original evidence should be presented to satisfy the reader of the relationship between the evidence and the conclusions (validity)
- There should be adequate consideration of cases or evidence which might refute the conclusions

Amended February 2010

Appendix I
Online Recruitment

Research Poster

MALE MENTAL HEALTH RESEARCH

REMOTE CLINICAL PSYCHOLOGY RESEARCH – INTERVIEWS VIA PHONE

Looking for Young Men to Take Part in Clinical Psychology Research

Are you male between the ages of 16-25 years old? Have you experienced or are experiencing stress and anxiety?

You May Qualify If You:

- Have noticed that at times you find it hard to stop or control worrying
- Find or have found it difficult to relax
- Felt or are feeling an impact on daily life due to stress or anxiety

Participation Involves:

- Involvement will be anonymous (no identifiable information will be used in the research)
- You will be asked to take some photos on your phone to represent how anxiety and stress feels like for you in your daily life
- One 45-60minute interview with the researcher talking about your experience of stress, anxiety and seeking support

Potential Benefits:

- You will get the chance to contribute to clinical psychology research with the aim to support young men
- You will receive a £15 gift Amazon voucher as a token of thanks for your participation
- You will be given a summary of the project findings upon completion

Please note that we are looking for a maximum of 10 people for this study

---

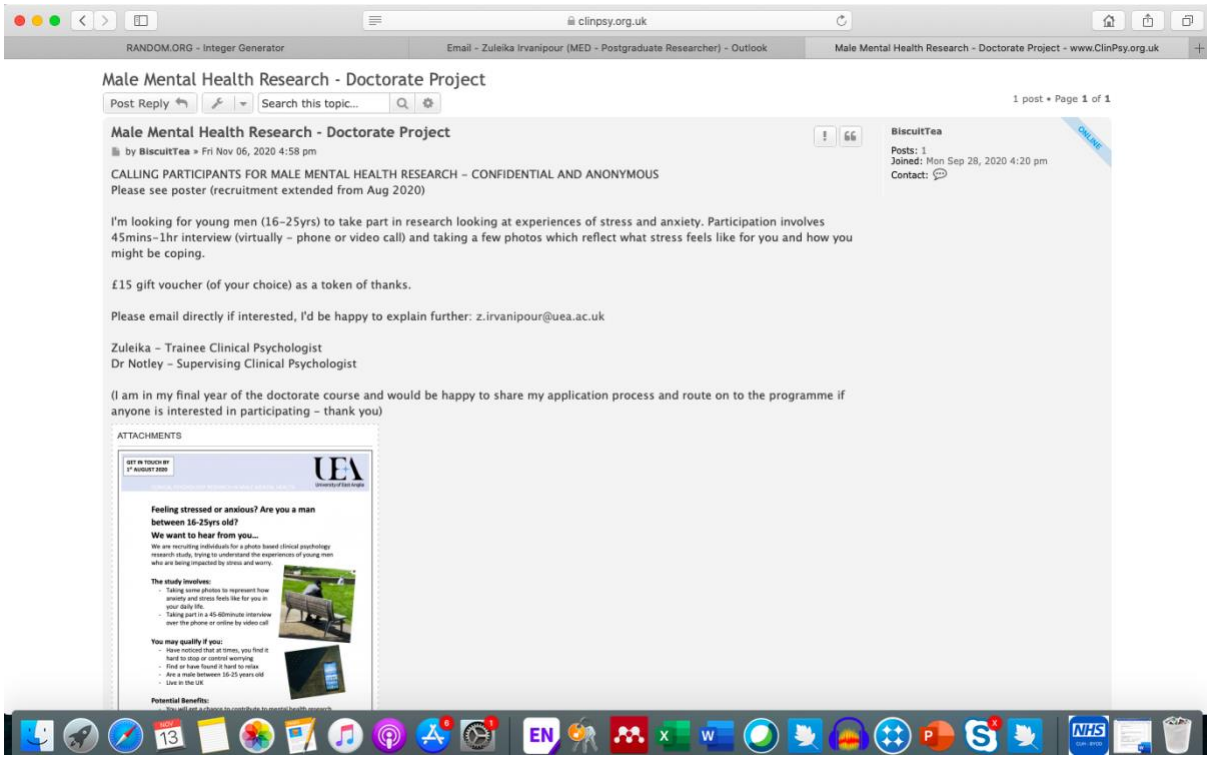
FOR MORE INFORMATION
Please contact Zuleika Irvanipour (Clinical Psychology Trainee) on 0000-000-000 or email z.irvanipour@uea.ac.uk

This project is being supervised at the University of East Anglia by Dr Caitlin Notley and Dr Paul Fisher

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

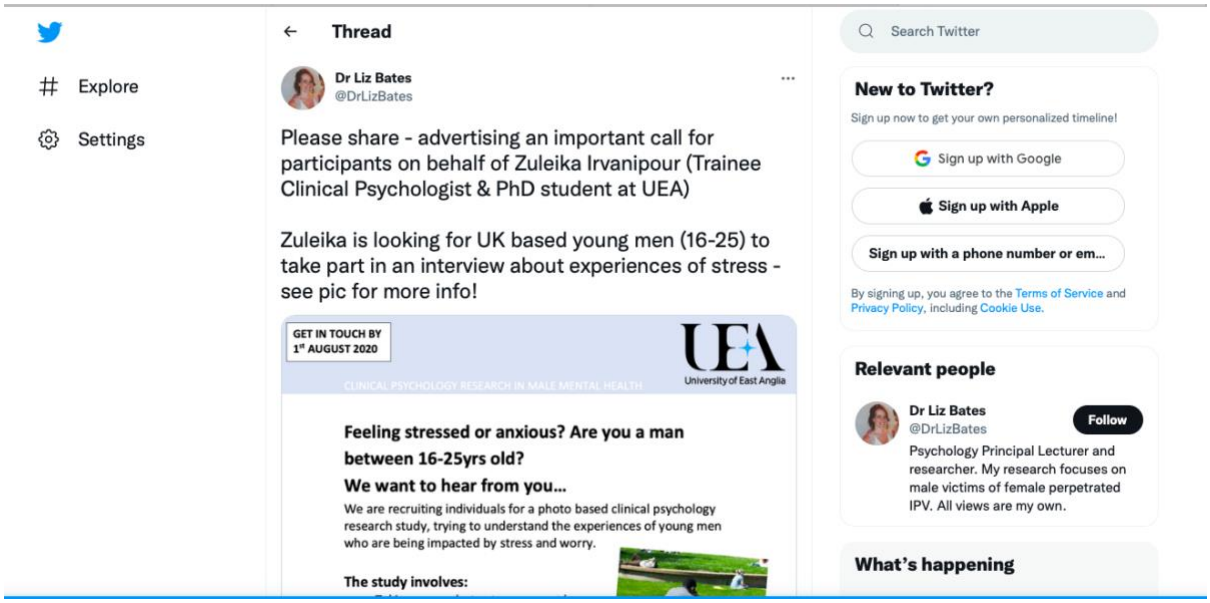
Example of online recruitment (Clinpsy forum)

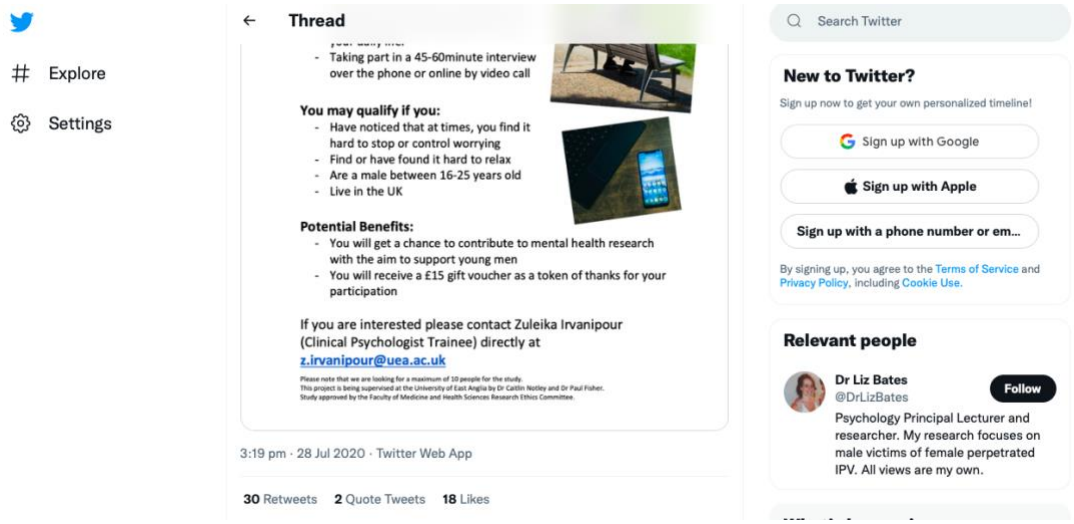


Appendix J

Social Media Recruitment

Example of social media recruitment (Twitter)





Appendix K

Interview Schedule

1. Can you tell me about your experience of living with stress and anxiety?
   a. How do you experience stress and anxiety?
   b. What contributes to your feelings of stress and anxiety?
   c. Are there things in the wider society that cause you stress?

   PHOTOS:
   Can you tell me a bit more about why you took these photos?
   What does this photo represent for you?
   What prompted you to take this particular photo?
   Can you share with me what this photo represents for you?
   Does what you are saying relate to any of the photos you took?
   Were there any photos that you would have liked to take but didn't get to?

2. What does feeling stressed or anxious like for you?
   a. What is your experience of everyday life with stress (e.g. family, friends at school)?
   b. In your own way can you tell me how stress and anxiety impact your daily life?
   c. How does it impact you;
      emotionally,
      physically,
      what you do or don't do,
      thoughts that you have?

3. Does being a young man affect the things that cause you stress; way you manage stress?

4. In what ways do you try and manage stress and anxiety?
   a. Are there things that can help things feel better?
   b. Are there things that can make stress and anxiety feel worse?
   c. Are there ways of coping that you would like to try but haven't yet been able to?

5. Do you feel able to talk about how you feel to others?
   a. (YES) How does it feel like talking to others? How does it feel a little bit afterwards maybe the next day?
      Who do you talk to about your feelings/emotions?
      When do you talk about feelings/emotions?
   b. (NO) How do you think it might feel if you were to talk to another person?

6. Have you experienced support from wellbeing services e.g. gp?
   a. (YES) Can you tell me a bit more about your experience of receiving some support from a professional?
      How does it compare to other methods/people you may have gone for support?
   b. (NO) Can you share me your views of wellbeing services for example the NHS?
   c. As a man is there anything you would like from the NHS that could help?

7. Is there anything else that you would like to share with me today?

Is there anything we haven't covered that you would like to share?
Are there any questions about this topic you would have liked me to ask?

8. How has it been like for you today speaking with me about stress and anxiety?

AFTER INTERVIEW

- Debrief
- End of research project once written up I can provide a summary of the research findings
- Gift voucher

Appendix L
Excerpt from Research Journal

28th Feb 2021.

Quick note to self:
I remember in T4 (sport), T5 (racism), T6 (kidnapping) and T7(uni) I felt like I took a step back in awe in my head during the interview as I was quite floored by how confident these young men were. The unwavering self-belief contrasted the conversations I have had with many different girls/women growing up and still now there are few women I know that have this level of confidence at such a young age. They were unashamedly able to say how they felt good and confident in themselves, whereas I've experienced a lot more self-deprecation and doubt with conversations I've had with female colleagues and friends and family. T1 was a bit self-deprecating and had concerns about his image, which is something I have noticed within the narratives with other women in my life/work. I wonder if these other men T3-T7 also have these worries but did not feel comfortable to voice them. I wonder if completing the study with an anonymous survey/webchat type method would have created different results. I also think it is worth considering that T3, T4 were face to face and the rest were over the phone. Although this may introduce another element with regards to a lack of anonymity, it has not substantially effected the content and codes arising from the f2f interviews compared to remote interviews.

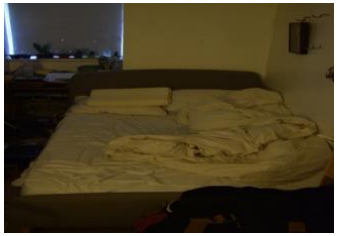
Reflection: Looking through 6th transcript, the explanation around the kidnapping and the effect on his body felt like a vulnerable thing to share, and it's reflected in his speech, the pauses, repeating of 'I,I'm' and I feel like this is important work to get out there and I'm happy and grateful that he was open and exposed something maybe a bit painful.

A lot of corrections so far in all transcripts. Quite irritated that this was a professional transcription service. The process has been to listen to all the audio with the transcripts and fill in gaps, check the content is correct. Many discrepancies, misspelled words, missing words and incorrect transcription.

Appendix M
Examples of Extracts from Data Synthesis

Initial idea for interpretive repertoire	*Initial idea for subject positions*	*Line number*	*Participant*	*Quote*	*Any photos used*
Attributes emotion to surroundings, having self-reflected back in environment	Invokes sense of calm in and out of self	126-142	Iman	the first photo was like um I think of um like a green a field R: yes Pt: kind of yes a field and because me and my this area is near my house and I sometimes go there just walk through there like on my walk and um R: yes so it was the green field I'm looking at the same thing as well it looks quite peaceful Pt: yes yes it is quite peaceful very quiet um not many cars even pass through like travel through there R: it's a lovely photo I was wondering Pt what made you want to take that photo on that day Pt: um so actually I took the photo before actually it was taken well back actually but I felt this photo would capture what I was feeling R: ok lovely Pt: um yes I mean I yes I was sending you this photo because um I was feeling quite calm on that day	

				R: yes Pt: and content and I thought that this photo kind of displays, shows that because it's and you can see it's quite um a natural place it's	
		573-582	Ayaz	Pt: yes no so the second one was this tool that you know a powerful thing that someone once said years ago they quote they were like you know if you're ever in a stressful scenario just take a moment maybe close your eyes think about like that happy place that vision and then like always when I think about a stereotype of heaven or this after life or whatever it may be I always think of this there's this famous scene in Gladiator where like Russell Crowe is going to heaven it just like seeing like you think of I think of like bright lights I think of like water the sounds of water hitting the ocean the beach somewhere like remote far away something like maybe in the distance but not quite like so quite so I think this incapsulates it perfectly and like you know the image that I have in my mind is very similar to this second picture	

	Invokes sense of dark in and out of self.	748-750	Iman	Pt: felt quite frustrated then just yes frustrated and just agitated and I thought this image displayed that because it's obviously all black well the sky is dark let's say dark and um darkness is usually obviously associated with um kind of negative feelings you know	
	Invokes sense of worthlessness inside and outside of self	858-859	Harry	Pt: it all seemed useless and so for me that unmade bed is kind of like the manifestation of feeling like it's useless	
			Harry	Pt: but back then I would stay in my room all day and it would be a tip TIME: 54.17.6 R: and that Pt: it was because I didn't feel like it was worth, I didn't feel like I was worth any of that	

Appendix N

Research Study Information Pack

‘Gatekeeper Information Sheet’

Norwich Medical School,
Postgraduate Research Office,
Elizabeth Fry Building,
University of East Anglia,
Norwich,
NR4 7TJ
Email: z.irvanipour@uea.ac.uk
Tel.: Study mobile (TBC)

GUIDE FOR PROFESSIONALS FOR THE RECRUITMENT OF PARTICIPANTS

Dear Professionals,

> **RE:** “The views of males between the ages of 16-25 years old and their discourses of stress, anxiety, and help-seeking”

Thank you for taking the time to consider whether this research is suitable for the young people you work with.

The aim of this study is to explore the views of young men aged 16-25 years old and their unique experiences of stress and anxiety on their life. The research aims to encourage discussions around the idea of masculinity and if there is a role in how they have felt distress and also ways of managing.

It is hoped that by gaining an insight into the experiences of young men, we may learn more about how they understand their own mental health and how they are likely to communicate this to others. The hope is that this research would help identify ways to improve mental health access for young men so that they feel more able to engage in mental health support that is tailored to their needs.

This guide aims at directing you through the process of identifying suitable participants. Please note that the ‘Participant Information Sheet’ provides detailed information about the study in an easy-read format.

Identifying potential participants:

The inclusion and exclusion criteria below outline recruitment considerations for the proposed study:

Inclusion Criteria:

- Age 16-25
- Fluent in English
- Access to a smartphone and internet if wanting to take photos for the research
- Living in the UK and in the community
- Identifying as male
- Self-identifies that stress and anxiety is having or has had a significant impact on daily life

Exclusion Criteria:

- Significant mental health difficulties and/or substance misuse that are likely to prevent engagement in the study.

<u>Information you may wish to share with potential participants</u>

- This study is conducted by Zuleika Irvanipour, a Clinical Psychologist Trainee at the University of East Anglia, under supervision of two Clinical Psychologists Dr Caitlin Notley and Dr Paul Fisher.
- The study aims to explore young men's experiences of stress and anxiety and their ways of coping.
- If participants show an interest in taking part in the study, the researcher will contact them for an initial discussion to talk about the research project. It will be explained that participants will be asked to take up to 5 photos within a week to represent their experience of stress and anxiety in everyday life as well as methods of coping. These photos can then be sent via WhatsApp to the researcher's phone which will be stored confidentially. The researcher will frame this method as 'Imagine you are creating a photo collection of images to represent your experience of stress and anxiety in your everyday life and how you cope'. Additionally, screenshot photos of music played from a participant's phone will be given as an option. If they do not want to take photos or are unable to they may still be able to participate in the research and participate in the interview stage.
- After photos have been sent they will be invited to a 45-60 minute long interview (either at their home or the recruitment service / organisation) that will be recorded. The researcher will ask questions on their experience of the anxiety and stress, the impact this has had and how they manage.
- The study is not connected to participants' involvement with services / organisations and does not impact their involvement within the organisation they are being recruited from.
- Participation is voluntary; they can participate if they feel comfortable to do so and fit the inclusion criteria.
- Please provide the service user with the 'Participant Information Sheet', which provides detailed information about the study in an easy-read format. Any questions or concerns regarding this research can be raised with the researcher when contact has been made.
    - Please reassure potential participants that even if they have consented to be contacted (completed the 'Consent to Contact Form'), there is no

obligation to continue with the study. Participants can withdraw at any time until one week after the interview is conducted without having to provide any reason.

Next steps

- If the service user is interested in taking part in this research, please complete the 'Consent to Contact Form' and inform me.
- Please inform them that I will be in contact as soon as possible to discuss their participation in this study further.

Thank you very much for taking the time to support this research project. If you have any questions please feel free to contact me.

Many thanks,

Zuleika Irvanipour
Trainee Clinical Psychologist
Phone: 0000-000-000
Email: z.irvanipour@uea.ac.uk

‘Participant Information Sheet’

INFORMATION ABOUT THE STUDY

Dear Prospective Participant,

> **RE:** The experience of anxiety, stress and help-seeking among 16-25 year old young men

I would like to start by saying thank you for showing an interest in this research study. The aim of this document is to provide some information regarding the research to help you decide whether you would like to participate or not. Participation is voluntary.

If you wish to take part in this study, you will be asked to complete a ’Consent to Contact Form’, so that I can speak with you on the phone to discuss next steps in participating the study. Please note that you can withdraw from this study up to one week after the interview is conducted.

Summary of the Research
This study is trying to look understand how teenage males and young men experience distressing emotions like stress and anxiety, as well as looking at views on seeking help. Currently the research exploring this topic is limited in this age group. Because talking about emotions can be challenging for many people, we have employed the use of photos, where participants will be asked to take one to five photos that they feel best represent their experience of stress, anxiety and/or help seeking. These photos cannot include any identifiable information from anyone but the participant. The participant will have about one week to take these photos and send them to the researcher via email to an NHS email that will be provided by the researcher. The interview will last roughly 45-60 minutes and the researcher will as questions about the experience of stress and anxiety in daily life and the experience of managing stress and anxiety.

Will taking part be confidential?
Any identifiable information will be anonymised using pseudonym (made-up name) and all collected data from photos sent to the researcher’s NHS email will be saved on to a password protected memory stick and the original photo will be deleted. Audio recordings will also be stored on an encrypted memory stick.

As with any research conducted in Clinical Psychology, the researcher has a duty of care to the participant. This means that if the researcher feels that during the

interview process you or others are in harm's way, they will take steps to support you and or others.

What are potential benefits and disadvantages of participating?
Possible Benefits:

- Your voice will be heard and included in clinical research.
- Research findings could help mental health care professionals integrate therapies better to meet the needs of the younger male population.
- Findings from the research could help our understanding of the experience of stress and anxiety in young men in the UK.
- A gift voucher of the sum of £15 will be given to each participant as a token of thanks.

Possible Disadvantages:

- For many talking about issues that impact their wellbeing can be very positive, however it can also be difficult. The interview aims to be a place to share your thoughts, however it is equally important that it is flexible. To make it as comfortable as possible there will be the choice to have breaks, shorten the interview and reschedule if needed.

What if I change my mind and want to withdraw my consent to take part?
That's ok. You can withdraw from the study up until one week after the interview is completed, as after one week the data will be anonymised and analysed.

Is this an opportunity for counselling?
No, this is a research participation opportunity where a clinical psychologist in training will explore some ideas and thoughts with you regarding experiences of stress and anxiety in a safe, confidential space. If you would like psychological support the best place to discuss this would be with your GP or self-refer to your local IAPT service (https://www.nhs.uk/service-search/other-services/Psychological%20therapies%20(IAPT)/LocationSearch/10008).

Who can I contact for any questions I might have regarding the study?
Feel free to email me on z.irvanipour@uea.ac.uk or text me on XXXXX XXX XXX

Many thanks,
Zuleika Irvanipour
Supervised by Dr Caitlin Notley

‘Consent to Contact Form’

UEA Header

CONSENT TO CONTACT FORM

Title of Study:

Exploring the views of young men aged 16-25 years old and their experiences of stress and anxiety in their life. A photo elicitation qualitative study

Please place your initials in the following boxes as appropriate.

1. I confirm that I have been informed about the above-mentioned study by a professional and I have been provided with a ‘Participant Information Sheet’.

2. I confirm that I have been asked to take part in the above-mentioned study and have agreed to be contacted by the researcher.

3. I give consent for the professional who informed me about the above-mentioned study to share my contact details with the researcher.

   Contact details (either telephone number or email address):

   _____

_____		_____		_____	
Name of Participant	Date		Signature		
_____		_____		_____	
Name of Link Person (if applicable)	Date		Signature		

‘Consent to participate form’

UEA Header

CONSENT TO PARTICIPATE FORM

Title of Study:
Exploring the role of masculinity on the experience of stress, anxiety and help-seeking: A photo elicitation qualitative study

Please place your initials in the following boxes as appropriate.

1. I confirm that I have read the ‘Participant Information Sheet’ for the above mentioned study

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time, up until one week after the interview has taken place.
3. I understand that the photographs I provide and the audio recording of the interview might be used in the publication of this research, e.g. direct quotes and photo images. I understand that my responses will be anonymised; no personally identifiable information will be used.

4. I understand that my personally identifiable information will be held securely on University of East Anglia (UEA) online servers and locked cabinets at UEA and that all data will be destroyed after 10 years. ☐

5. I agree to take part in the above research study. ☐

If you wish to receive a written summary of the findings from the above mentioned study please provide your contact details (postal address or email address) below:

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix O

Demographic information Sheet

The information below will be used for the purpose of the current research study and will help the researcher understand elements of your current personal situation. All information is stored confidentially.

Participant pseudonym and number:
Age:
Any additional needs? (E.g. dyslexia, dyspraxia, mobility etc)
Ethnicity:
Location participant lives:
Current status (please circle) Secondary School Sixth-Form College Not currently in education Apprentice Working full-time Working part-time Other
If in formal education what year?
Any current mental health or physical health concerns (please include conditions and any current medications)