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**EVIDENCE FOR A GENDER-BASED APPROACH TO MENTAL  
HEALTH PROGRAM: IDENTIFYING THE KEY CONSIDERATIONS  
ASSOCIATED WITH “BEING MALE”**

## **RAPID REVIEW**



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# REPORT COMPILED BY

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**Professor Steve Robertson**  
**Dr Anne-Marie Bagnall**  
**Dr Michael Walker**

This rapid review was commissioned by the Sax  
Institute, on behalf of the Movember Foundation.

25th November 2014

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# EXECUTIVE SUMMARY

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## AIMS

The aim of the evidence check was to find out what the evidence base is relevant to testing the proposal that “being male” is a key consideration for understanding mental health outcomes and service development i.e. that a gender-based approach to mental health programmes is defensible, especially for prevention, early intervention and stigma reduction.

## METHODS

Four electronic databases were searched for journal articles, as well as relevant websites and specific journals. Studies were selected if they were about being male, mental health, and inclusive of a broad array of programmes, campaigns and public health initiatives, and not limited to clinical interventions on referral. Once the main themes had been identified, supplemental searches were carried out where themes were felt to lack depth. Two researchers selected studies for inclusion, and one researcher coded the included papers for key information and collated the evidence.

## KEY FINDINGS

- It is important that programmes take a gender-based approach to working with men because there is a strong relationship between adherence to traditional masculinity and poorer mental health help-seeking, higher levels of mental health stigma, suicide attempts and body image concerns
- Programmes should pay particular attention to approaches that help men to become emotionally expressive because difficulty in expressing emotions is the element of masculinity most linked to negative mental health help-seeking, endorsement of mental health stigma and likelihood of suicide. (This holds true amongst different groups of men, including ethnic groups of men and gay men, where discrimination may increase the impact of these negative aspects)
- Programmes should also pay attention to approaches that help men develop or sustain feelings of self-esteem, control and responsibility (for example around work and family) as these are linked to more preventative self-care behaviours and

to positive coping with stressful life events

- Programmes should ensure they view men as positive assets and use male positive approaches (e.g. presenting help-seeking as ‘rational’ and as a strength) and language (e.g. using ‘regaining control’ rather than ‘help-seeking’) as this helps engage and sustain involvement in interventions (though caution should also be taken that these approaches don’t act to reinforce negative traditional male views)
- Part of using male positive approaches includes involving men in ‘doing’, in action-based approaches, especially doing traditionally male activities. Such approaches act to create a safe space that generates trust and thus facilitates talking and ‘opening-up’ emotionally.
- Furthermore, such action-based interventions also act to facilitate positive male social engagement which affects, and is affected by, the ability to be emotionally open and helps improve self-esteem through feelings of enjoyment and having a valued male identity

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# INTRODUCTION

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This evidence check was carried out by the Centre for Men's Health at Leeds Beckett University, and was commissioned by the Sax Institute on behalf of the Movember Foundation. The aim of the evidence check was to find out what the evidence base is relevant to testing the proposal that "being male" is a key consideration for understanding mental health outcomes and service development i.e. that a gender-based approach to mental health programmes is defensible, especially for prevention, early intervention and stigma reduction.

Specific questions were:

## QUESTION 1

What is the evidence base relevant to testing the proposal that 'being male' is a key consideration for understanding mental health outcomes and service development, i.e. that a gender-based approach to mental health programmes is defensible, especially for prevention, early intervention and stigma reduction?

## QUESTION 2

**2A.** What elements of the construct of 'being male' predict mental health outcomes that can be defined as positive?

**2B.** What elements of the construct of 'being male' predict mental health outcomes that can be defined as negative?

**2C.** Do positive and negative outcomes vary with modality of delivery or access for males – in particular, is there evidence supporting male preferences for (or better engagement with) technology deliveries such as online or apps?

**2D.** Do positive and negative outcomes differ for specific sub-groups of males?

## QUESTION 3

**3A.** Overall, provide an opinion on how strongly the available evidence supports a gender-based approach to mental health, particularly for the design and evaluation of prevention, early intervention and stigma reduction initiatives (including policy directions)

**3B.** What are the key considerations of 'being male' which can be recommended as deserving priority attention when seeking to promote positive outcomes for male mental health programmes in the five nations of interest?

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# BACKGROUND

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The Movember Foundation is a global charity which raises funds for men's health and supports programmes across 21 countries. The signature campaign for the Foundation is "Movember", which has been held annually and internationally during the month of November since 2003.

As a strategic investor in research and health programmes, The Movember Foundation has identified mental health in males as a key priority. The Foundation has established a small Global Mental Health team to oversight this initiative (led from Australia). This team will work internationally with local experts to determine best directions for investment of The Movember Foundation resources in male mental health and wellbeing programmes. The broad mandate is to fund innovative and collaborative results-focused projects in the areas of prevention, early intervention and stigma reduction.

Within the mental health priority, The Movember Foundation has three results that they are seeking to achieve in the community (i.e. strategic goals):

1. Men and boys are mentally healthy and take action to remain so.
2. When men and boys experience mental health problems they take action early.
3. Men and boys with mental health problems are not discriminated against.

The Movember Foundation is committed to 'real world' programmes for males (men and boys) which offer broadest reach with maximum value (impact) for resource investment. To meet this objective, the Global Mental Health team has identified a knowledge gap with respect to the potential interaction between attributes of the masculine identity ('what it means to be male') and effective engagement of males with mental health supports, services and/or interventions. The team has requested an evidence check to address this knowledge gap.

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# METHODS

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## LITERATURE SEARCH

The following databases were searched: MEDLINE/ PubMed; CINAHL; PsycINFO; Web of Science. We also searched relevant websites for grey literature i.e.: The Movember Foundation; The Centre for mental health; Mental health Foundation; Men's Health Forum; The King's Fund; MIND; Samaritans; "Time for Change"; Young Minds; "Choose Life"; Ministry of Justice; Therapeutic Communities.

The following journals were hand searched: International Journal of Men's Health; Journal of Men's Health; American Journal of Men's Health; Psychology of Men and Masculinity; Men and Masculinities; Journal of Men's Studies; Journal of Therapeutic Communities.

Once the main themes had been identified, supplemental searches were carried out where themes were felt to lack depth.

## INCLUSION CRITERIA

### POPULATION:

Being male refers to identification with male gender and the construct of 'masculinity' (examples include but are not limited to: toughness, stoicism, action-orientation, risk-taking), inclusive of all age groups and potential identities (e.g. homosexual, bisexual and transgender). Mental health is defined as "a state of wellbeing in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her own community" (WHO 2014<sup>1</sup>). It is more than the absence of mental illness.

Sub-groups of potential interest include but are not limited to:

- Age: boys, young men, working-aged/middle years, older adults
- Personal demographics such as relationship status (including bereaved) and parenting status
- Cultural and linguistic diversity (CALD) variables, including ethnicity
- Socioeconomic variables, including education
- Indices of remoteness and service access.
- Occupational status, including unemployed or retired.
- Sexual orientation and gender identity

- Country setting, specifically the five nations of interest: Australia, New Zealand, Canada, United Kingdom, and United States of America.

Interventions:

Inclusive of a broad array of programmes, campaigns and public health initiatives, and not limited to clinical interventions on referral. Interventions can include those where the target populations are service providers. Studies that are not about interventions were also eligible for inclusion.

### OUTCOMES:

Outcomes of primary interest are not clinical measures per se (e.g. adherence), but behaviours indexing self-care, preventative health management, self-awareness of mental health concerns, and engagement in help-seeking (defined elsewhere as "an adaptive coping") Outcomes may also relate to perceptions or views of others, such as health provider perspectives or attitudes that appear to reflect gender-based considerations.

### STUDY DESIGNS:

Peer-reviewed publications and reports, in English only, with a priority focus on research from: Australia, New Zealand, Canada, United Kingdom, United States of America.

Grey literature with a priority focus on reports in the public domain addressing male mental health in (a) policy papers, and (b) programme evaluations.

Published in the past ten (10) years for peer-reviewed publications, and the past five (5) years for grey literature.

<sup>1</sup> [http://www.who.int/features/factfiles/mental\\_health/en/](http://www.who.int/features/factfiles/mental_health/en/)

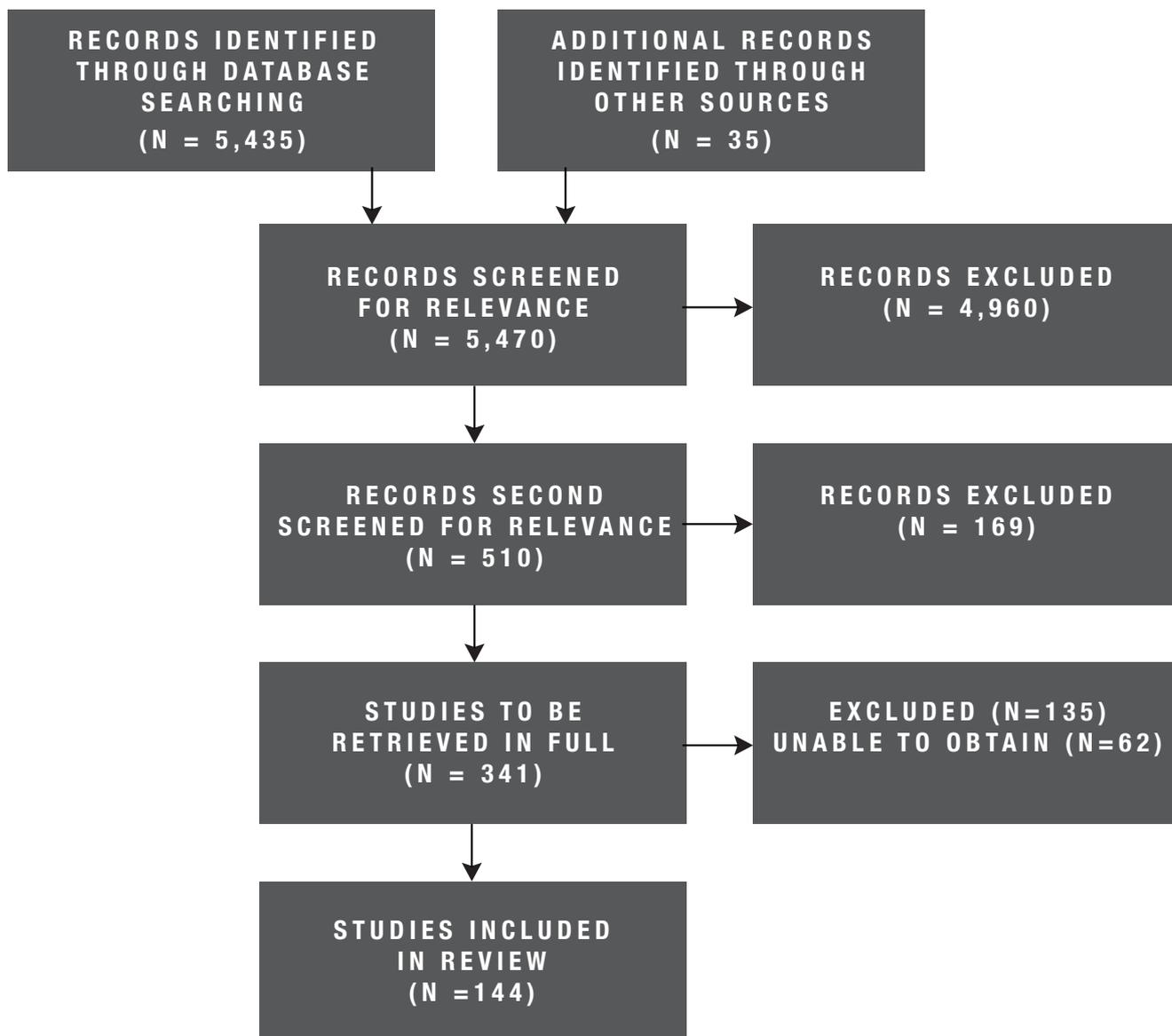
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# FINDINGS

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Electronic database searches yielded a total of 5435 titles and abstracts. After an initial screen for relevance, 475 hits remained, and after a second screen this was reduced to 306. An additional 35 records were obtained from searches of websites or from other experts in the field. Full text papers and reports were retrieved for 264 of these records (we were unable to obtain 62), and after further screening, another 135 were excluded, leaving 144 included studies. See Appendix 1 and 2 for lists of included, excluded and unobtainable studies.

**Figure 1: Study selection process**



# MAP OF THE LITERATURE

## COUNTRIES

The North American population was the most well-represented, with 49 of the 144 included studies being from USA and a further 13 from Canada. 24 of the included studies were from the UK, while 20 were from Australia. Six were from Sweden, three from Japan and Norway, two each from Brazil, Finland, Hong Kong, Turkey, South Africa and New Zealand, and one study each from the Netherlands, Saudi Arabia, Spain, and Ireland

COUNTRY	NUMBER OF STUDIES
USA	49
UK	24
Australia	20
Canada	13
Sweden	6
Japan	3
Norway	3
Brazil	2
Finland	2
Hong Kong	2
Turkey	2
South Africa	2
New Zealand	2
Netherlands	1
Ireland	1
Saudi Arabia	1
Spain	1

## STUDY DESIGN

The most popular study design was a survey (n=48), followed by qualitative study (n=37). The remaining studies comprised a wide range of other study designs, including 10 reviews, of which 1 was a systematic review.

STUDY DESIGN	NUMBER OF STUDIES
Survey	48
Qualitative study	37
Literature Review	7
Mixed methods Evaluation	4
Cohort study	4
Primary study	4
Case study	2
Cross-sectional study	3
Conceptual	3
Discussion	2
Exploratory study	2
RCT	2
Systematic review	1
Controlled experiment	1
Diagnostic study	1
Exploratory study	2
Ethnographic study	1
Medical file audit	1
Meta-synthesis	1
Scale validation	1
Scoping review	1
Service use analysis	1

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## FOCUS

The largest collection of studies had a focus on help-seeking (n=38), but significant numbers of studies were also found on body image (n=8), fatherhood (n=12), suicide or self-harm (n=15), depression or psychological distress (n=15), older men (n=6), ethnicity (n=8), eating disorders (n=3), gay men (n=6), alcohol or substance abuse (n=7), adolescent or young men (n=5). Other themes were: mental health services, anger or violence, gender role or identity, prisoners, armed forces, psychosis, HIV and cancer.

FOCUS	NUMBER OF STUDIES
Help-seeking	38
Suicide/ self-harm	15
Depression/ psychological distress	15
Fatherhood	12
Body image	8
ethnicity	8
Alcohol/ substance use	7
Older men	6
Gay men	6
Mental health services	6
Anger/ violence	6
Adolescent mental health	5
Gender role/ identity	4
Prisoners	3
Eating disorders	3
Sport and exercise	3
Armed forces	2
Psychosis	2
HIV	1
Cancer	1
Stigma/ discrimination	1
Self-esteem	1
Unemployment	1

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# NARRATIVE SYNTHESIS

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The following synthesis explores key themes, and references some but not all of the included studies.

## **HELP-SEEKING:**

Thirty-eight studies touched on the area of help-seeking (Alfred et al. 2014; Cabassa 2007; Chan & Hayashi 2010; Eckert et al. 2010; Ellis et al. 2013; Emslie et al. 2006; Foster 2011; Good & Robertson 2010; Gorman et al. 2007; Green et al. 2010; Greenberg et al. 2009; Hammer & Vogel 2010; Houle et al. 2008; Hoy 2012; Inkle 2014; Iwamoto et al. 2012; Johansson & Olsson 2013; Johnson et al. 2012; Levant et al. 2013; Levant et al. 2011; Lindsey & Marcell 2012; Lindsey et al. 2010; McKelley & Rochlen 2010; Nahon & Mander 2008; Nguyen et al. 2012; O'Brien et al. 2007; Oliffe et al. 2010; Oliffe et al. 2012; Reilly et al. 2014; Roy et al. 2013; Shepherd & Rickard 2012; Spandler et al. 2014; Syzdek et al. 2014; Tremblay & L'Hereux 2005; Valkonen & Hanninen 2012; Vogel et al. 2014; Vogel et al. 2011; Wilson et al. 2012 ).

Given the on-going significance attributed to men's lower rates of help-seeking, particularly in the context of psychosocial health and wellbeing, it is no surprise that this was a theme that was present and returned more papers than any other. The relationship between men, masculinity and help-seeking is often presented as a straight-forward and negative relationship – ways of being socialised as a man lead to reluctance to seek help, particularly for emotional/mental wellbeing concerns. However, the evidence generated here suggests a more complex and nuanced relationship.

## **USING TRADITIONAL MASCULINITY NORMS AS A 'HOOK' TO HELP-SEEKING:**

Whilst this review does not focus specifically on interventions, the scope does include considering the role that masculinity might play in engaging men. We therefore considered mental health interventions where elements of 'masculinity' were utilised or commented on in relation to help-seeking.

There was fairly clear evidence that approaches specifically aligned with certain traditional masculine norms, particularly those utilising 'male' language, had some impact on help-seeking and self-stigma. One US study (McKelley & Rochlen 2013) comparing the same approach but using either 'therapy' or 'executive coaching' to describe this showed that men with more traditional views on masculine norms had higher self-stigma to help-seeking and viewed 'therapy' less

favourably. Another US study (Hammer & Vogel 2010) showed similar results in improving attitudes to help-seeking and reducing self-stigma toward counselling through development of a 'male-sensitive' brochure which used language compatible with traditional masculine roles and images of 'more stereotypically masculine men'. Syzdek et al (2014) in the US used similar language adjustments (again avoiding terms such as 'therapy') in developing and trialling Gender-Based Motivational Interviewing and they found a moderate effect on mental health stigma and on improved informal but not formal help-seeking. In Australia, Ellis et al (2013) suggest that mental health online interventions that are self-help and action-oriented rather than talk-focused are more likely to be appealing for young men. The evidence here then is a little contradictory: those men that hold more traditional masculine views have a more negative view of help-seeking (and feel greater mental health stigma) yet utilising aspects of traditional views, particularly around using assertive statements about help-seeking and avoiding 'feminised' language associated with 'therapy', or 'counselling' can facilitate greater engagement – but perhaps only for certain men. This paradox of the positive and negative role that gender/masculinity can play in mental health interventions was also noted in a UK based football intervention where the policing of traditional masculinity norms (particularly around heteronormativity) were apparent but ran alongside transgressive alternatives that included care, concern and group-bonding (Spandler et al 2014).

As an adjunct to this, professional approaches that take a positive (rather than a pejorative) view of boys and men seem to have greater potential for engagement. A study from Sweden (Johansson & Olsson, 2013) showed the importance of therapists taking a positive approach to boys with low mood and how understanding of masculine stereotypes was key to this. Specifically, approaches that recognise and focus on men's strengths (i.e. that present help-seeking as a 'strong' decision) can help normalise help-seeking in mental health and, as such, can be effective in promoting early intervention (Tremblay & L'Heureux 2005; Nahon & Lander 2008; Good & Robertson 2010; Inkle 2014). However, these papers from Canada, the US and the UK are descriptive accounts of the development/delivery of therapeutic programmes for men that draw on the tacit knowledge of those involved; they are not empirical, research-based studies.

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## **ELEMENTS OF MASCULINITY AND THEIR ROLE IN ENABLING OR RESTRICTING HELP-SEEKING:**

A range of both quantitative and qualitative studies have been completed over the last ten years that shed interesting, if somewhat embryonic, evidence on the elements of masculinity that can facilitate or restrict mental health help-seeking.

Psychological studies in the US using various gender scales have demonstrated that the internalising of dominant masculinity ideals is related to less favourable mental health help-seeking attitudes and higher levels of mental health stigma (Vogel et al 2011), lower psychological wellbeing (Alfred et al, 2014), less likelihood of confiding in family and friends following a stressful life event (Houle et al, 2008) and, conversely, lower masculine norm adherence has been related to higher levels of self-compassion (Reilly et al 2014). However, other research (Greenberg et al, 2009) shows similar levels of adherence to masculinity norms in depressed and non-depressed college men but higher levels of problem-solving behaviours amongst the non-depressed group. Collectively these studies may imply that adherence to hegemonic masculinity norms does not play a role in male depression per se but may have a role in mental health stigma and help-seeking and that such adherence may be less important than elements such as problem-solving ability in self-managing common stressful or emotional life events. Related to this, Shepherd & Rickard (2012) demonstrate that, for men, gender role conflict is negatively correlated to help-seeking variables and is a significant predictor of self-stigma of seeking help and this in turn influences willingness to seek help.

When looking at elements of masculinity norms (sub-scales within these bigger gender norm scales) in more detail, 'restrictive emotionality' and 'restrictive affectionate behaviour' (difficulty and fears about expressing one's feelings and of outwardly demonstrating affection) have been linked in US studies to making men less likely to refer family and friends to seek help for mental health concerns and to them endorsing mental health stigma (Vogel et al 2014); to homeless men reporting lower levels of problem solving confidence and skills; higher levels of psychological distress and negative attitudes to help-seeking (Nguyen

et al 2012) and 'emotional control' to depressive symptoms in incarcerated men (Iwamoto et al, 2012). Chan & Hayashi (2010) also show that adherence to masculine norms of 'success, power and competition' and 'restrictive emotionality' are particularly likely to be related to negative views about help-seeking. The work of Levant et al (2011) in the US shows that overall conformity to masculine norms is associated with less health promotion behaviours. However, when considered in detail, there are some interesting, perhaps counter-intuitive, findings. Masculine norms of 'controlling emotions' and 'making work a top priority' and 'winning' were related to avoidance of 'anger and stress' and of 'substance misuse'. On the other hand, conformity to masculine norms of 'dominance', 'self-reliance' and 'restrictive emotionality' were associated with less avoidance of 'anger and stress' and of 'substance misuse'. When looking specifically at preventative self-care scores, norms of 'dominance' and 'primacy of work' were again related to greater preventative self-care whilst the 'pursuit of status' norm was related to poorer preventative self-care. Levant et al (2013) also provide evidence that increasing mental health problems can overcome the reticence to seek help even amongst those who hold strongly to traditionally masculine norms and this may be particularly so for men with high self-efficacy.

In qualitative work, a meta-ethnography of men's perspectives on psychological distress and help-seeking outlines how emotional repression is a key factor that creates a barrier for men's help-seeking in mental health and emotional distress contexts. However, the same work also demonstrates the positive opportunities that men took for seeking support particularly from family members and friends (Hoy 2012). Similarly, work from Finland (Valkonen & Hänninen, 2012) provides evidence that hegemonic masculine values vary in their impact on mental health and help-seeking. They can act as a positive force giving life direction, meaning and drive and also help in coping with minor mental health experiences. However, they can also prove problematic when difficult circumstances arise and holding to some of these values, particularly around autonomy and emotional control, is not possible. Gorman et al (2007) show that (rural) men in Australia positively incorporated elements of hegemonic masculinity - such as inner-strength, control (including

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information seeking) and discipline - in coping with emotional difficulties and mental health in a rural context. However, they also highlighted how approaches that might be seen as antithetical to hegemonic norms - such as being self-aware, acknowledging the need for help and talking about issues - as being important. This ambiguity and the role of these elements is reinforced by an international review of research on male farmers and mental health (Roy et al, 2013). This research resonates with other work from Canada (OliFFE et al, 2010; OliFFE et al, 2012) and the UK (Emslie et al 2006) which show that elements such as control and responsibility could be beneficial in coping or recovering from depression whilst conforming to other aspects of hegemonic norms (such as not showing weakness or vulnerability) could be detrimental and maybe associated with suicidal behaviour. Again, Johnson et al (2012) show that there are strong male discourses at play around self-reliance and fear of vulnerability that generate problems for help-seeking. However, there are also discourses of responsibility and independence that act as enabling factors in help-seeking and an ability (once trust is established) to desire 'genuine connection' that involves being able to talk openly but, importantly, as empowered partners within care contexts.

Another rural study from Australia (Wilson et al 2012) suggested that the stigma attached to possible loss of social status by seeking support for mental health acts as a barrier to early intervention. This is supported by UK evidence that men believe admitting a mental health problem will result in a lower status position relative to women and other men and that this differed from admittance of a physical health concern: this has obvious implications for mental health help-seeking (O'Brien et al 2007). This fear of disclosure of mental health concerns or emotional weakness because of its impact on status was particularly apparent amongst certain communities of men where hegemonic male norms tend to be more closely observed such as in the military (Green et al, 2010) and in the prison population (Foster, 2011). This fear of mental health concerns being visible to friends was also found amongst African-American adolescent boys (Lindsey et al 2006). In contrast, qualitative work with Latino Immigrant men in the US showed these men mainly felt that help-seeking

for depression was acceptable but more so with family members or friends and less so from formal services (Cabassa, 2007).

#### **SUMMARY (HELP-SEEKING):**

To summarise, it seems from both the quantitative psychological literature and the qualitative work that similar elements of hegemonic (traditional) masculinity are negatively associated with help-seeking: these are primarily those that relate to the ability to be emotionally expressive or to show vulnerability and they have been suggested as having a particularly negative impact on formal mental health help-seeking. These same elements are also related to greater mental health stigma and to a desire to hide or mask mental health concerns to peers for fear of losing social status especially so in younger men and in communities of men where masculinity is observed (and policed) at close quarters. Other aspects of hegemonic masculinity, particularly aspects of autonomy and control (especially when linked to high self-efficacy), can be useful in dealing with minor emotional or mental health concerns and, if harnessed well by practitioners, can be used as a lever to help make help-seeking part of assertive and positive decision making. They can also be useful in the same way in helping the management or recovery from minor mental health morbidity (particularly depression). However, these elements can also prove detrimental if mental health concerns reach certain levels such that autonomy and control need to be (at least partly) relinquished in order to obtain the necessary help.

Finally, there seems to be some evidence of a shift in mental health literacy and views on help-seeking over time with more men recognising mental health symptoms and fewer men agreeing that it was helpful to deal with problems on their own in 2008 than in 1998 (Eckert 2010). This could be linked to wider changes in the nature of 'masculinity' that have been widely discussed and debated.

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## SUICIDE

Fifteen studies looked at suicide or self-harm (Alpass & Neville 2005; Bennett 2005; Biong et al. 2008; Bramness et al. 2010; Emslie et al. 2006; Galligan et al. 2010; Gilchrist & Sullivan 2006; Houle et al. 2008; Lamis & Lester 2012; McAndrew & Gamsen 2007; Meehan et al. 2007; Oliffe et al. 2010; Oliffe et al. 2012; Payne 2008; Peter & Roberts 2010;).

Given the significantly higher rates of male suicide in developed countries, and the links that are made between this and the role masculinity plays, it was important that this theme be explored as these links could be significant in what they tell us more widely about the importance of masculinity to mental health promotion, early intervention and stigma. Despite how frequently the links between masculinity and suicide are made in opinion based literature we were surprised at how little empirical work seems to have been done to date around the role of gender/masculinity in suicide, parasuicide or suicidal ideation and we suggest this should form an area for future research.

Psychological research from Canada exploring male gender role norms and suicide attempts (Houle et al, 2008) showed that adherence to traditional norms was a significant predictor of suicide attempts even when controlling for: previous mental health disorders; being in a couple; annual income. These norms were also associated with less likelihood of having sought help from family and friends for the most stressful event of the last year. A more nuanced study in young men from the US (Galligan et al, 2010) showed that elements of masculinity such as 'success, power and competition' could act as protective factors against suicidality whilst 'restrictive emotionality' was a risk factor. Research from the US in college men (Lamis & Lester, 2012) showed that depression, hopelessness and alcohol-related problems were all predictive of lower 'reasons for living' scores whilst social support from family and from friends were predictive of higher scores. However, links to gender and masculinity were under-addressed within this study.

Further psychological work from Canada (Peter & Roberts, 2010) explored sex differences in the relationship of 'internalising' and 'externalising'

factors to suicidal ideation and parasuicide amongst youth. [NB 'Internalising' factors are those linked to emotional or mood disorders (such as propensity to depression or anxiety) whereas 'externalising' factors are those linked to behaviours (such as; aggression, vandalism, stealing or lying, substance misuse, rule violation)]. Results were contrary to expectations and whilst both internalising and externalising factors were 'red flags' for suicidal ideation and parasuicide, internalising factors (specifically anxiety) had a significant impact only for boys (for suicidal ideation but not for parasuicide) and externalising factors (specifically the deviant behaviour measure, sexual activity and alcohol use) had a significant impact only for girls for suicidal ideation and parasuicide. A study in older men in New Zealand (Alpass & Neville, 2005) showed suicidal ideation was significantly related to income, stress, loneliness, hopelessness, and depression. However, the study made no attempt to link this to gender/masculinity.

A fascinating study from Norway (Bramness et al, 2010) shows that self-reported mental health symptoms are closely related to increased risk of completed suicide and much more so for men. They suggest this may be because of poorer ability amongst males to communicate and verbalise mental health concerns, possibly linked to stronger feelings of shame, guilt and stigma in admitting mental health concerns amongst men. Likewise, a broad review of the literature on gender and suicide (Payne et al 2008) shows that suicide-related behaviours are influenced by (and influence) demonstrations of masculinities and societal male roles. In a qualitative study from Sweden looking at young men, substance abuse and suicidal behaviour (Biong, 2008), it is postulated that both pressures to conform to hegemonic male norms, and the difficulties of doing so, can create a state of existential angst where suicide seems to offer a legitimate and rational path out of perceived untenable situations. It further suggests that controlling death may function as a foundation for men's sense of self as men. This resonates with work from Canada (Oliffe et al, 2010; Oliffe et al, 2012) and the UK (Emslie et al 2006). It also shows how the pressure of conflicting cultural ideas of what constitutes 'masculinity' for immigrant or migrant men might also generate a perceived untenable

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situation that engenders suicidal thoughts and this resonates with work from Canada on immigrant college men (Oliffe et al, 2010; Oliffe et al, 2012).

Work with young people in Australia (Gilchrist & Sullivan, 2006) suggests that hegemonic male norms (as well as traditional expressions of femininity) remain pervasive and powerful in their possible influence on suicide. This resonates with US work on young people's perceptions about suicide (McAndrew & Garrison, 2007) where there was strong agreement on likely methods that men (violent means) and women (drowning, overdose) might use and a more limited range of acceptable reasons for male suicide (mainly failure to achieve and financial problems). Work with young people in South Africa (Meehan et al, 2007) found that males and females broadly used similar coping strategies in stressful situations. However, there was a significant correlation between dysfunctional coping strategies (denial, withdrawal, alcohol/substance misuse) and negative suicidal ideation scores amongst males but not females and a significant correlation between functional coping strategies (seeking advice & support; assessing situations and looking for compromise within oneself) and a positive outlook on life for females but not for males.

A qualitative study of older widowers in the UK (Bennett, 2005) showed that, alongside social relationships, male notions of determination, stoicism ('keeping a stiff upper lip') and responsibility played an important role in some men's decision to live.

### **SUMMARY (SUICIDE):**

Despite the recognised importance of sex differences in suicide, and the amount of available work on such sex differences, there is currently only a limited amount of empirical work on the links between masculine gender and suicidal ideation, suicide attempt and suicide and this constitutes a knowledge gap in the field.

Psychological research suggests that adherence to traditional masculine norms is a significant predictor of suicide attempts with elements such as 'restrictive emotionality' being a particular predictor but with elements around 'success, power and competition' being protective. Work in boys suggests that internalising factors (particularly anxiety) and dysfunctional coping strategies are linked to suicidal ideation. This seems to reinforce ideas that struggling to fulfil hegemonic norms of strength (instead feeling weak and/or vulnerable) and poor mechanisms for dealing with this, may contribute to suicidal thoughts. Qualitative work likewise suggests that suicide becomes a valid, possibly rational, option when circumstances determine that coping alone and keeping control of a situation (or the feelings that relate to it) seems no longer possible; that is, it becomes the ultimate way of exerting control thereby demonstrating to oneself and others a male self.

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## DIVERSITY

Masculinity often does not 'stand alone' as an aspect of identity but is more commonly intersected by other aspects such as ethnicity, age, sexuality etc. Within this theme we review the work on what is known about the relationships of particular intersections (specifically; ethnicity, older age, gay men) to mental wellbeing.

### ETHNICITY, MASCULINITY AND MENTAL WELLBEING:

Eight studies looked at ethnicity (Bryant et al. 2014; Bryant-Bedell & Waite 2010; Caldwell et al. 2013; Chong et al. 2009; Hammond 2012; Iwamoto et al. 2010; McCalman et al. 2010; Mellsop & Smith 2007). Psychological research with non-resident African-American fathers in the US (Caldwell et al, 2013) identified 'culturally-based traditional beliefs' and 'interpersonal connection' sub-scales alongside a 'hegemonic' masculinity sub-scale when looking at masculinity ideologies amongst these men. The 'culturally-based' element (using statements such as "expressing love for family and friends", "being a good provider") was significantly associated with lower depressive symptoms whilst the 'hegemonic' element (using statements such as "having power", "being physically strong") was significantly associated with higher depressive symptoms. Further US work with African-American men (Hammond, 2012) shows that, in parallel with the work presented in the previous section on help-seeking, 'restrictive emotionality' is associated with higher depressive symptoms for these men. However, they also show that the positive association between 'everyday racial discrimination' and depressive symptoms was stronger for those men with high 'restrictive emotionality' giving some indication about the interplay between masculinity, race and the generation of depressive symptoms. In work with Asian-American men (Iwamoto et al, 2010), male norms of 'dominance', linked with avoidant coping strategies (such as alcohol or substance misuse) were associated with higher depressive symptoms whilst endorsement of norms of 'winning' were associated with lower levels of depressive symptoms. They suggest this latter finding may be because those who endorse 'winning' norms may be better able to self-regulate negative thoughts and make adjustments to negative life experiences whilst adherence to 'dominance' norms may create strain

in a range of interpersonal relationships. This again is in line with the evidence presented in the previous section on help-seeking.

Work from the US amongst African-American males (Bryant-Bedell & Waite, 2010; Bryant et al, 2014) highlighted the links between mental health pressures, masculinity and social structures for these men. It further highlighted a strong tendency to denial of minor mental health concerns (depression) that was related to the stigma of appearing weak and not feeling that emotional expression was acceptable as a 'real' man (was not masculine) and particularly so as a real Black man. This was also linked to not wanting to lose pride and was felt to be particularly the case for Black men where historical struggles for material resources and status gains have been hard won. These views were said to generate tactics of self-coping for emotional issues with negative implications for help-seeking particularly from 'White' dominated formal services that did not understand their needs or use culturally appropriate approaches. In a similar vein, other work from the US with young South Asian men (Chong et al, 2009) shows that attempts to be resilient in social contexts marked by alienation and discrimination may generate acts of violence in order to comply with the "code of the street" and make meaning out of the intersection between race and gender to survive or even thrive in difficult environments. This has implications for wellbeing and the authors are clear that such acts of violence whilst possibly generating a form of resilience in the short term may be maladaptive in the longer term.

In a meta-synthesis of work on indigenous men's support groups (McCalman et al, 2010), these have been shown to be useful in addressing perceived issues of gender inequity that disrupt wellbeing and have increased partnership working in a range of personal and community contexts.

There is evidence (Mellsop & Smith, 2007) that clinician perception of the intersection of race and gender may play a role in how behaviours are labelled and this has consequences for whether diagnoses are made (or missed), whether interventions are suggested and what type of interventions are suggested.

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## **GAY MEN, MASCULINITY AND MENTAL WELLBEING:**

Six studies looked at gay men (Aggarwal & Gerrets 2014; Bybee et al. 2009; David & Knight 2008; Fischgrund et al. 2012; Korner et al. 2010; McAndrew & Warne 2010).

Work from the US looking at the links between masculinity and mental health status amongst gay men (Fischgrund et al, 2012) showed significantly higher levels of depression associated with the endorsement of traditional masculinity. It is possible that this is due to increased experience of internalised homophobia amongst these men. Ethnographic work from Holland (Aggarwal & Gerrets, 2014) supported this hypothesis suggesting the pressures associated with heteronormativity are part of the reason for such internalised homophobia.

Other work from the US (Bybee et al, 2009), identifies identity conflict amongst gay men, particularly the process of emotional suppression associated with not 'coming out', as being significantly associated with increased mental health concerns, most likely through processes of discrimination. This is ameliorated for gay men who have higher self-esteem and are better able to be emotionally responsive. Additionally, age seems to play a part and older gay men reported less anger, higher self-esteem and more emotional responsiveness. Research from Australia (Körner et al, 2010) shows that difficulty in expressing emotions - combined with difficulties in aligning with hegemonic norms of rationality, assertiveness, competitiveness and success - may create particular tensions and difficulties for gay men as they negotiate life's challenges.

Qualitative work from the UK (McAndrew & Warne, 2010) highlights the challenges gay men face during their formative years in feeling compelled to meet hegemonic standards or engage in hegemonic practices (playing football, being aggressive etc) whilst often wanting to resist such conformity. This leads to some emotional suppression and creates interpersonal and intrapersonal conflict impacting on wellbeing.

These studies again collectively point to the importance of the role of emotional suppression in the generation of mental health problems and the

difficulty of responding to mental health concerns. It also supports our proposed model (presented later) in terms of the positive role that self-efficacy/self-esteem can play in off-setting the negative elements of being emotionally repressed.

Intersectional research from the US looking at the relationship between sexuality, ethnicity, age and stress/coping (David & Knight, 2008) showed that effects of (age, racial, sexuality) discrimination and the impact on mental health are synergistic. Furthermore, being a member of a marginalised group was significantly linked to disengaged coping styles (denial, substance misuse). This seems to imply a relationship between marginalised and subordinated masculinities and negative coping mechanisms and mental health engagement.

## **OLDER AGE, MASCULINITY AND MENTAL WELLBEING:**

Six studies looked at older men (Bates & Taylor 2012; Golding 2011; Mental Health Foundation 2010; Milligan et al. 2013; Ormsby et al. 2010; Wilson et al. 2013). There is very limited empirical work that links aging, masculinity and mental health.

Psychological work from the US (Bates & Taylor, 2012) looking at the impact of grand-parenting on older men's mental health showed that involved grandfathers had fewer depressive symptoms and significantly higher scores of 'positive affect' (positive emotions and interactions with others). The authors suggest that the relationship between involvement and positive affect could be in either direction: that is, more involvement generates greater positive affect or those men with greater positive affect are more able to be involved. From work in the previous section on help-seeking around 'restrictive emotionality' it seems likely that men with greater positive affect, those more likely to resist hegemonic norms of emotional suppression, are better placed to engage in relationships with their grandchildren and that this is beneficial to mental wellbeing.

There has been useful information that has emerged about the links between aging, masculinity and mental health from the tacit knowledge of those working

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with this group and particularly from consideration of the men's shed movement. A systematic review of men's sheds and gendered interventions on health and wellbeing (Milligan et al, 2013) shows some evidence of positive effect on mental health and social wellbeing. In particular, they highlight the importance such interventions can play in helping older men (re)gain a sense of male identity (recreate a masculine identity) following retirement and generate an improved sense of being valued and of self-esteem. Work from Australia reinforces the importance of action-orientation – the involvement in regular, practical hands on activity – in the self-reported promotion of mental health and wellbeing for older men. Golding (2011) shows that the value of this interaction was particularly powerful when it moved beyond the individual and cerebral; that is when it was physical and social, involving other men and benefitting the community. As with the systematic review mentioned previously, this study reaffirmed the role such activity can play in establishing a valued, male identity allowing men to be 'blokes together' in positive and therapeutic (rather than negative or hegemonic) ways. Almost identical findings emerged from Ormsby et al (2010) where "men's space" and male company in a hands-on environment was not only central to this valued identity but this, in turn could act as a cushion against the negative health impact of a range of losses older men face. Wilson and colleagues (2013), also in Australia, show how the action-oriented shed approach can also be effective in promoting mental health and wellbeing when used as intergenerational peer mentoring for older men and boys. A large part of this mutual benefit was deemed to have accrued from positive gendered (male) role-modelling and the development of mutual respect. Work in the UK (Mental Health Foundation, 2010) has recognised that engaging with this group requires sensitivity to gender and hegemonic norms including; reaching out positively, using male imagery and language (avoiding terms such as 'mental health') and using action and solution focused approaches. This links with the work in the previous section on help-seeking that showed how aspects of masculinity are important in effective gender-sensitive engagement with men.

### **SUMMARY (DIVERSITY):**

Endorsement of traditional masculinity, the pressure to live up to hegemonic standards and particularly the requirement for emotional suppression, is linked to higher depressive symptoms in minority ethnic men and gay men. Such emotional suppression (or being emotionally restricted) seems to heighten the negative impact of discrimination leaving minority ethnic men and gay men who are limited in their ability to be emotionally expressive more prone to depression. Emotional suppression is most likely linked to not wanting to appear weak for ethnic minority men (who are culturally represented as 'strong') and to fear of the consequences of 'coming out' for gay men. The impact of discrimination seems to be reduced, or limited, for minority ethnic men when they can draw on positive cultural beliefs and for gay men who have higher self-esteem; both of which help create a greater repertoire of available coping mechanisms. Other elements of masculinity, particularly 'winning', were associated with lower levels of depressive symptoms for some minority ethnic men possibly because it is an indicator of an ability to self-regulate negative thoughts and find ways to adjust to stressful life events. There is strong evidence that, for older men, being socially engaged, including being physically active (with grandchildren, groups of peers, through intergenerational mentoring etc) is key to promoting wellbeing through the maintenance of a valued (male) identity as men move away from a 'work based' identity. Evidence suggests that the effects of age, racial, and sexual discrimination work synergistically in their negative impact on mental health for men.

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## **FATHERING, MASCULINITY AND MENTAL WELLBEING:**

Twelve studies looked at fatherhood (Bennett & Cooke 2012; Bronte-Tinkew et al. 2010; Casselman et al. 2014; Davis et al. 2009; Finn & Henwood 2009; Foli & Gibson 2011; Foli et al. 2013; Ford et al. 2008; Foster et al. 2007; Giallo et al. 2013; Premberg et al. 2008).

### **EXPECTATIONS OF FATHERHOOD:**

A study of men's talk of becoming first-time fathers (Finn & Henwood, 2009) found that identification as a modern father enabled men in the study to dissociate themselves from patriarchal tradition and its perceived malfunctions, putting aside a masculine bravado as inappropriate and redundant.

### **POSTNATAL AND POST-ADOPTION DEPRESSION:**

Bennett and Cooke (2012) studied the male experience of postnatal depression in seven men. They found that "surviving postnatal depression" was a dynamic process, moving from "out of control" through to "the road to recovery", and the experience involved significant distress, with both positive and negative effects on their relationship. For some men there was a sense of vulnerability and emotional drain, but all men developed an increased understanding and gained personal insight into themselves, their partner and people in general.

### **FATHERHOOD IN THE FIRST YEAR:**

Three studies looked at fathering in the first year (Premberg et al. 2008, Giallo et al. 2013, Davis et al. 2011). A qualitative phenomenological study (Premberg) found that major constituents of the first year as father were "to be overwhelmed", "to master the new situation" and "to get a new completeness in life". Fathers attending an early parenting service were found to be experiencing some psychological distress (Giallo) although this is not surprising as the service was for those with early parenting difficulties. Poor physical health severity of child's sleep disruption, low socio-economic position and poor self-care were associated with high distress. Another study (Davis) found that depressed fathers were nearly 4 times more likely to report spanking and less than half as likely to report consistently reading to their 1 year old children. Two studies by Foli et al. looked at depression in

adoptive fathers. One of them (Foli and Gibson 2011) reported gender differences in depressive symptoms: fathers who experienced post-adoption depression were perceived as more likely to become disengaged from the family and more likely to display anger and frustration rather than sadness or melancholy.

### **PARENTING AND ATTACHMENT:**

An unusual study (Ford et al, 2008) which sought to evaluate fathers' differentiation and identity status as predictors of their attachment to their children using structural equation modelling, found that attachment theory (which was originally intended to study the relationship between mothers and children) may not be broad enough to accurately model the father-child dyad. A large survey of 2139 resident fathers (Bronte-Tinkew et al, 2010) found that paternal aggravation and stress in parenting is significantly associated with lower levels of father engagement and with less supportive coparenting relationships. Findings also indicated a more negative association between paternal aggravation and stress in parenting and father engagement and co-parenting for fathers with household incomes below the poverty threshold, suggesting that policies aimed at decreasing parenting stress may be especially beneficial for fathers living in poor families.

### **EFFECTS ON SONS:**

One study (Foster et al, 2007) examined fathers' daily parenting hassles and coping strategies to determine their association with fathers' emotional expressiveness and predict their sons' development of socioemotional competence. Parenting hassles were associated with less rational, more emotional and more avoidance coping as well as negative emotional expressiveness. Fathers' negative expressiveness was predictive of their sons being rated as more aggressive and disruptive by their teachers. Another study (Casselman & Rosenbaum 2014) developed and tested a path model that examined the purported relationships between college males' perceptions of their fathers' rejection and traditional masculine ideology endorsement, and their own self-reported aggression. The results indicated that perceptions of their fathers as rejecting and hypermasculine predicted aggression in the final path model. There was also support for the mediating roles of the son's traditional masculine ideology endorsement, masculine gender role stress, self-esteem

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and anger. The authors suggested that males with hypermasculine fathers might be at risk for aggressive behaviour because they adopt hypermasculine beliefs that, in turn, could lead to higher levels of masculine gender role stress, anger and aggression. Perceptions of being rejected by their fathers was a stronger indicator for sons' aggression than was traditional masculine ideology endorsement.

### **SUMMARY (FATHERS):**

An identifiable group of men appear to be having difficulties adjusting to the challenges of the role of father and evidence indicates that significant numbers of fathers are experiencing post-paternal depression following the birth or adoption of their baby. The men experiencing post-paternal depression seem to be largely being missed in primary health care settings possibly because their distress is generally below the level required for referral to specialist mental health team. Depression and other psychological or socioeconomic difficulties in the early years of parenting seem to be associated with sub-optimal parenting practices (such as spanking) and lower levels of engagement (although as one study points out, fathers may be misrepresented by attachment theory which was originally developed to study the relationship between mother and child). We found two studies which specifically looked at the effects of fathers' behaviour and beliefs on their sons. Aggression in sons was associated with negative expressiveness from their fathers (in one study) and with perceptions of their fathers as rejecting and as hypermasculine (in the other study). It seems clear that early intervention to support new fathers who may be experiencing difficulty coping could potentially have positive effects on the mental health of both generations.

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## BODY IMAGE

This section reviews evidence from eight research studies on body image incorporating work on the 'drive for muscularity' (Calzo et al. 2013; Dakanalis et al. 2012; Hunt et al. 2013; Kimmel & Mahalik 2004; Martin & Govender 2011; Mussap 2008; Shepherd & Rickard 2012; Tiggeman et al. 2008). As they have a diagnosis classification, eating disorders were not included unless the research was linked to wider aspects of gender/masculinity and body image.

Evidence from research in Australia with college men (Hunt et al, 2013), demonstrates how threats to masculinity reduced confidence in physical ability and in perceptions of muscularity compared to men who experienced affirmation of their masculinity. A further study reported in the same paper provided evidence that men reported lower appearance anxiety and drive for muscularity when their masculinity was threatened than when their masculinity was affirmed suggesting men may be motivated to deny appearance concerns following threats to their masculinity.

Psychological research from the US with college men (Kimmel & Mahalik, 2004) shows that masculine body distress is significantly linked to conformity to masculine norms; particularly norms of 'being a winner' but also to norms of 'pursuing status', 'primacy of work', 'being a playboy' and 'distaining homosexuality'. This is complemented by other US work with college men (Shepherd & Rickard, 2012) which provides evidence that male gender role conflict is significantly correlated to the drive for muscularity. Work from South Africa looking at boys aged 15-19yrs (Martin & Govender, 2011) further confirms this significant correlation between traditional masculinity norms, the pursuit of muscularity and body image discrepancy. Furthermore, within this study there was evidence that Indian boys experienced greater body image discrepancy than their Black and White counterparts. Research with men in Australia aged 18-40yrs (Mussap, 2008) again affirms this link showing that greater male gender role stress is significantly related to the drive for muscularity, and, to a lesser extent, to the drive for thinness and to disordered eating symptoms. They further suggest that this concern with, and pursuit of, muscularity and leanness is particularly strong for men who deviate from norms of 'feeling effective' and of 'controlling and accessing emotions'.

Broader work considering men's body image and dissatisfaction was completed in Australia with men aged 18-40yrs (Tiggemann et al, 2008). This work moved beyond issues of muscularity and showed that men were most worried about weight, penis size and height. Concern with these, along with muscularity, were related to lower appearance self-esteem (whereas head hair and body hair were not). Research from the US with University men aged 16-30yrs demonstrated that 'body checking behaviours' (which measures global muscle checking, chest and shoulder checking, comparative checking with others and body testing to assess size and shape) were positively correlated with; weight and shape concern, symptoms of muscle dysmorphia, depression, negative affect and use of performance enhancing drugs. Neither of these studies incorporated measures of or comment on gender/masculinity though.

There are some specific issues when looking at the intersection between gender/masculinity and sexuality. Research from the US (Calzo et al, 2013) shows that boys and young men (ages 9-25yrs) who self-reported as fully or mostly gay or bisexual (labelled as the 'sexual minority group') were less likely to report weight gain attempts than those self-reporting as 'fully heterosexual'. However, this sexual minority group experienced greater increases in weight and body shape concern with increasing age than did the heterosexual males. Work from Italy (Dakanalis et al, 2012) possibly provides some explanation for this in outlining how gay men scored significantly higher on measures of depression, eating disorders and body surveillance and this correlated more closely to exposure to sexually objectifying media for the gay men than for the heterosexual men in the study.

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## **SUMMARY:**

Evidence of the relationship between gender/masculinity and body image is complicated. There is fairly robust evidence that conforming to masculine norms and fear of not meeting these standards is linked to body image discrepancy/distress and to the drive for muscularity. Further, there is limited evidence that the elements of masculinity relating to 'being a winner', to 'feeling effective' and to 'controlling and accessing emotions' are perhaps those most linked to this body image distress and the pursuit of muscularity. However, sexuality also plays a role with gay men having higher reported rates of body image concern and bodily surveillance and were more influenced by sexually objectifying media than heterosexual men.

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# DISCUSSION

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This review was undertaken with the overarching aim of gathering evidence on how masculinity, 'being male', relates to and has relevance for mental health promotion, early intervention and stigma. Given how frequently the link between masculinity and poor mental health is espoused in academic, professional and media literature it was surprising how little good quality empirical work the review uncovered. This summary discussion highlights the key areas where evidence is present and provides thoughts on what this means for The Movember Foundation's approach to mental health (including suggesting some areas where knowledge gaps remain).

The strongest evidence available relates to the elements of masculinity that seem to be most influential in restricting or facilitating mental health help-seeking and in suicide, suicide attempts and suicidal ideation. Several psychological studies from North America showed significant correlations between overall adherence to traditional gender role norms and poorer mental health help-seeking (both formal and informal), higher levels of mental health stigma and suicide attempts. No studies were found that contradicted this finding. Conformity to these norms, and/or fearing not meeting these standards, is also linked to body image discrepancy/distress and to the drive for muscularity.

On closer examination of the different elements of masculine norms, there was strong evidence that those elements related to 'restrictive emotionality' (difficulty and fear about expressing feelings) are those most linked to negative mental health help-seeking, endorsement of mental health stigma and suicidality. There was slightly weaker evidence that elements relating to 'restrictive affectionate behaviour' (demonstrating affection), 'pursuit of status' and 'success, power and competition' were linked to reduced preventative self-care and negative mental health help-seeking. Elements of 'being a winner', 'feeling effective' and 'controlling and accessing emotions' were those most linked to body image distress and the pursuit of muscularity. However, this evidence was also slightly contradictory as the latter was also shown to be a protective factor for suicidality in one study. There is moderate evidence that other norms, particularly 'controlling emotions', 'winning' and 'primacy of work', were related to greater preventative self-care

and avoidance of poor (maladaptive) coping strategies (e.g. anger, aggression and substance misuse). This evidence from North American psychological studies was reinforced by qualitative work from across the five main countries of interest. All these studies showed that hegemonic discourses and practices of masculinity remain pervasive and powerful in relation to mental health. Certain aspects, particularly emotional repression, were strongly implicated in both the generation of mental health problems (the strain of living up to and/or being unable to live up to societal expectations) and with difficulties in dealing with stressful life situations when they arise. Fear of being seen as weak or vulnerable, and the stigma and possible loss of status associated with this, was particularly influential in restricting formal and informal help-seeking. These same components were also said to be indicators of suicidal thoughts or actions in the majority of these studies. However, like the psychological studies, all these studies also recognised that certain aspects of hegemonic masculinity were also drawn on in positive ways. The importance of work, and the desire to succeed, were highlighted as driving factors that could give life meaning. Likewise, inner-strength, control, responsibility and even stoicism, were recognised as important for dealing with a range of difficult social circumstances (e.g. the isolation of rurality, bereavement) and in dealing with, and recovery from, minor mental health issues such as depression.

There is moderate evidence that poor coping strategies are significantly linked to suicidal thoughts in men (but not women) and that self-reporting mental health symptoms is a greater predictor of suicide completion for men (than for women). This evidence further implies a situation where mental health concerns are hidden, repressed, by men more so than by women, until they reach a level where it becomes too difficult to contain them.

There is moderate evidence from studies with fathers' and grand-fathers that the ability to be emotionally expressive affects, and is affected by, social engagement with these close relatives and influences not only the men's mental wellbeing but also that of the children/grand-children.

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## DISCUSSION POINT 1

It is possible that there may be a ‘tipping point’ for men in relation to the timing of choosing to take action about life stress or mental health concerns and the type of action this might be. For those men able to be emotionally open, this action point may come quite soon and may take the shape of positive strategies such as informal or formal help-seeking. For those men not able to be so emotionally open, this action point may come much later or may more likely take the shape of ‘emotional masking’ and negative coping strategies – aggression, substance misuse, and, at its extreme, suicide. However, for both these groups, the need to take action could safely occur later if they have high levels of self-efficacy (i.e. they have high ability to achieving desired outcomes by controlling a situation or by having the confidence, skills or resources to adjust to meet challenges). From this we tentatively suggest the following model highlighting those groups of men with greatest mental health vulnerability:

This model is tentative and requires more work to garner evidence about its validity. It currently lacks the inclusion of social context influences and is therefore rather ‘intrapsychic’ in nature; this more external aspect requires further development. Nevertheless, we feel it has sufficient merit at this point in time to help guide the nature of different types of approaches and interventions that might be established for different men. We consider this further in discussion point 2.

**Figure 1: Men and Mental health vulnerability**

	EMOTIONALLY OPEN	EMOTIONALLY CLOSED
HIGH SELF-EFFICIACY	<b>HO</b> (LOW VULNERABILITY)	<b>HC</b> (MODERATE VULNERABILITY)
LOW SELF-EFFICIACY	<b>LO</b> (MODERATE VULNERABILITY)	<b>LC</b> (HIGH VULNERABILITY)

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There is moderate evidence that the influence of masculinity elements, particularly the negative role of emotional repression, holds across ethnic groups of men and for gay men – though research here is limited, mechanisms may be different for these two groups and this should be an area for future work. Current evidence further suggests that experiences of personal and structural discrimination (racism, homophobia etc), that can come from being an ethnic minority male or a gay man, may magnify the negative impact of these elements. In line with our suggested model above, we postulate that this may be because of the negative impact that such discrimination and associated subordination and marginalisation can have on self-efficacy and self-esteem. There is also evidence that fear of disclosure of vulnerability or mental health concerns (and therefore the need to repress emotions) was greater in certain contexts, particularly amongst communities of men where hegemonic norms are more closely observed and ‘policed’ - such as in prisons or in military contexts (Older work also suggests school yards as another site where gender is closely ‘policed’). More research needs to be done to identify 1) how some men cope with disclosing vulnerability/mental health concerns in such contexts and 2) which other contexts are similar in their influence (for example, is it similar in both the construction industry and in finance, both male dominated, if not then why not; what makes for this difference)

The review has also provided interesting insights into the role that masculinity/gender can play in mental health interventions for men (though this was not its main focus). There is moderate to strong evidence that utilising ‘male’ approaches, using ‘male’ language, and especially avoiding ‘feminised’ language, is more likely to facilitate initial engagement for men with formal services. Examples of this were using ‘coaching’ rather than ‘therapy’ (Hammer & Vogel 2010) and ‘personalised feedback’ rather than ‘psychotherapy’ alongside using ‘regaining control’ rather than ‘help-seeking’ (Syzdek et al 2014) and using football metaphor rather than mental health terms in counselling work with men with minor depression

(Spandler et al 2014) . This careful use of language and approach seems particularly important for men who hold traditional masculine views. There is moderate to strong evidence that presenting help-seeking as a strength, and viewing men as a positive asset within formal services, can secure more engaged and sustained involvement. There is moderate evidence that action-oriented approaches may have appeal for particular groups of men and that this is related to the positive influence of interactions with other men. Online interventions with an action-orientation seemed to fit with aspects of male identity for young men and the hands-on ‘shed’ approach seemed key to many older men in helping them (re)gain a valued sense of male identity and in enjoying positive male company following retirement.

<sup>2</sup> This resonates with ‘on-the-ground’ feedback form projects in the UK such as ‘CALM’ who speak of the importance of using terms like ‘feeling shit’ rather than ‘being depressed’ as part of a more direct approach that men appreciate. Similar examples have also been found about the importance of language in a review of ‘what works’ in health promotion interventions with men Robertson et al (2013).

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## DISCUSSION POINT 2

The relationship of masculinity/gender to designing mental health interventions for men is highly important and needs to be approached with the right mix of enthusiasm and caution. It is apparent that utilising aspects of traditional masculinity – particularly using approaches and language that have a ‘male feel’ about them – can and does help initial engagement with men (though it can also act to exclude other men such as some gay men). In addition, recognising men as a positive resource, highlighting and working with the positive elements of masculinity that they endorse, and particularly incorporating interactive action elements, is also useful in developing trust, facilitating enjoyment and therefore in sustaining engagement (see also Robertson et al 2013). Taking a positive view of men is key to tackling the damaging aspects of masculinity, such as emotional repression, and building on the more positive aspects of control and responsibility and this requires those involved in such work to be reflexive about gender. Examples such as reconceptualising (reclaiming) help-seeking as a responsible and rational thing to do within programmes and encounters has been shown to legitimate talk and ‘opening up’ around emotional and psychosocial issues serving a dual purpose of challenging emotional suppression and building self-efficacy and sense of control (e.g. Tremblay & L’Heureux 2005). Likewise, examples of using peer mentoring, of passing on practical skills, or of developing men engaged in initiatives as future programme leaders, all similarly act to encourage the aspects of masculinity shown to have positive benefits and generally require men to become more verbally communicative and emotionally articulate. Finally, across a range of initiatives, an initial emphasis on an activity of interest to the particular group of men being engaged (building on something they enjoy and feel familiar and confident/competent with), without a focus on ‘talking’, often forms a crucial first step in generating the trust required to subsequently facilitate sharing (to move beyond emotional suppression) especially for marginalised groups of men (those from socioeconomically deprived locations, from certain ethnic groups, gay men etc) who often have negative experience of service engagement and concomitant loss of trust (e.g. Robertson et al 2013; Spandler et al 2014). The process here is one where

familiar and enjoyable activity with peers promotes a sense of camaraderie and engenders a sense of safety which facilitates both self-efficacy and a subsequent ability to feel secure about sharing.

However, as we have pointed out elsewhere (Robinson & Robertson, 2010), care needs to be taken that whilst utilising positive elements of masculinity that more damaging elements are not inadvertently condoned and/or replicated. For example, Spandler et al (2014) have shown how football based initiatives can act to replicate homophobia and to foster unhealthy forms of competitiveness. Fleming et al (2014) show how a sexual health programme for men, ‘Man-Up Monday’, acted to replicate harmful aspects of masculinity and create inadvertent public health problems. Similarly, Smith & Robertson (2008) and Robinson & Robertson (2010) suggest that programmes like the ‘pit stop’ campaign can act to foster mechanical views of men’s bodies undermining the importance of mental wellbeing and campaigns using sexual imagery to engage men might legitimate the objectification of women and thereby add to wider public health problems. Nevertheless, evaluation across several large sports based men’s health promotion interventions has highlighted this challenge but has also indicated that achieving the right approach is possible (Robertson et al 2013). We suggest this is best achieved when interventions are highly cognisant and reflexive about the elements of gender/masculinity that are at play in the design of an intervention and explicitly monitor this when the intervention is implemented. Too many interventions currently fail to consider masculinity/gender in the design of projects or take a simplistic view that drawing on masculinity (without defining which aspects) is automatically effective and positive and thus fail to consider the wider impact. As part of this reflexive process we suggest that self-reflection on the part of those involved, and training around gender-sensitive work with men, should be a key element of future mental health intervention design.

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## KEY FINDINGS

- There is strong evidence across psychological and qualitative studies for a significant relationship between overall adherence to traditional (hegemonic) masculinity and poorer mental health help-seeking, higher levels of mental health stigma, suicide attempts and body image discrepancy/distress
- There is strong evidence that ‘restrictive emotionality’, emotional repression, is the element of masculinity most linked to negative mental health help-seeking, endorsement of mental health stigma and suicidality
- There is moderate evidence that elements of ‘being a winner’, ‘feeling effective’ and ‘controlling and accessing emotions’ are those most linked to body image distress
- There is moderate evidence that the negative influence of emotional repression holds, and could be more significant still, amongst different ethnic groups of men and gay men and could be linked to poorer coping strategies as ways of ‘surviving’ difficult social contexts
- There is moderate to strong evidence that these negative elements, and their impact on mental health, may be amplified in contexts where hegemonic norms are more closely observed and ‘policed’ (e.g. prisons or military contexts)
- There is moderate to strong evidence that giving importance to work and having the ability to exert control, to be stoic, may be linked to more preventative self-care behaviours and coping more positively with stressful life events (avoiding maladaptive coping strategies such as anger and substance misuse)
- There is moderate evidence that alternative cultures and communities (ethnic cultures, gay communities) for some groups of men may provide protective elements in relation to experiencing and dealing with stressful life events or mental health problems
- There is strong evidence that social engagement promotes/maintains mental wellbeing in older men through creating a valued male identity
- There is moderate evidence from studies with fathers’ and grand-fathers that the ability to be emotionally expressive affects, and is affected by, social engagement with these close relatives and influences not only the men’s mental wellbeing but also that of the children/grand-children.
- There is moderate evidence that conforming to traditional masculine norms, or fear of not meeting these standards, is linked to body image discrepancy/distress
- There is moderate evidence that poor coping strategies are more linked to suicidal thoughts in men and that self-reporting mental health symptoms is a more likely predictor of suicide completion for men (because such self-reporting implies a high level of distress)
- There is moderate to strong evidence that utilising gender-sensitive language, especially avoiding ‘feminised’ language, is more likely to facilitate initial engagement for men with formal services. This was particularly the case for men who held traditional masculine norm views
- There is moderate to strong evidence that presenting help-seeking as a strength, and viewing men as a positive asset within formal services can secure more engaged and sustained involvement
- There is moderate evidence that action-oriented approaches, particularly that involve groups of men engaged in traditionally male activities, may have specific appeal for men

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## LIMITATIONS

As this was not a full systematic review, due to time and budget constraints, the included studies have not been assessed for methodological quality, nor has a detailed formal data extraction process taken place. The literature searches took place in two stages, with supplemental searches being performed in areas that had already been identified as key from the first search. We were unable to obtain 62 papers which may have been of interest. All these issues may lead to bias in that the sample of papers included in the review as it is not fully representative of all those that have been published in this very broad topic area.

The original scope asked for information on indices of remoteness, and on differences between countries, but we did not find much information on the former, and did not pick up any consistent differences in the latter.

Not enough on masculinity/gender and coping strategies. From prior knowledge, it is likely that there is a great deal of information on the relationships between masculinity/gender, mental health and coping strategies (such as drinking, violent behaviour etc). The search terms required to consider such relationships would be significant.

Not enough on health professionals' perceptions of masculinity/gender and the impact/influence of this. There could/should be an additional review of work in this area that could shed light on 1) the impact of the two way relationship of gender perceptions within the professional/client mental health encounter 2) how positive professional perceptions of men can benefit mental health interventions.

There is more that could be done on emotional expressivity and mental health outcomes in children/grandchildren and we have not done anything specific here on emotionally expressivity and relationship disharmony/abuse etc – these would require different searches though but would be interesting as they take the concern with the importance of the influence of 'masculinity' beyond the impact on just the men's mental health.

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# CONCLUSIONS

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There is an existing evidence base that confirms the assertion that 'being male' (masculinity) should be a key consideration in understanding mental health outcomes and in shaping approaches to improving the mental health and wellbeing of men.

Pressure to conform to hegemonic male norms does have a negative impact on men's mental health help-seeking and outcomes. Specifically, difficulties with experiencing and expressing emotions seems to play a particularly negative role for men in seeking help for mental health concerns, in experiencing or expressing stigma about mental health concerns, in maladaptive coping strategies to stressful events and in suicidal ideation, attempt and completion. Difficulties in being emotionally expressive also negatively impact the mental wellbeing of those closest to men, particularly their children/grandchildren. However, other elements of 'hegemonic' or 'traditional' masculinity - specifically giving importance to work, 'winning', control and responsibility - act as positive drivers for mental health help-seeking, for positive coping strategies and as protective factors against suicidality. Both these negative and positive gender/masculinity elements interact with other psychological elements, particularly self-esteem, in being generative of mental health help-seeking, stigma and outcomes and more work needs to be completed on these relationships. Furthermore, how all these elements are connected to men's wider social contexts in influencing mental wellbeing is also an area of work that is currently under-developed.

The influence of these elements seems to hold across sub-groups of males; certainly in terms of ethnicity and sexuality. However, other factors come into play. The negative role of emotional suppression seems to be exacerbated by experiences of (or fear of) discrimination in creating negative mental health outcomes for both minority ethnic men and gay men. But, being able to draw on positive cultural beliefs, or having positive community support, can help bolster positive identities, facilitating a wider range of coping mechanisms and thereby helping promote mental wellbeing for these two groups of men.

There is some evidence that being cognisant of gender/masculinity in developing and delivering services – particularly paying attention to language and having a positive view of and approach to men - can improve both initial engagement and likelihood of sustaining engagement. However, more work needs to be done in this area to explore how drawing on elements of masculinity in service development can best be used in positive ways that do not also act to replicate more damaging elements. We did not uncover sufficient information to show whether positive and negative outcomes vary with modality of delivery.

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# APPENDIX 1

## BIBLIOGRAPHY OF INCLUDED STUDIES BY STUDY FOCUS

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# APPENDIX 2

## LIST OF EXCLUDED OR UNOBTAINABLE STUDIES

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