ABSTRACT (173 words)

In line with the shift towards prioritising lay accounts and narratives of chronic illness in sociology, there is an emerging literature on men, their subjectivities and experiences of mental distress. We argue in this paper that subjectivities and distress among men are an important area for critical sociological research. Very little is known about mens' subjectivities or the meanings they give to – and how they cope with or seek help for – distress. At the same time, current theories of gender relations, performativity and wellbeing as they pertain to men are likely to shed further light on subjectivity and distress. However, current theories (and qualitative research involving men and women) are pointing to considerable complexity. In this paper, we outline what is known about distress and men, and consider the utility of gender relations, performativity, subjectivities and wellbeing for better understanding distress. We also ask: What else influences distress, and how should these be considered in relation to men and masculinities? What are the implications for research and policy?

Disorder and distress

On the surface, men have better mental health than women in Britain, yet there are variations according to socio-economic category (SEC), as well as complications associated with gender relations. Mental disorders involve clusters of symptoms officially recognised as diagnoses by psychiatric classification systems, and around one in six British adults are thought to have a common mental disorder (e.g. depressive episode, anxiety) (Jenkins et al. 2003). In 2007, 12.5% of men compared to 19.7% of women were assessed by trained interviewers (using the Clinical Interview Schedule) as having a 'common mental disorder' in the Adult Psychiatric Morbidity Survey for England (McManus et al. 2009). However, men with the lowest household income had almost three times the rate of common mental disorders compared to men with the highest household income (23.5% vs. 8.8%) (McManus et al. 2009). And gender differences in common mental disorders virtually disappear in the lowest income group, with around one in four of both men and women affected. There is an argument put forward by some commentators that men may express their distress (like stress, anxiety, anger, and low mood) and disorders in ways that are different to women e.g. as anger directed at others (Branney and White 2008; Health & Consumer Protection Directorate-General 2004; Kantor 2007; Kilmartin 2005). Those who argue for atypical male distress and disorders point out that suicide rates for men in the UK are 3 times higher than those of women (ONS 2005). In the UK, men also account for around 2 out of 3 deaths related to alcohol (Office for National Statistics 2009). While commentators continue to argue about atypical categories for male distress and disorder (Branney and White 2008; Kilmartin 2005; Smith 2008), there is a complication: It is not clear the extent to which male behaviours – like alcohol use – relate to distress and/or the way men come up against gender relations and feel the need to perform as men (e.g. risk taking). In this paper we discuss gender relations, performativity, subjectivity and wellbeing as key concepts that will better elucidate distress, men and coping. We also outline likely future directions in scholarship, research and policy in this area.

Masculinities and performativity

Critical approaches to men's health have often emerged from feminist critiques which point to the socially constructed nature of gender, while challenging hegemonic masculinity and gendered power relations (Lohan 2007). Feminists generally agree that men are privileged through being linked with valued characteristics like reasoned action and good health, while women are devalued through connections with attributes like illness and intuition (i.e. they are

less reasonable) (Annandale and Clark 1996). Further, feminists and other scholars (e.g. queer theorists[1], sociologists) have shown that real life is much more complex than such dualistic conceptions (e.g. masculine/feminine, sex/gender) would suggest (Peterson 2009). Two key theories for understanding gender emerged to highlight this complexity in recent decades: i). gender as performance, and ii). the construction of multiple masculinities. In terms of performance, since the 1970s, ethnomethodologists have explored how gender is achieved through action and interaction (Brickell 2005). West and Zimmerman (1987) drew on these theories to suggest that gender is a 'routine, methodical and recurring accomplishment', and that gender is something that men and women 'do' rather than an attribute they possess. Subsequently, the concept of gender as repetitive acts that establish an apparently coherent and stable 'core' gender identity was elaborated by Butler (1990). Subsequently, much academic and research attention turned towards how men and women 'perform' as gendered subjects.

Secondly, a theory of plural and hierarchically arranged 'masculinities' was developed out of Australian research in the 1980s (Connell 1995). Here again, gender was considered dynamic and enacted by men in various arenas of social life (e.g. sports, corporations). Thus, different kinds of masculinities were thought to emerge locally, constructed through everyday practices and relationships. Additionally, different masculinities competed for power and normative status (Connell and Messerschmidt 2005), and the masculinity that dominated as the current 'most honoured way of being a man' (pg. 832) in any local situation was termed 'hegemonic'. Hegemonic masculinities were viewed socially as the natural state of masculinity, and men enacting masculinities not coherent with dominant constructions of hetero-normative masculinity risked being singled out for contempt and marginalisation. But men in general struggle to live up to hegemonic ideals (Courtenay 2000; Moller-Leimkuhler 2002). An implication of this system of competing and evolving hegemonic/non-hegemonic masculinities was that gender could now be seen as an inherently relational social system, rather than about individual traits. There were also consequences of the proliferation of masculinities. For instance, for men trying to emulate hegemonic ideals, the social risks could include poor social relationships and higher levels of substance abuse (Courtenay 2000). Choosing (or feeling obliged) to adopt a marginalised masculinity in any particular context also had consequences. For instance, studies illuminated the way social pressures associated with the marginalisation of male homosexuality (e.g. stigma, violence, discrimination)

contributed to distress and disorders (Allen and Oleson 1999; Diaz et al. 2001; Meyer 1995; Plummer 1999; Warner et al. 2004; Williamson 2000).

Both performativity and hegemonic masculinities emphasise how masculinity is produced in everyday social life. Here, the focus is on individual agency, variations in performances, social relations and the role of local circumstances in the way men and women enact gender (Seale and Charteris-Black 2008). Thus, in practice, there may well be much variation within – and not just between – men. This understanding of gender as diverse and produced in practice is contrasted with the binary notion of men/women that feminists have deconstructed over past decades (Annandale and Clark 1996), as well as earlier approaches presupposing differences between – and homogeneity within – gender (e.g. recall gender role theory with its emphasis on norms of behaviour (Connell 1995)). This freeing up of our understanding of gender has become reflected in research. For example, binge drinking among young female high school students can be viewed as involving carefully pitched gendered transgressions in some contexts (e.g. risk taking, aggressiveness) traditionally associated with hegemonic masculinity (Sheehan and Ridge 2001). And men can apparently reject 'masculine' performances, identifying more with traditionally 'feminine' ways of being in the world (de Visser 2009; Seale 2006).

Subjectivity, masculinities and performance

Theorising and uses of Connell's theory of hegemonic masculinities proliferated over the decades, and the theory was challenged. While the wider critiques cannot be rehearsed here, one debate suggested that hegemonic masculinity tended to obscure the subject in favour of the social (Whitehead 2002). Connell and Messerschmidt (2005) challenge this, for example, pointing to the importance of psychoanalytical ideas about layered personalities that underpinned the original formulation of hegemonic masculinities. Writers like Jefferson (2002) argue that in practice (if not original intent), an 'oversocialized' view of male subjectivity emerged. Similarly, Roper (2005) notes that even though writers talk about political discourse opening up masculine subjectivity, they do not always demonstrate 'what that subjectivity might consist of' (pg. 58). He suggests focusing our gender analyses on the unconscious (e.g. using concepts from psychoanalysis), human relationships, a biographical perspective on the formation of identity and emotions, and an emphasis on early family relations 'as a crucible of subjectivity.' In a similar vein, Jefferson (2002) talks about the 'anxious biography' and unconscious life that is inevitable in becoming human. He points out

that early subjectivity may or may not be ordered by gender forces, depending on your theoretical perspective. For example, a Freudian perspective (Oedipal conflict) is obviously gendered, but a Kleinian (pre-Oedipal conflict) perspective does not rely on gender in theorising early subjectivity. Thus, while researchers like Riska and Ettorre (1999) argue that gender is firmly embedded in subjectivity, moods and distress, the role of gender in subjectivity may be more complicated than previously thought.

Performativity theory has begun to incorporate affect, subjectivities and social relations in complex ways also. Boys coming into contact with performances of masculinities and hegemony through schooling can find the experience conflicting, frustrating, traumatic and distressing (Keddie 2006). Here, performativity links affect, relations and social institutions in complex ways. Sara Ahmed (2004a) takes this much further, and argues that emotions are integral to performativity including mediating 'the relationship between the psychic and the social, and between the individual and collective'. For Ahmed, emotions are powerfully performative: 'in reading the other as being disgusting, for example, the subject is filled up with disgust, as a sign of the truth of the reading' (Ahmed 2004b). Ahmed moves away from a focus on the interiority of emotions to examine affect in terms of 'signs' and how signs become 'sticky with affect', working on - as well as in relation to - bodies. On the subject of embodiment and emotions, other researchers have argued that the male body is more than representational: It is also material, and subjectivity – including affect – emerges *from* the body (Robertson et al. 2010). Mellstrom (2004) has also incorporated affect into embodiment, examining the emotional relationship between men and machines, and how machines can become a symbol as well as a felt extension of the body. That is, the material body as well as objects play an important role in forming emotions and subjectivities. Social relations and circumstances are also important in performativity. In the area of telework[2], research by Marsh and Musson (2008) shows how men working from home may adopt emotional expressiveness and discourses usually ascribed to women, including talk about unconditional love and commitment. Following Hochschild (2003), Emslie and colleagues (2009) show that in the area of spousal support following colorectal cancer, men engage in emotional work[3] that involves the full spectrum from suppressing to displaying emotions. Seale and Charteris-Black (2008) – analysing qualitative data from the DIPEx research group on patient experience – found that higher SEC (socio-economic category) men were more comfortable in displaying diversity in their expression of feelings than lower SEC men, for instance revealing a more 'feminine' language for feelings. While higher SEC men revealed greater

variability in 'masculine' performances, they were still apparently working within a framework of exercising male power. On the other hand, lower SEC men were more restrained in their performances, and more comfortable with discussing their anger. Taken together, the above research points not only to the ways in which bodies, performances and structural issues might shape and produce subjectivities, but also to the complex ways in which gender relations play out according to circumstances.

Wellbeing and men

Wellbeing is a concept used increasingly across a range of disciplines and has implications for expanding how we consider mens' subjectivities. However, the term is used in diverse and conflicting ways to conceive of subjectivity and the social, and it currently lacks conceptual clarity (Hanlon and Carlisle 2008). In popular media discourse, whereas wellbeing was previously used to describe the 'body politic', by the mid-1980s the move was towards identifying and pursuing valued individual attributes through personal practices (Sointu 2005). According to Sointu, constructs of subjectivity have since changed, with an increasing emphasis on choice, consumption and 'self-mastery.' One outcome is the shift in emphasis from physical health towards new forms of subjectivity and social citizenship. In psychology, there is a division between writers who construct wellbeing as essentially about happiness, and those who see the term as involving more complex constructs like personal growth, acceptance, authenticity and life purpose (Carlisle et al. 2009). The sociology of wellbeing is exploring the link between the individual and the collective (de Chavez et al. 2005). Research here is showing up complex lay understandings of wellbeing, including individualism, managing emotions, sense of personal responsibility and agency (Sointu 2006). At the same time, writers are attempting to re-connect the concept of wellbeing to the social. For instance, Carlisle and Hanlon (2007) link wellbeing to the environmental debate as a counter-balance to dominant Western discourses of individualism. There are resonances here in the discourses about wellbeing and male subjectivities. According to Riska and Ettorre (1999), men struggle with dualistic subjectivities. Men feel subjected to external pressures (e.g. work) with the body instrumental in interfacing with the world and achieving masculine status. However, men are also encouraged to construct a largely autonomous self that is 'in control' (even to the point of avoiding help during a known medical emergency according to research by Charmaz (1999)). Thus, men experience themselves in conflict: both as having choices as well as being constrained by their social circumstances. While subjectivities have hardly

begun to be explored in terms of masculinity and wellbeing, discourses in these fields already share a similar binary construction.

Men and emotional distress

There are few studies examining men and their distress. As if to reinforce the gender binary construction of men (healthy) and women (unhealthy) discussed earlier, studies pertaining to emotional distress have tended to focus on women exclusively or predominately, or make only passing comment on the wider issues of gender and men**.** Indeed, the term 'gender' has become synonymous with 'women' in the mental health literature (Rogers and Pilgrim 2003). Only a small group of studies on emotional distress have studied both men and women. Consequently, it is difficult to make clear statements on the subject of men, gender and distress. Nevertheless there is some evidence emerging from the literature. One North American phone interview study (using establish indexes like the Center for Epidemiological Studies Depression Scale (CES-D)) found that while women *experience* emotional distress (e.g. sadness, anxiety) about 30 percent more often than men, alcohol and substance use may be masking distress among men (Mirowsky and Ross 1995). As well as differences in experiences of distress, studies also suggest that men and women can at times express their distress differently (Winkler et al. 2005). For example, one randomised self-administered questionnaire study among Catalonian students (14-19) found that young women facing chronic illness were more likely than healthy counterparts to *report* emotional problems and needing professional help for these problems, while no such differences in reports were found between chronically ill and healthy young men (Suris et al. 1996).

The little we know about men and distress mainly comes out of research with people who are facing chronic conditions like cancer or who have a mental health diagnosis like depression. Some research into cancer support groups (face-to-face and online) suggests that men prefer to share information while women prefer to give emotional and social support (Klemm et al. 2003; Seale et al. 2006). However, other research in the area of online cancer support has found similar emphases on information and support between the genders (Gooden and Winefield 2007). Nevertheless, subtle differences were found by Gooden and Winefield in language used. For example, while "women clearly expressed their emotions, men tended to imply emotion." While women focused on nurturing, men preferred to use battle metaphors in discussing cancer. Seale (2006) has also found that men may prioritise emotional communication on online breast cancer sites when discussing their partners, yet

they may be uneasy about transgressing concepts of traditional masculinity. In terms of depression, studies point to similarities in the experiences of distress among men and women (e.g. in feelings of isolation and difficulties finding the words to articulate distress) (Emslie et al. 2007; Ridge 2009). However, these studies also point to apparent differences in the experiences of men and women. In an Australian study, Brownhill and colleagues (2005) showed that while men and women (who identify as having been 'down in the dumps') can process their distress in similar ways (e.g. using distraction, avoid thinking about problems), men in particular reported managing their distress differently, including avoiding their distress (e.g. numbing, escapist and avoidant behaviour) until a later 'build up' of distress and externalisation (e.g. aggression towards self and others, suicide attempts). These findings point to potentially delayed presentations of distress/depression in men compared to women. However, the study relied on a convenience sample of teachers and students, and it is not clear how the findings would hold up in a more varied sample of participants. In a Swedish study that compared a small number of narratives of men and women with a diagnosis of depression, Danielsson and Johansson (2005) found that women had a greater vocabulary for expressing feelings, thus articulating their distress more so than men. On the other hand, men talked more about holding back discussions of emotional distress while being more likely to express their aggression. Women were also more focused internally with feelings of self-blame and guilt, while men talked more about external factors that had suddenly struck them down (Danielsson et al. 2009).

Help-seeking for distress:

The dominant narrative about masculinity in the literature is that men are more reluctant to seek help than women, regardless of their health concern. There is likewise, in the mental health literature, a strong narrative that men are resistant to help-seeking for their distress (Moller-Leimkuhler 2002). However, more recent papers are showing that the links between gender and help-seeking are more complex than once thought. Biddle and colleagues (2007) point to interpretive complexity in help seeking. They found that their young participants of both genders (16 to 24 years) undertook a process of 'lay diagnosis' in attempting to make meaning out of their distress. This process included negotiating stigma as well as accommodating, normalising and denying problems, even to the point of crisis (e.g. self-harm). Here, lay diagnosis was important in assigning 'realness' to distress and thus the need for help, if any. And help-seeking itself could influence the level of 'realness' attributed to distress. An 'unexpected' finding in research by MacLean et al. (2009) with Scottish young

people (aged 10 to 15) was that both boys and girls felt under at least some pressure to underplay health symptoms, especially to peers. Both boys and girls perceived negative consequences for demonstrating psychological symptoms, although the consequences for boys were described as more severe. Hunt and colleagues (2009) found that while there is little research comparing consultation rates for men and women experiencing the same conditions, both men and women may understand help-seeking for health as 'a last resort'. Additionally, some men are not particularly reluctant to seek help, and there are circumstances in which men will readily use health services. For example, O'Brien and colleagues (2005) found that fire-fighters in their study constructed their gender identity around having a fit body in order to work effectively. Therefore, they perceived help-seeking as a way of preserving masculinity, rather than as a threat to masculinity. Additionally, those men who are prepared to challenge the tenets of hegemonic masculinity may choose to explore their emotional vulnerability with the help of professionals (Emslie et al. 2006). However, there is some research in the UK that suggests that compared to women, men have a higher threshold for distress before they seek help, and women are more likely to seek help from family and friends than men are (Riska and Ettorre 1999). In other research, while respondents of both genders were hesitant to tell their doctors they were not coping, men were especially reluctant to do so (Rogers et al. 2001). Men (particularly those most influenced by hegemonic ideals) may fear exposing their emotional vulnerabilities by asking for help (O'Brien et al. 2005). And some groups of men (e.g. prisoners at risk of suicide or self-harm) may be particularly – but not uniformly – distrustful of health professionals and 'the system' (Howerton et al. 2007).

In terms of help-seeking, we also need to focus on relations between men, professionals and institutions. The way women are at times more able than men to express their distress to professionals may mean that they increase their chances of receiving a mental health diagnosis (Mirowsky and Ross 1995). Some men's relative inability to articulate their distress can also mean their emotional problems remain more hidden from professionals (Brownhill et al. 2005; Danielsson and Johansson 2005; Men's Health Forum Editorial Group 2006). It is also possible that professionals are not always successful in de-coding the language used by men to refer to their distress – distress which may be hidden or minimised (McQueen and Henwood 2002). And professionals may not look for emotional distress in men (Courtenay 2000; Moller-Leimkuhler 2002). For example, in the area of cancer treatment, there appears to be differences in the way doctors behave towards men and women, with relatively less

recognition of distress in men (Kiss and Meryn 2001). Indeed, performances of 'stoical masculinity' may well be encouraged by some doctors (Broom 2005), with some sociologists arguing that traditional masculinities are institutionalised in cancer care (Moynihan 2002). Even more than this, some commentators argue that psychiatric classifications systems like the *Diagnostic and Statistical Manual* lead professionals to bias in overlooking expressions of distress among men (e.g. with a focus on acting out like hostility, substance use, blaming others) in favour of female presentations (e.g. feelings of guilt and unworthiness) (Branney and White 2008; Kantor 2007; Madsen and Juhl 2007). Some sociologists argue that mental health classification thus reinforce social constructions of gender by diagnosing women and ignoring men (Clarke and van Amerom 2008). So the evidence here is that institutionalised health care can play a role in organising the expression of distress in ways that can keep male subjectivity concealed.

Finally, to add even more complexity to the issue of help-seeking, in recent times there has been increasing recognition that people can develop their own expertise to self-manage their health, sometimes without professional involvement. Fox (2002), for example, notes that health promoting behaviours have to engage at some level with multiple perspectives on health, hazards and living. In practice, any health advice is 'refracted through the lens of experience', and the priority given to health is determined by a complex play of meaning, self, embodiment and contexts (Fox and Ward 2006; Fox et al. 2005). Thus behaviours that some men might consider an unacceptable risk to health might be prized by other men as the very embodiment of masculinity (Ridge 2004). Thus, tensions between lay male and professional narratives about health, wellbeing and help-seeking are inevitable (Frank 1991; May et al. 2004). Men and women faced with the complexity of their own distress can have reasons for choosing to manage their problems in ways that do not match professional frameworks (McMullen and Herman 2009; Ridge 2009). Thus, useful explanations about the way men go about coping and seeking help for their distress need to acknowledge the operation of multiple meaning frameworks.

CONCLUSION

While little is known about personal experiences of mental disorder among men, even less is understood about male experiences of 'distress'. Despite the relative invisibility of men in mental health research to-date (Riska 2009), the research suggests that men have a rich subjective life which has been neglected, and they do experience distress – albeit they may

express their suffering in ways that are not always the same as women. Men may also process their distress in similar or different ways to women (e.g. self help or self medicating, allowing distress to build before blowing off steam). Nevertheless, despite the growing body of research shedding light on the subjectivities and distress of men, it seems fair to say that we still only have a one dimensional understanding. In addition, men may narrate their distress in ways which are hidden from view or difficult to interpret (White 2006). We also argued in this paper that social institutions (e.g. medicine) may encourage performances of stoical masculinity, rather than acknowledge distress in men.

Theory and distress

In terms of gender theory, we expect the focus will continue to be on performativity and relational aspects of gender. However, interesting revisions of hegemonic masculinities and gender performativity are underway which are likely to inform future work on men and distress. While previous research could be accused of obscuring the subject in favour of structural issues, the future agenda might be productively invested in exploring more deeply what the subjectivity of men actually looks and feels like, and how it is changing. Whether subjectivity is inherently gendered or not can be debated, but addressing the complexity of subjectivities and distress is now timely. Early life, the unconscious, biographies, relationships, discourses, performativity, affect, gender relations, material bodies, social contexts and constructions of wellbeing may all be important in understanding men, their subjectivities and distress. At first glance, this research agenda seems daunting, and we know relatively little. But there are already some interesting directions, such as the work by Ahmed on the way emotions are powerfully performative in mediating between the psychic and the social. And then there is the work by researchers like Seale and Charteris-Black and others pointing to the role of macro issues in shaping gendered performances. The links between wellbeing discourses and gender performativity also raises interesting questions. Wellbeing is obviously a contested discourse, but its focus on individual and collective dimensions may open up new ways of understanding subjectivities. Wellbeing discourses themselves have interesting parallels to constructions of masculinity, where both refer to individualism, agency, and collective strife. Certainly, men's constructive approaches to wellbeing are only just beginning to be recognised in the literature (Emslie et al. 2006), but must surely be integral to understanding distress. We cannot help concluding that studies into the subjectivities and distresses of men – like the concept of wellbeing itself – are likely to be contested and multifaceted.

Men have been constructed problematically as an homogeneous group by writers in the past e.g. masculinity as lethal or at least dangerous (Crawshaw 2009). Interestingly though, in the area of mental health, it is men who have been relatively invisible, and women have been problematised (Riska 2009). Not surprisingly then, how men experience their subjectivities, express and cope with distress – as well as the role of gender relations in their distress – has not received much attention from sociologists to-date. Where there is research, the tendency is to use the term 'gender' to mean 'women', or refer to men only in passing. The literature also focuses on specific mental health diagnoses like depression (especially for women), rather than examining the much wider issues of subjectivities, distress and wellbeing. As shown in this paper, this situation has begun to change in recent years with more attention paid to male subjectivities in various social contexts. An understanding of the complexities of emotions and distress among men is now emerging from qualitative research. Here, more rigid notions of 'women's emotional distress' or 'men's emotional distress' are being challenged by relational and performative theories of gender. Here, we seem to be moving toward a more nuanced understanding of subjectivity and distress. There are still though concerns in critical sociology about the way men and women are constructed as homogenous, as well as the potential for individualisation, medicalisation and subsequent surveillance of social life including masculinities and health (Crawshaw 2009; O'Brien et al. 2009). More critical approaches in sociology continue to question the notion of men as a unified group in need of specific health interventions. We share these concerns and believe that research into men, subjectivities and distress can be part of the critical sociology agenda. For instance, research into men and subjectivities could well end up highlighting men's agency and the way power distorts our understanding of men through discourse, perhaps challenging the focus on using specific interventions among men as a group (Peterson 2009).

Research and policy directions

Individual and institutional pressures on men to remain silent may contribute to the invisibility of male experiences of distress, compounding the difficulties that men have in finding the words for, publicly acknowledging, self-managing and seeking help for their distress. This situation also means that male distress could continue to be played out with institutional silence, contributing to the discourse that men do not need more support in this area. However, outcomes like higher suicide and substance abuse rates among men urge us to re-consider distress and gender constructions more closely. While there are a number of clues

about men's subjective experiences of distress as outlined in this paper, we do not yet have anything like an enlivened understanding of this important area of contemporary social life. The complexity here is likely to be considerable. Dimensions like the unconscious, early life experiences, life course, gender relations, performativity, sexuality, wellbeing, macro issues and institutional practices are all likely to make up male subjectivities and experiences (Arling 1987; Fenton and Sadiq-Sangster 1996; Murray et al. 2006; Warner et al. 2004).

Future research into distress and men could usefully focus on a number of areas. For example, fleshing out new understandings (and perhaps new forms) of subjectivity and men; better elucidating the intersection between performativity and subjectivities; further clarifying discourses and narratives of distress and wellbeing between men and women; beginning to explore how men engage with 'wellbeing' (and further challenging the 'men as deficient' narrative); research that takes into account the influence of bounded social circumstances as well as wider contexts and/or specific groups of men; as well as the influence of early life and the life course. While it is important not to presuppose *a priori* rigid gender differences in distress between men and women, it is useful to examine the similar and different subjectivities, circumstances and experiences of men and women. This is important, not least because current mental health policy (while identifying the specific needs of women and younger men in particular) is considered by a number of commentators to be not sensitive enough to the complexities of gender relations (Riska 2009; Wilkins et al. 2008). Nevertheless, policy drivers are now being put into place that may allow for interesting developments in the area. Much of current health policy is recognising that moving towards a broader view of mental health and its promotion may provide more success in reducing the burden of mental illness among both men and women. For instance, the World Health Organisation's summary report on *Promoting Mental Health* is an attempt to broaden the mental health vision beyond psychiatric morbidity (Herrman et al. 2005). This is also the case with the new *European Pact on Mental Health and Wellbeing* which may encourage more action at the EU and country level on preventative action (McDaid 2008). This re-emphasis may end up promoting services to increase their sensitivity to issues for vulnerable men.

There are concerns we know little about men and distress, as well as fears about constructing men as being in need of surveillance and interventions. Nevertheless, there is an emerging policy focus on men and their health needs. The recent *Irish Men's Health Policy*, the forthcoming *Australian Men's Health Policy* and the American *"Men and Families Health*

Care Act of 2009" are all examples of new policy. The US act was introduced with the intention of setting up an Office for Men's Health to set male specific policy. In the UK the approach has been different. With the establishment of the *Equality Act* in 2006 it is a requirement that public services be seen to be meeting the needs of both men and women. There is now a new national strategy being developed out of the '*New Horizons Consultation*' in mental health. It is possible that this new strategy could seek ways of preventing mental health problems, including among men (Department of Health Mental Health Division 2009). In other countries, there is activity with regard to highlighting the issue of men and mental health specifically. For instance in the United States, the '*Real Men, Real Depression*' campaign launched in 2003 by the *National Institute of Mental Health* sought to raise public awareness of depression and mental health among men (Rochlen et al. 2005). Some health charities are pushing for specific services for men's mental health. In the UK MIND (2009) published, '*Men and Mental Health: Get it Off Your Chest.*' This report aligned itself with the theory of 'hidden' mental distress among men. Thus it seems timely to bridge the gap between research and policy in the area of distress.

Moving past the current focus in the research on mental disorders (like depression) and women, to investigate the rich construction of subjectivities and distress seems worthwhile. Allowing men to define distress for themselves in qualitative research will likely open up important insights into 'invisible' aspects of their emotional life. Currently we know little about the languages and stories men deploy *before* their problems potentially progress to become a 'disorder'. But qualitative approaches like in-depth interviewing are likely to present challenges. As Robertson (2006) suggests men 'do' gender when they are giving others the impression that they are not 'doing' health, especially mental health. In focus group research with men, O'Brien and colleagues (2009) found suggestions that some men apparently learnt to police their own masculine behaviours as if other men were monitoring them (as in Foucault's description of the 'panopticon'). One-to-one qualitative interviews in the area of male subjectivities and mental health could thus also turn out to be another opportunity to rehearse dominant masculinities (Emslie and Hunt 2009). If interviews themselves involve some level of gender performance, then our research approaches with men need to be sophisticated enough to take the potential for performance into account. Specific interview strategies can be adopted with men that take into account the potential for performance in interviewing and analysis (Oliffe and Mroz 2005)**.** Additionally, researchers do locate men willing to challenge dominant narratives and ways of being male (Emslie et al.

2006). Finally, gender and mental health issues like distress are a complex area to study. Even when comparing samples of men and women, it is difficult to sort out what differences are to do with societal gender relations, the performance and construction of masculinities, or other dimensions that could be influencing subjectivities including circumstance, social class, or just being a human being in the 21st Century. There is thus a case for doing more comparative research between men and women, as well as exploring the subjectivities of men specifically.

|FOOTNOTES

1. Queer theorists emerged in recent decades from a loose collection of post-structuralist academics engaged in feminist and sexualities studies. They generally work to challenge and rethink dominant discourses of sex and gender, such as heteronormativity (Edwards 1998).

2. i.e. working from home while linked up to the office electronically

3. defined broadly as that difficult work we do to manage/regulate emotions to do with the self and others (James 1992)).

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