'THAT FANTASY THAT YOU CAN DEAL WITH EVERYTHING YOURSELF AND MOVE MOUNTAINS', AN EXAMINATION OF MEN'S BELIEFS AND MEDIA REPRESENTATIONS ABOUT MENTAL HEALTH SERVICES

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Abstract

Young men tend to be less likely to seek help for mental distress due to barriers to help-seeking. Lack of knowledge and negative attitudes regarding services is one such barrier to help-seeking; however, little research examines what men who have not accessed services believe services involve. Likewise, there is little research assessing how services are presented in news media. This project comprised two studies designed to address these gaps in the literature. Both studies utilised inductive thematic analysis within a social constructionist epistemology to examine possible influences on men's help-seeking.

Study One aimed to develop an understanding of young men's beliefs about mental health treatment when they have not utilised such services. Ten young men who had not accessed services participated in a semi-structured one-on-one interview. Participants expressed a preference to fix problems independently if possible, negative views of the possibility of relying on prescription medication, and they likened talk-therapy to informal social supports. They also acknowledged the limits of their understanding of services, stating that most of their beliefs were based on fictional depictions of services, and that in a consultation they would likely listen to their doctor's advice. It was concluded that better public education regarding services and treatment may affect attitudes and behaviours towards services; however, the culturally embedded imperative to deal with problems independently also requires challenging.

Study Two aimed to understand how services were presented in digital news media. A preliminary quantitative content analysis identified recent rates of mental health reporting on the news platforms Stuff and NZ Herald. Articles were taken

from May and February 2019, the most recent peak and trough, respectively, of mental health related articles. Thematic analysis of these articles indicated that news media presented positive outcomes of mental illness through recovery. However, articles also stated that services were underfunded, and understaffed, that mental illness is a rising issue in New Zealand, and that government was not doing enough to improve services. Thus, although the news media gave the message that recovery is possible, it also framed services as struggling, which may have implications for intentions to help-seek.

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List of Abbreviations

ADHD	Attention Deficit Hyperactive Disorder
APA	American Psychological Association
AT&R	Assessment, Treatment, and Rehabilitation
CA	Content Analysis
CDHB	Canterbury District Health Board
COA	Cycle of Avoidance (model)
DHB	District Health Board
GHQ-12	General Health Questionnaire 12
GP	General Practitioner
GRSP	Gender Role Strain Paradigm
MP	Member of Parliament
NEM	Network Episode Model
NGO	Non-Governmental Organisation
PCT	People who Conduct Therapy
PHO	Primary Health Organisation
PMI	People with Mental Illness
PSAID	Psychiatric Services for Adults with an Intellectual Disability
PSH	People who Seek Help
TA	Thematic Analysis
WHO	World Health Organisation

Reflexivity

At the time of writing this, I was a 28-year-old male. I was registered as an intern psychologist in my clinical internship year; my ninth year of formal university study of psychology. I had also worked for nearly four years as a public servant at the New Zealand Ministry of Health. At this stage, I felt that I had a basic understanding of how mental health services work. It occurred to me that if, after all of this, mental health services still seemed complex and mysterious to me, it was no wonder that men without my privilege and learning fail to access services that they do not know about or understand.

When I was nineteen years old, I suffered regular panic attacks. To me, the panic attacks were crippling and terrifying to the point where I avoided leaving my home except to go to 'safe' places where I knew that I could easily escape if I felt that I had to. I stopped going to parties with my friends, I could not bear going into town to go shopping. I even moved out of my flat (shared house) with friends to move closer to university campus because walking more than five minutes away from home caused me too much anxiety. I did not understand what was happening to me, and I was far too embarrassed by my strange fears to reach out for help.

After a year of this crippling anxiety, I was certain that I would be incapacitated by panic attacks for life – that I would never be able to get a real job or have a family. In these dark moments, it occurred to me that I needed help. However, I did not know where I could get help – the idea of seeing a GP did not occur to me, nor did the idea of calling any of the free support lines available in New

Zealand. The only idea I had was to email one of my psychology lecturers who seemed kind, but I was too proud even to do that.

Eventually I was forced to overcome my fears due to an upcoming mandatory class field trip, which I knew I was too anxious to attend. I stubbornly forced myself to stand in places where I had panic attacks until the panic subsided, and eventually anxiety's grip on me loosened. I was a student in my third year of a psychology degree who did not understand his own mental illness and had no idea about mental health services that were available. I never sought help, and I never even knew how.

After my own experiences with mental distress, I decided that I did not want other young men to have to go through what I did without help, which motivated me to continue studying psychology and to eventually train as a clinical psychologist. I firmly believe that there are other young men out there who are just like I was – unwilling to ask for help, unable to understand what is happening to them, and uncertain where help could even come from. This research reflects my desire to help other young men who are like I was.

Chapter 1: Introduction

Research has consistently shown that men tend to underutilise mental health services and have low rates of help-seeking for mental health related problems. Moller-Leimkuhler's (2002) review concluded that men utilised mental health services substantially less than women and suggested that this was related to men's relatively poorer ability to express emotions. Moller-Leimkuhler acknowledged that it may appear appropriate for men to seek help less often than women, given that rates of depression and anxiety are often reported as being twice as high in women compared to men. However, she also pointed to substantial literature that posits that men are less likely to be diagnosed with mental illness, and rates may be significantly underreported. Furthermore, Moller-Leimkuhler referred to a study in which young men were found to be less likely to seek help than women with similar levels of distress; indeed, the young men were less likely to seek help even when they reported higher levels of distress (Rickwood & Braithwaite, 1994, as cited in Moller-Leimkuhler, 2002). Based on this analysis it appears that men's help-seeking for mental health related issues is a matter that warrants exploration. Speaking to the stability of this phenomenon, Moller-Leimkuhler found that over the twenty years of literature reviewed, there had been no change in men's likelihood to seek help for mental health conditions.

The World Health Organisation (2002) have noted that throughout the developed world, men tend to under-utilise mental health services. More recent literature (e.g. Pattyn et al., 2015) and initiatives (such as the Men's Health Forum in London, 2014) indicate that men still tend to under-utilise mental health services. It

appears that there is a long-standing legacy of men who either refuse to acknowledge they need help or are deterred from accessing mental health services due to existing barriers.

Despite - or perhaps, because of - men's low use of mental health services, men have a higher rate of suicide than women in New Zealand (a ratio of 2.9:1 (New Zealand Ministry of Health, 2016), and in most developed countries in the world (WHO, 2002). Additionally, the suicide rate amongst the age group 15-24 years old has risen from the lowest, as compared to other adult age groups in 1972, to the highest in 2012 (New Zealand Ministry of Health, 2016). There were also more suicides amongst people living in areas of high deprivation. These findings highlight that young men living in areas of high deprivation are most at risk of suicide, yet research suggests that they are among the least likely to seek help (Clement et al.,2015).

Much of the extant literature concerned with why men tend to have lower rates of mental-health related help-seeking conceptualises the problem as resulting from 'barriers' to help-seeking. Barriers to mental health service utilisation may result from a variety of causes. For example, Andrade et al. (2014) identified two types of barriers: attitudinal (such as stigma, lack of perceived need, and fear of disclosure), and structural (such as cost, distance, and time commitments). Structural barriers have a variable impact that tends to relate to deprivation among other things; however, Andrade argued that attitudinal barriers have a greater impact. The aim of the present project is to explore one attitudinal barrier to help-seeking, which, at the time of writing, has not been thoroughly explored: beliefs and attitudes towards mental health services. This barrier will be explored from two perspectives; men who

have not used services (Study One); and descriptions in the news media (Study Two).

Mental health services ('*services*') is a term that may have various definitions. For the purposes of this study, when referring to 'services', I define these as any 'services' that men or news media identify as mental health services. That is, when referring to services, my present perspective is that any entity that men engage with the intention of obtaining support for some form of mental distress, is a 'service.' Thus, services may include General Practitioners (GPs), Psychologists, Counsellors, volunteer groups such as Lifeline, religious groups, and mentors.

1.1 THESIS STRUCTURE

In the literature review (Chapter 3) I provide an overview of the literature regarding men's rates of help-seeking, concluding with a summary of why men's rates of help-seeking are an area worthy of investigation. I also explore the concept of hegemonic (normative) masculinity, which is a construct underlying much of the research regarding men's help-seeking, and thus provides important contextual information. The literature review also introduces and explains social constructionism as the epistemology grounding this research. I also explore 'pathways' and models to help seeking, first providing important contextual information about mental health services and service utilisation in New Zealand, and then presenting some major models of help-seeking. These models provide explanations for men's low rates of help-seeking, though their limitations are also explored. The literature review then addresses the impact of attitudes/beliefs on help-seeking first by presenting the literature regarding the impact of attitudes on behaviours, then addressing the current literature regarding men's attitudes towards

services, and finally by presenting the research regarding sources of beliefs and attitudes and the limitations of this research. In section 3.6, I present the aims of this research.

Study One (Chapter 4) begins by presenting the method of interviewing real men regarding their beliefs about services. The thematic analysis method of interpretation is then described and presented within the social constructionist epistemology. The thematic analysis is subsequently presented whereby short data extracts supporting the five thematic areas are presented alongside commentary. These thematic areas represent inductive data contributing to an understanding of how young New Zealand men describe services and issues relating to mental health. Finally, Chapter 4 ends with discussion of the thematic areas found in Study One. This discussion links the findings of this study with previous research explored in the literature review and explores the implications and potential applications of these findings.

Study Two (Chapter 5) follows a similar format to Chapter 4. It begins by outlining the method of collecting data for analysis. That is, the method of quantitative content analysis to identify newspaper articles is described, followed by the description of thematic analysis of these newspaper articles. Chapter 5 then introduces the thematic analysis of these newspaper articles by including short data extracts alongside commentary to present the four thematic areas generated. This analysis explores how services are presented in New Zealand news media. Chapter 5 ends with a discussion of the thematic areas as they relate to existing literature, and the possible implications and applications of these findings.

Finally, Chapter 6 synthesises the findings of Study One and Two. It briefly summarises the findings and explores how these findings relate to the broader area of

mental health related help seeking. Chapter 6 also provides suggestions for future research that may extend the present studies.

Chapter 2: Literature Review

2.1 MEN'S HELP-SEEKING

2.1.1 *Gender and help-seeking*

Although the WHO (2002) and historical literature (Nathanson, 1975) indicate that men have lower rates of mental health service utilisation, this fact alone does not establish an imperative for investigation or change. Indeed, research has found that women have higher rates of both physical and mental illness (Crimmins et al., 2010; Moller-Leimkuhler, 2002; Nathanson, 1975). Therefore, it may appear reasonable that men would have lower rates of health-service utilisation given their ostensibly lower rates of need. However, many researchers have attempted more nuanced exploration of men's rates of morbidity and health-service utilisation practices and some have questioned the usefulness of gender as a variable. This section explores the usefulness of gender as a categorising variable regarding help-seeking.

To address the preliminary question of whether men's rates of mental health service utilisation constitutes a social and professional issue, or whether it is simply a result of lower rates of mental distress amongst men, it is necessary to look at rates of help-seeking while standardising for levels of distress. That is, if a group of men and women both reported the same levels of distress, would their rates of help-seeking also be similar? Kessler et al. (1981) addressed this question and analysed data from four large health surveys, concluding that women tended to be more likely than men to indicate mental distress. Kessler speculated that this was likely resulting from higher rates of distress, better awareness of internal distress, and greater openness to disclosing mental distress. Kessler also found that women were more likely to seek

mental health services. However, Kessler also found that men who recognised distress tended to be just as likely as women to indicate a need for professional services. Kessler concluded that men's lower rates of mental health service utilisation were not due to lower rates of distress, nor reluctance to seek help, but from difficulty recognising symptoms resulting from psychological causes.

In contrast to the findings of Kessler et al. (1981), more recently Oliver et al. (2005) found that despite similar scores on the General Health Questionnaire-12 (GHQ-12 - a short self-report measure of mental distress), men indicated that they would be less likely to seek help than women. Additionally, they found that younger men (particularly men in the 16-24-year-old age group) preferred social support to seeking professional help, in comparison to older men (men in the over 45-year-old age groups were more likely to endorse help-seeking than younger men). Likewise, Rice et al. (2020) noted that men with depression have low rates of help-seeking, and within men as a group, young men tended to be less likely to seek help than older men.

Pertaining to social constructions of gender impacting help-seeking, Nathanson (1975) posited three potential explanations for the difference in health-care utilisation between men and women; firstly, men are less likely to seek help for health issues due to social norms relating to vulnerability and help-seeking, secondly, traditional female home-maker roles allow for illness whereas traditional male working roles do not permit sickness, and thirdly, higher levels of physical and cultural pressure on women (i.e. to bear and raise children) results in higher rates of physical and mental illness. These explanations are based, at least in part, on culturally constructed gender roles, therefore it is important to consider to what

extent these roles are still valid today, which more recent studies have assessed. Donnelly et al. (2015) found that contemporary younger generations ('Millennials') tended to have positive attitudes towards looser gender roles including roles not fitting with hegemonic norms, such as working mothers, and stay-at-home fathers. Donnelly's findings may suggest that Nathanson's explanation of gender difference in service utilisation need to be considered in the light of changing gender roles. Additionally, Nathanson's explanation may not account for people living outside of the nuclear family norm; for example, gay families, families with two working parents, and individuals who choose to remain single, are a poor fit with the second and third of Nathanson's explanations outlined above. Nevertheless, as it pertains to men's service utilisation, men still tend to use services at a lower rate than women, and contemporary authors still consider Nathanson's social and cultural explanations as useful for understanding lower rates of health service utilisation (Pattyn et al., 2015).

Although this section has thus far explored whether men's lower rate of help-seeking is relative to lower rates of mental illness than women, it may be premature to accept such a binary claim. Hill and Needham (2013) postulated that men and women may have similar rates of mental distress but different ways of expressing it, which may result in more women being diagnosed with mood disorders than men. Hill and Needham's review found insufficient evidence to support the claim that men express distress through externalising disorders and women express distress through mood disorders. Although the authors acknowledged that men do have higher rates of externalising disorders and women have higher rates of mood disorders, they argued that it is impossible to state whether men or women have higher rates of mental disorders overall and that much of the literature that does so is based on a

social agenda rather than science. Furthermore, the very definition of mental disorders is constrained by diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders, fifth edition, which have been critiqued for reflecting social constructions and norms that may affect rates of 'illness' (Pickersgill, 2014). Hill and Needham also concluded that there is insufficient evidence to suggest that men exhibit risk-taking behaviours resulting from stress instead of feeling distressing emotions. Thus, it may not be accurate to claim that women have higher rates of mental illness than men, and therefore it would be inappropriate to expect men to have lower rates of service utilisation.

Despite evidence showing that men tend to seek mental health services at lower rates than women (Moller-Leimkuhler, 2002; Pattyn et al., 2015), men are not a homogenous group, and there is significant variability in help seeking rates. Exploring rates of help-seeking by groups of men may provide insight into the factors that prevent men from seeking help for mental health related issues. For example, Kerridge et al. (2017) found that gay, bisexual, and people who were questioning their sexual orientation tended to have higher rates of mental illnesses compared to heterosexual men. Likewise, Mizock (2017) noted that transgender and non-binary individuals tend to have higher rates of diagnosed mental disorders compared to cisgender people. Additionally, Keown et al. (2016) demonstrated that lower socio-economic status and younger age (i.e. the 20-39-year-old age group) were associated with greater rates of severe mental distress for people living in urban areas. Indeed, even subcultures within masculinity such as sports participation have been shown to affect factors relating to help-seeking (Ramaeker & Petrie, 2019). In other words, it appears that a complex and dynamic set of factors affect mental health, which may indicate that gender is only one contributing factor to mental

health and help-seeking. It appears that while gender is an important factor to consider, there is a need for a more multi-faceted definition of gender when exploring issues of service utilisation. Viewing masculine identity as a unitary factor may disguise the underlying narratives about diversity within the stereotype.

A factor worthy of consideration through its implication in gender differences in help-seeking is the impact of socially constructed masculine norms. Although the values associated with these norms may differ across cultures, research has shown remarkable similarities in hegemonic norms in various cultural settings, particularly in a modern, globalised society (Tan, et al., 2013). Although men are likely to understand and adhere to (or resist) these norms to different degrees, regardless of sexual orientation, gender diversity, wealth, or even culture, they may be exposed to similar norms. For example, Ramaeker and Petrie (2019) found that men differed in their endorsement of masculine values based on whether they were part of a sporting subculture; however, they also found that irrespective of sports involvement, men experienced stigma relating to masculine values, which impacted their beliefs about help-seeking and services.

Vogel et al. (2011) sought to explore whether normative masculine values and associated behaviours (i.e. stoicism, autonomy, reduced emotionality) impacted on mental-health related help-seeking attitudes among men from both minority and majority cultures (including sexual and ethnic minorities). They assessed attitudes towards mental health services, agreement with dominant masculine norms, and levels of self-stigma (typically manifesting as feelings of shame and guilt relating to behaviours perceived to be non-masculine) in a wide pool of participants. Vogel found that men who self-stigmatised tended to have more negative perceptions of mental health services and tended to agree more with traditional masculine norms of

behaviour. Additionally, Vogel found that the impact of self-stigma and masculine norms was significant across cultural groups, suggesting that hegemonic masculinity is a broad gender-related factor. Based on these findings, it appears that social expectations and rules of what normal masculine behaviour involves are internalised by many different cultures/subcultures. In other words, there appears to be a powerful social force that may drive men towards certain attitudes and values regarding mental health and help-seeking. Nevertheless, it is important to embrace diversity and openly explore how this cross-cultural force interacts with other factors to create inequities in health outcomes and help-seeking.

The previous literature has suggested that men's rates of help-seeking are lower than should be expected, perhaps due to poor recognition of symptoms. However, some authors have argued that there is insufficient evidence to support the claim that men have lower rates of mental distress. Different groups of men have different rates of help-seeking, suggesting the idea of using a gender binary perspective is inappropriate. However, research has shown that men are subject to pressure from the norms of masculinity, and therefore may be worthy of consideration as a group. The present study considers this force from a social constructionist perspective and aims to explore men's attitudes towards mental health services within the context of socially constructed norms and pressures, which a diverse range of men strive to adhere to.

The focus of this study is on the impact of gender, based on a body of literature that has utilised a similar lens (e.g. Moller-Leimkuhler, 2002; Pattyn et al., 2015; Tan et al., 2013; Vogel et al., 2011). However, it is important to recognise that there are tensions of intersectionality when one factor - in this case gender - is predominant.

Considerations such as the impacts of age, sexuality, class, and ethnicity (to name only a few) on perceptions of services remain relevant and gender is not independent from these factors. That is, in this research, gender is dominant, but never stands on its own. There are other analyses and positions that could foreground issues of culture, class, or sexuality in this area; nevertheless, it is also possible that gender stereotypes affect these other factors. Likewise, previous research has highlighted gendered social clusters as relevant constructs to consider (e.g. Vogel et al., 2011). Thus, although the impact of other factors in relation to help-seeking are acknowledged, this project takes a strong gendered lens for pragmatic reasons, and to conceptually align with previous literature exploring issues of gender.

2.2 GENDER, MASCULINITY, AND CONSTRUCTIONISM

2.2.1 *'The Myth of Masculinity'*

The term 'Social Constructionism' was popularised by Gergen (1985) as a way of understanding previously taken-for-granted 'knowledge.' Subsequently, Burr (2006, 2015) described social constructionism as an umbrella-term for any methodology, particularly in social sciences, which conceptualises constructs as existing not objectively, in a vacuum, but rather, as products of time, place, and circumstance. That is, social constructionism is a way of understanding concepts based on the social context that created and continues to shape these concepts. For this study, a broadly social constructionist perspective was taken regarding ideas of gender, and resulting behaviours based on gender. This section provides an epistemological background to this research and outlines previous research of relevance to men's help-seeking, which considers gender from a social constructionist perspective.

One example of literature that used a social constructionist perspective prior to Gergen's (1985) writing, and which is important to the present study is Pleck's (1981) 'The Myth of Masculinity.' Pleck considered decades of literature and research regarding gender and masculinity, and argued that differences between men and women are not the result of objective, natural differences between those who have the XY chromosome pairing and those who have the XX chromosome pairing, but rather, resulting primarily from cultural norms and pressures to behave in particular ways. Although Pleck acknowledged that natural differences between male and females do exist, he proposed that masculinity and femininity are artefacts of the culture within which they were created. One such difference, which has been shown in much research, is the sexual drive difference. In their literature review, Baumeister et al. (2001) found that men tend to have greater urges towards sexual promiscuity and frequent sexual intercourse than women. However, this finding, or 'knowledge,' may be viewed from a social constructionist perspective which argues that men's ostensibly greater sexual drive stems from social and cultural norms of promiscuity, likewise, women's sexual drive may be linked to cultural norms that pressure women to be chaste and 'pure' (Parker & Gagnon, 2013).

The present research takes a similar view of masculinity as Pleck (1981), such that men's help-seeking behaviours and the barriers therein are viewed primarily as social constructs (structural barriers such as cost and wait-lists not withstanding). This perspective seems both intuitive and useful as many of the forces that have been shown to impact on men's likelihood to seek help for mental distress appear to result primarily from social pressures and expectations (Pattyn et al., 2015). Indeed, it would be difficult to fathom how men's attitudes towards help-seeking, feelings of stigma, and understanding of mental illness might exist as objective and natural

realities, rather than as results of social norms and cultural expectations. Seidler et al. (2018) articulated the socially constructed nature of masculinities by noting that there are not a finite set of behaviours and values that define masculinity. Rather, they suggested, masculinities are dynamic, contextual and are created in social interactions.

One social constructionist perspective of gender that helps explain help-seeking is the Gender Role Strain Paradigm (GRSP), which posits that people are pressured via explicit feedback and internalised self-expectations to behave in ways that align with the most powerful gendered norms of that time and place (Levant 2011; Pleck 1981). The GRSP argues that people are not born with inherent knowledge of gendered differences, but rather, learn them through modelling and behavioural contingencies. Nevertheless, GRSP posits that these socially constructed rules are commonly broken, as they are learnt rather than innate, may be incompatible with an individual's values and responsibilities, and some rules directly oppose others. For example, Emslie et al. (2006), found that social pressures to be well and strong overrode opposing pressures to be stoic and independent in firefighters who would frequently seek help for physical and mental issues. However, Levant (2011) noted, breaking the social rules can come at a cost. Men who act in ways contradictory with gendered norms may experience consequences both internal such as guilt and shame, and external such as anger or mockery from others.

Within the GRSP, there are three types of gender role strain relevant to the present study. Firstly, 'discrepancy strain' refers to a man's internal distress or unpleasant feelings that arise from him enacting behaviours that are inconsistent with his conceptualisation of masculinity (Pleck, 1995). For example, if he believes that men do not show vulnerability, a man may experience discrepancy strain after crying

in front of a friend. Secondly, ‘dysfunction strain’ refers to the negative outcomes of a man enacting behaviours that are consistent with his conceptualisation of masculinity (Pleck, 1995). For example, a man who hides his distress may lose opportunities for support. Thirdly, ‘trauma strain’ refers to the emotionally traumatic impact of young boys learning to adhere to hegemonic masculinities (Levant, 1998). However, it is important to note that there are likely to also be reinforcing aspects to behaving in a gender normative way, for example, a man may reap these benefits through maintaining his social standing as a ‘hard man’ amongst peers. These three types of gender role strain all have explanatory power regarding men’s help-seeking behaviours. Therefore, based on the impact that Pleck (1995) suggests masculinity has on men, I suggest that masculinity is not a myth; while it may not be a biologically determined natural phenomenon, masculinity exists as an abstract force with tangible effects such as behaviour, dress, voice and so forth

It is also important to consider some of the key cultural contexts relating to masculinity in this study, which is based in Aotearoa/New Zealand. That is, Aotearoa/New Zealand is a bicultural nation whereby Māori cultural practices and perspectives are recognised as valuable, and often distinct from western perspectives (Hodgetts et al., 2017). Therefore, the concept of normative masculinity should be considered from a critical bicultural perspective, which includes Māori constructions of masculinity. For example, Hamley and Le Grice (2020) noted that colonisation has had a substantial and harmful impact on Māori constructions of masculinity. Prior to colonisation, Hamley and Le Grice noted, men and women had roles that may not have aligned with traditional western gender roles. Traditional Māori constructions of gender allowed for leaders who were masculine and feminine. Likewise, warriors were masculine and feminine, and all genders had roles in

nurturing and supporting whānau. Nevertheless, Hamley and Le Grice also noted that, like other cultures, Māori culture is not homogenous, and therefore masculinity was socially constructed and is not a finite or discrete concept.

Hamley and Le Grice (2020) noted that current, western constructions of Māori masculinity differ from traditional Māori constructions, and tend to be reductionist and harmful. They described that there are two common constructions of Māori masculinity: that of a subservient, passive, and assimilated man, the other of a brutish, aggressive, and uneducated man. Regarding mental health services, Hamley and Le Grice argued that both of these constructions of Māori men tend to result in negative health outcomes through inappropriate and often mandatory treatment, rather than voluntary and culturally acceptable treatment. Therefore, although this study focusses on young men who have not accessed services as the key cultural factor, there is also recognition of Aotearoa/New Zealand's bicultural background and the ongoing effect of colonisation on constructions of health and masculinity.

Social constructionism rejects the positivist ideas that gender differences exist in an objective reality. Rather, it postulates that many gender differences exist due to a social context. Likewise, the Gender Role Strain Paradigm posits that young men learn the normative ways to act through observation and modelling. The present study considers barriers to help seeking among men fitting with a social constructionist perspective and based upon the premise that men are not naturally or inherently less likely to seek help for mental distress, but rather, that social norms construct ways of being that are often incompatible with mental health related help-seeking. In other words, gender differences in help-seeking go beyond simple biological determinism. Likewise, it is recognised that the present study takes place in a bicultural setting, whereby constructions of masculinity are likely influenced by

ongoing impacts of colonisation, and 'normative masculinity' should be considered as a concept constructed by a dominant culture, which may eclipse other forms of normative masculinity.

2.2.2 *Normative Masculinity and its impact on help-seeking*

Hegemonic masculinity is a concept that explains enduring gender-related power dynamics and practices that privilege masculine traits. That is, hegemonic masculinity may be viewed as the driving force behind pressure for men to appear stoic and in control, and to dominate those who exhibit feminine traits such as openness and emotionality (Jewkes et al., 2015). Within constructionist literature, the concept of hegemonic (sometimes referred to as normative) masculinity has been used in many men's health studies, in which hegemonic masculine behaviours are often presented as incompatible with the apparently more feminine behaviour of help seeking. In other words, previous research has often considered hegemonic masculinity as a sufficient explanatory variable accounting for why men tend to resist seeking help (e.g. Cleary, 2012; Krum et al., 2017; Moller-Leimkuhler, 2002). Hegemonic masculinity contributes to a tendency for men to prefer not to express emotions associated with weakness, such as anxiety, sadness, and vulnerability.

Although 'hegemonic masculinity' is often used to denote a set of socially constructed pressures negatively relating to help-seeking beliefs and behaviours, it is important to note that hegemonic masculinity is not solely or inherently negative. For example, Seidler et al. (2018) discussed the importance of utilising the strengths and positive aspects of masculinity when considering improving men's help-seeking. Likewise, Sagar-Ouriaghli et al. (2019) pointed to growing literature attempting to use positive aspects of masculinity to improve help-seeking in men. In contrast, the

concept of ‘toxic masculinity’ refers exclusively to the negative and problematic behaviours resulting from pressures of masculinity, often behaviours that are normalised or accepted in the context of normative masculinity (Kupers, 2005). Although I present masculinity as it has been described in existing literature, in this study, I conceptualise masculinity as diverse and dynamic, and having various impacts, depending on context.

The term ‘hegemonic masculinity’ was originally coined as an explanation for power dynamics in an Australian high school (Kessler et al., 1982); however, it has been used in a variety of academic disciplines to explain behaviours that maintain the power of certain masculine values over feminine and other, non-normative, masculine values (Connell & Messerschmidt, 2005). As Broverman et al. (1972) and more recent authors (e.g. Cleary, 2012; Krum et al., 2017; Moller-Leimkuhler, 2002) have noted, the desired male identity includes independence, lack of emotional expression, logic, and control – all traits that may be compromised by seeking help. Interestingly, Pattyn et al. (2015) found that these masculine traits are enforced not only by other men, but also by women, suggesting a broad, shared acceptance of these traits and what it is to be a “man.”

Carrigan et al. (1985) conceptualised the term hegemonic masculinity in response to sex-role theories, which were popular in the decades preceding their work (Connell, & Messerschmidt, 2005). Unlike sex-role theory, the theory of hegemonic masculinity acknowledged and considered the impact of power relations, particularly the normalisation and proliferation of men’s power over women. Indeed, one of the key social functions of hegemonic masculinity was to continue the power of the patriarchy (a term, which here refers to a common hierarchy in which straight adult men hold greater power and influence than other groups such as women or

children). However, Carrigan noted that hegemonic masculinities do not promote power only over women; but that they also promote the power of the patriarchy over other types of masculinity such as homosexual men and feminine men. Although the concept of hegemonic masculinity has evolved, the core idea that it enables the power of a dominant, patriarchal masculinity over other types of masculinities and femininities remains (Messerschmidt, 2018).

The remainder of this section will focus on how hegemonic masculinity relates to help-seeking. Interestingly, early examples of the impact of normative masculine roles precede the concept of hegemonic masculinity. Broverman et al. (1972) found that traits such as aggression, lack of emotionality, independence, logic, and being calm in a crisis were considered masculine and desirable for men; whereas the opposite to each of these traits (i.e. passivity, easy emotional expression, frequent dependence on others) was considered feminine and tended to be seen as undesirable. Recent research sought to test the impact of hegemonic masculinities on mental health problems among men more directly. For example, Cleary (2012) found that several factors including emotional distress, poor understanding of symptoms, and fear of disclosure due to conflicting values regarding their masculine identities was associated with young men attempting suicide. These findings suggested that hegemonic masculine pressures not to show vulnerability contributed to resistance to seeking help, and perhaps even suicidality. Likewise, Krumm et al. (2017) reviewed qualitative research regarding men's understanding of depression and found that hegemonic expectations regarding masculinity related to men viewing depression as a threat to their masculinity, 'closing-up' about it, and avoiding seeking help.

As well as impairing men's ability and desire to express emotions, Ridge et al. (2011) noted that normative gender role expectations are also held by service providers, meaning that general practitioners may be less likely to assess emotional and mental health symptoms in men. It appears then that men are in a double-bind situation such that they may have learnt that it is desirable to deal with problems independently, and to avoid emotional expression, while others – including service providers – also enact the same trait expectations on men, thereby reducing their likelihood of receiving appropriate help (even if it is sought).

Despite the implications of hegemonic masculinity on help-seeking, it is important to note that the traits associated with hegemonic masculinity are not prescriptive, nor are they explicitly taught to young men – rather they are constructed and learnt (Levant, 1998). Indeed, some literature, while acknowledging the primary barrier to help seeking that masculinity creates, have noted exceptions whereby a desire to maintain a masculine identity facilitates help seeking. O'Brien et al. (2005) wanted to understand how men constructed their masculinity in relation to their help seeking behaviour. They held focus groups with men discussing mental health issues and help-seeking. Consistent with previous research, they found participants preferred not to seek help and tended to avoid talking directly about depression, preferring to reframe it in more masculine terms (either by minimising or reframing depression as 'stress'). Additionally, O'Brien found that the men expressed an inability to talk about it to other men for fear of being judged. However, the authors also found that when the symptoms of the mental distress threatened other normative masculine traits (for example, depression reducing a man's ability to provide for his family), the men tended to be more likely to seek help. Additionally, a group of firefighters who participated tended to be willing to seek help early, even for trivial

problems, in contrast to the rest of the group. O'Brien argued that the firefighters saw seeking help for problems as exercising masculine traits by exerting control of one's own health, rather than as challenging masculine traits.

2.3 MODELS/PATHWAYS TO HELP-SEEKING

The present study was conducted in New Zealand where the mental health system must be considered as it provides the context for services men may be able to receive, and the barriers they may face. Likewise, it is useful to consider existing models and theories regarding pathways to help-seeking. The present section provides a brief contextual overview of mental health services and pathways in New Zealand. It also provides an overview of existing models of help-seeking behaviour, including the Network Episode Model (Pescosolido, 2011), the Cycle of Avoidance Model (Biddle et al., 2007), and the Psychological Antecedents of Help-Seeking Model (Cramer, 1999). Each model provides plausible explanations for help-seeking and lack of help-seeking, and each is considered regarding how well it explains men's low rate of help-seeking.

2.3.2 *Mental health pathway in Aotearoa/New Zealand*

Gauld (2016) described the New Zealand health care system as providing access to publicly funded services for the needs of the population. New Zealand is divided into twenty health districts, with health services (primary and secondary) in each being coordinated by a District Health Board (DHB). Each DHB is allocated central government funding for services, some of which is ring-fenced for government mandated priorities/services, and other funding available for new initiatives and services. Regarding mental health care, Gauld noted that services are predominantly provided under the government funding model. In this model there is

lower availability and access to private services in comparison to other healthcare models, such as the United States' primarily insurance-based model (Mossialos et al., 2016). Additionally, Gauld noted that mental health services in New Zealand tend to be community based, and most people access services via a general practitioner who acts as a 'gatekeeper,' but it is also common to access services through schools and non-government organisations (NGOs). Regarding secondary (hospital provided, inpatient, and acute) mental health services, these services are provided via DHB hospitals and facilities (Gauld, 2016). This description of the mental health services in New Zealand largely aligns with the public information available on the New Zealand Ministry of Health's website, which states that mental health services are available through a GP and lists the numbers for emergency services and helplines (Ministry of Health, 2018).

The New Zealand Ministry of Health data on mental health service use suggests more men than women were seen by mental health and addiction services in the most recent reported period – the 2015/16 financial year (89,379 men were seen, while 81,654 women were seen (Ministry of Health, 2018)). However, the data also allows for these activities to be broken down by which service they were seen. This data suggests that more men than women accessed inpatient hospital services, alcohol and drug, and forensic services. In comparison, more women than men accessed community services, specialty services, and eating disorder services. However, this data only described secondary mental health services. To have a comprehensive understanding of men's mental health pathways in New Zealand, it would be necessary to understand primary service use including rates of GP mental health consultations. At the time of writing, data regarding primary mental health care provision in New Zealand was unavailable.

2.3.3 *The Network Episode Model*

As well as understanding the local context of mental health services, it is necessary to understand the dynamic person-centred factors that impact upon whether an individual will engage with these services. Several models exist, which attempt to explain the circumstances under which an individual will or will not engage with help-seeking. Pescosolido (2011) proposed a model of understanding mental health and mental health related service use: The Network Episode Model Phase-III (NEM). The basic theory of the NEM is that mental health problems and mental health related service use are influenced by social networks. Further, even when acknowledging the impact of internal (i.e. biological and genetic) factors on the aetiology of mental illness, social networks (and factors) shape how and whether mental illness eventuates in an individual. Regarding treatment and support for mental illness, the NEM asserts that the social networks and the healthcare system in an individual's context are the primary factors influencing their outcomes and reactions to mental illness. However, the lack of specificity about individual pathways and factors makes the NEM useful as an explanatory model that accounts for social influences but limit the amount of insight it provides. Further, the NEM conceptualises impacts on mental health outcomes primarily from a social and biological perspective and appears to lack consideration from cognitive and emotional perspectives. In relation to the present study, the NEM contributes a framework for considering social factors (such as modelling, stigma, and advice) as they pertain to men's help-seeking but does not add significant depth to existing understandings of why men do or do not seek help.

2.3.4 *Masculinity and help-seeking context framework*

Addis and Mahalik (2003) created a framework for understanding how socially constructed factors (particularly masculinity) and internal psychological processes of a person interact to lead to help-seeking. The authors noted that men are not a homogenous group, and any attempt to characterise them as such would be fruitless. Nevertheless, Addis's framework for help-seeking assumes that different situations and contexts interact with a man's sense of masculinity to create the behaviour of help-seeking. The authors posited that there are five key processes that impact on whether a man will seek help.

The five processes are as follows; firstly, 'normativeness' of the problem (i.e. how common is the problem that the man is experiencing. The normativeness of a problem is constructed by the context within which a man lives and who he knows), secondly, perceived ego-centrality of the problem (i.e. does the problem conflict with something central to this man's sense of self? For example, anxiety may conflict with a man's sense of stoicism). Thirdly, ability to reciprocate (i.e. men are more likely to seek help if they feel they can reciprocate by helping others). Fourth, how will others react if he seeks help? Fifth, what can the man lose if he asks for help? (e.g. a man may experience a loss of sense of self-control). Addis and Mahalik (2003) stressed that a key aim of their framework was to acknowledge different social contexts between men, which create different opportunities and barriers to seek help. For example, a young man training as a mental health counsellor may consider the onset of trouble falling asleep as a common (*normal*) problem that is external to his sense of self. He may seek advice from a senior counsellor, knowing that he will be able to share what he learns with others eventually, and that the senior counsellor will likely praise him for his courage in seeking help. In contrast, a young man with little

knowledge of common mental distress may begin to worry that he is going crazy and will never be able to sleep again following difficulties falling asleep. He worries that his friends will think he is weird for needing help with the simple task of falling asleep, and that he will lose his ability to fall asleep normally if he gets prescribed sleeping medication. In these two extreme examples, Addis's framework provides a useful means of understanding how men in social contexts construct their problems differently, and consequently their help-seeking behaviour differs. This framework also aligns well with the concept that diversity within masculinity should be embraced and explored as to how it affects help seeking.

Although Addis and Mahalik's (2003) framework for help-seeking contributes a framework for articulating how men construct their problems and considers cognitions that may facilitate or block help-seeking behaviours among men, it focuses primarily on the impact of masculinity on the help-seeking pathway. This framework may also suggest that wider social contexts, such as common beliefs portrayed in media may contribute to men's likelihood to seek help. For example, news media portrayals of mental illness may influence perceived normativeness of problems, and the perception of how others will react (which might also be displayed through how peers react to news media stories containing mental distress). However, this framework fails to account for the rest of the help-seeking pathway, in which attitudes toward services (Pattyn et al., 2015), availability of services (Andrade et al., 2014), encouragement from others (Harding & Fox, 2014), previous utilisation of services (Sierra et al., 2014), and other factors may ultimately block or facilitate help-seeking.

2.3.5 *The Cycle of Avoidance (COA) Model*

Previous models have focussed on social factors that impact on how an individual may experience and understand their problem, which may impact their resulting behaviours (such as whether and how they seek help). Another consideration in the pathway to help-seeking is the timing of help-seeking. That is, once (and if) an individual identifies that they are experiencing mental distress, at what point might they deem the distress severe enough to justify seeking help? Biddle et al. (2007) created the 'Cycle of Avoidance' (COA) model to understand the timing of help-seeking. Although the COA is not a gender-specific model, it is a useful explanatory model for mental-health related help-seeking avoidance among men. They posited that everyone has a 'health career,' similarly to Pescosolido's (2011) proposed illness career in the NEM. In the COA model, the health career represents the ways in which people react to illness by attempting to adapt to their new state, and to normalise their symptoms, but also in which people seek help.

The COA proposes that people with mental distress cycle through different reactions (avoidance, normalising, adapting/coping, and 'temporalizing') to their distress, while it becomes increasingly severe (Biddle et al., 2007). At a certain point of severity, the distress reaches a threshold at which time the individual chooses to seek help. Additionally, Biddle et al. (2007) found that participants would only seek help with extreme distress, while 'normal' distress (which ranged from day-to-day stress to severe depression) would be addressed by strategies in the cycling phase. Interestingly, this research did not approach help-seeking from the perspective of barriers, but rather, from the perspective that subjective meanings attached to symptoms are primary factors, a perspective that is like Addis and Mahalik's (2003) masculinity and help-seeking context framework

Biddle et al.'s (2007) COA model is pertinent to the study of men's help-seeking as it recognises subjective experience and reactions to mental distress resulting from social context and constructions of meaning. Biddle noted that different individuals have varying thresholds at which they would consider their distress 'real' and seek help. It is possible that men who do not seek help for mental distress have high thresholds before help-seeking and are less likely to consider symptoms 'severe.' Indeed, research has suggested that young men tend to normalise mental health related symptoms more often than women and older men (Kessler et al., 1999) and that some men believe that part of their masculine role is to cope with distress, rather than seeking help (White, 2009). Given that men may be more likely to normalise and cope with mental distress, it is possible that some men become 'stuck' in the cycle phase of the COA, and rarely reach the threshold to seek help unless they are in crisis. It is also plausible that external dialogues may impact on a person's threshold, for example if they learn through friends or news media that services are at capacity and only available for the most severe problems, a person may adjust their threshold based on these perceptions of pragmatic reasons. However, although the COA gives voice to the importance of subjective meaning in mental distress, it may be useful if a more in-depth analysis of variance in threshold was offered. Factors such as stigma, self-concept in relation to masculinity, and level of education relating to mental distress are likely to have important impacts on individual thresholds for help-seeking. Additionally, structural barriers, particularly among people in areas of high deprivation, have been found to have an important role in likelihood to utilise mental health services (Walker et al., 2015), and should be considered.

2.3.6 *Psychological Antecedents of Help-Seeking Model*

Research has consistently shown that personal factors, beliefs, and attitudes may act as barriers or facilitators to help seeking (Cramer, 1999). Cramer (1999) wanted to turn these factors relating to mental-health help-seeking into a predictive directional model. He based the model on four factors identified in previous research: personal distress, attitudes towards counselling, social support, and self-concealment. He utilised data from previous studies to develop the model and found several interactions relating to likelihood to seek help. Cramer found that high distress and positive attitudes towards counselling predicted help-seeking. Additionally, lower levels of social support and higher levels of self-concealment predicted higher distress, likewise, higher levels of self-concealment predicted lower levels of social support and worse attitudes towards counselling. Cramer concluded that the decision to seek help is particularly complex for individuals who self-conceal. Although self-concealers are likely to have greater distress, which is a predictive factor for help-seeking, they are also likely to report more negative attitudes towards counselling, which reduces likelihood to seek-help.

Although Cramer's (1999) pathway model of help-seeking was not developed specifically with men in mind, it is interesting to note that previous research has shown that men with gender role conflicts have higher levels of self-concealment and are less likely to seek help (Pederson & Vogel, 2007), which fits with Cramer's proposed pathway. The interactions in Cramer's pathway model also imply that men with high levels of self-concealment are likely to have generally negative views towards counselling. Additionally, some research has suggested that men tend to have less social support than women (Belle, 1991; Dalgard et al., 2006; Zimet et al., 1988), which based on Cramer's model, suggests higher distress, and possibly higher

self-concealment. It appears that self-concealment is a key factor in help-seeking, and appropriately, it has been explored in depth in the extant literature (although terminology varies). Specifically, it appears that some forms of stigma (i.e. self-stigma and fear of stigma from others) and beliefs relating to masculine roles/behaviours are major contributing factors towards self-concealment and therefore negative attitudes towards counselling (Cleary, 2012; Krumm et al., 2017; Moller-Leimkuhler, 2002; Vogt, 2011; Yousaf et al., 2015). However, men's attitudes towards counselling are relatively less understood, with most literature only exploring these attitudes at a categorical level (Furnham, 2009; Furnham & Telford, 2012; Lauber et al., 2005). Given that Cramer found that attitudes towards counselling have a stronger predictive effect than distress (i.e., someone with high levels of distress and strong negative attitudes towards counselling may be less likely to seek help), there appears to be a basis for further exploration of men's attitudes towards counselling.

Understanding specific national models of mental health service and pathways to service use is an important context for an investigation of men's help-seeking. In New Zealand, a primarily government funded model of mental health care is used, in which general practitioners act as the 'gatekeepers' to mental health services. However, there is little information regarding mental health consultations in primary care available. Existing models of mental health related help-seeking pathways appear to place emphasis on the help-seekers' social context, and their individual meaning making of their symptoms. These models give useful frameworks for understanding and focussing on the way that meaning is constructed in social context, but they are insufficient for a full understanding of help-seeking in men, as they tend to lack consideration of structural barriers.

2.4 OTHER BARRIERS TO HELP-SEEKING

There is abundant literature that explores barriers to help-seeking among men, yet much of the literature focuses on one specific barrier, or, at best, barriers specific to one step in a man's journey to receiving help. In their review of the literature regarding barriers to help-seeking in men, Gulliver et al. (2010) argued that barriers vary across the pathway to help-seeking and an in-depth investigation of each barrier is required. Although each barrier may have an impact on a man's likelihood to seek help, considering only one barrier without acknowledging a man's entire pathway to help-seeking ignores the complexity inherent in this area. While the intention of this study is to examine a specific barrier to help-seeking in men (men's attitudes and beliefs towards mental health services), I acknowledge that it is only one factor in the pathway to help-seeking. Consequently, this study represents an in-depth investigation of attitudes and beliefs towards mental health services, in the context of the broader pathway to help-seeking. The following section provides an overview of barriers to help-seeking based on existing literature.

2.4.2 *Structural barriers*

Throughout this research, the primary focus is on attitudinal barriers to help-seeking, as they have been shown to have a key impact on men's likelihood to seek help (Andrade et al., 2014; Harris et al., 2016; Rice et al., 2020). However, structural barriers also have an impact on ability to seek help and may represent a more important barrier to certain cohorts of men (such as men with intentions to seek help, but insufficient financial means to do so). That is, although some authors have argued that attitudinal barriers have more impact than structural barriers, this is unlikely to be true for all men and dismissing structural barriers may mean ignoring issues of equity. In this context, structural barriers relate primarily to men's ability to

access services. For example, structural barriers are likely to include the cost of services, distance to services, and long waiting times on accessing services (Andrade et al., 2014). This section will examine extant literature regarding the impact of structural barriers on help-seeking.

Walker et al. (2015) studied factors associated with barriers to mental health service utilisation. They examined data from a large United States mental health survey. The authors also looked at participant attitudes towards mental health services, and self-described 'unmet need'. Walker found that there were large proportions of people who did not receive treatment for mental health issues, and that participants with health insurance had higher rates of mental health service utilisation. Regarding barriers to help-seeking, the authors found that participants who did have health insurance tended to cite attitudinal reasons for not accessing services, while participants without health insurance tended to cite structural barriers as their primary reason for not accessing services. The authors concluded that both structural and attitudinal barriers reduce access to mental health services, and that both must be addressed. In Walker's study, it appears that the primary structural barrier is likely to be the cost of services, given the impact of insurance cover on accessing services. However, these findings may not be completely transferrable to New Zealand, where mental health services are predominantly part of publicly funded services, rather than the United States' insurance-based system (Mossialos et al., 2016).

Other research has suggested that financial concerns are not the only structural barrier. For example, Rice et al. (2017) conducted a study to understand the barriers and facilitators to help-seeking in young men. They recruited a sample of men who

had previously accessed community mental health services and interviewed them regarding the main difficulties in accessing mental health services. Participants described both attitudinal and structural barriers to help-seeking. Regarding structural barriers, the participants stated that the complexity of the mental health pathways made seeking help complicated, and that accessing services was a slow and confusing process. Regarding attitudinal barriers, Rice found that poor understanding of mental health services and the impact of hegemonic masculine norms made participants reluctant to seek help.

Structural barriers may have a particularly strong impact on individuals who have lower than average financial means to support mental health service use (Walker et al., 2015), but they may have a compounded impact on recent migrants. Kung (2004) sought to understand the impact of barriers to mental health service utilisation on Chinese American migrants. In contrast to previously cited literature that conceptualises barriers broadly as attitudinal or structural, Kung conceptualised barriers to service use as 'cultural' or 'practical'; however, Kung's practical barriers largely fit with the current research's description of structural barriers. Kung analysed data from a survey assessing Chinese American participants' ratings of statements relating to pre-formulated barriers. Kung found that participants had the highest overall agreement with the statement that the cost of treatment is a barrier, and that language restrictions, having enough time to attend treatment, and being able to navigate complex health pathways were also regarded as barriers. Kung also found that understanding symptoms and acknowledging that help would be beneficial was a barrier commonly rated as true, suggesting mental health literacy and attitudes towards services were another barrier. The author concluded that practical barriers tend to have a larger impact on mental health service use, but that

the relative impact of practical and cultural barriers varies based on the circumstances of the individual. The findings of this study reinforce the previously stated structural barriers of cost (Walker et al., 2015), and of navigating complex mental health systems (Rice et al., 2017), but it also adds two new and important structural barriers: language and time.

It seems that structural barriers have a variable impact on likelihood to seek help. Although attitudinal barriers and structural barriers often co-exist (Rice et al., 2017), structural barriers become a primary concern in disadvantaged groups. People who are unable to afford mental health services, who are unable to speak the language of the service, and who are unable to make the time to attend regular appointments are at a distinct disadvantage in their ability to access and seek help. Therefore, it seems pertinent to reduce structural barriers to accessing mental health services, particularly for disadvantaged groups. However, structural barriers appear to be a type of systemic barrier that affects men but is not specific to men. Therefore, although addressing structural barriers should be a key objective for health providers, it should not be assumed that by doing so, men's low rates of mental health service utilisation would be remedied (though they would likely be alleviated). Nevertheless, when engaging with men and attempting to understand their help-seeking it appears that structural barriers should be considered alongside attitudinal barriers. That is, if a man is suffering from mental distress, and is not seeking services, the impact of structural barriers should be considered in parallel with addressing concerns of stigma, threats to masculine identity, and negative attitudes towards mental health services.

2.4.3 *Recognising and articulating symptoms*

Perhaps the first step in the pathway to accessing help for men is recognising that they have a problem. Gulliver et al. (2010) reviewed the literature regarding barriers to help-seeking and noted that a common barrier was inability to recognise symptoms. Similarly, Cleary (2012) found that young men who attempted suicide had poor knowledge of their own symptoms and could only identify depression as a possible psychological cause for their distress. As there is little targeted messaging to men around psychological symptoms (except, perhaps, for depression (Rice et al., 2017)), it is unsurprising that men have difficulties self-identifying symptoms of mental distress. This issue is compounded by the fact that men tend to somaticize and normalise their symptoms (Danielsson et al. 2009), suggesting that even if a man understands the common symptoms of depression, his depression may involve different symptoms. Furthermore, Moller-Leimkuhler (2002) and Krumm et al. (2017) found that men who experience recognisable symptoms of depression tend to hide or ignore these symptoms.

There has been substantial research regarding public mental health literacy, and its impact on help-seeking. Thompson et al. (2008) wanted to understand why Australians with mood and anxiety disorders tended not to seek help until a significant time after their symptoms first developed. They conducted a survey with patients at a mental health clinic regarding their help-seeking and found that the average time elapsed between onset of symptoms and first contact with professional services was around eight years. Thompson found that poor understanding of symptoms was a strong predictor of delayed help-seeking and concluded that low mental health literacy was associated with likelihood of help-seeking. Likewise, Jorm (2000, 2012), argued that the American public has poor mental health literacy,

which results in reduced ability to recognise symptoms, and delayed help-seeking. Although this appears to be a general issue, some research has demonstrated gender differences in ability to recognise mental health issues. For example, studies have found that women tended to have higher accuracy than men in attributing symptoms in a vignette to depression (Cotton et al., 2006; Swami, 2012).

In the gender role strain paradigm (GRSP), one of the key strains affecting men is 'trauma strain,' which results in what Levant (1998) labelled 'normative male alexithymia.' Alexithymia refers to reduced emotional literacy, or simply, an inability to articulate feelings (Levant et al., 2003; Levant et al., 2009). It also appears that alexithymia relates to hegemonic masculinity, as Levant et al., (2003) found that alexithymia was predicted by adherence to hegemonic masculine values.

Berger et al. (2005), found that men who endorse more hegemonic masculine attitudes, which relates strongly to alexithymia, have unfavourable views of mental-health related help-seeking. Likewise, due to this alexithymia, it is likely that men who do attempt to seek help may be less able to recognise their own emotional distress and may therefore express their problems in a way that normalises or somaticizes them (Danielsson et al., 2009). Additionally, normalising psychological symptoms may increase the chances of the GP misdiagnosing or failing to recognise a psychological basis of distress (Kessler et al., 1999).

Men's poor mental health literacy results in low understanding of mental health symptoms, even in relatively common disorders such as depression (Cotton et al., 2006; Swami, 2012). Resulting from their poor knowledge of symptoms, men may be less likely to seek help, or do so after considerable delays (Thompson et al., 2008). Men tend to be less able to articulate emotions than women (Levant et al.,

2009), which may result in somatising, or normalising symptoms, which can hinder health care professionals' ability to diagnose and treat these symptoms (Kessler et al., 1999). Nevertheless, even when symptoms are recognised, research indicates that many men who have poor mental health literacy also have poor understanding of and negative attitudes toward mental health services, (Cotton et al., 2006; Jorm, 2012). Therefore, although recognition and articulation of symptoms may be a necessary facilitator to service access, alone these factors are unlikely to be sufficient facilitators.

2.4.4 *Stigma*

There is considerable evidence supporting the theory that stigma is a barrier to help seeking among men (Clement et al., 2015; Vogt, 2011). However, the concept of stigma is dynamic, as are its effects. Stigma may be broken down into several forms, which are presented here in a non-exhaustive list. Firstly, self, or internalised stigma relates to internalised feelings of guilt and shame (Clement et al., 2015). Secondly, feared, or perceived stigma relates to the perception that others will stigmatise an individual based on their mental health needs (Barney et al., 2006; Vogt, 2011). Thirdly, actual, or experienced stigma exists in the form of negative judgement and blame for mental health issues (Pattyn et al., 2015). Men are particularly vulnerable to all forms of stigma, which results in lower levels of help-seeking (Clement et al., 2015). The impact of stigma on help-seeking is explored next.

Clement et al.'s (2015) literature review found that in most of the studies, stigma was moderately negatively related to help seeking. As well as looking at studies specifically regarding the impact of stigma on help seeking, Clement reviewed articles that compared the impact of attitudinal barriers on help-seeking.

They found that internalised stigma had a moderate impact on help-seeking, while fear regarding disclosure had a larger effect on help-seeking. However, Clement found that the impact of various barriers differed depending on the demographic of participants. For example, stigma tended to be viewed as a greater barrier in studies that included men than in women-only studies, which is consistent with Pattyn et al.'s (2015) conclusion that men are more vulnerable to stigma in relation to help-seeking. Clement noted that men may be more sensitive to help-seeking stigma due to a combination of gender norms and mental health-related stigma. Additionally, they suggested that young people may be more sensitive to stigma due to the impact of mental health stigma on the formation of self-identity. The finding that internalised stigma affected likelihood to seek help is consistent with Levant's (1995) discrepancy strain, which relates to internal feelings of discomfort regarding behaviours that do not align with internalised ideas of what normative masculinity looks like. Similarly, a review conducted by Vogt (2011), regarding barriers to help seeking, found that perceived stigma constituted a significant barrier.

Barney et al. (2006) wanted to understand the mechanisms of how stigma impacted on help seeking behaviours. They found that people felt more internal stigma about seeking help from a mental health specialist, and so preferred to seek help from their GP. However, Barney also found that participants expected the most stigma from their GPs – in other words, participants felt they would be most judged by their GP but judged themselves most for visiting a mental health specialist. Likewise, participants expressed high levels of perceived stigma from their friends and family, particularly regarding seeing mental health specialists. It appears that stigma has a complex impact on potential help-seekers and is not limited to external stigma that people with mental health diagnoses may face (Reavley & Jorm, 2011).

Pattyn et al. (2015) posited that all interactions, including health-related interactions, are constructed as gendered - either masculine or feminine. Consistent with Andrade et al.'s (2014) findings that men reported lower perceived need for mental health services, Pattyn stated that to be masculine regarding health is to be stoic and in charge (i.e. not to need help), whereas to be feminine is to be open and to rely on others. In other words, one cannot be both a masculine man and a vulnerable and obedient patient. Due to Pattyn's proposed incompatibility of help-seeking and masculinity, the authors sought to explore whether men are more vulnerable to stigma – both from others and from themselves when they seek help. They presented men and women with a gendered vignette featuring a character who had mental health problems, and measured respondents' attitudes towards the character. The results of the study indicated that the gender of the character in the vignette was more important than the gender of the respondent. Both men and women stated that the vignette depicting a man should use self-care options more than the vignette depicting a woman, and that psychotherapy would be more useful for the vignette depicting a woman than the vignette depicting a man. The men also attributed more blame to the vignette depicting a man than the vignette depicting a woman, suggesting stigmatising views towards men with mental health problems (Pattyn et al., 2015). Based on these findings, the authors suggested that men may utilise mental health services less than women due to hegemonic norms regarding masculinity, and that men are also expected to conform to these norms by women as well as other men. Although the GRSP mentions discrepancy strain, which reflects a form of self, or internalised stigma, Pattyn's research suggests that men who seek help are likely to also face external stigma from those around them – which may compound and exacerbate internal stigma.

2.4.5 *Men's attitudes and beliefs towards mental health services*

Some of the key barriers that may influence whether a man will choose to seek help or prefer to self-manage for mental distress are their level of knowledge and attitudes towards health services (Yousaf et al., 2015). However, unlike other barriers such as stigma and masculinity, which can be conceptualised primarily as attitudinal barriers to seeking help, men's attitudes towards services may also reflect structural barriers. This section examines the literature regarding men's attitudes and beliefs towards mental health services, and the impact of these upon help-seeking.

Yousaf et al.'s (2015) review regarding delays in help-seeking among men found that factors relating to stigma and masculinity affected likelihood to seek help, but also that misunderstanding of available services, fear of diagnosis, and unhelpful relationships with service providers were commonly described barriers. In general, the public has a mixed understanding of the process of talk therapy (i.e. treatment where the active component involves talking rather than medical interventions) (Cramer, 1999; Furnham & Wardley, 1990)) and men tend to have a less positive view of talk therapy than women (Wong, 1994). More recent literature has shown that little has changed, and that men still express that poor understanding of what talk therapy involves is a barrier to utilising services (McKelley & Rochlen, 2007; Rice et al., 2018; Vogel et al., 2007). In addition, some men express a general distrust of health-services, feel alienated by their general practitioner, and are frustrated by the lack of services for them (Coles et al., 2010). Other research has shown that some men believe pharmaceutical treatment is the only option available (House et al., 2018), and there is substantial evidence indicating that men (and the public in general) believe that psychopharmaceuticals are dangerous and unhelpful (Harding &

Fox, 2015; Lauber et al., 2005). Specifically, there is evidence to suggest that the public believe that psychotropic medication is addictive (Paykel et al., 1998). Although research has indicated that attitudes towards medication have improved, it appears that the public still tend to hold fearful views regarding medication (Mirnezami et al., 2016). In contrast, there is alternate evidence suggesting that people hold generally positive views of talk-therapy and general practitioners (Furnham & Wardley, 1990; Lauber et al., 2005; Wong, 1994); however, participants in these studies tended to be from well-educated backgrounds, some of whom were psychology students, who may have better informed views (and perhaps in the case of some students training in the field, a positive bias) regarding talk-therapy. Additionally, participants in these studies may have been better resourced to access services, and therefore may have had better experiences with health services.

Despite substantial literature suggesting that men often have a poor understanding of what is involved in mental health treatment, it appears that men who have experienced treatment tend to endorse more positive views of talk-therapy. For example, Sierra et al. (2014) found that men who had been treated in outpatient settings rated individual talk-therapy as their preferred option of treatment over medication and group therapy. Likewise, Prins et al. (2008) found patients being treated for anxiety and/or depression saw the benefit of treatment, and preferred talk-therapy to medication. Other research, in contrast, has shown that men prefer medication over talk therapy (although roughly half of the male participants still endorsed talk-therapy (Harris et al., 2016)).

Although there is mixed evidence regarding what type of treatment men prefer, it appears that men who have never had treatment often express negative and anxious views of what treatment involves, whereas men who have utilised treatment tend to

express more positive views towards seeking treatment. In other words, it seems that the problem is one of education regarding treatment for men - a statement that has been supported by men's own accounts (Harding & Fox, 2015; McKelley & Rochlen, 2007) and through educational interventions, in which educating men has reduced fear and improved attitudes towards services (Hammer & Vogel 2010). Relating specifically to New Zealand, the People's Mental Health Report (Elliot, 2016) recommended that there should be a programme of education for New Zealanders relating to mental health conditions and what mental health services look like and offer. Although talk-based therapies and psychopharmaceuticals only make up two components of mental health services, it appears that many men are relatively uninformed regarding mental health services and this may negatively impact their likelihood to seek professional services.

Despite there being significant interest regarding attitudes towards available services, there appears to be scarce in-depth understanding of this area. Much of the extant literature considers men's understanding of available services only to the extent that it contributes as a barrier in relation to other barriers (e.g., Coles et al., 2010; Harris et al., 2016), or through mostly quantitative research designed to explore service preferences/correlates (Furnham, 2009; Furnham & Wardley, 1990; Lauber et al., 2005; Von Sydow & Reimer, 1995). In the literature there is a lack of focussed investigation of men's attitudes towards services. However, Midgley et al., (2014) conducted a semi-structured interview study designed to assess beliefs about what therapy would involve with a large group of young people, most of whom had not experienced talk-therapy before. They found that many participants did not know what might happen in therapy; however, they also found that some participants believed therapy would involve talking to someone about their problems and being

allowed to vent their problems. Other participants believed that therapy would involve being prescribed medication. Midgley concluded that it is important for talk-therapists to explain what therapy will involve, and for services providers to offer more information about their services. Since young men were included in this study it is likely that their beliefs regarding talk-therapy will be held by other young men who have not accessed services. However, this study asked specifically about talk-therapy, and did not consider other aspects of mental health services, which men may also hold barrier-causing beliefs about.

A study that provided a good basis for understanding men's attitudes and beliefs towards mental health services was conducted by Harding and Fox (2015) who wanted to understand what help-seeking men believed were the key factors that enabled them to seek help. The authors interviewed nine men who had previously utilised services and identified several themes relating to how these men came to seek help. The themes included having an encouraging person in their life, structural barriers, stigma, and the themes also addressed the men's experience with, and beliefs relating to available services. Regarding the men's beliefs around utilising specialist mental health services, the authors found that the men were worried that their only options were "Freudian couches and personality changing drugs" (Harding & Fox, 2015, p. 457). The authors reported that all the men had previously held negative perceptions of treatment, misunderstood what treatment would entail, and felt relief when they attended treatment and it did not match their negative expectations. As participants were service users, their beliefs are likely to be different to men who have not accessed services, and they may represent a group of men who are willing to seek help for mental health problems. To address the barrier to help-seeking that appears to be resulting from men's misunderstanding of health

services, it is important to explore how these beliefs are articulated by men who have never utilised mental health services. That is, how do men who have never utilised services understand these services?

2.5 ATTITUDES AND BELIEFS TOWARDS MENTAL HEALTH SERVICES

2.5.2 *Aetiology of attitudes and beliefs*

The present study aims to assess beliefs and attitudes towards mental health services as they are constructed by young men and media, to consider how this might act as a barrier towards help-seeking. As this study relates strongly to attitudes and beliefs, with some assumption that they may impact behaviour, the present section attempts to define attitudes and beliefs, and explore what role they might have in help-seeking.

Before discussing research regarding definitions and uses of the terms 'attitudes' and 'beliefs,' it is important to consider how these concepts align with the social constructionist epistemology of this project. Tuffin and Danks (1999) highlighted that research regarding attitudes has a history of positivist grounding, whereby attitudes have been positioned as stable and measurable phenomena. However, they also noted the limitations of this positivist grounding such as the contextual variations in attitudinal expression and the recognition that attitudes imperfectly lead to actions. Tuffin and Danks suggested that attitudes may be viewed in a way that resists the reification of these constructs, whilst acknowledging the social-contextual function of conversation in which 'attitudes' are constructed. That is, attitudes may be constructed in conversation, and likely reflect the context of that conversation. Thus, the present study uses the terms 'attitudes' and 'beliefs' as

pragmatic codes to signal the discussion of services and gender related issues. Therefore, although literature regarding attitudes and beliefs is explored pragmatically in the present study, these concepts should be considered as social and gendered constructs rather than reified phenomena.

Attitudes have been the subject of considerable philosophical and psychological scrutiny for many years. Although definitions vary, Fazio's (1986) definition of attitudes fits with the present study's conceptualisation: "An attitude is typically considered to involve categorisation of an object along an evaluative dimension" (p. 214). In the present study, the 'object' of evaluation is mental health services. The specific detail of what a service is will likely differ between individuals and media articles.

The present study considers not only men's attitudes towards mental health services, but their beliefs and the formation of these attitudes and beliefs, and as such, it is worth noting the differences between the two concepts. Petty (2018) argued that whereas attitudes primarily comprise an emotional valence towards the object (e.g., "Richard does not *like* counselling", or "Brett is *afraid* of anti-anxiety medication"), beliefs comprise statements about the features, uses, makeup and so forth (whether true or untrue, and regardless of valence) of an object (e.g., "Richard believes counselling involves talking about feelings" or "Brett believes that anti-anxiety medication is highly addictive").

One of the key reasons that attitudes have been studied is because of the impact that they are thought to have on actions. Likewise, beliefs have also been the subject of considerable investigation, although typically because of their indirect impact on actions via their impact on attitudes (Petty, 2018). Nevertheless, beliefs and attitudes are often considered together, and are considered to have an interactional

relationship. Petty (2018) noted that through changing beliefs, attitudes may be changed, which in turn may change behaviour.

Fazio (1986) noted that while there is substantial evidence linking attitudes to behaviours, the relationship between the two is not perfectly predictive, and so Fazio sought to establish a model of how (and under what circumstances) attitudes impact on behaviours, which he labelled the attitude-to-behaviour process. The attitude-to-behaviour process involves several steps, each of which may cause behaviours that are not directly related to attitudes. First, attitudes must be salient or 'activated' in a situation to have an effect. Although some strongly held attitudes are easily accessible, others are not, and may be triggered by certain events. For example, seeing a poster warning against the addictiveness of cigarettes in a pharmacy may prime negative/fearful attitudes regarding addictiveness of anti-anxiety medication. Second, the object must be socially ambiguous, thereby allowing for the attitude to impact perceptions of whether the object is positive or negative. Third, the constraints and social norms of the event itself may override the impact of attitude on behaviours. This model of the attitude-to-behaviour process is useful as it provides a more nuanced understanding of how attitudes may impact behaviour – but also how they might not. Interestingly, Fazio's consideration of the impact of social norms on a situation suggest that even men who have *positive* attitudes towards services may be blocked from seeking help in situations where the three steps in the attitude-to-behaviour process are not completed. However, it seems that men who are struggling with mental distress may be likely to be in a relatively constant state of attitude activation due to salience (for example, when experiencing low-mood and feelings of guilt or confusion about their mental state).

As well as considering the potential impact of attitudes and beliefs on behaviour, it is important to also consider how attitudes are formed and maintained. Maio et al. (2018) summarised much of the influential research regarding attitudes and noted that there are three major contributing factors towards attitude formation: cognitions, behaviour, and affect. Regarding the cognitive contributors towards attitudes, Maio posited that beliefs are often a key point from which attitudes are formed. Further, Maio stated that beliefs are formed via an external source of information and aspects such as the credibility of the source, the recipient's existing knowledge, and the delivery of the information influence whether the information affects beliefs and subsequently attitudes. For example, a man with little existing knowledge of mental health services may be particularly susceptible to belief formation based on sources such as experts in news articles.

Additionally, Maio et al. (2018) noted that the recipient's own motivation and capacity to process information is also an important contributing factor as to whether information will go on to influence beliefs and attitudes. Regarding the impact of affect on attitudes, Maio noted that an important factor was the association between the emotional state of an individual and the object of attitudinal evaluation. For example, individuals who are in a positive emotional state may be more likely to generate positive appraisals of an object, which may be a result of classical conditioning or through the mood-state causing biased perception to mood-congruent features of the object. However, Maio also noted that affect may vicariously influence attitudes such that an observer may see someone react to an object with a negative affect, which may cause the observer themselves to develop negative attitudes towards the object. This may be particularly true regarding mental health services, where news media often reports negative stories about service deficits

(McGinty et al., 2016). It also speaks to attitudes being constructed through, and reflecting social context.

Maio et al. (2018) highlighted that behaviour is not solely an output of attitudes, but in many cases, behaviour may result in attitudes. That is, an individual may act in a specific way towards an object without cognitively assessing their attitudes towards the object, and as a result, the individual may therefore derive their attitude towards that object based on how they acted (Self-Perception Theory, Maio et al., 2018). For example, a man who experienced a brief episode of low mood, and who did not utilise services, though without explicit consideration, may subsequently deduce that they do not trust services. Further, Maio noted that there are three factors that influence the type of attitude resulting from behaviour: whether the experience was lived or vicarious, whether the result was positive or negative, and whether the behaviour was to approach or to avoid. Importantly, many experiences in relation to mental health services are vicarious. Therefore, it appears that men who have never utilised mental health services are likely to develop beliefs and attitudes through vicarious channels such as socially and through media.

Another way in which behaviours may influence attitudes is through conflict between an attitude and behaviour, sometimes referred to as *cognitive dissonance* (Festinger, 1962; Harmon-Jones & Mills, 2019), which may result in feelings of unease or confusion, and may lead to attitudinal changes. Regarding male help seeking, men who engage with mental health services may experience cognitive dissonance due to gender role strains causing negative attitudes towards expressing vulnerability and seeking help (Levant 1995); However, this discrepancy between

attitude and behaviour may lead to attitude changes towards services once they have been accessed (Harding & Fox, 2015).

Maio et al.'s (2018) three factors in attitude formation may offer some insight into help-seeking. First, regarding the cognitive (or informational) influences on attitudes; it appears that scarce information relating to services is available, as men in several studies have not only expressed misinformed beliefs regarding what services involve (McKelley & Rochlen, 2007; Rice et al., 2018; Vogel et al., 2007), but have also explicitly stated that it would be useful if more information was available (Harding & Fox, 2015; McKelley & Rochlen, 2007). Furthermore, due to low rates of mental health service utilisation (Pattyn et al., 2015), it appears that much of the information influencing men's beliefs and resulting attitudes towards services is vulnerable to misinformation. For example, Schultz (2005) argued that attitudes towards services are disproportionately impacted by media sources (including news media, films, movies, etc.) due to a relative lack of lived experience. Additionally, Vogel et al., (2007) demonstrated that men's attitudes towards mental health services were considerably influenced by the attitudes and behaviours of their friends and family. Therefore, men who are frequently exposed to media that discusses services with negative valence (Orchowski et al., 2006), and who do not have other sources of information, may be likely to express negative attitudes towards services. Additionally, also resulting from low frequency encounters with services, men may be unlikely to experience exceptions and cognitive dissonance that could otherwise challenge or influence their attitudes towards mental health services.

2.5.3 *Influences on men's attitudes and beliefs towards mental health services*

Understanding the attitudes of men who have never accessed services is an important step towards understanding the barrier that these attitudes may comprise; however, it is also important to consider the possible causes of these attitudes. As mentioned previously, attitudes may be formed vicariously or through lived experience, and several factors such as the recipient's existing knowledge, the expertise of the source, and affect can impact the formation of attitudes (Maio et al., 2018). Given that many men have not accessed services, it is likely that many beliefs regarding services are formed vicariously. This section explores research about the impact of media on understanding of services.

One likely source of attitudes relating to services is the mass media. In Bandura's (2001) explanation of the impact of media, he discussed social cognitive theory as the innate capacity of humans to learn through observation, which explains the huge impact of mass media on thinking patterns and resulting behaviours. Indeed, many people have never directly experienced any form of mental health treatment, yet most still express specific beliefs and attitudes regarding what services will involve. However, it is less clear how these influences contribute towards a gender difference in help-seeking.

Previous research has shown that men tend to have poorly informed views regarding mental health care, and less knowledge of mental illness than women (McKelley & Rochlen, 2007; Swami, 2012), which indicates that their beliefs may be more susceptible to vicarious influence (Maio et al., 2018). Additionally, people may be more likely to consume media that represents mental health services in ways

aligning with their existing views (i.e. confirmation bias, Nickerson, 1998), and given that some men tend to hold negative views towards mental health services (Calear et al., 2017), they may be more likely to consume media that portrays services negatively. Alternatively, if the portrayal in media is ambiguous, men with negative views may interpret the information in ways aligning with existing views due to confirmation bias. Likewise, it is also plausible that as men experience high levels of self and perceived stigma regarding mental illness (Barney et al., 2006; Pattyn et al., 2015), they may prefer not to discuss their problems with peers and may therefore be more susceptible to vicarious learning through media. However, there is little empirical testing of these theoretical gender-biases in attitude formation, and they should be explored further.

The impact of the media on understanding of mental health and mental health professionals has been an area of interest among researchers, with some researchers claiming that the practice of clinical psychology is particularly open to media influence in comparison to other professional fields. Schultz (2005) argued that attitudes towards professionals such as general practitioners and lawyers are impacted by the media, but that these views are buffered and mediated by actual lived experience (aligning with Maio et al.'s (2018) description of attitude formation), as many people will have first-hand experiences with GPs and lawyers. It is worth noting that GPs make up a substantial part of mental health services in New Zealand, and therefore attitudes to these mental health services may be mediated by lived experiences. Nevertheless, previous literature suggests that when men consider mental health treatment, talk therapy and psychotropic medication are what they tend to imagine (Harding and Fox, 2015), rather than GPs. In contrast,

many will not encounter clinical psychologists and other specialist mental health professionals, leading to beliefs built entirely from vicarious learning.

Wedding (2017) conducted a review of how the media has influenced understanding of psychologists, and how psychologists have made efforts to influence these perceptions. Wedding noted that although psychology has had various stages of (and reasons for) notoriety since the early 20th century, improving public knowledge and understanding of the field is still a key area of focus for the American Psychological Association (APA). Additionally, Wedding posited that popular television programmes and films have had - and continue to have - the largest impact on public perception of mental health care professions.

Orchowski et al. (2006) conducted a review of how talk-therapists are portrayed in films. The authors categorised therapists portrayed in movies into four subtypes: The Oracle, The Societal Agent, The Eccentric and Romantic Therapist, and The Wounded Healer. Each of the categories could be portrayed as either 'good' or 'bad' therapists. Orchowski acknowledged that it is practically and financially logical for film producers to present therapists according to stereotypes that elicit humour or drama; however, doing so has a negative impact on the profession. The authors also noted that movies tend not to differentiate between various mental health professions, and often give unrealistic expectations for the outcomes of therapy. Orchowski concluded that realistic portrayals of mental health professionals should be encouraged and supported by professional groups to improve public understanding of the professions. Although the public may receive more positive and realistic messages about mental health professionals from alternative media, such as online videos and forums (Wedding, 2017), it is likely that only people who already

have an interest or positive view of professionals will be exposed to the realistic media, reflecting a confirmation bias. In contrast, men who have no specific interest in mental health services, may be more likely to be exposed to mental health professionals through popular media's portrayal of them (such as major film), which is often unrealistic and caricatures the profession (Orchowski et al., 2006).

While there is little doubt that popular media influences people's attitudes and beliefs towards mental health treatment (Orchowski et al., 2006; Wedding, 2017), it is less clear specifically how popular media influences attitudes, and what attitudes they tend to affect. Maier et al. (2014) wanted to understand how film and television psychotherapy affects viewers' beliefs and attitudes. The authors presented the paradox that the American public appears to be drawn towards talk-therapy in their entertainment preferences, yet they still tend to hold negative attitudes towards seeking talk-based treatments for themselves. Indeed, Vogel et al. (2008) found that people who reported watching more content relating to therapy had greater fear and reduced confidence towards services, suggesting a negative impact of media portrayals on attitudes towards services.

Maier et al. (2014) categorised fictional characters in the portrayal of mental health treatment into three groups: People who Seek Help (PSHs), People with Mental Illness (PMIs), and People who Conduct Therapy (PCTs). The authors recruited a sample of introductory psychology students, asked them to name popular media in which psychological treatment was presented, and then rate their own help-seeking beliefs and attitudes towards characters in these television shows and films. Maier found that participants who had high self-stigma tended to hold more negative views of PCTs and PSHs, but not PMIs (fitting with Clement et al.'s (2015) findings that self-stigma was negatively related to help-seeking). The authors concluded that

people who hold negative views of PCTs are more likely to self-stigmatise about seeing PCTs and are therefore less likely to seek help (and previous research has shown that men are vulnerable to self-stigma (Clement et al., 2015)). The authors concluded that the popular media has a strong influence over help-seeking attitudes and behaviours. These findings align with, and extend upon, the Psychological Antecedents of Help-Seeking model, which found that self-concealment predicted negative attitudes towards counselling (Cramer, 1999). Maier's findings suggest that the impact of self-stigma extends to fictional counsellors in media.

Despite there being evidence supporting the idea that popular media impacts people's attitudes towards mental health services (Maier et al., 2014; Orchowski et al., 2006; Von Sydow & Reimer, 1998), it is difficult to know what media vulnerable groups, such as young, poorly-educated men, have been exposed to. For example, although Maier et al.'s (2014) study examined a young cohort, the participants represented an American population with an interest in psychology. The media influences on Maier's sample is unlikely to generalise to a New Zealand sample of males who have never sought therapy or elected to study it. That is, although young New Zealand men may have been exposed to popular American film media, their views may have also been influenced by New Zealand specific media, including targeted mental health campaigns such as Sir John Kirwan's depression campaign (Wardell, 2013) and national and local news reporting on mental health services. Additionally, these men's views are likely to have also been influenced by the local cultural (including their family, friend-groups, and workplace) attitudes towards mental health services. For example, Vogel et al. (2007) found that the behaviours and perceived beliefs of university students' social groups (including family and

friends) correlated strongly with the student's own beliefs and behaviours towards utilising mental health services.

An aspect of media that has not been well-covered in existing literature though, is local and national news media. New Zealand news media focuses on national and local issues and is likely to have an impact on attitudes towards mental health services (particularly with the common use of experts (Maio et al., 2018)). Therefore, in addition to examining international media as a source of attitudes and beliefs, it is important to address national news sources, particularly as they may reflect culturally specific constructions of mental health service issues. Although much of the information that men have - which contributes towards their attitudes towards services - is likely to be from a variety of sources, it is useful to examine how popular news media construct mental health services, and how this is likely to impact men's beliefs and attitudes. The following section explores literature regarding news media discussion of mental health.

2.5.4 *News Media representations of mental illness*

Much of the extant literature regarding news media and mental health appears to focus on how news media portrays mental *illness*, and how these portrayals affect stigma. Relatively little literature examines the impact of discussion of mental health *services* in the news media. This section presents literature regarding mental health in news media to understand how news media is academically interpreted (with a focus on New Zealand literature). It then presents literature regarding reporting on services, to examine what is already known.

Unlike reporting on services, the subject of news reporting on mental illness has seen considerable academic and legal scrutiny. Blood and Holland (2004) discussed the way in which Australian news media constructs 'risks.' They

demonstrated news media constructions of risk by using a case study where two psychiatric patients had 'escaped' from the inpatient unit. The authors noted that articles framed the event in a way suggesting a mental health crisis, and of mental health patients being a danger to the community. This analysis of news media uses 'Framing Theory,' which explores the way that media *frames* the objects of their discussion. With framing theory, it is acknowledged that news topics are presented in ways aligning with a particular social construction of the topic. Blood also noted that these news articles were written in a way as to appear objective and descriptive (through describing the 'facts' and having quotes from experts), yet the articles still construct the event in a way aligning with a dominant but misleading portrayal of mental health patients as dangerous. Such analyses demonstrate that news media, just as interactional speech, constructs information in ways aligning with common beliefs and ideologies. While men discussing mental health services may frame things from hegemonic masculine values (or against these values), news media is likely to frame similar topics in ways aligning with dominant public beliefs and attitudes. Likewise, analyses of how New Zealand news media frames topics suggests unhelpful framing for people with mental illness. For example, Sieff's (2003) analysis of representation of mental illness found that New Zealand news media tended to use frames that were unhelpful and create/maintain stigma around mental health issues.

As well as frame analyses, there have been other analyses of New Zealand news media representations of mental health. Nairn et al. (2001) conducted a discourse analysis of news media stories relating to mental health. They found that most of the themes in these stories were negative and aligned with stigmatising discourses regarding mental health issues. Similarly, Coverdale et al. (2002) conducted a content analysis of all news items over a four-week period, with the

objective of understanding how mental health was constructed. They found that most constructions related to people with mental illness being a threat to the community, while a small fraction of the articles constructed people with mental illness as being successful and contributing to their communities. More recently, Thom et al. (2012) conducted a content analysis of news articles to understand the rate and appropriateness of coverage of suicide. They found that there was a high rate of coverage of suicide in the news media, and that much of the reporting was appropriate (based on New Zealand Ministry of Health guidelines, New Zealand Ministry of Health, 2011). The authors concluded that overall reporting is good; however, an increased focus on positive outcomes and recovery stories should be emphasised. These findings may suggest that the news media in New Zealand is responsive to guidelines on appropriate reporting; however, it appears that there is still greater reporting on negative events and outcomes (likely for their higher 'newsworthiness' (Blood & Holland, 2004)), which may continue to impact negative public constructions of mental health.

More closely related to understanding presentation of services in news media, a recent study sheds some light on how services are constructed in news media. McGinty et al. (2016) wanted to understand how mental illness was presented in the United States' news media over the past 19 years. They constructed a key-word coding tool and undertook a content analysis of news media articles over that period. The results indicated that a small majority of news articles regarding mental health related to violence, and a large minority of articles related to mental health treatment. McGinty noted that of the articles relating to treatment, most were focussed on problems with treatment such as lack of availability, cost of treatment, and unhelpful treatment; only a small portion of articles described treatment with positive

outcomes. Additionally, the authors noted that the proportion of type of reporting did not change over the 19-year period. These findings suggest that mental health services tend to be depicted from a deficit perspective in the news media. Depicting mental health services as having poor quality and lacking in funding may create another barrier to help-seeking in men – a belief that services are unavailable, and low-quality when they are available.

Interestingly, although McGinty et al.'s (2016) findings suggested that only a small portion of news articles focussed on treatment with positive outcomes, research suggests that these types of articles may have a positive effect on attitudes towards mental health services and mental illness (McGinty et al., 2015). Likewise, Corrigan et al. (2013) found that news articles that focussed on positive outcomes of mental health resulted in lower levels of mental health stigma among readers; whereas articles that focussed on the deficits and problems with services resulted in higher levels of stigma among readers.

Although there is a significant body of literature examining the impact of news media representations regarding mental health, it appears to primarily focus on representations of individuals with mental illness (or incidents involving those with mental illness), and how these affect public constructions of mental illness. These representations undoubtedly influence barriers to help seeking by affecting stigma related to mental illness. However, there appears to be less consideration of representations of services, despite these representations also being likely to affect public constructions of services, and therefore barriers to help-seeking. That is, if services are constructed in a negative way, this may create a public discourse that services are unhelpful or inaccessible, and therefore reduce public likelihood to seek

such services. For example, Torjesen (2013) noted that news media representation of an English palliative care service resulted in both the public, and service providers being reluctant to use these services. Additionally, it is likely that the news media may have a strong impact on public beliefs and attitudes towards services, based on low rates of service use, and on the common tendency in news media to draw upon expert sources to strengthen story claims (Albæk, 2011), both of which may increase the influence of news stories on beliefs and attitudes (Maio et al., 2018). Therefore, it would be useful for research to seek to better understand how news media constructs services.

2.6 THE PRESENT STUDIES

2.6.2 *Summary and implications of literature review*

The existing literature indicates that young men have relatively low rates of help-seeking for mental health related problems. Socially constructed concepts of hegemonic masculinity explain why young men are pressured to act in particular ways which tend to be incompatible with seeking help or admitting vulnerability. Additionally, models of help-seeking have attempted to provide causal explanations for help-seeking, yet while each model adds value to this understanding, it appears that they often reduce a complex pathway into one aspect of the pathway.

Considerable research has demonstrated that many barriers including structural barriers, stigma, and poor mental health literacy contribute to men's low rate of help-seeking. However, research also suggests that beliefs and attitudes regarding services contribute to low rates of help-seeking, though there is little research regarding what these beliefs and attitudes entail. Nevertheless, it is evident that attitudes towards services impact the decision to seek help.

Literature suggests that attitudes and beliefs play an important role in determining behaviour, particularly in ambiguous situations. Because many men have not accessed services, attitudes tend to be formed vicariously through external sources. Extant literature suggests that film and television portrayals of mental health services tend to caricature these services, which likely has a negative impact on men's attitudes. However, local news media, which is likely to have a strong impact on attitudes due to the use of experts and non-fiction reporting, has not been examined regarding what messages it creates about services.

2.6.3 ***Research questions***

Based on my examination of the existing literature, I have identified a gap in the understanding of barriers to help-seeking in men: men's attitudes towards services. I proposed an inductive study to answer the research question: What are young men's beliefs and attitudes towards mental health services?

To extend this understanding to a broader New Zealand context, I also proposed a second question: How are mental health services presented in New Zealand news media? The aim of this study was to contribute to an academic understanding of how services are constructed, and to consider whether this affects attitudes towards services.

Reflexively, I believe it is important to address the relationship between the two studies and the limitations therein. The link between these two studies is a broad one; both explore attitudes and beliefs about mental health services. Study One explores the beliefs and attitudes of young men, as they are constructed in conversation, while Study Two explores the beliefs and attitudes as they are constructed in the news media. There may be further, more specific links between

these two sources of data; however, these would be incidental findings. It is possible that young men's attitudes and beliefs towards services are based on information presented in the news media. Likewise, it is possible that news media constructions of services reflect common themes described by young men. However, the present study did not seek to establish such causality. Given the inductive design of this research, it was possible that direct links between the two studies may have been drawn based on common themes, but it was equally possible that no common themes be identified between the two datasets. Therefore, Study One and Study Two are distinct, independent studies that both make a useful and unique contribution to the literature, and which are connected in that they both attempt to explore constructions of mental health services in New Zealand.

Chapter 3: Study One: Interview study to explore men's attitudes and beliefs towards mental health services

3.1 METHODOLOGY AND RESEARCH DESIGN

3.2.1 *Design*

This study aimed to explore an open question regarding men's beliefs and attitudes towards mental health services with reference to existing literature regarding barriers to help-seeking. To explore this open question, this study applied an inductive qualitative design. The present study, in part, aimed to replicate and expand upon Harding and Fox's (2015) research, utilising the same methodology: Thematic Analysis (TA). TA was selected as a method due to its value in structured synthesis of data and generation of emergent themes that occur over an entire set of data in relation to open research questions (Braun & Clarke, 2012). This approach has been described as less rigid than other qualitative methodologies because it supports an iterative process of analysis, which is useful for inductive research (Braun & Clarke, 2012).

The TA used in this study was a 'reflexive' design based on Braun et al.'s (2019) discussion of the various 'schools' of TA. I chose this reflexive design, as it theoretically aligns with the constructionist epistemology used in this research (Braun et al., 2019). Reflexive TA is distinct from other forms of TA particularly in the coding phase of analysis, whereby the primary researcher(s) codes the data and

does so inductively to allow codes to emerge from data. This reflexive style of coding differs from 'coding reliability,' whereby multiple coders are used to establish inter-rater reliability, which Braun argued aligns with quantitative, positivist methodologies, and does not fit with constructionist methodologies. Therefore, this research acknowledges and is impacted by my own subjective attitudes and perspectives as a male who has experienced mental illness (see reflexivity statement in Chapter One for more on this).

Men's beliefs and attitudes regarding mental health services were elicited via semi-structured interviews. Interviews were chosen to allow for a flexible, iterative process of gathering information and generating themes. Additionally, interviews provide data that is readily open to the kind of analysis that TA requires. One-to-one interviews have been described as allowing for greater depth of exploration and are less influenced by social conformity and group dynamic effects in comparison to focus groups (Burnard et al., 2008). Individual interviews enable a conversational interaction whereby the researcher can follow the participant's discussion, and prompt or clarify where needed.

3.2.2 *Ethical considerations*

This study was assessed through the Massey University research ethics process and deemed 'low-risk.' As a low-risk study, this research was not subject to formal review from the Massey University Human Ethics Committee; however, it was peer-reviewed for risk by an independent academic staff member. Resulting from this peer-review process, this study was deemed to pose low possibility of harm to participants and researchers.

Participants were given an information sheet and consent form (Appendix A and B), which explained the purpose and scope of the research and highlighted the

freedom to withdraw at any time. Additionally, participants were provided with a list of local and national mental health services, including emergency services (Appendix C). A list of services was provided to participants to maintain the Massey University human ethics principles of 'avoidance of harm' and 'enhancing benefit.' Although hearing participants' opinions on services was of benefit to this research, it would not have been ethical to hear participants discuss a lack of knowledge regarding services without subsequently providing them some succinct information on these services. To maintain the comfort, safety, and confidentiality of participants and the researcher, interviews were conducted in semi-private rooms in public areas (see Recruitment for more information).

Participants were informed that pseudonyms would be used to protect their privacy in the final report, and all data was stored on a password protected university computer.

3.2.3 *Cultural considerations*

To respect Treaty of Waitangi (Treaty) principles regarding engagement of Māori in research, Hudson and Russell's (2009) guidelines regarding including Treaty principles were followed. Regarding the principle of Partnership, to include Māori data in this study, it was deemed essential that the study include participant(s) who identified as Māori. Regarding the principle of Participation, this research was ethically assessed by a Māori researcher, allowing input into the research plan. Additionally, to adhere to the principles of Protection and Partnership, Māori cultural values were included in the plan to engage with participants. Specifically, participants were offered an option to open and close the session in a way that would be most comfortable for them, and a karakia (blessing/transition) was offered.

Additionally, shared kai (food) of biscuits was brought to each interview. Tangible benefits of this research to Māori may include better understanding of barriers to help-seeking in a New Zealand context, and possible improvements made based on the knowledge of these barriers.

3.2.4 ***Recruitment***

The inclusion criteria for this study were highlighted in the recruitment advertisement (Appendix D) and the information sheet. Men between the ages of 18 and 30, who had not utilised mental health services, and were not working in or studying a mental health related profession/field were eligible to participate. As there is some ambiguity regarding what constitutes a mental health service (for example, visiting a GP regarding sleep issues could be considered a mental health service or a physical health service), that inclusion criterion was based upon participants' own definition of mental health services. Enabling participants to decide whether they were eligible to participate was considered a potentially valuable source of qualitative information and context. That is, participants demonstrated what they consider a mental health service to be. For example, one participant stated that he understood the inclusion criteria yet also indicated that he had seen a counsellor. Additionally, self-inclusion was useful as it did not unnecessarily restrict who was able to participate in the study. There were no exclusion criteria for this study relating to specific demographic factors such as ethnicity, sexual orientation, or occupation.

Participants were recruited through advertising on social media (i.e., Facebook). I created a Facebook 'page' (named 'Men's attitudes towards mental health services doctoral research page') with the explicit purpose of recruitment. I then contacted the administrator of the Facebook group 'Vic Deals,' which, at the

time of contact had 140,322 members, and the advertisement was approved. Vic Deals was described as a 'free online trading and discussion forum for students and locals of Wellington City, New Zealand.' The advertisement was posted on Vic Deals due to the large potential pool of eligible participants available through this medium. The advertisement included the offering of a supermarket voucher to the value of $40 as koha/thanks to participants for sharing their time and knowledge, fitting with the criteria outlined in the Massey University revised (2017) code of ethical conduct for research, teaching, and evaluations involving human participants (Section 2 – compensation of participants). People interested in participating were able to send a message to the research page or email the researcher directly.

After participants made initial contact, they were sent digital copies of the information sheet and consent form to read and asked whether they would like to continue to an interview. The participants and researcher then agreed upon an interview appointment and location. A private meeting room at the Massey University Wellington Library was offered to all participants; however, three participants preferred alternate locations – private meeting rooms at the Victoria University Library and in a government building, both in Wellington. At the beginning of the interview, participants were asked to read and sign the consent form prior to the interview. Participants were briefed on what the interview would entail, including audio recording and use of interview data and were afforded an opportunity to ask any questions. Participants were also reminded that there were no right or wrong answers and encouraged to give their free and frank opinions. *Reflexively, despite emphasising that there were no right or wrong answers, it occurred to me that participants may have seen me as a representative of mental health and may have attempted to give answers that they believed would have been*

acceptable to me. Following the interview, participants were given an opportunity to ask any follow-up questions, and to indicate whether they would like to receive updates on the progress of the research.

3.2.5 ***Participants***

Ten men who did not meet the exclusion criteria and were between the ages of 19 and 29 years old were interviewed. Although the focus of the present study is on gendered identities, other aspects of participants' lives affect their constructions of their identities and of services and thus are recognised here. Regarding ethnicity, two participants described themselves as Māori, one as Samoan, two as Indian, one as African, and four identified as New Zealand European or 'White.' Three participants described themselves as 'gay,' one as bi-sexual, and six participants described themselves as 'straight.' Participants also described their occupations; four participants worked in tourism and hospitality, two were unemployed, two worked in government organisations, and two were students. The number of ten participants was decided upon based on Braun and Clarke's (2012) guidelines regarding number of participants in relation to project sizes for TA. Braun and Clarke (2012) suggested that for a master's or professional doctorate utilising TA, ten participants is an appropriate number.

3.2.6 ***Data Collection***

The interviews followed a schedule, which was designed to elicit answers pertinent to the research questions (these questions primarily explored participants' understanding of mental health services – see a sample interview schedule in Appendix E). However, as this study used semi-structured interviews, I encouraged participants to discuss areas of importance to them, and follow-up questions and prompts not on the interview schedule were included as needed. Additionally, not all

questions on the interview schedule were asked – I used the questions as prompts to cover various topics related to mental health services, and to address areas not covered during the interview. The interviews ranged in duration between 26 and 53 minutes, with an average length of 39 minutes. A total of ten interviews comprised 134 pages of transcript data.

This study used an orthographic style of transcription (Braun & Clarke, 2012), whereby I used the standard spelling of words, and transcribed complete words, cut-off/partial words (words and partial words that were cut off are denoted by a dash), and sounds (e.g. 'mm'). Major non-verbal gestures and reactions (including laughter) were denoted by descriptions of the gesture in closed brackets (e.g. '(laughs)'), and notable pauses were denoted with an ellipsis ('…'); pauses were not timed. Words that were emphasised with increased volume were marked in bold (e.g. '**that's not** a position') and words that were lingered on or emphasised with dramatic articulation were marked in italics (e.g. 'I don't *really*'). Extracts where the beginning of the talk is omitted (i.e. where a smaller chunk of speech was taken from a longer overall utterance to illustrate a point) are indicated by bracketed ellipses (e.g. '(…) I think that was') to denote that the participant said more before the beginning of the extract (or after the end of it). Data was not modified for grammatical sense or length, to preserve the organic 'feel' of the discussion. This method of transcription was based on the guidance of Braun and Clarke (2006; 2012), who noted that orthographic transcription that reflects the content of speech in a generally realistic and readable manner is adequate for thematic analysis.

3.2.7 ***Data Analysis***

Data were analysed based on Braun and Clarke's (2006; 2014; 2019) suggested six phases of thematic analysis: becoming familiar with the data, generating initial codes, searching for themes, reviewing themes, defining and naming themes, and producing the report. This allowed for a clear and consistent methodological approach, which may be replicated in future research.

The initial familiarisation with data began during participant interviews, at which point I started generating ideas around participants' understandings of mental health services. Familiarisation of data continued into the next steps of the research, which included listening to the recordings and transcription, where I began noting overarching points of relevance. *Reflexively, initial familiarisation with the data made me aware of my privileged position of understanding not only mental health services, but mental illness as a concept. Perhaps due to years of socialising with many other psychology students, I had assumed that mental health problems were well known and understood in general; however, the interviews challenged my perspective on this.*

The next phase of analysis involved generating initial codes. In this process, I began by reading transcripts and noting features of the data in shorthand on the transcript (for example, in a transcript that said 'that's how – what they're portrayed as doing on like TV shows and movies' the attached code was 'Media informed view'). There was no limit to how many codes a transcript or a piece of data had. These initial codes were iterative such that I went back over transcripts and re-coded them for consistency and ease of reference. Throughout the process, I collected codes on a Microsoft Excel spreadsheet, and by the end of this process, there were 150 codes.

During the next two phases of analysis, searching for themes and reviewing themes, I looked for similarities across the codes, and grouped codes according to apparent overarching themes. I then collated all data fitting with the codes within emergent themes and re-read this data in order to check if there was an apparent theme connecting it and removed data and codes that did not fit with the theme. Through this process, I continually refined and reviewed the thematic groupings, until a coherent theme was evident in the grouped data. In this process, it became apparent that several codes contained enough data to be elevated to potential themes. As with the other phases, the next phase of defining and naming themes was iterative. Specifically, I gave the themes tentative names, which I then finalised after writing the report and defining the scope and limits of each theme. The final phase - writing the report - involved identifying the extracts with the most relevance to the theme, and which added unique meaning to the theme. I included several extracts for each theme and wrote a brief analysis of how the extract relates to the theme, and what it means regarding the research question. Using a social constructionist epistemology, I considered participants' speech to represent their construction of meaning positioned within their worldviews and social circumstances regarding mental health services, rather than as reflecting objective truths about these services.

3.2 RESULTS

3.2.1 *Thematic analysis*

Analysis of the data resulted in identification of five distinct themes, which are presented in table 1.

Theme 1	'This is all based off what I know from television'

Theme 2	Therapy as social surrogates
Theme 3	‘Maybe just deal with it yourself first’
Theme 4	‘Pills… to almost rely on them’
Theme 5	‘Cause they’re the doctor, they know – they know what’s best for you’

Table 1. Study One themes

The first theme presented is ‘This is all based off what I know from television,’ as it provides the participants’ description of the source and limitations of their knowledge of mental health and services. Second, the theme ‘Therapy as social surrogates’ is presented, in which participants compare talk therapy to informal social support. The third theme, ‘Maybe just deal with it yourself first’ reflects participants’ drive for control and autonomy over their mental health. The fourth theme ‘Pills… to almost rely on them’ appears to reflect the drive for autonomy noted in the previous theme, but also adds a unique element of concern around chemical dependency. Finally, the theme ‘Cause they’re the doctor, they know – they know what’s best for you’ acknowledges participants’ respect for the expertise of mental health professionals, despite contrasting attitudes towards mental health services (such as concern around the addictiveness of psychotropic medication).

Reflexively, although I have attempted to analyse and interpret the data in a transparent way, such that the data ‘speaks for itself’ and the themes are readily apparent, I acknowledge that true objectivity of such interpretation is neither possible, nor expected from a social constructionist perspective. This data was interpreted through my lens as a young, heterosexual, Pakeha (New Zealand European) man. Thus, these analyses are limited by my perspectives. This is particularly important to note as the participants in this study are diverse (though all

are young men) and include Māori men. It is possible that my perspective lends me to interpret the data from a western psychological perspective and miss other interpretations that may resonate with other cultural approaches. For example, it is possible that a researcher from a collectivist culture may have interpreted different themes based on this data. Nevertheless, the presence of consistent themes despite the diversity of the participants may speak to the strength of these findings. Furthermore, readers are invited to reflect on their own positionality whilst viewing these results and make their own interpretations of the following data.

'This is all based off what I know from television.'

Participants noted that their knowledge of mental health services was based on mass media (primarily movies and television shows). They described their lack of knowledge and education regarding mental health services, a gap which was filled by the media. They also expressed a desire for more education regarding mental health services. In the following excerpts, participants discussed what they believe happens in inpatient mental health services, acknowledging that their descriptions are based on media representations:

(1) *Phil: Um do they... uh... I'm just thinking (laughs) like scenes from movies like-*

J: Yeah, no go ahead, like go ahead if that's what comes to mind -

Phil: Do they lock them - you know like - chain their hands up or um do they put them in a room where there's like no knives or something like that - you know? (laughs)

(2) Arjun: (...) You know, um I don't - I - I don't think that screaming and shouting and being physical and aggressive and um you know - having some kind of traumatic experience is going to help a person in a situation like that. Um even though that person may be - you know - being wild and like - you have to understand they're not in the correct space uh mentally so... I - I don't think being very aggressive is - is and maybe that's just an assumption cause of movies but (hah) um I hope that's not the case in real life.

Phil and Arjun described extreme evocative scenarios regarding their perception of inpatient mental health services. However, they both acknowledged their inexperience by pointing to two dimensional fictional visual accounts, which speaks to the lack of alternative and more nuanced readily available sources of information. Although participants acknowledged the limited validity of media as a source of information, they are forced to draw upon these sources when expressing their impressions of inpatient services. Media informed views were framed as being inaccurate, yet their representations were most available to participants and therefore may still have some impact on attitudes.

As well as inpatient services, participants drew upon images from mass media when describing their image of what happens in talk-therapy:

(1) Timothy: Um honestly, I think uh - most of what I know is from movies - you know, you sit down on a chair and then they go... 'What's up?' and you

explain what's happening and then they go 'Well how do you feel?' (Laughs) (...)

(2) Geoff: Um I... Oh... okay, this is all based off what I know from television, basically, so - you know, there'd be a nice big comfy couch… and then the other person would be sitting on a comfier couch, something like that and sort of you would either sit down or lay down or something and you'd probably just start exploring like - you know - how you're feeling... (...)

(3) Wiremu: I literally just imagine it's one of those like - long seats and you sit on it, or lie down and then... the person is sitting on a chair across from you and (laughs) you're just telling them things (laughing) But again I don't know if that's just one of those cases that's what you see on TV shows and movies so that's just what you associate with it. For me that probably is because that's all I've known talk therapy as because I've - again, I've never used it, so I don't actually know what it would involve.

Using what they had seen in film and television, participants described familiar scenes of a patient sitting (or reclining) in a therapist's office. However, participants differed in how reliable a source they framed media as being. Timothy and Geoff framed their descriptions of therapy as knowledge ('what I *know*') based on television and movies. However, citing television and movies as a source of information may implicitly indicate limitations of the accuracy of this information. In contrast, Wiremu explicitly acknowledged that his perception of what talk-therapy involves was likely inaccurate due to the influence of media depictions. Therefore, it

is possible that in some instances, the impact of media on knowledge of services is buffered by the recognition that media portrayals are often inaccurate. However, with a lack of alternative sources of information, it may be difficult to differentiate realistic portrayals from inaccurate ones. As a result viewers may have some confidence in the accuracy of certain aspects of media portrayals as sources of information particularly if these aspects are consistent across depictions, in which case these common aspects may be considered as useful pieces of 'knowledge' gleamed from the media for some.

As well as indicating that much of their knowledge regarding mental health services is from movies and television, some participants suggested that there should be more education regarding mental health and mental health services:

> *J: In terms of those people who do use alcohol and stuff instead, why do you think that is? What do you think the reason is?*

> *Geoff: I think it's... uh I reckon it's probably just a lack of education, I'd say. Or a lack of accessibility to education. Or - you know - a lack of accessibility to um... you know - like money to see counsellors or - yeah to see people. Um so they sort of feel like 'aw' they don't have anyone they can... they don't have anyone to talk to and they you know - that's - I guess that's the way that they see it - maybe - I mean I'm generalising a bit here a little bit - but to suppress their depression maybe, I don't know. Yeah. Or maybe they don't realise that - you know - a counsellor could help them or something or they don't know where to get access to or... where to go, or who to see um... yeah.*

Geoff emphasised the role that knowledge plays in help seeking. He discerned two important aspects of knowledge and education regarding mental health services: the knowledge that a counsellor could help, and the knowledge of how to access services. Without easily accessible information regarding how a counsellor might help and how to access services, people would turn to alcohol to manage their mental distress.

Without a more reliable source of information, participants drew upon accessible scenes from film and television to describe what might happen in services. By citing media representations, participants appeared to acknowledge the limitations of their understanding of services. However, it appeared that confidence in media representations of services varied such that some participants inferred that what they knew was likely unrealistic, while others were somewhat more tentative, describing what they knew based on media portrayals (and possibly highlighting the useful and true aspects of media portrayals). Nevertheless, participants consistently highlighted a lack of other sources of information or knowledge of services.

Therapy as social surrogates

When describing the process and benefits of talk-based therapy, participants tended to compare it to informal social support. They described factors such as listening, being available to talk, and advice giving as the mechanisms through which therapists attempt to help patients. Participants recognised the value of a confidential, safe space to talk; however, they were unable to express unique techniques used in therapy that may not occur in informal social support.

Although participants saw the value of talk-therapy for those who are unable to talk with friends and family, they described limits to the effectiveness of 'just' talking:

J: (...) So broadly, as a type of - way of helping someone - how useful do you think that is - the kind of talking-cure?

Timothy: I mean I think it's good. I think it is helpful. I think like - you know - while there might be people who have like a massive friend group in dealing with that stuff, they have every avenue in their own life to go and talk to anyone they want, there are people out there who are just - you know - they're in their home. They don't talk to their family, they don't really have friends, they don't feel they can trust anyone enough to talk to - I think in those kind of situations they are extremely helpful, but that being said, I don't think they're - kind of - the only thing that needs to happen - like some people just need a vent and they can get it out and they're fine, but obviously there are people who - they should be on medication. They might need further kind of help beyond what they're getting. So, I think... I don't think you can always beat it just by talking (...).

Timothy acknowledged the usefulness of talk-therapy among people who lack trustworthy confidants to whom they can talk. However, he also outlined the limitations of 'just-talking,' describing a difference between those who need medication, and those who can feel better by venting. This suggests a hierarchy of mental distress and appropriate treatment, in which medication is necessary for more severe mental distress. This construction of talk-therapy and medication suggested that talk therapy is useful through the trustworthy support it offers to people who do not have such support available; but may add little additional benefit to people who

have trustworthy informal supports or more severe mental health problems. It also suggested that the mechanism through which people get better via talking is 'venting.'

Previously, Matt explained the steps that he would take if he were having mental health problems. Speaking to friends and family were Matt's first step, and after that, Matt stated that he would use phone-lines or seek face to face therapy. In the following excerpt, Matt explains when talk therapy may be necessary over informal social support:

> *Matt: If... they're not providing an environment for you to be open about your mental issues. Cause even within a family, you can be afraid to open up about your mental issues. Being afraid of them going 'Ah... (laughs) we didn't know it was like that.' (laughs) You know? They can... so and... if they don't provide the environment for you to open up and get better then quickly seek the phone and then go from there. But if they provide an environment for you to open up and get help, then stay with them because you know they care and they - two ha- four hands is better than two hands. So, we have a support system and in mental health what you need most is a good support system to carry you through. Yeah man.*

To Matt, the most important part in overcoming mental health problems was having a 'good support system,' which should be provided by family, but may also be provided by professional services. That is, talk-therapy serves a similar function to informal social support but provides benefit in being available when family is not.

The following excerpt provides another example of talk therapy as a surrogate to informal social support. In this example, Tane explains what he imagines would happen in talk therapy:

> *Tane: Um I would suspect it's mainly just... I would suspect there would be mainly obviously talking about things on your mind that you're not - might not be comfortable talking to close family members with... which I'm not sure why you would be - maybe because you don't want to - you know, want them to see you.*

Tane appears to position talking to family members about mental health problems as the preferred strategy and therapy as an alternate to this. Likewise, for Tane, it seems that talk therapy adds value through providing a safe space to expose vulnerability when talking to friends or family appears too difficult or might make things worse. It appears that the key benefit of talk therapy is that it would be useful for people who do not want their family to know that they are suffering ('maybe because you don't want them to see you'); which suggests a sense of potential self-stigma for some men in exposing their problems to family. This description suggests that some men may feel more comfortable disclosing distress to a confidential and professional stranger than to their own family.

Participants also described talk-therapy as a form of regular and readily available social support:

J: (...) What sort of things do you think a counsellor, or a therapist would do to help you fix your problems? Or how do you think... - what's their role in that?

Simon: Um apart from like a touch base of one-on-one obviously, I think it would be more of um like touching base with - in terms of - hey look, emails and things like that. Or 'hey can I book another-' or 'look this has happened this week, I need to talk back and forth.' So, it would be some form of social aspect to it.

Simon stated that a therapist would be helpful through their availability as a dedicated support person. This description suggests that having someone available to talk to about day-to-day problems is useful to reduce mental health problems. This description of the therapist positions them similarly to a supportive friend or family member; however, Simon also alludes to the more formal aspects of the therapeutic relationship through stating that the patient would need to book another session.

As well as framing talk-therapy as a surrogate for informal social support, some participants suggested that the benefit of therapy is not in the talking itself, but simply in the knowledge that there is someone to talk to:

Timothy: Um I think... I think just having um kind of the ability to have that there, to say 'you know there are counsellors you can talk to,' 'There are people out there who will listen if you feel like you have no one else' or just... you know - just someone who's there at all, I think - this might be me just being cynical - but I feel like this helps more than the counselling itself

sometimes. Just knowing that when all things are helpless, there is something you can do...

For Timothy, the person with a mental health problem may benefit more through the knowledge that there are services available than through the service itself. As he differentiated between the 'counselling itself' and the value of hope, Timothy suggests that it is not the counselling, but simply having someone to talk to that benefits patients. However, Timothy did acknowledge that the therapy may add value, by hedging his 'cynical' view with the statement that the hope may provide more benefit than the actual therapy *sometimes*. This may indicate that simply having hope and something to turn to has powerful healing impact, though it may also indicate that counselling itself adds variable value in comparison to knowing that there is someone to talk to.

Participants considered talk-therapy as synonymous to supportive talking, and social support that may be provided by friends and whānau; however, participants also noted that talk therapy adds value through offering safe and trustworthy spaces to talk, when informal supports did not. Participants were unaware of, or unable to articulate unique factors of therapy that do not occur outside of informal trusting and supportive relationships. Consequently, it seems that it was participants' attitudes towards talking, rather than talk-therapy specifically, which influenced their perception of the usefulness of talk-therapy. This is unsurprising, given that these participants have not experienced talk-therapy, and therefore must use other ideas such as their understanding of a supportive conversation about mental health or stress to construct their attitudes towards talk-therapy. Nevertheless, this theme reflects

limited understanding of talk therapy, which may result in devaluing of its usefulness, or misunderstanding of the value that it may add.

'Maybe just deal with it yourself first'

Participants described their preferences for assessing and 'dealing' with their own problems before, and in some cases, instead of seeking help. In this section, I will first present examples where participants expressed that problems should be dealt with by themselves, and subsequently present examples where participants described the importance of evaluating their own life and looking for controllable factors that might be causing the mental health problem. In the following example' Kris explains how he imagines he would react if offered psychotropic medication by his doctor:

> *Kris: I honestly wouldn't like that very much at all. I would prefer just not to. I don't really like the idea of being on prescription medication of any sort. Even my inhaler that I have to take.*
>
> *J: Why's that?*
>
> *Kris: As much as possible, I'd like to just do it myself. If I know there's something I can't do - like breathe properly, (laughs) I'd rather try and fix that than rely on something that I have to pick up from the pharmacy every week, even though that is a wee bit silly. Definitely not beneficial, but it's just the way I would feel about it.*

Medication is not an attractive option as Kris explains that he would prefer to fix his problems himself. By describing himself as "a wee bit silly," he appears to be recognising and acknowledging that in many cases it is more beneficial to accept and take medication than to try to fix the problem himself; however, he ends his statement with an apparently resigned explanation of "but it's just the way I would feel about it." This statement suggests that despite his beliefs that it is silly to try to deal with medical problems himself, his *feeling*, or perhaps, his attitude overrides this belief. He does not fully articulate why he *feels* this way towards medication – though he does mention a structural barrier of having to collect medication from the pharmacy every week. Consider the next extract, which gets to the heart of the masculine need for control – where Kris has been asked to clarify if he would not want to seek counselling:

> *Kris: Probably I'd hesitate to do it. It would be an uncomfortable thing to go and admit that you need help with something. That kind of shatters that fantasy that you can deal with everything yourself and move mountains. If it was something that needed to be done, it needs to be done.*

Kris highlights what is perhaps a typical masculine ideal of being able to fix problems and 'move mountains.' Interestingly, he also describes a contrasting value, which may also be a hegemonic masculine value of doing what 'needs to be done' despite discomfort. Kris's comments evoke a sense of powerful autonomy, fitting with the overall theme and his previous comments, but he also creates the image of needing to act even with discomfort. Despite his preference to fix problems himself,

he acknowledges that he would seek help if he needed to, which softens the rigidity of his allegiance to independence yet maintains his allegiance to masculine values.

Prior to the following statement, Tane was asked what someone with a mental health problem could do to seek help. Here, he explains his preferences for coping with mental health problems:

> *Tane: Well I sort of have... I sort of have like a belief - maybe - it's not a really strong belief, like it's not set in stone, but um obviously trying to maybe just deal with it yourself first. Like try to have a look at yourself aye, like... Just try get in touch with yourself, see what you're doing - like who are you around, what are your habits, you know what I mean?*

For Tane, rather than seeking mental health services, the initial response to distress should be to attempt to assess what is causing the problem and then to fix the problem by changing habits and who 'you' are around. Redirecting his response to autonomous self-help, rather than explaining external help-seeking, may demonstrate the importance of independence. In this conceptualisation, mental health problems are caused by bad habits and associates, which fosters hope, as it suggests controllability and agency in mental distress. Tane displayed his preference for independence by listing a range of options that he would explore to understand and control the problem himself. Nevertheless, he used the word 'first,' which suggests that services may be acceptable if independent attempts fail.

The concept of fixing problems by oneself, and the idea of personal agency and control regarding mental health was also apparent when Tane explained his reaction to seeing mental health related issues on television or movies:

Tane: Mm... Well if I see someone like on the media that's depressed, or if I see someone talking about... People being depressed, my first initial thoughts when I hear that doesn't really have anything to do with - like - seeking counsellors at all. When I hear something like that it doesn't - I don't automatically think: 'Oh go see a counsellor.' You know what I mean? I just... I go just further back and think 'Aw well how did you get there?' and you know, 'what can you change?' so yeah, my initial thoughts aren't really to seek a counsellor, if you know what I mean? So, no I don't think about that when I hear something like that.

His reaction to seeing someone on the media with a mental health problem reinforces Tane's emphasis of personal control and agency regarding mental health. As he linked depression to behaviour, Tane made a causal attributional search for the controllable factors that may have caused the mental health problems. By noting that counsellors do not feature as a consideration, it appears that the imperative for independence is not only a thoughtful response to mental health problems, as demonstrated earlier, but an automatic response that takes precedence over other options. Explaining that he has these thoughts for someone he sees in media demonstrates that Tane's beliefs about control and autonomy are not a set of rules that he applies only to himself but apply more widely.

When discussing talk-therapy, Manish described his reason for preferring to deal with problems independently:

J: Yeah. And how do you feel about - you know - if it's these sort of problems - how do you feel about telling people? Are you quite comfortable, or are you sort of - how do you feel?

Manish: I'm... not really too comfortable doing that. I personally try to just handle it myself. If I can't do it, then yeah, I'll discuss it with my friends.

Manish creates a hierarchy of steps which prioritises autonomously 'handling' the issue by himself due to his discomfort in disclosing his problems to others. Despite the context of discussing talk therapy, his next step would be to discuss the problems with his friends. Seeking professional services does not feature on his hierarchy and perhaps discussing the problem with friends deviates less from the imperative for autonomy than utilising professional services would, though this is speculation. Manish's description suggests that his drive for autonomy in mental health is due to discomfort in alternatives that require disclosure.

Another aspect of this theme reflects the steps that participants stated they would take prior to, or instead of, seeking mental health services. In the following extract, Geoff explains how he would know if he had a mental health problem requiring professional help:

Geoff: Um... I don't know... I just - I guess sometimes you can get kind of like in a bit of tunnel vision and sometimes you just need to sort of step back and look at what you're going through, why you're feeling that way, what are the things that are causing you to feel that way in your life. What can you control, um you know - are there people in your life that are making you feel

that way or is it just you know 'Aw I've got this going on, I've got this going on.' Um... yeah... and then if you find - I don't know - if you find that you can't sort of - if there's things that are unexplainable for the way that you're feeling then yeah um yeah... that's the way I kind of discern it.

By stating that mental health problems cause tunnel vision, Geoff appears to be suggesting that there may be solutions to the problem, which the person is not seeing. This idea of simple solutions outside of the field of vision gives an impression of controllability – that mental health problems can be controllable by taking a step back to gain a new perspective. In Geoff's description, it is up to him to assess what is wrong in his life and control or remove it and professional services should be sought only when independent options have been exhausted.

In the following extract, Wiremu discusses psychotropic medication, and how he might react to being offered a prescription, describing independent steps he would prefer to take before accepting medication:

J: (...) if you went to see your doctor and you were having these sort of problems and they said they were going to prescribe you an anti-depressant, how would you feel?

Wiremu: I think it depends like if I was feeling... quite down, I would probably be like 'Yeah okay, I'll try it for a while.' But then if I was feeling like - I wasn't feeling down but I was feeling like a bit like hmm (makes 'hmm'ing noise), I'd probably be like 'Is there anything else that I could try? Like should I start exercising more or something, because I know that's like

great for tackling depression - or meant to be good for it.' So, I guess it depends... but then it's like if you're in that mindset that 'I'm feeling like shit, I'm always feeling down.' Of course, you're going to be like 'Oh, okay, I'm going to take this.' Like 'This is meant to make me better.' So...

Wiremu does not explicitly state that he would prefer to manage his own problems. Nevertheless, his suggestion of exercise over taking medication may demonstrate that he is more comfortable with an autonomous option that provides more agency than medication. For Wiremu, taking psychotropic medication would depend on the severity of how he was feeling, but he would prefer to explore other options, such as exercise. This extract relates to two themes: firstly, the preference to have autonomy and independence in managing mental health problems and secondly, attitudes and beliefs towards medication.

Participants expressed that fixing a mental health problem requires effort and work from the person with the problem. Although they presented various views regarding mental health services and tended to prefer independent solutions, the consistent thread in this theme was that significant personal effort is required – whether to overcome discomfort and engage in services, or to assess and manage symptoms independently.

'Pills… to almost rely on them.'

Participants demonstrated a common set of beliefs that medication can lead to reliance and even addiction. The present section relates to the theme about 'Maybe just deal with it yourself first' as it also reflects a preference for independently managing problems. In this section I first present data in which participants express concerns that medication can lead to reliance, which reduces opportunities to learn to

self-manage problems. Second, I present data where participants express concern that reliance can lead to symptoms and changes with negative consequences.

Wiremu expressed concern that people tend to be put on medication when they do not need to be. In this extract, Wiremu explains why he believes it is problematic for people to be inappropriately prescribed psychotropic medication:

> *Wiremu: Probably prescription medication, I know you can become quite hooked on it, but also if you're on something for anti-depressants and you go on it for a really long time and then you have to come off for it, you don't exactly know how to deal with coming off of it. Well I think you don't know how to deal with coming off it, because you've been on it for such a long time and you've never been taught anything else. Like you go on it and then you're on it for - say - six months and then you're like 'okay no,' you're done and you decide to come off it, you're probably not gunna exactly know how to handle like your emotions or the moods that you'll suddenly be going through because you've just been so mellow and numb for like the past couple of months. Like I think it would be quite a bad shock for you. But then flowing on from that, like you may just turn to other ways of trying to cope with that because you haven't dealt with your emotions over the past, say six months, because they've always just been like mellowed out, so you may just turn to other forms to try to cope with something - like alcohol or like other drugs or something, so...*

In describing the problems associated with weaning oneself off psychotropic medication, Wiremu created a narrative of what he imagines might happen to

someone who has been on the medication for a ‘really long time.’ He was concerned that in coming off psychotropic medication the patient would not have learnt any other strategies for dealing with emotions. As a result, the patient may become reliant on emotional numbing and be unable to manage their emotions. Wiremu then speculated that these patients may turn to alcohol or other drugs to further manage their emotions, suggesting a path to developing generalised reliance on substances to manage emotions.

The following extract provides another example of the idea that medication leads to reliance, which results in an inability to self-manage problems. Prior to this extract, Phil was asked how useful he believes psychotropic medication to be, which he responded hesitantly to, stating that he has ‘his personal opinions on it:’

J: Yeah, I would love to hear them (laughs)

Phil Um I don't know. I feel like people... they just become immune to taking certain drugs and then it doesn't really work.

J: Right. So, kind of like a tolerance to the drug...

Phil: Yeah! And then like it just becomes almost like a chore, really. Um Or they become reliant on it, that could happen. Um and that's not really good, 'cause ideally you want them to function without that. Yeah.

It appears there is a futility and drudgery in taking prescription medication for Phil. He initially states that people develop tolerance to medication, leading to the

medication no longer working. However, this initial statement contrasts to his second idea, in which a person might become reliant on the medication and be unable to function without it. These alternate scenarios suggest that for Phil, there are negative long-term outcomes to medication even if it is initially useful. Additionally, Phil's subsequent clarification of why relying on medication is not good ('ideally you want them to function without that.') fits with the theme of 'Maybe just deal with it yourself first,' in which participants appeared to emphasise the importance of being able to manage their problems autonomously.

In the extract below, Geoff explains his concerns regarding the 'dependency' of psychotropic medication:

> *Geoff: (...) Um... and then I've got some people I know that are just trying to like wean themselves off it. Um and I think they're doing pretty well, actually. I think they like went from like a high dose and then went to a lower dose and lower dose and lower dose and lower dose, but um... I think they're kind of effective, but it's kind of dangerous to sort of... these are long term things. You don't want the body to kind of rely on them. Because I think the way that it - I think - my understanding of it is that... it increases your melatonin levels which... Oh not melatonin (snaps fingers) - serotonin! Serotonin levels, which make you like happier and everything... but if you rely on it for too long then your body becomes reliant on it. It doesn't create its own serotonin, so um... yeah.*

> *Geoff: (...) I think - like from what I've heard it's quite hard to come off them, aye. It's like "Oh why can't I come off them now?" Because - this is one*

example I have but you know - went through - had anti-depressants through university: "Oh I can't come off because I'm in my third year, it's really stressful. I can't come off because I'm going into my first job, and it's really stressful. I can't come off 'cause... I've got this big project coming up and you know - I get..." You know?

Geoff drew upon a real-life example, in which someone he knew tried to 'wean' themselves off medication and 'actually' did 'pretty well.' It appears that it was surprising to Geoff that the person did well in coming off medication. Through this language, and by creating the image of a difficult and perhaps pain-staking process, it seems that for Geoff, coming off psychotropic medication via graduated reduction in amount is no mean feat. He emphasised this idea of dependency by using a biomedical explanation of how the body might come to 'rely' on the medication. Likewise, his concerns regarding reliance speaks to some awareness of psychological dependency. These concerns were elaborated in the second extract where he created scenarios that highlight the difficulty in finding the right time to 'come off' psychotropic medication. He imagined that only in a stress-free time (which Geoff implies is non-existent) would someone be able to wean themselves off medication.

The following example illustrates the idea that participants saw prescription medication as leading to reliance, which may result in other negative outcomes. In this example, Arjun explained his beliefs regarding psychotropic medication:

Arjun: I think that's just a start for another problem. Um I'm not anti-medicine but um I think that's just an opportunity for someone who's suffering

through something to get addicted to something else. Something new which could lead to a bigger problem. I mean - people get addicted to Panadol - you know? So (laughs) it's - it's not that hard but I don't think it's the right thing to do to someone who's already mentally - not weak - but um you know - vulnerable in a way... you know - you're just giving them another reason to get addicted to something, which could - could later on turn into a worse problem you know. Cause once - once you stop giving them - it just leads... It's a spiral.

Despite expressing an ostensibly strong negative attitude towards psychotropic medication, Arjun noted that he is not 'anti-medicine.' Positioning himself as 'not anti-medicine' may function to remove some subjectivity and personal bias from what follows, thereby increasing the validity of his argument. Although Arjun did not describe 'reliance' on psychotropic medication explicitly, he described addiction. This implies a worse outcome with more complexity – that is, for Arjun, people do not simply rely on prescription medication, but they become *addicted*. By pointing to the fact that people get addicted to common, household painkillers (Panadol), Arjun emphasised his point of how easily people may get addicted to psychotropic medication. Likewise, by describing people who have a mental health problem as 'vulnerable,' Arjun suggested increased personal susceptibility to addiction, which along with other factors in addiction may lead to a 'spiral' of other problems. He also went to some effort not to equate weak with vulnerable, perhaps mitigating a negative gendered view of mental 'weakness' through his stress on a less negative 'vulnerable.'

The following extracts are taken from Tane's discussion of prescription medication; the second from a discussion where Tane used an example of his cousins who take medication for bi-polar disorder:

(1) J: (...) So another type of service that people can get when they're - you know - having mental illness is prescription medication, so pills. So how useful do you think this type of treatment is?

Tane: Pills? Mm... To almost rely on them. Almost.

J: You think people do?

Tane: Well how useful it would be if I had to rely on a pill...Personally I wouldn't - I don't want to take pills at all.

(2) J: (...) So sort of yeah, some not so great things. And you talked about relying on them too - so can you tell me a little bit more about that?

Tane: Yeah well if you're - so for instance - if my cousins were going off it, they'd be in the hospital.

Tane's belief that pills cause addiction is apparent in his rhetorical question ('how useful would it be if I had to rely on a pill?'). He assumed, and rejected dependency upon medication, stating emphatically that he would not want to take medication. In the second interaction, Tane drew upon an example of his cousins; he

believed they would go to hospital if they were to stop taking their medication. Although it is not clear whether he believed they would go to hospital because of withdrawal symptoms, or because of a return of the bi-polar symptoms, the context of the question he is responding to ('you talked about relying on them too – so can you tell me a little bit more about that?') suggests that Tane may be referring to negative outcomes of reliance on the medication.

Participants expressed beliefs that taking psychotropic medication would lead to relying upon it. They expressed varying beliefs regarding the mechanism of reliance; whether it would be due to physiological adaptations, emotional numbing, or addiction. Nevertheless, consistent across participants was an attitude that coming to rely upon medication would not be a desirable outcome.

'Cause they're the doctor, they know – they know what's best for you'

Despite describing discomfort with prescription medication and admitting the need for help, participants valued expert knowledge and advice of professional mental health care providers. This theme appeared to take two forms; first, participants described that they would trust, or defer to the expert opinion of the healthcare provider. Second, participants highlighted areas of mental health that they felt incompetent to deal with and should be left to the 'experts.' In this section, I will present data for the two aspects of the theme in the order they were described above.

Despite previously expressing concerns that psychotropic medication is inappropriately prescribed, Timothy would listen to his doctor if he were offered a prescription:

> *J: So, if you were to be prescribed one of these medications by someone, how would you feel about that? Would you take it?*

Timothy: Yeah. I mean yeah - I would take it. Like my kind of view on any sort of medication is like 'I'm not a doctor,' like this person has gone through X amount of years of training to get to this point and like I'm not going to sit there and go like 'No! I'm not going to trust your judgement here because I read something on Facebook and they said medication's bad' so I'm guna - yeah I'm guna trust the person who's got the personal experience talking to me and the - you know - the expertise of their degrees and qualifications and that kind of stuff. Yeah over just the random noise (laughs) of the world.

As he explained his approach to psychotropic medication, Timothy created a dichotomy between expert knowledge and the 'random noise of the world,' which serves to dilute his previous expressions of concerns regarding medication, perhaps by classing those beliefs among the 'random noise.' He acknowledged that many of his beliefs regarding medication were based on unreliable sources, which enabled him to act against his previously stated beliefs, and hypothetically accept the doctor's recommendation.

In the following extracts, Kris described how he might react to offers of prescription medication and how useful he believes counselling might be:

(1) J: Um so if you were to get prescribed a prescription medication for your mental health, would you take it? Or would you talk to the doctor and say you didn't really want it? What do you think you would do?

Kris: Uh I'd listen to the doctor. They definitely know more than I do but I would - every time I go in for a re-evaluation - try to get off it.

(2) J: So, you also mentioned counselling that you can get via the university services. How useful do you think that would be?

Kris: I would imagine quite useful, you know, talking to someone who's sat down and done courses and training related to people coming in feeling certain ways, and so they're going to know a whole lot more about mental health than I would. And so, they can - not necessarily uh fix anything, but point you in the right direction so that you could...

In both examples, Kris acknowledged the service provider's expertise regarding mental health. In so doing, he places more importance upon the knowledge of the professional than his own attitudes towards services, which contrasts with his previous comments. Nevertheless, in both instances, Kris preserves his own autonomy by stating that he would attempt to come off medication, and that while the counsellor could help to point him in the right direction, he would have to fix his own problems.

The following examples highlight participants' willingness to follow the advice of a doctor, even when it contrasts to their own beliefs. Prior to the following exchanges, Wiremu stated that he would ask for an alternative to medication and Manish stated that he would be hesitant about taking medication and does not know how the medications work:

(1) Wiremu: Yeah. But then again, it's one of those things where it's coming from your Doctor so you- I'd just actually think that what they're trying to give me would probably be best for me. Kind of thing, so it's one of those - 'Cause they're the doctor, they know - they know what's best for you, so it must be good for me.

(2) J: Okay and you don't really have much thought about how they actually work in terms of what they do.

Manish: Not really (laughs). Even now when I go to a doctor, if - for any illness or something, they just prescribe a medicine. If - sometimes I have time, I just go through and google the name and stuff, and like what it is, but at the end of the day I just take whatever's needed.

These examples demonstrate a paternalistic view of the doctor for these participants; Manish and Wiremu indicated that the doctor's decision overrides their own attitudes and the doctor knows what is best for them. Despite earlier hesitancy regarding prescription medication, Wiremu expressed trust that the doctor would do what is 'best' for him. Manish does indicate some critical consumption of medical advice; however, this is sacrificed if under time pressure. In cases where there is time pressure, Manish expressed his trust by stating that he was comfortable in not knowing what it is he has been prescribed and taking 'whatever is needed.'

As well as privileging the expertise of mental health care professionals, participants tended to note a point at which professional help would be needed. That is, for participants there were certain issues that they felt incompetent to handle and

need professional input. Timothy describes a time when he did not seek help for his own mental health problems as he believed it would compromise his ability to care for his girlfriend who had mental health problems:

> *Timothy: (...) I think that was a big reason for me not getting help but um I definitely believe if someone was in the position I was in, they - **that's not** a position someone who's unqualified - you know - kind of really should be monitoring I guess. Like it's - I think I was doing it because I was hopeful for this person like I loved them, I wanted to be there, but I think that only goes so far before it's like 'this is beyond (laughs) you know - my control here - this shouldn't be me doing it anymore but I didn't accept that (laughs) so I stuck around and she's doing fine now so that's good, but um... Yeah, I - I think I have no idea how to handle a situation like that but I think definitely you should seek out help*

In hindsight, Timothy believed that as an unqualified helper; he was out of his depth in helping his partner. He acknowledged the limits of his own ability to deal with mental distress, noting that there is a point at which the issue is 'beyond his control,' and which requires professional input.

The following extract presents another example of participants recognising a level of problem where professional help would be needed. In this example, Simon was explaining the types of problems that would require professional help:

> *Simon: (...) Anything such as talking about per se suicide, depression, things like that - that would need to be seeking help - in my opinion. Even though*

colleagues, friends and family can help with that and have a different understanding towards the person and give them their opinions, I think that has to be drawn at a line where you have to seek professional help. Suicide, depression, any form of other mental illnesses so to speak - in inverted commas. Yeah. that's where I would draw the line.

Simon recognised the limits of informal support for mental distress by providing examples of problems requiring professional input. The examples of depression and suicide may speak to the usefulness of public health campaigns that encourage help-seeking for depression.

Despite concerns and hesitation towards some types of services such as medication and talk-therapy, participants said they would listen to their doctor. Participants used the expertise of professionals as justification for acting in ways that do not align with previously stated values and beliefs regarding services. This theme also demonstrated an acceptance of the knowledge and qualifications of medical professionals, based on the belief that the doctor knows what is best for the patient (even if it does not align with the patient's beliefs). Participants also expressed limits in the ability of non-professionals to deal with some mental health problems, stating that there is a point at which professional intervention is necessary.

3.3 DISCUSSION

The aim of Study One was to understand young men's beliefs and attitudes towards mental health services, particularly regarding how these may affect help-

seeking. Five themes emerged suggesting complex sets of beliefs and attitudes regarding services. These themes are summarised and discussed below.

3.2.1 ***Sources of knowledge***

Participants stated that their knowledge about mental health services was limited, and much of it came from television and movies in the theme 'This is all based off what I know from television.' The finding that young men's knowledge of mental health services is vicariously learnt from mass media aligns with the theses of Orchowski et al. (2006) and Wedding (2017), both of whom argued that movies and television have a large impact on attitudes towards mental health services through their portrayal of them. Additionally, participants describing their inexperience of mental health services aligned with Schultz's (2005) suggestion that specialist mental health professionals are particularly vulnerable to the influence of media portrayal in comparison to other professions (such as GPs and lawyers), due to a lack of lived experience among viewers. These statements also fit more broadly with McKelley and Rochlen's (2007) and Swami (2012)'s findings that men have limited knowledge of services.

Participant's limited understanding of services has implications for help-seeking and service utilisation among men. Based on previous literature regarding the characterisations of mental health services in television and movies (e.g. Maier et al., 2014; Orchowski et al., 2006), it appears that movies and television tend not to represent services in helpful ways, which suggests that if such media is the primary source of understanding for these young men, it may create misconceptions of what services involve. Likewise, McKelley (2007) suggested that men are unlikely to engage with talk-therapy due to a deficit of knowledge of talk-therapy, which is filled by negative portrayals in the media. McKelley's findings align with those of

the present study, at least inasmuch as participants acknowledged that they had limited knowledge aside from what was offered in media. In other words, films and television shows are likely to influence understandings of mental health services - understandings that may not be balanced by other sources of information. These media-informed beliefs may affect likelihood or desire to seek help from services, thereby reflecting a possible attitudinal barrier.

Despite participants stating that their only source of information regarding services was film and television, they were cognisant of the sources of their knowledge. Participants' awareness of the inaccuracy of film and television may suggest that they are open to being educated and learning information contrary to their current media-informed beliefs, which could buffer the impact that these sources have. However, there may be times when the influence of media-informed beliefs more subtly influences attitudes. That is, some media may depict services in ways that are obviously caricatures, while other media may attempt to present services in more 'realistic' ways, which may still be inaccurate. Additionally, based on the young men's responses in this study, it appears that despite acknowledging their sources as untrustworthy, the movie and television representations of mental health services were still the most accessible images of services for participants, suggesting some impact on beliefs and attitudes.

3.2.2 ***Masculine attitudes towards help-seeking***

Participants expressed a belief that mental health services should be a final resort, and that they preferred to 'deal with it' (i.e. to resolve a hypothetical mental health problem) themselves first. The theme 'Maybe just deal with it yourself first' suggests an autonomous, pragmatic masculine preference of coping. This finding fits

with literature regarding the impact of hegemonic masculinities on help-seeking. For example, Cleary (2012) and Krum et al. (2017) argued that a normative masculine identity values independence, control, and repressed emotionality; all traits that participants' desire to deal with problems by themselves preserve. Equally though, men may see exerting control over their mental health as aligning with masculine ideals, which may lead to a pragmatic 'do what I must' attitude, as also seen in the data. There is also perhaps a New Zealand cultural stereotype being evoked here – making do and finding a solution with little at hand.

The finding that participants preferred to fix problems themselves first fit with Pattyn et al.'s (2015) finding that both male and female participants judging a vignette with mental health problems stated that men should use self-care options (i.e., fix the problem independently) rather than seeking outside help. The consistency of this theme with literature regarding hegemonic masculine traits reinforces that manhood is commonly constructed as an ability to fix problems without help. It also appears that this pressure towards fixing problems autonomously is amplified in relation to mental health. That is, seeking help for mental distress may not only compromise a sense of independence and control, but also compromise the belief that men should not express feminine emotions such as sadness and anxiety (Cleary, 2012).

Participants' description of their perceived discomfort in a variety of help-seeking situations also aligns with discrepancy strain within Pleck's (1995) GRSP. Discrepancy strain refers to the feelings of distress and discomfort that a man may experience when he exhibits behaviours inconsistent with his belief of what it means to be a man (Pleck, 1995). In this instance, participants described an expectation of discrepancy strain by stating that they would feel uncomfortable in discussing their

problems or admitting that they are unable to fix a problem on their own, with one participant explicitly stating that doing so would conflict with his beliefs about his ability to fix problems independently.

The finding that participants preferred to deal with problems themselves before seeking help suggests there is a barrier towards help-seeking that may be in part created by prototypical hegemonic masculine norms where control, autonomy, and stoicism are valued (Cleary, 2012; Krum et al., 2017). Additionally, the theory that this preference creates a barrier to help-seeking was supported by participants' statements that they expected to feel uncomfortable in seeking help and may therefore be slower to do so.

The finding that participants preferred to fix their own problems and expressed discomfort at seeking help also align with a body of literature that considers the pressure of hegemonic masculinity, and its incompatibility with help-seeking (particularly regarding mental health) as a key explanatory factor in why men seek help at lower rates (Cleary, 2012; Krum et al., 2017; Moller-Leimkuhler, 2002). That is, previous studies have suggested that hegemonic values are the reason men tend to be slow and unlikely to seek help. Therefore, this study suggests that participants' beliefs that they should be able to manage and fix their own problems could create a barrier to seeking help when needed.

Although the preference to fix problems independently likely relates to hegemonic masculine pressures, it is worth noting that such a preference may also be a common socially normative response to health problems, and not resulting only from gender-role pressures. Likewise, the issues referred to regarding masculinity should be viewed with a more nuanced view that acknowledges these issues are not

exclusively gendered. For example, Biddle et al.'s (2007) COA model posits that people attempt to cope with and normalise problems independently until they reach a threshold of distress that causes them to seek help (i.e. they preferred to attempt to fix it themselves first). Likewise, there are other explanations than hegemonic masculinity as to why people might prefer to fix health problems without professional help. For example, Andrade et al. (2014) found that the cost and time commitment of using services was an important structural barrier to service use among men. That is, it may be simply cheaper to fix problems without services. Additionally, visiting a potentially expensive health professional for ambiguous health issues that may resolve without professional intervention may seem like a poor investment. Therefore, attempting to resolve issues independently is likely to be a preference for pragmatic reasons that go beyond dualistic gender-role explanations.

As well as pragmatic reasons, previous research suggested that the impact of perceived and experienced stigma affects the decision to help-seek (Barney et al., 2006; Vogt, 2011). Barney et al. (2006) found that men feel high levels of self-stigma at seeking help for mental health issues, and that they reported expecting highest levels of stigma from their GP, both findings that suggest that seeking professional help may be a highly distressing internal experience, and that self-management would be preferable, if possible. Therefore, it appears that a variety of factors such as gender role strain, financial and time issues, and feared stigma may influence the decision to attempt to self-manage mental health problems. Nevertheless, in this study, participants' explanations most closely aligned with the idea that conflicts between their sense of masculine identity and help-seeking caused their preference to independently manage distress.

3.2.3 *Beliefs and attitudes towards specific services*

Without lived experience of talk-therapy, participants compared talk-therapy to informal social supports such as talking with family and friends. They suggested that the primary benefit of talk-therapy was that it provided people with a safe and trustworthy space to discuss their problems when their informal supports were not providing this space. The finding that participants expressed that talk-therapy consists of peer-support type talking is similar to the findings of Midgley et al. (2016), who found that some young people expected talk therapy to comprise of a chance for them to talk about their problems.

Before discussing how these findings may be explained by literature relating to masculinity, it is important to acknowledge that the bicultural context of this study and the ethnic diversity of participants likely influenced their constructions of services. For example, positive attitudes towards constructions of talk-therapy as a form of social support may reflect Māori models of health care, where the importance of relationships is central (Hamley & Le Grice, 2021). Likewise, it is possible that fearful and negative views of services discussed in relation to television depictions and medication may reflect salient cultural fears of mental health services due to higher rates of involuntary and harmful services for Māori men (Drown et al., 2018). Nevertheless, themes were identified in this study that reflected the speech of young men who were ethnically diverse, suggesting similar constructions, despite diversity. Therefore, although interpretations based on other aspects of culture are acknowledged, this interpretation focusses primarily explanations relating to the masculinity of these participants.

These findings regarding talk-therapy indicated that participants tended to have positive views towards talk-therapies, as might be expected based on the

findings of Prins et al. (2008) and Sierra et al. (2014) that men endorsed positive views towards talk therapies (although these were men who *had* used services); however, the views in the present study were mediated by the participants' beliefs regarding how effective social support-type talking was for coping with mental health problems. However, some participants seemed to consider talking as an option with limited usefulness compared to medical treatments, which fits with previous research suggesting men prefer medication to talk-therapy (Harris et al., 2016).

Participants with positive views about the usefulness of talking appeared likely to endorse speaking to a therapist for themselves and others if informal social supports were not available; however, those who believed that talking alone is not enough appeared ambivalent about talk-therapy. Literature suggests that the relationship factors between a client and therapist are important predictors of the successfulness of therapy (Lambert & Barley, 2001), which indicates that participants' idea that talk therapy helps by offering a safe place to talk is accurate. However, regardless of the therapeutic efficacy of supportive relationships, it is the beliefs of the man that will influence his attitudes towards talk-therapy (Petty, 2018) and therefore if he believes talk-therapy to be unhelpful, this may create a barrier to help-seeking. That is, a man who believes that having a safe space to discuss his problems will help may be more likely to utilise talk-therapy than a man who believes that such talking cannot resolve his problems. In other words, the belief that talk-therapy primarily comprises supportive talking may be a barrier to help-seeking for some men, and a facilitator for others. This difference in beliefs highlights the variations within men regarding understanding services and reinforces the importance of considering individual experience over categorising beliefs as gendered.

These findings regarding talk-therapy likely also reflect a lack of understanding of what these services involve, a void that is filled in by media representations, and assumptions. Perhaps if talk-therapies were better defined to the public, particularly regarding what the services involve, and the known effectiveness of such treatments, people who do not believe talking is enough (i.e. the men for whom this belief is a barrier) would have a different view about the usefulness of talk-therapy and may be more likely to seek help through these channels. It is also important to understand what is meant to these participants by talking. Talk-therapy is, by definition, 'just talking;' however, aspects of it such as behavioural experiments, functional analysis, and exposure, which may be used in Cognitive Behavioural Therapy (Leahy et al., 2011) go beyond what some might consider 'just talking,' and it is possible that these young men who see limited value in 'just talking' would be encouraged to learn of these pragmatic and active interventions that are included in many talk-therapies. This suggestion is supported by research, which has shown that after experiencing talk-therapy and learning that it was not what they expected, some men held more positive attitudes towards services (Harding & Fox, 2015).

Participants expressed concern about reliance on prescription medication in the theme 'Pills… to almost rely on them.' This finding seemed to reflect an overarching preference not to use prescription medication, which contrasts with some previous literature suggesting that men prefer medication over talking therapies (Harris et al., 2016). However, the results are equivocal as other studies have suggested that men prefer non-medical options (Prins et al., 2008; Sierra et al., 2014), aligning with the findings of this study. Likewise, research regarding attitudes towards psychotropic medication found that the public tends to perceive medication

as addictive and unhelpful, which is like what men in this study expressed (Mirnezami et al., 2016; Paykel et al., 1998).

It appears that these participants' disfavour of medication is contingent on the belief that medication leads to reliance and does not foster long-term autonomous coping skills. Therefore, it seems that participants' preference to manage problems independently may be relating to their preference not to use medication. That is, hegemonic masculinity values autonomy and control, while prescription medication may reflect a loss of control and autonomy. In this theme, participants also expressed concerns regarding the addictiveness of medication, and problems with coming off the medication. Therefore, it may be that gendered values influence attitudes towards medication; however, broader public attitudes towards medication are likely to also influence beliefs found in this study.

In the theme, 'Cause they're the doctor, they know – they know what's best for you,' participants expressed the belief that mental health professionals know better than laypeople do, and that their advice should be trusted. This theme demonstrated a tendency among participants to state they would accept what their doctor tells them, even, in some instances, when it goes against attitudes and beliefs that they might construct in other contexts (for example, a participant stated that if he were prescribed psychotropic medication, he might take it because the doctor knows what is best for him, despite having previously expressed negative views towards such medication).

The apparent discrepancy between attitudes towards treatment options such as medication, and participants' belief that they would follow the doctor's advice may reflect early literature regarding the formation of attitudes. For example, in Fazio's (1986) model of impacts upon attitudes and behaviour, he stated that attitudes may

be overridden by the normativeness of a situation. In this instance, it may be that participants recognise a negative attitude towards medication; however, they also recognise the social normativeness of listening to their doctor. Additionally, Maio et al. (2018) posited that the credibility of an information source has a strong effect on subsequent beliefs and attitudes that are developed; perhaps participants recognised that what they know based on television and movies is less credible than what they might hear from a mental health professional, and they were therefore inclined to assign more weight to the professional's view, consequently affecting their likelihood to accept medication.

This finding also presents an interesting conflict between situationally normative behaviours and hegemonic masculine norms. Hegemonic masculinity values autonomy and control; whereas social norms towards medical professionals appear to dictate that the doctor knows best, and patients should listen to their doctor (thereby lowering control and autonomy). Pattyn et al. (2015) articulated this conflict highlighting strains between the role of masculine man and patient of a health service. The results of this study suggest that these participants are either able to maintain their masculine identity and listen to their doctors, or perhaps that their masculinity can be temporarily set aside in certain situations such as in a health service. However, it is unclear whether participants would seek this consultation, despite acknowledging that they would accept the doctor's expert advice.

Participants described a paternalistic attitude towards doctors whereby the doctor-patient relationship is akin to a parent-child relationship, in which the parent knows best and has the final say. This paternalism has often been considered the normative means of interaction for medical doctors (Árnason & Hjörleifsson, 2016); however, this study suggests that potential patients, not only doctors, endorse this

relationship (or at least recognise that it is a normative relationship). It appears that in this situation, participants value the socially normal behaviours specific to interacting with health professionals over the more general masculine norms (i.e. controlling one's own health, and not being vulnerable). This finding may suggest that attitudes towards doctors are a facilitator towards help-seeking, perhaps even overriding negative attitudes towards medication; however, it may be worth recognising that these attitudes are situational and may not be activated (Fazio, 1986) if a man does not enter services. That is, if a man has strong negative attitudes towards medication, he may avoid seeing his doctor for fear of being prescribed such medication, though he might accept such a prescription if he were to see his doctor.

3.2.4 ***Research Applications***

Based on the findings of this study, improving education regarding mental health services appears to be warranted, and would be a useful application of this research. Previous research has shown that education campaigns targeted to men reduce barriers to help-seeking through improving attitudes towards services and reducing fear of stigma (Hammer & Vogel 2010). Additionally, men have expressed that education regarding mental health and services would be useful (e.g. Harding & Fox, 2015; McKelley & Rochlen, 2007). Therefore, the findings of the present study may be used to inform the content of any education campaign designed to reduce barriers. *Reflexively, during the interviews, several participants discussed a New Zealand ad campaign in which an ex-All Black (national rugby team player) talked about his experiences of depression. All the participants who spoke of this were positive and noted the impact it had on them regarding their understanding of mental illness. Although this data did not feature in the final thematic analysis, it left me*

with the impression that even a short television advertisement campaign can have a lasting impact.

The findings of this study suggest that an education campaign that focusses on mental health services and what they comprise may be useful. First, it may be useful to have small 'profile' type videos, in which mental health professionals describe who they are and what they do, with a focus on explaining how services operate. This may be useful as an alternative source of information to television and movies. Additionally, in these short videos, the professionals could discuss services in a way that addresses some of the attitudinal barriers noted in this study. For example, one video may include a clinical psychologist – preferably a young male - describing his hobbies and who he is (to dispel film and television misconceptions of what therapists look like). He would then briefly describe the work he does – noting that he uses evidence-based therapies that empower people to have better control over their mental health, and that it does not involve lying down on a couch, but it may involve exposing oneself to fears, and talking about feelings (to dispel beliefs that talk-therapy is like talking with a friend, and other ideas of what talk therapy involves such as the common romantic connection seen between patient and therapist as noted by Orchowski et al., (2006)). This type of profile video may also be useful to reduce the barrier that men prefer to deal with problems independently if emphasis is put on the clinician helping people to become independent and learn to self-manage.

Another profile-type film addressing medication may be useful, in which a professional with prescribing rights (such as a psychiatrist or GP) openly discusses the possible risks and benefits of medication, with a specific focus on addressing the

belief that medication leads to reliance, by framing medication as a tool to support independence. The dissemination of these videos would likely need to occur on multiple platforms, as previous research has shown television advertisement campaigns to be effective in public health campaigns (e.g. Wilson et al., 2005); however, changes in how media is consumed, such as increasing rates of social media use (Austin et al., 2015), suggest that online platforms and social media should also be utilised to increase public knowledge of mental health services. Previous research has suggested that social media-based public health campaigns are effective at improving knowledge and influencing public discourses on health areas (e.g. Freeman et al., 2015; Madathil et al., 2015; Xu et al., 2016).

Finally, this research demonstrated that even amongst a small group of young men, there were a variety of attitudes and beliefs regarding services, suggesting varied preferences. For example, some participants appeared to endorse talk-therapy, while others indicated that medication is superior. This finding suggests that service users should have clear and open options regarding their care. Where possible, service users should be offered choice in their treatment: some participants in this study appeared to highly value social support, and may prefer counselling-type services, while other participants suggested that they would like the doctor to tell them what to take, and that they would trust their doctor. Additionally, this group of young men preferred to manage their problems on their own and thus, services should have a place in facilitating independence and autonomy. It appears then, that all services should be offered with clear information about what the options are and what these options will involve, to allow service users to retain their autonomy and choice in managing their health.

3.2.5 ***Limitations and future research***

The present study had some limitations, which should inform future research to develop better understanding of this area. The young men who participated in this study all met the inclusion criteria such that they were all between the ages of eighteen and thirty. Additionally, the participants comprised a range of demographics including heterosexual, homosexual, and bisexual men. Likewise, a range of ethnicities and occupations were included in this study. However, it is possible that participants with a tendency to be interested in services volunteered for this study, rather than men with little interest in mental health. *Reflexively, most of the participants seemed enthusiastic and eager to discuss mental health with me at the outset of the interview, which I suspect may reflect a self-selecting bias. Although most participants stated that they had little knowledge of mental health services, several of them had known friends and family with mental illness and appeared to have an investment in expressing their beliefs*.

Additionally, the necessary information and consent process for this study (along with the interview itself) may have had the effect of encouraging participants to consider mental health services more than they might have otherwise. This reflection on beliefs may have impacted the form of such beliefs. That is, requiring participants to articulate their beliefs in conversation may have facilitated the construction of more nuanced beliefs (e.g. the recognition that beliefs were based on movies and television). In other words, having participants express their beliefs in conversation inevitably influenced and shaped these beliefs (somewhat like Tomm's (1987) notion that questions are interventions and are never neutral). Without such explicit consideration in conversation, beliefs may be constructed differently and therefore have a different impact on attitudes. Therefore, there may be a gap

between the construction of beliefs in this study and the impact and form of beliefs among men who are not required to discuss them in some depth.

This study is premised on the assumption that infers a link between barriers and facilitators to help-seeking and the opinions of men who have never used services. That is, there is an assumption that the beliefs of these young men might affect their behaviours (and the behaviours of others like them). Although there is reasonable evidence to suggest that beliefs and attitudes do affect behaviours in some contexts (Petty, 2018), there are limitations to how much can be assumed about help-seeking behaviours based on beliefs articulated in interviews. Beliefs influence attitudes, which influence behaviours; however, it is not a perfect causal relationship (Petty, 2018).

Likewise, beliefs elicited in these interviews may not reflect the most pertinent beliefs held by participants. Fazio (1986) noted that attitudes need to be activated to have an effect. Some attitudes and beliefs may not have been salient to participants during the interview, but in situations involving help-seeking may become activated and be highly influential. Furthermore, the method of data collection – semi-structured interviews – was useful in order to form an inductive understanding of attitudes towards services, though it may not reflect beliefs and attitudes that occur in a context where hegemonic masculine pressures are more present. That is, in a private room with an interviewer who has explicit ties to mental health research, these participants may have been more likely to draw upon positive beliefs and attitudes relating to services and mental health than they might have in other settings.

Future research could build upon the findings of the present study by interviewing more specific groups of men. For example, a group of young men who identified as having experienced a mental illness or severe mental distress, but who

did not access services could be interviewed in order to understand the factors that prevented them from seeking help. This would be a useful way to understand what they perceive the main barriers to help-seeking as, but also in order to understand how men who have not sought help despite suffering (rather than men who have never utilised services) perceive mental health services. Additionally, groups of men who live in high deprivation areas could be interviewed to understand whether they hold similar beliefs towards mental health services as the men in the present study, as deprivation was not an inclusion criteria in this study, but does relate to lower help-seeking (Walker et al., 2015). It is possible that men from high deprivation areas would have more commentary regarding structural barriers, based on the findings of Walker et al. (2015). Future research should also consider peer-led interviews or focus groups to facilitate a context that may be less biased towards accepting mental illness and services.

The issue of barriers to help seeking and attitudes and beliefs towards services may also be addressed from different angles. For example, service providers may provide useful insight into the barriers that are apparent for their perspective. Additionally, quantitative data looking at service use may illustrate some of the barriers to different populations.

Subsequent studies may also utilise non-interview type methodology to understand key features of how men perceive mental health services. For example, a survey could be utilised, which asks men to describe key features of mental health specialists, and features of various types of treatment. This would allow for a more deductive approach to understanding attitudes towards services, based on the foundation that the present inductive research has established. Additionally, future

research could use experimental design whereby participants are asked to state beliefs and rate aspects of services, before being given information dispelling common myths and misconceptions, and then asked to re-rate services in order to assess the effectiveness of such information.

Chapter 4: Study Two: Analysis of how mental health services are constructed in New Zealand news media

4.1 METHODOLOGY AND RESEARCH DESIGN

4.2.1 *Design*

To investigate how mental health services are portrayed in New Zealand news media, a similar inductive qualitative design to Study One was utilised: Thematic Analysis (TA). TA as outlined by Braun and Clarke (2006; 2014; 2019) is a flexible methodology that has been shown to be effective in studies exploring how issues are presented in popular news media (e.g. Balanovic et al., 2018). Furthermore, using TA enabled comparisons of the themes from Study One (i.e. how men construct mental health services) and Study Two (how the news media constructs mental health services). Likewise, the use of TA in Study Two enabled data to be analysed from a constructionist perspective, fitting with the overall epistemology for this research.

Although the primary analysis for this study was TA, in order to select articles for inclusion in this study, a brief summative Content Analysis (CA) (see Domas White & Marsh, 2006; Hsieh & Shannon, 2005; Macnamara, 2005) was conducted with the purpose of identifying recent periods when mental health services have been most frequently reported on. This methodology is based on research from Goodwin et al. (2014). The present study's 'CA–to–TA' method provides a replicable structure and rationale for data collection, and highlights periods of intense

media scrutiny. This method also allows for a better understanding of the context around the news media at the time of the publication of the articles by demonstrating trends in reporting.

4.2.2 ***Data collection – content analysis***

CA data were collected via the search engine 'Newztext' on the archival and live web platform 'The Knowledge Basket' (https://www.knowledge-basket.co.nz/). Newztext is a search engine that enables customised searches on a variety of New Zealand news media platforms and has been used in other studies analysing New Zealand news media (e.g. Frewin et al., 2009). Search criteria consisted of *"Mental Health" ~5* as the key words in all search zones (resulting in the inclusion of any article with the words 'mental' and 'health' no more than five words apart in either the body, title, or the author/source of the text. For example, if the text of an article contained the phrase 'Mental illness and health problems,' it would be included in the results of the search, as there are less than five words separating 'mental' and 'health'). This search criteria reflects a broad inclusive analytical focus. This criteria was reached through an iterative process, as more specific searches (e.g. "mental health service", or even "mental health") resulted in sparse data, with many possibly relevant articles omitted, whereas results from searching with more inclusive criteria allowed for an inductive process of theme generation from a wide pool of data. The CA covered a 3.5-year period, with articles that were published between January 2016 and July 2019 (inclusive) included, as contemporary constructions of mental health services were sought. This period span was selected to present a useful pattern of reporting trends, whilst also remaining recent and contemporary.

Finally, although Newztext offers a variety of news media platforms to search (including blogs, magazines, newswires, and newspapers), two news article sources

were selected: Stuff (www.stuff.co.nz) and The New Zealand Herald (www.nzherald.co.nz), which were, at the time of writing, New Zealand's two most visited online news platforms (Myllylahti, 2017). Although excluding other forms of media may have reduced the potential range of constructions of mental health services, the scope of the present study made analysing all potential media sources unfeasible.

4.2.3 ***Data selection – thematic analysis***

The CA search results were quantified and grouped by month to show periods of highest reporting on mental health. Results of the preliminary CA demonstrated monthly variance in the volume of articles meeting the search criteria across the search period. The CA also demonstrated a greater volume of articles in the NZ Herald compared to Stuff. The monthly variation in articles meeting the search criteria, and the difference in reporting volume between Stuff and NZ Herald are presented in Figure 1. Articles for TA were taken from the most recent peak (May 2019) and trough (February 2019) in reporting, indicated by the white and black diamond respectively (the addition of the trough in reporting is explained below).

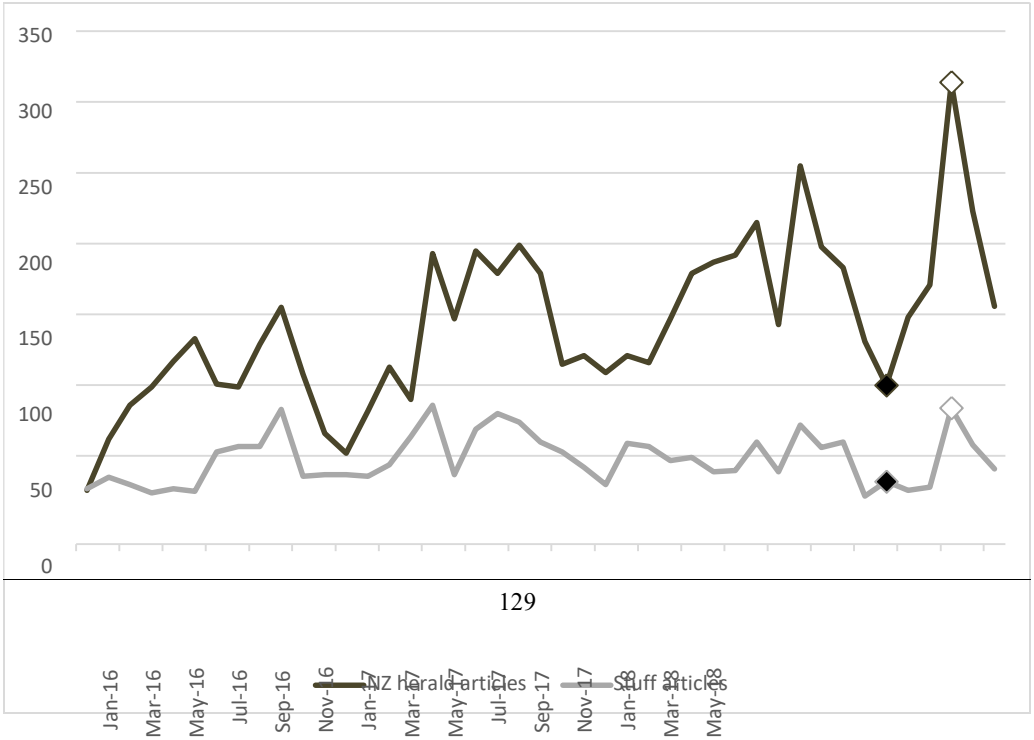

Figure 1. Number of Stuff and NZ Herald articles matching search criteria over 3.5 years

The search resulted in a total of 9238 articles across both news sources over the 43-month period (an average of 215 articles per month). However, the total volume includes some duplication, as articles from NZ Herald were often published on Stuff, and some articles were republished across multiple newspapers, leading to multiple results.

Fitting with Goodwin et al.'s (2014) method, I then selected the twenty most relevant articles to the search criteria (based on descending order in the search results, whereby the top article was rated the most relevant to the search by Newztext). In other words, I searched down the list of results, taking articles for analysis, and excluding those that I deemed unrelated to mental health (based on subject and content of the article). The initial sample size of twenty articles was based on recommendations by Braun and Clarke (2012) regarding sample sizes relative to project sizes; however, in the process of the initial reading and selection of these articles, it became apparent that there was significant homogeneity in the topic of the articles from May 2019.Therefore, an additional month of reporting, February 2019, was added to the dataset. The additional period was selected as it represented the most recent 'trough' in reporting, thus data comprised a recent peak and trough; periods when mental health was a popular and less popular topic. Finally, I identified two articles in the dataset that were direct duplicates and removed them, leaving a total dataset of 38 articles for TA.

A brief categorisation in which I classified each article according to its apparent topic demonstrated that most articles from the sample in May 2019 related to discussion of the New Zealand government's 2019 budget announcements, which

featured a heavy focus on mental health funding, whereas articles from February 2019 related to a wider range of subjects (see Table 1).

February 2019 article categorisation	Volume	**May 2019 article categorisation**	Volume
Personal mental health narrative	3	Personal mental health narrative	1
Encouraging Wellbeing/ MH awareness	2	Description of new funding/initiative resulting from 2019 budget	1
Fundraising for Mental Health	2	Fundraising for mental health	1
Difficulty accessing services	4	Difficulty accessing services	1
Criminal justice mental health/court case	1	Barrier to service use	1
Need for more investment/mental health improvement	1	Comment on/discussion of new funding resulting from government budget	14
Inappropriate mental health care	2		
Call for early interventions	1		
Reporting on a study relating to mental health	2		
Report on promising mental health initiative	1		

Table 2. Categorisation of articles from February 2019 and May 2019

Both Stuff and NZ Herald articles are represented in the data; however, it should be noted that both news websites publish articles written by other news sources (e.g. Bay of Plenty Times), as well their own articles; hence the variety of article sources. Each article included in the TA was numbered for reference in the analysis. The article author has not been included as authors were not always identified by the news platform. All articles, the source of the article and the article's reference number is presented in Table 2.

Article Source	**Article title**	**Article reference number**
Stuff	Mental health advocate Mike King named 2019 New Zealander of the Year	Article 1
	Housing, migrants, mental health – there's a lot to work on in Southland	Article 7
	'Serious concerns' over patient in hospital secure unit for 14 years	Article 8
	Smoking cannabis as a teen increases risk of depression and suicide as a young adult, says study	Article 12
	Bipolar disorder treatment in New Zealand, the vision and the reality	Article 13
	Epalahame Lauaki still thinks of his brother every time he laces up the boots	Article 14
	Suspected ADHD cases put pressure on mental health services	Article 15
	Mental health patients in seclusion given cardboard box as toilet	Article 16
	Programme helping Cantabrians into work expanding to help another 200	Article 17
	Older renters' health differs from home owners	Article 18
	Were Maori sidelined in the mental	

	health inquiry? Ministry to fund March 15 mental health recovery plan – CDHB boss	Article 28
Te Awamutu Courier	Looking after mental health in workplaces	Article 31
Stratford Press	Running for mental health fundraising	Article 3
Kapiti News	Art project taken on beach	Article 4
Whanganui Chronicle	Mother struggles to obtain mental health help for son Threats by teen a huge concern Editorial – Much rides on mental health action	Article 5 Article 25 Article 36
Bay of Plenty Times	Tauranga man accused of dad's murder assessed for trial fitness Budget 2019: So what do the locals make of it? Focus on mental health, addiction 'long overdue' Tauranga Mayor Greg Brownless Waiariki MP Tamati Coffey Maori and mental health priorities	Article 6 Article 22 Article 26 Article 27 Article 34
The Northern Advocate	Mental health campaign goes viral Budget gets tick from Northland	Article 9 Article 35
New Zealand Herald	Intervene early to lessen trauma for kids Osaka's refreshing honesty opens up a new game on mental health New mental health body tipped Big Budget hopes for alcohol and drug treatment sector Ross discusses mental health with psychiatrist in podcast Plans could need vast workforce	Article 10 Article 11 Article 20 Article 29 Article 30 Article 33
Indulge HBT	Ministers put in touch with district issues	Article 19
The Daily Post	Editorial – Funding for mental health	Article 21

	services overdue Lack of mental health help for pupils Boost for mental health 'overdue'	Article 23
Hawkes Bay Today	Massive boost for mental health Mental health service under-used	Article 32 Article 24 Article 37
Waihi Leader	To the trig for charity	Article 38

Table 3.

Articles used in TA with source newspaper and article reference number

4.2.4 ***Data analysis***

Preliminary data analysis consisted of a summative CA. As in Goodwin et al. (2014), the preliminary CA comprised a descriptive quantitative analysis of news articles meeting the search criteria. However, the primary aim of this CA was to enable data collection for the TA, thus the CA is described in more detail in the Data Collection section of this chapter.

Primary data analysis comprised TA of the thirty-eight articles identified in the preliminary analysis. TA was based on Braun and Clarke's (2006; 2014; 2019) six phases of TA, as in Study One.

Over the course of this analysis, I familiarised myself with data, first during my initial reading/screening of articles for inclusion, and subsequently through reading and re-reading each article. Subsequently, I read through the data and created codes, which were both numeric (for grouping purposes), and descriptive, for example 'Role-modelling help-seeking (3)'. I coded all the data in this way and collected these codes in a separate Microsoft Excel spreadsheet. There were 48 codes in total. Next, I began to search for themes, initially by looking at the final list of codes and grouping these together into possible themes. I then grouped data excerpts into tentative themes and reread the data to check if it matched tentative theme names. I defined and named the themes based on the best match with the data, and then wrote

the report by offering theme definitions followed by presentation and examination of data for each theme.

This analysis was oriented towards addressing the research question ('how are mental health services described in New Zealand news media?'); however, this study took an inductive approach, allowing for the best fit themes to emerge from the data, rather than seeking themes based on pre-existing research or ideas. The analysis style was primarily descriptive, as I attempted to describe what the data was 'doing' across the theme (Braun & Clarke, 2012). The themes identified in this study were identified and analysed independent of the themes identified in Study One. However, the overall orientation of this study was towards understanding how mental health services are constructed in the news media, and in turn how these constructions may affect attitudes towards help-seeking.

4.2 RESULTS

4.2.1 *Thematic analysis*

Analysis of data resulted in the identification of four themes, which are presented below in Table 4.

Theme 1	Positive attributes in people with mental illness
Theme 2	Commonality of mental health problems
Theme 3	Lack of mental health service capacity
Theme 4	The government needs to do more

Table 4. Study Two themes

The first theme: 'Positive attributes in people with mental illness' explored how people with mental health issues were constructed as possessing strengths and positive qualities. The second theme 'Commonality of mental health problems,'

described the high rates and growth of mental health problems and suicide in New Zealand. The third theme is 'Lack of mental health service capacity.' This reflected a tendency to highlight long waiting times to access mental health services, and construction of services as understaffed and pressured. Finally, the theme 'The government needs to do more' positioned mental health service issues within a political frame, placing the responsibility of improving mental health services upon government organisations.

Positive attributes in people with mental illness

Articles presented people with mental health issues in a positive light, highlighting strengths and qualities (including seeking help) that allowed people to move through their mental health problems. These articles also gave a message of hope by contrasting bleak and difficult mental health conditions to the positive outcomes that occurred subsequently. Therefore, the current section provides data that presents people who have experienced mental health problems as role models, and data that presents strengths and positive attributes associated with overcoming or managing mental health problems.

The following data was taken from an article discussing Mike King, a New Zealand comedian whose mental health issues and advocacy had been in the public arena over the years preceding this extract, and who was also named as the 2019 New Zealander of the Year:

> *Article 1: (...)"It's that courage and resolve that makes him so relatable to at-risk rangitahi (youth) that others can't reach, Mike King is a great New Zealander of the Year," Bennett said.*

Working alongside other mental health professionals, King has been the driving force behind many initiatives helping shift the way New Zealanders think about mental health, drawing on his own experiences of mental illness. (…) (Stuff)

Article 1: (…) He discovered booze at 13. Drugs followed.
Although humour was his ticket to social acceptance and would become his livelihood, he spoke of being an angry man struggling with his demons, which included two suicide attempts.
It wasn't till he was 45 that he sought help for his mental well-being. He got clean, ditched the drink and drugs and went on to start his radio show, the Nutters Club, on which callers discuss mental health issues. (…) (Stuff)

This description of King's long battle with mental health problems positioned the experience of illness not as a source of weakness, but rather, an eventual source of personal growth. Qualities including 'courage,' 'resolve,' and leadership appear to be attributed to King's extended struggle with his demons, suggesting that experiencing mental health problems develops transferrable knowledge, while overcoming mental health problems develops and reflects strength. There is also a message of hope – despite struggling with long term mental health problems, King won the battle and was positioned as an influential change maker and public figure who openly acknowledged mental health issues and provided a forum for discussion of these on the radio. Additionally, King was positioned as driving his own recovery from mental health problems, by describing his change as coming about through his behaviours ('he sought help;' 'he got clean and ditched the drugs'). Although this

example stressed the importance of seeking help, by implying that seeking help is an important part of overcoming mental health problems.

News articles appeared to frame individuals with mental distress as role-models, even when the individual discussed did not consider themselves that way:

> *Article 11: (...) Last April, having won her biggest title at Indian Wells, Osaka revealed: "Yesterday I woke up and I was really depressed, but I don't know why. Like, I'm so sad right now."*
> *Admissions like these are uncomfortable but potentially game-changing in a sport that has traditionally had an awkward relationship with mental health. The usual pattern has been for players to suppress their concerns until it is too late.*
> *Eight-time grand slam champion Andre Agassi is an example of this trend, opting to stay quiet until revealing all in his explosive autobiography Open, in which he compared the life of a tennis player to "solitary confinement". Removing the stigma around mental health is precisely why Osaka's candour is so important.*
> *Seeing a player of her standing speak in these terms will help normalise the discussion. (...) (New Zealand Herald)*

> *Article 11: (...) When asked last year what tips Osaka would give to young athletes, she said: "The only advice is, don't look up to me."*
> *The reality is that they could do far, far worse. (New Zealand Herald)*

Despite not yet overcoming her mental health problems, Osaka was presented as a role-model. This article framed her depression disclosure as a positive attribute and focussed on it. Osaka was positioned within a discussion of mental health stigma, and it was suggested that she speaks about her problems despite discomfort, thereby proving her candour and bravery. The contrast in this example between Osaka's comments about herself ('don't look up to me') and the article's positive description of her as a role-model appears to suggest that even when depressed and experiencing negative thoughts, it is still possible to have a positive influence by being open about mental health struggles, or perhaps it highlighted another positive attribute - humility.

In the following example, Epalahame Lauaki, a rugby League player, described his mental health problems and the passing of his brother:

> *Article 14: (...) Upon arriving home he officially retired from rugby league and in the middle of battling his own depression, lost his brother - and best friend - just weeks later.*
> *"I was in a real dark place for a while there, and it made me realise what's truly important," he said. (...) (Stuff)*

> *Article 14 (...) Coupled with his mental health work, Epalahame Lauaki has become a leader in the local community - a far cry from the brutal enforcer he was as a professional league player.*
> *Junior players and local kids look up to him, not only because he played 69 NRL matches, but because he is a constant voice of support to anyone in the side in need of guidance, he said.*

"People say I'm a bit of a leader, that's cool, it's a long way from where I was a few years ago," he said.
"When I was with the Warriors and in the UK I was just that big angry dude you know, but nowadays I like to think I have levelled out a bit and that shows through my footy and especially my home life. I'm in a good place. Finally." (...) (Stuff)

This article suggested that depression and distress were the catalyst for Lauaki's personal growth and change. This presentation of change following from mental distress suggests that a positive outcome of depression is possible. In this article, Lauaki was presented as a role model, with his attributes of leadership, support, and guidance highlighted and compared to his prior role as a "brutal enforcer." This article reframed grief and depression from a negative experience to one of growth.

Finally, the following article discussed a woman's personal experience with recovery from bipolar disorder, and the treatment options available in New Zealand:

Article 13: (...) From 11 years old Sarah began feeling worthless and thoughts of suicide flooded her mind from nowhere.*
The administrative executive, now 27, spent her teenage years cycling through inexplicable and extreme moods that seemed completely outside her control. (...) (Stuff)

Article 13: (...) Sarah said therapy had given her the confidence to manage her moods and wellbeing - something she once thought impossible.

She was acutely aware others were unable to access the support and education she received and instead were treated with medication alone. "I do feel quite sad for people who don't have family and ... end up in a cloud of medication and not actually getting to live their life."

This article presented the outcome of successful therapy. Sarah's traits were contrasted pre and post treatment, with the article highlighting a sense of confidence and control that she gained through treatment and recovery. Strong, evocative language of Sarah's history of difficulties as a teenager and the 'happy ending' present a message of hope and of personal growth. This article also suggested that seeking help in the form of therapy was a key aspect of this positive outcome of mental illness. By emphasising the importance of talk-therapy, this article privileged the importance of autonomy and control in recovery; that is, although it presented hope for recovery, it suggested that positive outcomes are best achieved with personal growth through supportive therapy, and that a "cloud of medication" does not lead to such outcomes; a powerful metaphor that aligns with the concerns of interview participants in Study One.

These examples highlight a type of recovery focussed news reporting, whereby narratives of people who struggled with (or continue to struggle with) mental health problems are presented in a hopeful light. These articles focussed on positive personal traits associated with seeking help and disclosing distress, suggesting that even in the direst situations, growth and recovery are possible.

Commonality of mental health problems

Mental health problems and suicide were presented as being common and growing in New Zealand. These articles reflected and contributed to ideas of a national mental health crisis. Additionally, they referred to troubling rates of suicide; suggesting that any level of suicide is too high, but that New Zealand has a particularly bad issue.

The following extract is taken from an editorial that discussed mental health problems, supporting the idea that mental health problems are common and growing:

> *Article 27: The steady stream of mental health-related stories in recent years has become a tsunami. It appears that stress, anxiety, addiction, depression, despair and suicide are affecting ever-increasing numbers of New Zealanders, and our statistics paint a dismal picture compared with most countries whose values and standards of living we like to align ourselves with.*
> *Of huge concern is the fact many people suffering from, or trying to help those with, mental health issues feel their needs are going unmet (...). (Whanganui Chronicle)*

This editorial used an evocative metaphor of tsunami, as well as reference to statistics to present the high rates of mental health issues, and growing incidence of suicide. By pointing to both increased volumes of articles regarding mental illness and statistics, the article presented a powerful argument for the point that New Zealand's rates of mental illness are high. This article also noted a lack of services for mental health issues, which may be both an outcome of, and contributing to the rising rates of mental distress and suicide.

The following example discussed the comments of the Mental Health commissioner, Kevin Allan and supports the idea that suicide rates in New Zealand are disproportionately high:

> *Article 21: (...) Allan said while the idea of a 20 per cent suicide reduction target — another of the inquiry's recommendations — was controversial, "what is not controversial is that we have to do more to address the level of suicide in New Zealand".*
>
> *Shaun Robinson, Mental Health Foundation chief executive, said an impending announcement on a mental health commission was a "no-brainer".*
>
> *"But if that's all that came out, that would be pretty pathetic. (...) (New Zealand Herald)*

This article suggested that although suicide is a societal issue that would need to be addressed even with low rates, not enough is being done to address suicide in New Zealand. These statements imply that rates of suicide are too high, and there are not enough services for mental health. By presenting the comments of experts (the Mental Health Commissioner, and CEO of the Mental Health Foundation) regarding addressing suicide, this article gives weight to the idea that New Zealand has a suicide crisis. Allan's comments that it is widely accepted that suicide needs to be addressed in New Zealand appear to suggest that it is publicly accepted that rates of suicide are at crisis level. Articles appeared to emphasise that link between New

Zealand and suicide rates, perhaps suggesting that these rates are a national shame, or that New Zealand should be able to do better.

Other articles presented views aligning with this idea that suicide rate in New Zealand is too high. The following extract was taken from an article where Whanganui locals were asked about the recently released government budget:

> *Article 38: (...) Joanne Russ was pleased to see a focus on mental health.*
> *"Suicide shouldn't be happening in New Zealand, not in 2019, it just shouldn't be happening.*
> *"I'll be happy [if] they make it work and the money goes to the right places. (...) (Whanganui Chronicle)*

This article aligns with the idea that suicide rates in New Zealand are a national crisis. Additionally, by presenting the comments of a member of the public this article suggests that high rates of suicide are a common public concern, and not simply in the realm of health professionals and government agents. Russ contextualised suicide rates as an issue specifically in New Zealand and in 2019, which emphasises the impact of suicide rates on the national identity, and suggest that in a modern, wealthy society, such issues should not be happening.

Some articles pointed to statistics and key events to support the claim of growing mental health problems and suicide rates. Article 31 discussed challenges for the drug and addiction services, while article 33 discussed mental health plans following the March 15 Christchurch terror attack:

Article 31: (...) Funding for the mental health and addiction treatment sector has not kept pace with demand. A 2018 report from the Mental Health Commissioner said that the number of people checking in for those services had increased by 73 per cent in the last three years, while funding had only gone up 40 per cent. (...) (New Zealand Herald)

Article 33: (...)
"This event has caused very deep harm to Cantabrians," the plan said.
It followed a string of other traumatic events, most notably the Canterbury earthquakes, meaning there could be an "additive effect".
"This is a population at risk; it requires an active, well coordinated response."
There had been a significant increase in the number of mental health, family harm and suicide-related callouts to police since 2011, the plan said.
It expected such callouts would increase sharply after the terror attack (...)

Article 31 presented contextualised evidence for increasing mental health problem rates. This example described increases in addiction service use; though this may not explicitly indicate increasing mental health problem rates in New Zealand, as increased service demands may result from changes in referral process, access criteria, or acceptability of these services among consumers. However, this distinction leads to a question of what constitutes increased rates of mental illness, a question that may be answered by census data regarding incidence but is also likely to be based on rates of service use. Nevertheless, the example strongly implies that

rates of mental health problems have increased substantially over the three years examined.

Article 33 fits with the overall theme that mental health problems and suicide rates are rising; however, it presented these phenomena as linked to traumatic events. By likening the terror attacks to the effect of the 2011 Christchurch earthquakes, which resulted in demonstrable increases in police callouts for suicide and mental health, the article presented evidence for a trend in increasing rates of mental health problems and suicide. Interestingly, this article also framed the trauma of the 2011 Christchurch earthquake from the impact it had on police callouts. Connecting the mental health problem rates to police-call out rates indicated that mental health is an issue that affects the community, rather than only specific health providers. Alternatively, this may suggest that the police are to be considered among front-line mental health providers.

Articles tended to present information from experts to add legitimacy to their claims, yet they also presented the opinions of the public, which showed the generalisability and ubiquity of these concerns. Consider the following articles: Article 26 describes the reaction of a Rotorua woman to the 2019 New Zealand government budget announcement and Article 29 contains the Member of Parliament for Waiariki's comments regarding mental health:

> *Article 26: (...) Earlier this week Jo Keefe told the Rotorua Daily Post she hoped the Budget would address mental health so she's happy it did just that — announcing a $1.9 billion Mental Health package.*
> *"Everyone has been personally touched or known someone affected by mental health issues," Keefe said. (...) (The Daily Post)*

Article 29: (…) "Everyone knows somebody affected by mental health challenges. If someone needs help, they should get help."
"That's why we're taking mental health seriously in the Wellbeing Budget by providing much-needed support for mental health in our communities." (…) (Bay of Plenty Times)

Both interviewees used strikingly similar language in their description of mental health issues – 'everyone knows somebody,' which demonstrates the perceived ubiquity of mental health. Article 26 is the perspective of a Rotorua local who hoped that the budget would address the common mental health problems experienced in the community. In contrast, Article 29 presented the words of a Member of Parliament (MP). The similarities between the two descriptions may reflect an MP's interest in advocating for the perceived needs of the population, but also may reflect that leaders and the general population hold the same concerns (and construct the same mental health arguments). The almost interactional nature between these two articles demonstrates that the theme of rising mental illness is reported within various contexts including experts, government, and the public.

Throughout this theme, the data suggests that mental health problems were pressing and growing issues in New Zealand. Perhaps further emphasising the commonality of mental health problems and suicide, articles tended to present claims of high rates of mental health problems and suicide. These articles presented this issue through various perspectives and via various voices, which emphasised the legitimacy of the mental health crisis.

Lack of mental health service capacity

Articles described mental health services as lacking capacity, ensuring delays for patients. Additionally, services were described as having long waiting lists or staff shortages (often resulting in the long wait lists). Interestingly, these articles seldom described what services entail, and whether they are appropriate, but tended to focus on the issue of access.

The following extracts highlight lengthy waitlists, and both come from articles discussing Attention Deficit Hyperactivity Disorder (ADHD). However, Article 5 focuses on a specific woman's experience with ADHD services for her son who was in crisis, while Article 15 has a more general discussion of mental health services for ADHD:

> *Article 5: (...) However, Oldehaver stuck to her guns, calling a local service again and demanding a consultation despite being told at first that the wait would be at least a month (...) (Whanganui Chronicle).*

> *Article 15: (...) Bull said wait times varied drastically around the country, but were often better in the main centres. He believed public services were trying their hardest, but it was still challenging for families.*

> *"You don't suddenly have ADHD. Often you start to realise you need to see a specialist when you're in crisis mode."*

> *In Canterbury, young people suspected of having the condition make up more than half the overall waitlist for youth mental health services. At the end of January, there were 144 patients waiting with suspected ADHD.*

Figures provided by the Canterbury District Health Board (CDHB) show the average wait time from referral to a face-to-face appointment with a specialist was 90 days (…) (Stuff).

In Article 5, Olderhaver's determination and perhaps even stubbornness are highlighted in the description of her attempts to book a consultation for her son. By describing her as sticking to 'her guns' and 'demanding' the consultation, it seems that this article is describing the need for sustained determination to access mental health services. This article also positioned the waiting time for services as inappropriate. Article 5 referred to an individual's experience with service issues, while Article 15 presented official data to reinforce the idea that services are delayed. The article also noted that the waiting time for services varies across the country, and this tends to be better in main centres, suggesting an inequity of access. Additionally, Article 15 suggested that many people who need to see a specialist are 'in crisis mode,' which links the present theme relating to a lack of services with the previous theme of mental health crisis. Both extracts suggest that there are long waiting times for specialist services for ADHD, and that even in crisis, these waiting times are unacceptably long.

Article 25 discussed difficulties with school children accessing necessary mental health services, based on survey data from principals:

Article 25: Long wait lists and criteria thresholds are stopping some students from getting expert mental health help, according to local principals who say the number of struggling teens has risen exponentially.

The National Survey of Secondary Schools 2018 found just under two-thirds of principals said their school could not access expert support for working with students with mental health issues (...) (The Daily Post).

This example creates a picture of barriers to accessing mental health care, and rising need for care. By positioning the message regarding mental health services as the opinion of local principals, yet by describing phenomena noticed by multiple school principals, this example suggests these views come from a credible source of expertise on the challenges facing youth, but also a group that is not aligned with mental health service provision and funding. This example suggests a double issue in accessing mental health services; with criteria thresholds acting as a tight 'front-door,' preventing some from accessing services, and long wait lists delaying the services for those who can meet criteria thresholds. The impact of these two factors are summarised with the statement "Their school could not access expert support," which suggested that the two barriers to services are perceived by principals as impassable blockades.

The following extract also speaks to long waiting times to access mental health services. This extract was taken from an article that discusses the needs of addiction services in relation to upcoming government budget announcements:

Article 31: (...) Odyssey chief executive Fiona Trevelyan said referrals had increased 34 per cent from 2017 to 2018.

"This is impacting the length of time people have to wait for admission. The median length of time for 2017 and 2018 was 2.5 to 3 months. The first four

months of 2019 the median has increased to 104 days." (...) (New Zealand Herald)

In this example, the long waitlist to access mental health services was contextualised regarding how it has changed over time, and to the perceived causes for the long waitlists. It suggested that an increasing demand has caused an increase in waiting time. Describing the increasing need in the population rather than the lack of capacity in services frames the long wait times as related to external pressures on Odyssey rather than internal issues within it. This focus also fits within a theme of growing rates of mental health problems in New Zealand as described in Theme 2; perhaps suggesting that increased wait times are an inevitable outcome of this. By presenting waiting times as a trend, this article suggested that waiting for mental health services is a phenomenon that is becoming worse (rather than a static issue).

The following example introduces the idea of staffing shortages in mental health services, while also noting the issue of wait lists. This article expresses a reaction to increased mental health funding announced for the New Zealand 2019/20 government budget:

Article 35: (...) Drug and Alcohol Practitioners' Association executive director Sue Patton also supported a doubling of the annual budget — but sees it as the bare minimum.

That workforce would need to almost triple by 2023 to meet the service targets, he said.

"Three years. It's not long ... I'm unclear how they're going to address that shortage in the workforce."

Professor Harvey White, deputy chairman of the New Zealand Medical Association, said expanding the workforce would be the main hurdle, but the investment was "transformative" and badly needed.

"I think it's all do-able. And GPs would welcome this ... our mental-health services are terrible. You phone up, get told to write a referral letter, then they say it's a three-week waiting list or something. This is not at the bottom of the cliff — this is at the top of the cliff or even back from that." (...) (New Zealand Herald)

This example described two issues in services: patients must wait inappropriate lengths of time to access services, and that there is a workforce deficit in mental health services. As both interviewees in this article had their titles recognised, and are positioned as mental health service experts, their opinions add legitimacy to the idea there is a lack of appropriate services. White and Patton welcomed increased funding, suggesting they believe the changes to be positive; however, in welcoming the increased funding, the interviewees also highlighted the need and hitherto lack of services. Although the article suggested that it is imperative and overdue that the service targets are met, it also highlights the challenges to doing so.

The next extract was taken from an article that described circumstances noted during an inspection at a specific mental health unit:

Article 16: (...) During the inspection, two staff in the AT&R (Assessment, Treatment, and Rehabilitation) unit needed sick leave after being assaulted by a patient. Stuff reported last July that five staff in the unit had collectively been off work for more than 1150 days due to work-related injuries.

"Staff reported feeling overwhelmed at times and were often covering double shifts to ensure coverage for staff shortages," Boshier wrote in his report on the unit.

In PSAID (Psychiatric Services for Adults with an Intellectual Disability), staff turnover climbed to 36 per cent in the 2017/18 financial year. In the same period, there was an average of 152 hours of sick leave per full-time role, equating to nearly four weeks of leave.

"Inspectors were concerned the high level of sick leave taken by staff and the upward trend of staff turnover had the potential to negatively impact on consumer's care and treatment," Boshier said.

The situation was similar in Te Whare Manaaki, where staff turnover increased to 40 per cent in 2017/18. Nurses were often required to work overtime or double shifts to ensure full staffing on the unit, the report said. (...) (Stuff)

This example supports the idea that there are service issues (specifically workforce deficits) through describing a specific example. Staff shortages were positioned as both a cause and result of staffing problems; that is, staff were described as likely to resign and take sick leave due to the stresses of working in an understaffed environment, which in turn increased the stresses of the understaffed facility. Interestingly, Article 16 also stated that similar issues were happening in another mental health unit (Te Whare Manaaki), implying that these workforce problems may be generalizable to other units. By providing another example, this article goes from providing a specific case study, which may be unique, to broader comment on mental health units and their lack of capacity to support New Zealand's mental health needs.

The following extract provides an example of the idea that mental health services are not offered, despite being needed. In Article 13, the author discusses how bi-polar disorder should ideally be treated in comparison to what is routinely available in New Zealand:

> *Article 13: (...) Mental Health Foundation manager Shaun Robinson said the Government's Mental Health Inquiry made it clear access to talking therapies for all mental health disorders including bipolar was "woefully inadequate" and "unacceptable".*
>
> *Robinson was diagnosed with bipolar disorder 25 years ago and treated immediately with medication. He was strongly advised to get counselling but not offered it - despite having recently attempted suicide. (...) (Stuff)*

This highlighted a historical gap in mental health services between what 'should' be offered, and what is offered. The use of Robinson's personal experience provided illustration of the idea that there is a lack of appropriate services. The example suggested quickness in reacting with medication ('treated immediately'), in contrast with the total absence of counselling – despite being 'advised to get counselling.' The article also notes that at the time of his treatment, Robinson had recently attempted suicide, using this as further justification for why counselling should have been offered. It appears that this article was suggesting that insufficient support was provided, suggesting that counselling should have been included in treatment.

Overall, the data in this section reflect a message that there are struggling and underfunded mental health services in New Zealand, evidenced through long waitlists, workforce shortages, and inappropriate services.

The government needs to do more

Articles suggested that mental health services need more funding, and that the government needs to do more to support mental health services. This theme primarily relates to a political discussion regarding public health services, though some of the issues noted across this theme are consistent with those raised about mental health service capacity in Theme 3.

Consider the following example, in which Comedian, Mike King discusses his role in the government suicide prevention panel:

> *Article 1: (...) He sat on the Government suicide prevention panel but quit last year, saying the draft plan was deeply flawed.*

"I knew the day I started on the panel in 2015 that I was going to be leaving when they started talking about funding, when they talked about starting with a blank piece of paper."(…) (Stuff)

This example mentioned problems that King had with the government's plan for suicide prevention and funding. Although it is unclear whether King saw the problems as being with the focus on funding, or with the amount of funding, both reflect perceived issues with the government approach to mental health. By noting that King was a member of the Government suicide prevention panel, this example implies that he is a credible source to comment on the flaws of the approach.

The following extract is from an article that discussed meetings between government officials and various groups from the Tararua District:

Article 20: (…) "We've been battling for services for our young people under the age of 18 for quite some time. There are services available in Palmerston North but the closure of the Manawatū Gorge has made it difficult for them to access what is available and for the past few years we've been in consultation with the MidCentral District Health Board, but have been told there is no money."

The lack of mental health and addiction services in Dannevirke was raised at a district health board meeting in Dannevirke some time ago, but nothing happened and there was no follow up, Hynes said. (…) (Indulge HBT)

This example highlights a lack of funding at a regional level, suggesting geographic disparities in mental health services. DHBs in New Zealand are part of the public health system, and in this case, the DHB is positioned as the authority that is not doing enough for the people. This language creates an image of divided interests – the 'people' versus the money-holders. The article also framed attempting to get services as a 'battle,' which has been futile with no headway gained due to a lack of funding.

The desire for more mental health service funding is also demonstrated in articles where people's priorities for the government budget were queried. In Article 36, Luke Bradford, the co-chairperson of Western Bay of Plenty PHO (Primary Health Organisation) discusses the upcoming government budget, and in Article 38, Whanganui residents gave their opinions on the upcoming budget:

> *Article 36: (...) Bradford said the PHO would like to see primary mental health initiatives funded to address the findings of the Government's inquiry into mental health and addiction last year.*
>
> *He said the PHO supported a focus on primary care as a foundation for mental health and addiction treatment, along with more accessible and affordable health services.*
>
> *The PHO would also like to see funding keep pace with the increased costs of providing primary care services.*

He said community-based health services provided better outcomes, but these services required appropriate funding to ensure the practices aren't put under strain. (...) (Bay of Plenty Times)

Article 38: (...) Funding for mental health was high on the wishlists of many sector leaders and locals in the lead-up to yesterday's Budget announcement.

Its prominence reflected growing unease about increasing mental distress in New Zealand and the pressure this is placing on those at the frontline trying to help. (...) (Whanganui Chronicle Sat)

Article 36 provides an example of a sector leader calling for more mental health funding, as Bradford noted that PHOs need more funding for more mental health support. Fitting with the overall theme, this is an example of the government being asked to do more to support mental health services. The example supports the validity of investment into primary mental health by citing Bradford's statement that community-based health services lead to better outcomes, with appropriate funding (though this may be wider reaching than mental health). Article 36 creates a strong argument for more funding for mental health services by using the words of someone who is an expert in the primary health organisation, leveraging his position to add legitimacy to the message.

Article 38 suggested that mental health funding was a priority not only to professionals and leaders in the mental health field, but also to laypeople – locals. The inclusion of both 'leaders' and 'locals' may be a mechanism through which the importance of mental health funding is amplified, as the juxtaposition between sector

leaders who may be experts and are likely to understand service issues, and locals who may be less aware of service issues suggests that the need for funding is not only a niche, expert supported concern, but also broad enough and far-reaching enough that average people are interested in it. Additionally, describing 'leaders' and 'locals' in an article relating to the government budget may be an implicit description of the voting public's interests. Although this example did not demonstrate the 'prominence' of the desire for increased mental health funding that the article refers to, the article uses generalising statements to reinforce this prominence ('growing unease about increasing mental distress in New Zealand'). This example also notes the increase in mental distress (fitting with Theme 3), which may function to further justify the need for mental health funding.

As well as calling for more funding, some articles feature reactions to the budget announcements. The following example, which is a reaction to the 2019 government's budget announcement, provides further evidence supporting the idea that there is insufficient funding for mental health services:

> *Article 24: (...)" The most significant investment in this area in a long, long time, if not ever ... and long overdue."*
>
> *That was Bay mental health worker Vaughan Cruikshank's review of the Government's nearly $2billion investment in mental health and addiction services. (...) (Bay of Plenty Times)*

Although Vaughan acknowledged the size of the proposed mental health funding, he did so by noting the lack of mental health service funding prior. By

stating that this funding is 'overdue,' he positions mental health services as historically underfunded. Therefore, although Vaughan appeared to be supportive of the investment into mental health services, his comments were nevertheless challenging to the government, as the message seems to be that it has taken too long to get to this point. Although Vaughan's comments are general, the article positions him as an expert by noting his position as a mental health worker.

Data in this section supports the idea that mental health is an oft politicised issue within New Zealand news media. The ideas presented in these articles suggested that services in New Zealand have long been underfunded, and that it is the government's responsibility to fix these issues. The data presented calls for more funding in the context of services 'overdue' for greater support and critique the government approach to these issues.

4.3 DISCUSSION

The aim of Study Two was to understand how mental health services are presented in New Zealand news media. The results of the initial content analysis demonstrated that the volume of news articles regarding mental health had a trend of increasing (albeit with notable peaks and troughs in reporting) over the past three years, particularly on NZ Herald. Initial categorisation of articles from the most recent peak and trough appears to suggest that peaks in reporting on mental health services occur in reaction to relevant public events, with the content of articles reflecting those events. In contrast, it appears that troughs in reporting may represent a broader range of topics, with reporting tending to cover smaller events with fewer articles. In other words, during periods of major events relating to mental health, there is more journalistic coverage of fewer events, whereas at other times there appears to be greater breadth of journalistic coverage.

In addition to the frequency count that uncovered peaks and troughs in reporting, more detailed interpretative analysis of articles from the most recent peak and valley was conducted. This analysis provided insight into the major themes of reporting on mental health in New Zealand and how these may affect attitudes towards services. Four themes were identified: 'Positive attributes in people with mental illness,' 'Commonality of mental health problems,' 'Lack of mental health service capacity,' and 'The government needs to do more.' The themes reflect what McGinty et al. (2016) found in their analysis of mental health representations in American news media. Specifically, McGinty found that a common theme in news articles was discussion of problems with services. They found that across 19 years of reporting, articles often focussed on the inaccessibility of services, insufficient funding for services, and lack of quality treatment options. These findings match the findings of the present study in the themes 'Lack of mental health service capacity,' and 'The government needs to do more.' As suggested by Corrigan et al. (2013), a problem/deficit focussed description of services may increase mental health stigma via the effect of media representations on attitudes. That is, deficit-focussed descriptions of services in the media are likely to influence attitudes towards services. These descriptions may create an attitudinal barrier to help-seeking through a perception of insufficient service capacity (that is, an attitudinal barrier based on the *perception* of structural barriers due to media depictions). McGinty also found that a small portion of American news articles described positive outcomes of mental illness, which appears like the theme identified in this study: 'Positive attributes in people with mental illness.' Data in this theme discussed successful recovery from mental illness, and positive attributes associated with recovery.

The similarities between the findings of the present study and those of McGinty et al. (2016) suggest that the focus of articles and rate of reporting have some consistency internationally and across timeframes. These consistencies may indicate that several of the themes identified in this study reflect common western ways of discussing mental health and services; that is, services are strained, and overcoming mental illness is possible. However, a notable difference between the present study and McGinty's research was the presence of a common discussion linking mental illness and inter-personal violence in the American news media, and the lack of this focus in the New Zealand news media. *Reflexively, although there was some evidence of a theme linking mental illness and violence in the coding for the present study, there was insufficient evidence to suggest a common 'theme' amongst the data.* This difference may reflect the drastically higher rates of interpersonal gun violence in America compared with New Zealand (Grinshteyn & Hemenway, 2016), or perhaps it relates to differences in mental health reporting policies in New Zealand (i.e. the guidelines offered by the Mental Health Foundation of New Zealand, which emphasises stigma-reducing language).

Previous studies that have focussed on news media framing of mental health tend to focus on how descriptions of people with mental illness contribute to stigmatisation (e.g. Blood & Holland, 2004; Cloverdale et al., 2002; Fountaine & McGregor, 2002; Nairn et al., 2001; Sieff, 2003). However, the present study did not identify themes relating to negative framing or stigmatisation of people with mental illness. The lack of clear themes relating to negative framing of people with mental illness may reflect a societal shift in news reporting regarding mental illness, such that specific policies and guidelines have been released recommending non-stigmatising methods of news reporting (e.g. Mental Health Foundation of New

Zealand, 2018). Additionally, given that much of the literature regarding stigmatising framing of people with mental illness is over ten years old, it may simply reflect changing beliefs regarding mental illness. However, based on the findings of the present study and of McGinty et al. (2016), it appears that negative framing of mental health *services* has not changed despite evidence suggesting that such negative framing affects attitudes (Corrigan et al., 2013).

In the theme 'Positive attributes in people with mental illness,' articles presented what appeared to be a hopeful construction of people who had (or were in the process of) overcoming a mental illness. These articles tended to describe the challenges of mental health problems, and then contrast these challenges with the strengths associated with recovery. Attributes such as knowledge, courage, wisdom, and candour were associated with overcoming a mental health problem. This type of reporting was also found in North American news media by McGinty et al. (2016), though it was found in a minority of news articles. Previous literature (e.g. McGinty et al., 2015) has classified media framings regarding mental health as either positive or negative based on the attitudinal valence. Using such a classification system, this theme of recovery may be considered as a positive construction regarding mental health. McGinty et al. (2015) found that positive/recovery depictions of mental illness in news media reduces stigma and contributes to a discourse of mental illness as transient and services as useful. Therefore, regarding barriers to help-seeking, this theme may reflect ways in which the media reduces barriers through de-stigmatising mental illness, and framing recovery as possible through introspection and help-seeking.

The narratives of overcoming mental illness in 'Positive attributes in people with mental illness' tended to be depicted as relating to self-control, which aligns with the findings of Ridge et al. (2006) who found that firefighters framed help-seeking as exerting control over their health. This emphasis on the importance of control and autonomy in overcoming mental health problems also aligns with the perspective that mental health problems should (and *can*) be fixed relatively independently, fitting with hegemonic masculine values (Krum et al., 2017). Therefore, these articles suggest empowerment and encouragement to overcome mental illness in ways aligning with socially normative positive masculine values. However, by encouraging self-empowerment and control over one's health, such articles appear to relegate the use of medication to a less favourable 'temporary-fix' position (in some instances, explicitly). Therefore, while these types of articles may attempt to normalise mental illness, and encourage seeking help, they also seem to align with discourses that medication is of less value than hard work and control, which may influence attitudes and behaviours towards treatment modalities (as noted in Study One with the theme 'Pills… to almost rely on them'). Nevertheless, overall, it seems that articles fitting with this theme give the message that it is okay to have a mental health problem, and it is possible to overcome this problem and grow stronger as a result.

The theme, 'Lack of mental health service capacity' reflected a type of article in which mental health services were presented as being stretched and unable to cope. The descriptions of long waiting lists to access services gives a bleak message that even with severe ('crisis') mental health problems, people in New Zealand must wait a long time to access services. The finding that New Zealand news media

reports on inaccessibility of mental health services is consistent with McGinty et al.'s (2016) finding of American news articles reporting a similar message.

Interestingly, although there appears to be a consistent thread in the news media regarding availability, there appears to be a gap in discussion regarding the appropriateness of services. Indeed, it seems that the depiction of what mental health services involve is an area left to popular mass media (such as television and movies (Orchowski et al., 2006; Wedding, 2017)). Perhaps news articles focus on whether services are *available*, rather than whether they are appropriate, as it may be perceived as the more pressing issue at the time. It seems that the availability of services is considered 'news,' while a more nuanced presentation of what services involve is not news. This speaks to the issue of the lack of useful information regarding services described in Study One ('This is all based off what I know from television'). Although news media has an impact on attitudes (Corrigan et al., 2013), this impact is limited to topics that are considered 'news,' while other topics are left to fictional depictions. Perhaps there is an opportunity for news media to use their influence on attitudes to educate and provide an alternate source of information through exploring the type and appropriateness of services as well as availability.

The focus on availability of services may reflect an implicit trust that when available, services are helpful. In other words, lack of media commentary on usefulness of services may suggest trust in doctors to fix problems - if there is the service capacity for them to do so. This would reflect the normativeness of a paternalistic relationship with doctors (Árnason & Hjörleifsson, 2016), whereby the doctor is believed to know best (as articulated in the Study One theme 'Cause they're the doctor, they know what's best for you'). However, this implicit trust in services

may not be shared by all, as research has shown that some men distrust services (Coles et al., 2010). Nevertheless, these articles describe a workforce under pressure, with deficits in staff resulting in lack of capacity, long waiting lists, and high threshold to access services.

Using Andrade et al.'s (2014) definition of barriers to help-seeking, it appears that the news media tends to report negatively on structural barriers predominantly. Yet, there also appears to be an effort made in the news media to address attitudinal barriers through presentation of positive outcomes in the theme 'Positive attributes in people with mental illness. The theme 'Lack of mental health service capacity' appears to give the message that services are difficult to access for New Zealand citizens. There may even be a sense of futility in these messages, as the waiting lists are described as increasing. It seems that from the perspective of men's help-seeking, there is a paradox in the influence of news media representations. That is, while news media may help to reduce attitudinal barriers to help-seeking (particularly regarding stigmatisation of mental illness and help-seeking), the news media presents another barrier to help-seeking through its presentation of structural barriers that will delay access to help.

The theme, 'The Government needs to do more,' suggested a tendency in the news media to present mental health services as lacking funding and suggested that the public wants the government to fund more mental health services. Fitting with 'Lack of mental health service capacity,' this theme suggests that services are struggling due to underfunding. This finding also fits with the findings of McGinty et al. (2016), who found that American news media has commonly discussed issues of service funding over the 19 years of data they assessed. This suggests that news

media discussion of funding issues, and framing of services problems as relating to government issues, is a common topic.

The theme 'Commonality of mental health problems' presents mental illness as a pressing and growing concern in New Zealand. This finding appears to be somewhat novel in comparison with previous studies, which have focussed on framing the impact of mental illness (e.g. Blood & Hammon, 2004), rather than rates of mental illness. Therefore, it is unclear what effect this type of framing may have on public attitudes regarding mental health and services. It seems that framing mental illness as common could reduce stigma of mental illness; however, it also seems to offer little hope for positive outcomes. Articles fitting with this theme appear to suggest that mental health problems and suicide are commonplace in New Zealand, and that it is common knowledge that these are large issues. Although a unique theme, this idea relates to the overall story that is apparent in the previous and subsequent theme; a story of high rates of mental health problems, which likely relate to huge waitlists and service strain, which are in turn related to a lack of mental health funding. This theme may not explicitly have a message regarding mental health services, but rather, the state of mental health in the nation.

4.2.1 ***Implications and Applications***

A predominantly negative framing of mental health services, even if it describes accessibility rather than quality, has been shown to increase stigma towards those suffering from mental illness (McGinty et al., 2015). Although there have been no studies to date testing the impact of negative news framing on attitudes towards mental health services, it is possible that these negative framings will also have an impact on public attitudes towards mental health services. To wit, news media

appears to present information as credible and informed through using expert opinions (Albæk, 2011; Blood & Holland, 2004), which increases the impact of information on attitude formation (Maio et al., 2018). Likewise, many men may not have lived experience with services, which increases the influence of vicarious information on attitude formation (Maio et al., 2018).

Regarding barriers to service use, the presentation of services as difficult to access and underfunded, along with the description of mental illness as an overwhelming and growing issue is likely to create a perception of structural barriers. It is unclear what, if any, practical effect this might have on first-time service users who may need to access services, but it may create a sense of futility in the prospect of help-seeking by suggesting that they are unlikely to meet criteria, and even if they do, they will have to wait a long time before reaching services.

Regarding the theme of 'Positive attributes in people with mental illness,' McGinty et al. (2015) found that such presentations reduce mental illness stigma and improve attitudes towards services. These positive framings may have the effect of reducing attitudinal barriers to help-seeking by creating the perception that mental illness can be overcome, and that help-seeking and services do work. However, these stories of recovery are embedded in hegemonic masculine values as they suggested that traits such as determination and courage are required for recovery (Krum et al., 2017). This may suggest the development of a more adaptive link between hegemonic masculinity and mental health. However, these attitudes may also serve to marginalise men who have not recovered, perhaps enforcing views that they lack the required masculine qualities to recover.

As with previous studies regarding news media framing, the applications of this study relate to news media practice and guidance on responsible reporting. With

three out of four themes presenting mental health services in negative frames, the news media may have negative impacts on beliefs towards mental health services. The Mental Health Foundation of New Zealand has a set of guidelines for the media regarding mental health reporting. These guidelines focus primarily on how to reduce stigma and increase understanding for those with mental illness (Mental Health Foundation of New Zealand, 2018). For example, the guidelines suggest that the media have stories where there is a positive outcome of mental illness, which appears to be reflected in the theme 'Positive Attributes in People with Mental Illness.' Additionally, these guidelines suggest that the media should encourage people getting help. However, there is a relative lack of consideration of how services should be discussed and framed, and little consideration as to how consistent negative framing of mental health services might impact people's attitudes towards services and help-seeking. Based on McGinty et al.'s (2015) findings, it is recommended that future iterations of guidelines be broadened to include guidance on how to discuss mental health services.

Although stories of service failure - particularly during pre-election campaigns - may be more newsworthy, it is likely beneficial for services and service users to balance negative stories with positive stories regarding services. While mental health services may be strained, it is unclear whether it is damaging for news media to report on this and contribute to a public belief of incapable mental health services. Additionally, stories appear to focus primarily on structural barriers to accessing services, with little attention to reporting on what these services include as it is not considered 'news.' Previous research has demonstrated that men would like more education and understanding about what treatment entails (Harding & Fox, 2015; McKelley & Rochlen, 2007), a request that has also been made in a local New

Zealand context (Elliot, 2016), and research has shown that education about services improves men's attitudes towards services (Hammer & Vogel, 2010). Therefore, it may be useful if some news articles take a case-study approach to services, perhaps in a similar way to the existing case studies regarding recovery demonstrated in 'Positive attributes in people with mental illness.' These case studies could include service providers describing who they are and the work they do, and with consent, service users could describe what they experienced in services and how it affected them.

4.2.2 *Limitations of this study and future research*

As a qualitative, inductive study, which looked at data from two one-month snapshots of reporting, this study provides a good starting point for understanding how mental health services are framed in the New Zealand media. However, this method has limitations regarding how well it can address the research question. Although an inductive thematic analysis gives a good picture of the main themes present in media reporting, it was not able to capture smaller, novel pieces of data found during analysis that better answered the question of 'How are mental health services portrayed in news media?' Although, that these types of articles were not common enough to constitute themes is useful information of itself. Nevertheless, there may be some common tendencies regarding how services are portrayed in news media, which were not reported in the present study due to the methodology. Even with infrequent reporting, such portrayals may have a strong impact on perceptions of services, particularly given that there is relatively little public knowledge of services (Elliot, 2016).

The method of data selection for this study may have led to a bias towards specific results. As noted in the preliminary content analysis, it was apparent that

articles in May 2019 appeared to be skewed towards critiquing mental health services, likely because of the imminent release of the government commissioned mental health report. I attempted to alleviate this skew by adding another sample of data, February 2019, where mental health appeared to be less topical. Nevertheless, the results of the thematic analysis demonstrated a tendency for the media to negatively frame mental health services, which may reflect the strong influence of the sampling period on the outcomes. However, with such a news media analysis, it is likely that there will always be some specific skew upon the data, and perhaps this does not reflect a data-collection bias, but simply the social context within which the news is produced. Likewise, the use of content analysis to select data points, and the selection of articles based on the most 'relevant' results, as defined by a search engine was somewhat arbitrary. However, this enabled a replicable, inductive methodology.

Finally, while this research gave a good picture of how mental health and services are portrayed in the news media, it did not answer the question of how these portrayals influence the public (men who have not used services, in particular), with help seeking. It is unlikely that the messages that the news media give and the attitudes that men have towards services match perfectly, or even modestly, and this leaves a gap of assumption and speculation based on previous literature regarding men's attitudes, and literature regarding belief and attitude formation.

Future research should address these issues by conducting studies with a narrower focus. Rather than a broad, inductive thematic analysis of news media, future research could use a more specific search in order to find news articles that have discussed services in detail and use methodologies such as interpretative

phenomenological analysis or discourse analysis to conduct in-depth analyses of these news articles and explore the ways in which services are constructed. Additionally, it would be useful for future research to test the stability of the current findings over time. A larger-scale content analysis of news articles over the past ten or twenty years (see McGinty et al., 2016) could assess New Zealand news media in order to understand what is most commonly discussed over time, and whether this changed in response to media guidelines and the socio-political climate. Finally, future research should engage with men and use experimental methodology or interviews/focus groups to further understand the impact of different media framings on men's attitudes towards services and help-seeking.

4.2.3 ***Conclusions***

This study was novel in seeking to understand how services are presented in New Zealand news media. Although this study did not establish a causal link between news media representations and public attitudes of services (nor did it seek to do so), it provided useful clues to understanding public beliefs and attitudes regarding mental health services. Recovery from mental illness was depicted as possible; however, this depiction was within the boundaries of hegemonic masculine values. It appeared that through being independent and determined, one may take control of their health and recover from a mental health problem. There was an undertone of personal responsibility to this framing of recovery, and inherent in such an undertone lives the brother to personal responsibility - blame. Yet in these narratives, the blame appeared to be placed on the services, which were depicted as stripping away personal control and responsibility in those who had not yet recovered and supporting personal control and responsibility in those who had. Such a dichotomous presentation of services may improve hope and foster determination

in those with mental health problems, but it could have a varying effect on attitudes towards services. That is, services may be the enemy of responsibility and self-determination when done poorly, and a powerful ally when done well.

The remainder of the data in this study appeared to endorse predominantly negative views towards *accessing* services, though without the nuance of exploring what services should be accessed. It may be that simply through seeing services as difficult to access, the public has more negative attitudes towards them. Alternatively, with the framing of difficulties accessing services as resulting from funding deficits, the public may share a sympathy for services and direct their negative attitudes towards funders (that is, the government). Nevertheless, attitudes towards *help-seeking* (rather than attitudes towards *services*) may be impacted by the framing of services being difficult to access, which may create a perception of futility in seeking help. Additionally, substantial research suggests that men hold negative attitudes towards services (Coles et al., 2010). Although such negative attitudes towards services may not be strongly related to news representations based on the present study, there may be an additive effect on intentions to help-seek whereby negative attitudes generated through other sources are compounded by representations that services are difficult to access in the news media. Therefore, although the results of this study provide limited insight into what attitudes towards services entail, it does provide useful information into the broader picture of help-seeking.

Chapter 5: Conclusions

5.2.1 ***Background to this research***

Reflexively, the subject of men's mental health and help-seeking is one that I have been passionate about for a long time. My own passion for seeking to understand, and ultimately, improve men's mental health is shared by a large group of psychological and health researchers. Through conducting this research, I was forced to challenge and shift my ideas about what it means to be a man seeking (or more aptly, not seeking*) help. I had initially believed that a deep sense of shame and misunderstanding was the force behind not seeking help. Although that was borne out in the literature through the impact of stigma and pressure to adhere to masculine gender norms, it also became apparent that this shame thrived in a void of knowledge. During my own episode of mental unwellness, I lacked basic knowledge of what help was available or how to access it. On this, and other aspects, the participants in this study were far more informed than I was. Perhaps this reflected a change in information availability over the years between my mental unwellness and this research.*

As with all the ideas in this area of research, I often found myself agreeing with the explanations for barriers to help-seeking, at times with too much enthusiasm. Occasionally this has gotten me into trouble by pulling me away from a scientific, data-driven perspective, and into the space of a young man excited to find a simple and compelling explanation for his own experiences. I often must remind myself that there may not be such an explanation. This research has demonstrated that each of us exists in a complex social, biological, and psychological environment. Although

tidy and compelling explanations and ideas exist, they must be approached with careful nuance and appropriate scepticism. Indeed, as Kahneman (2011) explained, it is human to be drawn towards simple explanations – heuristics - but it is only with a slower, more thoughtful process that 'algorithms' are created (algorithms, in this context refer to slower, more nuanced thought processes rather than the algorithms used on social media sites to direct advertisements).

5.2.2 ***General research findings***

The findings of this research suggest that young men have little knowledge of what mental health services involve, and much of what they do know is influenced by popular media sources, which aligns with previous literature relating to knowledge of services and the impact of media (McKelley & Rochlen, 2007; Vogel et al., 2007; Vogel et al., 2008). That participants derived their knowledge from the media likely evidences a barrier to help-seeking recognised in previous literature (Rice et al., 2017). Fitting with this lack of knowledge regarding services, New Zealand news media appears to fit a specific role in the information that it provides; specifically, it does not appear to act as a source of information regarding what services involve. Rather, it appears that the news media tends to discuss those with mental illness regarding their strengths, while services are presented as insufficient and mental illness as a growing crisis. These constructions of mental illness and services appear to reflect an acceptance of what is 'newsworthy,' such that access to services and rates of mental illness are newsworthy, while the makeup of services not. Indeed, from this perspective, the findings of Study One and Study Two aligned well. That is, the news media seldom discussed the content of services in Study Two and participants cited film and television, rather than news media as the source of their knowledge of services in Study One. From an exploratory perspective, this

congruence between Study One and Two suggests that news media may not be a key source of attitudes and beliefs regarding services, and that it may be more fruitful to explore film and television as sources of attitudes and beliefs. Additionally, the findings of the present research are useful as they may highlight a gap in the news media that could be used to inform attitudes and beliefs towards services.

Reflexively, participants in Study One did not appear uninfluenced by news media. Indeed, many participants described confident beliefs that the mental health system in New Zealand was struggling and underfunded based on the news media. They described a need for better pay for service workers and were easily able to identify the growing mental health need in New Zealand. Although this data was not elevated to the level of theme, it left a strong impression that participants were confident *of their knowledge based on news media but were less confident of their knowledge based on television and films. It appeared that although news media did not have an explicit impact on beliefs regarding service makeup, it did have a strong impact on beliefs regarding the broader mental health system, and is therefore worthy of inclusion in exploring barriers to help-seeking.*

The idea that particular beliefs regarding services may lead to negative attitudes was borne out by the men in this study, who appeared to view medication as negative and addictive; whereas talk-therapy was viewed more positively, though seen as limited, by some, through its conceptualisation as a proxy for social support. Although it was unclear specifically what information informed these views, there was some consistency between participants' negative beliefs regarding medication and their more positive views of talk-therapy in Study One, and the presentation of recovery and lack of 'appropriate' treatment in Study Two. Specifically, articles tended to frame medication negatively ("*end up in a cloud of medication and not*

actually getting to live their life.") while pointing to a lack of available counselling (*"He was strongly advised to get counselling but not offered it - despite having recently attempted suicide.").* This consistency may represent common negative attitudes towards medication and preferences for talk therapy, and it may also imply an impact of news media on public attitudes.

Participants in Study One articulated beliefs that men should attempt to fix their own problems first and that they imagined they would feel discomfort in admitting the need for help. These beliefs likely reflect the pressures caused by acting against hegemonic norms as in GRSP (Levant, 2011), and align with literature regarding barriers to help-seeking caused by hegemonic norms (Krum et al., 2017). The impact of hegemonic masculine norms, unlike barriers regarding knowledge of services, appears to have been reflected in the news media's portrayal of people with mental illness. The news media described people with mental illness in ways that emphasised their positive attributes, and which framed help-seeking and recovery as personal achievements leading to improved self-awareness and knowledge. That is, taking control and exerting autonomy in one's mental health was framed as a crucial way to overcome mental health problems, which is fitting with hegemonic views of independence and control.

Based on the guidelines for responsible media reporting of mental illness (Media Guidelines, Mental Health Foundation of New Zealand, 2018), the news media should encourage help-seeking, and focus on recovery and strength among those with mental illness. The media depictions of recovery noted in this study challenge stigma regarding mental health, and views of help-seeking as reflecting weakness and loss of control (traits that are incompatible with hegemonic norms for men (Pattyn et al., 2015)). Nevertheless, the young men in this study still seemed to

feel confronted by the prospect of seeking help and admitting that they are unable to control problems themselves. This suggests that pressure for men to be in control and be able to deal with things on their own has deep roots and may be difficult to change.

Another possible impact of information presented by the news media relates to the views the young men held regarding medication. Participants held negative beliefs that medication leads to reliance and even addiction. This belief appeared to be reflected in the news media alongside other negative discourses such as services having long waitlists, staffing shortages, and underfunding. These presentations of services may reflect attitudinal barriers towards help-seeking (McGinty et al., 2015). Interestingly, such news discussions regarding difficulties accessing services and that medication is a first-option treatment may reinforce barriers to help-seeking based on fear of medication. That is, young men who hold negative attitudes towards medication may be less likely to seek help if they are exposed to information that they are likely to be offered medication and that alternatives are difficult to access. Additionally, some research suggests that some men believe medication is the only treatment option available (House et al., 2018), a belief that may be reinforced by such news reporting. Nevertheless, these barriers may be softened by the positive beliefs towards listening to a doctor that some participants expressed.

This research presented a picture of a complex set of factors that may impact help-seeking behaviours. However, more education regarding what mental health services involve is an important step towards addressing a lack of knowledge and often ambivalent attitudes. The news media can play an important role in providing accurate information about what services are available and how to access them.

5.2.3 ***Strengths and limitations of this research***

Using an inductive design to allow for post-hoc themes that were grounded in the data is a strength of this research. Likewise, selecting data from men who have not utilised services and from news data broadly relating to mental health mean that this research presents constructions that may be transferrable to common attitudes and beliefs regarding services. Previous research regarding attitudes towards services has tended to be either quantitative (e.g. Furnham, 2009; Furnham & Wardley, 1990; Lauber et al., 2005; Von Sydow & Reimer, 1995), and typically deductive, with pre-determined ideas and suggestions regarding services, or relating only to men who *have* used services (e.g. Harding & Fox, 2014), and therefore perhaps not transferrable to men who never utilise services.

Previous literature regarding services' presentation in media tends to have focussed on television and movies (e.g. Orchowski, 2006; Schultz, 2005; Wedding, 2017). Whereas articles investigating the news media tend to have focussed on how the news media frames mental illness, and those with mental illness (Corrigan et al., 2013; Fountaine & McGregor, 2002; Sieff, 2003). Additionally, the research that does investigate discussion of services tends to use quantitative word-count methodology, and not in a New Zealand context (McGinty et al., 2016), leaving a gap in knowledge regarding discussion of services in New Zealand news media. The present study makes progress towards filling that gap by addressing New Zealand news media descriptions of services with an open, inductive qualitative framework.

A limitation of this research is that the findings are unable to be directly linked to help-seeking behaviour, rather they must be indirectly linked to help-seeking as potential contributing factors via the effect of beliefs and attitudes upon behaviours. Although there is literature suggesting that attitudes - and beliefs via their impact on

attitudes - do affect behaviours (Petty, 2018), there are factors that mitigate the impact of attitudes upon behaviours (Fazio, 1986).

This research serves its purpose in providing an understanding of men's attitudes towards services, and the presentation of services in news media; however, this information should be considered as only an initial step in what would be a much larger undertaking to assess perceptions of mental health services. The news media sampled in this research was taken only from two popular online sources, which provides a useful foundation for dominant constructions of services; however, a wider range of sources should be used in future research. Future research endeavouring to understand how media portrays mental health services could include social media, televised, and radio media and seek longer periods of data to measure change over time. Such research could include quantitative and qualitative methodologies to enable wider coverage of contexts in which services are discussed, and to enable detailed analyses of the constructions of services that are presented in these media. Additionally, future research could endeavour to have participants based on different criteria, including a group of young men living in areas of high deprivation, to capture those most at risk for mental illness and least likely to seek help (Clement et al., 2015). Future research could interview young men who identify as having (or having had) a significant mental illness, but who have not used services, to more directly assess what barriers blocked them from seeking help, and what their perceptions of services consist of.

5.2.4 ***Final Conclusions***

The process of conducting this research has been an important one for my learning and, I hope, one which contributes to this field of research and makes a difference for those needing help but are unable to do so due to the myriad barriers.

Through the process of writing and re-writing, and re-writing again my results sections, it occurred to me that I had underestimated the complexity of qualitative research, and that my previous academic training had provided little grounding in qualitative methods. By writing this research, I broadened my researching skills and learnt much more than I had expected.

This thesis emphasises the complexity in understanding barriers to help-seeking in men, while attempting to better understand one of these barriers. Perceptions of services is an area that affects likelihood to seek such services, and therefore is worth exploring. At the commencement of this project, I perceived barriers to help-seeking in men to be a niche area; however, it is an area with a rich body of literature and many threads worth exploring. This research has moved into an area within men's help-seeking literature that has not been well-researched, and it has some clear and simple implications and applications for health promotion, while also setting out a path for future research.

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Chapter 6: Appendices

6.2.1 – *Appendix A - Information Sheet*

Men's attitudes towards mental health services study

PARTICIPANT INFORMATION SHEET

Aim of the study

Men tend to be slow to seek help for mental health related issues and have low rates of service use. Some research suggests that men's attitudes and lack of knowledge regarding mental health services is one of the reasons they have low rates of service use. However, there has been no research allowing men who have never used mental health services to explain what they think about these services. The purpose of this study is to explore what men who have never accessed mental health services think about these services.

Who can participate?

English-speaking men living in (or able to travel to) Wellington, who are between the ages of 18 and 30, who has never used mental health services, and who aren't working or studying in the field of health, counselling, or psychology are eligible. Mental health services include, but are not limited to: Clinical Psychologists, Psychiatrists, Counsellors, and therapists. If you aren't sure

whether you have used mental health services and you want to participate, please feel free to contact the researcher and ask.

What participation involves

If you meet the above criteria and would like to participate in this study, please contact the lead researcher (see below). You will be sent a consent form to read and complete. A time and date for the interview will then be agreed upon by you and the researcher. All interviews will take place in central Wellington at locations such as the public and Massey University Library.

During the interview you will be asked questions about mental health services. **There are no right or wrong answers, we simply want to understand your opinions**. Interviews are anticipated to last approximately one hour, and with your permission, will be audio recorded. All information gathered in the interview will be completely confidential and anonymised if used in the final report. Only the lead researcher will have access to recordings and transcripts. You are free to decline to answer any questions. You will then be presented with $25 as thanks for your time.

Ethics

This study has been peer-reviewed and has received ethical approval from the Massey University Human Ethics Committee.

Please feel free to contact the researchers if you have any questions about this study.

6.2.2 – ***Appendix B - Consent form***

Men's attitudes towards mental health services study

PARTICIPANT CONSENT FORM

Please ensure you read each numbered point and sign only if you agree with all

1. I have read and I understand the information sheet about participating in this study designed to explore men's attitudes and beliefs about mental health services.
2. I have not been coerced or pressured into participating in this study.
3. I understand that participating in this study is voluntary and I may withdraw from the study at any time.
4. I understand that my interview will be audio-recorded.
5. I understand that everything I say during my interview is confidential and any identifying information will be removed if my opinions are reported in research.
6. I understand that the content of my interview will be used for research purposes, and this research may be published in academic journals.

7. I understand that basic demographic information about me (such as my age, occupation, and ethnicity) may be included in a report of this study, but my name will *not* be included.
8. I understand that direct quotes from my interview may be included in a report of this study, but they will be anonymous and will not include any identifying information.
9. I understand that I will receive $25 as thanks and acknowledgement for my time, not as payment for work.
10. I have read and understand this form

I _____ consent to participate in this study.

Signed _____ **Date:** _____

Date of birth (DD/MM/YYYY) _____

Would you like to receive email updates regarding the progress of the study?

YES / NO

This study has been given ethical approval by the Massey University Human Ethics Committee.

For more information, please contact the lead researcher.

6.2.3 –*Appendix C - List of mental health services*

MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUROA
UNIVERSITY OF NEW ZEALAND

Mental Health Services

What to do in an emergency

If you're seriously concerned about someone's immediate safety:

- call 111 or take them to the Accident and Emergency Department (A&E) at your nearest hospital
- phone your nearest hospital, or your district health board's psychiatric emergency service or mental health crisis assessment team
- Remain with them and help them to stay safe until support arrives.

Helplines

- Need to talk? (1737 – free call or text)
- The Depression Helpline (0800 111 757)
- Healthline (0800 611 116)
- Lifeline (0800 543 354)
- Samaritans (0800 726 666)
- Youthline (0800 376 633)

- Alcohol Drug Helpline (0800 787 797)

Sourced from The Ministry of Health (https://www.health.govt.nz/your-health/services-and-support/health-care-services/mental-health-services)

6.2.4 – *Appendix D -Recruitment Advertisement text*

Seeking Wellington men who have never used mental health services to participate in a study about opinions of mental health services in New Zealand!

Kia ora, my name is Jake and I am a doctoral student at Massey University. As part of my research to understand why men generally do not use mental health services, I am seeking to interview men who have never used these services.

All English-speaking men between the ages of 18 and 30 who have never used mental health services, and who are not studying or working in the field of mental health are eligible. You will be asked to participate in an interview that will last up to one hour in Wellington. There are no right or wrong answers, and everything you say will be confidential. You will be offered $25 as thanks for your time, and an additional $15 to cover expenses for travel and parking.

If you are interested or if you aren't sure about something, please send me a message. Please also feel free to share this post with any friends who you think may be interested.

Like Comment

6.2.5 *- Appendix E -Interview Schedule*

Interview Schedule

Note that the interview schedule contains eight primary questions (presented below) to elicit information regarding attitudes, beliefs, and the suspected sources of these attitudes and beliefs. Suggested prompts have been included under each question to aid participants if they are struggling with the question; however, these prompts are not unique questions and will only be used if necessary. Likewise, the interview is participant led, and if participants address subsequent questions in their discussion of earlier questions, those subsequent questions will not be repeated.

Questions:

1. What does mental health care in New Zealand involve?

   • Can you tell me about a time that someone you know had a mental illness or was really distressed?

   • How did they cope, what do you think about how they coped?

2. What sort of people would benefit from mental health services?

   • Does this apply/is it different for men?

   • What sort of things do you think people seek mental health care for?

3. What does therapy involve?

   • In your mind, what does therapy look like?

   • What do psychologists do with patients?

4. When you think of therapists, who comes to mind? What are some of their characteristics?

- Can you think of a therapist from a movie or TV show? What were they like?

5. Tell me about medications for mental illness, as you understand them.

   - How do medications for mental illness usually work?

   - How can people get prescribed medication?

6. How effective is therapy?

   - What are some of the risks?

   - What are some of the benefits?

7. How effective is medication for mental illness?

   - What are the risks and benefits?

8. How is mental health care portrayed in the media? Has that influenced your views?

   - When people on the news talk about mental health services, are they positive or negative?

   - How much do you think the media influences people's attitudes towards mental health care?

6.2.6 – ***Appendix F – Clinical Case Study***

Research Case Study

Exploring young men's understanding of mental health services, and New Zealand media representations of services – a clinical practice perspective

Presented as part of the requirement for fulfilling the Doctor of Clinical Psychology at Massey University

Jake Gallagher
Intern Psychologist
Community Mental Health Service
Taranaki District Health Board

This case study represents the work of Jake Gallagher during his research from 2018 to 2020 and reflections as an Intern Psychologist in 2020

Candidate: Jake Gallagher [redacted]
Date: 21/11/2020
Supervision Panel Clinical Mentor: Clifford van Ommen [redacted]
Date: 16/11/20

Abstract

This case study presents an overview of the research conducted by the author and reflects upon the contribution of this research to clinical practice during the internship year. Research has shown the young men tend to be less likely to seek help for mental-health related issues due to barriers to help-seeking. Lack of knowledge regarding services has been shown to be a significant barrier to help-seeking. In Study One of this project, young men who had never accessed services were interviewed to explore their understanding of services. Five themes were identified based on data collected in this study, the themes suggested that young men prefer to fix problems themselves, are wary of medication, have relatively poor understanding of services, and are willing to trust doctors. Another relevant factor to understandings of services is how services are presented in media. Research has shown that media depictions of mental health and services tend to be inaccurate and unhelpful; however, there is sparse research regarding New Zealand news media depictions of services. Thus, Study Two collected local news articles to explore how services were constructed in the news. Results of a thematic analysis suggested that news articles tended to present services in a negative, deficit focused way; however, individuals with mental illness were presented in more positive, hopeful lights. These findings have highlighted the commonality of misinformation, and the intersectional variety of beliefs regarding services, which has reinforced the importance of exploring client's beliefs regarding services and providing them with accurate and helpful information.

Keywords: *Help-seeking, barriers, clinical practice, men's mental health, media depictions, qualitative research, mental health services*

Research Overview

The aim of this research was to better understand a barrier in the pathway to mental-health related help-seeking - attitudes and beliefs regarding services. This project was guided by a social constructionist epistemology, whereby attitudes and beliefs were not seen as data that inherently existed, but rather, as constructions of speech and actions during the interview process. This project sought to explore how young men who had never utilized services constructed services in their conversations – and to consider whether these constructions influence likelihood to seek help. Likewise, this project sought to understand how services were constructed by New Zealand news media, and to consider how these media constructions may reflect (and influence) service use.

Background

As a young man (by the present study's definition of 'young man' – that is, between the age of eighteen and twenty-nine) at the time of conducting this research and completing the clinical internship, this study was founded upon my own experience of mental health and services. Several years prior to commencing my clinical training, I experienced an episode of moderate mental unwellness, which I eventually overcame without utilising services. Thus, my own attitudes and beliefs towards mental health services was fertile ground to grow my interest in researching this area. However, even before my mental unwellness, I was exposed to a tapestry of constructions of mental health services in my life - as, I believe, we all are. In films, it appeared that services were constructed often as brutal madhouses, eccentric 'shrinks,' and mind-altering medication. Likewise, the appropriate users of these services were constructed as 'crazy people,' a vague, nebulous term that broadly categorised service users as 'other.' Upon this background, at the time of my own mental unwellness, I was unable to draw a connection between my experience and the need for help, and I did not know what help would look like.

Now, as a mental health service provider, if asked to describe mental health services, I would likely talk about general practitioners, student counselling services, and hospital mental health services; however, how I construct services would likely differ depending on who I was speaking to, and what I believed their needs and resources to be. With this change, I see two sides to my experience, and a need for bridging of these two sides. I see my 'unwell self' as a young man who may have

benefited from mental health services but was unable to access these services due to barriers of knowledge. I also see my 'service provider and researcher self' as someone who may be able to help better understand the barriers that blocked my unwell self, and perhaps even consider ways to address these barriers.

Literature regarding barriers to help-seeking

Although barriers to accessing mental health services may be considered from a variety of valid perspectives such as ethnicity, socio-economic status, or educational level, there is evidence to suggest that a gender-lens adds a valid and unique perspective of barriers. For example, the World Health Organisation (2002) released a document in which they noted that throughout the developed world, men tend to under-utilise mental health services. Likewise, more recent literature (e.g. Pattyn et al., 2015) and initiatives (such as the Men's Health Forum in London, 2014) indicate that men still tend to under-utilise mental health services. Pointing to reasons why male gender may be an important variable in help-seeking, Moller-Leimkuhler (2002) found that men's lack of emotional expression may be a causal factor in their lower rates of help-seeking (and also of service provision, possibly due to misdiagnosis of psychological/emotional symptoms).

Another factor that reinforces the utility of male gender as a key variable in considering barriers to accessing services is the rate of suicide amongst men. For example, the suicide rate amongst men in New Zealand is approximately three times that of women (New Zealand Ministry of Health, 2016), and a similar trend has been found in most developed countries around the world (WHO, 2002). Furthermore, evidence suggests that suicide is an increasing problem among younger men in the 15-24-year-old age groups (New Zealand Ministry of Health, 2016). In addition, research suggest that the young male demographic is less likely to seek help than other demographics (Clement et al., 2015).

Barriers to mental health service utilisation may result from a variety of causes. For example, Andrade et al. (2014) identified two types of barriers: attitudinal (such as stigma, lack of perceived need, and fear of disclosure), and structural (such as cost, distance, and time commitments). Structural barriers tend to relate to deprivation among other things; however, Andrade argued that attitudinal barriers have a greater impact. The aim of the present project was to explore one attitudinal barrier to help-seeking, which, at the time of writing, had not been thoroughly

explored: beliefs and attitudes towards mental health services. This barrier was explored from two perspectives; men who have not used services (Study 1); and descriptions in the news media (Study 2).

Method

This project used a qualitative, inductive approach, following a social constructionist epistemology based on Burr (2015). This constructionist approach posited that phenomena, in this case, such as attitudes and beliefs towards services, were constructed in speech and action, and impacted by social and cultural contexts. Based on the inductive approach, thematic analysis based on Braun and Clarke's (2012) outline was used as the primary method of data analysis in both studies.

Study One

The design of Study One was based upon and set to expand upon the method used by Harding and Fox (2014), who conducted semi-structured interviews with men who had accessed services. Harding and Fox used thematic analysis to identify themes among their conversations with these men. The present study was assessed through the Massey University Ethics process and deemed to be a 'low-risk' study, thus, rather than being subject to a full ethics committee review, it was peer-reviewed for ethical issues a Massey University academic staff member.

Participants for this study were recruited via advertisements on social media, and promised the koha (gift, thanks for participating) of a $40 supermarket voucher. The exclusion criteria for this study were that participants must be men between the ages of 18 and 29 and have never accessed mental health services (men could self-identify whether they had accessed services). Ten men fitting the inclusion criteria who contacted the researcher via the advertisement were selected and invited to attend an interview. The men were advised that the interviews would be recorded and used in a research project, and each man gave their informed consent to participate and have their data used under pseudonyms.

Interviews took place in private rooms at Massey University campus, Victoria University campus, and at a government building. All interviews occurred in Wellington, New Zealand. The interviews ranged in duration between 26 and 53 minutes, and followed a semi-structured format designed to elicit discussion of mental health services and help-seeking. The interviews were independently

transcribed and analysed by the researcher. Braun and Clarke's (2014) six phases of thematic analysis were used to guide analysis. That is, familiarising with data, generating initial codes, searching for themes, reviewing themes, defining, and naming themes, and producing the report.

Study two

To investigate how mental health services are portrayed in New Zealand news media, a similar inductive qualitative design to Study One was utilised: Thematic Analysis (TA). Although the primary analysis for this study was TA, in order to select articles for inclusion in this study, a brief summative Content Analysis (CA) based on research from Goodwin et al. (2014) was conducted with the purpose of identifying recent periods when mental health services have been most frequently reported on.

CA data were collected via the search engine 'Newztext' on the archival and live web platform 'The Knowledge Basket' (https://www.knowledge-basket.co.nz/). Two news article sources were selected: Stuff (www.stuff.co.nz) and The New Zealand Herald (www.nzhearld.co.nz), which were, at the time of writing, New Zealand's two most visited online news platforms (Myllylahti, 2017). The CA search results were quantified and grouped by month to show periods of highest reporting on mental health. Articles for TA were taken from the most recent peak (May 2019) and trough (February 2019) in reporting. The search resulted in a total of 9238 articles. I then selected the twenty most relevant articles to the search criteria (based on descending order in the search results, whereby the top article was rated the most relevant to the search by Newztext).

Primary data analysis comprised TA of the thirty-eight articles identified in the preliminary analysis. TA was based on Braun and Clarke's (2006; 2014; 2019) six phases of TA, as in Study One. This analysis was oriented towards addressing the research question ('how are mental health services described in New Zealand news media?'); however, this study took an inductive approach, allowing for the best fit themes to emerge from the data, rather than seeking themes based on pre-existing research or ideas.

Findings

Study One

The aim of Study One was to understand young men's beliefs and attitudes towards mental health services, particularly regarding how these may affect help-seeking. Five themes emerged suggesting complex sets of beliefs and attitudes regarding services.

Participants stated that their knowledge about mental health services was limited, and much of it came from television and movies in the theme 'This is all based off what I know from television.' Based on previous literature regarding the characterisations of mental health services in television and movies (e.g. Maier et al., 2014; Orchowski et al., 2006), it appears that movies and television tend not to represent services in helpful ways, which suggests that if such media is the primary source of understanding for these young men, it may create misconceptions of what services involve.

Participants expressed a belief that mental health services should be a final resort, and that they preferred to 'deal with it' (i.e. to resolve a hypothetical mental health problem) themselves first. The theme 'Maybe just deal with it yourself first' suggests an autonomous, pragmatic masculine preference of coping. This finding fits with literature regarding the impact of hegemonic masculinities on help-seeking. For example, Cleary (2012) and Krum et al. (2017) argued that a normative masculine identity values independence, control, and repressed emotionality; all traits that participants' desire to deal with problems by themselves preserve.

Without lived experience of talk-therapy, participants compared talk-therapy to informal social supports such as talking with family and friends. They suggested that the primary benefit of talk-therapy was that it provided people with a safe and trustworthy space to discuss their problems when their informal supports were not providing this space. The finding that participants expressed that talk-therapy consists of peer-support type talking is similar to the findings of Midgley et al. (2016), who found that some young people expected talk therapy to comprise of a chance for them to talk about their problems.

Participants expressed concern about reliance on prescription medication in the theme 'Pills… to almost rely on them.' This finding seemed to reflect an overarching preference not to use prescription medication, which contrasts with some previous literature suggesting that men prefer medication over talking therapies (Harris et al., 2016). However, the results are equivocal as other studies have

suggested that men prefer non-medical options (Prins et al., 2008; Sierra et al., 2014), aligning with the findings of this study.

In the theme, 'Cause they're the doctor, they know – they know what's best for you,' participants expressed the belief that mental health professionals know better than laypeople do, and that their advice should be trusted. This theme demonstrated a tendency among participants to state they would accept what their doctor tells them, even, in some instances, when it goes against their own personal beliefs and attitudes.

Study Two

The aim of Study Two was to understand how mental health services are presented in New Zealand news media, in order to understand how these presentations may impact beliefs regarding services, and whether this impact may be a barrier to help-seeking.

The results of the initial content analysis demonstrated that the volume of news articles regarding mental health had a trend of increasing (albeit with notable peaks and troughs in reporting) over the past three years, particularly on NZ Herald. Four themes were identified in the thematic analysis of the news articles.

In the theme 'Positive attributes in people with mental illness,' articles presented what appeared to be a hopeful construction of people who had (or were in the process of) overcoming a mental illness. These articles tended to describe the challenges of mental health problems, and then contrast these challenges with the strengths associated with recovery. Attributes such as knowledge, courage, wisdom, and candour were associated with overcoming a mental health problem. This type of reporting was also found in North American news media by McGinty et al. (2016), though it was found in a minority of news articles.

The theme, 'Lack of mental health service capacity' reflected a type of article in which mental health services were presented as being stretched and unable to cope. The descriptions of long waiting lists to access services gives a bleak message that even with severe ('crisis') mental health problems, people in New Zealand must wait a long time to access services. The finding that New Zealand news media reports on inaccessibility of mental health services is consistent with McGinty et al.'s (2016) finding of American news articles reporting a similar message.

The theme, 'The Government needs to do more,' suggested a tendency in the news media to present mental health services as lacking funding and suggested that the public wants the government to fund more mental health services. Fitting with 'Lack of mental health service capacity,' this theme suggests that services are struggling due to underfunding. This finding also fits with the findings of McGinty et al. (2016), who found that American news media has commonly discussed issues of service funding over the 19 years of data they assessed. This suggests that news media discussion of funding issues, and framing of services problems as relating to government issues, is a common discourse.

The theme 'Commonality of mental health problems' presents mental illness as a pressing and growing concern in New Zealand. This finding appears to be somewhat novel in comparison with previous studies, which have focussed on framing the impact of mental illness (e.g. Blood & Hammon, 2004), rather than rates of mental illness. Therefore, it is unclear what effect this type of framing may have on public attitudes regarding mental health and services. It seems that framing mental illness as common could reduce stigma of mental illness; however, it also seems to offer little hope for positive outcomes

Clinical Psychology Internship

My internship, which commenced in January 2020, comprised working across two services – the adult community mental health service (CMHS) and child and adolescent community mental health service (CAMHS) at Taranaki District Health Board. I worked two days a week at each service over the course of a twelve-month contract. The following section presents my reflections of the impact of attitudes and beliefs upon service use and engagement, with an additional focus on the impact of gender (and other demographic factors).

Considerations on understandings of services, engagement, and masculinity

The process of my research highlighted to me the importance of considering clients' pre-existing knowledge of, and attitudes towards services. Throughout my clinical training, the importance of checking in with new clients on their experience with services has been noted; however, my research and clinical practice have demonstrated the complexity and breadth of this area. It is a simple question to ask a client 'Have you seen a psychologist before?' and although this question may lead to

fruitful information about the client's strengths, and attitudes towards services, it does not fully uncover the nuances of feelings and thoughts about entering a mental health services that may be constructed for this individual by their social context, age, gender, and expectations.

Throughout my internship, I have worked with both male and female clients. The proportion of male to female clients I have seen leans slightly towards a female bias, which may reflect the issues of male help-seeking and barriers to help-seeking noted in my research. Another initial point to note is that although there was only a slight bias towards females in my clinical practice, if I further split my clinical practice into those who I have seen for therapy and those who I have seen for assessment only (e.g. Autism Spectrum Disorder assessment, cognitive functioning assessment), the gap grows wider. That is, I saw significantly more females for therapy than I saw men. This (anecdotal) difference is a fascinating one for me; does it perhaps suggest that clinical psychology services are constructed as serving different purposes based on gender? Do our gender roles suggest that men should be assessed for a firm, concrete outcome of what is wrong with them, while women should be more gently walked through a softer process of therapy?

In my clinical practice, I have, of course, only seen males who have entered mental health services – and thus, I have no conception of who the men are who *do not* attend mental health services; understanding this group was the aim of my research project. Nevertheless, the men who I met through my clinical practice were all, at one point, men who had never entered a service. Therefore, it is useful to consider how they make sense of being men in mental health services, and how that aligns with their attitudes and beliefs. Based on my clinical practice, it was not clear whether a coherent set of themes or attitudes towards services was elicited in my male participants, rather it appeared that they each had different social contexts that informed their attitudes and beliefs.

Throughout my clinical practice, I saw much more nuance and individual difference in clients than could necessarily be attributed to gender. Perhaps this reflects the differences between aggregated data and individual experience. That is, although data comparing one million men and women (for example) would likely highlight differences in service use, emotional expression, and other areas of interest, these data-level differences are less apparent in individual interactions. I believe this

was also reflected in my research. In my research, I interviewed ten young men, and they told me ten different stories. Although there were commonalities (i.e. themes) across what these men said that connected their experiences, there were also differences. This acts as an important reminder of the care that must be taken when interpreting aggregate level data. Assumptions based on aggregate data may be useful at governmental and policymaking levels but may lead to unhelpful assumptions and even biases when dealing with individuals. For example, whilst the literature suggests that men tend to be worse at understanding and expressing emotion, which is likely true at an aggregate data level, in my clinical practice I met several young women who had significant and impairing difficulties in expressing their emotions and disclosing their distress beyond what some of my male clients displayed. This difference between data and individual differences speaks to the nuance needed in being a 'scientist-practitioner,' that is, whilst it is important to be aware of the data, it is also important to recognise any given individual is unlikely to be a 'perfect fit' with the inferences made by the aggregate data.

If I were to highlight the gender related difference in interacting with services that was most visible to me, it would be differences I saw in the parents of young people in mental health services. It seemed that there was few striking gender-based differences between the male and female clients who I saw, yet there were often obvious differences between the parents of these clients. It seemed that the mothers of children in services took a more active and engaged role in their child's care. That is, the mother would attend services and sessions (often taking time off work to do so), while the father would work. Likewise, when the male parent of young people was involved in the service (either through attending, or liaising), they frequently appeared to be more directive towards the service, and more pragmatic in their need for solutions. I can easily think of examples of male parents asking me questions such as 'when will they be fixed?' and telling me to fix their child as soon as possible. Such pragmatic, directive language evoked a metaphor of a car mechanic fixing an engine to me (though this may reflect my own gendered construction of the interaction). However, I must also be aware of the socially constructed nature of these interactions – first, it may be that I treated and responded differently to male parents, thereby creating the differences that I expected. Second, I must also be aware of confirmation bias regarding gender differences, as I am able to find

exceptions to my observations about female and male parents. That is, I can also think of examples of male parents being emotionally engaged and vulnerable in their child's treatment. Likewise, I can think of examples of female parents being directive and asking for practical, 'car-mechanic' type updates. It is likely a complex mix of genuine individual differences and socially constructed expectations based on gender roles created the differences that I noticed in the parents of service-users.

One of the useful lessons of my research for my clinical practice is the socially constructed nature of gender role expectations. Upon reflection, I am now able to point to a specific example where I constructed gender role differences. Early in the year I began working with an eight-year old male client. This client had previously been in the service and was known to disengage and storm out of sessions. Therefore, to better engage him and help him to establish rapport, I decided to hold our initial sessions in a basketball court where we could talk whilst throwing a ball around. This strategy proved effective and helped the young man to feel comfortable in a service where he previously felt very uncomfortable, and thus was successful. No doubt, this was a useful example of adapting services to a young man with negative attitudes towards service. However, upon closer reflection, I realise that I never offered such alternative service settings to any of the young woman whom I worked with. This may reflect an unconscious gender bias of offering sports as an alternative treatment setting to a young man, while not considering the same for young female clients, thus constructing gender role biases in my own practice.

To summarise, the similarities and inconsistencies between my research and clinical practice have taught me several important lessons for my clinical practice. First, client attitudes and expectations towards services are an important area to consider and address. I have seen clients from different cultures, age-groups, and genders apparently expect different things from treatment. Based on my research, and clinical best practice, it is important to explore with clients what they expect treatment to involve and what their fears might be, as these may impact their engagement with treatment. Second, although categorical gender differences are demonstrable in aggregate level data, it is important to be aware of the individual in clinical practice. Research regarding gender (and other demographic differences) provides a foundation and clues for issues to engagement that may be important to address; however, individuals will frequently misalign with such aggregate data, and

thus their individual needs and backgrounds must always be considered. Finally, while it is important to be aware of gender (and other demographic differences) in clients, it is also important to be aware of – and willing to challenge - how my gender attitudes and beliefs create such pressures and reinforce differences in practice through different treatment of clients based on gender.

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