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ORIGINAL ARTICLE

What discourses shape and reshape men's experiences of accessing mental health support?

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Abstract

The research employs a single embodied case study design with the aim to examine the discourse of men accessing and receiving mental health support alongside those who are the providers of the support. Three groups of adults were interviewed: men who had experienced mental health problems and had attempted to access mental health support; lay people who supported them, such as partners and non-mental health professionals and professionals, such as mental health nurses, social workers, clinical psychologists and general practitioners. Critical discourse analysis (CDA) is used to identify discourses around three emergent themes: well-being, power and dominance and social capital. Participants seeking mental health support often referred to mental health services as not listening or that what was offered was not useful. A lack of belonging and community disconnectedness was apparent throughout all participant interviews. The study is reported according to the COREQ guidelines.

KEYWORDS
critical discourse analysis, mental health, rural

INTRODUCTION

This paper focuses on men's experiences accessing mental health support in a rural setting. Various studies explore why men are reluctant to access mental health help (Ferris-Day et al., 2021; McIver et al., 2022); Scholz et al. (2022). A common theme that emerges in the literature is how men construct masculinity and how it affects health practices. These include men presenting as staunch and not being perceived as weak (Haynes et al., 2017; Li, 2022; Li & Gal, 2022). However, research has shown (Brenes et al., 2015; Brew et al., 2016; Fennell & Hull, 2018) that it is just as problematic for men and women to access mental health support, especially in a rural community, with gossip and the likelihood of everyone getting to know your business being the inhibiting factors. However, Moorthy (2021) questions, regardless of what mental health services are offered, whether they adequately meet people's needs. Rosenberg and Smith (2009) also comment that it is important to note that gender is just one factor among many when considering mental health disparities. Smith et al. (2018) suggest that focusing on similarities and differences between genders may obscure the actual lived experience of men. Other determinants invariably interact with gender, including socioeconomic status, healthcare access and life experiences, and all these need to be considered (Kutek et al., 2011).

Gluckman (2017) advocates for the need to design a well-being structure that is enabled by social investment. Such an approach goes beyond mental health and health. It addresses an entire community's needs, with Conrad and White (2018) emphasising that both men and women benefit from community connections and that connectedness significantly contributes to a person's well-being. This current study is set in a rural location and uses critical discourse analysis (CDA) to explore the experiences of men accessing mental health support. The research question is: What are the discourses that shape and reshape men's experiences of accessing mental health support?

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BACKGROUND

Over the last few years, New Zealand has had many reviews of its mental health services (Ministry of Health, 2018, 2021). All the reports have similar intent, using descriptors that include equity of access, no barriers to accessing support, no wait time and are 'flexible' to meet health needs. However, discussions on the challenges of accessing mental health and well-being support in rural locations are ongoing, and how to address such problems is varied (Hull et al., 2017; Malatzky & Bourke, 2018; Morales et al., 2020). Solutions include devolving responsibility from one service to another, such as the move away from big psychiatry and secondary health services to community-based or, as it has been coined, big community (Allison et al., 2019). The basis for such a move rest on the belief that large community initiatives will decrease the need for secondary mental health services. However, limited evidence supports this effect (Mulder et al., 2017). Yet, the general discourse continues to be that of increasing services, albeit moving services from one structural system to another and expecting there to be an improvement. Jorm et al. (2017) have argued that overall, there has been little improvement in the global burden of mental health challenges and that mental health early intervention or, indeed, prevention is piecemeal and has limited coordination. The impetus for this study is to examine the challenges associated with how and where men access rural mental health support. Instead of focusing on the obstacles, Marmot (2006) proposes that individuals should engage in their social environment, as this is essential for enhancing both health and well-being. Such a position is echoed by Gluckman (2017), who suggests the need to focus on the social determinants of health, with an emphasis on what is being offered. What do people need, and how accessible is the actual support? Accordingly, this research aims to examine the discourse of men accessing and receiving mental health support alongside those who are the providers of the support.

METHODOLOGY

The consolidated criteria for reporting qualitative studies (COREQ) were used to guide the reporting of this study. The research employed a single embodied case study and used critical discourse analysis (CDA) to analyse social action, text and social identity, seeking to uncover how power operates within discourses by examining how language is used to create and maintain power differentials. The study utilises two theoretical positions, social order and social order of discourse (Fairclough, 1993), alongside Foucault's positioning of power (Foucault, 1972, 1977).

Fairclough's social order and social order of discourse will provide an understanding of rural mental health's complexities, power dynamics and biases. Fairclough argues that discourse plays a crucial role in constructing and maintaining social order, with social order referring to power relations, social hierarchies and dominant ideologies (Fairclough, 2010). CDA allows researchers to examine how discourse contributes to the reproduction or transformation of power relations and social structures. This study also draws on the works of Foucault (Foucault, 1977, 1980) and how people's actions and attitudes are shaped by and shape dominant discourses. This includes identifying and defining a particular issue or topic as a problem within a specific historical and social context, emphasising the role of power in shaping and constructing knowledge. In CDA, problematisation enables researchers to identify the discourses that frame and normalise certain issues while marginalising others.

Fairclough's concept of social order and social order of discourses complements Foucault's (1977) analysis of power and how knowledge is controlled to shape and regulate societal norms; Foucault calls this the 'regimes of truth' that determines what is true in society by those in power (Cadman, 2010; Ravazzani & Maier, 2017; Zanoni & Janssens, 2015).

Fairclough and Fairclough (2018) stress the importance of researcher impartiality and their transparency in personal biases and political leanings. Regarding this study, Finlay's (2002) reflexive approach was utilised to examine the author's positioning. Reflexivity assisted the researcher in reflecting on how their actions, values and perceptions affected the research, including data collection and analysis (O'Leary, 2021). This was completed using diaries and memorandums, ensuring the researcher's personal perspectives were not lost. Yet, Savolainen et al. (2023) argue that research integrity rests more on methodological transparency and rigour and less on positionality. Figure 1 presents a pictorial representation of the methodology and the underpinning ontological and epistemological approaches used.

Data collection

Ethical approval to conduct the study was granted by Massey University Human Ethics Committee, Application 21/16 Southern A. All participants completed a consent process, with anonymity and pseudonyms used throughout the research and writing process. Both females and males were interviewed, with a total of 22 participants. Participants were between 19 and 85 years of age. The research questions that guided the conversations were as follows: How is mental health supported in a rural community? What is the experience of men accessing mental health support? How and why do men access mental health support services, and what is the family/ support people experience?

The interview schedules were open-ended but included prompt questions to ease the participants into telling their stories. These were 'What happened to you?

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Reflexivity (Finlay, 2002)

Philosophical positioning

Study design:

Single embodied case study

Ontology- (how we view the world- our reality)

Guiding theory: Foucault

- Problematisation
- Power

Guiding theory: Fairclough

- Social orders (macro, meso, micro)

Men accessing mental health support.

Analytical lens:

Critical Discourse Analysis

Epistemology (the knowledge that led to understanding the world)

What discourses shape and reshape men's experiences of accessing mental health support?

FIGURE 1 Research Methodology: Adapted from Byrne et al. (2021).

What is your story?'; for professionals, 'What is your role and how have you supported people experiencing mental health challenges?'; and for nonprofessional people, 'What is your story of supporting someone with mental health challenges?' This allowed the participants to have a free narrative associated with their experiences of receiving mental health support or providing support from a professional, for example, a mental health nurse, psychologist, counsellor or general practitioner. Throughout the interviews, follow-up questions allowed for clarification points to be raised or for the further expansion of the topic being discussed.

Data analysis

The researcher transcribed interviews verbatim using Otter software™, checked them for accuracy against the original recordings, made amendments and then printed copies. Finlay's (2002) reflexive practice model was used to ensure the researcher was explicit in reviewing and acknowledging personal influences that could influence the study and subsequent analysis. To aid the analysis process, the researcher followed Barbrook-Johnson (2022) suggestion of creating fuzzy maps, scrutinising each transcript, manually mapping out initial ideas and themes for the analysis process, coding the interviews and then presenting the ideas on paper. After this, each transcript was uploaded to Nvivo for further analysis (Nvivo, 2022).

A CDA framework was used to examine the narrative, including Fairclough's (2015) social order, addressing the interconnecting micro, meso and macro levels. The macro-level study included government-driven frameworks and policies. Mental health resources were at the meso level, focusing on localised context and micro the discourse of people receiving

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or providing support. For instance, social norms and structures at the macro level influence power imbalances. Understanding the interrelationship of macro, meso and micro levels allows for a more comprehensive analysis of the power dynamics and seeks to uncover how power is enacted and maintained through discourse. By examining language use, CDA aims to reveal how power is wielded, resisted and negotiated within social, political and cultural contexts. To understand social order, Fairclough (2015) suggested several questions: what is going on (activity, topic, purpose); who is involved and what are power relationships? To ensure a robust approach to the analysis and reporting, the COREQ checklist for qualitative data was used (Tong et al., 2007).

RESULTS

All participants in the study expressed challenges associated with accessing and or providing professional mental health support. The language used by participants included being desperate, often due to delayed access to accessing help. Support by partners was often fraught with challenges and occurred because no other help was available. Additionally, a high degree of mental health unwellness that people need to meet before receiving a service prevents many people from accessing professional mental health support. However, mental health professionals also felt frustrated as they had to prioritise help for some individuals while leaving others with no support. The results were indicative and associated with men aspiring to be heard and, in that respect, align with the work of Feo and LeCouteur (2013), who suggest that men desire to talk and be listened to. The focus of this section is primarily to present the micro elements of the participant's discourse with relationships to the meso and macro presented in the discussion chapter.

Three key themes emerged during the analysis: (i) well-being, with sub-themes taking control and feelings of belonging (ii) power and dominance, with sub-themes of roadblocks to receiving a service (iii) social capital, with sub-themes networks and community resources. The presented results elaborate on the challenges experienced.

Discursive theme 1: Well-being

The notion of well-being is a theme that emerged across all participant groups. It was common for partners of the person experiencing distress to arrange to attend initial appointments, such as a general practitioner. Principally, to voice concern or be the voice when they knew their partner would not express what was happening. However, the partner was often prevented from attending a joint appointment because of what would appear to be privacy issues. In essence, the partner's voice was being silenced; wait outside, the professional would address the problem; additionally, waiting outside purports the position of authority.

> **Extract 1:** 'The wife was going to be the voice piece of the husband, and what happened? The GP says oh well, it's actually to do with your husband, if you wouldn't mind waiting outside'. (M- professional mental health worker)

Well-being had a common theme associated with participants making sense of their own distress or their experiences of providing support. One participant, after many years in and out of mental health support services, stated that they chose to look at their life differently; it was from this perspective that fostered wellness, not previous intermittent support centred on crisis intervention. No participants commented on gender as an impediment to accessing support services; however, some men were encouraged to seek help by their partners. This was in the context of men knowing they needed help but citing the need to continue working and thus being unable to take time off work to see a general practitioner or health worker. However, well-being was also discussed in the context of belonging and people caring or, conversely, not caring. An element of this was people not feeling heard or connected to their community and not knowing how to access support or where to go.

Feelings of belonging

Needing to feel connected and part of a community was viewed as a goal that many participants wanted to achieve. For some participants, getting support and connecting with others was a major factor in their journey to wellness, with some participants noting that joining a group and talking about their mental health was a significant factor in improving their general wellness. It was important for many participants who had experienced mental health challenges to have the belief that people cared, which in many cases was no more than a phone call to see how they were doing.

> **Extract 2:** 'The most critical part of any journey to wellness is that connectivity, connecting to something and belonging'. (H- male mental health consumer)

Service

However, not all participants favoured joining a group, with one person commenting that it would be their idea of hell. Yet, having someone to talk to and not feeling lonely significantly fostered overall well-being. Being part of a community and having strong social ties were

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seen to aid overall well-being; just being listened to and feeling that people cared was seen to be an invaluable resource. Strong family connections were also an essential connecting point for many men who had experienced mental health challenges.

Taking control

For well-being to emerge, taking back responsibility for their wellness was important. This shift in mindset empowered individuals to take ownership of their mental health journey, acknowledging that they had an active role in maintaining their well-being. Many participants spoke about receiving professional support that was of little use; change occurred when confronted with continuing down a path that was not useful or taking ownership.

Extract 3: 'He wanted to change. And despite seeing all the professionals, you know, everyone was trying to help, but nothing was helping. And then I feel he had to get to the point that I'm about to lose my wife and kids. He decided that he wanted to get better, he'd had enough of it, he could see, you know, where this was potentially heading, and he didn't want a trip in that direction'. (J-wife of mental health consumer)
Extract 4: 'I didn't talk to anybody about it until the kids started telling me I needed to do something. So, I told my daughter, who told the rest of the family, then I listened, and yes, I needed help'. (C-male mental health consumer)

Discursive theme 2: Power and dominance

The discursive theme of power traversed all participants. All participants acknowledged the service they gave or received was sometimes neither creative nor useful. Such positioning aligns with the work of Fairclough (2015), who recognises that those with power can exercise and keep it through coercion, including the role of language in maintaining unequal power.

Extract 5: 'I was stressed out, and I even went to my manager to alert her I was suicidal, to which she responded, sorry, that's not my problem. I need you here to work'. (T-male mental health consumer)
Extract 6: 'When I first reached out and asked if I could talk to someone, they told me it would be a seven-week wait to talk to someone, which is not what you want to hear when you're thinking about suicide'. (J-Male mental health consumer)

Both extracts show men reaching out for help but not receiving it in a timely manner. The relationship between language and power is not neutral but rather a tool used to construct and perpetuate societal power dynamics and how certain groups or individuals are marginalised or empowered through language use. Language can reinforce and perpetuate discrimination and maintain power imbalances, or it can foster understanding and empower marginalised voices. Milyavsky et al. (2017) comment that professionals expect that their expertise will justify their dismissive behaviour, with the receiver feeling dismissed when they perceive that providers were rude or did not take action (Hildenbrand et al., 2022).

Participants had a universal voice of wanting to be treated respectfully and heard. Men voiced challenges of reaching out for help; the support offered often meant being put on a waiting list to see someone in the future, and if things got worse, they could be referred to another agency, hopefully, to be seen earlier. An example of the latter includes one participant being referred to a mental health agency whilst on the waiting list to be seen by another. When they saw him, they told him he did not meet their criteria. After that, he returned to his original service and was placed further down an even longer waiting list.

Roadblocks

Many participants referred to the challenges of accessing professional support due to not being unwell enough to meet the threshold to be seen. Additionally, some participants noted that the low number of mental health professionals in the study region made it difficult for participants to receive timely and appropriate care for their mental health needs. Yet, the consistent message from government reports is one of improving access to mental health services.

Kia Manawanui report states it aims to ensure people and whanau have their basic needs met, know how to strengthen their own mental well-being, and live in communities with diverse, well-integrated avenues for support when and where it is needed (Ministry of Health, 2021, p1).

Several participants did attempt to access mental health services by trying to visit their general practitioner (GP). However, in many instances, the wait time to see a GP resulted in a three-week wait to receive an appointment. Participants also commented that even if they see a GP, accessing formal mental health support is also fraught with challenges and is exacerbated by the rurality of their location.

Extract 7: 'We have struggled to retain psychologists in the public mental health system. So, there's not as much intervention as there used to be I'm not saying it's not there, but usually, only the very acutely unwell get seen, or when the person has reached a tipping point. (M- mental health professional)'

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Discursive theme 3: Social capital

Social capital is associated with the characteristics of social organisation, networks and rules that facilitate coordination and cooperation for mutual benefit, trust, community solidarity, social relationships and shared values (Crowther et al., 2019; Flores et al., 2018). Community connectedness is promoted by the Kia Manawanui report (Ministry of Health, 2021), yet participants note many ongoing challenges, such as struggling to find and receive help. Fuelled by issues pertaining to lack of support in locations that are accessible and meet the needs of those needing help. However, people often discussed topics such as stigma, which made them not want to attend services or seek support. This was because of the potential that people they know may work or be associated with the service.

> **Extract 8**: 'They don't like being referred to certain agencies in the community because of their aunt, uncle, grandmother, or relative who works at that organisation'. (J- Mental health professional)

Although participants voiced concerns about other people knowing their business or the reluctance to be referred for support because of the chance that others may know, such positions were not universal. In the discussions with participants, people were investing in their own capital to find meaning and solutions to distress, and they were working around the obstacles that impeded growth.

> **Extract 9:** Once we knew he would survive, it was. Let's get through this journey. Let's just do what we have to do. (R- wife of mental health consumer)

Networks

Personal networks and connections to the people and resources around you were seen as pivotal. Many participants did not know who the professional mental health was or how to contact them; many participants saw community connectedness through personal and local networks as central to the cohesiveness of a community. Knowing who they could contact and who they would feel safe with.

> **Extract 10:** 'It is the fact that it's an hour's drive to places where cell phones don't work in other places. And so, there are a whole lot of things like that. Yeah, texting a mate here is easy, but if you're outside cell phone coverage that doesn't work, especially the outlying rural areas which are isolated, small, tight communities'.

Another participant commented.

> **Extract 11:** 'The thought of talking to someone I didn't know about my problems just made it worse. So, we're not just looking for professionals all the time; it is that lower level of support, you know, looking after the family, or friends looking after friends'. (C-male mental health consumer)

Community resources

Community resources were discussed by many. Most commented on the lack of a cohesive approach by the different agencies and support systems, with poor coordination and communication central to most discussions. Yet, rural communities often rallied around offering help when a situation became significant. A common discussion by most participants on community resourcing was what they would like to see developed.

> **Extract 12:** 'I'd like to completely change mental health services to become models about well-being and community engagement. What we need is youth services, parenting services, education and community involvement councils, and church and police'. (R-male mental health consumer)

One participant also commented on their belief that some professional services focused on a medicalised approach to mental health problems rather than addressing the socioeconomic underpinnings.

> **Extract 13:** 'I think we were looking at the wrong end, you know, we're looking at medicine. The damage has already been done. You know, the number of children that go through such a difficult time growing up, and, you know, the social problems exist, and the effect it has on the kids. Now, those kids go through such a horrible time in adolescence; what makes you think they can have a great time for the rest of their lives? I mean, it just, you know, sets the foundation for distress'. (P-mental health professional)

DISCUSSION

The purpose of this study was to examine the discourse emerging from men receiving mental health support and the people who support them. The study is couched within a case study and is bound within a specific geographical rural area. The analysis is limited to the region and the study's time frame. The analytical framework is embedded in the concepts of Foucault's micro capillaries of power, such as flexibility, diversity and choice, using various interim stages, including micro, meso and macro. According to Fairclough (2015), power is a commodity that represents social struggles, with CDA

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examining whose interests are being served and whose are being ignored.

Participants were largely universal in expressing language that was demonstrative of being let down by the systems designed to be supportive and accessible. The Ministry of Health (2021) Kia Manawanui New Zealand report proclaims: 'Our future approach will enable free and immediate access to a range of support options…designed with communities and tailored to their needs' (p28). Local service delivery also iterates such a position. Yet, there are examples of people being unable to access support (Cardwell, 2021; Meier, 2021), similar to many of the study participant's experiences. Mental health reports call for greater community connectedness and state that the government's role is more of an enabler; however, there is no clarity regarding what enables self-help or how communities become connected.

Participants in this current study discussed failing to get mental health support when they did not meet the threshold of unwellness. Bourgois et al. (2017) discuss such a position in the context of structural vulnerability, whereby structural factors, health and social inequality result in people being disadvantaged. Yet, various professionals also relayed their dismay at being unable to provide what was needed and wanted, constrained by the systems imposed upon them. It is on this point that Foucault (1977) recognises such constraints, discussing that the discourse of power does not just affect the oppressed but also the oppressor. Foucault (2009) suggests we should question and challenge the taken-for-granted assumptions and norms that govern social practices and institutions rather than accepting assumptions as natural or inevitable. Foucault's problematisation involves identifying the historical and social conditions that give rise to specific problems or issues. He emphasises problems are not inherent but are constructed through discourses and power relations. By problematising a particular issue or practice, the underlying power dynamics and how knowledge and power are intertwined become apparent (Foucault & Gordon, 1980).

Fairclough (2015) also proposed that discourses in social order, like health care delivery, become normalised and people accept the system they are given. However, all three groups of participants in this study raised concerns about the delivery of health services, explicitly mentioning barriers to receiving mental health support, such as not meeting criteria for admission and services not being accessible in localities that were accessible.

Drawing on Foucauldian concepts of power, the notions of Foucault's interpretation of parrhēsiastes are apparent (Foucault, 2005, 2011). For Foucault, parrhēsiastes involves voicing concerns to bring about meaningful and enduring social transformation. However, the researcher, in interviewing participants, noted participants were comfortable expressing concerns but restricted them to the privacy of the conversation and were reluctant to voice them in public or professional forums. Mental health professionals feared potential repercussions if their opinions were revealed, and participants worried that expressing the lack of help received could negatively affect their future needs.

According to Fairclough (2015), the practice of individuals inside a social structure involves accepting and perpetuating common regulations within a social order. Maftoon and Shakouri (2012) contend that tensions arise only when conflict happens, accordingly, the discourse-analytic investigation seek to make explicit the transition or movement between the micro and the macro. Adopting a micro–meso–macro trajectory to examine power helps to determine the global or macro-strategies of domination through micro-discursive practices. Within the study region, the macro discourse of the government presents itself as transformational. Foucault (2011) discusses such a position with a government encouraging its citizens to be responsible to each other and to be as self-sufficient as possible; however, Foucault and Gordon (1980) have argued that this stance is solely to reduce their government's financial liability.

Reports such as the Kia Manawanui (Ministry of Health, 2021) refer to community connectedness and devising ways to find their own solutions. Yet, in the region where the study was conducted, at least one community had funding withdrawn that was previously used to enhance social connectedness (Ministry of Social Development, 2023). Community connectedness and the importance of having diverse local opportunities to socialise, engage and interact with others are pivotal in addressing overall well-being. Potter et al. (2018) highlight that mental health extends beyond being solely a health issue; it is a complex matter encompassing various interconnected challenges, including housing and community disconnection. Hooper et al. (2020) also discuss such a position, identifying the need to develop communities that bring people together, arguing that the focus should be less on creating new services and more on prioritising the building and development of interactive and connected communities.

Strengths and limitations of the study

The study sits within a bounded case study and is not representative as to what may occur in other regions. The researcher's awareness of assumptions and biases is implicit within the study's overall design. It presents a detailed understanding of multi-layered contextual factors, including dominance, the oppressed and the researchers' perspectives. To address the methodological critiques regarding self-selecting data, including news archives, semi-structured interviews and national and local government policy, the researcher engaged in a reflexive process that included memoing and diary completion that became part of the overall CDA.

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Conclusion

The study emphasises the factors that affect the provision of mental health support, including people's experiences, backgrounds and world perspectives. The findings suggest that discursive formation has opposing discourses within an assemblage, including social, cultural and political contexts. This study highlights the need for a more nuanced and inclusive approach to mental health support in rural contexts. Ensuring community connectedness is at the heart of service creation is central to people receiving meaningful support that actually meets people's needs.

RELEVANCE FOR CLINICAL PRACTICE

Clinical and well-being support for people experiencing mental health challenges is essential. Yet, despite repeated reviews, general improvements in service delivery to address mental health remain problematic. Mental health services and support systems need to be integrated into accessible community structures. Rural locations have challenges, often associated with services being in centralised areas, and therefore disadvantage people's access. Mental health clinical services are only part of the solution to address well-being challenges. Rather than advocating for more clinical services, clinicians need to advocate for a greater emphasis on community connectedness that fosters belonging and early intervention instead of being clinical gatekeepers that only provide for the most unwell.

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CONFLICT OF INTEREST STATEMENT

Dr Andrea Donaldson is a peer reviewer for the International Journal of Mental Health Nursing.

DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

ETHICS STATEMENT

Full ethics approval has been granted through Massey University Ethics committee: HEC: Southern A Application SOA 21/16.

PARTICIPANT CONSENT

Each participant consented to the research as per ethics approval- no identifying information is present.

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